Court File No. COA-25-CV-0166

COURT OF APPEAL FOR ONTARIO

B E T W E E N:

KRISTEN HEEGSMA, DARRIN MARCHAND, GORD SMYTH, MARIO MUSCATO, SHAWN ARNOLD, CASSANDRA JORDAN, JULIA LAUZON, AMMY LEWIS, ASHLEY MACDONALD, COREY MONAHAN, MISTY MARSHALL, SHERRI OGDEN, JAHMAL PIERRE, and LINSLEY GREAVES

Appellants

- and -

CITY OF HAMILTON

Respondent

APPELLANTS' APPEAL BOOK AND COMPENDIUM – VOLUME 11

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Court File No. CV-21-00077187-0000

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

APPLICATION UNDER 14.05 OF THE *RULES OF CIVIL PROCEDURE*

AFFIDAVIT OF SHARON KOIVU

I, Sharon Koivu, of the City of Port Stanley, in the Province of Ontario, AFFIRM:

1. I am a physician practicing in Ontario. I have been retained by the law firm of Gowling WLG (Canada) LLP on behalf of the respondent to provide an expert opinion in this matter. This Affidavit contains matters that are within my personal knowledge and professional expertise. Where my knowledge is based on information and belief, the source of that knowledge is identified.

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City of Hamilton Land Acknowledgement

2. 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.

3. Today, the City of Hamilton is home to many Indigenous people from across Turtle Island (North America).

Background and Qualifications

4. I have been a physician practicing in Ontario for 39 years. I have been an Addiction Physician for 12 years. I have my Certificate of Added Competency in Addiction Medicine from the College of Family Physicians of Canada.

5. My work as an Addiction physician has been primarily providing inpatient Addiction Medicine Consultations for inpatients in both urban and small urban hospitals, London Health Sciences Centre (LHSC) and St. Thomas Elgin General Hospital (STEGH). The patients that I see are admitted to hospital and have a substance use disorder. The reason for the admission may or may not be related to their substance use.

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6. From 2012-2021 I was the sole health care provider offering Addiction Medicine Consults at LHSC. From 2023-2024 I have worked as part of an Addiction Medicine Consultation Team in LHSC, and I remain the sole Addiction practitioner in the STEGH.

7. I also served as an acting Medical Officer of Health in Elgin-St. Thomas for 10 years and have experience in Public Health. I have been a Lawson research scientist. I am an Assistant Professor at Western University and have been responsible for teaching, Addiction Medicine, Palliative Care, Chronic Pain Management, Medical Ethics and Indigenous Cultural Safety.

8. I have been involved in numerous committees addressing the opioid crisis including the Community Opioid Overdose Prevention Program: Middlesex London Health Unit, Opioid Crisis Working Group: Middlesex London Health Unit, Opioid Use Disorder Standards Advisory Committee: Health Quality Ontario, Preventing and Managing Infectious Disease Among People Who Inject Drugs in Ontario: McMaster University Health Forum.

9. I have been a volunteer member of numerous organizations, including Street Level Women at Risk Committee, London, the London Homeless Coalition, the Sexual Assault Centre, London, Canadian Mental Health Association, St. Thomas, Violence Against Women Services, St. Thomas Ontario, Physicians for Social Responsibility the Canadian Society of Addiction Medicine.

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10. Many the patients that I see are vulnerably housed or experiencing homelessness. I have seen patients who are living in homeless shelters in tent encampments and in both environments.

11. Additionally, I lived in a neighbourhood in London within 1 km of London InterCommunity Health Centre in which many encampments formed. I regularly walked in the area and spoke with people living in the encampments, often providing food, clothing, sleeping bags or other essentials.

12. A copy of my curriculum vitae is attached hereto as **Exhibit "A"**.

Duty of Expert

13. My executed Form 53 in respect of my opinion is attached hereto as **Exhibit "B"**.

14. Additionally, I confirm I have reviewed Rule 4.1 of the *Rules of Civil Procedure* with respect to the duty of an expert.

Instructions to Expert and Scope of Opinion

15. I have been asked to provide my opinion, from the perspective of my area of expertise, with respect to health outcomes for people experiencing homelessness who live in encampments, as compared to in shelters.

16. My opinions, findings, and conclusions are set out below under three main headings, namely:

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(a) Opinion on health outcomes for people experiencing homelessness who live in encampments, as compared to in shelters;

(b) Comments on opinion evidence (affidavits) of the Applicants' witnesses;

(c) Final Comments

17. The numbered references in superscript in my opinion below correspond to the list of Works Cited attached hereto as **Exhibit "C"**.

Opinion on heath outcomes for people experiencing homelessness who live in encampments, as compared to in shelters

18. Homelessness currently is a complex crisis in Canada. Encampments have developed as a response to this crisis. Unsheltered people experiencing homelessness have a 2.7-fold increased risk of mortality compared to those who are sheltered.[15] Encampments pose extensive health and safety risks to the people living in the encampments as well as public health and safety risks to the community.[2,3,4,6,7,8,15,18,44,45,49] They are not a safe alternative to housing or to a shelter.

19. There are significant health risks to all people experiencing homelessness. There are some particularly serious risks associated with living in encampments. I would like to address risks that I have witnessed as a physician, risks that I am aware of from the literature and the media, and risks that I have observed living near encampments.

20. There are significant health risks to those living in encampments due to exposure to the elements. While extreme cold increases the risk, injury and death can occur in moderately cold temperatures.[20,21,22.] I have seen numerous patients who developed

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serious frostbite. At times this has led to the loss of fingers, toes, feet. I have had patients who have required bilateral leg amputations due to injury from frostbite. This form of tissue damage is extremely painful. These physical injuries are life-altering make people even more vulnerable. Gangrene resulting from frostbite can lead to sepsis and death.

21. Hypothermia, a decrease in body temperature from exposure to cold temperatures, is a problem in encampments and can lead to cardiac arrest and death.[24,25]

22. The risk of these injuries is increased in people who have a prolonged decrease level of consciousness, such as using sedating drugs including opioids, benzodiazepines and alcohol.

23. Trying to stay warm while in an encampment can lead to dangerous practices. I have had patients who have received severe burns from tent fires. These have included burns which have made their face unrecognizable, and have involved large areas of their body, leading to damage of function of extremities. I am aware of several people dying in tent fires. [26,27,28.]

24. Fires are also uses for cooking. This can occur all year long. People in encampments are at risk of burns from fires beyond the winter months.

25. I am aware of risks from propane tanks used to heat tents, including explosions causing injury and death and carbon monoxide poisoning.[29.]

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26. In June of this year a tent at an encampment in Hamilton was set on fire as a targeted, violent attack. It was not anti-encampment statement. It illustrates risks of violence to people living in an encampment.[30.]

27. Prolonged exposure to damp and wet conditions can lead to another painful condition, a non-freezing cold injury, trench foot. I have seen trench foot complicated by skin breakdown and infection. Complications of trench foot can lead to amputation.[31.]

28. Adverse weather events, including windstorms and lightning are dangerous to people living in encampments. Windstorms can destroy tents, lead to broken tree branches, and blowing debris that can cause injury and death.[33] I have had a patient who was killed by a falling branch. Lightning can strike a tent, tree, or the ground and cause harm.

29. Heat exposure also poses risks for people in encampments. Extreme heat can result in heat stroke.[32] Heat, without accessible water can cause dehydration. Excessive heat exposure and dehydration can cause a very serious condition called rhabdomyolisis. Rhabdomyolysis is a condition in which there is skeletal muscle tissue breakdown and cell death.[17] This causes the release of various substances into the blood that can damage the kidneys.

30. Severe dehydration and overheating accelerates muscle breakdown. Kidneys are unable to dispose of the body's waste without plenty of fluids. This can cause kidney failure.[17]

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31. Rhabdomyolisis can also occur directly as a direct result of drug use such as Methamphetamine[10,13]. The combination of heat, dehydration and Methamphetamine increases the risk of kidney failure. I have seen patients require dialysis as a result.

32. Tissue damage, particularly from lying in one place for an extending period, can also cause rhabdomyolisis and kidney failure. The risk of these rhabdomyolisis increases in people who have a prolonged decrease level of consciousness, such as using sedating drugs including opioids, benzodiazepines and alcohol. Complications of heat, dehydration and drug use can result in death.[17.]

33. Rodents pose serious risks to people living in encampments and to neighbouring communities. I had a patient who woke after opioid use to discover that they had damage to their face. It is believed that the damage was most likely caused by a rodent attack.

34. People in encampments are at risk of infectious diseases carried by rodents.[34,37,39.] Many infections are caused by exposure to rodent droppings or urine. These include Hantavirus which can cause Hantavirus Pulmonary Syndrome. Rodents can also be the source of other infections including Lyme Disease and Rat-bite fever. These harms can be spread to neighbouring communities.[7,15,35,36]

35. Rodents can also be a source of rabies. Fortunately, rabies is rare in Ontario. However, I have had an unhoused patient who was bitten by a skunk and required Rabies shots.

36. While people have expressed the benefit of having a dog in an encampment, I have seen patients who have had serious dog bites. These have included bites to the

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face, hands and forearm. There are also example of dogs posing a danger to people working in areas where there are encampments. Children could be at risk if encampments are in parks or near playgrounds.[40.]

37. Due to lack or inadequate sanitation, people in encampments are at risk of developing infections spread through feces. There are examples of Hepatitis A outbreaks in encampments.[2,7,41.]

38. Viruses, bacterial, fungal and parasitic infections can spread through feces. Some can be severe, even life-threatening, particularly combined with malnutrition or dehydration.[15,18]

39. While living in the neighbourhood in which an encampment formed it was common to see feces on the back steps and front entrances to businesses. This puts the community at risk of acquiring infections through fecal contact.[3,42.]

40. Body fluids, including blood and urine, can also spread infections. Blood is more likely to be present in areas of violent assaults such as stabbings and where there is inadequate access and disposal of menstrual products. Sharing needles and paraphernalia increases the risk of spreading blood borne infections including HIV and Hepatitis C. Improperly discarded needles and contaminated products poses a risk to people in the encampments, including people living there, working, walking through or playing in the area. While transmission of HIV or Hep. C from a needlestick injury would be much less in the community than in a hospital setting as these viruses generally do

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not survive outside the body for very long, a needlestick injury can be very stressful and require bloodwork.[4,8,12,18,39,41,43,49,54.]

41. In my experience injection drug use in encampments increases the risk of infectious complications, including sepsis likely because of the unsanitary conditions and the method of using the paraphernalia.[1,48.]

42. While there is a lack of the environmental impact on urban homeless encampments there is an indication that they may contaminate urban surface water which can be a risk for people in the encampment and community.[3,42.]

43. Porta-potties are now often installed to mitigate the risk of fecal contamination. If not kept clean they can be a site of transmission of bacteria, viruses and parasites including Ecoli, Norovirus, Salmonella and hepatitis A.[2,7.]

44. There are numerous reports of people dying from overdose deaths in porta-potties.[46,47,48.] They get hotter than the outside air by several degrees making the risk higher if people take a sedating drug in a porta-potty during extreme heat. The municipality of London installed a porta-potty to support an encampment. It was set on fire shortly after the installation which created additional safety risk.

45. People experiencing homelessness are more at risk of developing other serious communicable diseases than the generally population. Additionally, they have a higher mortality rate from these diseases than someone in the general population who acquires the same disease.[7,15,18,19,44,45.] Reportedly, a Thyphus outbreak have been associated with an encampment.[7] Other illnesses include respiratory illnesses such as TB,

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Coronavirus, influenza as well as skin infections such as scabies and lice. Many of these conditions can occur in both encampments and in homeless shelters.[7,15,18,41.] However Homeless shelters can put safeguards in place to mitigate the risks, including social distancing, masks, and using clean linen which are not available in encampments.[11]

46. People experiencing homelessness have a higher incidence of many chronic diseases than the general population.[15.] A study in Vancouver compared chronic physical health conditions among people experiencing homelessness who were sheltered with those who were not sheltered including living in encampments. Those not in shelters has a statistically higher incidence of many conditions including neurological disorders, musculoskeletal disorders, long-term illness such as cancer, diabetes and anemia, gastro-intestinal disorders, cardiovascular disease and sensory disorders including glaucoma, cataracts and hearing loss when compared to those in shelters. There were no instances where being in a shelter posed a risk over not being sheltered.[9] This study is consistent with my experience.

47. People who experience homelessness are often victims of physical violence, intimidation and threats of physical violence. While violence can happen in shelters, in my experience people living in encampments have a higher risk of violence, and the violence is more severe.[30,55,56,57,58,] I have seen many patients who have been victims of stabbings and beatings. I have had many patients, particularly women and those with physical disabilities tell me that they are threatened with violence if they do not relinquish much of their prescribed opioids, “Safe Supply”. I have had patients tell me that they would rather risk having an overdose death from smoking illicit fentanyl then risk getting

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an infection, such as a spine infection, from injecting regulated drugs such as Dilaudid, as having a disabling infection makes them vulnerable. I have had patients who have developed a severe disabling infection such as a spine infection causes a gait disturbance or have lost a fingers or feet to frostbite express who expressed fear of being discharged back into the encampment because the physical disability changed their position in the (hierarchy of the) community and made them vulnerable to violence.

48. I am aware that encampments in Hamilton have been the sites of violence including stabbings, beatings, shootings, theft and a tent being set on fire.[30,55,56.]

49. Sexual violence, sexual exploitation and sexual traffic are real concerns in encampments. I have had a patient inform me that they were sexually trafficked. The CEO for Oneroof, an agency that has offered youth services in Kitchener has expressed concerns that girls as young as 12 are being groomed for sexual trafficking at a local encampment.[52,53,54.] One of the negative consequences of this sexual abuse is sexually transmitted illnesses (STI's). STI'S are more common in people who experience homelessness than the general population. Among the homeless population the rates of all STI's are higher in in women and girls than among men and boys, including HIV, syphilis, chlamydia, and gonorrhea providing supporting data that women and girls are vulnerable to sexual exploitation.

50. While sexual violence can happen within a shelter, shelters generally are often age and gender specific and have staff available to safeguard against such occurrences.

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51. People experiencing homelessness have a higher incidence of mental health issues than the general population. The Canadian Mental Health Association estimates that 25 to 50 per cent of homeless people live with a mental health condition.[51.]

52. The Homeless Hub states:

> "People with poor mental health are more susceptible to the three main factors that can lead to homelessness: poverty, disaffiliation, and personal vulnerability. Because they often lack the capacity to sustain employment, they have little income. Delusional thinking may lead them to withdraw from friends, family, and other people. This loss of support leaves them fewer resources to cope with times of trouble. Mental illness can also impair a person's ability to be resilient and resourceful; it can cloud thinking and impair judgment. For all these reasons, people with mental illness are at greater risk of experiencing homelessness.
>
> Homelessness, in turn, amplifies poor mental health. The stress of experiencing homelessness may exacerbate previous mental illness and encourage anxiety, fear, depression, sleeplessness, and substance use."[50.]

53. I have witnessed problems resulting from this vulnerability. People with Mental health issues are often exploited. I have had patient with severe mental health issues who have much of their prescribed opioids taken from them. Patients with poor mental health are more likely to be sexually exploited.

54. The location of encampments can also be problematic. People are attracted to areas that are not safe to be, both for people living in the encampments and the

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surrounding community, because of the presence of diverted drugs. When there was significant drug diversion occurring in the community, encampments formed near a pharmacy in which I was informed that much diversion of prescribed opioids took place. This is an area with no greenspace with multiple adjoining parking lot behind local businesses. I had patients who had been housed who left their homes and apartments to live in the encampment. They advised me that they had moved to the encampment because diverted prescribed opioids were cheaper and more plentiful at this location than farther from this source of diversion.[65,66.]

55. Homelessness, addiction and mental health are very complex and often interconnected.[50,51.] A number of my patients came from middle class and affluent families locally or in other regions Ontario. Some were not able to live at home with their families. Some had relatives who wanted them to come home. Some chose encampments instead of shelters even when they were available. Some were not allowed to return to any shelter, often because of a violent history.

56. Frequently patients expressed being attracted to the encampments because of the lack of restrictions on drug use and absence of rules.

57. I observed deterioration in physical and mental health in people who moved into encampments. For many people this led to bad health outcomes and even death.

58. Most patients reported an increase in drug use in encampments They were also less likely to practice safe techniques when using paraphernalia or attend the supervised injection site. The amount of drug use increased. Patients reported progressing from

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prescription opioids to illicit fentanyl. Patients, even those whose drugs of choice were opioids, reported a high use of stimulants, particularly Methamphetamine to stay awake to protect themselves from assault or theft. This led to a further deterioration in their mental and physical health and increased risky behaviour.

59. Hositalized patients who expressed interest in recovery advised me that recovery was essentially impossible within an encampment. Drugs are accessible, available and cheap.[64,65,66.] Regular exposure to drug use is a trigger making recovery not feasible. I have also heard from people who were not living in encampments that exposure to public drug use has been a trigger that contributed to a relapse. Studies on tobacco have shown that when smoking is normalized and allowed in public places it increases the risk that youth will smoke. This contributed to banning cigarette smoking in and around playgrounds.[5.] While it is important to end stigma of addiction, public drug use will have negative consequences to people in encampments and the community.[5459,60,61,62,63.]

60. Encampments pose extensive health and safety risks to the people living in the encampments as well as public health and safety risks to the community. They are not a safe alternative to housing or to a shelter.

Comments on opinion evidence (affidavits) of the Applicants' witnesses

61. I value the knowledge and compassion expressed in the Affidavits that have been provided to me.

62. A list of the Affidavits that have been provided to me is attached as **Exhibit "D"**.

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63. Many suggest that tents are a safe, alternative to shelter. This includes the Affidavits from Kate Hayman, Stephen Hwang. The Affidavit from Aaron Orkin suggests that tents are a healthy choice.

64. Tents do no provide adequate protection from the environment to prevent serious harms. They also increase the risk of many infectious diseases, burns, injury from animals and rodents, sexual exploitation and assault.[2,6,7,9,15,18,19,20,21,22,24,25,26,27,28,29,31,32,34,35,37,39,40,41,42,44,45,49,52,53.]

65. Encampments are a significant public health risk to the people living in them as well as the surrounding communities.[2,3,4,5,6,7,8,12,15,18,19,34,35,36,37,39,42,44,45,48,49,54,59,60,62,63.]

66. The Affidavit from Claire Bodkin suggests the remaining in a tent would have prevented frostbite and its complications. The patients that I have had with severe complications of frostbite were in tents.[20,21,22,24.]

67. The affidavit from Kaitlin Schwan brings up the important issue of the special needs of women and gender diverse women. She stated that some women feel safer in an encampment when compared to a shelter. Feeling safer and being safer are very different. There are very high risks for women and gender diverse persons in encampments which include sexual exploitation.[52,53,] Additionally, women are overrepresented in the patients that I have seen with severe injuries from the elements.[9,15.]

68. Andrea Sereda mentioned the important issue of community services including Home Care Nursing PSW, Physio or OT. These services are generally available only for

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people with an address or people must go to services which can be difficult experiencing homelessness. Fortunately, a shelter is an address, and these services are regularly provided to people in homeless shelters. She also brought up many issues which demonstrate the challenges that health care providers working in a hospital setting face. I agree that stigmatization has been a significant problem and many marginalized patients have had experiences with health care providers that they feel are traumatic. I have also witnessed significant improvement and the vast majority of health care providers that I have worked with in a hospital are compassionate, caring individuals who provide excellent care. Hospitals can be intimidating environments. Most health care recommendations are made to improve outcomes while meeting the patient's gaols of care. For example, research showed that patients with Tricuspid Valve Infective Endocarditis, as a complication of Injections drug use, had a longer life expectancy if they did not have surgery than if they had surgery.[16] Infecting a Peripherally Inserted Central Catheter (PICC line) by injecting an unsterile drug into it could worsen outcomes as PICC line as PICC lines are inserted into a vein near the palm side of the elbow and extend to near the heart[14]. Unfortunately, community health care providers often do not appreciate the complexity if inpatient care. When patients return to the community, community health care providers at times promote the stereotype that hospital care is not compassionate. This can itself traumatize a patient. It would be healthier for the patient if community health care providers attempted to understand and support hospital health care providers instead of assuming and propagating a negative narrative as appears in this Affidavit.

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69. I agree with Ameil Joseph that marginalized people require equity and equality, not further marginalization. However, I do not agree with his conclusion. Believing that encampments are an acceptable place to live is a form of marginalization and colonialization. From living in a community in which encampments formed while I was there that had not been there previously, and from seeing multiple media reports of concerns of people living near encampments, living in an encampment further alienates people, and adds to stigma.[54,59,60,61,62,63.]

70. Dr. Rachel Lamont gave affidavits regarding patients she has cared for. I have not provided care for these people and have not had access to any other medical records. I do not feel that I have sufficient information to have a medical opinion. I do note that she referred to one patient as having “severe suicidal ideations” and another “contemplates suicide regularly”. If she believed them to be suicidal, under the Mental Health Act of Ontario, she would be required to proceed with either a voluntary or involuntary institutionalized assessment at an appropriate facility. I do not see that that took place which would indicate she did not feel that the patients were at risk of suicide.

71. Jill Wiwcharuk gave Affidavits on people she has cared for. I have not provided care for these people and have not had access to any other medical records. I do not feel that I have sufficient information to have a medical opinion. She states for one patient Casandra Jordan that she a significant burn to the back of her leg. The cause is not clear but is consistent with a tent fire. She states that one patient, Cory Monahan had a “desperate desire to be housed,” reinforcing the goal of housing. I note that she does not mention offering patients Buprenorphine either daily sublingual, or subcutaneous, every

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4 weeks. Buprenorphine decreases the risk of overdose deaths[67] and injections every 4 weeks can be very stabilizing.[68.] She does not indicate that she is an Addiction Physician. Patients with complex needs including Opioid Use disorder benefit from care from a physician who is trained in Addiction medicine and can offer a comprehensive range of treatment options.[69]

72. Dr. Monica De Benedetti gave an Affidavit on a patient she was involved with. I have not provided care for these people and have not had access to any other medical records. I do not feel that I have sufficient information to have a medical opinion. However, that the patient, Julie Lauzon, was a 24-year-old patient. She was brought to the emergency department by her mother. I do not know the circumstances as to why she is not able to live with her mother, but it illustrates, as is my experience, that people in encampments often have families in the city.

73. I do not agree that encampments are a safe alternative to shelter or a healthy choice. I do not agree that encampments promote equity, equality, improve marginalization, or will help to decrease stigma. While people my feel a false sense of security, living in an encampment poses severe risks to health and safety of people living in the encampment and a public health risk to the community.

Final Comments

74. My overarching concern, and reason for providing this Affidavit, is that there is a developing false and even dangerous narrative, as demonstrated in the Affidavits with which I have been provided, that encampments are safe and even desirable places to

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live. From speaking to patients this narrative has been a factor in people choosing to leave safer environments. Encampments are extremely dangerous places to live, and these dangers can result in poor outcomes and death. Additionally, there is no evidence that encampments have had a positive impact on ending stigmatization and marginalization, yet there is suggestive evidence, from community response, that they are having a negative effect. They do not represent equality or equity within society.

75. The conversation, and to a degree funding, has shifted away from homeless shelters, homeless hubs, housing security and appropriate housing, to a focus on encampments, their location, their size, and what services including sanitation will be provided. Those providing care to people living in encampments, may be well meaning, but are not necessarily adequately trained to meet the complex mental health and addiction needs of the people living there.

76. I make this affidavit for the purpose of introducing my opinion as evidence in this application and for no other or improper purpose.

AFFIRMED by Sharon Koivu at the City of London, in the County of Middlesex, before me at the City of Hamilton, in the Province of Ontario, on July 26, 2024, in accordance with O. Reg. 431/20, Administering Oath or Declaration Remotely.

DocuSigned by:
Bevin Shores
75E43E7E402846E...

Commissioner for Taking Affidavits
(or as may be)

BEVIN SHORES (LSO No. 56161F)

Signed by:
Sharon Koivu
FB0B9A309CD4439...

SHARON KOIVU

Docusign Envelope ID: 4417A1DA-7E4A-465D-A5B7-6B8E04B3F49F

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This is **Exhibit "A"** referred to in the Affidavit of Sharon Koivu affirmed before me at the City of Hamilton, in the Province of Ontario, on July 26, 2024 in accordance with O. Reg. 431/20, Administering Oath or Declaration Remotely

DocuSigned by:
Bevin Shores
75E43E7F402846F...

Commissioner for Taking Affidavits
(or as may be)
Bevin Shores (LSO No. 56161F)

Docusign Envelope ID: 4417A1DA-7E4A-465D-A5B7-6B8E04B3F49F

Curriculum Vitae

DR. SHARON L KOIVU

MD, MCFP PC AM

Assistant Professor - Department of Family Medicine
Schulich School of Medicine and Dentistry,
London Ontario

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APPOINTMENTS

Academic Appointments

2010 - present Assistant / Associate Professor, Department of Family Medicine, Western University

Clinical Appointments

1998-2008 Acting Medical Officer of Health Elgin St. Thomas
2002-2003 Palliative Care Physician Consultant, Parkwood Hospital
2003-2008 Palliative Care Physician Consultant, St. Thomas Elgin General Hospital
2008 – 2021 Palliative Care Physician Consultant, London Health Sciences Centre

2012-present Addiction Medicine Consultant, London Health Sciences Centre
2021-present Addiction Medicine Consultant, St. Thomas Elgin General Hospital

Consulting and Academic Positions

2017 - 2020 Mentor, Medical Mentoring for Addictions and Pain Network (MMAP), Ontario College of Family Physicians
2020- 2020 Consultant Advisor and Opioid Clinical Primer, University of Toronto
2020- 2021 Consultant lead team, module development, Opioid Clinical Primer, Course 6: Treating Opioid Use Disorder: Initiating Buprenorphine in Primary Care, Emergency Department and Inpatient Settings. University of Toronto
2018 - present CPSO Peer Assessor, Palliative Care, CPSO
2016 - 2017 Medical Advisor, Government of Ontario
2014 - present Physician Lead, in-Patient Consult Addiction Service, London Health Sciences Centre, Western University
2018 Ontario Opioid Use Disorder Community Quality Standard Advisory Committee

Other Positions

2011 - 2020 Site Chief, London Health Sciences Centre, University Hospital
2011 - 2012 Clinical Staff, Interim Chronic Pain Clinic, London Health Sciences Centre
2008 - 2011 Chronic Pain Management Physician, St. Thomas Elgin General Hospital
2007- 2008 Chronic Pain Management Physician, Centre for Pain Management, London, Ontario
2006 - 2008 Past President, Professional Medical Staff, St. Thomas Elgin General Hospital
2005 - 2008 Medical Director, Continuing Care Unit, St. Thomas Elgin General Hospital
2004 - 2006 President, Professional Medical Staff, St. Thomas Elgin General Hospital
2003 - 2008 Physician Assistant, Oncology Unit, St. Thomas Elgin General Hospital, Satellite, London Regional Cancer Program
2003 - 2007 Medical Director, St. Thomas Elgin General Hospital
2002 - 2008 Applicant Interviewer, Faculty of Medicine, University of Western Ontario
2002 - 2004 Vice President, Professional Medical Staff, St. Thomas Elgin General Hospital
2002 - 2003 Medical Director, Palliative Care Parkwood Hospital, St. Joseph's Health Care London
1999 - 2005 Chief, Continuing Care Centre, St. Thomas Elgin General Hospital
1998 - 2008 Acting Medical Officer of Health, Elgin-St. Thomas Public Health
1996 - 1998 Medical Director, Caressant Care Nursing Homes
1995 - 2002 Consulting Physician, Corporation of the County of Elgin
1991 - 1993 Vice Chair, Board of Directors, Women's Place
1985 - 2019 Physician Examiner, Qualifying Examiner, Part II, Medical Council of Canada
1985 - 2002 Family Practice Physician
1984 – 1985 Intern, St. Joseph's Health Care London

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Administrative Committees

National
2003 Member, Accreditation Ethics Working Group, The Canadian Council on Health Services Accreditation (CCHSA), St. Thomas, Ontario

Provincial
2016- present, Member Meta:Phi Network, Mentoring; Education and Clinical Tool for Addiction: Primary Care-Hospital Integration
2006 - 2007 Member, Cancer Care Ontario Program in Evidence Based Care Practitioner Feedback Team
2006 - 2007 Member, Cancer Care Ontario Southwest Alliance Planning Committee
Cancer Care Ontario
2007 - 2008 Medical Advisor, Regional Advisory Board Medication Review

Regional
2006 - 2007 Member, Southwest Palliative Care Review Team, Standardized Best Practice Pain and Symptom Management Guidelines
2000 - 2002 Member, Elgin County Working Group, Thames Valley District Health Council, London, Ontario
1995 - 1996 Vice Chair, Board of Directors, Violence Against Women Services Elgin County, St. Thomas, Ontario
1995 - 1996 Member, Sexual Assault Protocol Committee, County of Elgin, St. Thomas, Ontario
1992 - 1996 Member, Elgin County Coordinating Committee Against Women Abuse, Stop Women Abuse Now (SWAN), St. Thomas, Ontario
1992 - 1993 Member, Elgin County Review Task Force, St. Thomas Psychiatric Hospital, St. Thomas, Ontario
1991 Member, Mental Health Task Force, Thames Valley District Health Council, London, Ontario
1984 President, Board of Directors, Physicians for Social Responsibility - London Chapter, London, Ontario
Southwest LHIN
2014 - present Member, London Middlesex Hospice Palliative Care Collaborative Meeting

Hospital
London Health Sciences Centre
2015 - 2017 Founding Member, Narcotic Prescription-Quantity Committee
2015 - 2017 Founding Member, Patient Related Drug Diversion Committee
2014 Member, Cerner Optimization Assessment Project-PROVIDER round table discussions
2014 Member, HUGO Go-Live Leader Check-in
2013 - 2021 Member, Program/Division of Palliative Care within Family Medicine
2013 - 2020 Member, Planning the Work of Medicine/Family Medicine Clinical Strategy
2013 - 2014 Member, Palliative Care Accreditation Committee
2013 - 2014 Member, Dedicated Bed Model Project Team
2012 - 2020 Member, Leadership Forum
2012 - 2020 Member, Ethics Leadership Council
2012 - present Member, Palliative Care Recognition and Management Project Language Development Committee
2012 - 2014 Member, Guidelines for Peripherally Inserted Central Catheter (PICC) Line Use Committee
2012 Member, Healthcare Undergoing Optimization (HUGO), Phase 0, Impact Analysis Committee
2012 Member, Palliative Care Recognition and Management Project, Stakeholder Feedback Meeting
2011 - present Member, Palliative Care Recognition and Management Project, Policy and Form Team

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2011 - 2019 Member, Leadership/Cultural Transformation Journey
2011 - 2020 Chair, University Hospital Family Medicine Operations Committee
2011 - 2020 Member, General Internal Medicine Clinical Teaching Unit (CTU) Leadership Committee
2011 - 2014 Member, Palliative/Sub-Acute Medicine Unit (SAMU)/Continuous Quality Improvement (CQI) Council
2010 - present Member, Palliative Care Program Committee

London Hospitals
2011 - 2021 Member, Citywide Department of Family Medicine Executive Committee
2008 - present Member, Citywide Department of Family Medicine
St. Joseph's Health Care London
2002 - 2003 Member, Ethics Committee, Parkwood Hospital
2002 Member, Accreditation Planning Committee, Parkwood Hospital
St. Thomas Elgin General Hospital
2005 - 2008 Member, Interdisciplinary Service Delivery Advancement Project, Continuing Care Centre
2005 - 2006 Member, Accreditation Planning Committee, Continuing Care Centre
2005 - 2006 Member, Medication Safety Committee
2003 - 2008 Member, Wound Care Committee
2003 - 2006 Member, Palliative Care Core Team
2002 - 2006 Member, Board of Directors
2002 - 2003 Member, Accreditation Planning Committee, Continuing Care Centre
2001 - 2008 Member, Palliative Care Consultation Team
2000 - 2005 Member, Ethics Committee
1999 - 2008 Medical Advisor, Medical Advisory Committee
1999 Member, Ad Hoc Committee for the Development of a Clinical Associates Model
1996 - 2001 Member, Infection Control Committee
1991 - 1997 Member, Credentials and Ethics Committee
1987 - 1991 Chair, Nursing/Medical Liaison Committee
St. Thomas Psychiatric Hospital
1993 Member, Duplication and Gap Sub Committee

Palliative Care Network, 2014 Nov 12, Brampton, Ontario, Canada

PRESENTATIONS

Invited Lectures

1. Keynote Speaker, The Streets of London, Nursing Council, 2018 May 24, London, Ontario, Canada

2. Invited Lecturer, Reducing Harm, Empowering Lives: Responding to the Needs of People who Inject Drugs during an Opioid Crisis, Pegusus, Presenters: Dr. Koivu, Brian Lester,ED. RHAC London, 2018 Apr 29, Toronto, Ontario, Canada

3. Keynote Speaker, Harm Reduction: Compassionate Care of Persons with Substance Use Disorder, Guelph General Hospital And Homewood Health Centre, Presenters: Dr. Koivu Madison Cruickshank, Addiction Cousellor, 2018 Apr 11, Guelph, Ontario, Canada

4. Invited Lecturer, Why Worry Abpout the Opioid Prescribing Crisis, 14th Annual Innovations In Palliative Care Conference, McMaster University, 2017 Nov 22, Hamilton, Ontario, Canada

5. Presenter, Changing the Patient Experience Through Collaborative Care, CSAM, Presenters: Dr. Gupta, Dr.Lee, 2017 Oct 21, Niagara Falls, Ontario, Canada

6. Presenter, Dimenhydrinate the other Iatrogenic Addiction, CSAM, 2017 Oct 21, Niagara Falls, Ontario, Canada

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7. Invited Lecturer, The Assessment and Management of Patients with Opiid Use Disorder, Dept. of Psychiatry, St. Michael's Hospital, Toronto, 2017 Sep 12, Toronto, Ontario, Canada
8. Keynote Speaker, Being HIV Positive, Regional HIV/AIDS Connection, 2017 Jun 22, London, Ontario, Canada
9. Invited Lecturer, "METHADONE & MEDICAL MARIJUANA: A MODEST METHOD TO UNMUDDLE MANY MYTHS & MERITS, CPDPsychiatry, 2017 Apr 18, London, Ontario, Canada
10. Keynote Speaker, Turn Tragedy into Triumph for Hospitalized Patients with Injection Drug Addiction, Dept. of Family Medicine St Mary's Hospital, 2017 Feb 13, Waterloo, Ontario, Canada
11. Keynote Speaker, Opioid Use and Abuse: Turning Tragedy into Triumph for Hospitalized Patients with Injection Drug Addiction in 2017, Dept. of Family Medicine, Grand River Hospital, 2017 Feb 13, Kitchener, Ontario, Canada
12. Keynote Speaker, Tools to Tackle the Opioid Tragedy, 2017 Feb 9, Brantford, Ontario, Canada
13. Invited Lecturer, Managing Addiction in Primary Care: Clinical Pearls, CPD Program, 2017 Feb 9, London, Ontario, Canada
14. Keynote Speaker, Knowledge is Chronic: Can Help Reduce Opioids Now in Canada, Canadian Association of Nephrology Nurses and Technologists, 2016 Oct 29, London, Ontario, Canada
15. Panelist, Opioids and the Canadian Epidemic, CSAM, 2016 Oct 20, Montreal, Quebec, Canada
16. Invited Lecturer, Opioid Use Disorder: Issues in Palliative Care, Addiction Journal Club, 2016 Oct 11, London, Ontario, Canada
17. Invited Lecturer, Optimizing Inpatient Care for People who use IV Drugs, Canadian Society of Hospital Medicine, 2016 Sep 17, Niagara Falls, Ontario, Canada
18. Panelist, Caring for Patients with Complex Mental Health, Addiction and Pain Issues, The OCFP Collaborative Netork and Medical Mentoring For Addictions and Pain, 2016 Mar 5, London, Ontario, Canada
19. Invited Lecturer, Managing Chronic Non-Cancer Pain, The OCFP Collaborative Netork and Medical Mentoring For Addictions and Pain, 2016 Mar 5, London, Ontario, Canada
20. Invited Lecturer, Physician Assisted Dying, Dept. of Medicine London Ontario, 1, 2015 Aug 27, London, Ontario, Canada
21. Invited Lecturer, Physician Assisted Death, Dept. of Endocrinology London ontario, 1, 2015 Jun 17, London, Ontario, Canada
22. Invited Lecturer, Treatment Considerations in Hospitalized Patients with Infective Complications of Prescription Drug Abuse- Beyond Antibiotcs, Depts of Cardiology and Cardiac Surgery, 1, 2015 Jun 17, London, Ontario, Canada
23. Invited Lecturer, The Dying Patient, Dept. of Medicine, London ontario, 1, 2015 Jun 17, London, Ontario, Canada
24. Invited Lecturer, Treating Hospitalized Patients with Infective Complications of Prescription Drug Abuse- Beyond Antibiotcs, Dept.of Medicine, 1, 2015 Apr 23, London, Ontario, Canada
25. Invited Lecturer, Understanding Addiction in HPC Populations, Waterloo Wellington Interdisciplinary HPC Team, 1, 2015 Mar 26, Waterloo, Ontario, Canada
26. Invited Lecturer, Medical Marijuana in Palliative Care-Risks and Benefits, Waterloo Wellington Interdisciplinary HPC Team, 1, 2015 Mar 3, Waterloo, Ontario, Canada

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27. Invited Lecturer, Prescription Opioid Addiction-A Local Epidemic, Fanshawe College, 2015 Feb 9, London, Ontario, Canada

28. Invited Lecturer, Prescription Narcotic Addiction-Risks You Need to Know, Dorchester Public School, 2015 Jan 19, Dorchester, Ontario, Canada

29. Invited Lecturer, Attitude Addiction Recovery- Moving a Hospital to change, Medical Staff Huron Perth Healthcare Alliance, 2015 Jan 9, Stratford, Ontario, Canada

30. Invited Lecturer, Medical Marijuana-Risks and Benefits, Fanshawe College, 2014 Nov 21, London, Ontario, Canada

31. Invited Lecturer, Enhancing the Care of Patients Suffering from Intravenous Drug Addiction in the Hospital and Community, LHSC Board of Govenors, 2014 Oct 29, London, Ontario, Canada

32. Presenter, Palliative Equality for People with IV Drug Addiction, International Society of Addiction Medicine, 2014 Oct 5, Yokahama, Japan

33. Invited Lecturer, Caring for Patients with IV Drug Addiction, A Herculean Task: Transforming AMA (Against Medical Advice) to AMA (Arduous Meaningful Accomplishment), Staff Education LHSC, 2014 Sep 24, London, Ontario, Canada

34. Invited Lecturer, Caring for Patients with IV Drug Addiction, A Herculean Task: Transforming AMA (Against Medical Advice) to AMA (Arduous Meaningful Accomplishment), Staff Education LHSC, 2014 Sep 24, London, Ontario, Canada

35. Invited Lecturer, IVDU/Addiction-A Local Epidemic, My Sister's Place, 2013 Oct 22, London, Ontario, Canada

36. Invited Lecturer, The Role of Physicians in Social Justice and Activism, Dorchester Public School, 1, 2013 Oct 17, Dorchester, Ontario, Canada

37. Invited Lecturer, Prescription Narcotic Addiction-Risks You Need to Know, Dorchester Public School, 1, 2013 Oct 17, Dorchester, Ontario, Canada

38. Invited Lecturer, Endocarditis and Harm Reduction, London CAReS – Community Committee, 2013 Sep 18, Canada

39. Invited Lecturer, IV Drug Addiction in Palliative Care - Pilot Project, A Refresher Day in Hospice Palliative Care, 2012, London, Ontario

40. Invited Lecturer, Iatrogenic Circulatory Overload in Patients at LHSC, LHSC Board of Govenors: Quality and Patient Safety Committee, 2011 Jan 11, London, Ontario, Canada

41. Presenter, Perfectly Practical Pearls for Pain Management in Palliative Care, for Family Physicians, London, Chatham, Sarnia, Windsor, St. Thomas, Woodstock, 2011

42. Presenter, Physical and Mental Health Issues of War Resistors in Canada, 2009, London, Ontario

43. Presenter, Choosing Peace, Hiroshima Day, 2009, St. Thomas, Ontario

44. Presenter, Comprehensive Advanced Palliative Care Education (C.A.P.S.E.) Ethical and Legal Issues in End-Of-Life Decision Making, 2005, St. Thomas, Ontario

45. Presenter, Comprehensive Advanced Palliative Care Education (C.A.P.S.E.) Symptoms Management, 2004, St. Thomas, Ontario

46. Presenter, Severe Acute Respiratory Syndrome (S.A.R.S.) - The Ethical Issues with Dr. Robert Butcher, Ethicist, 2004, St. Thomas, Ontario

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47. Presenter, Ethical Case Reviews with Ethics Committee, St. Thomas Elgin General Hospital, 2004, St. Thomas, Ontario
48. Presenter, Gastro-Intestinal Symptoms in Palliative Care, Woodstock, 2004, St. Thomas, Ontario
49. Presenter, The Palliative Experience, 2004, St. Thomas, Ontario
50. Presenter, The Symptom Control Kit, 2004, Woodstock, Ontario
51. Presenter, Elderly in Elgin County, 2003, St. Thomas, Ontario
52. Presenter, Spirituality in Healing, London Regional Cancer Clinic, 2000, London, Ontario
53. Presenter, Children with Learning Disabilities and Attention Deficit Disorder, Board of Education Office, 1994, St. Thomas, Ontario
54. Presenter, Being a Woman in Medicine, Future Horizons Program, 1994, St. Thomas, Ontario
55. Presenter, Remembering Montreal; Violence and Power: From Recognition to Action, Unitarian Fellowship, 1993, London, Ontario
56. Presenter, Child Development - Prenatal to Adolescent, Arthur Voaden Secondary School, 1993, St. Thomas, Ontario
57. Presenter, Issues of Violence Against Women in Elgin County, Canadian Panel on Violence Against Women, 1992, London, Ontario
58. Presenter, Peace: More than the Absence of War, Unitarian Fellowship for Hiroshima Day Service, 1991, London, Ontario
59. Presenter, Vaginitis, Women's Health Day, Althouse College, 1986, London
60. Presenter, The Threat of Nuclear War and the need for Peace Education, London Board of Education, 1985, London, Ontario
61. Presenter, Nuclear Threat: A Look at the Problem and a Search for Solutions, University Hospital, 1984, London, Ontario
62. Presenter, Nuclear Threat: A Look at the Problem and a Search for Solutions, Multiple Secondary Schools, 1984, London, Ontario
63. Invited Lecturer, Too Much, Too Little, Too Late, Exploring Our Love/Hate Relationship with Opioids in Chronic Pain, Annual Clinical Day in Family Medicine, Western University, 2012-present, London, Ontario
64. Invited Lecturer, Too Much, Too Little, Too Late, Exploring Our Love/Hate Relationship with Opioids in Chronic Pain, Grand Rounds University Hospital, 2012-present, London, Ontario
65. Invited Lecturer, Circulatory Overload, Quality and Patient Safety Committee, 2011
66. Invited Lecturer, Progressing Towards a Greener Future, How Saving the Planet Helps Our Health, 2009, St. Thomas, Ontario
67. Invited Lecturer, Opioid Issues and Medical Care, Elgin St. Thomas Public Health, 2008, St. Thomas, Ontario
68. Presenter, The Pearls (and Perils) of Pain Management in Palliative Care, St. Thomas, London, Tillsonburg, Woodstock, Windsor, Grand Bend, Wallaceburg and Various Other Ontario Locations, 2003-2008
69. Presenter, Medical Issues in Advanced Directives, Fingal United Church, 2001, Fingal, Ontario

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70. Presenter, Advanced Directives, Imperial Order of the Daughters of the Empire. 2001, St. Thomas, Ontario

71. Presenter, Spirituality and Healing, St. John's Anglican Church, St. Thomas, Ontario

72. Panel Member, Communicating About Advance Directive, 2000, Union, Ontario

73. Presenter, Critical Thinking in Medical Ethics, 2009-2010, Central Elgin Collegiate Institute, St. Thomas, Ontario

PUBLICATIONS

1. Shetty N, Nagpal D, Koivu S, Mrkobrada M. Surgical and Medical Management of Isolated Tricuspid Valve Infective Endocarditis in Intravenous Drug Users. J Card Surg, 2016 Feb 1; 31 (2): 83-8

2. Mulling J (RN), **Baker S**, Lee L (RN). Experiencing Spirituality - Smudging: A Native Cleaning and Purifying Ritual. Anthology of Reading in Long-Term Care, 3rd Edition, 2001

3. Mulling J (RN), **Baker S**, Lee L (RN). Experiencing Spirituality - Smudging: A Native Cleaning and Purifying Ritual. Canadian Nurse 97, 2001

4. Weir M , Slater J, Jandoc R, Koivu S, Silverman M **The risk of infective endocarditis among people who inject drugs: a retrospective, population based time series analysis** *CMAJ* 2019 January 28;191:E93-9. doi: 10.1503/cmaj.180694

5. Silverman M, Slater J, Jandoc R, Koivu S, et al. Hydromorphone and the risk of infective endocarditis among people who inject drugs: a population-based, retrospective cohort study. Lancet Infect Dis 2020;20:487-497.

6. Ball LJ, Venner C, Tirona RG, Koivu S, et al. Heating Injection Drug Preparation Equipment Used for Opioid Injection May Reduce HIV Transmission Associated With Sharing Equipment. J Acquir Immune Defic Syndr 2019;81:e127-34.

7. Johnstone R, Khalil N, Shojaei E, Koivu S, et al. Different drugs, different sides: injection use of opioids alone, and not stimulants alone, predisposes to right-sided endocarditis. Open Heart 2022;9:e001930.

8. Katherine J Kasper, Iswarya Manoharan, Brian Hallam, Charlotte E Coleman, Sharon L Koivu, Matthew A Weir, Johan Delport, John K McCormick, Michael S Silverman A controlled-release oral opioid supports S. aureus survival in injection drug preparation equipment and may increase bacteremia and endocarditis risk PLoS One. 2019; 14(9): e0223079.
Published online 2019 Sep 19. doi: 10.1371/journal.pone.0223079

9. Charlie Tan, MD; Esfandiar Shojaei, MD; Joshua Wiener, BHSc; Meera Shah, BMSc; Sharon Kovu, MD; Michael Silverman, MD Risk of New Bloodstream Infections and Mortality Among People Who Inject Drugs With Infective Endocarditis *JAMA Netw Open.* 2020;3(8):e2012974. doi:10.1001/jamanetworkopen.2020.12974

10. Matthew Meyer, Lise Bondy, Sharon Koivu, John Koval, Andrew D. Scarffe, Michael S. Silverman New hepatitis C diagnoses in Ontario, Canada are associated with the local prescription patterns of a controlled-release opioid J Viral Hepat 2020 Aug;27(8):774-780.doi: 10.1111/jvh.13292. Epub 2020 Apr 8.

11.Meera Shah , Ryan Wong , Laura Ball , Klajdi Puka , Charlie Tan , Esfandiar Shojaei , Sharon Koivu, Michael Silverman Risk factors of infective endocarditis in persons who inject drugs Harm Reduct J 2020 Jun 5;17(1):35. doi: 10.1186/s12954-020-00378-z

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ABSTRACTS

Abstracts Published

Peer Reviewed

Published

1. **Sharon Koivu**. Palliative Care Equality for People With IV Drug Addiction. International Journal of the Medical Council on Alcohol; Yokahama, Japan; 2014. p. i-65
2. **Sharon Koivu** Chantal Dubois. Attitude Addiction Recovery: Transforming a Hospital from Precontemplation to Maintenance in the care of Patients with infectious Complications of IV drug use. International Journal of the Medical Council on Alcohol; Yokahama, Japan; 2014. p. i-46
3. **Baker S**. The Role of the Family Physician; 1982. National Conference of Canadian Student Pugwash, Ottawa, 1982
4. **Baker S**. Palliative Care: An Advancing Humanitarian Field; 1982. National Conference of Canadian Student Pugwash, Ottawa, 1982
5. **Baker S**. Ethical Issues in Genetic Screening; 1982. National Conference of Canadian Student Pugwash, Ottawa, 1982

Posters Presented

1. Street Level Workers at Risk Community Response, 2016 Oct 21, International Society of Addiction Medicine, Montreal, Quebec, Canada
2. Dr. Silverman, Dr. Gupta. Dr. Lee, From Pre-contemplation to Action during Acute hospitalization for patients with infectious complications of injection drug addiction: recognizing and responding to a devastating epidemic, 2016 Oct 21, International Society of Addiction Medicine, Montreal, Quebec, Canada
3. **Sharon Koivu**, Palliative Equality for People with IV Drug Addiction, 2014 Oct 5, International Society of Addiction Medicine, Yokahama, Japan
4. **Sharon Koivu**, Addiction in Palliative Care: Stop Diverting the Issues, 2014 May 29, Canadian Society of Palliative Care Physicians, Toronto, Ontario, Canada
5. **Sharon Koivu**, Hospitalized Patients with IV drug addiction Need Enhanced Medical Support, 2014 May 2, Pegasus Conference, Toronto, Ontario, Canada
6. **Sharon Koivu** Hospitalized Patients with IV Drug Use Need Enhanced Medical Response, 2012, Ontario College of Family Physicians 51st Annual Scientific Assembly, Toronto, Ontario
7. **Sharon Baker**, Anne De Vries, RN, Interdisciplinary Care in a Community Hospital, 2005, 15th Annual Ontario Provincial Conference on Palliative and End-of-Life Care, Toronto
8. **Sharon Koivu**, Anne De Vries, Resuscitating Palliative Care in a Community Hospital and The Synergy of Interdisciplinary Team Building, 2004, 14th Annual Ontario Provincial Conference on Palliative and End-of-Life Care, Toronto
9. **Sharon Koivu**, Mary Beth Blokker, Methadone for the Treatment of Pain and Metoclopramide Toxicity, 2003, Humber College 13th Annual Hospice Palliative Care Conference, Toronto

HONOURS AND AWARDS

Honours

Received

2021 Certificate, Indigenous Cultural Safety Training

2019 Dana Winterburn Memorial Award, Award Chosen by members of the Dept. of Family Medicine, London, Ontario, for outstanding physician in Palliative Care or Aboriginal Health

2016 Certificate in Added Competence, Addiction Medicine, CFPC

2014 Certificate in Added Competence, Palliative Care, CFPC

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2002 The Queens Golden Jubilee Medal, For significant contribution to Elgin St. Thomas in the Field of Medicine. This was for my development of Palliative Care services and contribution to Public Health.
2002 Certificate of Achievement, From City of St. Thomas for outstanding excellence and contribution to the community
1993 Outstanding Service Award, Ontario College of Family Physicians, Peer Presenter Program
1984 Department of Family Medicine Practice Award, For the Medical Student found to be the most outstanding in Family Medicine. The University of Western Ontario

Nominated

2015 Western's Best Core Family Medicine Teaching Award, Award Chosen by Family Medicine Residents in their Graduating year, Western
2014 Consultant of the Year Award, Award Chosen by Members of the Dept. of Family Medicine, I had to withdraw from award as on selection committee as Site Chief, Dept. of Family Medicine, Western
2012 and 2013 Dana Winterburn Award, Award Chosen by Members of the Dept. of Family Medicine for outstanding physician in Palliative Care or Aboriginal Health; I had to withdraw from award as on selection committee as Site Chief, Dept. of Family Medicine, Western

SERVICE AND ADMINISTRATION

Professional Affiliations and Activities

Professional Associations

2013 - present Member, International Society of Addiction Medicine
1999 - 2001 Member, Choir Group, St. John's Anglican Church
1997 - 2001 Member, St. Thomas Hockey Mother's Association
present Member, The Canadian Society of Addiction Medicine
Member, The Canadian Society of Palliative Care Physicians
Member, The Canadian Hospice Palliative Care Association
Member, The Canadian Medical Association
Member, The College of Physicians and Surgeons of Ontario
Member, The Elgin Medical Association
Member, The Ontario Medical Association
Member, The College of Family Physicians of Canada
Member, The Ontario College of Family Physicians
Member, The Canadian Association of Wound Care
Member, Canadian Association of Physicians for the Environment
Member, Canadian Pain Society
Member, Canadian Pain Coalition
Member, St. Thomas Walk-in Medical Clinic
Member, Professional Staff Organization, London Health Sciences Centre
Member, Physicians for Global Survival
Member, Department of Family Medicine, University of Western Ontario
Member, Society of Friends, Yarmouth Monthly Meeting

Peer Review Activities

Peer Reviewer

2006 - 2007 Manuscript Reviews, Cancer Care Ontario Program in Evidence Based Care Practitioner Feedback Team

Administrative Committees

International

1977 - 1978 Member, Amnesty International, London, Ontario

National

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2003 Member, Accreditation Ethics Working Group, The Canadian Council on Health Services Accreditation (CCHSA), St. Thomas, Ontario
1990 - 1992 Member, Board of Directors, Canadian Mental Health Association, St. Thomas, Ontario
1990 - 1992 Member, Policy and Programming Committee, Canadian Mental Health Association, St. Thomas, Ontario
1990 - 1992 Member, Community Advisory Committee, Canadian Mental Health Association, St. Thomas, Ontario

Provincial

2012 - present Member, Investigation and Resolution Assessor Networking Forum, College of Physicians and Surgeons of Ontario
2006 - 2007 Member, Cancer Care Ontario Program in Evidence Based Care Practitioner Feedback Team
2006 - 2007 Member, Cancer Care Ontario Southwest Alliance Planning Committee

Cancer Care Ontario

2007 - 2008 Medical Advisor, Regional Advisory Board Medication Review

Regional

2006 - 2007 Member, Southwest Palliative Care Review Team, Standardized Best Practice Pain and Symptom Management Guidelines
2004 - 2006 Member, Symptom Control Kit Committee, Elgin County
2000 - 2002 Member, Elgin County Working Group, Thames Valley District Health Council, London, Ontario
1995 - 1996 Vice Chair, Board of Directors, Violence Against Women Services Elgin County, St. Thomas, Ontario
1995 - 1996 Member, Sexual Assault Protocol Committee, County of Elgin, St. Thomas, Ontario
1992 - 1996 Member, Elgin County Coordinating Committee Against Women Abuse, Stop Women Abuse Now (SWAN), St. Thomas, Ontario
1992 - 1993 Member, Elgin County Review Task Force, St. Thomas Psychiatric Hospital, St. Thomas, Ontario
1991 Member, Mental Health Task Force, Thames Valley District Health Council, London, Ontario
1984 President, Board of Directors, Physicians for Social Responsibility - London Chapter, London, Ontario

Southwest LHIN

2014 - present Member, London Middlesex Hospice Palliative Care Collaborative Meeting

Local

2011 Member, Medicine Access and Flow Retreat
2008 - present Member, Yarmouth Monthly Meeting of Society of Friends (Quaker) Peace and Social Justice Committee
2003 Member, End Racism Committee
2002 Member, Palliative Care Stakeholders Day

1993 - 1994 Member, Media Committee, Londoners Against Racism
1992 - 1993 Member, Program and Policy Committee, Sexual Assault Centre
1992 - 1993 Member, Board of Directors, Sexual Assault Centre
1989 - 1990 Member, Teen Mom's Program Advisory Committee, YWCA of St. Thomas-Elgin
1978 - 1979 Member, Jeremiah's Field Committee, Cross Cultural Learner Centre
1978 - 1979 Member, Board of Directors, Cross Cultural Learner Centre
1977 - 1979 Member, Committee in Support of Native Concerns

Centre For Organizational Effectiveness

2014 Medical Advisor, London Community Plan Regarding Street Involved Sex Workers

London Homeless Coalition

2015 - present Member, London Homeless Coalition

Middlesex London Health Unit

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2013 Member, Community Opioid Overdose Prevention Program : community stakeholder meeting

Media Appearance

1. Invited Lecturer, TVO- Political Blind Date
Support for Supervised Consumption Sites, 2017 Nov 1, London, Ontario, Canada
2. Participant, Canadian Broadcasting Corporation (CBC) award-winning Documentary, University of Western Ontario School of Journalism, 2011, London

Symposia

1. Expert, Roundtable Discussion on Opioids, Ministry Of Health, Presenters: Dr. Jane Philpott et al, 2017 Jul 6, London, Ontario, Canada
2. Expert, People For Peace: Palliative Care Delegation, Presenters: Lead Dr. Larry Librach, 2010 Nov 1, China

Workshop

1. Presenter, Clinical Encounters Workshop, Clinical Education Coordinator Undergraduate Medical Education, 2015 Feb 5, London, Ontario, Canada
2. Presenter, Precontemplation to Compassion: My Journey in Treating Patients with IVDU, LHSC Medical Residents, 2015 Jan 9, London, Ontario, Canada
3. Presenter, What's "News" Reviewing Current Medically Related Headlines, Dept of Medicine LHSC, Presenters: **Sharon Koivu**, 2014 Sep 19, London, Ontario, Canada
4. Facilitator, Advanced Directives, Dept of Medicine LHSC, Presenters: Robert Sibbald **Sharon Koivu**, 2014 Aug 22, London, Ontario, Canada
5. Facilitator, Talent Management Conference: Enhanced Leadership :, LHSC, Presenters: Facilitated By **Sharon Koivu** and Candace Gibson, 2014 Jan 22, London, Ontario, Canada

Memorial Services

1. Presenter, Performed celebration of life services for staff and families of patients who died in the Hospital Palliative Care Unit, St. Thomas Elgin General Hospital, 2006, St. Thomas, Ontario
2. Presenter, Performed celebration of life services for staff and families of patients who died in the Hospital Palliative Care Unit, St. Thomas Elgin General Hospital, 2005, St. Thomas, Ontario
3. Presenter, Performed celebration of life services for staff and families of patients who died in the Hospital Palliative Care Unit, St. Thomas Elgin General Hospital, 2004, St. Thomas, Ontario

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This is **Exhibit "B"** referred to in the Affidavit of Sharon Koivu affirmed before me at the City of Hamilton, in the Province of Ontario, on July 26, 2024 in accordance with O. Reg. 431/20, Administering Oath or Declaration Remotely.

DocuSigned by:
Bevin Shores
75E43E7E402846F...

Commissioner for Taking Affidavits
(or as may be)
Bevin Shores (LSO No. 56161F)

Docusign Envelope ID: 4417A1DA-7E4A-465D-A5B7-6B8E04B3F49F

Court File No. CV-21-00077187-0000

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

APPLICATION UNDER 14.05 OF THE *RULES OF CIVIL PROCEDURE*

ACKNOWLEDGMENT OF EXPERT'S DUTY

1. My name is Dr. Sharon Koivu. I live in the City of Port Stanley, in the Province of Ontario.

2. I have been engaged by or on behalf of the Respondent 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 July 26, 2024

Signed by: Sharon Koivu FB0B9A309CD4430...

Signature

NOTE: This form must be attached to any expert report under subrules 53.03(1) or (2) and any opinion evidence provided by an expert witness on a motion or application.

Docusign Envelope ID: 4417A1DA-7E4A-465D-A5B7-6B8E04B3F49F

Court File No. CV-21-00077187-0000

KRISTEN HEEGSMA et al. - and - CITY OF HAMILTON

Applicants Respondent

ONTARIO
SUPERIOR COURT OF JUSTICE

PROCEEDING COMMENCED AT HAMILTON

ACKNOWLEDGMENT OF EXPERT'S DUTY

GOWLING WLG (CANADA) LLP
Barristers & Solicitors
One Main Street West
Hamilton, ON L8P 4Z5

Tel: 905-540-8208

Bevin Shores (LSO#56161F)
Tel: 905-540-2468
bevin.shores@gowlingwlg.com

Jordan Diacur (LSO#65860E)
Tel: 905-540-2500
jordan.diacur@gowlingwlg.com

Lawyers for the Respondent

Docusign Envelope ID: 4417A1DA-7E4A-465D-A5B7-6B8E04B3F49F

This is **Exhibit "C"** referred to in the Affidavit of Sharon Koivu affirmed before me at the City of Hamilton, in the Province of Ontario, on July 26, 2024 in accordance with O. Reg. 431/20, Administering Oath or Declaration Remotely.

DocuSigned by:
Bevin Shores
75E43E7F402846F...

Commissioner for Taking Affidavits
(or as may be)
Bevin Shores (LSO No. 56161F)

Docusign Envelope ID: 4417A1DA-7E4A-465D-A5B7-6B8E04B3F49F

Works Cited:

1. Ball LJ, Puka K, Speechley M, Wong R, Hallam B, Wiener JC, Koivu S, Silverman MS. Sharing of Injection Drug Preparation Equipment Is Associated With HIV Infection: A Cross-sectional Study. J Acquir Immune Defic Syndr. 2019 Aug 1;81(4):e99-e103. doi: 10.1097/QAI.0000000000002062. PMID: 31021986; PMCID: PMC6905403. (Sharing equipment increases HIV)

2. Foster M, Ramachandran S, Myatt K, et al. Hepatitis A Virus Outbreaks Associated with Drug Use and Homelessness---California, Kentucky, Michigan, and Utah, 2017. MMWR Morb Mortal Wkly Rep 2018;67:1210. DOI: http://dx.doi.org/10.15585/mmwr.mm6743a3

3. Gerrity Daniel, Papp Katerina, Dickenson Eric, Ejjada Meena, Marti Erica, Quinones Oscar, Sarria Mayra, Thompson Kyle, Trenholm Rebecca A., Characterizing the chemical and microbial fingerprint of unsheltered homelessness in an urban watershed, Science of The TotalEnvironment,Volume840,2022,156714,ISSN00489697,https://doi.org/10.1016/j.scitotenv.2022.156714.(https://www.sciencedirect.com/science/article/pii/S0048969722038116)

4. Haber PS, Young MM, Dorrington L, et al. Transmission of hepatitis C virus by needle-stick injury in community settings. J Gastroenterol Hepatol 2007;22(11):1882–5.

5. Henderson E, Continente X, Fernández E, Tigova O, Cortés-Francisco N, Gallus S, Lugo A, Semple S, O'Donnell R, Clancy L, Keogan S, Ruprecht A, Borgini A, Tzortzi A, Vyzikidou VK, Gorini G, López-Nicolás A, Soriano JB, Geshanova G, Osman J, Mons U, Przewozniak K, Precioso J, Brad R, López MJ; TackSHS project investigators. Secondhand smoke exposure in outdoor children's playgrounds in 11 European countries. Environ Int. 2021 Apr;149:105775. doi: 10.1016/j.envint.2020.105775. Epub 2020 Nov 20. PMID: 33228970.

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6. Kimberlin DW, Brady MT, Jackson MA, Long SS, eds. Red Book: 2021 Report of the Committee on Infectious Diseases, 32nd edn. Itasca, IL: American Academy of Pediatrics, 2021:166-9. American Academy of Pediatrics, Committee on Infectious Diseases. (Injuries from discarded needles in the community)

7. Liu CY, Chai SJ, Watt JP. Communicable disease among people experiencing homelessness in California. Epidemiol Infect. 2020 Mar 30;148: e85. doi: 10.1017/S0950268820000722. PMID: 32223777; PMCID: PMC7189346. (communicable diseases, Hepatitis A)

8. Moore DL. Canadian Paediatric Society, Infectious Diseases and Immunization committee. Needlestick injuries in the community. Paediatric Child Health 2008;13(3):205–10.

9. Nikoo, Nooshin; Motamed, Marjan; Nikoo, Mohammad Ali; Strehlau, Verena; Neilson, Erika; Saddicha, Sahoo; and Krausz, Michael (2014) "Chronic Physical Health Conditions Among Homeless," Journal of Health Disparities Research and Practice: Vol. 8: Iss. 1, Article 5. Available at: https://digitalscholarship.unlv.edu/jhdrp/vol8/iss1/5 (Chronic Illnesses, Shelter vs Unsheltered)

10. Nantapong Chansaengpetch, Wisarn Worasuwannarak, Suchin Worawichawong, Methamphetamine-induced profound rhabdomyolysis and myoglobin cast nephropathy: A case report and a literature review, Journal of Forensic and Legal Medicine, Volume 96, 2023,102530,ISSN1752928X,https://doi.org/10.1016/j.jflm.2023.102530.(https://www.sciencedirect.com/science/article/pii/S1752928X23000483)

11. O'Shea T, Bodkin C, Mokashi V, Beal K, Wiwcharuk J, Lennox R, Guenter D, Smieja M, Bulir D, Chong S. 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. Clin Infect Dis. 2021 May 4;72(9):1639-1641. doi: 10.1093/cid/ciaa743. PMID: 32511704; PMCID: PMC7314119. (No Covid-19 outbreaks in shelter)

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12. Res S, Bowden FJ. Acute hepatitis B infection following a community-acquired needlestick injury. J Infect 2011;62(6):487–9.

13. Richards JR, Johnson EB, Stark RW, Derlet RW. Methamphetamine abuse and rhabdomyolysis in the ED: a 5-year study. Am J Emerg Med. 1999 Nov;17(7):681-5. doi: 10.1016/s0735-6757(99)90159-6. PMID: 10597089.

14. Rodger L, Shah M, Shojaei E, Hosseini S, Koivu S, Silverman M. Recurrent Endocarditis in Persons Who Inject Drugs. Open Forum Infect Dis. 2019 Sep 9;6(10):ofz396. doi: 10.1093/ofid/ofz396. PMID: 31660358; PMCID: PMC6796994. (IE if abuse PICC line)

15. Roncarati JS, Baggett TP, O'Connell JJ, Hwang SW, Cook EF, Krieger N, Sorensen G. Mortality Among Unsheltered Homeless Adults in Boston, Massachusetts, 2000-2009. JAMA Intern Med. 2018 Sep 1;178(9):1242-1248. doi: 10.1001/jamainternmed.2018.2924. PMID: 30073282; PMCID: PMC6142967.

16. Shetty N, Nagpal D, Koivu S, Mrkobrada M. Surgical and Medical Management of Isolated Tricuspid Valve Infective Endocarditis in Intravenous Drug Users. J Card Surg. 2016 Feb;31(2):83-8. doi: 10.1111/jocs.12682. Epub 2015 Dec 20. PMID: 26687478.

17. Torres PA, Helmstetter JA, Kaye AM, Kaye AD. Rhabdomyolysis: pathogenesis, diagnosis, and treatment. Ochsner J. 2015 Spring;15(1):58-69. PMID: 25829882;PMCID:PMC4365849.

18. https://www.publichealthontario.ca/-/media/documents/E/2019/eb-homelessness-health.pdf (homeless individuals experience higher rates of infectious diseases, such as tuberculosis, hepatitis and HIV compared to the general population)

19. Institute of Medicine (US) Committee on Health Care for Homeless People. Homelessness, Health, and Human Needs. Washington (DC): National Academies

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Press (US); 1988. 3, Health Problems of Homeless People. Available from: https://www.ncbi.nlm.nih.gov/books/NBK218236/

20. https://www.cbc.ca/news/canada/london/homeless-encampment-fire-1.6688483 (Fire or Frostbite)

21. https://www.thestar.com/news/gta/dennis-chantiloupe-fell-asleep-and-lost-all-his-fingers-to-frostbite-as-homelessness-soars-more/article_8fc10c48-95d4-11ee-9bfb-8335f24c6c4a.html

22. https://www.cbc.ca/news/canada/new-brunswick/frostbite-amputated-homeless-saint-john-jamie-langille-catherine-driscoll-1.7094514 (Frostbite)

23. https://www.thestar.com/news/gta/dennis-chantiloupe-fell-asleep-and-lost-all-his-fingers-to-frostbite-as-homelessness-soars-more/article_8fc10c48-95d4-11ee-9bfb-8335f24c6c4a.html (frost bite)

24. https://globalnews.ca/news/10235191/homeless-protections-extreme-cold-canada/ (hypothermia)

25. https://invisiblepeople.tv/homeless-people-face-hypothermia-every-winter-heres-how-you-can-help/ (hypothermia)

26. https://www.cbc.ca/amp/1.7174695 (tent fire death)

27. https://www.cbc.ca/amp/1.7174695 Fire destroys structure)

28. https://www.thestar.com/news/gta/this-kind-of-living-arrangement-outside-is-not-safe-acting-fire-chief-says-as-toronto/article_5a956cac-651a-5c4d-9b3a-5d30a6a92d61.html (Fire)

29. https://www.cbc.ca/news/canada/london/watson-street-park-london-ontario-homelessness-1.7205391 (Propane tank explosion)

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30. https://www.cbc.ca/news/canada/hamilton/tent-arson-1.7242387 (Tent set on fire in Hamilton targeted, not a Hate Crime)

31. https://www.cbc.ca/amp/1.6923018 (Trench foot London)

32. https://atlantic.ctvnews.ca/homeless-population-hardest-hit-during-hot-weather-souls-harbour-1.6955692

33. https://globalnews.ca/news/10121319/grand-parade-halifax-tents-wind-storm/ (Windstorm destroys encampment)

34. https://kitchener.ctvnews.ca/paramedic-union-raising-concerns-about-rats-at-kitchener-encampment-1.6285151?cache=/7.572778/7.315126/7.3151269rats Waterloo encampment)

35. https://www.thepeterboroughexaminer.com/news/peterborough-region/peterborough-homeless-encampment-had-been-overrun-by-rats/article_034aa81c-45bb-5c83-b163-3e369271baf9.html (Rats)

36. https://www.cbc.ca/amp/1.7241369 (rats in Etobicoke neighbourhood)

37. https://atlantic.ctvnews.ca/halifax-s-victoria-park-tent-encampment-dealing-with-rat-problem-1.6776767#:~:text=Wheelock%20says%20tent%20encampments%20are,With%20rats%20comes%20health%20risks. (rats Halifax encampment)

38. https://www.environmentalpestcontrol.ca/blog/what-diseases-do-rodents-carry

39. https://search.app/d5whhvkH4zXRCJsd9 (Seattle PH rodents, needlestick)

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40. https://www.thefreepress.ca/news/dog-bites-bylaw-officer-at-maple-ridge-homeless-camp-5115761 (dog bites bylaw officer)

41. https://www.homelesshub.ca/about-homelessness/health/infectious-diseases

42. https://globalnews.ca/news/10403413/kelowna-encampment-cleanup-displaces-people-homelessness/ (Contaminated site)

43. https://search.app/E4R5TyGXgjeZS8rT9 (Needlestick in Community)

44. https://www.cdph.ca.gov/Programs/CID/DCDC/CDPH%20Document%20Library/Immunization/2016-18CAOutbreakAssociatedDrugUseHomelessness.pdf (Hepatitis A)

45. https://www.google.com/search?q=Hepatitis+A+Outbreak+Associated+with+Drug+Use+and+Homelessness+in+California%2C+20162018+Final+update+as+of+April+11%2C+2018.&rlz=1C1CHBF_enCA807CA807&oq=Hepatitis+A+Outbreak+Associated+with+Drug+Use+and+Homelessness+in+California%2C+20162018+Final+update+as+of+April+11%2C+2018.+&gs_lcrp=EgZjaHJvbWUyBggAEEUYOdIBCDU3ODJqMGo3qAIIsAIB&sourceid=chrome&ie=UTF-8(Hepatitis A)

46. https://london.ctvnews.ca/mobile/homeless-man-dies-of-overdose-in-city-porta-potty-1.4941526?referrer=https://www.google.com/ (overdose death in porta-potty)

47. https://bc.ctvnews.ca/mobile/calls-for-more-checks-on-city-toilets-after-2-deaths-1.4909594?referrer=https://www.google.com/ (Deaths in porta-potty)

48. https://atlantic.ctvnews.ca/more/drug-paraphernalia-open-bathroom-use-at-encampment-worrying-for-dartmouth-n-s-residents-1.6953403

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49. https://www.homelesshub.ca/blog/top-ten-health-issues-facing-homeless-people (Health issues Homeless Hub)

50. https://www.homelesshub.ca/about-homelessness/topics/mental-health Mental Health Homeless Hub)

51. https://ontario.cmha.ca/documents/housing-and-mental-health/ (Housing and Mental Health CMHA)

52. https://www.therecord.com/news/waterloo-region/youth-and-children-are-exposed-to-drugs-and-sex-trafficking-at-tent-cities-local-agencies/article_d7c26953-ea61-54d4-bf64-41bd3de69671.html

53. https://edmonton.citynews.ca/2024/06/14/man-charged-in-connection-to-sexual-assaults-at-encampments/

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This is **Exhibit "D"** referred to in the Affidavit of Sharon Koivu affirmed before me at the City of Hamilton, in the Province of Ontario, on July 26, 2024 in accordance with O. Reg. 431/20, Administering Oath or Declaration Remotely.

DocuSigned by:
Bevin Shores
75E43E7F402846F...

Commissioner for Taking Affidavits
(or as may be)
Bevin Shores (LSO No. 56161F)

Docusign Envelope ID: 4417A1DA-7E4A-465D-A5B7-6B8E04B3F49F

List of Affidavits Reviewed:

1. Affidavit of Kaitlin Schwan sworn June 13, 2022
2. Affidavit of Ameil Joseph sworn June 14, 2022
3. Affidavit of Ameil Joseph sworn June 7, 2024
4. Affidavit of Stephen Gaetz sworn June 14, 2022
5. Affidavit of Dr. Aaron Orkin sworn September 14, 2022
6. Affidavit of Dr. Stephen Hwang sworn June 13, 2022
7. Affidavit of Dr. Stephen Hwang sworn February 27, 2023
8. Affidavit of Dr. Kate Hayman sworn June 13, 2022
9. Affidavit of Dr. Kate Hayman sworn February 28, 2023
10. Affidavit of Dr. Andrea Sereda sworn June 13, 2022
11. Affidavit of Dr. Andrea Sereda sworn May 12, 2023
12. Affidavit of Dr. Claire Bodkin sworn May 5, 2023
13. Affidavit of Dr. Jill Wiwcharuk sworn June 7, 2024
14. Affidavit of Dr. Rachel Lamont sworn July 4, 2023 re J Pierre
15. Affidavit of Dr. Rachel Lamont sworn July 4, 2023 re K Heegsma
16. Affidavit of Dr. Rachel Lamont sworn June 7, 2024
17. Affidavit of Dr. Timothy O’Shea sworn June 7, 2024
18. Affidavit of Monica De Benedetti unsworn

Docusign Envelope ID: 4417A1DA-7E4A-465D-A5B7-6B8E04B3F49F

Court File No. CV-21-00077187-0000

KRISTEN HEEGSMA et al. - and - CITY OF HAMILTON

Applicants Respondent

ONTARIO
SUPERIOR COURT OF JUSTICE

PROCEEDING COMMENCED AT HAMILTON

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File Number: H227899

TAB 143

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. Sharon Koivu, on an Affidavit dated July 26, 2024, taken upon affirmation in the above action this, 6th of September, 2024, conducted via videoconference hosted by the offices of Nimigan Mihailovich Reporting Inc.

APPEARANCES:

For the Applicants:

SUJIT CHOUDHRY

Haki Chambers Global

For the Hamilton Community Legal Clinic:

SHARON CROWE

CURTIS SELL

For the Community Legal Clinic of York Region:

MICHELLE SUTHERLAND

NONYE OKENWA

BENJAMIN HOGNESTAD

For the City of Hamilton:

BEVIN SHORES

JOJO JOHNSON

Gowling WLG (Canada) LLP

I N D E X

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Cross-Examination by MR. CHOUDHRY	6

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3	Canadian Affairs Article dated July 8, 2024.	32
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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] 68/11.

--- Commencing at 9:35 a.m.

DR. SHARON KOIVU,

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. CHOUDHRY:

1 Q. Good morning, Dr. Koivu. As we discussed off the record, I'm going to go through a number of logistical issues that I think you've been given advance notice of. And this is sort of a standard spiel I use to begin with all of my cross-examinations in this matter.

So I will begin by introducing myself. My name is Sujit Choudhry, and I am one of the lawyers for the Applicants.

As you know, I am cross-examining you on your affidavit, which has been filed by the City of Hamilton in a court case regarding homeless encampments. Your affidavit and this cross-examination will be put into evidence before the Court and so it's therefore important to tell the truth and you affirmed that you will do so.

If you would like me to repeat a question, please do so. If you would like a moment to collect your thoughts to answer a question, please take it. Although we know your time is valuable, it's not a race, so please

take a moment.

As I believe you've been asked, but I will ask you to confirm on the record, can you confirm you only have your affidavit and exhibits in front of you?

A. Yes.

2 Q. And you have no other -- sorry?

A. Yes. That's all I have. Now, I have on the screen my affidavit, right, with us. I have a hard copy of the affidavit, just my part, in case there was an Internet problem, but there's nothing else on it, and I wasn't going to refer to it unless we had some kind of problem with the internet. But I don't have anything else available.

3 Q. And, to be clear, Dr. Koivu, you're free to review to either the electronic copy of the affidavit or the written copy, whatever you want.

A. Okay. I wasn't sure.

4 Q. No. That's fine. The only thing you're not able to have are notes of any kind. And you can confirm that that's the case?

A. Yes, I can absolutely confirm that that is the case.

5 Q. Okay. And also can you confirm that you are alone?

A. Yes. I'm in my house, and I kicked my

husband out, so I am very alone.

6 Q. Okay. Good. Thank you. I appreciate it. And so I understand you've been a witness on a virtual cross-examination before; is that right?

A. Yes, that is correct.

7 Q. So I'm not sure what the lawyers in the other case did, but in this case, if I put materials to you that you don't have with you, or even if you do have them with you, I will put them up on the screen for screen share with zoom.

And please when I do, I don't know how big your screen is, so if you can't read it, tell me and I will enlarge it.

A. Okay.

8 Q. If you want me to scroll up and down the document, I can.

A. Okay.

9 Q. And if you need time to review it, I will proactively offer you time, and if you need more time, just tell me. Okay? Great.

A. Mm-hmm.

10 Q. So let's begin. So you have -- you are a witness in this hearing; correct?

A. Yes.

11 Q. In this matter?

A. Yes.

12 Q. Can you please explain what you understand your role to be in this proceeding?

A. My role is to give fair, unbiased, nonpartisan opinion based on my experience and my knowledge of the situation. And it's particularly pertaining to encampments versus shelter.

It's very important that what I say I answer truthfully and unbiased, with an unbiased perspective and will answer truthfully to your questions. And I made sure that that was mandatory for me to take this.

I will just say that when I was asked to be a witness, I realize now that that is also obviously part of being a witness, but it is very important to me that I give you a fair, unbiased and answer honestly to all of the questions.

And everything that I do is based on that.

13 Q. Okay. Good. Thank you.

And so I'd like to take you to you Exhibit A of your affidavit. So I'm going to use the screen share function now. So if you will give me a second, please.

A. Absolutely.

14 Q. Can you read the document on the screen?

I'm going to increase it a bit. Can you see that?

A. One second. Let me see if I can increase my screen somehow with the view options.

MS SHORES: So, counsel, what I see on your screen is Dr. Koivu's affidavit, but not Exhibit A.

MR. CHOUDHRY: Yeah, I'm not there yet, but I just want to just make sure that she can see the affidavit, and then I will take her to Exhibit A.

Can you see this, Dr. Koivu?

THE WITNESS: I can see it, but I can't read it, and for some reason you are really small on my screen, and I'm trying to make you bigger.

MR. CHOUDHRY: Can we just go off the record for a second?

-- OFF THE RECORD --

BY MR. CHOUDHRY:

15 Q. So, Dr. Koivu, do you see on your screen your affidavit?

A. Yes, I do.

16 Q. Okay. So, Dr. Koivu, I'm just going to use the table of contents here and take you to Exhibit A, which is your curriculum vitae.

A. Yes.

17 Q. Do you see this document?

A. Yes.

18 Q. And can you confirm that this is your curriculum vitae?

A. Yes.

19 Q. So I'd like to just go through -- I'm going to enlarge this a bit. Can you read that?

A. Yes.

20 Q. So I'd like to go through your clinical appointments, if I could.

A. Okay.

21 Q. Okay. So it says that -- here that your first clinical appointment was in -- was as the Medical Officer of Health in Elgin St. Thomas; is that right. I am just highlighting it here.

A. I was working in St. Thomas Elgin General Hospital prior to that, so from 1985 to 2002 I also had privileges at St. Thomas Elgin General Hospital and worked at St. Thomas Elgin General Hospital.

22 Q. Well, let's get into that, because I don't see that on your CV, so we just want to make sure we have your complete background. In that --

MS SHORES: I think it is under "other positions," counsel.

THE WITNESS: It might be under "other positions."

BY MR. CHOUDHRY:

23 Q. I see. Back here. Down here. Sorry. So these are the other positions you are referring to?

A. Yes.

24 Q. So you were a family practice physician --

A. Yes.

25 Q. -- from 1985 to 2002. And that was at -- it doesn't indicate here that that is at St. Elgin Hospital, as you described it.

Is that where you were?

A. My family practice was private, but during that time I had privileges at St. Thomas Elgin General Hospital, and I continue to have privileges at St. Thomas Elgin General Hospital.

Working in an independent family practice, I didn't think of it as a clinical appointment, but all of us at the time had privileges at the hospital. We ran the emergency department. I did all my own OB. It was a completely comprehensive family practice.

So in the statement of a family practice, it included a comprehensive family practice, which included working at St. Thomas Elgin General Hospital.

26 Q. Okay. So in 2008, you began working at the London Health Sciences Centre; correct? The London Health Sciences Centre?

A. Yes, that is correct.

27 Q. Am I correct in assuming that in 2008 you moved to London Ontario to take up this position?

A. No.

28 Q. Okay.

A. I didn't move. I was commuting at that time.

29 Q. I see. Okay. And did you move to London at some point?

A. Yes, I moved to London in 2013.

30 Q. Okay. And so it says here on your CV that you were -- from 2008 to 2021 you were a palliative care physician consultant at the London Health Sciences Centre; is that correct?

A. Yes, that is correct.

31 Q. Are you no longer a palliative care physician consultant at the London Health Sciences Centre?

A. That is correct. I am no longer a physician consultant at London Health Sciences Centre. And actually, if you keep going, I am now not working as of this June, which is after -- well, July, after this was written, I am no longer working at London Health Sciences Centre.

I have -- I did not renew my privileges to work at London Health Sciences Centre, and I am working

exclusively in St. Thomas at this time.

32 Q. I see. Okay. So let's just get some updates to this, if we could, because that's important for me to understand.

So it states on your -- so it states here on this CV, which was attached to your affidavit sworn in July of 2024, that you are at present, as of the time of swearing this affidavit, an addiction medicine consultant at the London Health Sciences Centre.

That information is out of date?

A. That information is out of date. I am very sorry about that.

33 Q. That's fine. It happens. So just so we can get on the record, so you were an addiction medicine consultant at the London Health Sciences Centre until what date?

A. Until June 30th.

34 Q. Of 2024?

A. 2024. Yes. That's right.

35 Q. And so are you able then -- and so do you currently have privileges at the London Health Sciences Centre?

A. No.

36 Q. It states in the CV that you are an addiction medicine consultant at St. Thomas Elgin

General Hospital. Is that still the case?

A. Yes. That is still the case.

37 Q. So just to summarize here, is it fair to say that your addition medicine practice as a consultant is now based at St. Thomas Elgin General Hospital?

A. That is fair to say, yes.

38 Q. Okay. And are you able to explain why you left London Health Sciences Centre -- or pardon me, why you did not renew your privileges at the London Health Sciences Centre?

A. I would say it is multifactorial. One is that I now live in Port Stanley. I wanted to spend more time with my family, particularly with my mother, who was needing help.

I also wanted to be able to speak freely on issues that I felt were important, and I felt that it was very important to me that I have that freedom within St. Thomas. And in London, there was a request for me to speak through the Public Relations Committee.

I felt that overall there were many reasons for leaving. I loved my position. I loved my job. I loved the team that I was working with, but felt that at this present time in my age and practice, I wanted to focus my practice in St. Thomas, which has a very different approach to addiction.

I would like to be able to expand my practice in St. Thomas and felt that this was really where I wanted to put my energy at this time.

39 Q. So, Dr. Koivu, you used the phrase issues that were important to you; is that correct?

A. Yes.

40 Q. Can you please explain what you mean by issues that were important -- that are important to you?

A. I think that issues that are important to me include things around problems that I'm seeing related to diverted drugs, being able to respond about things such as supervised injection sites, which I do support.

There are many issues in addiction that -- safe supply is one of them, but not limited, that I felt that I really wanted to be able to respond to questions about them if they came up and felt very supported by my colleagues, but also recognize that in London Health Sciences Centre, those things need to be run by PR.

It was one of many factors that made me make the decision that a good place for me to be working is in St. Thomas, which has had a very different approach to homelessness. It's had a different approach to people suffering with opioid use disorder. And this to me was an important fit for me.

41 Q. And when you say "questions that came up," questions posed by whom?

A. Questions that could be posed by particularly -- I'm going to say particularly if the media asked me questions, I wanted to feel free to respond, but not limited to that.

There can be -- even something such as being able to freely express myself in any forum, in medical forums. I just felt very supported in St. Thomas and felt that I didn't feel comfortable running -- I didn't feel comfortable running through the Public Relations Committee in London Health Sciences Centre to be having approval of things I say when a board member on the London Health Sciences Centre who, by virtue of being the chief of nursing, is also on the board of London Intercommunity Health, and I felt that there was a conflict of interest there that could affect my ability to speak freely.

42 Q. Okay.

A. Not my conflict of interest, but the board -- the London Health Sciences Centre.

43 Q. Okay. Thank you for that. We will come back to that in a moment.

So I want to just focus in a bit on the time that you were at London Health Sciences Centre where

you were both a palliative care physician consultant and an addiction medicine consultant. And if I understand correctly, that would have been from between 2012 and 2021 where you practiced in both areas; is that right?

A. Yes.

44 Q. And during that time, what percentage of your practice would you say was devoted to palliative care and what percentage was devoted to addiction medicine?

A. At the beginning of that time period, more of my practice was devoted to palliative care. It was actually in palliative care that I became interested in addiction.

I started seeing people who were dying from infectious complications of injection drug use and recognized that we had a -- in spite of being a tertiary care centre, there was very limited addiction support at the hospital.

So initially, my involvement was highly palliative care, and over time, it became almost exclusively addiction until it was exclusively addiction.

45 Q. Okay. We will come back to that as well. And then -- so in your role as an addiction medicine consultant at London Health Sciences, is it fair to say that your practice was an in-patient practice?

A. Exclusively.

46 Q. Exclusively, okay.

And so, again, I would like to come back to that. And so just to be clear, I don't see on your CV any practice experience in the City of Hamilton; is that right?

A. I have not done medical practice in the City of Hamilton, that is right.

47 Q. Okay. Thank you.

So I would like to scroll down to your presentations, if I could. And I'm sorry if this gives you a bit of nausea. Sometimes it does.

A. Yes, vertigo.

48 Q. Yeah. Okay. Sorry. So do you see the title "Presentations" here?

A. Yes.

49 Q. Okay. And I see that the last presentation -- or the most recent presentation on this list is the 24th of May, 2018?

A. Well, that's for an invited lecture as a keynote speaker. That's very different from presentations.

50 Q. Oh, so you've given other presentations since then?

A. I think if you keep scrolling down, you will see them.

51 Q. I didn't see them.

A. Oh, okay.

52 Q. Well, if you can direct me to it, I would be happy to take you there. And you are free -- Dr. Koivu, you are free to refer to your CV, because it is an exhibit to your affidavit.

I am just scrolling through here as well. I see media appearances. I see symposia. Is this what you are referring to? And workshops? This is on the last page of your Exhibit A.

A. Can you go back to the top of where that is, "invited lecture"?

53 Q. Sure. I'm just going to scroll up. You tell me when -- I'm going to take you where I think you are referring to, and you can tell me if that is right.

A. I have given talks since 2017 or '18.

54 Q. Oh, you have?

A. Yes, I have.

55 Q. So this CV is not up-to-date?

A. Yes, I am missing talks that I have given. I have given presentations since that time.

56 Q. Okay. So it would be helpful -- so, counsel, we would like an undertaking to provide Dr. Koivu's updated CV that contains any missing information.

MS SHORES: Yes. Of course.

---UNDERTAKING

MR. CHOUDHRY: Thank you.

BY MR. CHOUDHRY:

57 Q. So, Dr. Koivu, I want to ask you about a presentation that you gave recently to the House of Commons Standing Committee on Health on May 6, 2024.

Do you remember that?

A. Yes, I do.

58 Q. And so, Dr. Koivu, I'm going to put up on this screen -- and we will mark this as Exhibit 1 to the cross-examination. This is the Standing Committee -- these are the minutes of the Standing Committee of Health of May 6, 2024.

MS SHORES: So let me just interject with the respect to the marking of exhibits. We will mark this for identification, and you can put the question to Dr. Koivu to authenticate the document if she is able to do so.

-- EXHIBIT NO. 1: Minutes of the Meeting of the Standing Committee of Health dated May 6, 2024.

BY MR. CHOUDHRY:

59 Q. Sure. So, Dr. Koivu did you testify before the Standing Committee of Health of the House of Commons on May 6, 2024?

A. Yes, I did.

60 Q. Have you ever seen these minutes?

A. No, I haven't.

61 Q. You haven't. Okay. So, Dr. Koivu, these are on the House of Commons website, and they are official minutes of the House of Commons Committee of Standing Health, and they include your remarks and questions and answers.

And so because you haven't seen these, I'd like to give you a minute to refresh your memory of what you might have said. And so I'm going to enlarge this here. Can you read that?

A. Yes.

62 Q. Right. I'm sorry. I can't --

A. It's now too big, actually.

63 Q. It is? Okay. So, fine. So tell me -- tell me when -- how is that?

A. I think -- yes, that's fine.

64 Q. Okay. So it begins here:

"Dr. Sharon Koivu, addiction physician as an individual."

Correct?

A. Yes.

65 Q. Okay. So, Dr. Koivu, would you like a minute to just refresh your memory about this testimony

that you gave? Or do you recall it?

A. Okay. Everything on the screen I can see.

66 Q. Okay. I'm going to scroll to the next -- can you go to the next page?

A. Yes.

67 Q. Okay. So I've got the top half of the page, and when you are ready, I can move down.

A. [Reading].

68 Q. Okay. Can I scroll down?

A. Yes.

This is not me.

69 Q. No, it's not. So to the bottom of the left-hand column is you. And then I'm going to move up, if I could, Dr. Koivu. You continue your remarks. So what's reported to be your remarks are here up to this point on the right-hand column.

A. [Reading].

Okay.

70 Q. Okay. Have you reviewed your remarks as reported?

A. Yes, I have. And --

71 Q. I'm sorry. And --

A. Yes, I have. I'm moving out, because -- I'm sorry. Okay. Yeah, I believe I have reviewed my remarks.

72 Q. To the best of your recollection, are these minutes -- are these minutes accurate?

A. To the best of my recollection.

73 Q. Okay. And so I want to take you to one statement here that I'm going to highlight. And for the record, it reports you as having said:

"I have decided to speak out to bring a voice to the horrific suffering I have witnessed from safe supply."

Do you recall making that statement?

A. Yes.

74 Q. I want to ask you a question about the term that you used here, "speak out." When you used the term "speak out" here, do you do mean speak out directly to parliamentarians about safe supply?

A. In the term I'm using here, yes.

75 Q. Okay. In the term you are using here. Do you mean you use the term "speak out" elsewhere as well?

A. No. I don't believe that that is elsewhere in this document.

76 Q. Okay. And do you believe by speaking out here, do you mean speaking out on the public record about safe supply?

A. Yes. That would be accurate.

77 Q. So Koivu, I'd like to understand how you came to testify before the Standing Committee of Health. Were you issued an invitation --

A. Yes.

78 Q. -- by anyone to testify? Sorry.

A. I believe so, yes.

79 Q. And, Dr. Koivu, I'm sorry. I know you want to answer, and it's we're in a conversation.

A. Sorry.

80 Q. No, it's fine. I actually do it too much myself. But if you can just wait until I'm finished, and if I do the same for you. And if I don't, I'm sorry. But it helps the court reporter get the transcript down. So I will pose the question again.

Were you invited to testify before the Standing Committee on Health?

A. I'm trying to get the -- I mean, I want to make sure I'm answering this accurately. I was -- I requested to speak to the Committee, and then they invited me.

81 Q. I see. So do you remember when you contacted the Committee?

A. It was definitely before -- I think it was last -- oh, gosh. I'd have to look back. I think it was early on -- it feels like, I'm going to say, even December

of last year that I contacted the Committee.

82 Q. So you contacted the Committee in December of 2023?

A. I think so. I'm not -- to be honest, I'm not sure of that. I'm not sure of the accuracy of that. I know I contacted the Committee at a time when you were able to contact the Committee, and I don't remember exactly when that was.

83 Q. And can you explain why you contacted the Committee to offer to testify?

A. I think my understanding of this committee was that it was going to be reviewing safe supply and that it was -- my understanding was that it was a health committee and that it was going to be reviewing safe supply and it was going to be looking at the risks and benefits of safe supply, and I felt that I had important information to contribute.

84 Q. Okay. Thank you.

So, Dr. Koivu, I'd like to refer you back to your CV, if I could. So I'm going to go back. And there are a number of publications listed, which I will take you to in a moment.

Do you see that on your screen?

A. Yes.

85 Q. Is it too large or too small, or is it

okay?

A. That's fine.

86 Q. And so these are academic publications; correct?

A. That is correct.

87 Q. So you haven't listed on your CV any newspaper publications that you have; correct?

A. I don't consider those -- I don't consider those my publications at all.

88 Q. Okay.

A. And they aren't in the sense of basically when you are talking to the press, they don't -- they print things sometimes limited, sometimes out of context. I wouldn't refer to things in the press as publications, and certainly they are not medical publications.

89 Q. Okay. Well, let me take you to an article in the National Post. And so this is an article that we will mark for identification purposes as Exhibit 2. And it's dated -- do you see at on your screen?

-- EXHIBIT NO. 2: National Post Article, Dr. Sharon Koivu, special to the National Post, dated June 10th, 2024.

THE WITNESS: Yes, I do.

BY MR. CHOUDHRY:

90 Q. And it says:

"Dr. Sharon Koivu, special to the National Post."

Do you see that?

A. Yes.

91 Q. Did you write this article?

A. Let me see what the article is. I have written one op-ed in my life, and I wrote it to the National Post, so I'm assuming that's what this is.

92 Q. Sure. We can take a minute to have you go through it. And so for the record, do you see that it states here that it's published on June 10th, 2024?

A. Yes.

93 Q. And the title of this article is:

"Dr. Sharon Koivu: 'Safe supply' Has Only Worsened The Addiction Crisis In London Ontario."

Correct?

A. That's what it states. That is not the title I wrote. That is the title that the editor wrote.

94 Q. I see. What was the title that you wrote?

A. I don't remember, to be honest, but that is not the title that I wrote.

95 Q. Okay.

A. As I say, things that go in a paper are edited.

96 Q. Well, let's just look at what has been printed here. And I'd like you to indicate if this is, in fact, what you wrote.

So I think we will give you time to read this again. So I'm starting here on page 2. So tell me when you have finished reading this.

A. [Reading].

Okay.

97 Q. Okay. And this -- I will go to page 3.

A. Okay.

98 Q. And I'm going to scroll down to page 4.

A. [Reading].

Yes.

99 Q. And I'm going to scroll down again. Sorry This begins at the -- this is how this was printed.

A. [Reading].

Okay. We can move on.

100 Q. Sure. This is the next tranche of text.

A. [Reading].

Okay.

101 Q. Okay. And I'm going to continue until we finish. I'm sorry it comes in dribs and drabs like this.

A. [Reading].

Okay.

102 Q. Okay. And then this is where the article

ends.

A. [Reading].

Yes. Okay.

103 Q. Now, Dr. Koivu, you've now refreshed your memory. These are just kind of comments and garbage that it printed off. So that's the end of the article. Okay?

A. Okay.

104 Q. So, Dr. Koivu, I will now ask you this question again. Do you recognize this article?

A. Yes, I do.

105 Q. Did write the words in this article?

A. Yes, I did.

106 Q. And you stand by what you said in this article?

A. I think there was some editing, but I do stand by this article.

107 Q. Did you approve the publication of this article?

A. Yes.

108 Q. So I want to ask you -- and you didn't object to its publication after the edit?

A. No. I did not.

109 Q. No, you did not; is that correct?

A. I did not object.

110 Q. Okay. So I have two questions I want to

put to you about this article. The first is on page 2. And it's this paragraph that I've highlighted just to aid you a bit. And I want to ask you a question about the last sentence. And it says:

"I feel compelled to speak out about the harm safe supply is causing in my community."

Did you write those words?

A. Yes, I did.

111 Q. Can you please -- in this context, by "speaking out" did you mean speaking out publicly?

A. Yes, it does.

112 Q. And was it your hope in writing these words or making a submission to the National Post that your views would be read by members of the public?

A. Yes.

113 Q. I would now like to take you to page 7. And, again, I'd like to take you to just the final paragraph in your op-ed.

And I want to ask you a question about this sentence here. And it states, for the record:

"To prevent further harm, a moratorium on funding and expansion of 'safe supply' programs must be put in place."

Did you write those words?

A. Yes.

114 Q. Is it your understanding that the provincial government funds safe supply program?

A. Oh, goodness, no. It's a federally funded program.

115 Q. Federally funded. And so were you advocating that the federal government impose a moratorium on funding and expansion of safe supply programs?

A. Yes.

116 Q. Thank you. Okay. So, Dr. Koivu, with the caveat you've just given that you can be at times misquoted in the press, I'd like to put to you other instances of speaking out, to use your words, just to kind of have you confirm whether, in fact, what you are quoted as having said is accurate or not.

So I'm now going to take you to an article that we will mark for identification purposes as Exhibit 3.

-- EXHIBIT NO. 3: Canadian Affairs Article dated July 8, 2024.

BY MR. CHOUDHRY:

117 Q. It's an article that is entitled -- that appears in a publication called Canadian Affairs. And it's an article written by Mr. Liam Hunt, and it is dated

July 8, 2024.

Dr. Koivu, have you read this article before?

A. No.

118 Q. You haven't. Do you recall being interviewed by Mr. Hunt?

A. Yes, I do.

119 Q. Do you happen to recall when you were interviewed by him?

A. I would say likely in June of 2024.

120 Q. Okay. So, Dr. Koivu, because you haven't read this, I'm happy to kind of let you read the article again before I ask you questions about it, if you would like. Would you prefer that I do so? But I have some very specific questions. It's really your choice.

A. I guess --

MS SHORES: I think she should be given the opportunity to read the article, counsel.

BY MR. CHOUDHRY:

121 Q. Of course. Absolutely. And that's why I offered.

So, Dr. Koivu, I'm going to begin. We are going to have to scroll through this again. So you can see, this is page 1. So just tell me when you have finished reading the headline and subtitle and then I can

take you through it.

A. Okay.

122 Q. Okay?

A. Yeah.

123 Q. Okay. So I'm just going to go here. And tell me when you finish this screen, and I will continue to scroll down.

A. [Reading].

Yes.

Keep going.

124 Q. Okay.

A. Okay.

125 Q. Okay. I will stop here.

A. [Reading].

Okay.

126 Q. Okay.

A. [Reading].

Okay.

127 Q. Okay. And then you go there.

A. [Reading].

Okay.

128 Q. Okay. And then we will go to the end.

A. [Reading].

Okay.

129 Q. Okay. So, Dr. Koivu, I want to take you to a passage that begins -- two paragraphs, one that's at the bottom of page 4.

A. Yes.

130 Q. And one that runs from page 4 to page 5. So I just want to put those to you and ask you some questions about them.

So the author attributes the following view to you. The author states:

"Koivu considers herself a lifelong progressive and has historically supported the New Democratic Party."

Is that a fair characterization of your views?

A. Well, I am going to say yes, historically, I have supported the New Democratic Party and that I have felt that -- I think that is accurate.

131 Q. Did you state that? Do you recall stating that to the author?

A. I'm sure that's a paraphrase, but I grew up -- my dad ran for the NDP in 1974. I knew Tommy Douglas, David Lewis, Ed Broadbent. So yes, I have traditionally been involved in what would be referred to as left-wing and particularly in the NDP.

132 Q. The author states then:

"But she is concerned many left leaning politicians have ignored criticism of safer supply."

Did you express that view to the author of this article?

A. Yes. That would be consistent with what I expressed.

133 Q. Then there is a quote that is attributed to you in the next paragraph. The quote begins:

"'I went to a hearing in Ottawa of a standing committee to talk about addiction,' she said."

Do you recall stating that to the author?

A. I would have said that it was -- that I went to the hearing in Ottawa to discuss safe supply, but, you know, meaning that I might have -- to be honest, that's consistent with what I may have said.

134 Q. And then the author continues to quote you. Quote:

"We had five minutes to give a talk and then two hours to answer questions."

And then there's the author's words:

"But I didn't receive any questions from the NDP or from the liberals."

Do you recall making that statement to the author?

A. Yes.

135 Q. I'd like to now take you to another newspaper article that attributes quotes to you, and I want to confirm whether they are accurate or not.

So this is an article from the Toronto Sun, for the record. We will mark it for identification purposes as Exhibit 4.

-- EXHIBIT NO. 4: Toronto Sun Article, August 18, 2023.

BY MR. CHOUDHRY:

136 Q. And the title here is:

"LILLEY: Addictions specialist calls on Ford to clean house at SRCHC."

And it's dated -- it states here that it is published on August 18, 2023.

Dr. Koivu, for the record, have you ever read this article?

A. No.

BY MR. CHOUDHRY:

137 Q. You have not?

A. No.

138 Q. So, Dr. Koivu, because you haven't, I think it's only fair to let you read it before I ask you questions about it. I'm sorry. This will take time.

So, Dr. Koivu, I'm going to begin -- we will follow the same procedure. I'll put what I can on the screen, let you read it, and when you are done, we will move on to the next set of text.

So this is the beginning of the article. Can you read it? Is that too big or is that fine?

A. That's fine.

139 Q. Okay.

A. [Reading].

Okay.

140 Q. Okay.

A. Keep going.

141 Q. Okay.

A. [Reading].

Okay, okay.

142 Q. Okay.

A. [Reading].

Okay.

143 Q. Okay. Okay. And this is the end. And I will show you the rest of it is just material that turns up on PDFs. So why don't we finish here, and then I will scroll through the rest of this so you can see the rest of the page or the document.

A. Okay.

144 Q. And so then, Dr. Koivu, as far as I can tell, this is just stuff that turned up on the PDF afterwards.

A. Okay.

145 Q. So now, I want to ask you some questions about this article, if I could.

Do you recall -- as I've stated before, the author of this article is a Mr. Brian Lilley.

A. Yes.

146 Q. Do you recall being interviewed by Mr. Lilley?

A. Yes, I do.

147 Q. Do you happen to recall when you were interviewed by Mr. Lilley?

A. In 2023, shortly after the shooting that led to the death of the woman in front of the South Riverdale. So I think August would likely be accurate, August of 2023.

148 Q. Okay. Thank you. So I'd like to take you to a couple of statements that are attributed to you, or views that are attributed to you. The first one is here at the bottom of page 3.

A. Yes.

149 Q. Mr. Lilley attributes the following view to you:

"Specifically, Dr. Koivu takes

issue with the Centre's of philosophy published on the SRCHC website."

Did you take issue with the Centre's philosophy on its website in your interview with Mr. Lilley?

A. Yes.

150 Q. I'd now like to take you to a quote that's attributed -- first of all, a quote from the SRCHC. Just for context, it says:

"It is a philosophy about being simply respectful of and to people who use drugs. No judgement, no expectations, and no desire for people to stop using drugs."

And then there's a statement -- there's a quote attributed to you immediately after that which says the following, quote:

"That is like a cancer doctor refusing to offer a patient chemotherapy because it might be uncomfortable, Dr. Koivu said."

Do you recall making that statement to Mr. Lilley?

A. Yes, I do.

151 Q. And that statement is accurate?

A. This statement is accurate. It's somewhat out of context, but it's accurate.

152 Q. And so I'd like to -- yes, ma'am. Go ahead.

A. Can I -- I mean, the part of the statement that I have a problem with, and I said this, is specifically the no desire for people to stop using drugs. I support no judgement, no expectations -- I support no judgement absolutely, but no expectations and no desire for people to stop using drugs was the part of the philosophy that I took issue with. That is not clear in that statement.

153 Q. Okay. Thank you for that clarification. I'd like to now take you to another quote that is attributed to you. And this is on page 5 of the document. For the record, it says, quote:

"With this policy, South Riverdale Community Health Centre is not working to improve lives, Dr. Koivu said."

Let's stop with that. Do you recall making that statement?

A. No, I don't. But it's quoted, so I'm going to say that I made the statement. I don't recall it specifically, but it is a quote here.

154 Q. Okay.
A. I do recall the next part, which is that they are promoting dependency on a service that should be meant to help them, that no expectation and no desire to stop using drugs, my concern is that they were promoting a dependency on the service and not facilitating patients to access recovery and treatment programming, as is indicated in supervised injection sites.
155 Q. Okay. And so, Dr. Koivu, before making this statement, or since then, have you visited the South Riverdale Community Health Centre?
A. No.
156 Q. No. Have you met with the physicians who are on staff at that centre?
A. No.
157 Q. Have you met with any patients who have -- or any individuals who have -- who are clients of that centre?
A. No.
158 Q. So I'd like to continue then to these quotes that are attributed to you. And these are on page 7. The first quote is:
"There has to be a complete change in leadership, Dr. Koivu said."
Do you recall making that statement?

A. I don't recall specifically, but it is quoted, so I'm going to say I made that statement.
159 Q. Okay. And then I would like to take you to the next quote.
"Unfortunately, once people have drunk the Kool-Aid and think this is a good thing, it's hard to have the same workers recognizing the importance and value of facilitating a journey to recovery."
Do you recall making that statement?
A. Yes.
160 Q. And then finally, I would like to take you to -- I would like to just ask you a question. So you've said that you haven't -- you had not visited the SRCHC prior to giving this interview and making these statements; correct?
A. That is correct.
161 Q. And you have and done so since then; correct?
A. No, I haven't.
162 Q. And you haven't made an academic study of the work at the SRCHC, have you?
A. No, I haven't.
163 Q. Okay. So one more media quote here, Dr. Koivu, and then we will get back to your affidavit.

And I should also tell you at some point, if you need to take a health break or get a glass of water or so forth, just -- we are about to be at a natural time where you could if you want to, but it's really up to you. I'm happy to continue as well.
A. You can continue right now.
164 Q. Okay. But let us know if that changes. Okay?
A. Yeah. Thank you.
165 Q. So, Dr. Koivu, this last article is in the London Free Press. And I'm sorry that it's not -- can you read that?
A. Yes, I can.
166 Q. It's an article in the London Free Press that we will mark as Exhibit 5 for the purposes of identification.
-- EXHIBIT NO. 5: London Free Press Article, Harms of safe drug supply programs outweigh benefits: Addiction specialist.
BY MR. CHOUDHRY:
167 Q. The title is:
"Harms of safe drug supply programs outweigh benefits: Addictions specialist."
And then it states:
"A London doctor at the centre of

a national political debate over opioid program said she had no intention of becoming a talking point for the federal Conservative party."
The author of this article is a Mr -- pardon me -- is Randy Richmond. Do you recall being interviewed for this article?
A. Yes, I do.
168 Q. Have you read this article before?
A. No, I haven't.
169 Q. Okay. So we are going to follow the same procedure.
I'd like to take you through the article so you can read it before I ask you some questions about it. So can you confirm that you have read this page?
A. Yes, I have.
170 Q. Okay. I'm going to scroll down now. Okay. And I'm very sorry about the way that this has come formatted. Can you read that? The article begins here.
A. Yes.
171 Q. Okay. Can you read that?
A. Yes.
172 Q. So let's -- tell me when you've finished this screen, and I will continue to scroll down.
A. [Reading].

Yes. Okay.

173 Q. Okay.

A. [Reading].

Okay.

174 Q. Okay.

A. Okay. Okay.

175 Q. Okay. So I have a couple of questions about the sentence that I have side-barred here in the final page of this article. The first sentence states:

"Meanwhile, Koivu is calling for a moratorium on funding until there's more public discussion of the programs."

That's a statement or a view that's attributed to you. Do you recall making a statement like that to the journalist?

A. Yes, I did state that there should be a moratorium on funding safer supply -- or safe supply programs.

176 Q. The next sentence -- and I believe this is a typo. It says "Koivus," but it should be "Koivu." But it states:

"Koivus [sic] said she approached local NDP and Liberal MPs, who consider her opinions, but can't get her message beyond them to party leaders."

Did you tell the journalist that you had approached local NDP and liberal MPs?

A. Well, actually it's -- the NDP is an MPP.

177 Q. Oh, I see.

A. NDP is liberal. So in the writing -- in the same writing that I did speak to the liberal MP and the NDP MPP. And had I spoken to an NDP MP, it was specifically in the writing of London.

178 Q. So you approached the local NDP MPP and the local MP?

A. Yes. That is correct.

179 Q. And you approached them?

A. Yes.

180 Q. And then it says here:

"But can't get her message beyond them to party leaders."

Did you ask want -- did you ask them to convey your message to party leaders?

A. I would say, yes. Certainly with speaking with the liberal MP, I felt that it was very important for the federal government to understand concerns that were happening in London. So yes, he had been initially very engaged.

And I have known both of those men for quite a while and have had a very good relationship with both of them and spoke to both of them about this. And yes, I was hoping that they would speak beyond the local level.

181 Q. Okay. Thank you. So, Dr. Koivu, I'd like to go back to your affidavit. And I'm on Exhibit A. Again, these are your publications. Do you recognize this publication list?

A. Yes, I do.

182 Q. And so there I see here 11 publications. Is that list up-to-date?

A. I believe there are more. I think I have about 14 publications, but -- I believe there are about 14 publications at this time.

183 Q. And those additional publications would be on the CV that we will be getting from you soon?

A. Sure.

184 Q. Sure.

A. I will put them on.

185 Q. Okay. And so, Dr. Koivu, I looked at the list of publications, and it seems -- I want to put to you that these publications are principally about drug use, about addiction and so forth. If you'd like, I can put specific article titles to you.

A. Is that a question? I'm not sure.

186 Q. No. I'm trying to characterize the body of your research. I count here one -- so Article 1, then Article 4, Article 5, Article 6, Article 7, and then Articles 8, 9 -- 8 and 9, and then Article 11 as all being about the health effects of injecting drugs; is that fair?

A. That would be more accurate than I think the first way you put it, so, yes.

187 Q. Okay. And would you say that that is the principal focus of your research?

A. That has been the principal focus of the research that I have been involved in.

188 Q. When you say you "have been involved in," what do you mean by that?

A. That I am involved in all of those studies, so, yes, I have -- research is -- I am a clinician and do research. And the research I have been involved in has -- which has been supported -- that doesn't sound right.

So, yeah. I guess the answer is, yes. The research I have done has been primarily around the complications of injection drug use.

189 Q. Okay. So, Dr. Koivu, I'd like to take you to your affidavit now. Excuse me. I'm going to scroll up. And you are free to have it in front of you, as I have said before.

So I just want to take you to paragraph 5. And so this paragraph describes your work as an addiction physician?

A. Yes.

190 Q. And just to confirm, it states that you've primarily been providing inpatient addiction medicine consultations; correct?

A. Yes, correct.

191 Q. And then it says here:

"The patients that I see are admitted to hospital and have a substance use disorder."

Do you see that sentence?

A. Yes, I do.

192 Q. Okay. And so are you able to estimate how many patients you have seen as an inpatient addiction consultant between St. Elgin General Hospital and London Health Sciences Centre?

A. You mean altogether?

193 Q. Could you estimate over the course of -- yes.

A. It's a hard question if you're looking at number of consults versus number of patients, because some patients come in -- okay.

194 Q. Could you give both figures, perhaps? This

is not a trick question. I'm just trying to understand what the scale is of the patient population you have seen.

A. Thousands of patients.

195 Q. And just so I understand the logistics of how this works, because you are an inpatient addiction consultant, is it correct to say that patients are admitted to hospital by a different service, so by general --

A. Yes.

196 Q. Sorry. Go ahead.

A. Sorry. Yes.

197 Q. So, for example, they could be admitted by general surgery?

A. Yes.

198 Q. Or they could be admitted by psychiatry?

A. Yes.

199 Q. And then they are referred to the addiction consultant team?

A. Well, originally referred to me, and then when we got a team, they were referred to a team.

200 Q. Okay. So they would be referred to you, or when you had colleagues, to you or your colleagues on the addiction consultant team; correct?

A. Yes.

201 Q. And your role, your treatment mandate is to

treat those patients for their addiction issues?

A. My treatment mandate includes meeting the patients where they are, helping to keep them out of withdrawal, helping to support them in hospital so that they can stay in hospital for the treatment that is required, and to help facilitate addiction treatment and addiction recovery --

202 Q. Sorry. Go ahead.

A. I help facilitate addiction treatment and recovery, therapy or I see people with multiple types of addiction. So depending on the type of addiction, it is about trying to help, meeting the patients where they are, helping them to be able to stay in hospital, and helping them to facilitate treatment, helping to coordinate with community organizations and agencies and helping to facilitate their journey into recovery if possible.

203 Q. Okay. But you don't treat them for their other medical issues?

A. Generally not.

204 Q. So you don't treat them for their -- and you are not a psychiatrist, are you?

A. No, I am not.

205 Q. Okay. And so -- and because you see these patients on an inpatient basis, you don't follow up with them in the community on an outpatient basis, do you?

A. No, I do not.

206 Q. Okay. And so in your role as an inpatient addiction specialist, what percentage of your patients would you estimate are unhoused or homeless?

A. That has increased over time. Initially I would say that the number was fairly small. I would say that that number has risen to close to 40 per cent.

207 Q. Okay.

A. In London, before I left London.

208 Q. I see.

A. In St. Thomas, it would be a different number.

209 Q. What would the number be?

A. In St. Thomas it is a smaller number. I would say most of the patients I see in St. Thomas are housed.

210 Q. And when you see homeless patients, you see them in the hospital; correct?

A. Yes, that is correct.

211 Q. So you don't attend on them in shelters; correct?

A. I do not attend on them medically in shelters, no.

212 Q. No. And you don't attend on them medically in encampments, do you?

A. No. I don't.

213 Q. Okay. So, Dr. Koivu, there's a term that is sometimes used in the medical literature and also in this policy area called "living rough." Are you familiar with that term?

A. Yes, I am.

214 Q. So I'm going to put to you -- what do you understand that term to mean?

A. I think it has various meanings. So your meeting would be helpful, but living rough tends to mean living outside of a shelter.

So living rough can include living -- being homeless and living outside of a shelter system, outside of -- that would not include couch surfing or that sort of thing. It would be about living either -- it can refer to living in encampments, tents. It can refer to living outside, without the aid of tents or encampments.

Sometimes people will use it specifically to mean outside of even encampments. So how it is used can be variable.

215 Q. So, Dr. Koivu, that's very helpful. And I'm glad we are clarifying this.

So in this cross-examination, I'm going to use living rough in a narrower sense than you did. And so I will draw a distinction in some of my questions between living in an encampment and living outside but not in an encampment, so specifically not living in a tent.

Is that clear?

A. Okay. If that's how you will use the term living rough to mean living on the street or living outside of a tent or an encampment --

216 Q. Yes.

A. -- which are both different, but okay.

217 Q. That's correct. Just to be clear. Okay. And so I want to take you to paragraph 10. And you state here:

"Many the patients that I see[...]"

I assume you meant "many of."

"So many of the patients that I see are vulnerably housed or experiencing homelessness. I have seen patients who are living in homeless shelters in tent encampments and in both environments."

Correct?

A. Yes.

218 Q. Okay. What proportion of your addiction practice is devoted to shelter residents?

A. So of the homeless patients that I see -- and so the question is, how many are in shelters? So

40 per cent. That also has definitely changed over time. Initially most of the homeless patients I saw would have been living in shelters.

That has changed. I'm going to say it's about -- 50 per cent are living in shelters, and 50 per cent are living mostly in encampments.

I do not have a population of patients that I see that I would say are specifically living rough --

219 Q. Okay.

A. -- as you have defined it.

220 Q. Thank you. That's helpful. I want to take you to paragraph 15. And it's about the scope of your expert opinion. And so it says here:

"I have been asked to provide my opinion from the perspective of my area of expertise with respect to health outcomes for people experiencing homelessness who live in encampments, as compared to in shelters."

Can you confirm that that is what you were asked --

A. Yes.

221 Q. -- to provide?

A. Yes.

222 Q. Okay. And so you have not been asked to provide your opinion on the health outcomes for people experiencing homeless -- or comparing the health outcomes of people experiencing homelessness living rough compared to those living in encampments or living in shelters?

A. No. Not as you have defined it, no.

223 Q. Okay. I'd now like to take you to paragraph 18. And so here I'm going to highlight the first sentence. It states-- pardon me. Sorry, the first two or three sentence I have highlighted. I'd like to ask you about the third sentence.

A. [Reading].

Yes.

224 Q. Okay. And so I'd like to ask you about the -- so the third sentence states for the record:

"Unsheltered people experiencing homelessness have a 2.7-fold increased risk of mortality compared to those who are sheltered."

Correct?

A. Yes.

225 Q. And you cite to that -- for that reference for that proposition footnote 15; correct?

A. Yes. That is the Boston study.

226 Q. That's the Boston study. Okay. So I'm

going to take you to the Boston study. And so if you will give me a second. And I'm going to put it up here.

We will mark this as Exhibit 6 to the cross-examination.

-- EXHIBIT NO. 6: Boston Study.

BY MR. CHOUDHRY:

227 Q. Can you read that for identification? Do you recognize this paper?

A. Yes. Yes, absolutely I recognize the paper.

228 Q. And so this is a paper that was published in JAMA Internal Medicine. The title is:

"Mortality among unsheltered homeless adults in Boston, Massachusetts 2000-2009."

You referred to this as the Boston study. Is this the Boston study?

A. Yes. This is the study that I am referring to that I am calling the Boston study, yes.

229 Q. Okay. And so I'd like to take you to a couple -- did you review this article before reading -- before preparing your affidavit?

A. Yes, I did.

230 Q. Do you remember when?

A. I've -- I mean, I've read it previously. I

also read it more recently when I was doing my affidavit. So I'm going to say around the -- as I was doing my affidavit, this was one of the articles that I read.

231 Q. Okay. So I would like to take you to two parts of the study. So scrolling down here. So the first is -- so this is page 2 of the article. And I will just reduce it a bit so it is all on one screen.

Do you see that?

A. Yeah, but --

232 Q. It's too small? I can --

A. I can read it, but I'm --

233 Q. No, no.

A. -- going to be staring closely. It's --

234 Q. That's not the intention. So let me increase the size. Is that better?

A. Yes.

235 Q. All right.

A. Now I can only see one part, though.

236 Q. That's what I was trying to avoid, but let's do it this way.

A. Can you scroll it up a little bit?

237 Q. Of course.

A. If you scroll the other way.

238 Q. Scroll down?

A. I guess down, yes.

239 Q. Yeah.

A. I might be -- now I can't quite get --

240 Q. Can you see the bottom, Dr. Koivu?

A. I'm missing the top. I'm not quite able to see the whole thing.

241 Q. Okay. I know. Unfortunately, I can't do that and have you make it readable. So --

A. No, you can go smaller. I can still read it. You can go smaller than that and I should be able to still read it.

242 Q. Okay. Tell me when to stop.

A. Okay. Yes. I can read both parts. I can read both parts.

243 Q. Okay. Dr. Koivu, I'd like to take you to the method section of the article.

A. Yes.

244 Q. It starts here.

A. Yes.

245 Q. Do you see that?

A. Yes.

246 Q. And I'd like to take you to the study population --

A. Yes.

247 Q. -- paragraph. Can you just refresh your recollection by reviewing that paragraph?

A. Okay.

248 Q. It begins at the bottom of the left column and it goes up to the right column.

A. Yes.

[Reading].

Okay. Yes.

249 Q. Okay. And so would you agree that the authors of the article did not break down the unsheltered homeless population --

A. Absolutely.

250 Q. -- to those living rough and living in encampments?

A. Absolutely. That is one of the, for lack of the better word, weaknesses of this article is that they didn't break it down. Absolutely.

I completely agree with you that a problem with this article, with this study is that they did not break down what you would describe as living rough versus encampment.

So this is not -- you are right. Absolutely.

251 Q. Okay.

A. That is a flaw of this study or a limitation, I guess, is the right word that I'm looking for, in the study.

61

252 Q. Well, on the topic of limitations, I want to take you to the limitation section of the study. And so I'm scrolling down. And so this begins on page 5 of the PDF with the title "Limitations."

Do you see that?

A. Yes.

253 Q. I want to take you to a passage on the limitation section on the next page. May I do that, or would you like to read this first?

A. No, that's fine. You can take me to the passage.

254 Q. Okay. Great. And so I want to take you to this sentence here. Additional limitations. And it reads, for the record:

"Additional limitations included a lack of information about individual comorbidities or the chronicity of being homeless before and during the observation period. Both could have contributed to a more nuanced understanding of mortality risk in this population."

Do you see that?

A. Yes, absolutely.

255 Q. Okay. And so I want to put this into plain

62

English, if I could. So let me suggest something to you. And please let me know if this is accurate.

Are the authors stating here that they did not control for the comorbidities of the two homeless populations, those who are living in shelters and those living outside shelters?

A. I don't think this was a study where you control that in the sense that it's not a randomized controlled study. So I'm not sure "control" is the word, but I don't think they factored in or had the ability to know what the comorbidities and even the chronicity.

So I would say it's more things that could be -- contribute to living in a shelter or not living in a shelter, those sorts of comorbidities were not taken into consideration during this study.

256 Q. That's very helpful, Dr. Koivu. Let me kind of, again, in layman's terms, layperson's terms, put that point to you and see whether it's fair.

Is it fair to say that the authors did not observe chronicities or comorbidities and therefore could not factor those into their analysis of health outcomes?

A. Well, I wouldn't say they didn't observe them. They just didn't observe them before the observational period so that they couldn't say how they contributed to them.

63

So how this words is that they weren't able to say or they didn't observe prior, so specifically before -- you know, before or during, so they weren't observing them.

So I'm not -- so I think I'm agreeing, but not exactly. I think it is a wording thing. But, yes. They weren't -- the comorbidities and the chronicity of the illnesses weren't part of what they were looking at in the study and could be contributing factors that they did not take into consideration.

So I think we are saying the same thing. I just --

257 Q. Well, Dr. Koivu, just on that last point, did the authors not state that they didn't observe those either before or during?

A. Yes. It says before or during their observational period. Yes. So, yes, that's correct.

258 Q. So they didn't observe the comorbidities or chronicity during the observation period?

A. No, that is correct.

259 Q. So they had no information about them?

A. Yes, that is correct.

260 Q. And so they couldn't draw any conclusions about the role or lack of role of those chronicities or comorbidities on the outcome they observed; correct?

64

A. Yes, that is correct.

261 Q. Okay. Thank you.

I will take you back to your affidavit.

A. I think what is relevant in this study is those are the limitations. What is relevant in the study -- and I think -- you bring up a very good point, and I think you're going to be able to make that point with any study that we are extrapolating data and how we have that data interpreted. And there's going to be, I'm sure, more opportunities for you to do that.

I think what is also the strength of this study is that all of the people in the study had access to the same services.

So this is an American study. The types of services that they had access to are going to be maybe not similar to services in Canada, per se, but I think what was relevant about this study Is that they had access to the same services and yet found that 2.7-fold difference in mortality.

So there are limitations, I absolutely agree with you, there are limitations to the study. And you've pointed out limitations to the study. But I think the thing that for me is the strength of the study that makes it worth noting is that the people in the study were given access to the same services.

So it's not a matter of not having access. It is not a matter of people who were in a shelter had access to certain services that the other population didn't.

And I think that is what makes this study a valuable study. You are absolutely correct about the limitations of this study.

262 Q. And just to pick up on the point that you raised, this is an American study?

A. Yes, absolutely. And I think that that is a really important point, because American healthcare is different from Canadian healthcare.

And the -- so you are absolutely correct that being able to completely extrapolate what happens in Canada versus the States in many aspects are going to be different.

I think what makes this study, as I say, the most important part of the study is that people had access to the same services, regardless of whether they were sheltered or unsheltered. And I think that is the part that's important. Those services may be somewhat different, but that is the part that is most important.

263 Q. And just to go back to your affidavit, this is the only study you cite for this statement.

A. Yes. It's actually in another paper, but when I went back to that paper, I think it's the number 5, Liu paper, they are actually -- they use the same statement about mortality, the 2.7. I even think I saw that in some of the affidavits.

But when you look at the references, they are referring to that study, the same study. So I've seen it in other articles. The one -- I think it's number 5, that is from Liu is the author, I believe.

But if you actually read beyond their statement of the 2.7, they are getting it from the same study.

264 Q. Are you aware of any Canadian data?

A. No. No, I'm not aware of any. I think -- unfortunately, I'm not aware of -- I'm aware of the Canadian study that looks at -- is the one from Vancouver -- sorry, British Columbia, the Nikoo study that looked at comparing sheltered to unsheltered, but that was specifically about chronic illnesses. It is not about mortality.

265 Q. I see. Okay.

A. I do not know of a study -- I would love to see one -- I do not know of a study that is specific to Canada. So that -- that is referencing the Boston study. And any other references that I saw do go back and circle back and they are referencing the same study.

266 Q. Okay. Good. And so thank you, Dr. Koivu. I'd like to now take you to paragraph 20 of your affidavit, which I have put up on the screen.

A. Yes.

267 Q. Just to refresh your memory.

A. Sorry. I'm looking at the wrong paragraph.

268 Q. That's okay. Can you see it here, paragraph 20? It begins here.

A. Yes.

269 Q. Okay. And so this paragraph, it's fair to say, is about the risk of frostbite?

A. Yes.

270 Q. That you -- and it's your evidence that there are significant risk of frostbite to persons living in encampments; correct?

A. Yes.

271 Q. But, of course, you are aware that shelters don't provide 24/7 accommodation, are you?

MS SHORES: Well, hang on, counsel. I don't know that that's been established.

BY MR. CHOUDHRY:

272 Q. Well, Dr. Koivu, what's your understanding of the shelter accommodation?

MS SHORES: She is not being presented as an expert on the shelter accommodation. There's a way you can propose that to the witness that is both fair and proper and doesn't require her to speculate on shelter policies.

BY MR. CHOUDHRY:

273 Q. Well, Dr. Koivu, I would put it to you that shelters do not operate -- they do not offer shelter 24 hours a day?

MS SHORES: That's a refusal, counsel. Again, you can put that proposition to her without asking her to comment on shelter policies.

---REFUSAL

BY MR. CHOUDHRY:

274 Q. Well, Dr. Koivu, if an individual -- do you want to say something, Dr. Koivu?

A. I'm waiting for the question.

275 Q. So, Dr. Koivu, if an individual were outside during the day, would they not also experience the risk of frostbite?

A. Yes. The risk of frostbite, however, is increased with the amount of exposure, the length of exposure, the ability to also access a warm building, for example. People who are outside during the day could also go to a library during the day that isn't available at night.

So, yes, the longer you are outside, the

more likely you are to have problems such as frostbite. It also is worsened in environments in which the cold is sort of maintained.

So -- and you could -- well, I guess in answer to your question, if you are outside at any time of the day for a long period of time, particularly if during that period of time you are not conscious, such as being asleep or taking a sedating medication, you are at risk of getting frostbite at any time of the day.

Frostbite is not limited to nighttime. However, the temperatures tend to be different at different times of the day, as well as accessing warm structures is different at different times of the day.

276 Q. And, Dr. Koivu, to be clear, you haven't provided any evidence about access to warm structures during the day, have you?

A. No, I haven't, and that's not my intent. I'm just pointing out that when you're -- to the question that you asked about daytime, I don't know the policy of shelters. And I would say that access -- accessing a warm environment decreases your risk of getting frostbite, and not accessing a warm environment increases your risk of getting frostbite, regardless of the time of the day.

277 Q. And, Dr. Koivu, would you agree that being in a tent reduces the risk of frostbite relative to living in the rough?

A. No. I have absolutely no data to support that. If anything, if you are living in a tent, especially a small, domed tent, then your own body heat is going to be creating condensation on the tent, which can actually increase moisture in the tent, which can be a problem that can increase the risk of things, particularly trench foot.

But the amount of protection in a tent -- at least the tents that I've -- tents are not designed to be able to withstand temperatures to make a significant difference once we are talking about freezing temperatures.

278 Q. Have you -- can you cite a study for what you've just said?

A. What I can say is I know of no study that shows that tents are safer, that provide safety outside. And having been someone who's done an extensive amount of camping, which does not make me an expert on tents, I am well aware of the limitations of a tent and do not know of any study that would support what you have stated, which is that a tent will offer an advantage over not being in a tent once you are reaching the types of temperatures in which frostbite can occur.

279 Q. Oh, interesting.

A. I am not a tent expert.

280 Q. Thank you for clarifying that.

Counsel -- sorry. Dr. Koivu, I'd like to take you to paragraph 27, which is about trench foot. Do you see it?

A. Yes, absolutely.

281 Q. All right. And so you don't refer specifically here to the risk of contracting trench foot inside or outside a tent, do you?

A. No.

282 Q. No?

A. No.

283 Q. Okay. All right.

A. But my topic was specific to people who were in tents. So I was not making a comparison to people who were not in tents.

As I have mentioned, the risk of being in a tent, particularly because of how tents work where you get condensation from body heat that's going to be affecting -- essentially hitting the side of the tent and creating moisture within a tent -- sleeping bags, for example, can become quite moist just from body heat.

That's fairly standard. So absolutely the risks of developing trench foot within a moist environment -- and tents can be a very moists environment -- are what I was referencing.

284 Q. Dr. Koivu, you've referred more than once to condensation and body heat --

A. Yes.

285 Q. -- from living in tents. Is that anywhere in your evidence?

A. No. But my specific topic was about being in a tent and not comparing it to outside of a tent.

So, no, this is in answer to your questions.

286 Q. And is it a topic of your research expertise?

A. No, it is not, and I am not a tent expert. This is from my experience of being in a tent and from my understanding of condensation and how condensation works.

287 Q. Sure. And, Dr. Koivu, just to be clear, you're here to provide expert evidence based on your professional experience and research capabilities, not in your personal experience living in a tent. Can we clarify that?

A. Absolutely.

MS SHORES: Well, counsel, I'm going to interject, because she's here for a cross-examination on the expert evidence that she has given in her affidavit.

And as the witness just said in her

previous answer, she's answering the question that you posed to her.

MR. CHOUDHRY: Well, actually she has answered the question by reference to knowledge that she shouldn't be relying on to answer.

It's presupposing that any question put to an expert witness that they should only answer based on their expert -- on their expertise, not their personal experience, counsel.

BY MR. CHOUDHRY:

288 Q. So, Dr. Koivu, going forward, let's stick to your expertise, if we could.

MS SHORES: Well, counsel, she'll answer the questions as best she can. And if there are disputes over what's within her expertise, those can be dealt with in due course.

I think she explained what the limitations of her expertise were in answering your question. And if you're going to put a question to her, then you should expect that she's going to give an answer to it.

BY MR. CHOUDHRY:

289 Q. And so, Dr. Koivu, just for the record, you're not an expert on tents?

A. No, I'm not an expert on tents.

MS SHORES: She has said that several times now, counsel.

BY MR. CHOUDHRY:

290 Q. Good. And I'm glad we've got it on the record again.

So, Dr. Koivu, I'm going to take you now to paragraph 58. You state here:

"Most patients reported an increase in drug use in encampments."

Do you see that statement?

A. Yes, I do.

291 Q. You don't cite any research to support that statement, do you?

A. No. This is specifically patients have reported to me.

292 Q. Okay.

A. And so this is --

293 Q. I see.

A. -- my experience, absolutely. This is not something that I can say that has been well studied.

294 Q. And how many patients are "most patients"?

A. I am going to say every patient that we had the discussion with about their use within encampments stated that they had an increase in drug use in the encampments.

So of the people that were in encampments,

that conversation probably happened at least 75 per cent of the time.

295 Q. But you don't provide any evidence about the rates of drug use in shelters, do you?

A. No.

296 Q. Okay. I'd like to take you to paragraph 49. Do you see that paragraph? It's about sexual violence, sexual exploitation, and sexual traffic.

A. Yes.

297 Q. Dr. Koivu, I want to -- you cite -- the only source you cite in this paragraph are the notes that are marked as notes of 52, 53, and 54; is that correct?

A. Yes, that is correct.

298 Q. Okay. I want to take you to those sources first, if I could. So I'm going to stop this screen share.

And, Dr. Koivu, at this time, if you would like to take a break, this would be an opportune moment, or if you would like to continue, we can do so as well.

A. Okay.

--- RECESSED AT 11:27 a.m.

---RESUMING AT 11:38 a.m.

BY MR. CHOUDHRY:

299 Q. We are back on the record, Dr. Koivu.

So, Dr. Koivu, I want to take you back to paragraph 49 of your affidavit. I won't put it back up on the screen just now unless you would like me to.

When we last broke, or when we broke before the break, I was asking you about the three references you cited in footnotes 52, 53, and 54; correct?

A. Yes.

300 Q. I would like to take you to those references, if I may.

A. Sure. Yes.

301 Q. Okay. So I'm going to share with you a different -- a browser. And I have bookmarked these pages. So if you will bear with me, I will pull them up.

So, Dr. Koivu, this is -- at footnote 52 of your affidavit you provided a hyperlink.

A. Right.

302 Q. And the hyperlink takes us to this article?

A. Yes.

303 Q. Do you recognize this article?

A. Yes, I do.

304 Q. Okay. And so this is an article in the Waterloo Region Record; correct?

A. Yes, it is.

305 Q. And it's dated December 12, 2022?

A. Yes.

306 Q. And this is a story about the risk of

grooming for sex trafficking in Waterloo; correct?

A. Yes.

307 Q. And do you have any first-hand knowledge of the risk for sex trafficking in Waterloo discussed in this article?

A. Not specifically about Waterloo, no.

308 Q. And is your only knowledge of the risk of sex trafficking in Waterloo from this article?

A. Yes.

309 Q. Okay. Dr. Koivu, I'd like to now take you to the reference cited in footnote 53. This is an article that is from Edmonton City News. Do you see this?

A. Yes.

310 Q. Is this the article -- is this the web story, pardon me, that --

A. Yes.

311 Q. -- you cited in footnote 53?

A. Yes.

312 Q. And so is this story about a sexual assault of a minor in an encampment in Edmonton?

A. Yes, it is.

313 Q. Do you have any first-hand knowledge of the sexual assault discussed in this article?

A. No. I do not.

314 Q. So your only knowledge of this sexual

assault is from this story?

A. That is correct.

315 Q. Okay. Dr. Koivu, I'd like to take you now to the reference of footnote 54.

Dr. Koivu, do you see this article?

A. Yes, I do.

316 Q. It's in the Toronto Sun. It's dated October 1st, 2020, this title is:

"Levy: It took court action for Toronto to admit tent cities are problematic."

Do you see that?

A. Yes, I do.

317 Q. Is this the article you cited footnote 54?

A. I don't -- it could be. I am --

318 Q. Should I put --

A. I will go with yes. I know I cited this article. So I'm assuming that it was number 54.

319 Q. Okay. And Dr. Koivu, just to be clear, I just took these links from your affidavit.

A. Yeah. Yeah. And I'm sure then that it is the right number in the right place. I have definitely had this as a link.

320 Q. Okay. And so you remember reading this article, do you?

A. Yes, I do.

321 Q. And so this article, you would agree, is about human trafficking in an encampment in Toronto?

A. That is correct.

322 Q. And you don't have any firsthand knowledge about the human trafficking discussed in this article, do you?

A. No.

323 Q. Your knowledge about human trafficking discussed in this article is from this new story?

A. Yes, that is correct.

324 Q. Dr. Koivu, I'd like to take -- I'd like to stop this screen share for a moment. And I'm going to take you back to your affidavit for a minute, if I may.

Do you see that?

A. Yes.

325 Q. Okay. I'd like to -- I'm going to take you back -- I'm going to take you up in your paragraph -- pardon me -- up in your affidavit to paragraph 23.

And I'd like to take you to the last sentence in paragraph 23. Do you see it?

A. Yes.

326 Q. So you state there:

"I'm aware of several people dying in tent fires."

And then you provide three footnoted references, 26, 27, and 28; correct?

A. Yes.

327 Q. Okay. So, Dr. Koivu, I'd like to take you to the -- those references are in your affidavit, if I could scroll down. Excuse me. Just give me one second here. Are in Exhibit C and 26, 27, 28 are listed here.

Do you see those?

A. I think 27. I have the wrong link. If I remember right --

328 Q. Oh.

A. -- there are a couple places where I have the wrong link, and that is -- yeah, that's one of them, because if you look at 26 and 27, they are the same. They are actually the same article.

So unfortunately, I had the wrong link for that. So 27 is the same as 26. There is no extra link there. That was the wrong link that I added.

329 Q. Sure. So we will take the links as they are, because this is in your affidavit. So the link for 27 is incorrect; is that correct?

A. Yes, you are correct. The link for 27 is incorrect.

330 Q. So I'd like to take you to the link for the articles that are listed correctly on your evidence in

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footnotes 26 and 28, if I may. Okay. So I will just go back to the browser.

Dr. Koivu, is this the article you cited correctly in footnote 26?

A. Yes.

331 Q. It's a CBC article from London; correct?

A. Yes.

332 Q. And it says here it's dated April 16, 2024?

A. April 15th, but yes.

333 Q. Pardon me.

A. Sorry. The article is April 16th. The woman died on April 15th.

334 Q. Right. And so actually, Dr. Koivu, does the article not say that the death occurred on April 15, 2023?

A. Yes, that is correct.

335 Q. Okay. And so --

A. This is referencing the memorial that they had for this woman.

336 Q. I see. I see. And so were you an eyewitness to this fire?

A. No. I was not an eyewitness to this fire.

337 Q. Did you treat the deceased?

A. No.

338 Q. And did you know the deceased?

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A. No, I did not know the deceased. I knew people who knew her, but I did not know her.

339 Q. Okay. And so your only knowledge about this death is from this online news story?

A. No, that is not correct. I also knew people who knew her.

340 Q. But your only direct knowledge of this death is from this online -- you have no direct knowledge of this death. You've learned about her death from other individuals or from this new story?

A. I do not have direct knowledge of the death. I have learned about it from other individuals in London, as well as from the new story. I already knew about the death before the news story, but I did not know her. I did not witness it, nor see it individually.

341 Q. Thank you.

And so now I would like to take you to another -- to the link that I believe is cited in footnote 28. Do you recognize this story?

A. Yes.

342 Q. And this is the story you cited in footnote 28; correct?

A. Yes.

343 Q. And so this is a Toronto Star story on a tent fire death in Toronto; correct?

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A. Yes.

344 Q. Were you an eyewitness to the fire?

A. No.

345 Q. Did you treat the deceased?

A. No.

346 Q. Is your only knowledge about this event from the news story?

A. Yes.

347 Q. Thank you.

I'd like to now go back to your affidavit and take you back -- take you to paragraph 25. Do you see that?

A. Yes.

348 Q. And your evidence there is -- or you state:

"I am aware of risks from propane tanks used to heat tents, including explosion causing injury and death and carbon monoxide poisoning."

And you cite, again, to a footnote, footnote 29; correct?

A. Yes.

349 Q. Okay. I'd like to take you to Exhibit C where you list footnote 29. And, Dr. Koivu, is it true that this source here is a CBC news article; correct?

A. Yes.

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350 Q. Okay. And so I'm going to take you to that article. Dr. Koivu, can you read that article?

A. Yes.

351 Q. Let me increase the size. Is that easier?

A. Yes.

352 Q. And so, Dr. Koivu, is this the article that you cited in footnote 29?

A. Yes.

353 Q. And this is a CBC story on the propane explosion?

A. Yes.

354 Q. Were you an eyewitness to the explosion?

A. No. I was not.

355 Q. Did you treat the injured?

A. It is possible that I treated people who were injured from this explosion, but I do not know that specifically. I have certainly treated people with burns, that have been admitted to the hospital with burns. I cannot say specifically to this article.

356 Q. So you can't confirm that you treated individuals that were injured in this incident referenced in this article?

A. That is correct.

357 Q. Okay. Dr. Koivu, I'd like to take you back to your affidavit. And I'm going to take you to

85

paragraph 70.

And so do you see that paragraph?

A. Yes.

358 Q. Okay. So I want to take you to these two -- this -- these two sentences. You stated that:

"I have not provided care for these people and have not had access to any other medical records."

Correct?

A. Yes.

359 Q. And:

"I do not feel that I have sufficient information to have a medical opinion."

Correct?

A. True.

360 Q. And so, Dr. Lamont -- sorry. Pardon me. Dr. Koivu, just for the record, and so you would agree that without access to the medical records, you could not provide a medical opinion on Dr. Lamont's care of these patients; correct?

A. That is correct.

361 Q. Okay. Now, you have -- and so Dr. Lamont -- you describe Dr. Lamont's evidence and where she states that one patient -- she referred to one patient

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as having suicidal ideations; correct?

A. Yes. And there were more than one patient that she stated had suicidal ideations, but in my affidavit I have referenced one.

362 Q. I see. And you no reason to disagree with her diagnosis, do you?

A. No, I do not. I don't know -- well, the same patient that she referenced as having severe suicidal ideations was also seen by Dr. O'Shea, and he did not mention suicidal ideations in his affidavit.

That doesn't -- I can't -- if it was -- the way it was worded by Dr. Lamont made it sound like it was a very significant part of her experience.

It wasn't mentioned by Dr. O'Shea. There is a discrepancy, but I do not have enough information to know where the discrepancy is or exactly what that discrepancy is, but I did note that there was a discrepancy between the two.

363 Q. I see. But you have no reason to doubt that Dr. Lamont diagnosed the patient as having suicidal ideations, do you?

A. Well, she may have -- yes, I will say that I have no reason to doubt that she diagnosed them with suicidal ideations, as she stated that she diagnosed them with suicidal ideations.

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364 Q. Dr. Koivu, you refer to the Mental Health Act here.

A. Yes.

365 Q. Are you familiar with the Mental Health Act's requirements for involuntary institutionalized assessment?

A. My -- I believe I am familiar with it.

366 Q. Have you ever committed a patient for involuntary assessment?

A. Yes.

367 Q. You have. And so you know that the threshold for involuntary assessment is very high?

A. Yes.

368 Q. And so do you know that it's possible -- wouldn't you agree that it's possible that a patient could have suicidal ideations without meeting that threshold?

A. I think it's possible, but once you start using words like "severe," I feel that I would have difficulty knowing why the word "severe" -- because people can have suicidal ideations, but to contemplate suicide, suicidality, and to have severe suicidal ideations would seem to be approaching the threshold.

And it's that relevant to that person's experience that is noted would make it seem like those are very relevant factors in this patient, that this patient's

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suicidality is very important to the context, but I cannot say -- I cannot say more than that it is concerning that someone with severe suicidal ideations would meet the threshold.

I'm aware that the threshold is -- there is -- definitely the bar for that threshold is high to have involuntary institutionalization.

369 Q. So, Dr. Koivu, I'm not quite understanding. How is what you said not a medical opinion?

A. It's not an opinion about that particular patient, and it's just an observation that Dr. Lamont is stating that people have severe suicidal ideations, but has not felt that they were suicidal enough to feel that they needed to have a voluntary or involuntary assessment.

So I'm just commenting on her reference to severe suicidal ideations and balancing it with the fact that although she has used that word, she also did not feel they were severe enough to require institutionalization and institutionalized assessment.

I and just pointing out that fact. That's not a medical opinion about this case.

370 Q. Well, I guess that will be for the judge to decide.

So, Dr. Koivu, I'm going to take you to paragraph 71. And so, again, I want to note that you

repeated here that you haven't cared for the people she describes in her affidavit; correct?

A. Yes.

371 Q. You don't have access to their medical records; correct?

A. Yes. That is correct, yes.

372 Q. And so, therefore, you don't have sufficient opinion to give a medical opinion; correct?

A. Absolutely. That is correct.

373 Q. But then don't you go on here then -- you state here that:

"The cause is not clear but is consistent with tent fire."

Don't you?

A. Yes.

374 Q. So aren't you speculating here about the cause on a burn on the back of that patient?

A. Yeah, absolutely. And that's probably -- I definitely speculated based on what she wrote. That is absolutely speculation on my part.

375 Q. Okay. And so -- but you would have no way of knowing that for sure, would you?

A. No, absolutely not.

376 Q. So, Dr. Koivu, I just want to take you to one last set of questions. And this is about the

City of London where I know you practiced medicine until very recently.

And it's about the City of London's encampment's policies. Are you familiar with those at all?

A. They have been changing -- they have changed over time, so I'm not sure to what you are -- so I would not state that I know the current -- currently what the encampment policies are.

I do know that currently where I have seen a number of patients that had been in encampments behind the pharmacy that I referenced, they are no longer able to be there, and if they are there, they are removed.

I have seen them as recently as in August, but I also am aware that they are removed. At the time that I wrote this and am referencing that, those encampments were present, but I do know that that has changed with the new guidelines.

MS SHORES: Counsel, I'm going to interject before your next question. I've been giving you quite a lot of leeway in this examination, and I will continue to do so, but I do not see the relevance of the City of London's encampment policies. So perhaps you can help me with where you are going.

MR. CHOUDHRY: Sure. I'd like to know what

Dr. Koivu -- Dr. Koivu has offered a number of views. Her affidavit is about encampments and the health risks that she -- they pose. And I'd like to ask her for her views about the City of London's encampment policy and whether --

MS SHORES: That's completely irrelevant.

MR. CHOUDHRY: Well, I disagree, counsel, so I will put the question to the witness, and you can then decide if it's relevant or not.

MS SHORES: Very well.

BY MR. CHOUDHRY:

377 Q. So, Dr. Koivu, this is a -- I've put on the screen -- we'll mark this as Exhibit 8 for examination purposes.

-- EXHIBIT NO. 8: City of London Community Encampment Response Plan, dated June 25th.

MS SHORES: It will only be marked for identification.

MR. CHOUDHRY: Yeah.

BY MR. CHOUDHRY:

378 Q. It's a statement, and it seems to be a public announcement from the City of London website about a Community Encampment Response Plan, dated June 25th.

Are you familiar with the Community Encampment Response Plan?

A. No.

379 Q. You are not?

A. No.

380 Q. Okay. So you are not aware of any -- so didn't offer any views about this to London City Council?

A. No.

381 Q. And you weren't aware of it?

A. No. And I'm not sure that that is current, but --

382 Q. Well, Dr. Koivu, since you raise the question of currency, it says Tuesday, June 25th, 2024. And then it states here:

"London City Council has endorsed the Community Encampment Response Plan."

A. Okay.

383 Q. And this is the latest document I could find.

A. Okay. There's lots in the paper that seem to make -- that seem like things are changing and that it's --

MS SHORES: I'm going to interject again, because the policies that may or may not be in place in the City of London or how they may or may not be evolving is completely irrelevant to the issues in Hamilton.

BY MR. CHOUDHRY:

384 Q. Okay. And so, Dr. Koivu, just again, just to confirm, this is for Exhibit 9, the Community Encampment Plan, you haven't seen this before, have you?

A. No, I have not.

385 Q. Okay.

MS SHORES: Exhibit 9, again, will only be marked for identification. The witness has just said she's never seen this before.

And I'm again going to state that the policies regarding encampments in the City of London are irrelevant.

MR. CHOUDHRY: Thank you.

Dr. Koivu, those conclude my questions. Thank you very much for your time.

MS SHORES: All right. Off record.

---The Examination concluded at 12:00 p.m.

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. SHARON KOIVU, given under oath before me on the 6th of September, 2024.

Amy Armstrong, CVR-RVR

Certified Realtime Verbatim Reporter #7305

Certified Commissioner of Oaths

Certified this 9th of September,2024

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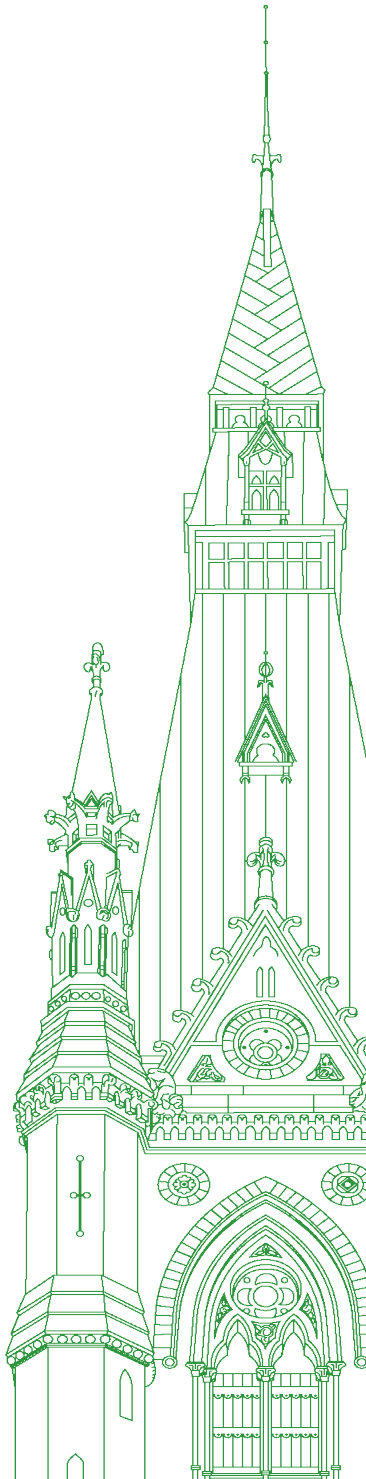
44th PARLIAMENT, 1st SESSION

Standing Committee on Health

EVIDENCE

NUMBER 114

Monday, May 6, 2024



Chair: Mr. Sean Casey

Standing Committee on Health

Monday, May 6, 2024

● (1545)

[*English*]

The Chair (Mr. Sean Casey (Charlottetown, Lib.)): Welcome to meeting number 114 of the House of Commons Standing Committee on Health.

Before we begin, I would like to remind all members and other meeting participants in the room of the following important preventative measures.

To prevent disruptive and potentially harmful audio feedback incidents that cause injuries, all in-person participants are reminded to keep their earpieces away from all microphones at all times. As indicated in the communiqué from the Speaker to all members on Monday, April 29, the following measures have been taken to prevent audio feedback incidents.

All earpieces have been replaced by a model that greatly reduces the probability of audio feedback. The new earpieces are black in colour, whereas the former earpieces were grey. Please use only an approved black earpiece. By default, all unused earpieces will be unplugged at the start of the meeting. When you are not using your earpiece, please place it face down on the middle of the sticker for this purpose, which you will find on the table, as indicated. Please consult the cards on the table for guidelines to prevent audio feedback incidents.

Also, the room layout has been adjusted to increase the distance between microphones and reduce any chance of feedback from an ambient earpiece.

These measures are in place so that we can conduct our business without any interruptions and to protect the health and safety of all participants, including the interpreters. Thank you for your co-operation.

In accordance with our routine motion, I'm informing the committee that all remote participants have completed the required connection tests in advance of the meeting.

I would like to welcome our panel of witnesses.

We have with us here in the room Dr. Sharon Koivu, addiction physician. Online is Dr. Bernadette Pauly, scientist with the Canadian Institute for Substance Use Research and professor at the School of Nursing, University of Victoria. By video conference, representing the Thunderbird Partnership Foundation, we have Dr. Carol Hopkins, chief executive officer. Finally, also by video conference, representing the Vuntut Gwitchin First Nation, is Chief Pauline Frost.

To all of our witnesses, thank you for being with us.

Parliament Hill is a place where rumours are a constant. I heard a rumour today that there's going to be a vote in roughly 45 minutes. If that happens, the meeting is likely to be interrupted, and we will be asking you to stay a little later than you might have anticipated. If you are able to stay with us to ensure that everyone gets a chance to fully converse on these matters, it will probably result in your time with us being extended from 5:30 until 6 o'clock or a little later. I'll give you a heads-up for that.

We can now go ahead with our opening statements, beginning with Dr. Koivu.

You have the floor for the next five minutes. Welcome to the committee.

Dr. Sharon Koivu (Addiction Physician, As an Individual): Thank you, Mr. Chair and members of the committee.

I have been a physician for 39 years. I have my certificate of added competence in palliative care and addiction medicine from the College of Family Physicians of Canada. I began working in addiction medicine in 2012. Until 2021, I was the sole health care provider offering comprehensive consultations in addiction medicine at the London Health Sciences Centre, where, in 2023, an interprofessional addiction team was established. I also provide addiction consultations in St. Thomas.

I have decided to speak out to bring a voice to the horrific suffering I have witnessed from safe supply.

Early in my addiction career, I identified a link between injecting long-acting hydromorphone capsules and developing a heart valve infection. An infectious disease specialist I worked with found a link between injecting these capsules and getting HIV. When this specialist and the department chair took our findings to the community agencies, we were initially criticized and called fearmongers.

Fortunately, we established community engagement and developed an integrated response. As part of the response, in 2016, the London InterCommunity Health Centre developed a program that provided high-risk sex workers using hydromorphone capsules with short-acting hydromorphone tablets, also called Dilaudid. This was the inception of the safe supply program in London. I initially supported the program. It is important to note that we did not have a problem with illicit fentanyl at this time.

Prior to the safe supply program, I rarely saw people with spine infections. In the following summer, I saw five patients in one month. The numbers continued to climb. The common thread among patients was that they were injecting Dilaudid tablets. Many told me they were buying Dilaudid diverted from the safe supply program.

Some patients were in the program. I had patients who were housed, using clean equipment and only injecting Dilaudid developing horrific infections. Spine infections cause perhaps the worst suffering I have ever seen. Not only are they unbearably painful, but they can also cause paraplegia or quadriplegia.

In June 2018, I had my first patient tell me that he left his apartment to live in a tent near the pharmacy, close to the safe supply clinic where much diversion takes place, because the safe supply pills were cheaper and more abundant near the source. I lived in the neighbourhood and watched this encampment grow.

Since safe supply began, I have been involved in about 100 hospitalizations of patients with spine infections. That's currently about one per month. However, spine infections are only a small part of the suffering we see. About 30 patients per month are admitted with another severe infection. Of patients admitted with opioid use disorder, 25% were receiving a safe supply prescription and 25% reported using diverted Dilaudid. Only 4% of the consultations we did were for unintentional overdose.

Generally, in hospital, we start patients on home medications. If we did this for safe supply patients, the results could be fatal. This is dangerous for patients and very stressful for health care providers.

For example, patient one was prescribed eight milligrams of Dilaudid, D8s, which was 40 tablets per day, along with 100 milligrams of long-acting morphine in nine capsules per day. When they were given less than half of their prescribed dose, they had a severe respiratory depression—that is, toxicity. Patient two has frequent admissions requiring intubation. They were prescribed 28 D8s per day. They tolerated about six to eight and said they never took more than 12 in a day.

The patient population has changed. I see more young patients and many more men. Now, most start opioids recreationally and not with a prescription for pain, as was the case in 2012. I am also repeatedly hearing disturbing stories that people with prescriptions are vulnerable to violence.

Importantly, as I mentioned previously, when safe supply started in 2016, we did not have a problem with illicit fentanyl. We do now. Many patients have told me that they sell or trade much of their prescribed safe supply to buy fentanyl. Others not in the program have told me that their dealer has claimed to be out of Dilaudid and has sold them fentanyl, starting them down this path.

● (1550)

Safe supply appears to be contributing to the illicit fentanyl crisis. Safe supply is not reducing illicit fentanyl or its harms within a community. Our hospital experience also shows that safe supply is preventing patients from choosing opioid agonist therapy and the opportunity for recovery.

I would like to mention a program that is showing significant benefits. The Central Community Health Centre in St. Thomas has a low-barrier approach using subcutaneous buprenorphine, also called Sublocade. They are having success serving a very similar population to that of the London InterCommunity Health Centre, without the unintended side effects. It should be a model that we are discussing.

Of note, while I have broad shoulders, I found some of the comments made by Dr. Sereda on February 26 about me and cardiac surgeons to be misleading, and I look forward to an opportunity to address this.

Thank you for your work and your time. *Meegwetch*.

The Chair: Thank you, Dr. Koivu.

Next is Dr. Pauly for five minutes.

Dr. Bernadette Pauly (Scientist, Canadian Institute for Substance Use Research, and Professor, School of Nursing, University of Victoria, As an Individual): Good afternoon. Thank you for the opportunity to be here.

I am Dr. Bernadette Pauly. I'm a professor in nursing at the University of Victoria and a scientist at the Canadian Institute for Substance Use Research. I'm a member of the research team conducting the B.C. provincial evaluation of prescribed safer supply.

Prior to the introduction of the prescribed safer supply policy, evidence of the need for that intervention was well demonstrated by the overdose deaths caused by the unregulated drug market. However, it's critical to generate evidence of ethically justified interventions and determine whether or not prescribed safer supply reduces overdose risk. To answer that question, our team designed a rigorous mixed methods study using state-of-the-art approaches combining administrative and primary data.

In January 2024, the team led by Dr. Slaunwhite and senior scientist Dr. Nosyk published the first-ever population-level study in the British Medical Journal, a high-impact journal. Everyone receiving risk mitigation safer supply prescriptions was included in the study and was carefully matched with people not receiving them on multiple variables, including receipt of opioid agonist treatment. For those receiving opioids through this program, the risk of dying from any cause was reduced by 61% and the risk of dying of an overdose was cut in half. If they received four days or more, their overdose risk was further reduced to 89%. This is known as a dose-response relationship, and the finding was independent of opioid agonist treatment. A similar pattern was found for stimulants, but the sample size was smaller so there was less certainty. This protective effect continues week after week as long as they're able to access a prescription.

However, only 7.6% of those with an opioid use disorder and less than 3% of those with a stimulant disorder received the intervention during the period of study. There was limited implementation, with implementation occurring mainly in urban areas like Vancouver and Victoria and among prescribers who had larger caseloads of people with substance use disorders and more complex problems. While the intervention did not fix all their issues, nor was it expected to, it was protective for reducing risk of overdose death and all causes of death.

In a qualitative analysis, we found that prescribers were hesitant to take up the intervention out of fear of audit from regulatory colleges, as well as criticism and censure from colleagues. Where there were networks of prescribers who had support, there was increased continuity of prescribing. However, prescribing alone is an inadequate response to a systems issue, namely prohibition and an unregulated, unsafe supply of drugs.

The intervention was often difficult to access. Participants in the qualitative arm of the study reported the need to climb a steep staircase with many steps. Often, potential participants did not know about the risk mitigation guidance or safer supply. When they got their hopes up, they had to find a prescriber and navigate highly medicalized systems to get an appropriate prescription, and then pick it up daily to keep it. This required self-advocacy and fortitude. In a primary survey of 197 people, less than half of participants received a prescription sufficient to reduce withdrawal. Reducing withdrawal is a minimum requirement, so there's room for improvement.

Prescribed safer supply is a not a competitor to OAT or any form of treatment. It provides a pathway for people to access a life-saving intervention as part of individual recovery journeys. It does not replace or threaten the need for treatment. In fact, as part of a system of care, treatment options must be available for people if and when they are ready. In spite of this, the number of people dispensed a prescription in B.C. is decreasing.

Fears of diversion causing death are unfounded. Hydromorphone was detected in 3% of overdose deaths in 2023. It's unregulated fentanyl that's responsible for 85% of the toxic drug deaths. The root problem driving this emergency is toxic drugs, which is a consequence of prohibition. The unregulated market is accessed by those with substance use disorders and those without.

● (1555)

We need to expand access to alternatives beyond the health care system to ensure safe and regulated access to substances of known safety, quality and composition. We should be scaling up, not scaling back, safer alternatives to the unregulated drug market and looking to end prohibition.

Thank you. I look forward to the questions and comments.

The Chair: Thank you, Dr. Pauly.

Next, on behalf of the Thunderbird Partnership Foundation, we have Dr. Carol Hopkins.

Welcome to the committee. You have the floor.

Dr. Carol Hopkins (Chief Executive Officer, Thunderbird Partnership Foundation): [*Witness spoke in Lunaape*]

[*English*]

I'm Carol Hopkins of the Lenape nation in southwestern Ontario. I'd like to acknowledge the lands that you are joining us from and that we're all coming together on today.

In 2023, the number of first nations deaths due to drug poisoning was 36 times those in the general population in Ontario. In eight short years, from 2016 to 2023, first nations deaths due to the toxic drug supply grew at a rate of 33 times those seen in the Ontario population.

During the pandemic, from 2019 to 2022, 28% of first nations people used opioids in a harmful way, and 18% used methamphetamines to survive in an environment where there were no resources for housing, food security or income security. Those who reported food insecurity were two times more likely to use methamphetamine, according to a survey that Thunderbird ran. Forty per cent of first nations people reporting methamphetamine use felt hopeless to change their lives. It was this hopelessness that increased their risk for using opioids in a harmful way.

This population also reports a high rate of trauma, grief and loss, with a lack of resources close to home to support their mental wellness. The use of fentanyl, benzodiazepines and xylazine has been increasing across all regions of Canada, including in first nations. They are core to the opioid and toxic drug crisis that we are talking about today. The impact of these drugs requires community-based health resources that often first nations communities lack. First nations communities that declare a state of emergency report no capacity for preventing deaths due to the toxic drug supply. They also report their vulnerability to gangs, gun violence and murders, as well as human trafficking, which is now present in many first nations communities for the first time.

The war on drugs, including the criminalization of people for their health and social needs, has been a long-standing experience of first nations people in Canada, who are only 5% of the population yet represent 32% of those incarcerated. Indigenous women represent 50% of the incarcerated population. The war on drugs and incarceration have not increased safety from the toxic drug supply, have not reduced crimes of survival for people who live with opioid dependency and have not eliminated the illicit and toxic supply.

Indigenous Services Canada does not provide for physician or pharmacy services in first nations communities. We know those things are the responsibility of the provinces and territories. In this context, the opioid crisis and toxic drug crisis do not depend on geography. Rural and remote first nations communities are not exempt from the toxic drug supply or opioid crisis. The crisis is about a lack of equitable, available and accessible health care for first nations, with access to primary health care, physician services, pharmacies and public health resources. These are all necessary components of a response to the toxic drug crisis. Live-in drug treatment aimed at abstinence is not the evidence base for addressing opioids, and it is not the first line of evidence-based intervention. Abstinence-based programs will not change drug dependency or address physical withdrawal from opioids.

Where live-in treatment programs have additional resources—for example through provincial health authorities, harm reduction networks and first nations-governed culture-based and land-based services—and have options for readmitting or keeping first nations people on a continuous basis, clients have gone on to gain employment, obtain housing and maintain their own wellness.

Buprenorphine treatment is initiated by the community's primary care physician, when they are lucky enough to obtain a partnership; by addictions physicians through telemedicine; or by fly-in locums, who dispense daily under supervision. It has proven to be effective, along with a recovery program involving community mental health workers who provide both conventional counselling and culturally relevant healing practice. This comprehensive approach has enabled many patients or first nations people to stop or manage their opioid use and return to work, school and family. A year after such programs have been initiated, criminal charges and medevac transfers decreased, the needle distribution program dispensed less than half its previous volume and rates of school attendance increased.

● (1600)

Addressing the opioid crisis has been challenging for first nations communities, most significantly because of inconsistent support and resources to community-governed and culturally relevant treatment. One study of community-based opioid misuse reported that among adults aged 20 to 50, 28% were on buprenorphine or naloxone, double the rate of adults in the community living with type 2 diabetes.

First nations people have the right to live—to live life. They have the right to the sacred breath of life, and that has to be our focus in any drug policies that are humane and sensible for first nations communities.

First nations communities require increased capacity for reducing harms related to opioids, opioid analogs, methamphetamines and xylazine, such as consistent support; access to prescribers, pharmacies, safe housing, food security and medication to address withdrawal; and a choice to continue to use drugs safely. Harm reduction kits and resources are needed. Human resources are also needed—

The Chair: Dr. Hopkins, I'm sorry to interrupt. If I could get you to wrap up, you will get a chance to expand on your presentation in questions and answers.

Dr. Carol Hopkins: Human resources are needed in community. The existing resources of treatment centres can also play a role, but they need additional resources and capacity.

Thank you.

● (1605)

The Chair: Thank you.

Last but not least, from the Vuntut Gwitchin First Nation, we have Chief Pauline Frost.

Thank you for being with us. You have the floor.

Chief Pauline Frost (Vuntut Gwitchin First Nation): Thank you. I appreciate the opportunity today.

I am the chief of a very small community—

The Chair: Excuse me, Chief Frost. I'm sorry. The bells are ringing, and that means we're obligated to vote unless we have unanimous consent to continue.

Do we have unanimous consent to allow Chief Frost to finish her opening statement before we head off to vote?

Some hon. members: Agreed.

[*Translation*]

Mr. Luc Thériault (Montcalm, BQ): Mr. Chair, while we're at it, to avoid interruptions, could the volume in the room be lowered a bit so that I can hear the interpretation better without having to turn up the sound? It's too loud in the room.

We should be doing tests at the beginning of every meeting to solve the problem. This isn't the first time I've had to intervene. I haven't interrupted the witnesses more often out of courtesy. However, the discussion is becoming difficult to follow.

[*English*]

The Chair: Okay.

Chief Frost, I'm sorry for the interruption. Go ahead and finish your opening statement. We'll likely suspend once you're done.

You have five minutes.

Chief Pauline Frost: Okay. Thank you.

As the former minister of health and social services for the government of the Yukon, I was responsible for identifying the opioid crisis, as well as the COVID pandemic. At the same time, I worked as a lead negotiator for my first nation, a small, isolated aboriginal community in north Yukon. We signed our self-government agreement 30-some years ago. We exercise our inherent right to self-determination. We have responsibilities for the general welfare of all citizens, our community, the land and the resources. As an isolated community, we're a resilient people, resilient in that we are connected to our roots, our traditions. At the same time, we are deeply affected by the opioid crisis and the toxic drug overdoses in the Yukon and across this country.

The serious challenges that we face and the high cost of living.... Food security is huge. Fiscal capacity is limited in our communities, causing significant challenges in addressing mental health. Substance use challenges have arisen in our history due to colonialism, racism and intergenerational trauma. All of this is a priority for my community.

In April 2020 and 2023, we declared a state of emergency and substance use crisis in my community. The reason is that we've suffered significant loss due to opioid, alcohol and drug use and abuse. Over the last five years, we've lost 15 Vuntut Gwitchin citizens linked to substance use.

Because of the small community, this is very complex, and it affects everybody, with compound impacts and effects. Every person in my community has been affected in one way, shape or form. Because we're an isolated community, our citizens are required to travel out of the community for amenities and medical supports. Therefore, we tend to see impacts and effects when they get to the city. There's an urban centre effect on average on northern isolated people.

We have worked tirelessly to support our citizens the best we can with healing and wellness. Our approach has been comprehensive and non-judgmental. We commit to facilitating easier access to treatment services. We set aside, last year, almost a million dollars for supporting our citizens to access treatment programs. That comes out of our FTA base funding that we get for programs and services.

Ensuring consistent availability of counsellors both locally and remotely is a priority for me as a chief. We are developing aftercare programs that provide supports to our community.

What I'm saying here is that we are working hard to combat substance use in our communities. We are utilizing the Yukon's Safer Communities and Neighbourhoods Act to address and combat drug trafficking and bootlegging. We've asked for changes to the security designation for our northern airports so they can implement passenger baggage and freight screening for northbound routes, equivalent to what's seen southbound. In other words, the drug traffickers can come into our community without restrictions whatsoever because we're remote fly-in.

Our tools are limited, but we are making significant headway, and we have sent over 70 people to a treatment facility in the southern parts of B.C. because the Yukon is not equipped. Treatment options are not available to us in the Yukon; we have limited availability. We need more. My first nation needs support to implement programs and improve the wellness of my people.

As we are on the ground, we know what's happening. We have the flexibility, but we are also trying to address the crisis. Adequate and secure funding for life-saving interventions is not going to save us. It's not going to help us. We need more supports in addressing the illicit drug overdoses and for program services.

We looked at a piecemeal funding program available to us through the federal government and the territorial government, which is not sufficient. We just asked last year, at the Prime Minister's forum, for direct access to funding and support. Put it in our base, and let us provide services. We don't have that flexibility. There needs to be consideration of the political, social, economic and cultural pressures that we're facing.

● (1610)

I want to quickly say that we've just finished a coroner's inquest in the city of Whitehorse, Yukon, for four overdose deaths at the emergency shelter facility. Two of those individuals were residents of my community.

We are proud of our community, because we are resilient. We've done amazingly. We own an airline. We don't have a housing crisis. However, our people are directly affected. We have to make a meaningful difference in the services that are provided, and the only way forward is by working together and jointly addressing this. We have looked at options, like a safe exchange in our community. We've educated our citizens. We have looked at alternative options. We are looking at recovery withdrawal supports in our community. We also have to look at a distribution program.

Everything we need to do is about building on healthier families and healthier communities. For the first time, we are actually focusing on our young people now, and we have a youth wellness program. We're bringing our youth together, and facilitators are coming in—

The Chair: Thank you.

Chief Pauline Frost: *Marsi*. I appreciate this time.

The Chair: Thank you, Chief Frost. We're going to suspend now to allow members to vote.

You can expect the suspension to last for about half an hour. Then there will be probably about an hour of questions, more or less. Stretch your legs. We'll be back once we've voted.

The meeting is now suspended.

● (1610)

_____(Pause)_____

● (1700)

The Chair: I call the meeting back to order.

We've finished the opening statements and are now ready to move to rounds of questions.

We're going to begin with the Conservatives for six minutes.

Dr. Ellis.

Mr. Stephen Ellis (Cumberland—Colchester, CPC): Thank you very much, Chair.

Thank you to the witnesses for their patience.

Dr. Koivu, I listened carefully to your opening statement. When we look at patients—you described a couple of them—we're really not offering them any therapy other than opioid therapy. Perhaps there are other things in addition to that.

For the sake of those listening at home, we all know that people who take opioids will eventually get habituated or used to the dose they're on and will require escalating doses. If that's the kind of medicine we're going to provide, is it not fair to say that we're providing these folks with palliative care?

Dr. Sharon Koivu: Absolutely. That is one of the significant problems with opioids. As you take them, your brain has changes in neurochemicals. What you're taking, your brain becomes used to. That becomes your normal. To get the same effect, you have to increase the dose you're taking. To get the same euphoria, you have to continue to increase the dose.

Perhaps even more importantly, when your brain readapts to this new level of normal, you have to take opioids. If you miss them, your brain will miss them and you'll go into what's called withdrawal, which is a horrific experience. You get severe pain, anxiety, nausea, vomiting and diarrhea. You can feel like you're literally going to die. You keep thinking you need more and you need a higher dose. Whenever you're in a scenario where you're taking an opioid regularly, you're always chasing the high, your dose continues to escalate and you're always trying to medicate away from the withdrawal.

An important thing that isn't always mentioned, which I want to add, is that as your brain regulates and gets used to a certain amount of opioids, you can generally tolerate it if you're well. If you develop pneumonia, endocarditis or any other illness that affects your cardiorespiratory system, that same dose can be toxic or fatal. When you're taking an opioid, it could be that you're always taking the same dose of your Dilaudid or fentanyl, but if you develop pneumonia or sepsis, that dose could become toxic because your brain wants more than what your body can tolerate.

When you are in a position of getting a treatment that's given to you daily to keep you going from one withdrawal to another, it's not allowing your brain an opportunity for recovery. You're staying in a cycle in which you are absolutely dependent on the medication, and you can be at risk of developing tolerance, needing a higher dose and needing a dose that will eventually be more than you can handle. From the cases that I mentioned in hospital, patients were being prescribed substantially more than they could tolerate when we had them in a position where we could see what they were taking. Had we given them the amount they were prescribed, it would have been fatal for them.

Mr. Stephen Ellis: Thank you very much for that, Dr. Koivu.

It's interesting that you started talking about dosages. When we looked at patient 1—I wrote this down—they had 900 milligrams of morphine and 320 milligrams of hydromorphone. Using an opioid calculator to look at the overall dose of milligrams of morphine, that would be equivalent to about 2,500 milligrams of morphine. Is that correct?

● (1705)

Dr. Sharon Koivu: That is correct.

Mr. Stephen Ellis: Looking at that for the average Canadian and again doing the math, that's about 640 Tylenol 3s. You don't have to trust me on that, but I used the same calculator to do it.

The reason I talk about this is people often think it's just one tablet of eight milligrams of Dilaudid. It's a bit concerning that for those who don't use opioids on a regular basis, even though it's one tablet, it's still a significant amount of opioid.

Maybe, Dr. Koivu, you can talk a bit about that.

Dr. Sharon Koivu: Absolutely.

One tablet is also equivalent to four Percocet or 20 milligrams of OxyContin. Those are doses we consider fairly high during the opioid crisis. Taking two of them would essentially be considered relatively safe for most people. Even one can be considered toxic if someone is not used to taking it.

The numbers we're seeing are substantially higher than the milligram equivalent of morphine that I was seeing during the time when people were prescribing heavily for chronic pain. These are the highest doses I've ever seen.

Mr. Stephen Ellis: Very quickly, Dr. Koivu, if we're talking about 2,500-milligram morphine equivalents, what would be the recommended amount that a prescriber should be very cautious about going over? I realize this is a different patient population from even the usual chronic pain population, but what would be a guideline for Canadians listening out there?

Dr. Sharon Koivu: The guideline is the equivalent of 100 milligrams of morphine per day or less.

Mr. Stephen Ellis: And these people are receiving up to 2,500.

Dr. Sharon Koivu: Yes—or more.

Mr. Stephen Ellis: Thank you.

The Chair: Thank you.

We'll go now to the Liberals.

Dr. Hanley, you have the floor for the next six minutes.

Mr. Brendan Hanley (Yukon, Lib.): Thank you very much.

Thanks to all the witnesses for being here.

I'm speaking today from the traditional territory of the Kwanlin Dün First Nation and the Ta'an Kwäch'än Council in Whitehorse, Yukon.

Dr. Hopkins, I want to address the bulk of my questions to you.

Unfortunately, Chief Frost had to leave early during our vote, but I noticed that you were listening acutely to her testimony and you were nodding. I wonder if you can indulge me. Was there anything in particular that resonated, based on your knowledge and experience, from Chief Frost's testimony as chief of an isolated northern community?

Dr. Carol Hopkins: We typically assume that the issue with resources and capacity to respond to the toxic drug supply is remoteness, that it's geographical. We are not asking for or expecting hospitals to be built in every one of our communities, but the Canada Health Act says there should be universal access to health, and its objective is accessible health care without barriers to our wellness.

I mention this because there are lots of Canadians who live in rural and remote communities, but we are talking specifically about first nations people. They have a right to access health care close to home, where they need it. When it's not available there, they will find it someplace else, which often draws them to urban environments.

In urban environments, they don't always have access to the appropriate health care they need when they have opioid dependency or addictions to methamphetamine or other stimulants or even to sedatives like benzodiazepines, which I mentioned, or the “tranq” drug xylazine, which is not a controlled substance. All of them have substantial effects on people when they don't have any health care resources close to home.

That isn't just because of geography. That has to do with decision-making. If the Canada Health Act says there should be universal access to health care for every resident in Canada no matter where people live, then where are the policies that ensure access to physician care, prescribers, nurse practitioners, pharmacies, public health resources and harm reduction resources when they exist for the rest of the population? Why are those not made available to Canadians and first nations populations no matter where they live?

Often this is referred to as a jurisdictional issue. Who's responsible? The Canada Health Act is clear: Our rights as defined in treaties, the Constitution and now the UN Declaration on the Rights of Indigenous Peoples do not erase our rights under the Canada Health Act. This is a decision, a policy decision, not just a matter of geography.

● (1710)

Mr. Brendan Hanley: If you don't mind, I'll jump in there, because my time is limited.

One thing Chief Frost referred to was having spent a million dollars of base funding from the VGFN to, in this case, send people out for treatment. I can't speak specifically to the number of individuals, but I think she mentioned 70.

We know that often when people go outside for treatment and come back into a community, they are at high risk not just for overdose but for relapse because the community supports—the aftercare—aren't there. Following up on your previous point, do you know of or could you describe models of care that work within a small community? Maybe there are success stories you know of or have seen about how care can be delivered within a community so that you have continuity through aftercare.

Dr. Carol Hopkins: There are communities, no matter how big or how small, remote or isolated, that have partnerships with local health authorities, physicians, prescribers and nurse practitioners, who deliver services by flying into the community from time to time or by monitoring their patients through video conferencing. There are partnerships with the chief and council and direction through a band council resolution on how health services are operating through the health centre, as well as these kinds of partnerships with elders and cultural practitioners. It's clinical support and medication, together with culture-based resources, that have made a difference.

I gave an example of a community in northern Ontario where that significantly reduced crime and the number of kids going into child welfare. Kids showed up to school with food in their stomachs, houses were filled with furniture, toys and food, and life returned to normal, because it's a whole-of-community approach and because the community, through a number of partners, had the resources it needed to respond to the whole population. It's not just about the impacts on the individual who uses drugs. It's about the impact on the family and the whole community.

The Chair: Thank you, Dr. Hanley. That's your time.

[*Translation*]

Mr. Thériault, you have the floor for six minutes.

Mr. Luc Thériault: Thank you, Mr. Chair.

Thank you to the witnesses for being here.

Personally, I have no preconceived ideas about the crisis we're trying to understand and fix by means of recommendations. In listening to the various witnesses, though, I end up feeling a little confused. There seems to be no scientific consensus. In fact, increasingly, there appears to be a division within the scientific community or among the professionals working in the field.

Professor Pauly, you talked about safe supply, which saves lives. I guess that was the purpose.

First, does safe supply necessarily have to be temporary? If so, how can we assess that?

Second, why is access to opioid agonist therapy at odds with the impact of safe supply?

● (1715)

[*English*]

Dr. Bernadette Pauly: These are two very important questions.

I just want to speak for a second about the split in scientific evidence that the member referred to. There isn't actually a split when you look at what is considered peer-reviewed evidence or evidence that's been reviewed by multiple scientists in the field.

Our team did a study where we looked at all of the evidence for safe supply. There are close to 40 of these types of peer-reviewed articles, and the evidence is overwhelmingly positive: It connects people to a safer alternative, reducing overdoses; connects them to health care and other types of supports, as needed, like housing; and reconnects them back to family and community. I just wanted to mention that evidence.

Should safe supply be temporary? This is a good question, because when it was introduced in British Columbia, it was introduced as a temporary measure. However, it became clear that we needed it as part of a systems response. I really want to emphasize this piece about a systems response. In British Columbia, we had some evidence early on that when we combined multiple interventions, like take-home naloxone with opioid agonist treatment and overdose prevention, it showed some really good results. However, it wasn't enough. Safer supply comes in as another form of intervention within a comprehensive approach.

As to your question about why there's opposition, I personally don't understand why safer supply is being scapegoated, because the real harms here are coming from a very toxic and unregulated drug market. That is what's killing people.

[*Translation*]

Mr. Luc Thériault: For example, what's your opinion on Dr. Koivu's statement regarding scientific consensus around safe supply?

[*English*]

Dr. Bernadette Pauly: Our evidence has shown that it reduces overdose deaths, and I can point to other studies where it has not been shown to increase rates. Rates of addiction have not been increasing since we introduced safer supply. The description that Dr. Koivu gave is about the ever-escalating need for increasing dosages. That's not what I see happening in the way that prescribers in British Columbia are practising. In fact, in our study, we found that safer supply medications were, at least in the first 18 months, at a lower dose than we see with traditional opioid agonist treatment.

I do a lot of qualitative research. I interview people who are receiving safer supply, and I often ask them about their goals. I would say that, frequently, what they talk about is the goal of getting off safer supply. That might include using safer supply for a period of time and maybe transitioning to OAT, but they have a plan because they too want to live a full life and have a high quality of life. Those kinds of goals are, I think, really important.

That's some of the reality that I see within the work I'm doing.

● (1720)

The Chair: Thank you, Dr. Pauly.

Next is Mr. Johns, please, for six minutes.

Mr. Gord Johns (Courtenay—Alberni, NDP): Thank you all for your testimony.

I'll start with you, Dr. Pauly.

You heard from Dr. Koivu. She raised concerns about infectious complications for people using safer supply. Is this something you found in your research with people who were injecting fentanyl and then switching over to safer supply, or people who started on safer supply? Is this what you're seeing in your research as well?

Dr. Bernadette Pauly: I'll give you a bit of background. When people are injecting from the unregulated and toxic drug market, there are additives. My colleagues on the panel have spoken to this and to how harmful the additives in the unregulated market are. They often cause abscesses and injections.

I believe the committee had a brief submitted by Dr. Gomes, who looked at administrative data for people receiving safer supply—this was in Ontario—and the rate of infections went down when they went into a safer supply program, likely because they were no longer injecting toxic substances from the unregulated market. However, they also would have had a connection to health care, and that's a really positive outcome of safer supply types of programs. In British Columbia, we have more injectable formulations, so if there is a concern about injection-related infections, that may be why those are being used more in British Columbia.

Mr. Gord Johns: Dr. Koivu, given what Dr. Pauly said, could you please submit, within 14 days, your own research to this committee that supports your claims on infections caused by hydromorphone?

Is it the will of the committee to get support for that?

Did the witness agree, Mr. Chair?

Dr. Sharon Koivu: I can—

The Chair: Well, if you've asked her to provide it and she agrees to provide it, I don't think you need everyone else's opinion.

Mr. Gord Johns: I wanted to make sure that was on the record.

Thank you so much.

I'm going to go to Ms. Hopkins.

You were a co-chair on the expert task force on substance use. The expert task force was unanimous in recommending that we scale up safer supply, stop criminalizing people who use substances and ramp up treatment on demand, recovery, prevention and education.

You had a really wide spectrum on the expert task force on substance use. Can you speak about your disappointment, maybe, with the government not following through with the recommendations and your experience with how important it would be to reinstate the expert task force and implement those recommendations?

Dr. Carol Hopkins: We're talking about using evidence, and the question is about whose evidence is more credible. That's quite a common conversation when it comes to first nations people, whose world view and culture-based evidence are typically set aside. However, that does not mean, for example, that culture and safer supply are completely incompatible.

Safer supply is one more tool in the tool box. There is no silver bullet. There is not one medication. There is not one strategy, method or form of care that will solve the opioid crisis or the toxic drug supply. There are many strategies that have to be used together in combination, like—

Mr. Gord Johns: I don't know if the question was heard properly. I apologize for that.

We just heard from the First Nations Leadership Council and the B.C. First Nations Justice Council. They're calling for an emergency cross-governmental and multilateral strategy that ensures the safety of people who use drugs.

Dr. Sayers, a BCFNJC member, said that "the toxic drug crisis needs to be treated and addressed as a public health issue, not a criminal justice issue." Grand Chief Stewart said that how we're proceeding right now is "very much wrapped up in the destructive impacts of colonialism."

Can you add your thoughts on those statements?

● (1725)

Dr. Carol Hopkins: I just want to emphasize the importance of safer supply. That's one tool that needs to be available to everybody.

In addition to understanding the context of first nations people, as I said earlier, we do not have the community-based resources necessary to address the impacts of opioid toxicity or the toxic drug supply. We don't have services close to home where people need them, when they need them. That often leads them to move, travelling off reserve for periods of time. Often, the crowds they find most welcoming are those involved in selling illicit drugs. Then they come back into the community, and now we're creating a new relationship that has significant impacts on families and the whole community.

For the first time ever, first nations communities are reporting murders, not by first nations people murdering first nations people, but by gangs from large urban environments coming onto reserves and committing these crimes. Gun violence and human trafficking have increased.

If we look at what the perception of that is, we could say that because of racism in Canada, first nations people will be blamed for those kinds of activities; they did this to themselves. That's the same sentiment for people who use drugs. They should just stop; they can just decide to. Why don't they choose something different when they're losing all these things? We're blaming the victims without supporting their right to health and social services.

The United Nations—

The Chair: I'm sorry. Thank you, Dr. Hopkins.

We'll go to Mrs. Goodridge, please, for five minutes.

Mrs. Laila Goodridge (Fort McMurray—Cold Lake, CPC): Thank you, Mr. Chair.

I want to thank all the witnesses for being with us and for being patient. It's unfortunate that Chief Frost had to leave us before we got a chance for questions. I found her testimony incredibly insightful.

Dr. Pauly, did the study you cited look at diversion as an issue?

Dr. Bernadette Pauly: That's such an important question, because it's definitely the issue that I would say is creating the most controversy.

I will speak to two ways in which.... While the study didn't directly look at diversion—

Mrs. Laila Goodridge: It didn't look at diversion.

Dr. Bernadette Pauly: No. I will explain—

Mrs. Laila Goodridge: It's yes or no. We have very limited time and I asked a very short question. The convention in this committee is that witnesses answer for about the same amount of time that the question took to ask.

Did diversion get looked at?

Dr. Bernadette Pauly: Diversion was not apparent, because there was a dose-response relationship. In other words, if people got more days of the medication, there was less risk of overdose, which suggests they were taking their medications.

There was a dose-sensitivity relationship. Higher doses meant less risk.

Mrs. Laila Goodridge: Thank you.

Dr. Bernadette Pauly: What this led to was people taking their meds in many cases.

Mrs. Laila Goodridge: Dr. Koivu, I'm sure you've seen the proposals coming out of the city of Toronto asking to move toward decriminalization for that city. Do you think that will have impacts on communities like London?

Dr. Sharon Koivu: I think anything that happens in Toronto is definitely going to have an impact on London. What we're seeing in London has been largely affected, I think, by decriminalization as it is.

We're certainly seeing a lot more open drug use. It's very common to see people injecting in parks, smoking fentanyl in parks and injecting Dilaudid in public spaces already, so I think that's something we'll have a problem with.

Mrs. Laila Goodridge: Really quickly, have you seen a change in the drug deaths in London since the so-called safer supply program came in?

Dr. Sharon Koivu: Absolutely.

I don't know how to answer that very quickly, but the first thing I'll say is that in 2016, our overdose deaths were equal to the province's. In 2022, for which we have information, the provincial rates went up by about 2.7% and London's went up almost fourfold. There's a significant increase in overdose deaths compared to the provincial average. There's also a significant increase in overdose deaths compared to the other community I work in just south of there, which had exactly the same rate in 2016 and now continues to be the same as the provincial average.

The other place where I see significant change is in youth. If you look at the youth population—this data is all available on Public Health Ontario's opioid tool—for people 15 to 24, London's rate was lower than the provincial average in 2016 and now it's substantially higher. It's the same with people 25 to 44. When I'm looking at people I would consider young, there has certainly been an increase in deaths.

The other thing is that hydromorphone is absolutely more common. It's twice as common to find hydromorphone in deaths in London than in the provincial average. Often, the provincial averages dilute things. If you go to Ontario, you'll find that where safer supply has been available, there are increases over provincial averages.

● (1730)

Mrs. Laila Goodridge: Thank you. I appreciate that.

I'm now going to move a motion that I put on notice on Friday. It says:

> That the committee invite the Minister of Mental Health and Addictions and Associate Minister of Health before the committee for no less than two hours; and that the study of the opioid epidemic and toxic drug crisis in Canada be extended by six meetings to invite further witnesses.

I think it is absolutely incumbent on us, as we've been hearing testimony and seeing the entire situation shift, that we have more witnesses come so we can explore some of the public safety and other aspects that we have not been able to fully explore through this committee. I understand that we've had some conversations about amendments.

With that, I will cede the conversation.

The Chair: Thank you, Mrs. Goodridge.

The motion is in order. The debate is on the motion.

Dr. Ellis has the floor.

Mr. Stephen Ellis: Thank you very much, Chair.

I appreciate the comments from my colleague on the need to continue this discussion. It's important that we underline for Canadians the fact that some controversy exists here. Not all of it is based on science and much of it is based on opinion, which is not necessarily helpful when we know there are good scientific-based arguments. Many of my colleagues may not like that those exist, but they do.

It's important to continue on this road to enable this committee to understand that some of the science that has been referenced here does not answer the questions that we need answers to. It's also important to understand that the Government of British Columbia has asked for an end to the decriminalization experiment, which has certainly been outlined by communities such as New Westminster, Richmond, Campbell River, Kamloops and Sicamous. As Canadians hear more and more about the experiment, Canadians are fearful for their own communities. They're fearful for their communities because of contamination from used paraphernalia. They are concerned because of the potential for exposure of drugs to children, and we've heard even to pets in some areas.

The other thing that I've heard directly from Canadians is they are concerned about the loss of accessibility to their downtowns. That's a concern that we heard very clearly from a deputy chief constable in Vancouver, who testified at this committee not that long ago. She made it very clear that the decriminalization experiment has led to the loss of downtowns. Substances are being used outside of businesses, outside of residences, on transit and near schools, parks and beaches. The deputy chief constable's testimony noted that police were powerless to stop this type of activity.

The Minister of Mental Health and Addictions has spoken very forcefully about this in the House of Commons and in the media in attempting to explain away the request by the Government of British Columbia to end the experiment. I find that interesting, because it was the Government of British Columbia that came to the federal government asking for the experiment, but we all know, even though this is not scientific in a sense, that when an experiment is going awry and the people in charge of the experiment say they need to end it, it needs to end. When doing a scientific experiment such as a randomized controlled trial, if the lead investigators understand that something has gone awry, they don't continue the experiment. They stop it, and they don't wait for days and days to stop it. They stop it immediately when those signals are out there.

I'm very disappointed in the NDP-Liberal government, and specifically in the Minister of Mental Health and Addictions. The British Columbia government has asked for the experiment to end, and now there are negotiations with the NDP-Liberal government to continue the experiment. If we want to talk about this and we use the metaphor I used, even though I realize it's not scientific, then we know clearly that the experiment must end now for the betterment of this country, because it's a failed experiment. We've heard that over and over. We know it's a failed experiment. The B.C. government knows it's a failed experiment.

The question that I have—

● (1735)

Mr. Gord Johns: I have a point of order, Mr. Chair.

Mr. Stephen Ellis: —is this: When will the NDP-Liberal government will know it's a failed experiment?

The Chair: Dr. Ellis, there's a point of order from Mr. Johns.

Mr. Gord Johns: Mr. Chair, just for clarification, the B.C. government has not asked to stop decriminalization in British Columbia—

Mr. Stephen Ellis: Excuse me, Mr. Chair, but that's not a point of order.

The Chair: Thank you, Mr. Johns. That is not a point of order. It's a question of debate, so I'm going to cut you off there.

Mr. Gord Johns: Mr. Chair, I think it's been ruled by the chair—

Mr. Stephen Ellis: Thank you very much, Mr. Chair.

When my colleague wants to have the floor, he can raise his hand and have his turn. He should know that. He's been here long enough. Even though perhaps he is ideologically motivated by his wacko comments, we need to continue on with this.

That being said—

Mr. Gord Johns: Mr. Chair, on a point of order, it is completely unacceptable for a member to be calling another member wacko.

The Chair: Mr. Johns, please contain yourself. He said that your comments were wacko. That may be unpleasant to hear, but it wasn't an attack on you. Your interruptions do not constitute points of order. I would ask that you wait your turn. You are on the speaking list; you're third.

Dr. Ellis, go ahead.

Mr. Stephen Ellis: Thank you very much for that, Mr. Chair.

I don't mean to disparage the member. As I said, his comments are wacko. I think it is important to understand that the citizens of this country no longer want to tolerate ongoing difficulties with the experiment. It has been termed by my friend and colleague Dr. Hanley from the Liberals as an experiment from the outset. It was part of the motion of this study here at the health committee.

I'll end my comments there. Thank you, Mr. Chair.

The Chair: Thank you, Dr. Ellis.

Madam Brière, please go ahead.

[*Translation*]

Mrs. Élisabeth Brière (Sherbrooke, Lib.): Thank you, Mr. Chair.

First, Dr. Ellis is clearly conflating decriminalization with drug use in public spaces.

Second, the government of British Columbia didn't request an end to decriminalization. Rather, it asked that its request be reviewed.

Regarding the motion, since the minister has already appeared before the committee and there will be a four-hour committee of the whole in the House before the end of the month, and given our upcoming trip next week during which we'll have the opportunity to meet people on the ground and ask all our questions, I suggest amending the motion to read as follows: “that the study of the opioid epidemic and the toxic drug crisis in Canada be extended by two meetings to invite further witnesses.”

[*English*]

The Chair: All right, we have an amendment. The amendment is in order. The effect of the amendment is to replace identifying the minister and the number of meetings, simply bringing it down to two additional meetings to hear from witnesses.

The debate is now on the amendment, and Mr. Vis has the floor.

Mr. Brad Vis (Mission—Matsqui—Fraser Canyon, CPC): Thank you, Mr. Chair.

I won't take too much time. I am a British Columbian, and it's nice to see you again. It's been a few years.

The Leader of the Opposition mentioned the Abbotsford Soccer Association in question period today. My son was playing on the weekend, and I asked Coach Gill, the youth coordinator for the first kicks program, about what was taking place and the letter that was featured widely in our local regional media.

Decriminalization in British Columbia has led to widespread chaos. There were kids who saw a woman get raped at our soccer field last year, and she was on drugs when it happened. The stuff is devastating. My office is adjacent to Haven in the Hollow, which was a homeless shelter that became a safe injection site. During the pandemic, it became a place where people could openly do any drugs they wanted and consume alcohol. It brought chaos to the neighbourhood where my office is. The Legion came to me a few weeks ago. It's less than a block away from the site, and every day they have to ask people not to consume meth, crack and other hard drugs on site.

The decriminalization order put forward by the government was very clear that it wouldn't apply to those types of places, but since it has been unleashed, the consequences have been grave for the residents of the Fraser Valley. I'll note as well, in the context of decriminalization, that in the health region where I reside, the Fraser Health region, we had, I believe, last year—and don't quote me on this—one of the highest per capita death tolls after Northern Health in British Columbia. At the same time as we had a record number of deaths proportionate to the rest of the population in British Columbia—the second- or third-highest number—there was no increase in funding to help people get clean and help people access a detox bed and a site that would give them the treatment they needed.

Decriminalization is killing a lot of British Columbians, and I would encourage everyone to vote for this motion. I think it's a good one.

Thank you for your time.

● (1740)

The Chair: Thank you, Mr. Vis.

Next we have Mr. Johns, and then it's Dr. Powlowski and Monsieur Thériault.

Mr. Gord Johns: Thank you.

First, in terms of extending the number of meetings, there are lots of reasons why we should have more meetings.

I look at Fort McMurray. They had an all-time high drug poisoning death rate in the last year. Alberta's death rate from toxic drugs has gone up 17% over the last year. They're on a trajectory to pass British Columbia by June. There are 43.3 deaths per 100,000. British Columbia is at 46.6 deaths per 100,000. Lethbridge has triple the toxic drug death rate of British Columbia. That's all without decriminalization and without safer supply. Regina has a 43% greater death rate per 100,000 than British Columbia.

It is absolutely a tragedy what is happening in the provinces without safe supply and without decriminalization. We are seeing a literal disaster happening. It's a health emergency. In fact, up in Alaska, which neighbours those provinces, there was a 45% increase in toxic drug deaths last year. It's a Republican state without safe supply and without decriminalization.

We're constantly hearing about the need to.... We heard from the police chiefs association that the diversion of safer supply is not what's killing people; it's deadly fentanyl. We heard from Dr. Pauly today that 85% of deaths are from fentanyl, and only 3% of people who died had traces of hydromorphone.

The police were clear that criminalizing people who use substances causes more harm. That's what we heard from the expert task force and the police chiefs association, and what we continue to hear from chief medical health officers, including every single chief medical health officer on Vancouver Island. They have been unequivocally clear that criminalizing people causes more harm and that safer supply reduces deaths.

We have peer-reviewed data that the very small amount of safe supply that is used to replace toxic street drugs—which are unregulated, and manufactured, marketed and sold by organized crime—reduces the risk of toxic overdose deaths. We have had a multitude of reports. I believe the chief medical health officer for Toronto is also asking for the government to consider decriminalization.

We've heard from the police chiefs association repeatedly about the fact that there is no going back on criminalizing people. “Those days are gone.” That is a quote from the president of the British Columbia Association of Chiefs of Police. They were looking for tools in British Columbia to move people out of public spaces so that they could make sure the public felt safe. At the same time, they were clear that they want to see more safe consumption sites.

I'm disappointed that we won't be in Lethbridge, because Lethbridge is where they closed a safe consumption site, and Lethbridge is ground zero in Alberta. It has the highest death rate in the province of Alberta. It has three times the toxic drug deaths that we're seeing in British Columbia. In Medicine Hat, there are 63 deaths per 100,000. That is almost 40% greater than the death rate we're seeing in British Columbia, and it's almost the highest death toll we've seen in any health authority in British Columbia.

I just wanted to highlight these really important reasons why we need to have more meetings. I support having two more meetings. I hope we can centre one of those meetings on getting a purely indigenous perspective. I think we should invite Ms. Hopkins back, out of respect, since this meeting might be cut short and her testimony might be cut short and minimized. I would hate to see that happen, especially when we know that indigenous people in my home province are seven times more likely to die from a toxic drug overdose. In her community, it was 36 times more.

● (1745)

We also heard from Ms. Petra Schulz from Moms Stop the Harm, when she testified, that the recovery model in Alberta is just a name. We heard that for a nation south of Lethbridge that was promised a therapeutic treatment centre, the only shovel that's gone in the ground was a ceremonial one three years ago. People are waiting. They're waiting up to six months to get help in certain parts of Alberta. That's if they want help.

The goal should be to keep people alive. Harm reduction, treatment and recovery go hand in hand. We don't need to have one without the other. This is a crisis that is ravaging North America. It is skyrocketing in Conservative provinces and Republican states. We need to change direction. We need to work collectively.

In Portugal, politicians were successful when they got out of the way and let the experts lead with evidence-based policy, evidence-generated policy and peer-reviewed research. That's how they moved forward. I can't think of another health issue where politicians are having their say like this and interfering with what is truly a health issue.

I support going to two meetings. I also wanted to make sure that my comments were on record.

The Chair: Thank you, Mr. Johns.

Dr. Powlowski, please go ahead.

Mr. Marcus Powlowski (Thunder Bay—Rainy River, Lib.): I would like to get back to the expert witnesses we've invited here and not listen to other MPs wax on about their views on this subject. I was certainly tempted to move a motion to adjourn debate, but I won't.

Can we not all decide to vote on this? There seems to be unanimity. Let's vote and let's get back to the witnesses. We are doing a study on this subject. We invited these people here to ask their opinions, and I'd like to get their opinions.

Thanks.

The Chair: Thank you, Dr. Powlowski.

[*Translation*]

Mr. Thériault, you have the floor.

● (1750)

Mr. Luc Thériault: Mr. Chair, I find it quite ironic that a motion is being tabled to hold more meetings and hear from further witnesses, while our witnesses are being sidelined today. We had many questions to ask them.

I'll be brief, so as not to contradict my previous statement. I said I was willing to extend the duration of this study. I believe we can trust ourselves. We want to present recommendations that will matter and not just be shelved. We'll be going to see what's happening on the ground. I would have been very comfortable with extending our study. If, one day, we realize that we need four meetings, we'll hold four meetings.

However, for today, I would like to hear what the witnesses have to say. This isn't the first meeting that has been interrupted by a motion. We should perhaps take a look at how the committee works. I would rather discuss our business in a subcommittee than during a study, where we make a spectacle of ourselves in front of witnesses about our understanding of the issue. I find it disrespectful. I'll stop there.

I'm ready to hear any proposals. However, when we have witnesses with us, let's ask them questions so that they can provide information.

In two and a half minutes, I would like to ask the remaining witnesses what they think of the situation in Vancouver and what they think of criminalization being reinstated in British Columbia.

The Chair: Thank you, Mr. Thériault.

[*English*]

There are no further speakers on the list. I presume that we are ready for the question.

The question is on the amendment. Just to be specific, the amendment is to delete the following words from the motion: “That the committee invite the Minister of Mental Health and Addictions and Associate Minister of Health before the committee for no less than two hours; and”. It would also change the word “six” to “two”.

The amendment would be the following: “That the study of the opioid epidemic and toxic drug crisis in Canada be extended by two meetings to invite further witnesses.”

All those in favour of the amendment?

(Amendment agreed to)

(Motion as amended agreed to)

The Chair: The motion is adopted unanimously.

Thank you, everyone. That brings us back to the witnesses.

Mrs. Goodridge, you have 47 seconds left in your turn.

Mrs. Laila Goodridge: Thank you for that, Mr. Chair.

I'll go really quickly to Dr. Pauly.

More people are dying in British Columbia despite both safe supply and decriminalization. Why do you think that is?

Dr. Bernadette Pauly: They're dying because 85% of deaths are caused by a toxic, unregulated drug market, and we haven't adequately scaled up interventions like harm reduction and treatment. It's a combination of those things that will reverse the trend.

Mrs. Laila Goodridge: Do you believe recovery from addiction is possible?

Dr. Bernadette Pauly: I believe recovery is absolutely possible, and it is an individual journey. There are many pathways to recovery.

The Chair: Thank you, Mrs. Goodridge.

I'll go to Dr. Powlowski, please, for five minutes.

Mr. Marcus Powlowski: Dr. Pauly, I'm sorry for putting you on the spot, but help the committee out. In response to Mr. Thériault, who said that the experts seem to have different opinions as to the evidence for safe supply, you said that you did a peer review and it seemed to pretty overwhelmingly show the benefits of safe supply.

Let me just point out what else our committee has heard. We asked Health Canada to appear before the committee. We had the experts who I think were behind approving B.C.'s request, and they seemed to be in favour of safe supply. They themselves admitted that there wasn't very good evidence for the benefits of safe supply. I would note the B.C. health officer, in a review of prescribed safer supply, said:

> Most of the limited published peer-reviewed studies lack a control or comparison group and the actual intervention received by study participants is in most cases a combination of broader access to wrap around health services including [safe supply]...and primary care, making it difficult to attribute any benefits to PSS alone.

They suggested that they need to have more studies.

The Stanford-Lancet commission, which looked at the opioid crisis—and I would point out that these aren't a bunch of right-wing fanatics—in their study said, “the evidence clearly shows the folly of assuming that population health inherently improves when healthcare systems provide as many opioids as possible with as few possible regulatory constraints as possible.” They, too, were against safe supply. We talked to the head of that commission, and he said the problem with safe supply is that basically you're replicating what has caused the problem to begin with, which was doctors prescribing too many narcotics, people getting on them and then people having trouble getting off them.

Do you continue, though, to say that no, the evidence is clear that safe supply is good?

● (1755)

Dr. Bernadette Pauly: I really appreciate that question about the science, because it has been very confusing and disturbing to see the way that some of the debates have played out.

To begin, many of the citations that you provided preceded 2020 and were from the very early days of the development of the body of evidence on safer supply. Since 2020, it's doubled. In fact, some of the strongest evidence has emerged in about the last six to 12 months. Our team is obviously at the forefront of producing evidence in British Columbia, where we are seeing positive impacts.

Yes, I stand by my statement. After a review of over 40 studies, the findings were overwhelmingly positive. What I really want to urge this committee to do is separate ideology from evidence. I don't think any of my colleagues wouldn't say we need more treatment, yet we know there are still challenges with treatment. People come out of treatment and do relapse. We need to look at what kind of comprehensive system we're creating instead of creating these ongoing tensions.

I'll stop there if you have a follow-up.

Mr. Marcus Powlowski: The B.C health officer's report was quite recent, as was Health Canada's, and after looking at the evidence, I certainly wasn't overwhelmed with it. However, let's change the subject.

Your study wasn't a randomized control trial, which is the gold standard, and the validity of your results depends on how well you matched the people getting safe supply with those who weren't getting safe supply.

One of my concerns with your study—and you can correct me if I'm wrong—is the comparison group, the people who weren't in safe supply. You got those names from various places, one of them being the discharge abstract database, which, in my understanding, is from hospital records of people who had been admitted for either a diagnosis or something to do with using opioids. My concern is that in your comparison group, you have a sicker population, because they've been in the hospital recently, either because they overdosed—

The Chair: Dr. Powlowski, you're out of time. If you could get to a question, we can get a short answer.

Mr. Marcus Powlowski: She's heard my question. I guess I get no response for her answer, but am I wrong?

Dr. Bernadette Pauly: Is it possible for me to answer?

The Chair: Do so as succinctly as possible, Doctor.

Dr. Bernadette Pauly: Okay. Thank you.

Our study came out after the provincial health officer's report, as did a number of other studies. On the control group, multiple linked databases were used to generate, through two different methods, the control group, matching on multiple variables. I'd be happy to refer you to Dr. Nosyk's seminar, which explains extremely well how the matching occurred and the similarity between the two groups.

● (1800)

[*Translation*]

The Chair: Mr. Thériault, you now have the floor for two and a half minutes.

Mr. Luc Thériault: Thank you, Mr. Chair.

In a previous meeting, we heard from Dr. Morin, who told us that addictions are complex chronic diseases. This complicates matters because multi-pronged action is required. Furthermore, we're told that relapse is part of the process. British Columbia is trying to correct course, in a manner of speaking.

My question is for Ms. Hopkins, but Ms. Pauly can also weigh in if there is time.

How do you see the situation in British Columbia, and what do you think about the government's desire to correct course? In your opinion, must this lead to “recriminalization”?

[*English*]

Dr. Carol Hopkins: Absolutely not. Thank you for the question.

The expert task force on substance use and mental health recommended safer supply and decriminalization, but they also said that it should be within a full spectrum of supports for people who use drugs or substances, or who wish to enter into a recovery journey.

The task force clearly recommended a more comprehensive and responsive system. When you provide people with the medication they need to live life every single day but they don't have a home, they don't have income security or food security, and they don't have people they can rely on to support them.... Every person needs another person to support them and to be a champion for their belief in their ability to succeed in life, whatever that means from their perspective. Those comprehensive supports are absolutely necessary as an addition.

As I said, there's no silver bullet. There are many instruments that will support change and will keep people alive. Safer supply and decriminalization are not a silver bullet. They're not meant to end the opioid crisis and the toxic drug supply, but they will keep people alive. They will ensure that human beings have the right to live life. That should be our goal: to make sure that human beings can continue to live life. There are many tools. There have to be many tools.

This is not an easy answer, and it's not an easy solution, but what we're seeing is a focus on one technique, one answer, and on criticizing it without considering the other resources that are necessary. When those other resources are in place, we've seen positive changes that have impacted families, their children and their communities. They increase safety, decrease the number of kids in child welfare, increase the number of kids going to school and increase safety in the community. I can't stress enough that a comprehensive approach is necessary.

The Chair: Thank you, Dr. Hopkins.

Dr. Carol Hopkins: Thank you.

The Chair: We'll go to Mr. Johns, please, for two and a half minutes.

Mr. Gord Johns: Dr. Pauly, you talked about the effectiveness of safer supply, and you cited some really important information. Can you also talk about why safer supply hasn't been scaled up? What are the barriers you're seeing?

Dr. Bernadette Pauly: This is a really important question. Without a doubt, part of the barrier is the politicization of safer supply and blaming it for what is a problem of the toxic and unregulated drug market. Safer supply is part of a comprehensive solution.

Some of the challenges related to increasing access—

The Chair: Excuse me, Dr. Pauly, but we're having a problem hearing you here.

Dr. Bernadette Pauly: I'm sorry. Is that any better?

● (1805)

The Chair: Yes. Please go ahead.

Dr. Bernadette Pauly: What I was saying is that part of the reason that safer supply hasn't been scaled up is it's been highly politicized. That's a harmful narrative when the real problem is a toxic and unregulated drug supply.

In terms of scaling up, we've had quite a lot of insight from the research we've done around prescribers, and particularly the idea of prescribers not being attacked or feeling criticized by their colleagues and recognizing the importance of the intervention and the support of regulatory colleges. One interesting finding is that nurse practitioners are three times more likely to prescribe safer supply. In that finding, there are opportunities to remove barriers, particularly in rural and remote communities. I'd also mention that in British Columbia, the First Nations Health Authority has a virtual substance use and addiction program, which was found to facilitate access for people in rural and remote communities.

We haven't talked much about non-prescriber-based models, but I wanted to highlight that in British Columbia, only a portion of the people who died of an overdose actually had an opioid or substance use disorder. We have to remember to consider alternatives that provide access and that are appropriate and well regulated for people who are accessing the toxic drug market and don't necessarily meet that criteria.

The Chair: Thank you, Dr. Pauly.

Thank you, Mr. Johns.

Next we will go back to Dr. Ellis for five minutes.

Mr. Stephen Ellis: Thank you very much, Chair.

I know it's been a bit of an up-and-down meeting for the witnesses. I appreciate your patience with all of us.

Dr. Koivu, I'd like to go back to the concept of safe supply. Maybe you could, for the benefit of Canadians out there, talk a bit about the specific difference between opioid agonist therapy and safe supply. Of course, we know that opioid agonist therapy has a significant amount of scientific literature supporting it. Could you explain the difference? I think that would be important to Canadians.

Dr. Sharon Koivu: Thank you for that question.

Opioid agonist therapy is about having people on a treatment that can stabilize them neurochemically, having them not chase what we talked about earlier with withdrawal and really allowing for recovery. The two main types of opioid agonist therapy are methadone, which has been around for years, and buprenorphine. Buprenorphine was not available at the time the study in London was started.

Buprenorphine is a chemical, an opioid. As to how it works, as you increase the dose, you don't get an increase in negative effect. It is the drug most proven to decrease the risk of overdose. When people are on it, they have a decreased risk of overdose from taking it and from taking other substances.

Buprenorphine now comes in a daily sublingual formulation. It also comes in an injectable formulation that is usually referred to as Sublocade, which is given every four weeks. This is a game-changer because it allows people to get their lives back and get back to the community. Not having to worry about accessing a pharmacy daily is certainly helpful in remote communities as well. It provides a healing of the brain to allow people to have recovery and function normally.

Safer supply programs are about continuing to give opioids at doses that aren't witnessed. I think it's important to recognize that when people are started on methadone and Suboxone, we check what they're able to take. We understand their tolerance. We work with them as we're witnessing what they're taking and we know what they're taking. When people are started on safe supply, that is not the case.

I'm going to be a bit more specific about my own community. A dose can continue to go up without reflection on whether it's a safe dose for a person or a safe dose for the community. It's generally given to them on a daily basis. Sometimes it's every few days. Then the dose is escalated. In my community, generally that's at request, without any evidence that it's what they need. Even when there is evidence that they don't tolerate their dose, it isn't necessarily decreased.

People will continue to have to go to a pharmacy, usually on a daily basis. It means that they're continuing to, from a neurochemical perspective, chase withdrawal. It is about continuing somebody in an addiction. They're maintaining their addiction. They're being maintained in a state where they are addicted to the medication.

● (1810)

Mr. Stephen Ellis: Thank you very much for that, Dr. Koivu.

I have a final question. I'm not sure if you know the answer to this or not, Dr. Koivu.

Our understanding from other testimony is that the street price of Dilaudid at eight milligrams has dropped significantly, which is evidence—perhaps not scientific—of diversion. Is that the experience in your community as well? Maybe you could talk about the price.

Dr. Sharon Koivu: Absolutely.

It's a market-driven economy. As there has been more diversion and more available.... My understanding from patients and from living in the area is that in 2016, a D8 was about $20. If you're close to the supply—close to where more diversion takes place or the core of London—then it varies, but it's usually about one to two dollars. As you get farther away, it's more expensive.

It really is about supply and demand. As the supply has gone up and there's more and more Dilaudid available in London, and from the amount of tolerance people have compared to what they're prescribed, certainly the amount I'm hearing about.... The numbers are certainly over a million D8s in a year, and as that number has gone up, the price has definitely gone down.

The Chair: Thank you, Dr. Koivu.

[*Translation*]

We will now move on to the last speaker.

Ms. Brière, you have the floor for five minutes.

[*English*]

Mrs. Élisabeth Brière: Thank you, Mr. Chair, and thank you to all of our witnesses.

Dr. Hopkins, I have one question for you. What does supporting the voice of people who use drugs mean to you?

Dr. Carol Hopkins: Many people who are experts in their field have expertise and know the science behind their expertise. They publish. They know their work very well. We rely on them often for evidence so that we make informed decisions. We don't typically understand or give credit to the experience of living life every day with the types of conditions we're talking about: living with a dependency on opioids, having to survive the processes of coming to the right dosage for them and how people feel about that. Every person's being, their physical being, is different from every other person's. The type of medication needed, the amount of medication needed to address the issues of dependency, and the neurotransmitters that are significantly changed because of the types of drugs being used are all in the story of lived and living experience. It's a credible source of evidence.

If you listen to people who use drugs, you will find similarities. Whether you're talking to somebody in Vancouver's Downtown Eastside or somebody from a first nations community in northern Ontario, they've never met each other, but they will describe the same experiences of withdrawal. They'll talk about their tolerance of incremental increases to their addictions medicine. That's credible evidence.

Listening to their voices means that we give credit to people, not because of their status in life because they're using and not because we're judging them or discriminating against them. We're listening to them because they can tell us a real story that is mimicked across the country. That's important evidence. Listening to those voices is just as important, if not more substantial, to the decisions that need to be made about the health care system and the wraparound services that are provided to any population of people to ensure they can continue living life without the mental anguish and physical anguish that go with withdrawal.

People don't wake up every morning wanting to die. They get to those hopeless stages when we have opinions that form decisions and when we make decisions without looking at all the variables that impact something like we are talking about: safer supply and the toxic drug crisis. We can look at any one perspective and say that one perspective is credible evidence, and it may be, but if we don't look at it in the context of the determinants of health, for example, and how people learn to survive every day, then we're shortsighted and we end up making decisions as though we're God. Not one of us has the right to decide who gets to live, who is expendable and who should die.

● (1815)

[*Translation*]

Mrs. Élisabeth Brière: Thank you.

You say that every individual is different and needs to follow their own path.

Do you think that a more holistic approach, which includes the four pillars, is the best option for responding to the current overdose crisis?

[*English*]

Dr. Carol Hopkins: Absolutely. We need every tool and every strategy that is instrumental for ensuring life. Not one individual can live on this earth all by themselves. We live in relationship to others. We live in relationship to the land and the environment. We have to consider those elements and those four pillars.

We have a substance use strategy in Canada that includes harm reduction. Now we have to figure out what that means. We have to ensure harm reduction, but not only for individuals. We have to ensure we make decisions, policies, resources and programs that reduce harms to families and communities. That does not mean erasing the right to medicine, the right to mental wellness, the right to live and the right to the sacred breath of life. We have to provide and look at life from a holistic perspective. We can't afford to say, “You as a population don't have the right to life” or “You as a population, because you use drugs, don't have the right to health.”

The outcome of the UN declaration on the world drug problem—which Canada supported—was that, instead of a war on people, we had to ensure the right to prevention and treatment. Unfortunately, we couldn't get harm reduction in the declaration at that point. However, this year, the UN Commission on Narcotic Drugs had a vote that passed, putting harm reduction in international drug treaties. Now it matches what Canada has said, and we have to invest.

The Chair: Thank you, Dr. Hopkins, Dr. Pauly and Dr. Koivu.

When we invited you, we told you that we would have you out by 5:30. You've been very generous and patient with your time and very thoughtful in your presentations. Our study will be better because of your contributions. Thank you so much for being with us here today.

Is it the will of the committee to adjourn the meeting?

Some hon. members: Agreed.

The Chair: The meeting is adjourned.

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Dr. Sharon Koivu: 'Safe supply' has only worsened the addiction crisis in London, Ont.

Since the program started in 2016, patient deaths and infections have shot up, and prescriptions have been diverted to the streets

Dr. Sharon Koivu, Special to National Post

Published Jun 10, 2024 • Last updated Jun 10, 2024 • 5 minute read

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A woman prepares to inject Dilaudid at her Windsor, Ont. residence on March 24, 2017. PHOTO BY DAN JANISSE/WINDSOR STAR

I have been a practicing physician in Ontario for 39 years, the last 16 of which have been in London. I have served in many capacities, including having a family practice and working as an acting medical officer of health. Since 2012, I have worked in addiction medicine. I feel compelled to speak out about the harm "safe supply" is causing in my community.

London is home to Canada's first "safe supply" program that started at London InterCommunity Health Centre in 2016. It was, in part, a response to a public health emergency of tricuspid valve endocarditis, HIV and hepatitis C related to the injection of hydromorphone capsules. The goal was to provide high-risk sex workers using these hydromorphone capsules with an alternative: short-acting hydromorphone tablets, also known as Dilaudid.

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I lived close to the health centre, and I initially supported the program. We did not have a problem with illicit fentanyl at the time.

The program later expanded to include people potentially at risk of overdose from illicit drug use. Clients are often prescribed 30 to 40 Dilaudid pills per day, many of which are being diverted. This is fuelling the use of illicit fentanyl, which began appearing on the streets of London in 2018, leading to an increase in overdoses. I am repeatedly hearing disturbing stories that people with prescriptions are vulnerable to violence. Diversion appears to have shifted from being sold to individuals to being sold to organized crime as more is appearing in large amounts in police seizures.

It is also causing significant harm to the patients I serve. From 2012 to 2017, I rarely saw patients with spine infections. In the summer of 2017, I saw five patients in one month. The numbers continued to climb. The common thread among most of them was that they were injecting Dilaudid tablets. Most told me that they were buying diverted Dilaudid from clients of the "safe supply" program, while others were in the program directly.

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I had patients who were housed, using clean equipment and only injecting Dilaudid, developing horrific infections. Spine infections cause perhaps the worst suffering I have ever seen. Not only are they unbearably painful, but they can also cause paraplegia or quadriplegia. Since 2017, I have been part of the care team in about 100 hospitalizations of people with injection drug-related spine infections.

In June of 2018, I had my first patient tell me that he had left his apartment to live in a tent near the pharmacy and "safe supply" clinic from which much diversion takes place. This was because "safe supply" pills were cheaper and more abundant near the source. After he moved to this encampment, he, too, developed a spine infection from injecting Dilaudid.

Over the past year, we have seen about one patient per month with a spine infection. Half of these were receiving a "safe supply" prescription and half reported buying diverted Dilaudid. About 30 people per month are admitted with another severe infection. Of patients admitted with opioid use disorder, 25 per cent were receiving a "safe supply" prescription and 25 per cent reported using diverted Dilaudid. Only four per cent of our consults were for an unintentional overdose.

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The failure of "safe supply" was predictable. Purdue Pharma's OxyContin helped start the addiction crisis, and Dilaudid, which is also manufactured by Purdue, is an even stronger and more addictive

opioid. I and many of my addiction physician colleagues have been warning about the pending harms from the start.

Public Health Ontario data shows that the harms we've been warning about are very real. Prior to the start of the "safe supply" program, the Middlesex-London area was principally less than or equal to the provincial average rates for measured harms from opioid toxicity (i.e., emergency room visits, hospitalizations and deaths). Since the "safe supply" program started and expanded, the harms experienced in Middlesex-London have escalated substantially, beyond the rates experienced in the rest of the province.

The rate of death from opioid toxicity is of utmost concern. In 2014, Ontario had a rate of death from opioid toxicity at 4.9 per 100,000 people. Middlesex-London had a rate of death from opioid toxicity that was much less, at 2.8 per 100,000 people — that's 43 per cent lower than Ontario's average. In both 2015 and 2016, London and the province of Ontario experienced equal rates of death from opioid toxicity.

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Since the onset of "safe supply," the rate of death from opioids has escalated at a much greater rate in Middlesex-London and has consistently remained higher than the Ontario rates. By 2022, opioid-related mortality in London had risen more than four times higher than the rate in 2015, 40 per cent higher than the rate for the province of Ontario.

This has particularly affected youth and young adults, ages 15 to 44. Lives lost in these age groups were generally less than the provincial average, but since "safe supply," they are much greater.

It has also been costly to the emergency department. In 2014, emergency department visits were lower than average. In 2015, they were five per cent higher in Middlesex-London than the rest of

Ontario. From 2020 to 2022, emergency department visits were, on average, 80 per cent higher.

Interestingly, London Health Sciences Centre has a $76 million deficit even after receiving a $95 million bailout from Queen's Park. While hospital budgets are complex and multifactorial, this deficit parallels the expansion of London's "safe supply" program. Instead of saving health-care dollars, "safe supply" is costly.

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Importantly, as I referenced previously, when "safe supply" started in 2016, we did not have a problem with illicit fentanyl in London. We do now. Many patients have told me they sell or trade much of their prescribed "safe supply" to buy fentanyl. Others, not in the program, have told me that their dealers have sold them fentanyl after claiming to be out of Dilaudid, starting them down that path.

Our hospital experience shows that "safe supply" is also preventing patients from choosing opioid agonist therapy and the opportunity for recovery.

Additionally, the percentage of people found to be positive for fentanyl at death has been very similar in Middlesex-London and the province of Ontario. However, in Middlesex-London, the percentage of people positive for hydromorphone has been 200 per cent higher than the provincial average.

The Public Health Ontario data is conclusive. "Safe supply" programs, evident from the London experience, are not effective at addressing illicit fentanyl or the tragic addiction crisis. "Safe supply" is not safe, and in fact, it substantially contributes to societal harm.

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We need a comprehensive, collaborative recovery-focused approach to the addiction crisis, including the expansion of evidence-based treatments that do not contribute to harm. To prevent further harm, a moratorium on funding and expansion of "safe supply" programs must be put in place. Finally, those currently in "safe supply" programs need the support of an effective exit strategy.

National Post

Dr. Sharon Koivu has been a physician in Ontario for 39 years and worked as an addiction medicine consultant for 12. In addition to front-line health care, her career has spanned teaching, research, leadership and advocacy.

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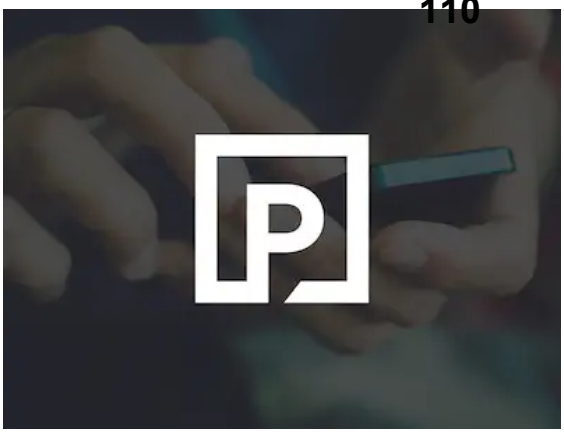
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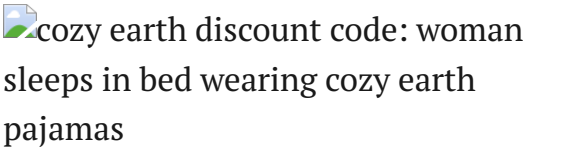


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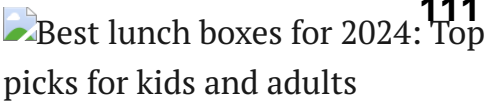


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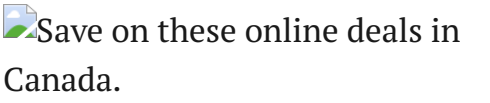
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Leading addiction doctor warns of Canada's 'safer supply' disaster

Addiction physician Dr. Sharon Koivu has seen the effects of safer supply programs in her clinical practice and personal life — and is sounding the alarm



by **Liam Hunt**
July 8, 2024



(Dreamstime)

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Dr. Sharon Koivu, an addiction physician and parent, believes her son might not have survived

to adulthood if Canada's "safer supply" programs had been in effect during his adolescence.

Having worked on the front lines of Ontario's opioid crisis, she views these programs as a catastrophic failure.

In an extended interview, Koivu explained the unintended consequences of these programs, which offer free tablets of hydromorphone — an opioid about as strong as heroin — to vulnerable patients with a history of addiction. While advocates of safer supply claim these programs mitigate the use of more dangerous illicit substances, there is evidence that most users divert — that is, sell or trade — their hydromorphone to acquire stronger substances.

Safer supply was first piloted in London, Ont., in 2016, before being widely expanded across Canada in 2020 with the help of **generous federal grants**. While the program looked good on paper, Koivu, who provides addiction consultation services at a London-based hospital, saw a different reality: her patients were destabilizing, relapsing and fatally overdosing because of safer supply.

Koivu says that "one hundred percent" of her colleagues working in addiction medicine have noticed safer supply diversion. Some patients have told her they have been threatened with violence if they do not procure and divert these drugs. She estimates that, because of safer supply, tens of thousands of diverted hydromorphone pills — also known as "Dilaudid," "dillies" or "D8s" — are flooding into Canadian streets every day.

For context, just two or three of these pills, if snorted, are enough to induce an overdose in a new user.

This influx has caused the drug's street price to crash by as much as 95 per cent. While eight-milligram hydromorphone pills used to sell for $20 each several years ago, they can now be bought for as little as a dollar or two. These rock-bottom prices have ignited a new wave of addictions and relapses, and lured opioid-naive individuals into experimenting with what is essentially pharmaceutical heroin.

Koivu estimates that 80 per cent of her opioid-using patients now take diverted hydromorphone.

"The biggest harm is that we've turned on the tap and we've made everything cheap, which is leading to a large increase in the number of people becoming addicted and suffering," she said.

"It is the most serious issue that I've seen in my lifetime."

Safer supply programs seem to regularly overprescribe opioids without considering patients' actual needs, Koivu says. Patients have come into her hospital with prescriptions that provide 40 eight-milligram hydromorphone pills a day, even though they can only tolerate 10 pills.

'That attraction is horrific'

Throughout the first few decades of Koivu's career, almost "everyone" in her patient pool developed addictions due to childhood traumas or from mishandling opioids prescribed for chronic pain.

Since the advent of safer supply, the origins of new opioid addictions have shifted toward social or recreational exposure. Concerningly, this exposure often occurs in patients' adolescent years.

"I'm seeing an increase in youth becoming addicted," said Koivu, who has had patients as young as 15 tell her their addictions began through diverted hydromorphone.

"Almost everyone I see who's started since 2018 started recreationally. It started as something that was at a party. It's now a recreational drug at the youth level."

Parents often seem completely unaware of the problem. Some have told Koivu they overheard their children discussing the availability of "D8s" at their high schools, only to later realize — when it was too late — they were referring to opioids.

"You can't walk into your house with a six-pack of beer. If you're smoking weed, people can smell it. But you can walk into your house with a lot of [tablets] in your pocket. So, it's cheap, really easy to hide, and is even called 'safe' by the government. I think that attraction is horrific."

"Our youth are dying at a higher rate … and we have a lot more hydromorphone found in [their

bodies] at the time of death."

While safer supply programs claim to make communities safer, Koivu's lived experiences suggest the opposite. She used to reside in London's Old East Village, where the city's first safer supply program opened in 2016, but moved away after watching her neighbourhood deteriorate from widespread crime, overdoses and drug trafficking.

"I moved there to support a supervised injection site," said Koivu. "Then I watched that community drastically change when safer supply was implemented. … I would go for walks and directly see diversion taking place. Homelessness is very complicated, but this has absolutely fueled it in ways that are unconscionable."

Koivu characterizes the evidentiary standards used by advocates of safer supply as "deeply problematic." She says many of the studies supporting safer supply are qualitative — meaning they rely on interviews — and use anecdotal data from patients who have a vested interest in perpetuating the program.

While Koivu has been blowing the whistle on safer supply programs for years, her concerns largely went unnoticed until recently. She has faced years of harassment and denigration for her views.

"When I came to say I'm concerned about what I'm seeing: the infections, the suffering, the encampments … I was literally told that I was lying," she said.

Last month, the London Police Service provided the National Post with data showing that annual hydromorphone seizures **increased by 3,000 per cent** after access to safer supply was significantly expanded in 2020. The newspaper has since raised questions about why this data was not released earlier and whether the police stonewalled attempts to investigate the issue.

Koivu considers herself a lifelong progressive and has historically supported the New Democratic Party. But she is concerned many left-leaning politicians have ignored criticism of safer supply. Many seemingly believe that opposition to it is inherently conservative.

"I went to a hearing in Ottawa of a standing committee to talk about addiction," she said. "We

had five minutes to give a talk, and then two hours to answer questions, [but] I didn't receive any questions from the NDP or the Liberals."

Although Koivu believes safe supply can play a role in the continuum of care for opioid addiction, she says it must be executed in a meticulous manner that prevents diversion and emphasizes pathways to recovery.

"It needs to be part of a comprehensive strategy to help people get their lives back. And right now, it's not."

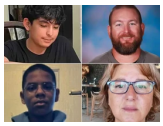
Above all, it is Koivu's experience as a mother that drives her to criticize safer supply. One of her sons struggled with addiction as a young adult. Although he eventually recovered, the experience could have killed him.

"Had this program been around … my family could have been another statistic from a drug death. That drives me. Because it's very real, and it's very personal."

Editor's Note: This article has been updated to say Dr. Sharon Koivu provides addiction consultation services at a London, Ont., hospital. An earlier version said she managed an addiction clinic at the hospital. We regret the error.

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LILLEY: Addictions specialist calls on Ford to clean house at SRCHC

Safe injection site tied to shooting and arrest of suspect has lost the plot by refusing to offering addiction treatment and recovery.

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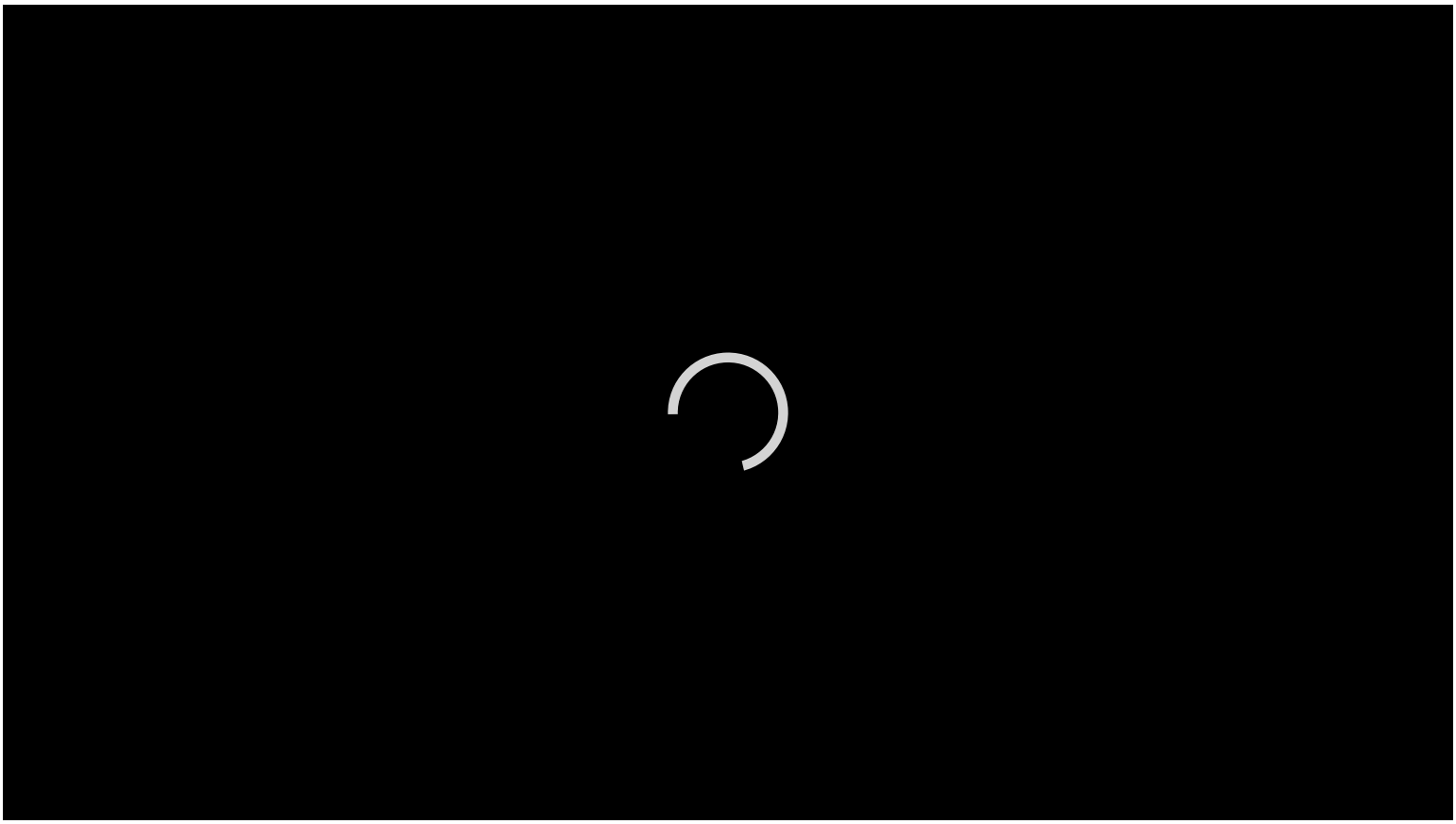
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The South Riverdale Community Health Centre and safe injection site at 955 Queen St. E. on Friday, July 14, 2023. PHOTO BY JACK BOLAND /Toronto Sun

A doctor specializing in addictions says the ideology on display by the South Riverdale Community Health Centre shows it's time to replace the leadership of the organization. The

SRCHC has been in the news for all the wrong reasons lately, starting with a shooting that took the life of an innocent woman on July 7 and the arrest of one of their safe injection workers on charges related to that shooting earlier this week.



They are currently under review by both the Ontario Ministry of Health, and as has been confirmed to the *Toronto Sun*, by Health Canada which grants them an exemption to dispense opioids as part of a "safe supply" program. It's the centre's stated philosophy though that has one addictions specialist concerned and calling for changes.

Dr. Sharon Koivu, a physician who helped open a safe injection site in London, Ont., and has shepherded many clients to treatment and recovery, says the people at the top of SRCHC have lost sight of the real goal.

> Specifically, Dr. Koivu takes issue with the centre's philosophy published on the SRCHC website.

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"It is a philosophy about being simply respectful of and to people who use drugs. No judgement, no expectations and no desire for people to stop using drugs," the SRCHC states.

"That is like a cancer doctor refusing to offer a patient chemotherapy because it might be uncomfortable," Dr. Koivu said.

She added that while treatment for addictions can be uncomfortable and painful at times, they save lives and that should be the focus of organizations dealing with addicts, not just

keeping them addicted. Dr. Koivu said the entire reason for bringing safe injection sites into being was to help guide people towards treatment, something the SRCHC policy would appear to abandon.

"With this policy, South Riverdale Community Health Centre is not working to improve lives," Dr. Koivu said. "They are promoting a dependency on a service that should be meant to help them."

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The philosophy, which has been posted to the organizations social media accounts and printed on official materials, is also contrary to provincial regulations for what the government calls "Consumption and Treatment" sites. According to provincial rules, such sites are required to offer "onsite or defined pathways to addictions treatment services."

The latest annual report issued by the centre boasts about the 868 visits per month for "safe drug consumption" with 129 overdoses reversed, just two calls to EMS and no calls to police. What the centre doesn't boast about is how many clients were directed to an addiction treatment or recovery program.

This philosophical break from provincial regulations and best practices for such sites should be enough to shut this facility down. If the Ford government isn't ready to go that far, they need to force out CEO Jason Altenberg, the entirety of the senior leadership in the harm reduction programs and demand the resignations of board members starting with chair Mike Wilson.

STORY CONTINUES BELOW

"There has to be a complete change in leadership," Dr. Koivu said, adding that some community level workers may need to be replaced as well.

"Unfortunately, once people have drunk the Kool-Aid and think this is a good thing, it's hard to have the same workers recognizing the importance and value of facilitating a journey to recovery."

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LILLEY: Doug Ford needs to shut down or take over safe injection site

Ontario Premier Doug Ford has long been skeptical of safe injection sites and capped the number in the province at 21. He's spoken out in favour of more treatment, something that clearly goes against the philosophy of the SRCHC, and many other activists on this file.

Seems some of those activists are deeply embedded in Ontario's Ministry of Health where multiple sources claim the health bureaucracy is pushing back against requests for options and action from Health Minister Sylvia Jones.

The Ford government, including the premier and minister Jones, need to find the strength

to do the right thing and either shut this facility down or fire everyone at the top. Anything short of that sends the message to the other facilities that following the rules and helping people get into treatment is no longer a priority.

The people of Ontario deserve better.

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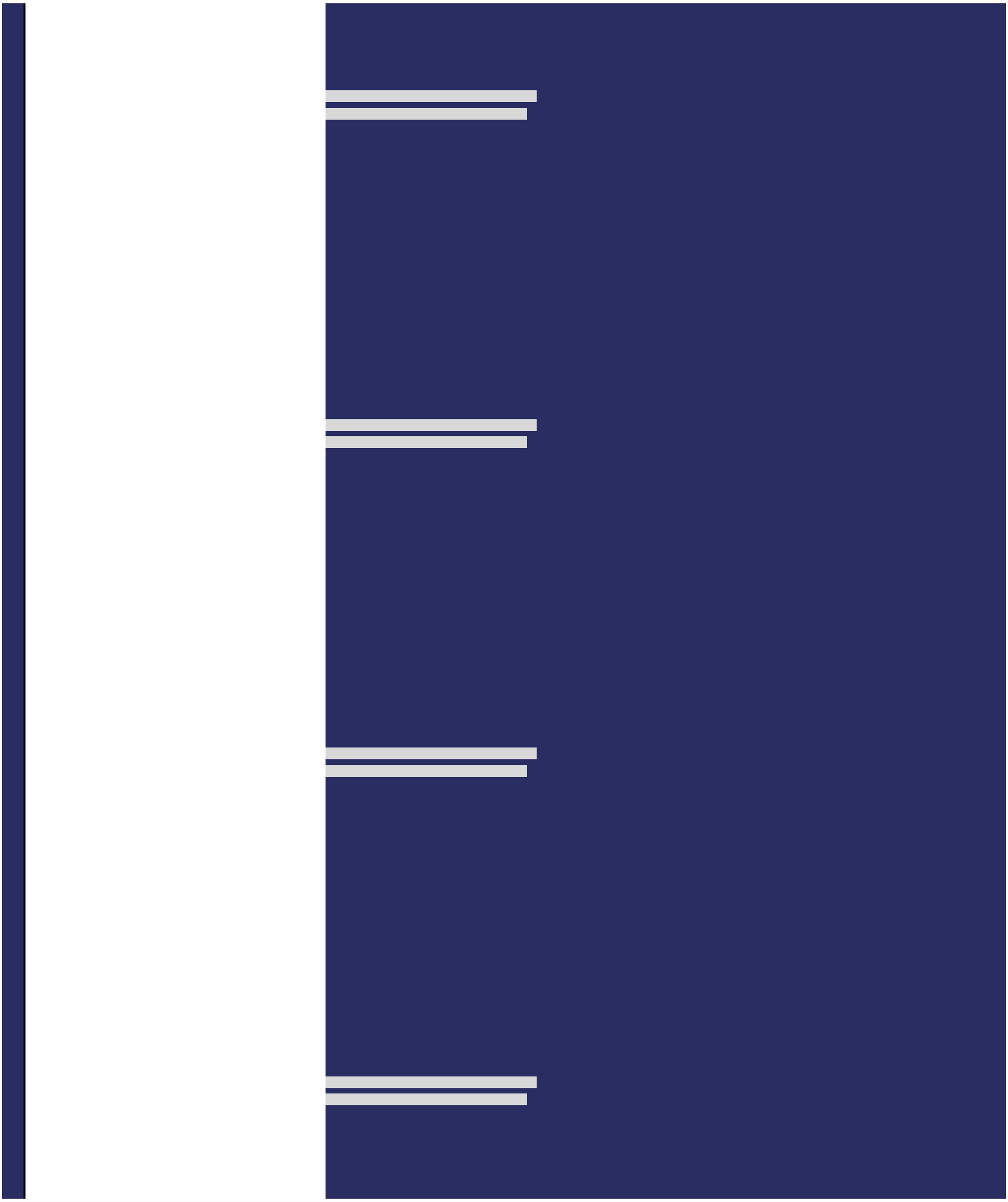
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Harms of safe drug supply program outweigh benefits: Addictions specialist

A London doctor at the centre of a national political debate over opioid programs says she had no intention of becoming a talking point for the federal Conservative party.

Randy Richmond

Published May 20, 2023 • Last updated May 20, 2023 • 4 minute read

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(File photo/Postmedia Network)

A London doctor at the centre of a national political debate over opioid programs says she had no intention of becoming a talking point for the federal Conservative party.

But remaining silent isn't an option in the face of evidence the program is harming people, says Sharon Koivu, an addictions specialist and researcher at London Health Sciences Centre.

"I've done a lot of work in social justice, advocacy work, for essentially all my life. So, I've never been associated with anything right wing. I don't consider my position to be a political one, just a voice of concerns for the suffering that I've seen," Koivu told The London Free Press.

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Koivu's views on London's safer supply program recently were published in a National Post story and reiterated in recent attacks from Conservative Leader Pierre Poilievre on the federal Liberal addictions policies.

Poilievre introduced a motion in the House of Commons Thursday calling for an end to safe supply programs in Canada, saying funding should go to treatment instead.

"Crime and chaos, drugs and disorder rage in our streets. Nowhere is this worse than in the opioid overdose crisis that has expanded so dramatically in the last several years," Poilievre said.

The opioid crisis claimed 34,455 lives in Canada from 2016 to September 2022, according to the latest Health Canada figures, with most of the deaths attributed to toxic street supplies of fentanyl that often include crystal meth and cocaine, Health Canada says.

About 473 people have died from opioid-related problems in London and surrounding Middlesex County from 2016 to the middle of 2022, with annual deaths increasing from 30 in 2016 to 130 in 2021, according to Public Health Ontario.

The safer opioid supply (SOS) program at the London InterCommunity Health Centre began in 2016 with a small group of street level sex workers and has increased to about 300 patients. The program provides patients with pharmaceutical grade hydromorphone, in the form of Dilaudid pills, so they can avoid dangerous street drugs.

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Research has shown safer supply programs can keep patients healthier as they work to their individual goals around addiction. A study released last fall concluded London SOS patients had fewer infections than people injecting drugs who were not in the program.

But Koivu said since London's safer opioid supply program began in 2016, the rates of infections in her patients and deaths among injection drug users have gone up. Dilaudid also has fuelled an increase in the use of fentanyl, including among younger people, and homelessness in London, Koivu contends.

"I believe the harms of the program outweigh the benefits. I believe the harms of putting all this money into the program at the expense of other programs outweighs the benefits. I want people to discuss it and decide as a society what's best," she said.

Safe supply supporters say they have research that shows the programs save lives and help people to stop injecting drugs, and in some cases, stop using at all.

Opponents have no statistics to back up their claims, supporters say.

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Poilievre slams 'so-called experts' pushing for government-funded supply of drugs to stop opioid crisis

Koivu questioned the research methods backing safe supply and said some statistics show at least a possible link between Dilaudid use and infections.

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The rate and number of invasive infections among people with opioid use disorders in London has jumped since 2016, while rates in Toronto and Ottawa have increased at a much smaller rate, she said, citing records from the Office of the Chief Coroner of Ontario.

Koivu said she was an early supporter of the safe supply program when it first started.

“But I began seeing a significant increase in infections that were related to injection drug use, and specifically infections of the spine, some of them leading to some very significant consequences: paraplegia and quadriplegia. Eighty to 90 per cent of the patients with these infections were injecting Dilaudid,” she said.

“The majority of the patients I saw were telling me they were buying diverted Dilaudid and that they were thinking it was safe.”

She counted more than 100 patients with the infections in 2017, the first year after the safe supply program began, Koivu said.

She suspects Dilaudid crushed and injected contains particles in the suspension that cause damage to blood vessels, but doesn’t have the research to back that up, or the research dollars to find out, Koivu said.

Dilaudid also leads to people seeking a greater high, and that has led to the spread of the more powerful fentanyl in London, she said.

“A lot of places where fentanyl is a problem also have safe supply programs. Trying to fix the problem of fentanyl by throwing more drugs at it is not working. It’s not working for the people in the program, and it’s not working for the community.”

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A leading drug researcher and a London streetfront doctor are firing back at a recent surge of criticism – echoed by a city councillor and the leader of the Conservative party – about safer opioid supply programs: https://t.co/gwJzgViu3z#LdnOnt #cdnpoli

— London Free Press (@LFPress) May 18, 2023

The impact of Dilaudid and fentanyl has led to more people becoming homeless, with many people choosing to live in encampments close to the safe supply program at LIHC where they can buy diverted supplies, she said.

Supporters of safe supply refute pretty much all of what Koivu says.

London's problem with homelessness has much do with an acute lack of shelter and supportive housing – both targets of a new community strategy developed over the winter – safe supply supporters say.

There's no empirical evidence of diversion being a large problem or Dilaudid causing infections, they say.

Meanwhile, Koivu is calling for a moratorium on funding until there's more public discussion of the programs.

Koivus said she approached local NDP and Liberal MPs, who considered her opinions, but can't get her message beyond them to party leaders.

Without the support from other parties, Poilievre's motion is bound to fail in a vote in the Commons.

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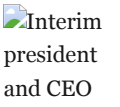
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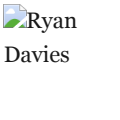
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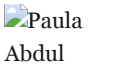
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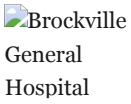
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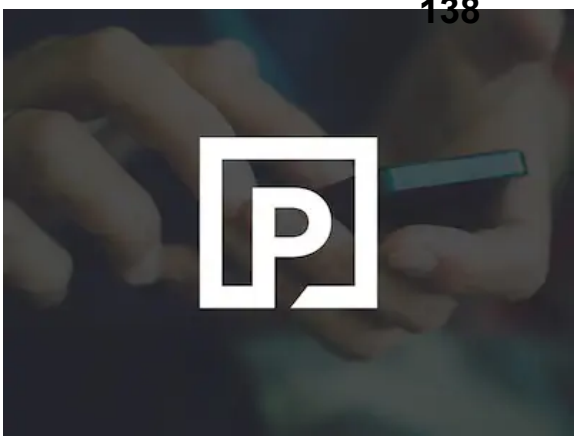
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JAMA Internal Medicine | Original Investigation

Mortality Among Unsheltered Homeless Adults in Boston, Massachusetts, 2000-2009

Jill S. Roncarati, ScD, MPH, PA-C; Travis P. Baggett, MD, MPH; James J. O'Connell, MD; Stephen W. Hwang, MD, MPH; E. Francis Cook, ScD; Nancy Krieger, PhD; Glorian Sorensen, PhD, MPH

IMPORTANCE Previous studies have shown high mortality rates among homeless people in general, but little is known about the patterns of mortality among "rough sleepers," the subgroup of unsheltered urban homeless people who avoid emergency shelters and primarily sleep outside.

OBJECTIVES To assess the mortality rates and causes of death for a cohort of unsheltered homeless adults from Boston, Massachusetts.

DESIGN, SETTING, AND PARTICIPANTS A 10-year prospective cohort study (2000-2009) of 445 unsheltered homeless adults in Boston, Massachusetts, who were seen during daytime street and overnight van clinical visits performed by the Boston Health Care for the Homeless Program's Street Team during 2000. Data used to describe the unsheltered homeless cohort and to document causes of death were gathered from clinical encounters, medical records, the National Death Index, and the Massachusetts Department of Public Health death occurrence files. The study data set was linked to the death occurrence files by using a probabilistic record linkage program to confirm the deaths. Data analysis was performed from May 1, 2015, to September 6, 2016.

EXPOSURE Being unsheltered in an urban setting.

MAIN OUTCOMES AND MEASURES Age-standardized all-cause and cause-specific mortality rates and age-stratified incident rate ratios that were calculated for the unsheltered adult cohort using 2 comparison groups: the nonhomeless Massachusetts adult population and an adult homeless cohort from Boston who slept primarily in shelters.

RESULTS Of 445 unsheltered adults in the study cohort, the mean (SD) age at enrollment was 44 (11.4) years, 299 participants (67.2%) were non-Hispanic white, and 72.4% were men. Among the 134 individuals who died, the mean (SD) age at death was 53 (11.4) years. The all-cause mortality rate for the unsheltered cohort was almost 10 times higher than that of the Massachusetts population (standardized mortality rate, 9.8; 95% CI, 8.2-11.5) and nearly 3 times higher than that of the adult homeless cohort (standardized mortality rate, 2.7; 95% CI, 2.3-3.2). Non-Hispanic black individuals had more than half the rate of death compared with non-Hispanic white individuals, with a rate ratio of 0.4 (95% CI, 0.2-0.7; $P < .001$). The most common causes of death were noncommunicable diseases (eg, cancer and heart disease), alcohol use disorder, and chronic liver disease.

CONCLUSIONS AND RELEVANCE Mortality rates for unsheltered homeless adults in this study were higher than those for the Massachusetts adult population and a sheltered adult homeless cohort with equivalent services. This study suggests that this distinct subpopulation of homeless people merits special attention to meet their unique clinical and psychosocial needs.

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Supplemental content

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A paucity of literature exists regarding the health status of unsheltered, urban homeless adults, also known as "rough sleepers." These elusive, yet highly visible unsheltered individuals eschew organized shelters and choose to sleep on park benches, in back alleyways, in doorways, under bridges, near train stations, and in abandoned cars.

In the United States, the unsheltered population constitutes more than a third of the overall homeless population, with an estimated 192 875 people sleeping unsheltered on a single night in January 2017.[1] Most of these individuals were men 24 years or older of white or non-Hispanic race/ethnicity.[1] Despite their visibility, this population wanders across our urban landscapes, and data on these individuals are difficult to gather. Previous studies of mortality have focused on the homeless population who primarily sleep in shelters, and these studies have found higher rates of death in homeless populations compared with nonhomeless populations.[2-9] Studies from the 1980s showed common causes of death to be from substance use disorders and unintentional injuries.[3-5] Studies from the 1990s revealed HIV/AIDS, when combined, to be a leading cause of death.[6,7] More recently, unintentional overdose was shown to have replaced HIV/AIDS as a leading cause of death in the homeless population.[10] Literature on the unsheltered population has shown that they have more risk factors for death, more behavioral health issues, more trauma, and poorer health than their sheltered counterparts.[11-13] However, these studies have not looked specifically at mortality outcomes for unsheltered individuals, whose unique blend of comorbidities and environmental exposures may place them at higher risk for death.

A better understanding of the demographics, mortality patterns, and causes of death among unsheltered individuals could inform social policy and clinical practice initiatives to improve outcomes in this vulnerable population. To address the current gap in the literature about this unique subpopulation, we conducted a 10-year, prospective cohort study using an unsheltered cohort from Boston, Massachusetts, that was established in 2000 and followed up through the end of 2009. We described the unsheltered cohort, examined causes of death, and calculated age-specific rate ratios and age-standardized all-cause and cause-specific mortality rates and compared this cohort with both the nonhomeless adult population living in Massachusetts and a cohort of homeless adults living in Boston who primarily slept in emergency shelters. We hypothesized that the unsheltered cohort would have higher all-cause and cause-specific mortality rates than the nonhomeless and sheltered homeless populations, and that those unsheltered homeless individuals would die prematurely from common but preventable and treatable causes, such as cancer, heart disease, and substance use disorders.

Key Points

Question What are the mortality patterns for unsheltered homeless adults who primarily sleep outdoors?

Findings In this 10-year cohort study of 445 unsheltered homeless adults, the age-standardized all-cause mortality rate was almost 3-fold larger than that for a cohort of homeless adults primarily sleeping in shelters and nearly 10-fold larger than that for the adult population of Massachusetts; both represented significant differences. Common causes of death were cancer and heart disease.

Meaning Interventions and models of care need to address the unique needs of the unsheltered homeless adult population to improve outcomes.

Methods

Study Population

The study population consisted of adults living outside who were primary care patients of the Boston Health Care for the Homeless Program's (BHCHP's) Street Team. Eligibility criteria for the study included the following: (1) sleeping outside for 1 or more nights during 2000; (2) 18 years or older by January 1, 2000; (3) at least 1 face-to-face encounter with the BHCHP's Street Team staff during 2000; and (4) a first and last name and either a date of birth or a Social Security number in the study database. Participants were excluded if there was a lack of identifying information in the study database. Of 568 records in the BHCHP's Street Team database, 445 unsheltered adults (78.3%) met the eligibility criteria. The study was approved by the institutional review board of Boston University Medical Center, Boston, Massachusetts. Participant informed consent was waived by BHCHP. The study posed minimal risk to privacy.

Study Design and Data Collection

We conducted a 10-year prospective study from January 1, 2000, through December 31, 2009. Data analysis was performed from May 1, 2015, to September 6, 2016. Data from face-to-face encounters with the BHCHP's Street Team were used for the study and stored prospectively. Face-to-face encounters for primary care consisted of a BHCHP's Street Team clinician meeting an unsheltered individual on the street or at an outside location during a daytime or nighttime clinical session. The clinicians of the BHCHP's Street Team documented these encounters on paper at the time of the visit and the notes were later transcribed by a research assistant into a database (Microsoft Office Access; Microsoft Corporation). Data collected at the initial and subsequent visits included the following information: first and last names, date and location of the encounter, date of birth, Social Security number, sex, race/ethnicity, medical and behavioral health diagnoses, and the name of the clinician performing the visit. Any new data, such as a date of death, was added to the database. The cohort had no known duplicates, and no individual was added to the cohort after December 31, 2000. Everyone in the cohort was alive at the time of enrollment.

After the study concluded, the database was matched to BHCHP's electronic medical record to confirm data such as the correct spelling of the first and last name, sex, race/ethnicity, date of birth, and Social Security number. The records were then matched with the Massachusetts Department of Public Health death occurrence files from 2000 to 2009 (received on CD from Massachusetts Department of Public Health; November 3, 2014) in the manner described below to confirm deaths, add the dates of deaths if they were previously unknown, and

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add the underlying and multiple causes of death. Over the course of the study, reports were requested from the National Death Index[14] in 2006 and in 2011 to investigate the possibility of a death occurring outside the state for a proportion of the cohort whose whereabouts were unknown. Data extracted from the National Death Index[14] reports included the date of death, the state in which death occurred, and the underlying and multiple causes of death.

All data describing the causes of death were in the format of the *International Statistical Classification of Diseases and Related Health Problems, Tenth Edition* (*ICD-10*) diagnosis codes. The data identifying the underlying and multiple causes of death taken from the Massachusetts Department of Public Health and the National Death Index[14] were previously processed by the National Center for Health Statistics using well-established computer algorithms to select the underlying cause of death from conditions reported on death certificates. Underlying causes of death codes were used for this study and grouped based on previous literature.[7,10,15,16] Definitions of codes from the Centers for Disease Control and Prevention (CDC) Wide-Ranging Online Data for Epidemiologic Research (WONDER) were also used for interpretation of the *ICD-10* codes.[17] The *ICD-10* groupings, terminology, and definitions used to combine the *ICD-10* categories can be found in the eTable in the Supplement.

Race/ethnicity categories created by BHCHP were as follows: non-Hispanic white, non-Hispanic black, and persons of color/unknown identified as Asian, Hispanic, American Indian, or unknown race/ethnicity. Age categories included 18 to 44 years, 45 to 64 years, and 65 to 84 years. Sex was dichotomous without unknowns. There were 2 variables with missing data: Social Security number was missing in 15 of 445 records (3.4%) and race/ethnicity, 7 of 445 records (1.6%).

Comparison Groups

Two comparison groups (the Massachusetts population and a sheltered homeless cohort from Boston) were used to calculate the standardized mortality ratios (SMRs). Data for the Massachusetts population were taken from the CDC's WONDER for ages 18 to 84 years from 2000-2009. The Massachusetts population was chosen as a comparison group because our study methods were analogous to methods used in a 2013 study by Baggett et al,[10] who also used the Massachusetts population as a comparison group.

Data for the adult homeless cohort were obtained from the 2013 study by Baggett et al.[10] They retrospectively assembled a homeless cohort of 28 033 adults 18 years or older who had 1 or more encounters with a BHCHP clinician between January 1, 2003, and December 31, 2008.[10] The comparison cohort included homeless adults who were seen by BHCHP from 2003 to 2008.[10]

Matching Data

Link Plus 2.0, a probabilistic record linkage program developed at the CDC Division of Cancer Prevention and Control in support of the CDC's National Program of Cancer Registries, was used to match BHCHP's data to the Massachusetts Department of Public Health data. Each match was manually reviewed. A death record was accepted as a match if it had the same data on 1 or more of the following: Social Security number; first and last name and month and year of birth within a range of 1 year; or first and last name and month and day of birth.[7,10,14] The algorithm was similar to that used by the National Death Index[14] to match records and has been reliably used by previous researchers who studied mortality among homeless populations.[7,10,14]

Statistical Analysis

We described the demographic characteristics of the unsheltered cohort overall and by subgroups, including sex and vital status (whether the cohort member was alive or dead and information about the decedent). Among those in the cohort who died, we noted the place of death and whether an autopsy was performed.

Crude mortality rates for all-cause and cause-specific mortality were calculated using the number of deaths in each category divided by person-years of observation for that category to create incident rates, expressed as events per 100 000 person-years. Strata-specific incident rate ratios were calculated by taking one crude mortality rate within a stratum and dividing it by another crude mortality rate within the same stratum. For rate ratios, women, non-Hispanic white, and the young age category (18-44 years) were used as reference groups.

Age-standardized all-cause and cause-specific mortality rates were calculated using indirect standardization, with the unsheltered cohort as the standard population. The SMRs were calculated as follows: by creating age-specific mortality rates per person-year for young (18-44 years), middle (45-64 years), and old age (65-84 years) categories for both the Massachusetts population and the adult homeless cohort; by multiplying the age-specific mortality rates by the age-specific person-years from the unsheltered cohort; by summing the 3 age-specific results to determine the expected number of deaths; and then by dividing the number of observed deaths by the number of expected deaths. The SMRs were calculated when the number of deaths in a category was 5 or more.[15]

Statistical analyses were performed using Stata, version 14 (StataCorp) and Microsoft Excel 2013 (Microsoft Corporation) and consisted of calculating incidence rates, rate ratios, and SMRs. Corresponding 95% CIs for rates and ratios were calculated using OpenEpi (Open Source Epidemiologic Statistics for Public Health), version 3.01.[18] A 2-sided significance level of <.05 was used for testing.

Results

Cohort Characteristics

The study cohort comprised 445 unique unsheltered adults who were followed for a total of 3608.7 person-years (mean, 8.2 years; range 0.1-9.9 years). The mean (SD) age at enrollment was 44 (11.4) years with a range of 18 to 81 years. Of 445 participants in the cohort, 299 (67.2%) were non-Hispanic white and 322 (72.4%) were men (**Table 1**).

Decedent Characteristics

Of the 445 unsheltered adults, 134 died during the study period. A total of 122 deaths were confirmed through linkage with the Massachusetts Department of Public Health data, and an additional 12 records were manually matched to the National Death

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Table 1. Characteristics of the Unsheltered Cohort, 2000-2009

Characteristic	No. (%)					
	Unsheltered Adult Homeless Cohort				Sheltered Adult Homeless Cohort ≥18 y (n = 28 033)[a]	MA 2000 Census Population ≥18 y (n = 4 849 033)[b]
	Full Cohort (N = 445)	Men (n = 322)	Women (n = 123)	Decedents (n = 134)		
Age, y						
18-44	248 (55.7)	165 (51.2)	83 (67.5)	56 (41.8)	17 298 (61.8)	2 569 111 (53.0)
45-64	176 (39.6)	140 (43.5)	36 (29.3)	65 (48.5)	9924 (35.4)	1 419 760 (29.3)
≥65	21 (4.7)	17 (5.3)	4 (3.3)	13 (9.7)	811 (2.8)	860 162 (17.7)
Race/ethnicity						
Non-Hispanic white	299 (67.2)	223 (69.3)	76 (61.8)	108 (80.6)	11 912 (42.5)	4 180 644 (86.1)
Non-Hispanic black	94 (21.1)	62 (19.3)	32 (26.0)	15 (11.2)	8066 (28.8)	236 027 (4.9)
Persons of color or unknown[c]	52 (11.7)	37 (11.5)	15 (12.2)	11 (8.2)	8055 (28.7)	432 362 (8.9)
Sex						
Men	322 (72.4)	NA	NA	116 (86.6)	18 612 (66.4)	2 289 671 (47.2)
Women	123 (27.6)	NA	NA	18 (13.4)	9421 (33.6)	2 559 362 (52.8)

Abbreviations: MA, Massachusetts; NA, not applicable.

[a] Adult homeless cohort from the study by Baggett et al.[10]

[b] Based on US Census Bureau data.[19]

[c] Individuals who identified as Asian, Hispanic, American Indian, or whose race/ethnicity was unknown.

Table 2. Stratum-Specific Mortality Rates and Rate Ratios of Unsheltered Cohort, 2000-2009

Characteristic	Deaths, No. (%)	Person-Years, No.	Mortality Rate, Deaths per 100 000 Person-Years (95% CI)	Rate Ratio (95% CI)	*P* Value
Overall	134 (100)	3608.7	3713.2 (3110.9-4397.5)	NA	NA
Age, y					
18-44	56 (41.8)	2124.6	2635.8 (1990.7-3422.2)	1 [Reference]	NA
45-64	65 (48.5)	1350.3	4813.8 (3716.0-6136.9)	1.8 (1.3-2.7)	<.001
65-84	13 (9.7)	133.8	9715.9 (5165.6-16589.9)	3.7 (1.8-6.8)	<.001
Race/ethnicity					
Non-Hispanic white	108 (80.6)	2325.2	4644.7 (3810.5-5608.3)	1 [Reference]	NA
Non-Hispanic black	15 (11.2)	835.4	1795.5 (1005.4-2962.9)	0.4 (0.2-0.7)	<.001
Persons of color or unknown[a]	11 (8.2)	448.1	2455.1 (1225.7-4393.3)	0.5 (0.3-1.0)	.03
Sex					
Women	18 (13.4)	1130.6	1592.1 (943.2-2515.3)	1 [Reference]	NA
Men	116 (86.6)	2478.1	4681.0 (3868.2-5614.7)	2.9 (1.8-5.1)	<.001

Abbreviation: NA, not applicable.

[a] Individuals who identified as Asian, Hispanic, American Indian, or whose race/ethnicity was unknown.

Index[14] reports. The mean (SD) age at death was 53 (11.4) years. Of the 134 decedents, 116 (86.6%) were men and 108 (80.6%) were non-Hispanic white. A mean (SD) of 13 (3.4) deaths per year occurred throughout the study. Most deaths (87 of 134 [64.9%]) occurred inside a health care facility (ie, inpatient wards, outpatient clinics, emergency departments, and nursing homes), and 48 (35.8%) resulted in an autopsy.

Mortality Rates

The crude mortality rate overall was 3713.2 (95% CI, 3110.9-4397.5) deaths per 100 000 person-years (**Table 2**). The race/ethnicity specific mortality rate ratio for non-Hispanic blacks was 0.4 times the rate ratio of death for non-Hispanic whites (95% CI, 0.2-0.7; $P < .001$) (Table 2). The SMR for the unsheltered cohort was 9.8 (95% CI, 8.2-11.5) relative to the Massachusetts population and 2.7 (95%CI, 2.3-3.2) relative to the sheltered adult homeless cohort (**Table 3**).

Causes of Death

Thirty-nine deaths (29.1%) were directly attributable to substance use disorders and unintentional overdose (Table 3). Nonpoisoning injuries represented 19 of the 134 deaths (14.2%). Mortality rates in the unsheltered cohort for HIV/AIDS (10 of 134 deaths [7.5%]) were considerably higher than rates in the Massachusetts population and in the sheltered adult homeless cohort, and SMRs were significantly elevated among the unsheltered cohort when compared with both the Massachusetts population (SMR, 63.8; 95% CI, 32.4-113.8) and the sheltered adult homeless cohort (SMR, 3.4; 95% CI, 1.7-6.0). The one exception was drug overdose, which did not differ between the unsheltered cohort and adult homeless cohort (SMR, 0.9; 95% CI, 0.4-1.7). No deaths occurred from diabetes or tuberculosis. External causes, such as suicide, homicide, and hypothermia, which were included in the nonpoisoning injury category, accounted for fewer than 5 deaths each.

Discussion

All-cause mortality rates in the unsheltered cohort were nearly 3 times greater than those in an adult homeless cohort and almost 10 times greater than in the Massachusetts population. Our cause-specific mortality findings underscore a high burden of substance

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Table 3. Age-Standardized All-Cause and Cause-Specific Mortality Ratios for the Unsheltered Cohort (2000-2009) Compared With the Massachusetts Population (2000-2009) and With a Sheltered Adult Homeless Cohort (2003-2008)[a]

Underlying Cause of Death[b]	Overall Deaths, No. (%) (n = 134)	SMR (95% CI)[c]	
		Unsheltered Homeless Adults vs MA Population	Unsheltered vs Sheltered Homeless Adults
All causes for entire cohort	134 (100)	9.8 (8.2-11.5)	2.7 (2.3-3.2)
Natural causes			
Cancer	21 (15.7)	4.8 (3.1-7.3)	2.8 (1.8-4.2)
Heart diseases	18 (13.4)	6.4 (3.9-9.9)	2.4 (1.4-3.7)
Chronic substance use	16 (11.9)	88.9 (52.7-141.5)	4.2 (2.5-6.7)
Chronic liver disease	15 (11.2)	32.2 (18.7-51.9)	4.5 (2.6-7.3)
HIV/AIDS	10 (7.5)	63.8 (32.4-113.8)	3.4 (1.7-6.0)
Ill-defined conditions	5 (3.7)	26.8 (9.8-59.3)	NC
External causes			
Nonpoisoning injuries[d]	19 (14.2)	33.3 (20.7-51.1)	7.1 (4.4-11.0)
Drug overdose	8 (6.0)	14.1 (6.5-26.7)	0.9 (0.4-1.7)[e]
Substance use disorder causes	39 (29.1)	43.6 (31.4-58.9)	2.5 (1.8-3.3)
Alcohol use disorder	30 (22.4)	110.2 (75.7-155.3)	NC
Opioid use disorder	9 (6.7)	15.7 (7.6-28.8)	NC

Abbreviations: *ICD-10, International Statistical Classification of Diseases and Related Health Problems, Tenth Revision*; MA, Massachusetts; NC, not calculated; SMR, standardized mortality ratio.

[a] Adult sheltered homeless cohort from the study by Baggett et al.[10]

[b] There were no unknown causes of death, and fewer than 5 deaths in each category were suppressed.

[c] The SMR was calculated when there were 5 or more deaths in each category.

[d] Nonpoisoning injuries (*ICD-10* diagnosis codes): transportation accidents (codes V01-V99), other external causes of accidental injuries (codes W00-X59, except X40-X49), and events of undetermined intent (codes Y20-Y34, except Y10-Y19). Methodology in combining the *ICD-10* categories were based on the Health of Boston 2014-2015 report.[15]

[e] The SMR was not significant.

use in this population. In addition to the deaths directly attributable to substance use, many of the deaths due to nonpoisoning injuries, which primarily included motor vehicle crashes, falls, and drownings, have been shown by previous researchers to be related to alcohol or other drug use.[20-22] The SMR for nonpoisoning injuries was high for the unsheltered cohort compared with the adult homeless cohort; these results may indicate a possibly greater risk of death for rough sleepers, but more research is warranted. Other common causes of death, such as cancer and heart disease, have a strong link to cigarette smoking, which is highly prevalent among homeless people.[20] To effectively decrease morbidity and mortality in the unsheltered population, it is necessary to have fully integrated clinical outreach teams to meet rough sleepers where they live on the streets in order to establish and maintain continuity of care.[13,23,24] Addiction treatment and recovery programs should be readily available, with treatment on demand to support motivation for action and prevent further morbidity and mortality. Future research should include harm reduction policies, such as managed alcohol programs or supervised injection sites within shelters and homeless programs, which might make shelters more tolerable for those who currently fear substance abuse withdrawal.[25,26]

Higher rates of death among non-Hispanic white individuals compared with non-Hispanic black individuals and persons of color have been consistently observed in previous studies of homeless persons, and the causes for this phenomenon are likely multifactorial.[2,4,5,7,8,10] Similarly, studies have shown that homeless men have higher rates of death than homeless women. Non-Hispanic white individuals and men, on average, have more economic resources than non-Hispanic black individuals and women and are less likely to have experienced adverse social and economic effects due to bias or discrimination.[27] Thus, non-Hispanic white individuals and men may, on average, have reached a higher threshold of comorbidities at the time that they become homeless compared with non-Hispanic black individuals and persons of color. Men, whether or not they are homeless, are at a higher risk of death at an earlier age than women because of risk-taking behaviors related to the male sex. However, more research with empirical data needs to be conducted to fully understand these disparities among the unsheltered homeless.

Limitations

Although the study was subject to some biases that we could not control, we believe the influences were minor. Some unsheltered adults living on the streets of Boston may not have been seen by BHCHP's Street Team during enrollment and were not included in the cohort, which created a potential selection bias toward those homeless adults who sought health services. Since Boston is a moderately sized city with an extensive network of outreach services provided by the BHCHP's Street Team and their community partners, the number of individuals not served by BHCHP during enrollment was likely to have been small. Additional bias could have occurred if someone entered the cohort and then traveled to another state and died while living in another state. Obtaining National Death Index[14] records improved our ability to detect deaths that occurred outside the state. The BHCHP's Street Team database contained 123 records with insufficient identifying information to be included in the study. These excluded individuals could be systematically different from individuals included in the study in important ways, such as their level of illness or the length of time that they were homeless. Based on our clinical experience, an alternative explanation was that most of these rec-

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ords with insufficient identifying information were duplicate records of identified cohort members because a new record was opened, rather than an existing one updated, when identifiers were learned.

Additional limitations included a lack of information about individual comorbidities or the chronicity of being homeless before or during the observation period; both could have contributed to a more nuanced understanding of mortality risk in this population. Some causes of death were too rare to ascertain mortality rates. A larger cohort would be required to address this limitation in future studies. Some overlap of the 2 homeless cohorts may have occurred, but the overlap was believed to have been small because BHCHP's data on sleeping location from 2008 showed that the proportion of patients sleeping outside was small (1%-3%) and the time frames of the 2 cohorts were not exact. If there was overlap, estimates of mortality using the sheltered adult homeless cohort as a comparison would be conservative.

Choosing Massachusetts as a comparison population instead of Boston could be considered a limitation of the study; however, some of our methods were based on those used by Baggett et al[10] in their 2013 study, in which the Massachusetts population was the comparison group. In addition, during the time frame of the study, the age-adjusted, all-cause mortality rate in Boston (687 per 100 000 population) was only slightly higher than the age-adjusted, all-cause mortality rate for Massachusetts (669 per 100 000 population).[15,28] We anticipated that confounding by race/ethnicity would be minimal given that the study cohort was disproportionately of non-Hispanic white race/ethnicity as was the Massachusetts population.

Generalizability to cities outside Boston could be affected by difference in access to homeless shelters, health insurance, and health care. Boston guarantees each homeless person access to emergency homeless shelters each night.[29] Not every city across the United States makes this guarantee, and the homeless people accessing shelters in Boston may differ from the homeless accessing, or not accessing, shelters in another city. Most of Boston's shelters have few limits on the length of stay and have little to no requirements regarding sobriety. These shelters accept individuals struggling with alcohol and other drugs, an important factor in minimizing the number of unsheltered individuals in Boston. Shelters in many cities have limits on the length of stay or requirements for sobriety and do not allow individuals with active substance use disorders, which increases the number of homeless people living outside. Access to health care and health insurance were available to our cohort, but it was not uniform across the United States, particularly during the time of the study. These factors could influence mortality for those individuals sleeping outside in different locations and thereby influence the generalizability of our results. Our study provides important insights about mortality patterns in this previously overlooked group of highly vulnerable individuals.

Conclusions

Our study results showed that unsheltered adults had a higher all-cause mortality rate than a mostly sheltered homeless adult population in Boston, a finding that to our knowledge is not previously reported in the literature. The unsheltered cohort died at a relatively young age of both noncommunicable and substance-attributable causes of death. Access to a patient-centered, outreach service model with integrated medical and behavioral health care delivered directly to the unsheltered population is necessary to begin to address these disparities. A better understanding of the social and supportive services is necessary to augment an integrated outreach team. Services such as harm-reduction models; greater availability and access to substance use disorder treatment, including smoking cessation; and a continuum of housing models with flexible social services to meet individual needs for successful tenancies and improved health are also needed to ultimately improve health disparities borne by those sleeping outside.[30]

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Acquisition, analysis, or interpretation of data: Roncarati, Baggett, Hwang, Krieger.
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Invited Commentary

Death Among the Unsheltered Homeless
Hidden in Plain Sight

Michael Incze, MD, MSEd; Mitchell H. Katz, MD

In early 2018, a United Nations special rapporteur on adequate housing made headlines during an unofficial visit to San Francisco and Oakland, California, by comparing the living conditions for those people residing on the streets of these cities with what she had observed in Mumbai, India, and by calling this state of affairs a violation of international human rights law.[1] Indeed, it is hard to explain how, in one of the wealthiest regions of the world at a time of human history when the overall standard of living has never been higher, we have encampments of people living without toilets, sinks, showers, refrigerators, or cooking facilities.

Related article page 1242

There are an estimated 190 000 homeless persons in the United States living outside rather than in shelters, exposed to the elements, and removed from health care and case management resources.[2] In this issue of *JAMA Internal Medicine*, Roncarati et al[3] report the results of a 10-year prospective study of a cohort of unsheltered individuals in Boston, Massachusetts, that found a 3-fold increase in mortality for unshel-

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City Council endorses Community Encampment Response Plan - Part of Health & Homelessness Whole of Community System Response

Ex # 8 m/d/y 09/06/2024 Pg 1 of 3
Exam of Dr. Sharon Koivu
Heegsma et al v City of Hamilton
Nimigan Mihailovich Reporting Inc.

TUESDAY, JUNE 25, 2024

London City Council has endorsed the **Community Encampment Response Plan**, which is the remaining strategy component of the Health and Homelessness Whole of Community System Response, following the previously endorsed **plan for highly supportive housing** and **plan for hubs offering transitional housing and health supports.**

The **Community Encampment Response Plan** is grounded in a human rights-based approach that supports individuals in encampments, and outlines transactional outreach and transformational case-management to support an individual's pathway out of homelessness and into housing and indoor spaces. The Community Encampment Response Plan includes safety protocols for individuals living in encampments to support wellness within encampments as well as the surrounding community.

The community-led plan was developed in consultation and collaboration with frontline sector experts and leadership, first responders, City of London staff, and with support from members of the community with lived and living experience. During community engagement opportunities hosted in May, over 200 Londoners joined in-person community engagement sessions to learn more about the plan and give feedback on its proposed safety protocols and guidelines.

"Cities across Canada, as well as smaller communities, are all dealing with the realities of unsheltered homelessness and encampments, and London's Community Encampment Response Plan does not simply acknowledge this harsh reality, but provides a strategy for how we can manage the impacts and support individuals to move indoors through a balance of compassion, community safety, basic needs provisions, and increasing our housing supply." - Mayor Josh Morgan, City of London

"As we make progress toward creating and opening highly supportive housing programs and hubs within London, it's important that the relationship-building and support work starts before opening those program doors. The Community Encampment Response Plan outlines how this transformational outreach works, and how each intentional engagement with an individual living unsheltered is to eventually support a transition into housing." - Chantelle McDonald, Director of Service, London Cares, Co-Chair of Encampments Strategy Table

"The Community Encampment Response Plan is rooted in the principle that housing is a fundamental human right and a critical determinant of health, and this is a fundamental shift in how we address homelessness in London. Another key element of the plan is outreach workers who can do the transformative

work of connecting individuals within encampments with tailored service pathways to help them move into safe and stable indoor spaces, whether it is a shelter, a hub, or highly supportive housing.“ – Greg Nash, Director, Complex Urban Health, London InterCommunity Health Centre, Co-Chair of Encampments Strategy Table

“The Community Encampment Response Plan is a key part the overall Whole of Community Response strategy in that it provides a balanced response to the encampment situation in London, recognizing the need to focus on housing solutions while providing interim safe and appropriate measures that support basic human needs until people can exit homelessness.” – Kevin Dickins, Deputy City Manager, Social and Health Development, City of London

“The supports proposed in the Community Plan for Encampments strengthen the Hubs Implementation Plan by helping unsheltered individuals achieve a greater state of health, wellbeing, and dignity than what is available today, so they can better transition into Hubs, which are spaces designed to enable the next steps toward housing. This means individuals can be more ready than ever to continue their journeys toward housing, whether that be in private market, rent-geared-to-income, supportive, highly supportive or otherwise.” – Chuck Lazenby, Executive Director, Unity Project, and Co-Chair of Hubs Implementation Table

About the Health and Homelessness Whole of Community System Response

London, like many cities in Canada, is facing a health and homelessness crisis. In 2023 Londoners came together from organizations and sectors across the city and developed the Health & Homelessness Whole of Community System Response – a new way to support the most marginalized Londoners experiencing homelessness and reduce strain on our health care and judicial systems. The approach being implemented by the Whole of Community System Response is to help Londoners with the highest needs move safely inside; help them get stabilized, wrap around them with supports, connect them to the right type of housing, and help them stay housed.

City Council endorsed the Whole of Community System Response approach in March of 2023. Since then, two hubs have been established, as well as 93 highly supportive housing units, with 50 more units in development, toward a goal of 600 highly supportive housing units within three years. The City’s plans for hubs and housing were shaped by previous community engagement sessions held in summer and fall of 2023.

For more information on the Whole of Community System Response, visit: **london.ca**

Last modified: Thursday, July 04, 2024

NEWSROOM MENU

All

Public notices

Calendar

Council briefs

Our City e-newsletter

TAB 144

Form 51A

Courts of Justice Act

REQUEST TO ADMIT

Court File No. CV-21-00077187-0000

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, GLENN 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

YOU ARE REQUESTED TO ADMIT, for the purposes of this proceeding only, the authenticity (see rule 51.01 of the Rules of Civil Procedure) of the following documents:

Data on Homeless Population, Including Shelter Use, Availability and Capacity

1. City of Hamilton, *2022 Homelessness Point in Time Count*, including Appendices A, B, and C: Point in Time Connection | City of Hamilton
2. City of Hamilton, Data from *Housing and Homelessness Dashboard* – including:
    a. Inflow/Outflow of Homelessness: Inflow/Outflow of Homelessness | Inflow/Outflow of Homelessness | Open Hamilton

b. Scale of Homelessness: Scale of Homelessness | Open Hamilton

c. Shelter Beds Available: Shelter Beds Available | Shelter Beds Available | Open Hamilton

d. Shelter Occupancy: Shelter Occupancy | Shelter Occupancy | Open Hamilton

City Council Meetings and Delegations Regarding Encampment Evictions

3. City of Hamilton, *Emergency and Community Services Committee*, July 13, 2020, including written delegations 6.2, 6.3, and 6.4: Emergency and Community Services Committee - July 13, 2020 (escribemeetings.com)
4. City of Hamilton, *Information Report*, September 9, 2021: filestream.ashx (escribemeetings.com)
5. City of Hamilton, *Emergency and Community Services Committee*, September 9, 2021 video recording: https://pub-hamilton.escribemeetings.com/Meeting.aspx?Id=85dcb10b-9e3b-49c7-b14e-5b0027c41917&Agenda=Merged&lang=English
6. City of Hamilton, *Council Meeting*, October 13, 2021: https://pub-hamilton.escribemeetings.com/Meeting.aspx?Id=87806c2e-34d6-45cf-9c7a-28e3830b9748&Agenda=Merged&lang=English
7. City of Hamilton, *Notice of Motion by Nrinder Nann*, December 9, 2021: https://pub-hamilton.escribemeetings.com/filestream.ashx?DocumentId=299338
8. City of Hamilton, *Motion to Planning Committee by Jason Farr*, March 22, 2022: https://pub-hamilton.escribemeetings.com/filestream.ashx?DocumentId=314312 and Appendix "A" at https://pub-hamilton.escribemeetings.com/filestream.ashx?DocumentId=314313
9. City of Hamilton, *General Issues Committee,* May 17, 2023 minutes at: https://pub-hamilton.escribemeetings.com/FileStream.ashx?DocumentId=364954 and video recording at: https://pub-hamilton.escribemeetings.com/Players/ISIStandAlonePlayer.aspx?Id=1d954544-be89-4959-a370-abd5ccfcd269
10. City of Hamilton, *City Council Meeting,* May 24, 2023 (minutes not yet available) recording found at: https://pub-hamilton.escribemeetings.com/Meeting.aspx?Id=a6132950-b909-48b1-93a5-d4371a05273b&Agenda=Agenda&lang=English&Item=37&Tab=attachments

Statements from City Councillors Regarding Encampments

11. Nrinder Nann, *Nrinder Nann/Ward 3 City Counsellor Encampment Response Update ,* on or about October 14, 2021: Our Ward 3 News for October 14th, 2021 — Nrinder Nann | Ward 3 City Councillor

12. City of Hamilton, *General Issues Committee*, December 9, 2021: General Issues Committee - December 08, 2021 (escribemeetings.com)

Information Reports on 2021 Point in Time Connection

13. City of Hamilton, *2022 Point in Time Connection Results Infographic:* https://www.hamilton.ca/people-programs/housing-shelter/preventing-ending-homelessness/point-time-connection
14. *City of Hamilton, 2022 Point in Time Count Results Infographic Description*: https://www.hamilton.ca/people-programs/housing-shelter/preventing-ending-homelessness/point-time-connection
15. City of Hamilton, *2021 Point Connection Results*: https://www.hamilton.ca/sites/default/files/2022-10/PIT-2021-City-of_hamilton-Results.pdf
16. City of Hamilton, *2021 Point in Time Count Indigenous Responses*: https://www.hamilton.ca/sites/default/files/2022-10/PIT-2021-Indigenous-Responses-Hamilton.pdf
17. City of Hamilton, *2021 PiT Infographic – Indigenous Respondents*: https://www.hamilton.ca/sites/default/files/2022-10/PIT-2021-Infographic-Indigenous-Respondents.pdf

Attached to this request is a copy of each of the documents referred to above.

YOU MUST RESPOND TO THIS REQUEST by serving a response to request to admit in Form 51B prescribed by the Rules of Civil Procedure WITHIN TWENTY DAYS after this request is served on you. If you fail to do so, you will be deemed to admit, for the purposes of this proceeding only, the truth of the facts and the authenticity of the documents set out above.

May 31, 2023

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Lawyer for the Respondent

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2b	City of Hamilton, Data from Housing and Homelessness Dashboard – Scale of Homelessness
2c	City of Hamilton, Data from Housing and Homelessness Dashboard – Shelter Beds Available
2d	City of Hamilton, Data from Housing and Homelessness Dashboard – Shelter Occupancy
City Council Meetings and Delegations Regarding Encampment Evictions	
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4	City of Hamilton, Information Report, September 9, 2021
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6	City of Hamilton, Council Meeting, October 13, 2021
7	City of Hamilton, Notice of Motion by Nrinder Nann, December 9, 2021
8	City of Hamilton, Motion to Planning Committee by Jason Farr, March 22, 2022
8a	City of Hamilton, Motion to Planning Committee by Jason Farr – Appendix A, March 22, 2022
9	City of Hamilton, General Issues Committee, May 17 2023 minutes and video recording
10	City of Hamilton, City Council Meeting, May 24, 2023 (minutes not yet available) and video recording

Statements from City Councillors Regarding Encampments

11 Nrinder Nann, Nrinder Nann/Ward 3 City Counsellor Encampment Response Update, on or about October 14, 2021

12 City of Hamilton, General Issues Committee, December 9, 2021

Information Reports on 2021 Point in Time Connection

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14 City of Hamilton, 2022 Point in Time Count Results Infographic Description

15 City of Hamilton, 2021 Point Connection Results

16 City of Hamilton, 2021 Point in Time Count Indigenous Responses

17 City of Hamilton, 2021 PiT Infographic – Indigenous Respondents

TAB 1

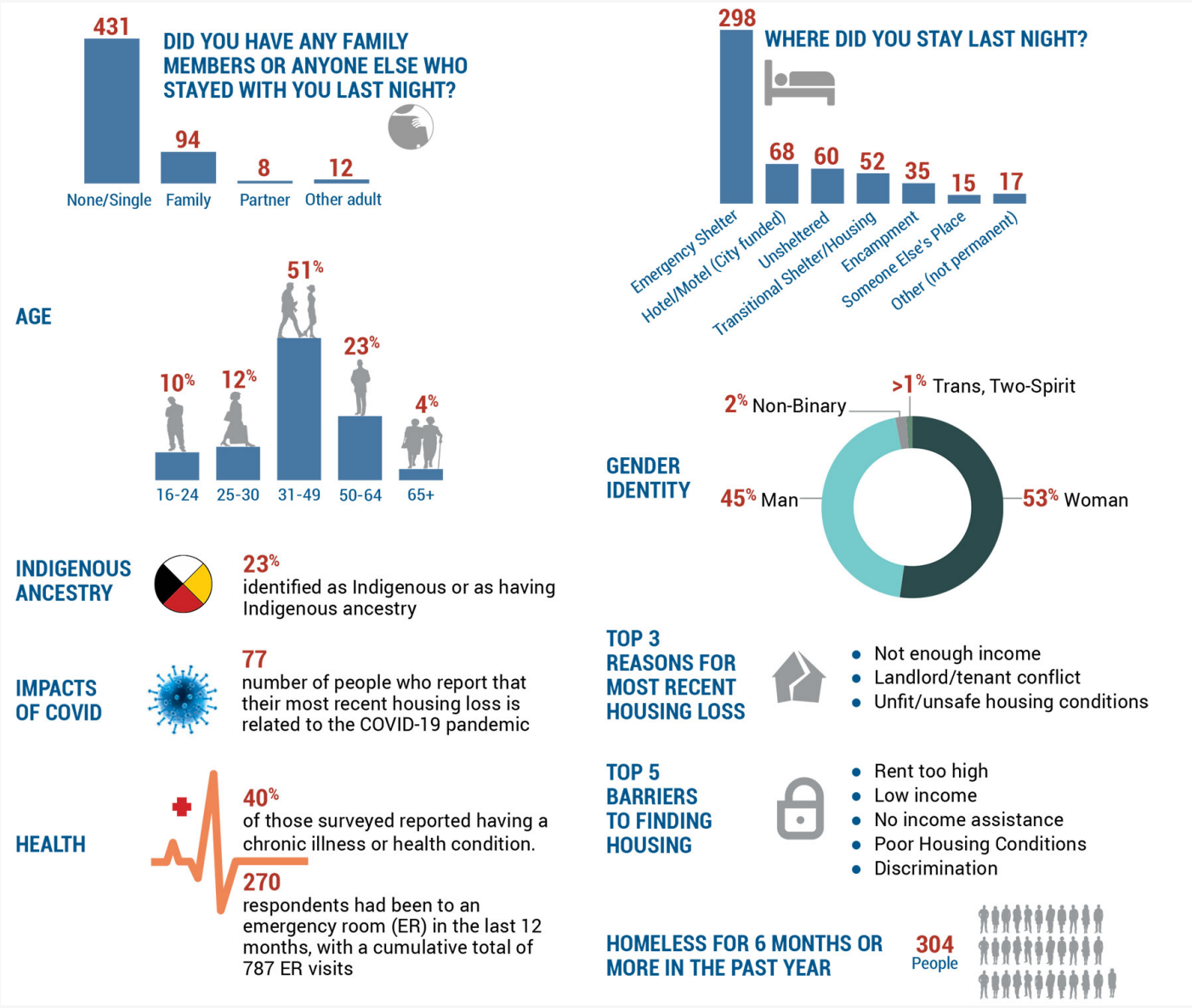
HOMELESSNESS

POINT IN TIME CONNECTION

From November 15 to 19, the City of Hamilton joined communities across Canada in participating in Everyone Counts: the third nationally coordinated Point-in-Time Count in Canada. This initiative, referred to locally as the Point in Time Connection, is a joint planning effort with City of Hamilton's Housing Services Division and the local Indigenous community through the Coalition of Hamilton Indigenous Leadership (CHIL).

During the initiative, staff from community-based social services organizations conducted surveys, hearing directly from unhoused residents, to better understand the needs of people experiencing homelessness in our community. 545 surveys were completed during the week at emergency shelters, drop-in programs, community agencies, and in unsheltered locations. Indigenous led magnet event was also held in Beasley Park on November 17 to provide an opportunity for Indigenous community members to be surveyed by Indigenous surveyors.

2022 POINT IN TIME CONNECTION RESULTS



2022 PiTC Results Infographic Description +

The goal of Hamilton's homeless-serving System is to connect people to the housing resources that will best meet their needs to access long-term sustainable housing. The system follows the principles of housing first and relies on person-centred data to facilitate the housing process.Point in Time Connection data helps to ensure available resources are leveraged as efficiently and effectively as possible to prevent and end homelessness.

- **City of Hamilton Point in Time Connection Results - 2021 (PDF, 1.09 MB)**
  In keeping with the principles of Indigenous data sovereignty, as directed by the Indigenous Community Advisory Board (ICAB), CHIL will continue to lead the analysis of Indigenous respondent data and the City of Hamilton will not use this data without the approval of the ICAB. See below for the full analysis of Indigenous respondent data, completed by CHIL and approved by the ICAB:
- **2021 Point in Time Count Indigenous Responses – Hamilton (PDF, 1.15 MB)**
- **2021 PiT Infographic - Indigenous Respondents (PDF, 800.43 KB)**

Coalition of Hamilton Indigenous Leadership

↗ BACKGROUND

- Completion of the PiTC fulfilled requirements of both the Federal government's Reaching Home: Canada's Homelessness Strategy and the Ontario Ministry of Municipal Affairs and Housing.
- The 2021 PiTC complements existing local efforts to collect and report on key data on the state of homelessness to inform homelessness prevention and reduction efforts.

- Hamilton was the second community in Ontario to undertake homelessness enumeration in 2016 and one of the first to put in place a Coordinated Access system underpinned by a By-Name Priority List.
- Hamilton's PiTC was initially planned for April 2020, however was subsequently postponed by the City of Hamilton and CHIL due to COVID-19 response and impacts, and to await further direction from Federal and Provincial Governments.
- Unlike in previous years, no additional volunteers were recruited to support the surveying. The 2021 PiTC survey was conducted over the course of the week of November 15-19, 2021 in order to: ease the burden on agency staff working to complete the surveys and provide essential services in the community; to enable more time to safely connect with individuals and families in a variety of settings; and to avoid large gatherings to reduce the risk of infection and community spread of COVID-19 within these settings.

2018 Point in Time Connection +

2016 Point in Time Connection +

Date modified: October 31, 2022

‹ Housing & Shelter

Preventing & Ending Homelessness

Cathedral Temporary Shelter

City of Hamilton Encampment Response

Emergency Shelters & Drop-ins

Hamilton's Homelessness Ending Strategy

Housing & Homelessness Action Plan

Housing Stability & Rent Ready Benefits

Point in Time Connection

Resources for Homeless-serving partners

Resources for Individuals at Risk of and Experiencing Homelessness

Contact Us

Homelessness Policy & Programs

Call 905-546-2424 ext. 4666

Email **homelesspolicyprograms@hamilton.ca**

RELATED PAGES

TAB 2a

Inflow/Outflow of Homelessness

Open Hamilton
Private Organization

Summary

Individuals who have had a shelter stay since October 2019.

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Dataset
Table

June 15, 2022
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Data Updated

May 5, 2022
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MONTH_YEAR	INFLOW	OUTFLOW	IN_OUT_RATIO
1/31/2020, 12:00 AM	256	24	256/24
2/28/2020, 12:00 AM	207	50	207/50
3/31/2020, 12:00 AM	199	206	199/206
4/30/2020, 12:00 AM	196	178	196/178
5/31/2020, 12:00 AM	140	212	140/212
6/30/2020, 12:00 AM	183	204	183/204
7/31/2020, 12:00 AM	172	231	172/231
8/31/2020, 12:00 AM	208	165	208/165
9/30/2020, 12:00 AM	232	226	232/226
10/31/2020, 12:00 AM	278	187	278/187
11/30/2020, 12:00 AM	229	197	229/197
12/31/2020, 12:00 AM	253	195	253/195
1/31/2021, 12:00 AM	175	162	175/162
2/28/2021, 12:00 AM	181	177	181/177
3/31/2021, 12:00 AM	238	231	238/231
4/30/2021, 12:00 AM	170	229	170/229
5/31/2021, 12:00 AM	166	191	166/191
6/30/2021, 12:00 AM	231	141	231/141

Inflow/Outflow of Homelessness

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MONTH_YEAR	INFLOW	OUTFLOW	IN_OUT_RATIO
6/30/2021, 12:00 AM	231	141	231/141
7/31/2021, 12:00 AM	281	222	281/222
8/31/2021, 12:00 AM	216	176	216/176
9/30/2021, 12:00 AM	227	185	227/185
10/31/2021, 12:00 AM	298	203	298/203
11/30/2021, 12:00 AM	325	254	325/254
12/31/2021, 12:00 AM	254	283	254/283
1/31/2022, 12:00 AM	214	271	214/271
2/28/2022, 12:00 AM	212	298	212/298
3/31/2022, 12:00 AM	248	226	248/226
4/30/2022, 12:00 AM	262	208	262/208
5/31/2022, 12:00 AM	228	283	228/283
6/30/2022, 12:00 AM	234	352	234/352
7/31/2022, 12:00 AM	264	306	264/306
8/30/2022, 12:00 AM	228	227	228/227
9/30/2022, 12:00 AM	296	240	296/240
10/31/2022, 12:00 AM	256	235	256/235
11/30/2022, 12:00 AM	262	215	262/215

Inflow/Outflow of Homelessness

Open Hamilton
Private Organization

Summary

Individuals who have had a shelter stay since October 2019.

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MONTH_YEAR	INFLOW	OUTFLOW	IN_OUT_RATIO
11/30/2021, 12:00 AM	325	254	325/254
12/31/2021, 12:00 AM	254	283	254/283
1/31/2022, 12:00 AM	214	271	214/271
2/28/2022, 12:00 AM	212	298	212/298
3/31/2022, 12:00 AM	248	226	248/226
4/30/2022, 12:00 AM	262	208	262/208
5/31/2022, 12:00 AM	228	283	228/283
6/30/2022, 12:00 AM	234	352	234/352
7/31/2022, 12:00 AM	264	306	264/306
8/30/2022, 12:00 AM	228	227	228/227
9/30/2022, 12:00 AM	296	240	296/240
10/31/2022, 12:00 AM	256	235	256/235
11/30/2022, 12:00 AM	262	215	262/215
12/31/2022, 12:00 AM	209	317	209/317
1/31/2023, 12:00 AM	221	207	221/207
2/28/2023, 12:00 AM	219	263	219/263
3/31/2023, 12:00 AM	310	196	310/196
4/30/2023, 12:00 AM	248	181	248/181

TAB 2b

Scale of Homelessness

Open Hamilton
Private Organization

Summary

Number of individuals experiencing homelessness in Hamilton and their length of homelessness.

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MONTH_YEAR	HOMELESS_FOR_MORE_SIX_MONTHS	HOMELESS_FOR_LESS_SIX_MONTHS	TOTAL_HOMELESS
1/31/2020, 12:00 AM	463	401	864
2/28/2020, 12:00 AM	587	509	1,096
3/31/2020, 12:00 AM	632	456	1,088
4/30/2020, 12:00 AM	616	489	1,105
5/31/2020, 12:00 AM	676	426	1,102
6/30/2020, 12:00 AM	655	373	1,028
7/31/2020, 12:00 AM	624	343	967
8/31/2020, 12:00 AM	622	347	969
9/30/2020, 12:00 AM	585	362	947
10/31/2020, 12:00 AM	653	334	987
11/30/2020, 12:00 AM	685	376	1,061
12/31/2020, 12:00 AM	657	427	1,084
1/31/2021, 12:00 AM	666	494	1,160
2/28/2021, 12:00 AM	649	489	1,138
3/31/2021, 12:00 AM	612	483	1,095
4/30/2021, 12:00 AM	746	340	1,086

Scale of Homelessness

Open Hamilton
Private Organization

Summary

Number of individuals experiencing homelessness in Hamilton and their length of homelessness.

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MONTH_YEAR	HOMELESS_FOR_MORE_SIX_MONTHS	HOMELESS_FOR_LESS_SIX_MONTHS	TOTAL_HOMELESS
5/31/2021, 12:00 AM	726	332	1,058
6/30/2021, 12:00 AM	717	362	1,079
7/31/2021, 12:00 AM	700	383	1,083
8/31/2021, 12:00 AM	687	495	1,182
9/30/2021, 12:00 AM	674	528	1,202
10/31/2021, 12:00 AM	763	617	1,380
11/30/2021, 12:00 AM	695	731	1,426
12/31/2021, 12:00 AM	632	909	1,541
1/31/2022, 12:00 AM	889	705	1,594
2/28/2022, 12:00 AM	803	720	1,523
3/31/2022, 12:00 AM	795	801	1,596
4/30/2022, 12:00 AM	326	1,409	1,735
5/31/2022, 12:00 AM	370	1,303	1,673
6/30/2022, 12:00 AM	373	1,166	1,539
7/31/2022, 12:00 AM	367	1,127	1,494
8/30/2022, 12:00 AM	395	1,081	1,476
9/30/2022, 12:00 AM	390	1,141	1,531

Scale of Homelessness

Open Hamilton
Private Organization

Summary

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MONTH_YEAR	HOMELESS_FOR_MORE_SIX_MONTHS	HOMELESS_FOR_LESS_SIX_MONTHS	TOTAL_HOMELESS
11/30/2021, 12:00 AM	695	731	1,426
12/31/2021, 12:00 AM	632	909	1,541
1/31/2022, 12:00 AM	889	705	1,594
2/28/2022, 12:00 AM	803	720	1,523
3/31/2022, 12:00 AM	795	801	1,596
4/30/2022, 12:00 AM	326	1,409	1,735
5/31/2022, 12:00 AM	370	1,303	1,673
6/30/2022, 12:00 AM	373	1,166	1,539
7/31/2022, 12:00 AM	367	1,127	1,494
8/30/2022, 12:00 AM	395	1,081	1,476
9/30/2022, 12:00 AM	390	1,141	1,531
10/31/2022, 12:00 AM	409	1,160	1,569
11/30/2022, 12:00 AM	542	1,128	1,670
12/31/2022, 12:00 AM	488	1,048	1,536
1/31/2023, 12:00 AM	494	1,051	1,545
2/28/2023, 12:00 AM	476	989	1,465
3/31/2023, 12:00 AM	556	1,015	1,571
4/30/2023, 12:00 AM	591	1,024	1,615

TAB 2c

Shelter Beds Available

Open Hamilton
Private Organization

Summary

Total number of shelter beds or rooms available on the last day of the month.

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MONTH_YEAR	MEN_BEDS	WOMEN_BEDS	FAMILY_ROOMS	YOUTH_BEDS	TOTAL_BEDS	TOTAL_ROOMS
1/31/2020, 12:00 AM	220	46	20	21	287	20
2/28/2020, 12:00 AM	193	46	20	21	260	20
3/31/2020, 12:00 AM	219	46	20	21	286	20
4/30/2020, 12:00 AM	150	46	20	21	217	87
5/31/2020, 12:00 AM	127	46	20	21	194	63
6/30/2020, 12:00 AM	127	46	20	21	194	63
7/31/2020, 12:00 AM	127	46	20	21	194	67
8/31/2020, 12:00 AM	127	38	20	21	186	82
9/30/2020, 12:00 AM	115	38	20	21	174	147
10/31/2020, 12:00 AM	142	26	20	13	181	152
11/30/2020, 12:00 AM	186	26	20	13	225	149
12/31/2020, 12:00 AM	186	26	20	13	225	143
1/31/2021, 12:00 AM	196	26	20	13	235	177
2/28/2021, 12:00 AM	223	26	20	13	262	178
3/31/2021, 12:00 AM	223	26	20	13	262	198
4/30/2021, 12:00 AM	223	26	20	13	262	199
5/31/2021, 12:00 AM	223	26	20	13	262	178
6/30/2021, 12:00 AM	223	26	20	13	262	183

Shelter Beds Available

Open Hamilton
Private Organization

Summary

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MONTH_YEAR	MEN_BEDS	WOMEN_BEDS	FAMILY_ROOMS	YOUTH_BEDS	TOTAL_BEDS	TOTAL_ROOMS
7/31/2021, 12:00 AM	209	26	20	13	248	169
8/31/2021, 12:00 AM	210	26	20	13	249	177
9/30/2021, 12:00 AM	218	26	20	13	257	185
10/31/2021, 12:00 AM	219	41	20	13	273	218
11/30/2021, 12:00 AM	238	41	20	13	292	235
12/31/2021, 12:00 AM	239	41	20	13	293	218
1/31/2022, 12:00 AM	245	41	20	21	307	268
2/28/2022, 12:00 AM	212	41	20	21	274	281
3/31/2022, 12:00 AM	212	96	20	21	329	210
4/30/2022, 12:00 AM	154	104	20	21	279	201
5/31/2022, 12:00 AM	154	104	20	21	279	220
6/30/2022, 12:00 AM	193	104	20	21	318	158
7/31/2022, 12:00 AM	193	104	20	21	318	157
8/30/2022, 12:00 AM	212	104	20	21	337	155
9/30/2022, 12:00 AM	212	104	20	21	337	124
10/31/2022, 12:00 AM	212	104	20	21	337	100
11/30/2022, 12:00 AM	201	107	20	21	329	100

Shelter Beds Available

Open Hamilton
Private Organization

Summary

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MONTH_YEAR	MEN_BEDS	WOMEN_BEDS	FAMILY_ROOMS	YOUTH_BEDS	TOTAL_BEDS	TOTAL_ROOMS
11/30/2021, 12:00 AM	238	41	20	13	292	235
12/31/2021, 12:00 AM	239	41	20	13	293	218
1/31/2022, 12:00 AM	245	41	20	21	307	268
2/28/2022, 12:00 AM	212	41	20	21	274	281
3/31/2022, 12:00 AM	212	96	20	21	329	210
4/30/2022, 12:00 AM	154	104	20	21	279	201
5/31/2022, 12:00 AM	154	104	20	21	279	220
6/30/2022, 12:00 AM	193	104	20	21	318	158
7/31/2022, 12:00 AM	193	104	20	21	318	157
8/30/2022, 12:00 AM	212	104	20	21	337	155
9/30/2022, 12:00 AM	212	104	20	21	337	124
10/31/2022, 12:00 AM	212	104	20	21	337	100
11/30/2022, 12:00 AM	201	107	20	21	329	100
12/31/2022, 12:00 AM	198	109	20	21	328	62
1/31/2023, 12:00 AM	198	109	20	21	328	62
2/28/2023, 12:00 AM	198	109	20	21	328	62
3/31/2023, 12:00 AM	198	81	20	21	300	62
4/30/2023, 12:00 AM	198	65	20	21	284	62

TAB 2d

Showing 39 of 39 rows

MONTH_YEAR	PERCENT_MEN	PERCENT_WOMEN	PERCENT_FAMILIES	PERCENT_YOUTH	PERCENT_EMERGENCY
1/31/2020, 12:00 AM	1.14	1.04	0.93	0.68	
2/28/2020, 12:00 AM	1.11	1.02	0.91	0.6	
3/31/2020, 12:00 AM	1.08	0.82	0.97	0.52	
4/30/2020, 12:00 AM	1.39	0.87	0.95	0.7	0.44
5/31/2020, 12:00 AM	1.14	0.8	0.64	0.46	0.5
6/30/2020, 12:00 AM	1.07	0.78	1	0.51	0.34
7/31/2020, 12:00 AM	0.91	0.78	1	0.42	0.31
8/31/2020, 12:00 AM	0.9	0.85	1	0.29	0.33
9/30/2020, 12:00 AM	0.9	0.9	0.79	0.36	0.39

Showing 39 of 39 rows

MONTH_YEAR	PERCENT_MEN	PERCENT_WOMEN	PERCENT_FAMILIES	PERCENT_YOUTH	PERCENT_EMERGENCY
10/31/2020, 12:00 AM	0.79	0.72	0.85	0.51	0.72
11/30/2020, 12:00 AM	0.92	0.99	0.95	0.49	0.72
12/31/2020, 12:00 AM	0.96	1.1	0.92	0.46	0.62
1/31/2021, 12:00 AM	0.91	0.96	0.86	0.32	0.52
2/28/2021, 12:00 AM	0.99	0.97	0.9	0.45	0.6
3/31/2021, 12:00 AM	0.93	1.03	0.85	0.59	0.67
4/30/2021, 12:00 AM	0.88	0.99	0.87	0.66	0.54
5/31/2021, 12:00 AM	0.81	1.02	0.78	0.44	0.46
6/30/2021, 12:00 AM	0.79	1.05	0.86	0.4	0.47

Showing 39 of 39 rows

MONTH_YEAR	PERCENT_MEN	PERCENT_WOMEN	PERCENT_FAMILIES	PERCENT_YOUTH	PERCENT_EMERGENCY
7/31/2021, 12:00 AM	0.85	1.03	0.88	0.49	0.58
8/31/2021, 12:00 AM	0.81	1.04	1	0.63	0.73
9/30/2021, 12:00 AM	0.81	1.08	1.14	0.61	0.74
10/31/2021, 12:00 AM	0.88	1.05	1.01	0.74	0.79
11/30/2021, 12:00 AM	0.96	0.99	0.98	0.84	0.87
12/31/2021, 12:00 AM	1	1.01	0.92	0.72	1.05
1/31/2022, 12:00 AM	0.96	0.96	0.93	0.45	1.02
2/28/2022, 12:00 AM	0.95	0.97	0.85	0.38	1
3/31/2022, 12:00 AM	0.98	0.8	1.01	0.48	1.07

Showing 39 of 39 rows

MONTH_YEAR	PERCENT_MEN	PERCENT_WOMEN	PERCENT_FAMILIES	PERCENT_YOUTH	PERCENT_EMERGENCY
4/30/2022, 12:00 AM	1	0.9	1.03	0.58	0.95
5/31/2022, 12:00 AM	0.97	0.88	1	0.47	0.97
6/30/2022, 12:00 AM	0.99	0.9	1.04	0.43	0.8
7/31/2022, 12:00 AM	0.97	0.93	0.99	0.58	0.75
8/30/2022, 12:00 AM	0.94	0.97	1.03	0.61	0.72
9/30/2022, 12:00 AM	0.96	0.97	1.03	0.57	0.6
10/31/2022, 12:00 AM	1.02	1	1.01	0.76	0.85
11/30/2022, 12:00 AM	1.02	0.98	1.04	0.82	0.68
12/31/2022, 12:00 AM	1.06	0.92	1.03	0.71	0.6

Showing 39 of 39 rows

MONTH_YEAR	PERCENT_MEN	PERCENT_WOMEN	PERCENT_FAMILIES	PERCENT_YOUTH	PERCENT_EMERGENCY
6/30/2022, 12:00 AM	0.99	0.9	1.04	0.43	0.6
7/31/2022, 12:00 AM	0.97	0.93	0.99	0.58	0.75
8/30/2022, 12:00 AM	0.94	0.97	1.03	0.61	0.72
9/30/2022, 12:00 AM	0.96	0.97	1.03	0.57	0.6
10/31/2022, 12:00 AM	1.02	1	1.01	0.76	0.85
11/30/2022, 12:00 AM	1.02	0.98	1.04	0.82	0.68
12/31/2022, 12:00 AM	1.06	0.92	1.03	0.71	0.6
1/31/2023, 12:00 AM	1.1	0.91	1.05	0.55	0.84
2/28/2023, 12:00 AM	1.1	0.92	1.04	0.75	0.77
3/31/2023, 12:00 AM	1.12	0.93	1.04	0.67	0.71

TAB 3

City of Hamilton
EMERGENCY & COMMUNITY SERVICES COMMITTEE ADDENDUM

Meeting #: 20-004
Date: July 13, 2020
Time: 9:30 a.m.
Location: Due to the COVID-19 and the Closure of City Hall
All electronic meetings can be viewed at:
City's Website: https://www.hamilton.ca/council-committee/council-committee-meetings/meetings-and-agendas
City's YouTube Channel:
https://www.youtube.com/user/InsideCityofHamilton
or Cable 14

Tamara Bates, Legislative Coordinator (905) 546-2424 ext. 4102

6. WRITTEN DELEGATIONS

*6.1 Kevin Gonci, Hamilton Collaborative Partnership Group, respecting Response to City of Hamilton Staff Report HSC20026 (City Wide) dated June 19, 2020

*6.2 Dr. Jill Wiwcharuk and Dr. Tim O'Shea, Hamilton Social Medicine Response Team, respecting the City's strategy about homeless encampments

*6.3 Jody Ans and Lisa Nussey, Keeping Six, respecting request that the City re-evaluate and change its approach to encampments

*6.4 Sharon Crowe, Nadine Watson, and Wade Poziomka, Hamilton Community Legal Clinic, respecting Dismantlement of Homeless Encampments

8. DISCUSSION ITEMS

*8.3 Adaptation and Transformation of Services for People Experiencing Homelessness Update 1 (HSC20020(a)) (City Wide)

10. NOTICES OF MOTION

*10.1 Signing of the AMO-OFIFC Declaration of Mutual Commitment and Friendship with Local Municipality and Friendship Centre Support

12. PRIVATE AND CONFIDENTIAL

12.2 Potential Litigation Report (LS20019) (City Wide)

Pursuant to Section 8.1, Sub-sections (e) and (f) of the City's Procedural By-law 18-270, as amended, and Section 239(2), Sub-sections (e) and (f) of the Ontario Municipal Act, 2001, as amended, as the subject matter pertains to litigation or potential litigation, including matters before administrative tribunals, affecting the City and the receiving of advice that is subject to solicitor-client privilege, including communications necessary for that purpose.

Delegation to Chair and Members of Emergency and Community Services Committee

July 13th, 2020

RE: Homeless Encampments

Thank you for accepting my delegation today. And thank you for all of your work throughout these unprecedented times.

Since the start of the pandemic, Hamilton has seen an increasing number of people experiencing homelessness who are choosing to sleep outside or "sleep rough". This is certainly not a new phenomenon and there are many reasons that people avoid the shelter system. Some people find the rules too restrictive at shelters (there are curfews and bed checks in place). Others lament all the theft that occurs and simply don't feel secure sleeping in a dorm style setting. Still others have pets that are not welcome in shelters and when people have so few supports in their lives, sometimes their pets take precedence above all else. As you know, people who are homeless suffer from a disproportionately high level of mental health issues and we often see people who are simply too anxious or too paranoid to be in close contact with so many people. Other people want to avoid the drug use that is often rampant in shelters. And on the flip side of that there are people who use drugs who are repeatedly evicted from shelters due to their drug use. Many times people are asked to leave shelters just because they have drug use paraphernalia on them. Peoples belongings are routinely searched and a clean needle or an unopened can of beer is enough to be restricted from a shelter. Lastly, there are very few shelter beds open for couples so different-sex couples are either forced to go to different shelters or opt to sleep outside so that they can stay together.

These are all reasons that people choose to sleep rough. Then you add a pandemic on top of that and hearing the repeated message that people living in congregate sleeping settings are at highest risk can be an added worry for people.

I have been working with many people who are sleeping rough during this pandemic. From a health perspective, I see how unwell these individuals often are. I have seen people with severe life-threatening infections, people who have untreated spinal cord issues that put them at risk of becoming paraplegic, women who are in their last few weeks of pregnancy, and so many folks who have addictions that they are desperate to get help with but lack the stability in their lives to make that possible. Imagine trying to get to a pharmacy every day for a dose of methadone when you don't know where your next meal is coming from, you have to somehow protect your belongings from theft, find a place to charge a cell phone so that you won't miss a call from your housing worker and acquire water for your dogs. Never mind finding a place to simply relieve yourself in the morning.

I know that in the past the City has felt they had to dismantle homeless encampments in response to complaints from residents. We saw that at Sir John A McDonald, Jackie Washington

Park and Ferrie Street not long ago. When this happens the connections that were made with people are lost. The outreach workers who have been working on housing applications, the health care workers who have been working on the physical and mental health piece – these connections are all lost when people are told to move along. I was working with an elderly gentleman with a fever and pneumonia who could not do much more than lay on the floor of his tent but refused to go to hospital. With minimal notice he was told to move along and I have not seen him since.

The city has slowed down on dismantling homeless encampments in recent weeks and I am grateful for that, as are my patients. I am asking that this continue to be the overarching principle in dealing with homeless encampments: let them be. This pandemic is unprecedented. We can't expect that responses that might have seemed reasonable in the past are appropriate during a pandemic. People do not cease to exist when they are told to move along. They still need a place to be and by virtue of sleeping rough they have shown that they do not fit into the current shelter system as it is**. The Centre for Disease Control (CDC) has issued guidelines stating that "Unless individual housing units are available, do not clear encampments during community spread of COVID-19. Clearing encampments can cause people to disperse throughout the community and break connections with service providers. This increases the potential for infectious disease spread."**

We are imploring you to recognize the severe health consequences facing people who do not have housing, to recognize that we are in a new era where the old rules are not necessarily the best ones and to refrain from moving encampments along whenever possible. From our perspective, it would only be acceptable to move people along when they are either being moved to housing units with appropriate supports or to an ultra low-barrier, highly supportive shelter model that will give them a chance of success. Moving people into one of the current shelters or hotels to have them evicted two days later only further decreases the trust that people have in the system, making them less likely to engage in the future.

We need to recognize that the current shelter system does not meet the needs of many of these individuals. I ask that, in the re-imagining of our city's response to homelessness that the pandemic has instigated, we make this group of high-needs individuals who sleep rough a priority. Currently, we see many of these folks being service restricted from all of the shelters in the city and turned down from city-run hotels due to the fact that their needs are too high. In the healthcare world, that is like saying that you are too sick so we are not going to offer you any care. Instead of turning our backs on them and continually telling them to move somewhere else so that they won't be seen, we need to find something that WILL work for them. What about a motel space that is as low-barrier as possible with intensive social and health supports? Other jurisdictions in Canada have done this with great success. The city has recently made a precedent of helping two people get directly from a homeless encampment into permanent housing. This was successful and there is no reason that it would not work for other folks as well. What this group needs are options and at this point viable options for them do not exist.

I understand that the focus for you right now is likely the encampment outside of First Ontario Centre. But our concerns about this issue predate that encampment. Part of the reason the FOC encampment developed was due to smaller encampments in the city being dismantled – groups of two or three tents at the back of a park that were told to move along, or a single tent along the rail trail somewhere. Another group of people outside FOC are people who have been service restricted from all of the shelters in the city. And other people sleeping outside of FOC have been illegally evicted from their residential care facilities (RCF's). The encampment developed in that particular spot likely because of the neighbouring shelters that offered community to people as well as the fact that amenities existed in that area. Toilets and meals have not been as easy to come by during the pandemic and people will go to areas where services exist.

So please, stop dismantling homeless encampments for the duration of the pandemic unless people are being moved to an indoor space where they will have a modicum of success. This is not only a matter of public health and best practise as per the Centre for Disease Control, it is also a matter of human dignity and human rights. We need to recognize that the current system does not work for many people who are sleeping rough and work to either get them directly into permanent housing with appropriate supports or accommodate them in a shelter/motel that is low-barrier and high-support enough to meet their needs. Barring that, our city needs to be following an evidence-based approach to this issue, follow the international health guidelines that are available to us and stop dismantling homeless encampments.

Dr Jill Wiwcharuk and Dr Tim O'Shea, Hamilton Social Medicine Response Team (HAMSMaRT)

KEEPING SIX HAMILTON
HARM REDUCTION ACTION LEAGUE

July 13, 2020

Dear Chair and Members of the Emergency and Community Services Committee,

Thank you for receiving our delegation. We are writing to you today on behalf of Keeping Six, Hamilton Harm Reduction Action League to request that the City re-evaluate and change its approach to encampments to better support the needs of those living in them and to facilitate service provision and access to housing. We believe that this can be accomplished in the following ways:

- that there be an explicit acknowledgement that the shelter system (including the pandemic hotels) do not meet the needs of many, and this is a significant contributing factor to the encampments in the city
- by including people with lived experience of living in encampments in the City led Encampments working group and providing the supports necessary for participation
- that people living in encampments be prioritized for supportive housing
- that ultra-low barrier shelter option or options be created
- that in the absence of suitable housing or shelter, people be offered the option of sanctioned encampments in locations suitable to the City and the encampments' inhabitants
- that, barring an alternative suitable to the people or person in question, a person's housing not be dismantled, at least for the duration of the pandemic, as recommended by the Center for Disease Control.

Let us begin by saying that we appreciate that this is a difficult subject and that you face extra-ordinary pressure from the tax and voting base to "get rid" of this problem and restore access to perceived security and tranquil green space. We also acknowledge that the issue has been hurtled into the minds and emails of many because of the highly visible First Ontario Centre Encampment.

As a group comprised of people and supporters of people living or who have lived in such encampments, we need for you to understand that the problem for us is broader than FOC and more pressing than access to green space. Further, we are not the pariah that people want to make us out to be, and that the moral leadership of the city on this issue could go a long way toward shifting that narrative and building a more inclusive city.
A mainstay of our work as an organization led by people with lived experience is being connected to the people on the ground. A constant refrain from the streets is that people are exhausted and undermined by being in a perpetual state of dislocation. Always being moved

along. It is next to impossible to make any *progress* in life while being consumed by sorting out where to be.

Another pillar of our work is to insist that the voices of people impacted by policy create that policy, or at least have a hand in it. Nothing about us, without us. This is of course about representation but also practicality; you would be surprised by how smart we are, how well we understand the issues and their nuance, and the ways in which we are able to propose realistic solutions and create buy in for them.

Our community has several times raised the idea of sanctioned sites, where we could establish some modicum of stability by doing away with the perpetual need to find a new place to live and acquire new belongings destroyed in the dismantlement. While it may not seem obvious at first glance, the stability and predictability of sanctioned or tacitly supported sites will decrease the problems associated with encampments, not increase them. Firstly, we will have an opportunity to create stable community and a sense of cohesion and ownership which fosters accountability to one another, our surroundings, and the community. Second, it facilitates access and continuity to services that might help us gain access to more stable housing (one of our number one goals), and health care. There is successful precedent for this in other cities in Canada and we would be happy to connect you to folks doing that work. K6 would also be first to engage people in such an encampment and would make it a priority for our existing outreach program.

Finally, a note to say, it gives us no great joy to come before you today and beg for people to be left to camp in the city. It is not what most of us want. But in the acknowledged absence of an alternative, with a run of systems failures that cross all levels of government, it is what we are left with.

The existing services for shelter in the city are valued and have hard working dedicated people in them and, we acknowledge, consume a great deal of resources. But we are all in agreement that the existing services do not meet some people's needs. Some of us simply do not succeed in them. Teams of people worked extremely hard to humanely and respectfully clear people from the Sir John A encampment. On a Friday most if not all were in shelter or hotel. By Monday many were discharged and back on the street.

Now, we can discuss why that it is and disagree about where to "lay the blame" as it were, but the facts the ground remain that as it stands, it doesn't work for some. We and many before us have long been in discussion about what could work. At every turn to every suggestion we hear: there are no resources for that, we have no funds, no staff. Excellent supportive programs like HOMES are oversubscribed and have long waitlists. The reality is that our current suite of Housing First services in Hamilton does not meet the housing needs of people who experience the most complex barriers to housing. The encampments we are talking about today are exacerbated by that gap in services.

This plea to not move encampments unless an acceptable alternative is available is an acceptance of that proposition, that the resources to solve this crisis don't currently exist. Our preference is definitely for people to have access to suitable indoor living arrangements. But in the current climate, we know that this is not possible. In a time when everyone comes to the city asking for

everything, we are asking for an end to the resource intensive perpetual make work project of moving people around from place to place, which only undermines any effort to “get rid of people”, because no matter what the complaining tax payers or voters want, moving us on does not make us evaporate. We need to be somewhere.

We appreciate that it is a complex subject that lends itself best to conversation and answering of questions. We have tried to anticipate some of your questions in the appendix and provide brief answers. We are happy to sit down at any time to discuss further how this shift in strategy could work.

Sincerely,

Jody Ans
Founding member of K6

Lisa Nussey
Co-coordinator of K6

Frequently Asked Questions

What is an encampment?

There is no agreed upon definition of an encampment. To us, in this submission, it means a person or group of people sleeping outdoors in temporary shelter, like a tent or an impermanent structure fashioned out of any number of materials, like tarps, umbrellas, wood, etc.

Don't people just want to sleep rough?

This may *occasionally* be true, but this choice is the exception, not the rule. People who are truly choosing to sleep rough are few and far between, and they are not the subject of this submission.

Aren't encampments dangerous to the people living in them?

Yes. Sleeping on the street is dangerous. There have been instances fires in some encampments. There have also been incidents of violence between people in encampments. This is part of the reason why we advocate first for safe, dignified housing for all. Until that is possible, however, people will sleep rough. This means that we must do our best to make rough sleeping safer. Moving people does not remove the potential for fire or violence. It simply displaces it and frankly aggravates it, by making people more on edge. Further, the stability of not moving encampments allows for us to make them safer by building community and supplying people with safety equipment.

Aren't encampments dangerous to people living near them?

We do not have good evidence to answer this question. Without oversimplifying, our intuition and experience is that when people are treated with respect and kindness, they largely give the same in return. Certainly, reduced displacement is a gesture of respect and provides opportunity for building links across differences in communities. There is some evidence out of the US to show that broadly speaking, crime stays the same or goes down in neighborhoods around sanctioned or tacitly supported encampments. There have always been similar arguments leveled again the creation of sanctioned Consumption and Treatment Centres, and this fear of increased crime has not borne out in reality.

What do we mean by a sanctioned site?

A sanctioned encampment is one where the City either explicitly or implicitly permits people to erect temporary shelter, offering the continuity and stability required to take some next steps in the journey toward housing. Beyond that, there could be on site hygiene facilities like toilets and handwashing stations. Services can be brought on site and more reliably connect with people. Food delivery by area agencies could take place. Regular garbage pickups could be organized. Resident led systems of governance and accountability could be fostered. There is some preliminary evidence out of the US that shows that this strategy could be successful in reducing homelessness.

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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January 2019

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July 10, 2020
VIA EMAIL

TO: Chair and Members of the Emergency and Community Services Committee

Re: Dismantlement of Homeless Encampments

Thank you for approving our written delegation. We submit this delegation on behalf of the Hamilton Community Legal Clinic and we have further partnered with Wade Poziomka, a partner with Ross & McBride, to highlight concerns relating to the dismantlement of homeless encampments.

The Hamilton Community Legal Clinic has worked with HAMSMaRT and Keeping Six with respect to the ticketing of individuals experiencing homelessness for offences under the *Emergency Management and Civil Protection Act* (*"EMCPA")* and related by-laws.

We appreciate that homeless encampments present unique challenges for the City, and that the City is required to respond to resident complaints with respect to same. In the midst of gaining compliance with *EMCPA*, the *Trespass to Property Act*, and local by-laws regarding the usage of park or public spaces, it is imperative to ensure that vulnerable groups, especially those who are experiencing homelessness, are not being penalized because of their socio-economic circumstances and/or disabilities, including mental health disabilities.

Throughout the duration of the pandemic, HAMSMaRT and Keeping Six have repeatedly implored the City to either not remove individuals from encampments, or to ensure that they are transitioned to stable housing. They have cited the CDC Guidelines, Interim Guidance on Unsheltered Homelessness and Coronavirus Disease 2019 (COVID-19) for Homeless Service Providers and Local Officials, (https://www.cdc.gov/coronavirus/2019-ncov/community/homeless-shelters/unsheltered-homelessness.html), which recommend that people not be moved from encampments "*unless individual housing units are available*" *(Emphasis Added).* Without going into detail, the Guidelines further explain the personal and public health risks involved in displacing people during the pandemic.

We agree that there are significant health-related reasons not to remove individuals experiencing homelessness from their encampments. We further submit that there are significant legal reasons to refrain from this conduct. The issue of homeless encampments, specifically during COVID-19, is not unique to Hamilton. Other municipalities have had to grapple with how to respond to public concerns while protecting private and public health interests. In Toronto, a coalition of legal clinics and advocates for individuals experiencing homelessness recently filed a lawsuit against the City which alleged, amongst other things, that the City failed to provide physical distancing standards across the shelter system. The litigation alleged that, by failing to ensure physical distancing within the shelter system, the City had infringed on the shelter residents' life, liberty, and security of the person, and their right to equal treatment (guaranteed under sections 7 and 15 of the *Charter of Rights and Freedoms* respectively).

The City of Toronto entered into an Interim Settlement Agreement and committed to numerous enforceable commitments relating to conditions in all shelter, respites, drop-ins and COVID-19 homelessness response hotel rooms operated or funded by the City. As of this week, the same coalition is taking the City back to court for failure to comply with the settlement terms. It is important to note that the declined capacity of the shelter system and failure to provide alternatives to congregate shelter has led hundreds of people to remain in encampments and to continue sleeping rough.

There is also precedent for jurisdictions moving in the right direction. In London, the City made the decision to allow temporary encampments and individual tents on municipal property for the duration of the pandemic with the ultimate goal of getting people housed. On July 7, Kingston City Council voted to extend by-law exemptions allowing an encampment to remain until at least July 31.

In British Columbia, the issue of dismantling homeless encampments as a *Charter* issue was specifically dealt with in two cases. In *Victoria (City) v. Adams*, 2009 BCCA 563 and *Abbotsford (City) v. Shantz*, 2016 BCSC 2437, the application of parks and streets bylaws prohibiting erecting a shelter was challenged primarily under section 7 of the *Charter*. The Courts found that, insofar as the by-laws prevented people from erecting temporary shelter for protection from the elements, this was a violation of their section 7 rights, and consequently of no force and effect. From our perspective, the right to erect temporary shelter for protection from the real and legitimate risk presented by COVID-19, when no other viable options for some individuals, presents a parallel fact pattern.

Housing is a basic human right. The right to adequate, safe housing, is further heightened during the era of COVID-19. Dismantling homeless encampments, in light of the significant risks to the individuals who are forced to move, infringes on their right to life, liberty, and security of the person. Given that many of the affected individuals are racialized, and/or have mental health, addiction and physical disabilities, these groups are also disproportionately impacted by displacement.

The City has a legal duty to accommodate individuals staying in encampments pursuant to its obligations under the *Human Rights Code* (the "*Code*"). As you know, there are many reasons why individuals "sleep rough" in encampments. Some of those reasons are unique to COVID-19 (a legitimate fear of exposure while in shelter). Other reasons for residing in encampments are directly related to *Code*-protected grounds. For example:

- Some individuals have mental health challenges that effectively preclude them from functioning in a shelter setting;
- Some individuals have drug or alcohol dependencies (addictions), and are ejected from shelters as a result of use (a symptom of their disability);
- Some individuals are unable to give up an animal, often the only companion they have and a necessity for emotional regulation, because some shelters do not permit animals, and
- Some individuals are married or in common law relationships, and most shelters do not accommodate couples.

The list of reasons why people may occupy encampments is extensive – what is clear is that those reasons are frequently related to *Code*-protected grounds. The fractures that exist in the shelter systems during the best of times are highlighted and exacerbated during the pandemic we are all experiencing. Rather than engage in knee-jerk reactions that results in dismantlement, it is imperative the City to work with social service organizations, local communities and experts to fully understand the situation and take steps to correct the problems with the system. The City needs to look at this situation holistically, instead of in a piecemeal fashion primarily focused on the rights of property owners and an unrealistic assessment of the threat posed by encampments.

It is essential that the City follow the principles set out in the Ontario Human Rights Commission's "Policy Statement on a Human-Rights Approach to Managing the COVID-19 Pandemic" to ensure that everyone's human rights are protected. Without these considerations, low income, racialized, Black, and First Nations, Inuit and Métis communities, persons with physical and mental health disabilities, youth, and the 2S & LGBTQQAI+ communities may be disproportionately impacted in the course of enforcement.

It is also essential that the City follow the principles developed by the UN Special Rapporteur on the Right to Housing in "A National Protocol for Homeless Encampments in Canada: A Human Rights Approach" calling for a rights-based response to encampments. Such a response requires that:

1. All government action with respect to homeless encampments upholds the human rights and human dignity of their residents;
2. Governments will not resort to criminalization, penalization or obstruction of homeless encampments;
3. Governments must explore all viable alternatives to eviction and may not remove residents from encampments without identifying alternative places to live that are acceptable to them;
4. Governments provide adequate alternative housing to all residents prior to any eviction.

5. Residents will meaningfully participate in all decision-making processes that directly affect them and engage in any decisions regarding relocation;
6. Relocation must not result in the continuation or exacerbation of homelessness, or require the fracturing of families or partnerships.

There have been several incidents of the City dismantling homeless encampments during the pandemic: from small groups or individuals along railways, to Sir John A. MacDonald, Jackie Washington and Ferrie St. While efforts were made to connect displaced individuals with supports, those efforts fell short of meeting actual needs. Several of the individuals placed in hotels or shelters were discharged shortly after for being unable (by virtue of disability) to conform to shelter and hotel rules. Others simply moved on, and have lost contact with the crucial medical and social supports previously accessed.

We acknowledge, and are thankful that the City has refrained from further dismantling in recent weeks. We also understand that there is an expiration date on current encampments, and that the City is facing considerable pressure from residents to move people along. The difficulty is that the City does not have a viable plan for many of those individuals. We therefore call on the City to immediately change its policy on homeless encampments as follows:

1. The City will not dismantle homeless encampments and/or displace of its residents unless it has first arranged for and/or secured inside spaces such as shelters, hotels, interim housing and/or individual housing units in stable, secure housing with appropriate supports. We encourage the City to prioritize individuals experiencing homelessness for urgent housing placement. In the context of shelter and hotel placements, the City must consult with stakeholders in the homelessness/shelter community to determine what supports are needed, how to remove barriers from hotel stays, and how existing shelter rules may need to be changed in order to accommodate individual needs.
2. Where inside spaces are not available, the City will not dismantle homeless encampments and/or displace of its residents. Such objective can be accomplished by one of the following initiatives:
    a. The designation of specific parks/public lands wherein individuals experiencing homelessness are allowed to set up tents/temporary structures. The City should consult with stakeholders prior to the designation to ensure that the sites are appropriately accessible for individuals and their support network;
    b. In the alternative, a streamlined, low-barrier, accessible process of issuing permits allowing for tents/temporary structures;
    c. Where encampments are located on private property, refraining from any enforcement measures save and except where property owners have made complaints. Any individuals removed would then be directed to a viable alternative as set out in subparagraphs a. and b. above.

We acknowledge the complexity of homeless encampments and appreciate the fact that encampments are not a solution to homelessness. However, we submit that it is critical that the City not dismantle homeless encampments until it can provide encampment residents with adequate housing with appropriate supports. Failure to do this will result in a violation of the basic human rights and dignity of all encampment residents in the City of Hamilton.

Respectfully,

Sharon Crowe
Staff Lawyer
Hamilton Community Legal Clinic

Nadine Watson
Staff Lawyer
Hamilton Community Legal Clinic

Wade Poziomka
Partner
Ross & McBride

This guidance is an update of https://www.cdc.gov/coronavirus/2019-ncov/community/homeless-shelters/plan-prepare-respond.html

Summary of Recent Changes

A revision was made on 4/21/2020 to reflect the following:

- Revisions to document organization for clarity
- Description of "whole community" approach
- Description of considerations for facility layout
- Description of considerations for facility processes
- Revisions with the understanding that many people might be asymptomatically infected with COVID-19
- Clarification of cloth face covering use by clients and staff
- Clarification of personal protective equipment use by staff
- Updated resources

Interim guidance for homeless service providers to plan and respond to coronavirus disease 2019 (COVID-19)

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This interim guidance is based on what is currently known about Coronavirus Disease 2019 (COVID-19). The Centers for Disease Control and Prevention (CDC) will update this interim guidance as needed, and as additional information becomes available.

People experiencing homelessness are at risk for infection during community spread of COVID-19. This interim guidance is intended to support response planning by emergency management officials, public health authorities, and homeless service providers, including overnight emergency shelters, day shelters, and meal service providers.

COVID-19 is caused by a new coronavirus. We are learning about how it spreads,, how severe it is, and other features of the disease. Transmission of COVID-19 in your community could cause illness among people experiencing homelessness, contribute to an increase in emergency shelter usage, and/or lead to illness and absenteeism among homeless service provider staff.

Early and sustained action to slow the spread of COVID-19 will keep staff and volunteers healthy, and help your organization maintain normal operations.

Community coalition-based COVID-19 prevention and response

Planning and response to COVID-19 transmission among people experiencing homelessness requires a "whole community" approach, which means that you are involving partners in the development of your response planning, and that everyone's roles and responsibilities are clear. Table 1 outlines some of the activities and key partners to consider for a whole-community approach.

Table 1: Using a community-wide approach to prepare for COVID-19 among people experiencing homelessness

Connect to community-wide planning
Connect with key partners to make sure that you can all easily communicate with each other while preparing for and responding to cases. A community coalition focused on COVID-19 planning and response should include: • Local and state health departments • Homeless service providers and Continuum of Care leadership • Emergency management • Law enforcement • Healthcare providers • Housing authorities • Local government leadership • Other support services like outreach, case management, and behavioral health support
Identify additional sites and resources

Continuing homeless services during community spread of COVID-19 is critical, and homeless shelters should not close or exclude people who are having symptoms or test positive for COVID-19 without a plan for where these clients can safely access services and stay. Decisions about whether clients with mild illness due to suspected or confirmed COVID-19 should remain in a shelter, or be directed to alternative housing sites, should be made in coordination with local health authorities. Community coalitions should identify additional temporary housing and shelter sites that are able to provide appropriate services, supplies, and staffing.

Ideally, these additional sites should include:

- Overflow sites to accommodate shelter decompression (to reduce crowding) and higher shelter demands
- Isolation sites for people who are confirmed to be positive for COVID-19
- Quarantine sites for people who are waiting to be tested, or who know that they were exposed to COVID-19
- Protective housing for people who are at highest risk of severe COVID-19

Depending on resources and staff availability, non-group housing options (such as hotels/motels) that have individual rooms should be considered for the overflow, quarantine, and protective housing sites. In addition, plan for how to connect clients to housing opportunities after they have completed their stay in these temporary sites.

Communication

- Stay updated on the local level of transmission of COVID-19 through your local and state health departments.
- Communicate clearly with staff and clients.
    - Use health messages and materials developed by credible public health sources, such as your local and state public health departments or the Centers for Disease Control and Prevention (CDC).
    - Post signs at entrances and in strategic places providing instruction on hand washing and cough etiquette, use of cloth face coverings, and social distancing.
    - Provide educational materials about COVID-19 for non-English speakers or hearing impaired, as needed.
    - Keep staff and clients up-to-date on changes in facility procedures.
    - Ensure communication with clients and key partners about changes in program policies and/or changes in physical location.
- Identify platforms for communications such as a hotline, automated text messaging, or a website to help disseminate information to those inside and outside your organization. Learn more about communicating to workers in a crisis.

- Identify and address potential language, cultural, and disability barriers associated with communicating COVID-19 information to workers, volunteers, and those you serve. Learn more about reaching people of diverse languages and cultures.

Supplies

Have supplies on hand for staff, volunteers, and those you serve, such as:

- Soap
- Alcohol-based hand sanitizers that contain at least 60% alcohol
- Tissues
- Trash baskets
- Cloth face coverings
- Cleaning supplies
- Personal protective equipment (PPE), as needed by staff (see below)

Staff considerations

- Provide training and educational materials related to COVID-19 for staff and volunteers.
- Minimize the number of staff members who have face-to-face interactions with clients with respiratory symptoms.
- Develop and use contingency plans for increased absenteeism caused by employee illness or by illness in employees' family members. These plans might include extending hours, cross-training current employees, or hiring temporary employees.
- Staff and volunteers who are at higher risk for severe illness from COVID-19 should not be designated as caregivers for sick clients who are staying in the shelter. Identify flexible job duties for these higher risk staff and volunteers so they can continue working while minimizing direct contact with clients.
- Put in place plans on how to maintain social distancing (remaining at least 6 feet apart) between all clients and staff while still providing necessary services.
- All staff should wear a cloth face covering for source control (when someone wears a covering over their mouth and nose to contain respiratory droplets), consistent with the guidance for the general public. See below for information on laundering cloth face coverings.
- Staff who do not interact closely (e.g., within 6 feet) with sick clients and do not clean client environments do not need to wear personal protective equipment (PPE).
- Staff should avoid handling client belongings. If staff are handling client belongings, they should use disposable gloves, if available. Make sure to train any staff using gloves to ensure proper use and ensure they perform hand hygiene before and after use. If gloves are unavailable, staff should perform hand hygiene immediately after handling client belongings.
- Staff who are checking client temperatures should use a system that creates a physical barrier between the client and the screener as described here.

    - Screeners should stand behind a physical barrier, such as a glass or plastic window or partition that can protect the staff member's face from respiratory droplets that may be produced if the client sneezes, coughs, or talks.
    - If social distancing or barrier/partition controls cannot be put in place during screening, PPE (i.e., facemask, eye protection [goggles or disposable face shield that fully covers the front and sides of the face], and a single pair of disposable gloves) can be used when within 6 feet of a client.
    - However, given PPE shortages, training requirements, and because PPE alone is less effective than a barrier, try to use a barrier whenever you can.
- For situations where staff are providing medical care to clients with suspected or confirmed COVID-19 and close contact (within 6 feet) cannot be avoided, staff should at a minimum, wear eye protection (goggles or face shield), an N95 or higher level respirator (or a facemask if respirators are not available or staff are not fit tested), disposable gown, and disposable gloves. **Cloth face coverings are not PPE and should not be used when a respirator or facemask is indicated.** If staff have direct contact with the client, they should also wear gloves. Infection control guidelines for healthcare providers are outlined here.
- Staff should launder work uniforms or clothes after use using the warmest appropriate water setting for the items and dry items completely.
- Provide resources for stress and coping to staff. Learn more about mental health and coping during COVID-19.

Facility layout considerations

- Use physical barriers to protect staff who will have interactions with clients with unknown infection status (e.g., check-in staff). For example, install a sneeze guard at the check-in desk or place an additional table between staff and clients to increase the distance between them to at least 6 feet.
- In meal service areas, create at least 6 feet of space between seats, and/or allow either for food to be delivered to clients or for clients to take food away.
- In general sleeping areas (for those who are not experiencing respiratory symptoms), try to make sure client's faces are at least 6 feet apart.
    - Align mats/beds so clients sleep head-to-toe.
- For clients with mild respiratory symptoms consistent with COVID-19:
    - Prioritize these clients for individual rooms.
    - If individual rooms are not available, consider using a large, well-ventilated room.
    - Keep mats/beds at least 6 feet apart.
    - Use temporary barriers between mats/beds, such as curtains.
    - Align mats/beds so clients sleep head-to-toe.
    - If possible, designate a separate bathroom for these clients.
    - If areas where these clients can stay are not available in the facility, facilitate transfer to a quarantine site.
- For clients with confirmed COVID-19, regardless of symptoms:
    - Prioritize these clients for individual rooms.

  - If more than one person has tested positive, these clients can stay in the same area.
  - Designate a separate bathroom for these clients.
  - Follow CDC recommendations for how to prevent further spread in your facility.
  - If areas where these clients can stay are not available in the facility, assist with transfer to an isolation site.

Facility procedure considerations

- Plan to maintain regular operations to the extent possible.
- Limit visitors who are not clients, staff, or volunteers.
- Do not require a negative COVID-19 diagnostic test for entry to a homeless services site unless otherwise directed by local or state health authorities.
- Identify clients who could be at high risk for complications from COVID-19, or from other chronic or acute illnesses, and encourage them to take extra precautions.
- Arrange for continuity of and surge support for mental health, substance use treatment services, and general medical care.
- Identify a designated medical facility to refer clients who might have COVID-19.
- Keep in mind that clients and staff might be infected without showing symptoms.
  - Create a way to make physical distancing between clients and staff easier, such as staggering meal services or having maximum occupancy limits for common rooms and bathrooms.
  - All clients should wear cloth face coverings any time they are not in their room or on their bed/mat (in shared sleeping areas). Cloth face coverings should not be placed on young children under age 2, anyone who has trouble breathing, or is unconscious, incapacitated or otherwise unable to remove the mask without assistance.
- Regularly assess clients and staff for symptoms.
  - Clients who have symptoms may or may not have COVID-19. Make sure they have a place they can safely stay within the shelter or at an alternate site in coordination with local health authorities.
  - An on-site nurse or other clinical staff can help with clinical assessments.
  - Provide anyone who presents with symptoms with a cloth face covering.
  - Facilitate access to non-urgent medical care as needed.
  - Use standard facility procedures to determine whether a client needs immediate medical attention. Emergency signs include:
    - Trouble breathing
    - Persistent pain or pressure in the chest
    - New confusion or inability to arouse
    - Bluish lips or face
  - Notify the designated medical facility and personnel to transfer clients that the client might have COVID-19.

- Prepare healthcare clinic staff to care for patients with COVID-19, if your facility provides healthcare services, and make sure your facility has supply of personal protective equipment.
- Provide links to respite (temporary) care for clients who were hospitalized with COVID-19 but have been discharged.
    - Some of these clients will still require isolation to prevent transmission.
    - Some of these clients will no longer require isolation and can use normal facility resources.
- Make sure bathrooms and other sinks are consistently stocked with soap and drying materials for handwashing. Provide alcohol-based hand sanitizers that contain at least 60% alcohol at key points within the facility, including registration desks, entrances/exits, and eating areas.
- Cloth face coverings used by clients and staff should be laundered regularly. Staff involved in laundering client face coverings should do the following:
    - Face coverings should be collected in a sealable container (like a trash bag).
    - Staff should wear disposable gloves and a face mask. Use of a disposable gown is also recommended, if available.
    - Gloves should be properly removed and disposed of after laundering face coverings; clean hands immediately after removal of gloves by washing hands with soap and water for at least 20 seconds or using an alcohol-based hand sanitizer with at least 60% alcohol if soap and water are not available.
- Clean and disinfect frequently touched surfaces at least daily and shared objects between use using an EPA- registered disinfectant.

COVID-19 Readiness Resources

- Visit www.cdc.gov/COVID19 for the latest information and resources
- Printable Resources for People Experiencing Homelessness
- Guidance Related to Unsheltered Homelessness
- Department of Housing and Urban Development (HUD) COVID-19 Resources
- ASPR TRACIE Homeless Shelter Resources for COVID-19

A HUMAN RIGHTS APPROACH

A National Protocol for Homeless Encampments in Canada

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EXECUTIVE SUMMARY
A National Protocol for Homeless Encampments in Canada: A Human Rights Approach

Homeless encampments threaten many human rights, including most directly the right to housing. People living in encampments face profound challenges with respect to their health, security, and wellbeing, and encampment conditions typically fall far below international human rights standards. Residents are frequently subject to criminalization, harassment, violence, and discriminatory treatment. Encampments are thus instances of both human rights *violations* of those who are forced to rely on them for their homes, as well as human rights *claims,* advanced in response to violations of the right to housing.

Ultimately, encampments are a reflection of Canadian governments' failure to successfully implement the right to adequate housing.

As encampments increasingly emerge across Canada, there is an urgent need for governments to interact with them in a manner that upholds human rights. This Protocol, developed by the UN Special Rapporteur on the Right to Housing and her lead researcher, Kaitlin Schwan, with the input of many experts, outlines eight Principles to guide governments and other stakeholders in adopting a rights-based response to encampments. While encampments are not a solution to homelessness, it is critical that governments uphold the basic human rights and dignity of encampment residents while they wait for adequate, affordable housing solutions that meet their needs. The Principles outlined in this Protocol are based in international human rights law, and the recognition that encampment residents are rights holders and experts in their own lives. The Protocol is intended to assist governments in realizing the right to adequate housing for this group.

PRINCIPLES

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 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.[1]

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

[1] A/HRC/43/43, para 36.
[2] A/73/310/Rev.1, para 26.

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.

A National Protocol for Homeless Encampments in Canada: A Human Rights Approach

I. Introduction

1 In the face of escalating homelessness and housing affordability crises, many cities across Canada have seen a rise in homeless encampments. In various Canadian communities, people experiencing homelessness have turned to living in s, vehicles, or other forms of rudimentary or informal shelter as a means to survive.[3] While they vary in size and structure, the term '*encampment*' is used to refer to any area wherein an individual or a group of people live in homelessness together, often in tents or other temporary structures (also referred to as *homeless camps*, *tent cities*, *homeless settlements or informal settlements*).

2 Homeless encampments in Canada must be understood in relation to the global housing crisis and the deepening of housing unaffordability across the country. Encampments must also be understood in the context of historical and ongoing structural racism and colonization in Canada, whereby Indigenous peoples have been systemically discriminated against and dispossessed of their lands, properties, and legal systems. Other groups have also endured systemic and historical disadvantage that has created barriers to accessing housing and shelters, including 2SLGBTQ+, Black and other racialized communities, people living with disabilities, and people who are criminalized. While encampments are often framed and discussed as matters of individual poverty or deficiency, they are the result of structural conditions and the failure of governments to implement the right to housing or to engage with reconciliation and decolonization materially and in good faith.

3 Homeless encampments threaten many human rights, including most specifically the right to housing. In international human rights law, homelessness - which includes those residing in encampments - is a prima facie violation of the right to adequate housing.[4] This means that governments have a positive obligation to implement an urgent housing-focused response, ensuring that residents have access to adequate housing in the shortest possible time and, in the interim, that their human rights are fully respected.

4 Government responses to homeless encampments often fail to employ a rights-based approach. Residents of encampments are frequently the victims of abuse, harassment, violence, and forced evictions or 'sweeps.' In many cases, the issues

[3] Encampments have arisen in cities across the country, including: Abbottsford, Vancouver, Victoria, Edmonton, Toronto, Ottawa, Gatineau, Peterborough, Winnipeg, Montreal, Nanaimo, Calgary, Saskatoon, Fredericton, Moncton, Oshawa, Halifax, and Maple Ridge.
[4] A/HRC/31/54, para. 4.

associated with encampments are within the jurisdiction and responsibility of municipal authorities, including through bylaws specific to policing, fire and safety, sanitation, and social services. This has led to a pattern whereby municipal governments deploy bylaws, local police, and zoning policies that displace people in encampments, in turn compromising the physical and psychological health of people who have no place else to go and who rely on encampments to survive, absent accessible alternatives.[5]

5 Provincial, territorial, and federal governments have historically left engagement with encampments to city officials, who receive little (if any) guidance and support. Municipal authorities are often unaware of their legal obligations under international human rights law, including with respect to the duty to ensure the dignity and security of encampment residents.[6] Further, accountability mechanisms with respect to the right to housing remain weak in Canada, meaning that people living in encampments have limited avenues through which to claim this right.

6 Ensuring a human rights-based response to homeless encampments should be a key concern for every Canadian city, and all governments should employ a human rights-based framework to guide their engagement with encampment residents.

II. Purpose of the National Protocol on Homeless Encampments

7 The purpose of this document is to provide all levels of government with an understanding of their human rights obligations with respect to homeless encampments, highlighting what is and is not permissible under international human rights law. This Protocol outlines 8 broad human rights-based Principles that must guide state[7] action in response to homeless encampments of all kinds.

8 This Protocol does not attempt to foresee every possible context or challenge that may arise within encampments. Governments and relevant stakeholders must apply human rights principles as described in the Protocol to each case as it arises, endeavouring at all times to recognize and respect the inherent rights, dignity, and inclusion of encampment residents.

9 This Protocol has been developed by the UN Special Rapporteur on the right to housing in consultation with a range of experts from across Canada, including those

[5] *Abbotsford (City) v. Shantz* (2016 BCSC 2437). Online, https://www.canlii.org/en/bc/bcsc/doc/2016/2016bcsc2437/2016bcsc2437.html?resultIndex=1

[6] A/HRC/43/43, para 7.

[7] 'State' refers to all levels and branches of government and anyone exercising government authority.

with lived expertise of homelessness, urban Indigenous leaders, community advocates, researchers, lawyers, and experts in human rights law.[8]

III. Encampments in Canada in the context of the Human Right to Adequate Housing

10 Under international human rights law, everyone has the right to adequate housing as an element of the right to an adequate standard of living.[9] This requires States to ensure that housing is accessible, affordable, habitable, in a suitable location, culturally adequate, offers security of tenure, and is proximate to essential services such as health care and education.[10] The right to adequate housing includes the right to be protected from: arbitrary or unlawful interference with an individual's privacy, family, and home; any forced eviction (regardless of legal title or tenure status); and from discrimination of any kind.[11]

11 Homelessness constitutes a prima facie violation of the right to housing. It is a profound assault on a person's dignity, security, and social inclusion. Homelessness violates not only the right to housing, but often, depending on circumstances, violates a number of other human rights, including: non-discrimination; health; water and sanitation; freedom from cruel, degrading, and inhuman treatment; and the rights to life, liberty, and security of the person.[12]

12 Encampments constitute a form of homelessness, and thus are a reflection of the violation of residents' right to adequate housing. People living in encampments typically face a range of human rights violations and profound challenges with respect to their health, security, and wellbeing. Encampment conditions typically fall far below international human rights standards on a variety of fronts, often lacking even the most

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[8] This Protocol was prepared by: Leilani Farha and Kaitlin Schwan with the assistance of Bruce Porter, Vanessa Poirier, and Sam Freeman. Reviewers include, among others: Margaret Pfoh (Aboriginal Housing Management Association), Cathy Crowe (Shelter and Housing Justice Network), Greg Cook (Sanctuary Toronto), Tim Richter (Canadian Alliance to End Homelessness), Anna Cooper (Pivot Legal Society), Caitlin Shane (Pivot Legal Society), Emily Paradis (University of Toronto), Emma Stromberg (Ontario Federation of Indigenous Friendship Centres), and Erin Dej (Wilfred Laurier University).

[9] United Nations Committee on Economic, Social and Cultural Rights Committee's General Comments No. 4 (1991) on the right to adequate housing and No. 7 (1997) on forced evictions.

[10] United Nations Committee on Economic, Social and Cultural Rights Committee's General Comment No. 4 (1991) on the right to adequate housing. At the domestic level, adequate housing and core housing need is defined in relation to three housing standards: adequacy, affordability, and suitability. The Canadian Mortgage and Housing Corporation defines these housing standards in the following ways: "(1) Adequate housing are reported by their residents as not requiring any major repairs; (2) Affordable dwellings cost less than 30% of total before-tax household income; and (3) Suitable housing has enough bedrooms for the size and make-up of resident households, according to National Occupancy Standard (NOS) requirements."

[11] A/HRC/43/43.

[12] A/HRC/31/54; A/HRC/40/61, para 43.

basic services like toilets.[13] Residents of encampments are also frequently subject to criminalization, harassment, violence, and discriminatory treatment.[14]

13 In the face of poverty and deep marginalization, people without homes face many untenable choices. For example, they may be forced to choose between 'sleeping rough' on their own (putting themselves at risk of violence and criminalization), entering an emergency homeless shelter (which may be inaccessible or inappropriate for their needs, or in which their autonomy, dignity, self-reliance, and/or independence may be undermined), or residing in a homeless encampment (in which they may lack access to basic services and face threats to their health). These choices are further narrowed for those living in communities that lack any emergency shelters, or where existing shelters are at (or over) capacity.

14 For people without access to adequate housing, the availability, accessibility, appropriateness, and adequacy of shelters plays a significant role in determining whether or not a person chooses to reside in a homeless encampment. In some cities, emergency shelters operate at 95-100% capacity,[15] necessitating that some individuals sleep rough or reside in an encampment. Existing shelters may also not be low-barrier, wheelchair accessible, trans-inclusive, or safe for people experiencing complex trauma or other challenges. Homeless persons with mental health challenges, drug or alcohol dependencies, or pets may find themselves barred from shelters. Under such conditions, some individuals may prefer, or feel they have little choice but to, reside in an encampment. Encampments thus may become a necessity or the best option available for some of those the most marginalized people in Canadian society.

15 For Indigenous peoples, a desire to avoid state surveillance and a mistrust of institutional settings, including shelters, may be a factor in turning to or living in an encampment. Negative or harmful interactions with colonial institutions, such as residential schools, the child welfare system, corrections, hospitals, asylums or sanitoriums, and shelters, may be intergenerational in nature and highly traumatic. For these reasons and others, Indigenous peoples are overrepresented in homeless populations across Canada, and further to this, are more likely to be part of "outdoor" or "unsheltered" populations – including homeless encampments.[16]

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[13] See Cooper, A. (2020). *Why People Without Housing Still Need Heat*. Pivot Legal Society. Available from: http://www.pivotlegal.org/why_people_without_housing_still_need_heat

[14] A/HRC/43/43, para 31; see also *Homelessness, Victimization and Crime: Knowledge and Actionable Recommendations*. Available from: https://www.publicsafety.gc.ca/lbrr/archives/cnmcs-plcng/cn35305-eng.pdf

[15] Employment and Social Development Canada. (2018). *Shelter Capacity Report 2018*. Ottawa. Available from https://www.canada.ca/en/employment-social-development/programs/homelessness/publications-bulletins/shelter-capacity-2018.html

[16] See Ontario Federation of Indigenous Friendship Centres. (2020). *Indigenous Homelessness in the 20 Largest Cities in Canada.* Submission to the Standing Committee on Human Resources, Skills and Social Development and the Status of Persons with Disabilities, Canada.

16 Regardless of the reasons why a person resides in a homeless encampment, homeless encampments *do not* constitute adequate housing, and do not discharge governments of their positive obligation to ensure the realization of the right to adequate housing for all people. Under international human rights law, "States have an obligation to take steps to the maximum of their available resources with a view to achieving progressively the full realization of the right to adequate housing, by all appropriate means, including particularly the adoption of legislative measures."[17] As part of these obligations, States must prioritize marginalized individuals or groups living in precarious housing conditions - including residents of homeless encampments.[18]

17 Governments have an urgent, positive obligation to provide or otherwise ensure access to adequate housing - for residents of encampments as they do for all people experiencing homelessness. Governments must act to immediately pursue deliberate, concrete, and targeted efforts to end homelessness by ensuring access to adequate housing. In the interim, governments must ensure the availability of sufficient shelter spaces - accessible and appropriate for diverse needs - where dignity, autonomy, and self-determination are upheld.

18 The fact that encampments violate the right to housing does not in any way absolve governments of their obligations to uphold the basic human rights and dignity of encampment residents while they wait for adequate, affordable housing solutions that meet their needs. The Principles outlined in this Protocol seek to support governments and other stakeholders to ensure that their engagements with encampments are rights-based and recognize residents as rights holders, with a view to realizing the right to adequate housing for these groups while respecting their dignity, autonomy, individual circumstances, and personal choices.

19 International human rights law does not permit government to use force to destroy peoples' homes, even if they are made of canvas or improvised from available materials and constructed without legal authority or title. States may not remove residents from encampments without meaningfully engaging them to identify 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, and access to, appropriate forms of legal or other protection, consistent with international human rights law is defined as a 'forced eviction' and is considered a gross violation of human rights.

20 Unfortunately, such forced evictions or sweeps have become common in Canada. Evictions have contravened international law by being carried out without meaningful consultation with communities and without measures to ensure that those affected have access to alternative housing. They have been justified on the basis that the

[17] International Covenant on Economic, Social and Cultural Rights, art. 2 (1).
[18] A/HRC/43/4.

residents are there illegally, are at risk to themselves, are on land that is slated for development, or are obstructing the enjoyment of the community by others. Declining conditions at encampments and public health and safety concerns are also frequently the grounds on which local governments and provinces seek injunctions for removal. The impact of municipalities' failure to proactively provide resources and services to mitigate or improve those conditions and concerns is most often ignored. Some communities have engaged bylaw officers or local police to tear down encampments at first sight.[19]

21 None of these reasons, however, justify forced evictions under international law. Forced evictions often have harmful or disastrous consequences for encampment residents.[20] Victims may face life-threatening situations that compromise their health and security, or result in the loss of access to food, social supports, social and medical services, and other resources.[21]

22 Few governments have recognized encampments as a response to violations of fundamental human rights and a response to the isolation and indignity of homelessness. They have failed to treat those living in such encampments as legally entitled to the protection of their homes and their dignity.

IV. Relevant Authority

23 Canadian governments' responsibilities and relevant authority to ensure the right to adequate housing, including for people residing in encampments, is found in: (1) international human rights treaties, (2) the *National Right to Housing Act*, (3) the *Canadian Charter of Rights and Freedoms* and human rights legislation, and (4) the UN *2030 Agenda for Sustainable Development* (*The Sustainable Development Goals*).

1. International Human Rights Treaties

24 Canada has ratified multiple international human rights treaties that articulate the right to adequate housing. In 1976, Canada ratified the *International Covenant on Economic, Social and Cultural Rights*, which contains the chief articulation of the right to housing under Article 11.1 "the right of everyone to an adequate standard of living for [themselves] and [their] family, including adequate food, clothing and housing, and to

[19] Ball, V. (2019). *Encampment residents fear eviction*. The Expositor. Available from: https://www.brantfordexpositor.ca/news/local-news/encampment-residents-fear-eviction
[20] A/HRC/43/43, para 36.
[21] UN Office of the High Commissioner. (2014). *Forced Evictions: Fact Sheet No. 25/Rev.1*. Available from: https://www.ohchr.org/Documents/Publications/FS25.Rev.1.pdf; Collinson, R. & Reed, D. (2018). *The Effects of Eviction on Low-Income Households*. Available from: https://www.law.nyu.edu/sites/default/files/upload_documents/evictions_collinson_reed.pdf

the continuous improvement of living conditions."[22] The right to housing and the prohibition against forced evictions has been interpreted in General Comments No. 4 and 7[23] by the UN Committee on Economic, Social and Cultural Rights. In addition, Canada has ratified other treaties that codify the right to adequate housing, including:

- *Convention on the Rights of Persons with Disabilities*
- *Convention on the Rights of the Child*
- *Convention on the Elimination of Racial Discrimination*
- *Convention on the Elimination of Discrimination against Women*

25 Human rights ratified by Canada "extend to all parts of federal States without any limitations or exceptions," thus federal, provincial/territorial, and municipal governments are equally bound by these obligations.[24] In interpreting the right to adequate housing, the Committee on Economic, Social and Cultural Rights has emphasized that "the right to housing should not be interpreted in a narrow or restrictive sense which equates it with, for example, the shelter provided by merely having a roof over one's head or views shelter exclusively as a commodity. Rather it should be seen as the right to live somewhere in security, peace and dignity."[25]

26 Canada has also formally recognized the *UN Declaration on the Rights of Indigenous Peoples*, which also codifies the right to adequate housing and affirms that Indigenous Peoples have the right to be actively involved in developing and determining housing programmes and policies that affect them.[26] Further, Indigenous Peoples' right to land and self-determination is indivisible from the right to housing under international human rights law, meaning that they "shall not be forcibly removed from their lands or territories and that no relocation shall take place without their free, prior and informed consent."[27] All encampments are located on the traditional territories of Indigenous nations, including in cities, towns, and rural areas. On these territories, Indigenous Peoples' right to land and self-determination is in effect, whether or not those lands are subject to land claims or treaty.

1. Canadian Housing Policy and Legislation

27 The right to housing has also recently been recognized in Canadian legislation. In June 2019, the *National Housing Strategy Act* (the *Act*) received royal assent in Canada. The *Act* affirms Canada's recognition of the right to housing as a fundamental human

[22] ICESCR, Article 11, masculine pronouns corrected.
[23] General Comment 4 (1991), UN Doc. E/1992/23; General Comment 7 (1997), UN Doc. E/1998/22.
[24] A/69/274.
[25] General Comment 4 (1991), para 7.
[26] A/74/183.
[27] A/74/183.

right and commits to further its progressive realization as defined under the *International Covenant on Economic, Social and Cultural Rights.*

28 The Preamble and Section 4 of the *Act* underscore the interdependence of the right to housing with other fundamental rights, such as the right to life and an adequate standard of health and socio-economic wellbeing. Specifically, Section 4 states:

> It is declared to be the housing policy of the Government of Canada to:
>
> > (a) recognize that the right to adequate housing is a fundamental human right affirmed in international law;
> >
> > (b) recognize that housing is essential to the inherent dignity and well-being of the person and to building sustainable and inclusive communities;
> >
> > (c) support improved housing outcomes for the people of Canada; and
> >
> > (d) further the progressive realization of the right to adequate housing as recognized in the International Covenant on Economic, Social and Cultural Rights.

2. The Canadian Charter and Provincial/Territorial Human Rights Legislation

29 The government of Canada's international human rights obligations must be considered by courts in Canada when determining the rights of residents of encampments under domestic law,[28] particularly the *Canadian Charter of Rights and Freedoms*.[29] The Supreme Court has recognized that the right to "life, liberty and security of the person" in section 7 of the *Charter* may be interpreted to include the right to housing under international law.[30] Canada has told the UN that it accepts that section 7 at least ensures access to basic necessities of life and personal security.[31]

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[28] It should be noted that a human rights-based approach under domestic law should entail mindfulness about core human rights and equality principles, such as substantive equality and non-discrimination, which recognizes that state interventions be particularly attuned to the specific needs of particular groups, including those impacted by systemic and historical disadvantage. In this regard, a 'one size fits all' approach may not fully capture the distinct needs of groups residing within encampments.

[29] *R. v. Hape,* [2007] 2 S.C.R. 292, 2007 SCC 26, para 56: "In interpreting the scope of application of the Charter, the courts should seek to ensure compliance with Canada's binding obligations under international law where the express words are capable of supporting such a construction."

[30] *Irwin Toy Ltd. v. Quebec* (Attorney General), [1989] 1 S.C.R. 927; See Martha Jackman and Bruce Porter, "Social and Economic Rights", in Peter Oliver, Patrick Maklem & Nathalie DesRosiers, eds, *The Oxford Handbook of the Canadian Constitution* (New York: Oxford University Press, 2017), 843-861.

[31] Canada's commitments are described in *Victoria (City) v. Adams*, 2008 BCSC 1363 (CanLII), paras 98-99. Online, http://canlii.ca/t/215hs

30 In Canada, courts have considered the human rights implications of encampments, and have emphasized that Section 7 life and security of the person interests are engaged where state action poses significant harm to the health and wellbeing of persons enduring homelessness and housing insecurity. For example, Canadian courts have recognized that the daily displacement of people experiencing homelessness causes physical and psychological harm. The Court accepted in the case of *Abbotsford (City) v. Shantz*, that "the result of repeated displacement often leads to the migration of homeless individuals towards more remote, isolated locations as a means to avoid detection. This not only makes supporting people more challenging, but also results in adverse health and safety risks." The court recognized that these health and safety risks include "impaired sleep and serious psychological pain and stress."[32]

31 In the case of *Victoria v. Adams,*[33] residents of an encampment challenged a bylaw that prevented them from constructing temporary shelter in a park, on the basis of which city officials had secured an injunction to evict them. The British Columbia Supreme Court agreed that while the *Charter* does not explicitly recognize the right to housing, international law is a persuasive source for *Charter* interpretation and found that the bylaw violated the residents' right to security of the person. The BC Court of Appeal upheld the decision of the BC Supreme Court and other decisions in British Columbia have followed.[34] In *British Columbia v. Adamson* 2016,[35] for example, the court found that in the absence of alternative shelter or housing for all people experiencing homelessness, encampment residents must not be evicted from their encampment. In *Abbotsford v. Shantz* 2015[36] the Court found that denying encampment residents space to erect temporary shelters on public property was "grossly disproportionate to any benefit that the City might derive from furthering its objectives and breaches the s. 7 *Charter* rights of the City's homeless."[37]

32 The right to equality is also protected under the Canadian Charter as well as under federal, provincial, and territorial human rights legislation. Not all levels of government interpret or administer human rights codes in the same manner, with each province and territory administering its own human rights codes.[38] Regardless of jurisdiction, the UN Committee on Economic, Social and Cultural Rights has stated that the right to

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[32] *Abbotsford (City) v. Shantz*, 2015 BCSC 1909, paras 213 and 219.
[33] *Victoria (City) v. Adams*, 2008 BCSC 1363 (CanLII), paras 85-100. Online, http://canlii.ca/t/215hs
[34] Key examples of case law includes: *Victoria v. Adams* 2008/ 2009, *Abbotsford v. Shantz* 2015, *BC v. Adamson* 2016, and *Vancouver (City) v. Wallstam* 2017.
[35] *British Columbia v. Adamson* (2016 BCSC 1245). Online, https://www.canlii.org/en/bc/bcsc/doc/2016/2016bcsc1245/2016bcsc1245.html?resultIndex=1
[36] *Abbotsford (City) v. Shantz* (2016 BCSC 2437). Online, https://www.canlii.org/en/bc/bcsc/doc/2016/2016bcsc2437/2016bcsc2437.html?resultIndex=1
[37] *Abbotsford (City) v. Shantz* (2016 BCSC 2437), para 224. Online, https://www.canlii.org/en/bc/bcsc/doc/2016/2016bcsc2437/2016bcsc2437.html?resultIndex=1
[38] For an overview of provincial and territorial human rights codes, see: https://ccdi.ca/media/1414/20171102-publications-overview-of-hr-codes-by-province-final-en.pdf

equality should be interpreted to provide the widest possible protection of the right to housing and has urged Canadian courts and governments to adopt such interpretations.[39]

33 While it is clear that the *Charter* provides some protection from forced evictions and sweeps of encampment residents, the extent to which it requires governments to address the crisis of homelessness that has led to reliance on encampments remains unresolved. The Supreme Court of Canada has yet to agree to hear an appeal in a case that would clarify the obligations of governments to address homelessness as a human rights violation. The Supreme Court has, however, been clear that the *Charter* should, where possible, be interpreted to provide protection of rights that are guaranteed under international human rights law ratified by Canada.

34 Governments should not use uncertainty about what courts might rule as an excuse for violating the human rights of those who are homeless. Canadian governments have an obligation, under international human rights law, to promote and adopt interpretations of domestic law consistent with the right to adequate housing. The UN Committee on Economic, Social and Cultural Rights has expressed concern that governments in Canada continue to argue in court against interpretations of the *Canadian Charter* that would protect the rights of homeless persons and residents of homeless encampments.

35 Therefore, it is critically important that, as part of a Protocol based on respect for human rights, municipal, provincial/territorial, and federal governments instruct their lawyers not to undermine international human rights or oppose reasonable interpretations of the *Charter* based on international human rights. They should never seek to undermine the equal rights of residents of homeless encampments to a dignified life, to liberty, and security of the person.

3. UN 2030 Agenda for Sustainable Development

36 In September 2015, member states of the United Nations, including Canada, adopted the *2030 Agenda for Sustainable Development* (*2030 Agenda*). Target 11.1 of the SDGs specifically identifies that by 2030, all States must "ensure access for all to adequate, safe and affordable housing and basic services and to upgrade informal settlements." This means governments must take steps to eliminate homelessness and make cities inclusive, safe, resilient and sustainable. Upgrading informal settlements

[39] CESCR, General Comment No. 9, para 15; E/C.12/1993/5, paras 4, 5, and 30.

includes the upgrading of homeless encampments.[40] States have affirmed that a rights-based approach to the SDG's is critical if they are to be achieved.[41]

V. Key Principles

37 It is critical that all levels of government in Canada employ an integrated human rights-based approach when engaging with encampments. The Principles outlined here aim to support the right to housing for all encampment residents as part of Canada's commitment to the right to housing under international human rights treaties and domestic law.

PRINCIPLE 1: Recognize residents of homeless encampments as rights holders

38 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. For many governments and those exercising governmental authority, this will mean a shift away from criminalizing, penalizing, or obstructing encampments, to an approach rooted in rights-based participation and accountability.[42]

39 This will mean understanding encampments as instances of both human rights *violations* of those who are forced to rely on them for their homes, as well as human rights *claims* advanced in response to violations of the right to housing. While encampments arise as a result of governments failing to effectively implement the right to housing, they can also be an expression of individuals and communities claiming their legitimate place within cities, finding homes within communities of people without housing, asserting claims to lands and territories, and refusing to be made invisible. They are a form of grassroots human rights practice critical to a democracy such as Canada's.[43] For Indigenous peoples, the occupation of lands and traditional territories vis-à-vis encampments may also be an assertion of land rights, claimed in conjunction with the right to housing.

40 In recognition of encampments as rights violations and rights claims, governments must rectify the policy failures that underpin the emergence of homeless encampments, while simultaneously recognizing residents as rights holders who are advancing a legitimate human rights claim. Their efforts to claim their rights to home

[40] A/73/310/Rev.1.

[41] The *National Housing Strategy* of Canada mirrors many of the commitments made in the *2030 Agenda*. However, the *Strategy* only commits Canada to reducing chronic homelessness by 50%, despite the *2030 Agenda*'s imperative to eliminate homelessness and provide access to adequate housing for all.

[42] A/73/310/Rev.1, para 15.

[43] A/73/310/Rev.1.

and community must be supported, not thwarted, criminalized, or dismissed as illegitimate or gratuitous protest.[44]

PRINCIPLE 2: Meaningful engagement and effective participation of encampment residents

41 Ensuring encampment residents are able to participate in decisions that directly affect them is "critical to dignity, the exercise of agency, autonomy and self-determination."[45] As rights holders, encampment residents are entitled to "participate actively, freely and meaningfully in the design and implementation of programmes and policies affecting them."[46] Meaningful engagement must be grounded in recognition of the inherent dignity of encampment residents and their human rights, with the views expressed by residents of homeless encampments being afforded adequate and due consideration in all decision-making processes.

42 Governments and other actors must engage encampment residents in the early stages of discussion without using the threat of eviction procedures or police enforcement to coerce, intimidate, or harass.[47] Engagement should proceed under the principle that residents are experts in their own lives and what is required for a dignified life.[48] Indigenous residents of encampments should also be engaged in decision-making processes in a manner that is culturally-safe and trauma informed.

43 In the context of homeless encampments, the right to participate requires that all residents be provided with information, resources, and opportunities to directly influence decisions that affect them. All meetings with government officials or their representatives regarding the encampment should be documented and made available to encampment residents upon request.

44 Participation processes must comply with all human rights principles, including non-discrimination. Compliance with international human rights law requires:

i. Provision of necessary institutional, financial, and other resources to support residents' right to participate
In order to participate in decisions that affect them, encampment residents should be provided with financial and institutional resources (e.g., wifi/internet access, meeting spaces) that support their active participation in decision-making. Such supports should include, but are not

[44] A/73/310/Rev.1.
[45] A/HRC/43/43, para 20.
[46] Ibid. See also the Committee on the Rights of the Child's General Comment No. 21 (2017) on children in street situations.
[47] A/HRC/40/61, para 38.
[48] A/HRC/43/43, para 21.

limited to: legal advice, social service supports, Indigenous cultural supports, literacy supports, translation, mobility supports, and transportation costs to attend consultations or meetings.[49] These resources should support democratic processes within the encampment, including community meetings, the appointment of community leaders, and the sharing of information.[50] Residents must be granted a reasonable and sufficient amount of time to consult on decisions that affect them.

ii. Provision of relevant information about the right to housing

Encampment residents must be provided with information about their right to housing, including information about procedures through which they can hold governments and other actors accountable, as well as specific information about the rights of Indigenous Peoples.[51]

iii. Provision of relevant information concerning decisions that affect residents, ensuring sufficient time to consult

Encampment residents must be provided with all relevant information in order to make decisions in matters that affect them.[52]

iv. Establishment of community engagement agreement between homeless encampment residents, government actors, and other stakeholders

In order to facilitate respectful, cooperative, and non-coercive communication between residents, government, and other stakeholders, government may seek to collaborate with residents to create a formal community engagement agreement (when appropriate and requested by residents).[53] This agreement should outline when and how encampment residents will be engaged,[54] and should be ongoing and responsive to the needs of the encampment residents.[55] It should allow the residents of homeless encampments to play an active role in all aspects of relevant proposals and policy, from commencement to conclusion. Residents should be able to challenge any decision made by government or other actors, to propose alternatives, and to articulate their own demands and priorities. Third party mediators should be available to protect against power imbalances that may lead to breakdown in negotiations or create

[49] Committee on Economic, Social and Cultural Rights' General Comment No. 4, para. 12, and the basic principles and guidelines on development-based evictions and displacement (A/HRC/4/18, annex I, para. 39).
[50] A/73/310/Rev.1.
[51] A/73/310/Rev.1, para 19.
[52] A/73/310/Rev.1.
[53] A/73/310/Rev.1.
[54] A/73/310/Rev.1.
[55] United Nations. *Guiding Principles on Extreme Poverty and Human Rights*, foundational principles, para 38.

unfair results.[56] Relevant government authorities and professionals should also be provided with "training in community engagement and accountability."[57]

v. Provision of equitable opportunities for the meaningful participation of all encampment residents

As a matter of human rights law, particular efforts must be taken to ensure equitable participation by women, persons with disabilities, Indigenous Peoples, migrants, and other groups who experience discrimination or marginalization.[58] Where possible, members of these groups should be afforded central roles in the process.[59]

Principle 2 in Action – The "People's Process" in Kabul, Afghanistan

The upgrading of informal settlements was identified as a key goal in the *2030 Agenda for Sustainable Development*, committing States to "upgrade slums" by 2030 (target 11.1). As identified by the UN Special Rapporteur on the right to adequate housing, "Participation in upgrading requires democratic processes through which the community can make collective decisions." Under international human rights law, the democratic processes required to upgrade slums mirrors encampment residents' right to participate in plans to resolve their housing needs. As such, democratic processes implemented to upgrade informal settlements in cities around the world can provide helpful examples for Canadian homeless encampments.

One such example is the "people's process" in Kabul, Afghanistan. This process delineates community leadership and control over the upgrading process, and includes an organizational structure that enables the community to engage different levels of government. As part of this process, "local residents elect community development councils responsible for the selection, design, implementation and maintenance of the projects." City staff are trained to work alongside informal settlement residents to implement and complete upgrading.

[56] A/HRC/43/4, para 42.
[57] A/73/310/Rev.1, para 20.
[58] A/HRC/43/4.
[59] Committee on Economic, Social and Cultural Rights, General Comment No. 21 (2009) on the right of everyone to take part in cultural life, in particular para 16.

PRINCIPLE 3: Prohibition of forced evictions of encampments

45 Under international human rights law, forced evictions constitute a gross violation of human rights and are prohibited in all circumstances, including in the context of encampments.[60]

46 Forced evictions are defined as "the permanent or temporary removal against their will of individuals, families and/or communities from the homes and/or land which they occupy, without the provision of, and access to, appropriate forms of legal or other protection … in conformity with the provisions of the International Covenants on Human Rights."[61]

47 Forced evictions are impermissible irrespective of the tenure status of those affected. This means that the forced eviction of encampments is prohibited if appropriate forms of protection are not provided – including all of the requirements described in this Protocol.[62] It may also be considered a forced eviction when governments' and those acting on their behalf harass, intimidate, or threaten encampment residents, causing residents to vacate the property.[63]

48 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.[64] Evictions (as opposed to "forced evictions") may be justified in rare circumstances, but they may only be carried out after exploring all viable alternatives with residents, in accordance with law and consistent with the right to housing, as described in this Protocol.

49 Governments must repeal any laws or policies that sanction forced evictions and must refrain from adopting any such laws, including for example anti-camping laws, move-along laws, laws prohibiting tents being erected overnight, laws prohibiting personal belongings on the street, and other laws that penalize and punish people experiencing homelessness and residing in encampments.[65]

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[60] A/HRC/43/43, para 34; CESCR General Comment No.7.
[61] CESCR General Comment No.7.
[62] A/HRC/43/43, para 34; also see: "Security of tenure under domestic law should not, consequently, be restricted to those with formal title or contractual rights to their land or housing. The UN guiding principles on security of tenure (A/HRC/25/54, para. 5), states that security of tenure should be understood broadly as "a set of relationships with respect to housing and land, established through statutory or customary law or informal or hybrid arrangements, that enables one to live in one's home in security, peace and dignity."
[63] UN Office of the High Commissioner. (2014). *Forced Evictions: Fact Sheet No. 25/Rev.1*. Available from: https://www.ohchr.org/Documents/Publications/FS25.Rev.1.pdf
[64] A/HRC/43/43, para 36.
[65] See, for example, Ontario's *Safe Street's Act* (1999).

Principle 3 in Action: Forced Eviction & Harassment of Homeless Encampment Residents

In cities around the world, people experiencing homelessness are frequently subject to discriminatory treatment, harassment, and extreme forms of violence because of their housing status. People residing in homeless encampments are exposed to similar or worse treatment, particularly when faced with pressure to relocate or disperse.

In some cases, local laws, policies, or practices can provide the mechanisms for this harassment. For example, in British Columbia local authorities enforced a bylaw prohibiting overnight shelters in parks by using tactics that included spreading chicken manure and fish fertilizer on a homeless encampment. Residents and allies of the homeless encampment subsequently filed a human rights complaint with regard to these practices (*Abbotsford (City) v. Shantz)*, and the BC Supreme Court found that certain bylaws violated encampment residents' constitutional rights to life, liberty and security of the person.

Under international human rights law, such activities are strictly prohibited and constitute instances of forced eviction, even if they align with local laws or policies. Given this, it is critical that Canadian governments review local and national policies and laws to ensure they do not violate the prohibition against the forced eviction of homeless encampments.

PRINCIPLE 4: Explore all viable alternatives to eviction

50 Government authorities must explore all viable alternatives to eviction, in consultation with encampment residents.[66] This means ensuring their meaningful and effective participation in discussions regarding the future of the encampment.

51 Free and independent legal advice should be made available to all residents to help them understand the options, processes, and their rights. Consultations should be conducted at times and locations that are appropriate and accessible for residents to ensure their participation is maximised. Financial and other support should be available to residents so that they can fully participate in all discussions regarding the future of the encampment and so that residents can retain outside consultants (e.g., environmental engineers, architects) where needed to assist them in developing alternative options to eviction.

52 Discussions regarding viable alternatives to eviction must include meaningfully engagement with Indigenous Peoples and be grounded in principles of self-determination, free, prior and informed consent. In urban contexts, for example, urban Indigenous organisations should be engaged early in the planning process to establish service delivery roles and to ensure the availability of culturally appropriate services.

[66] A/HRC/43/4.

53 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 any relocation is human rights compliant

54 Homeless encampments are not a solution to homelessness, nor are they a form of adequate housing. Governments have an urgent, positive obligation to ensure encampment residents have access to long-term, adequate housing that meets their needs, accompanied by necessary supports. Rather than eviction, governments must engage with homeless encampments with a view to ensuring residents are able to access such housing.

55 Despite this obligation, many governments respond to encampments by simply moving residents from one bad site to another through the use of law enforcement, physical barriers, or other means, and without meaningfully engaging residents. This in no way addresses the underlying violations of the right to housing experienced by residents of encampments, is often costly, and can contribute to increased marginalization. If relocation is deemed necessary and/or desired by encampment residents, it is critical that it is conducted in a human rights compliant manner.

56 As a starting point, meaningful, robust, and ongoing engagement with residents (as defined in Principle 2) is required for the development of any relocation of homeless encampments or of their residents. Meaningful engagement with communities should ensure the development of plans that respect the rights of residents and can be implemented cooperatively, without police enforcement.[67] 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."[68] If relocation is consistent with the human rights of residents, it will almost always be achievable without the use of force.

57 If government authorities propose the relocation of residents of homeless encampments, and the residents desire to remain in situ, the burden of proof is on the government to demonstrate why in situ upgrading is unfeasible.[69]

58 If, after meaningful engagement with those affected, relocation is deemed necessary and/or desired by encampment residents, adequate alternative housing must be provided in close proximity to the original place of residence and source of livelihood.[70] If governments have failed to provide residents with housing options that

[67] A/HRC/40/61, para 38.
[68] A/73/310/Rev.1, para 26.
[69] A/73/310/Rev.1, para 32.
[70] A/HRC/4/18, annex I, para. 60.

they find acceptable, residents must be permitted to remain or be provided with a satisfactory alternative location, while adequate permanent housing options are negotiated and put in place.

59 If, in the exceptional case there is no viable alternative to eviction by authorities, eviction must be compliant with all aspects of international human rights law.[71] Compliance with international human rights law requires:

i. **Prohibition against the removal of residents' private property without their knowledge and consent**
The removal of residents' private property by governments and those acting on their behalf, including the police, without their knowledge and consent, in strictly prohibited.[72] Such actions are contrary to the rights of residents and may contribute to the deepening of residents' marginalization, exclusion, and homelessness.[73] Governments and police must also seek to actively prevent the removal of homeless residents' private property by private actors or any other form of harassment.

ii. **Adherence to the right to housing and other human rights standards when relocation is necessary or preferred**
Adequate alternative housing, with all necessary amenities (particularly water, sanitation and electricity), must be in place for all residents prior to their eviction.[74] Alternative housing arrangements should be in close proximity to the original place of residence and to services, community support, and livelihood.[75] It is critical that all encampment residents be allowed to participate in decisions regarding relocation, including the timing and site of relocation.[76] A full hearing of the residents' concerns with the proposed relocation should be held, and alternatives explored.

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[72] A/HRC/4/18, *Basic Guidelines on Development Based Evictions,* see para 50: "States and their agents must take steps to ensure that no one is subject to direct or indiscriminate attacks or other acts of violence, especially against women and children, or arbitrarily deprived of property or possessions as a result of demolition, arson and other forms of deliberate destruction, negligence or any form of collective punishment. Property and possessions left behind involuntarily should be protected against destruction and arbitrary and illegal appropriation, occupation or use."
[73] National Law Centre on Homelessness & Poverty. (2017). *Violations of the Right to Privacy for Persons Experiencing Homelessness in the United States*. Available from: https://nlchp.org/wp-content/uploads/2018/10/Special-Rapporteur-Right-to-Privacy.pdf. See para 7: "For them, whatever shelter they are able to construct, whether legally or illegally, is their home, and their right to privacy should inhere to that home the same as it would for any regularly housed person. To deny them that right is to further marginalize and dehumanize this already highly marginalized and dehumanized population."
[74] A/73/310/Rev.1, para 34.
[75] Basic principles and guidelines on development-based evictions and displacement (A/HRC/4/18, annex I, para. 60) and A/HRC/4/18, annex I, para. 60.
[76] A/73/310/Rev.1, para 31.

iii. **Relocation must not result in the continuation or exacerbation of homelessness, or require the fracturing of families or partnerships**

Relocation must not result in the continuation or deepening of homelessness for residents.[77] Relocation must not require the separation of families or partners, as defined by rights-holders themselves, including chosen family and other kinship networks.[78] Governments should engage encampments with a view to keeping the community intact, if this is desired by the residents.[79] Governments should also ensure that relevant housing policies are supportive of the ways in which rights-holders define their own families, partnerships, communities and extended Indigenous kindship structures, and accommodate these whenever possible in public or social housing.

iv. **Access to justice to ensure procedural fairness and compliance with all human rights**

Access to justice must be ensured at all stages of government engagement with encampment residents, not just when eviction is imminent.[80] Access to justice and legal protection must meet international human rights law standards,[81] including the provision of due process, access to legal aid, access to fair and impartial legal advice, and the ability to file complaints in a relevant forums (including Indigenous forums) that are geographically proximate.[82]

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[77] A/73/310/Rev.1.

[78] UN Office of the High Commissioner. (2014). *Forced Evictions: Fact Sheet No. 25/Rev.1*. Available from: https://www.ohchr.org/Documents/Publications/FS25.Rev.1.pdf. See para 52: "States should also ensure that members of the same extended family or community are not separated as a result of evictions."; also, UNHR Summary Conclusions on the Family Unit, Available at https://www.unhcr.org/protection/globalconsult/3c3d556b4/summary-conclusions-family-unity.html , see para 8:"International human rights law has not explicitly defined 'family' although there is an emerging body of international jurisprudence on this issue which serves as a useful guide to interpretation. The question of the existence or non-existence of a family is essentially a question of fact, which must be determined on a case-by-case basis, requiring a flexible approach which takes account of cultural variations, and economic and emotional dependency factors. For the purposes of family reunification, 'family' includes, at the very minimum, members of the nuclear family (spouses and minor children)."

[79] A/HRC/43/43, para 42.

[80] A/HRC/43/43.

[81] Committee on Economic, Social and Cultural Rights, General Comment No. 7, para 3.

[82] It should be noted that broad and inclusive participatory-based processes can potentially foster access to justice for equity-seeking groups, and such processes should be responsive to the unique barriers to justice these groups face.

Principle 5 in Action - *Melani v. City of Johannesburg*

Globally, there are many compelling examples of courts upholding the rights of informal settlements or homeless encampments right to remain in place ("in situ") in their community. One such example is *Melani v. City of Johannesburg* in South Africa. In this case, the Slovo Park informal settlement challenged the City of Johannesburg's decision to relocate the community to an alternative location 11 km away. The court held that the Government's upgrading policy, as required by the constitutional right to housing, envisages "a holistic development approach with minimum disruption or distortion of existing fragile community networks and support structures and encourages engagement between local authorities and residents living within informal settlements." The Court concluded that relocation must be "the exception and not the rule" and any relocation must be to a location "as close as possible to the existing settlement." The Court ordered the City of Johannesburg to reverse the decision to relocate the community, and mandated the city to apply for funding for in situ upgrading.

The South African approach is an example of how some national courts are making the shift to adopt a human rights-based approach to encampments. This is a shift that moves in the right direction and should be applied by all courts in Canada.

PRINCIPLE 6: Ensure encampments meet basic needs of residents consistent with human rights[83]

60 Much of the stigma attached to residents of encampments is a result of governments failing to ensure access to basic services, including access to clean water, sanitation facilities, electricity, and heat, as well as support services.[84] These conditions violate a range of human rights, including rights to housing, health, physical integrity, privacy, and water and sanitation.[85] In these conditions, residents face profound threats to dignity, safety, security, health, and wellbeing.[86] The denial of access to water and sanitation by governments constitutes cruel and inhumane treatment, and is prohibited under international human rights law.[87]

[83] Details regarding securing basic needs consistent with human rights can be found in Schedule B.
[84] A/73/310/Rev.1.
[85] A/HRC/43/4.
[86] UN Water. *Human Rights to Water and Sanitation*. Available from: https://www.unwater.org/water-facts/human-rights/
[87] A/73/310/Rev.1, para 46: "Attempting to discourage residents from remaining in informal settlements or encampments by denying access to water, sanitation and health services and other basic necessities, as has been witnessed by the Special Rapporteur in San Francisco and Oakland, California, United States of

61 Canadian governments must ensure, at a minimum, that rudimentary adequacy standards are ensured in homeless encampments on an urgent and priority basis, while adequate housing options are negotiated and secured. Government's compliance with international human rights law requires:

i. Access to safe and clean drinking water
Water and sanitation are critical to health for all people. Through *Resolution 64/292*, the United Nations explicitly recognized the right to safe and clean drinking water and sanitation as a "human right that is essential for the full enjoyment of life and all human rights."[88] The *Resolution* calls upon States and international organizations "to provide safe, clean, accessible and affordable drinking water and sanitation for all." This obligation extends to those residing in homeless encampments.[89]

ii. Access to hygiene and sanitation facilities
Homeless encampments must be provided with sufficient resources and supports to ensure access to hygiene and sanitation facilities – toilets, showers, hand-washing stations, for example – within the encampment, or within very close proximity. Using existing facilities that remain open to the general public will not be appropriate. Facilities should ensure the hygiene and dignity of all residents irrespective of needs or identity. Peer-led hygiene and sanitation facilities have worked well in some contexts.

iii. Resources and support to ensure fire safety
General safety precautions should be implemented in an encampment environment to ensure residents are safe from fire and chemical exposure. Fire Departments should assist residents in developing a harm reduction approach to fire safety.

iv. Waste management systems
The lack of waste management systems in encampments has serious health and safety implications. Encampments necessarily create garbage during the course of daily activities. Garbage piles can become combustible fire hazards and can increase the risk of exposure to chemical waste. Human and animal biological waste also poses a particular danger. Without sanitary facilities, accumulated fecal waste can contaminate the

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America, 29 constitutes cruel and inhuman treatment and is a violation of multiple human rights, including the rights to life, housing, health and water and sanitation."
[88] A/RES/64/292, para 2. Available at: https://www.un.org/ga/search/view_doc.asp?symbol=A/RES/64/292.
[89] A/RES/64/292, para 3. Available at: https://www.un.org/ga/search/view_doc.asp?symbol=A/RES/64/292.

ground and transmit diseases.[90] The improper disposal of needles can also transmit diseases through puncture wounds or re-use of needles. It is the responsibility of governments to ensure that homeless encampments have sufficient resources for the establishment of waste management systems.

v. Social Supports and Services

Residents of homeless encampments should be ensured access to health, mental health, addiction, and broader social services in a manner equitable to other community residents and consistent with human rights. All supports should be culturally appropriate and anti-oppressive. Governments should consult encampment residents on how best to provide access to these services, including through approaches such as outreach and/or on-site service provision. The provision of social services should not be linked to data gathering of any kind.

vi. Guarantee Personal Safety of Residents

Although research indicates that unsheltered people in Canada are disproportionately targets of violence, rather than perpetrators,[91] interpersonal violence and exploitation can occur within encampments. interpersonal violence is often exacerbated when people do not have their basic needs met,[92] thus the provision of meaningful resources and supports will likely help ameliorate issues of safety.

It is the State's duty to protect the safety of all residents, particularly those who may be particularly vulnerable to abuse, harm, trafficking, or exploitation. Responses to violence must be guided by principles of transformative justice, rather that reproduce punitive outcomes and must be based in community-developed safety protocols. Governments must recognize that engaging police or other state authorities as a response to violence in encampments may put people at increased risk of harm, including due to risks of being criminalized or incarcerated.

vii. Facilities and resources that support food safety

Consuming contaminated food or water can cause a variety of foodborne

[90] CalRecycle. *Homeless Encampment Reference Guide*. Available at: https://www.calrecycle.ca.gov/illegaldump/homelesscamp#SolidWaste

[91] Sylvia, N., Hermer, J., Paradis, E., & Kellen, A. (2009). "More Sinned Against than Sinning? Homeless People as Victims of Crime and Harassment." In: Hulchanski, J. David; Campsie, Philippa; Chau, Shirley; Hwang, Stephen; Paradis, Emily (Eds.), *Finding Home: Policy Options for Addressing Homelessness in Canada* (e-book), Chapter 7.2. Toronto: Cities Centre, University of Toronto. www.homelesshub.ca/FindingHome

[92] Slabbert, I. (2017). Domestic violence and poverty: Some women's experiences. *Research on social work practice*, *27*(2), 223-230.

illnesses. Encampments are often more susceptible to foodborne illnesses due to a lack of storage, cooling appliances, improperly cooked foods, and limited or no access to clean water. Diseases can spread quickly in an encampment setting.

One of the best ways to prevent the spread of illness is to for governments to provide resources that enable the encampment to implement food safety measurements such as refrigeration facilities, which are also important for storing medicines.

viii. Resources to support harm reduction
Governments must provide encampments with the resources to implement effective harm reduction measures. Appropriate professionals should support residents to establish emergency protocols for responding to overdoses and other health emergencies.

ix. Rodent and pest prevention
The presence of rodents and pests can pose a significant threat to the health of residents. Appropriate prevention and treatment options should be available for pest management that are safe for use in human environments. Encampment residents should be provided with the resources to prevent and address the presence of rodents and pests.

62 In implementing these standards, it must be recognized that residents of encampments are experts with respect to their living spaces — they often know what resources are needed and how best to mobilize them. As a matter of human rights, residents must be engaged in planning and carrying out any measures developed to improve access to basic services. Practices, systems, and agreements residents have already put in place should be respected by government officials and should inform any further improvements.

PRINCIPLE 7: Ensure human rights-based goals and outcomes, and the preservation of dignity for encampment residents

63 As a matter of international human rights law, the rights and dignity of residents must be at the heart of all government engagement with homeless encampments.[93] Dignity is an inherent human rights value that is reflected in the *Universal Declaration of Human Rights*. As such, Canadian governments have an obligation to bring about positive human rights outcomes in all of their activities and decisions concerning homeless encampments.

[93] ICESCR.

64 Where Canadian governments at any level make decisions with regards to encampments, it is essential that they do so taking into account the full spectrum of human rights of residents and ensure that their enjoyment of those rights is enhanced by all decisions. Any decision that does not lead to the furthering of human rights, fails to ensure their dignity, or represents a backwards step in terms of their enjoyment of human rights, is contrary to human rights law.

65 More broadly, the Canadian government has an obligation to the progressive realization of the right to housing, alongside all other human rights.[94] A central component of that obligation is to address on an urgent basis the needs of those in the greatest need. This means that Canadian governments must move, as a matter of priority, towards the full enjoyment of the right to housing for encampment residents.[95] When governments fail to bring about positive human rights outcomes for encampment residents, they fail their obligation to progressively realize the right to housing.[96]

PRINCIPLE 8: Respect, protect, and fulfill the distinct rights of Indigenous Peoples in all engagements with encampments

66 Indigenous Peoples in Canada experience some of the most severe and egregious forms of housing need, and are dramatically overrepresented in homeless populations across the country, including specifically amongst those who are sleeping rough.[97] Under these conditions, many Indigenous Peoples experience profound violations of the right to housing and the right to self-determination, as well as violations of the right to freely pursue their economic, social, and cultural development.[98]

67 For Indigenous Peoples in Canada, encampments and political occupation may occur simultaneously as a means of survival and a means of asserting rights to lands and

[94] ICESCR, in General Comment No.3 on the nature of states parties' obligations under Art 2(1) of the ICESCR.
[95] ICESCR, Article 2(1).
[96] Further, if governments failed to ensure human rights outcomes were obtained for encampment residents, and residents suffered some detriment to their enjoyment of their rights (e.g., loss of dignity or ended up street homeless without any shelter at all), this might be classed as retrogression and a breach of obligations.
[97] See ESDC (Employment and Social Development Canada). (2019). *Everyone counts highlights: Preliminary results from the second nationally coordinated point-in-time count of homelessness in Canadian communities.* Retrieved from https://www.canada.ca/en/employment-social-development/programs/homelessness/reports/highlights-2018-point-in-time-count.html#3.5. Similarly, the 2018 Toronto Street Needs Assessment documented that 16% of those enumerated were Indigenous, and 38% of those sleeping rough were Indigenous. See also Patrick, C. (2014). *Aboriginal Homelessness in Canada: A Literature Review. Toronto: Canadian Homelessness Research Network Press*. Retrieved from https://www.homelesshub.ca/sites/default/files/AboriginalLiteratureReview.pdf.
[98] Article 3 of the *Declaration* and article 1 of the *Covenant*.

territories within cities and elsewhere. Whatever the impetus, any government engagement with Indigenous Peoples in encampments must be guided by the obligation to respect, protect, and fulfil their distinct rights. These rights are outlined in the United Nations Declaration on the Rights of Indigenous Peoples, as well as many other international human rights treaties.

68 Under international human rights laws, the enjoyment of the right to housing for Indigenous Peoples is "deeply interconnected with their distinct relationship to their right to lands, territories and resources, their cultural integrity and their ability to determine and develop their own priorities and strategies for development."[99] Recognition of the indivisible nature of Indigenous Peoples' human rights, and the obligation to uphold these rights, must shape all government engagement with Indigenous encampment residents, as well as the Indigenous Peoples who own or occupy the land or territories upon which the encampment is located.

69 Compliance with international human rights law requires:

i. Recognition of the distinct relationship that Indigenous Peoples have to their lands and territories

In order to ensure adequate housing for Indigenous Peoples, States, Indigenous authorities, and other actors must recognize the distinct spiritual and cultural relationships that Indigenous Peoples have with their lands and territories.[100] This recognition includes protection for Indigenous residents of encampments, who have the right to utilize their lands and territories in line with their own economic, social, political, spiritual, cultural, and traditional practices (as defined and assessed by the Peoples themselves).[101]

Under international human rights law, governments "should respect those housing structures which an Indigenous community deems to be adequate in the light of their own culture and traditions."[102] In the context of encampments, governments must respect Indigenous Peoples' right to construct shelter and housing in ways that incorporate their lived histories, cultures, and experiences.[103]

ii. Guarantee of self-determination, free, prior and informed consent and

[99] A/74/183, particularly para 6: "The right to adequate housing can be enjoyed by Indigenous Peoples only if its articulation under article 11 (1) of the International Covenant on Economic, Social and Cultural Rights is understood as interdependent with and indivisible from the rights and legal principles set out in the United Nations Declaration on the Rights of Indigenous Peoples."
[100] A/74/183.
[101] A/74/183.
[102] A/74/183, para 62.
[103] A/74/183.

meaningful consultation of Indigenous Peoples

Governments must ensure the participation of Indigenous Peoples in all decision-making processes that affect them.[104] Governments must consult with Indigenous encampment residents in order to obtain their free, prior, and informed consent before taking any action that may affect them.[105] Engagement with Indigenous communities should involve genuine dialogue and should be guided by "mutual respect, good faith and the sincere desire to reach agreement."[106] This consultation process must engage representatives chosen by Indigenous Peoples themselves, in accordance with their own procedures and practices.[107] As outlined in Principle 2, governments must provide Indigenous residents with necessary institutional, financial, and other resources in order to support their right to participate.[108] Indigenous women and girls must be consulted on a priority basis.[109]

iii. Prohibition against the forced eviction, displacement, and relocation of Indigenous Peoples

Indigenous Peoples' access to and control over their lands, territories and resources constitute a fundamental element of the realization of their right to adequate housing.[110] As such, international human rights law strictly prohibits the relocation of Indigenous Peoples in the absence of free, prior, and informed consent.[111]

iv. Protection and guarantees against all forms of violence and discrimination for Indigenous women, girls, and gender diverse peoples

Indigenous women, girls, gender diverse, and Two-Spirit peoples experience particular forms of violence – including sexual violence and

[104] United Nations Declaration on the Rights of Indigenous Peoples.
[105] United Nations Declaration on the Rights of Indigenous Peoples, in particular arts. 10, 19, and 23.
[106] A/74/183, para 56.
[107] United Nations Declaration on the Rights of Indigenous Peoples, art. 18. See also Indigenous and Tribal Peoples Convention, 1989 (No. 169), art. 6(1)(b); American Declaration on the Rights of Indigenous Peoples, arts. XXI (2) and XXIII (1); and A/HRC/18/42, annex (Expert Mechanism advice No. 2 (2011)). See also Human Rights Committee, General Comment No. 23 (1994) on the rights of minorities, para 7.
[108] Committee on Economic, Social and Cultural Rights' General Comment No. 4, para 12, and the basic principles and guidelines on development-based evictions and displacement (A/HRC/4/18, annex I, para 39).
[109] A/74/183, para 59.
[110] A/74/183, para 51. See also A/HRC/7/16, paras 45–48; The United Nations Declaration of the Rights of Indigenous Art. 26.2: "Indigenous Peoples have the right to own, use, develop, and control the lands, territories and resources that they possess by reason of traditional occupation or use, as well as those which they have otherwise acquired."
[111] United Nations Declaration on the Rights of Indigenous Peoples, Art. 10: "Indigenous Peoples shall not be forcibly removed from their lands or territories. No relocation shall take place without the free, prior and informed consent of the Indigenous Peoples concerned and after agreement on just and fair compensation and, where possible, with the option of return."

homicide – in relation to the intersection of their indigeneity, gender identity, socioeconomic and cultural status, and their housing status.[112] Canadian law recognizes the concept of multiple and intersecting forms of discrimination, and under international human rights law all Indigenous women, girls, and those who are gender diverse or Two-Spirited "must enjoy full protection and guarantees against all forms of violence and discrimination, whether inside or outside their communities."[113]

It is incumbent upon governments to provide Indigenous women and girls protection and guarantee against all forms of violence and discrimination within encampments, including from state authorities, in a manner that is consistent with Indigenous self-determination and self-governance.

[112] A/74/183, para 59.
[113] A/74/183, para. 59.

SCHEDULE A: Select Case Law on Homeless Encampments in Canada

Victoria (City) v. Adams, 2009 BCCA 563[114]

The City of Victoria made an application for an injunction to remove a "tent city" at Cridge Park. The City relied on its *Streets and Traffic Bylaw* and *Parks Regulation Bylaw, which* prohibits loitering and taking up an overnight temporary residence in public places. On appeal, the Court of Appeal established that the Victoria City bylaws violated section 7 of the *Canadian Charter* "in that they deprive homeless people of life, liberty and security of the person in a manner not in accordance with the principles of fundamental justice," and the provisions were not saved by section 1 of the *Charter* (para. 42). The Court of Appeal confirmed that the bylaw was overbroad "because it is in effect at all times, in all public places in the City."[115]

Abbotsford (City) v. Shantz, 2015[116]

The City of Abbotsford applied for an interim injunction requiring the defendants to remove themselves and their encampment from a city park. The Court concluded that the bylaws were "grossly disproportionate" because:

> "the effect of denying the City's homeless access to public spaces without permits and not permitting them to erect temporary shelters without permits is grossly disproportionate to any benefit that the City might derive from furthering its objectives and breaches the s. 7 *Charter* rights of the City's homeless."[117]

The Court concluded that allowing the City's homeless to set up their shelters overnight and taking them down during the day would "reasonably balance the needs of the homeless and the rights of other residents of the City."[118]

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[114] *Victoria(City) v. Adams* (2009, BCCA 563). Online, https://www.canlii.org/en/bc/bcca/doc/2009/2009bcca563/2009bcca563.html?resultIndex=1

[115] The Court of Appeal stated at para. 116 that: "The prohibition on shelter contained in the Bylaws is overbroad because it is in effect at all times, in all public places in the City. There are a number of less restrictive alternatives that would further the City's concerns regarding the preservation of urban parks. The City could require the overhead protection to be taken down every morning, as well as prohibit sleeping in sensitive park regions." This case is perhaps one of the most notable successes in homeless litigation in Canada.

[116] *Abbotsford (City) v. Shantz* (2016 BCSC 2437). Online, https://www.canlii.org/en/bc/bcsc/doc/2016/2016bcsc2437/2016bcsc2437.html?resultIndex=1

[117] Para 224

[118] The Court stated, "The evidence shows, however, that there is a legitimate need for people to shelter and rest during the day and no indoor shelter in which to do so. A minimally impairing response to balancing that need with the interests of other users of developed parks would be to allow overnight shelters to be erected in public spaces between 7:00 p.m. and 9:00 a.m. the following day."[para 276]

British Columbia v. Adamson, 2016 BCSC 584 [*Adamson #1*] and 2016 BCSC 1245 [*Adamson #2*][119]

The Province of BC applied for an interlocutory injunction to restrain the defendant encampment residents from trespassing on the Victoria courthouse green space. On the first application, the court concluded that the balance of convenience did not favour the granting of the injunction, stating

> "the balance of convenience is overwhelmingly in favour of the defendants, who simply have nowhere to move to, if the injunction were to issue, other than shelters that are incapable of meeting the needs of some of them, or will result in their constant disruption and a perpetuation of a relentless series of daily moves to the streets, doorways, and parks of the City of Victoria."[120]

Following this, a second injunction was filed based on new evidence of the encampment deterioration conditions, as well as supporting evidence that the Province would make housing available to encampment residents. The court made an order requiring the encampment to be cleared, but granting residents to stay until alternate housing options were made available to them.[121]

Vancouver (City) v. Wallstam, 2017 BCSC 937[122]

The City of Vancouver applied for an interlocutory injunction requiring encampment residents to vacate and remove all tents and other structures from a vacant city lot. The Court relied on the injunction test set out in *RJR-MacDonald.*[123] The court noted that:

> "The test requires that the *applicant* prove *it will suffer irreparable harm* if the injunction is not granted...When I asked counsel what harm the *City* would suffer if the injunction was not granted, he answered that not granting the injunction would mean that a 'vital social housing project won't go ahead' and that interferes with the public good. He also points out the timeline for development of the project requires the injunction urgently … While everyone can agree that more social housing is an important goal, I must balance that general concern against the position of the occupants that the tent city, as it currently exists, is now providing shelter and safe living space for the occupants."[124]

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[119] *British Columbia v. Adamson* (2016 BCSC 1245). Online, https://www.canlii.org/en/bc/bcsc/doc/2016/2016bcsc1245/2016bcsc1245.html?resultIndex=1

[120] Para 183.

[121] Paras 85-86,

[122] *Vancouver (City) v. Wallstam* 2017 BCSC 937 at para 60. Online, https://www.canlii.org/en/bc/bcsc/doc/2017/2017bcsc937/2017bcsc937.html?resultIndex=1

[123] In *RJR-MacDonald Inc. v. Canada (Attorney General)*, [1994] 1 S.C.R. 311

[124] Para 46-47.

The court concluded that the City failed to meet the *RJR-MacDonald* test and dismissed the City's application, but without prejudice to bring it forward again on a more complete factual record.[125]

[125] Para 64.

SCHEDULE B: An Elaboration on Principle 6

Ensure encampments meet basic needs of residents consistent with human rights

Canadian governments must ensure, at a minimum, that rudimentary adequacy standards are ensured in homeless encampments on an urgent and priority basis, while adequate housing options are negotiated and secured. Government's compliance with international human rights law requires:

i. Access to safe and clean drinking water

Water and sanitation are critical to health for all people. Through *Resolution 64/292*, the United Nations explicitly recognized the right to safe and clean drinking water and sanitation as a "human right that is essential for the full enjoyment of life and all human rights."[126] The *Resolution* calls upon States and international organizations "to provide safe, clean, accessible and affordable drinking water and sanitation for all." This obligation extends to those residing in homeless encampments.[127]

To ensure access to safe and clean drinking water, governments should provide homeless encampments with resources for:

- On site/close-proximity clean and safe drinking/potable water, ensuring a sufficient number of access points for water relative to the number of residents
- Dishwashing Station(s) with clean water, sufficient in number for the number of residents

ii. Access to hygiene and sanitation facilities

Homeless encampments must be provided with sufficient resources and supports to ensure access to hygiene and sanitation facilities – toilets, showers, hand-washing stations, for example – within the encampment, or within very close proximity. Using existing facilities that remain open to the general public will not be appropriate. Facilities should ensure the hygiene and dignity of all residents irrespective of needs or identity. Peer-led hygiene and sanitation facilities have worked well in some contexts.

Hygiene and sanitation facilities should include:

- Washing stations, including showers with privacy and safety for women and gender diverse peoples, stocked with soap, water, paper towels

[126] A/RES/64/292, para 2. Available at: https://www.un.org/ga/search/view_doc.asp?symbol=A/RES/64/292.
[127] A/RES/64/292, para 3. Available at: https://www.un.org/ga/search/view_doc.asp?symbol=A/RES/64/292.

- Adequate numbers of toilets based on the encampment population which must be accessible for residents with disabilities. Every toilet station must also have a hand-washing station
- Access to cleaning and bathing supplies
- Access to free laundry facilities
- Free feminine hygiene products
- Access to clean bedding

iii. Resources and support to ensure fire safety

General safety precautions should be implemented in an encampment environment to ensure residents are safe from fire and chemical exposure. Fire Departments should assist residents in developing a harm reduction approach to fire safety. Residents should be provided with resources to support best safety practices, including:

- Fire-safety approved sources of heat (e.g., safe metal vessels for heat)
- Warming tents
- In-tent heat sources
- Fire-proof tents
- Fire evacuation plan
- Signage indicating evacuation plans
- Accessible information on fire safety tips and how to handle and store flammable materials (e.g., gasoline, butane, propane)
- Fire extinguishers appropriately spaced and training for residents on how to operate them
- Electricity/charging stations for phones and laptops
- On-site ashtrays or cigarette disposal posts

iv. Waste management systems

The lack of waste management systems in homeless encampments has serious health and safety implications. Encampments necessarily create garbage during the course of daily activities, including during food preparation or shelter building. Unwanted materials can pile up quickly when there is no waste system in place to remove garbage from the area. Garbage piles can become combustible fire hazards and can increase the risk of exposure to chemical waste.

Human and animal biological waste also poses a particular danger. Without sanitary facilities, accumulated fecal waste can contaminate the ground and transmit diseases.[128] The improper disposal of needles can also transmit diseases through puncture wounds or re-use of needles.

[128] CalRecycle. *Homeless Encampment Reference Guide*. Online at https://www.calrecycle.ca.gov/illegaldump/homelesscamp#SolidWaste

It is the responsibility of governments to ensure that homeless encampments have sufficient resources for the establishment of waste management systems, which should include:

- Weekly garbage and recycling (more frequent if needed)
- Regular service for waste water and portable toilets
- Independent waste bins for flammable/hazardous waste (e.g., fuel, motor oil, batteries, light bulbs)
- Large rodent-proof waste bins with tight fitting lids
- Garbage bags, cleaning supplies, hand soap, hand sanitizer
- Waste water holding tanks (if there are no sewers near encampment)

v. Social Supports and Services

Residents of homeless encampments should be ensured access to health, mental health, addiction, and broader social services in a manner equitable to other community residents and consistent with human rights. All supports should be culturally appropriate and anti-oppressive. Governments should consult encampment residents on how best to provide access to these services, including through approaches such as outreach and/or on-site service provision. The provision of social services should not be linked to data gathering of any kind.

i. Guarantee Personal Safety of Residents

Although research indicates that unsheltered people in Canada are disproportionately targets of violence, rather than perpetrators,[129] interpersonal violence and exploitation can occur within encampments. interpersonal violence is often exacerbated when people do not have their basic needs met,[130] thus the provision of meaningful resources and supports will likely help ameliorate issues of safety.

It is the State's duty to protect the safety of all residents, particularly those who may be particularly vulnerable to abuse, harm, trafficking, or exploitation. Responses to violence must be guided by principles of transformative justice, rather that reproduce punitive outcomes and must be based in community-developed safety protocols. Governments must recognize that engaging police or other state authorities as a response to violence in encampments may put people at increased risk of harm, including due to risks of being criminalized or incarcerated.

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[129] Sylvia, N., Hermer, J., Paradis, E., & Kellen, A. (2009). "More Sinned Against than Sinning? Homeless People as Victims of Crime and Harassment." In: Hulchanski, J. David; Campsie, Philippa; Chau, Shirley; Hwang, Stephen; Paradis, Emily (Eds.), *Finding Home: Policy Options for Addressing Homelessness in Canada* (e-book), Chapter 7.2. Toronto: Cities Centre, University of Toronto. www.homelesshub.ca/FindingHome

[130] Slabbert, I. (2017). Domestic violence and poverty: Some women's experiences. *Research on social work practice*, *27*(2), 223-230.

Any approach to addressing interpersonal safety within encampments must:

- Center on the most vulnerable members of the encampment, namely: BIPOC, women, trans-people and other LGBTQ2S+ persons, persons with disabilities, and other groups who experience discrimination or marginalization.
- Provide resources and supports to allow for Indigenous and other non-colonial approaches to conflict resolution.
- Provide safe, confidential, accessible, and non-coercive mechanisms through which individuals experiencing violence can report these experiences and receive trauma-informed supports and services, ensuring that these individuals are able to access alternative safe housing (as desired).

vi. Facilities and resources that support food safety

Consuming contaminated food or water can cause a variety of foodborne illnesses. Encampments are often more susceptible to foodborne illnesses due to a lack of storage, cooling appliances, improperly cooked foods, and limited or no access to clean water. Diseases can spread quickly in an encampment setting.

One of the best ways to prevent the spread of illness is to for governments to provide resources that enable the encampment to implement food safety measurements. This includes:

- Rodent-proof storage containers, with lids that can be sealed
- Shelving units to ensure food is stored off the ground
- Soap and sanitizer to clean food preparation surfaces
- Cooling appliance(s) to prevent spoilage
- Cooking appliance(s) to ensure food is thoroughly cooked

vii. Resources to support harm reduction

Governments must provide homeless encampments with the resources to implement effective harm reduction measures within homeless encampments. Appropriate professionals should support residents to establish emergency protocols for responding to overdoses and other health emergencies. Encampment residents should be provided with:

- Overdose prevention training (e.g., CPR training)
- Overdose prevention supplies (e.g., Naloxone)
- Overdose Prevention Sites, where possible
- Puncture-proof containers for needle disposal
- Harm reduction outreach supports
- Regular servicing of puncture-proof containers by a certified waste-management company

- Information about available emergency services in the event of overdoses or other health-related crises

viii. Rodent and pest prevention

The presence of rodents and pests can pose a significant threat to the health of residents. Appropriate prevention and treatment options should be available for pest management that are safe for use in human environments (e.g., diatomaceous earth). Encampment residents should be provided with the resources to prevent and address the presence of rodents and pests, including:

- Resources and information on rodent and pest prevention
- A bait-station to detract rodents from sleeping tents, regularly serviced and monitored
- Cleaning materials and gloves to dispose of rodents

In implementing these standards, it must be recognized that residents of encampments are the experts of their living spaces — they often know what resources are needed and how best to mobilize them. As a matter of human rights, encampment residents must be engaged in planning and carrying out any measures developed to improve access to basic services for the encampment. Practices, systems, and agreements residents already have in place should be recognized by government officials and should inform any further improvements.

TAB 4

INFORMATION REPORT

TO:	Chair and Members Emergency and Community Services Committee
COMMITTEE DATE:	September 9, 2021
SUBJECT/REPORT NO:	Encampment Response Update (PED21188/HSC20038(c)) (City Wide)
WARD(S) AFFECTED:	City Wide
PREPARED BY:	Monica Ciriello (905) 546-2424 Ext. 5809 Edward John (905) 546-2424 Ext. 4860
SUBMITTED BY: **SIGNATURE:**	Jason Thorne General Manager Planning and Economic Development Department
SUBMITTED BY: **SIGNATURE:**	Grace Mater General Manger Healthy and Safe Communities Department

COUNCIL DIRECTION

At its August 9, 2021 meeting, Council approved the repealing of the By-law Enforcement Protocol that permitted some individuals to camp in public spaces for up to 14 days. Further to that decision and the three-week winddown associated with it, as of August 30, 2021, the City returned to pre-protocol enforcement of City by-laws that prohibit camping on City property, including park areas.

INFORMATION

The COVID-19 pandemic highlighted and exacerbated ongoing systemic challenges and inequities across Canada as it relates to housing and homelessness. This has been demonstrated by the rise in, and visibility of, unsheltered homelessness and encampments throughout many Canadian cities. Person-centred strategies and approaches are required to address urgent issues associated with supporting residents

experiencing homelessness and living in encampments, while supporting long-term adequate housing solutions and broader community needs.

Encampment Process

With the repealing of the By-law Enforcement Protocol, staff will proceed with the following Encampment Process:

Step one
Complaints are received by Municipal Law Enforcement (MLE) regarding structures/tents in parks, road allowance and private property.

Step two
MLE attends, determines if there is a violation of a City By-law including the Parks Bylaw, seeks voluntary compliance and notifies Housing Outreach.

Step three
Housing Focused Street Outreach attends site and carries out the following:

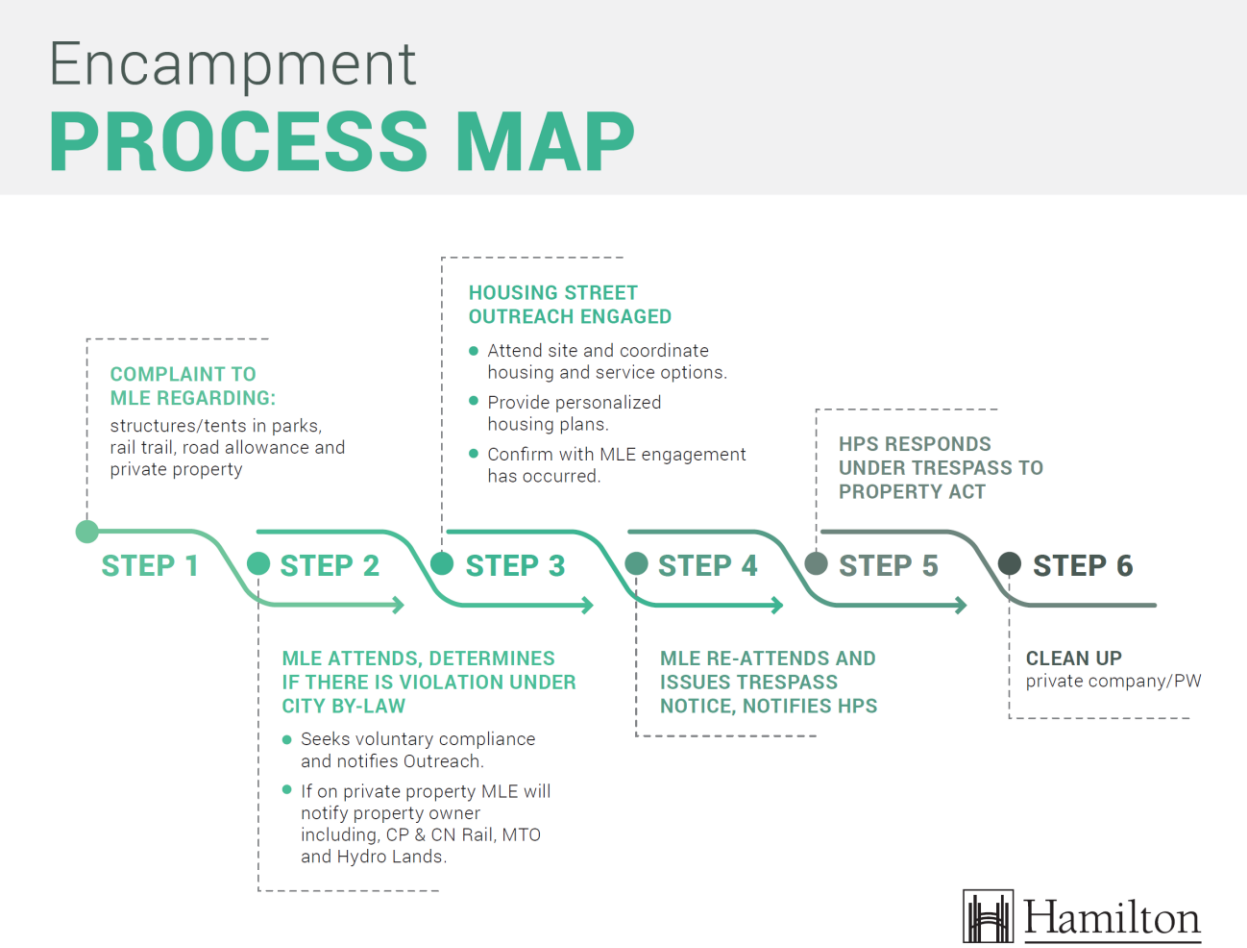
- Work from Housing Focused Street Outreach framework and within the context of Hamilton's Homeless Coordinated Access System
- Support individuals, families and groups, in order to promote connection to shelter, housing and the achievement of their optimal health and well-being
- Collaborative development of housing and service plans
- Assist individuals with obtaining necessary documents needed to obtain housing, including the completion of supportive and subsidized housing applications
- Collaborate and co-ordinate services with appropriate community and health agencies
- Crisis intervention
- Provide a summary of these actions (omitting any privileged and confidential information) in the form of an encampment assessment checklist to MLE pursuant to their request

Step four
MLE re-attends and issues a verbal trespass notice and notifies Hamilton Police Service (HPS).

Step five
Hamilton Police Service responds under the *Trespass to Property Act*, R.S.O. 1990, c. T.21

Step six
Park and Waste Divisions are contacted to coordinate a clean up.

Table 1



Encampment Response

The City of Hamilton's Licensing and Bylaw Services Division will be the first point of contact for complaints regarding structures and tents in parks, road allowances and private property. MLE Officers will attend to determine if there is a City Bylaw, including the Parks By-law 01-291 violation, which prohibits camping on City property, including park areas. MLE Officers will be responding to complaints proactively Monday to Friday and reactively on weekends along with other COVID-19 By-law and Provincial Regulation priorities. MLE Officers will attend, provide education and seek voluntary compliance under the City Bylaw, ticketing those who are unsheltered will not be a course of action. If determined to be private property, MLE Officers will notify the property owner, including CP & CN Rail and MTO. If voluntary compliance is not achieved, MLE Officers will reach out to the Street Outreach team within the Housing Services Division and the Social Navigator Program.

The Housing Focused Street Outreach team will, if not already, attend the site and engage with those individuals currently unsheltered. Outreach will endeavor to provide an update summary of the site including identifying potential opportunities for connection to services and housing for those individuals, assess their needs and update MLE of the actions that have occurred.

MLE Officers will re-attend the location and, a verbal trespass notice would be issued to those contravening the bylaw. MLE will contact the Hamilton Police Service as the *Trespass to Property Act*, R.S.O. 1990, c. T.21 is a Provincial Act enforced by HPS. The City will continue to collaborate with HPS and the Social Navigator with regard to the service pathway. The last step will be to contact the Public Works Department (Parks, Streets, Waste Management) to coordinate a clean up.

Following the Council decision to repeal the By-law Enforcement Protocol, the City of Hamilton's Housing Services Division remains focused on supporting individuals experiencing homelessness in securing safe and affordable housing, by continuing to take an individualized approach to connect them to available supports.

Housing Services' Housing Focused Street Outreach Team connects with unsheltered individuals, regardless of their circumstances, to assess their immediate needs and housing preferences. The team completes common consent and intake forms for individuals not yet on the City's By-Name List (BNL), supports with benefit applications, unit viewings, harm reduction supplies, connections and referrals. As part of the City's homeless-servicing system, Outreach uses a shared system-wide database to stay connected to residents in encampments and outside of encampments in areas such as alleys, vacant lands, etc. Outreach services are provided to unsheltered residents across the geographic area of Hamilton Monday to Friday from 8:00 a.m. to 8:00 p.m. and Saturday and Sunday from 8:00 a.m. to 4:00 p.m. On a daily basis, the team undertakes progressive engagement to offer shelter or other available (and appropriate) space, works with individuals to find safe and supportive housing options, and works to address any barriers including a referral to our health partners.

During the COVID-19 pandemic, emergency shelter capacity has been expanded; however, occupancy pressures exist, particularly for women. Challenges remain in the access to available beds and in a number of instances capacity is not available. For example, length of stay in shelters has increased significantly during the pandemic and, with factors such as unaffordable costs of rent, housing availability has not kept pace with demand. Longer stays impact shelter bed turnover frequency, thus reducing the capacity of shelters to serve a higher volume of individuals. Outbreak status, availability of appropriate supports, staff turnover, shortages and burnout further impact the responsiveness of the system. When a move from encampment to emergency shelter occurs, the City of Hamilton recognizes that this remains a temporary measure of accommodation until safe, secure and adequate housing is secured.

For individuals for whom emergency shelters are not an option, Housing Services' Outreach Team supports connection to health partners, works to address issues related to service restrictions, and continues progressive engagement towards accepting housing assistance. The City of Hamilton funds numerous agencies to assist in the housing of homeless individuals through funding streams such as the Federal Reaching Home program. City staff monitor, advise and assist these agencies in meeting predetermined targets through the homeless-serving sector's coordinated access system. From January 2020 to present, approximately 440 individuals and families have been housed by agencies funded by the City. Of the approximately 440 households housed, this includes people who have been unsheltered at one point during that time period. Since March 2020, more than 70 individuals were housed directly from encampments.

Outreach staff engage with every individual from a rights-based approach, ensuring dignity and confidentiality is maintained. On an ongoing basis, both Housing Services and agency staff work from a person-centred approach to engage with individuals in order to refer and make connections to appropriate support and resources. Referrals may include Intensive Case Management, Rapid Rehousing, Transitional or permanent supportive housing programs, in addition to housing affordability benefits, depending on individuals' needs, preferences and available resources. Increased engagement for the direct purpose of assessing effectiveness of approaches and appropriateness of available resources will continue to inform potential changes or adaptations to service and supports over time.

Coming Together to End Homelessness: Hamilton's Systems Planning Framework outlines a strategic local approach to preventing and ending homelessness, which must account for the systemic over-representation of Indigenous persons experiencing homelessness. The City is committed to ongoing coordination with Hamilton's Urban Indigenous Community to ensure that approaches to service coordination and provision are culturally appropriate, safe and built on principles of relationship, trust and informed consent. This includes ongoing discussion to achieve equitable access to resources including, for example, housing affordability benefits as they become available to support unsheltered individuals who identify as Indigenous. Through ongoing dialogue with the Indigenous community, the City aims to ensure appropriate referrals are consistently made from mainstream supports to Indigenous agencies, including at intake by City outreach staff.

The City continues to commit to permanent housing solutions by implementing increased prioritization of those in encampments for permanent housing and intensive case management support programs while continuing multi-sectoral discussions to enhance permanent housing with supports options. From September to December 2021, Housing Services Division, together with partner agencies, will undertake a

housing campaign to maximize resources and collaboration to house 250 households experiencing homelessness.

Health and Safety Concerns

Due to the vulnerability and transience of encampment populations, health and safety concerns are present for both residents and City staff. COVID-19 exposure, verbal and sometimes physical aggressions have been noted at various sites. MLE Officers are not trained in outreach or mental health engagement techniques and therefore cannot offer support to address health and safety for encampment residents. This fact extends to include staff themselves, who navigate a challenging array of health and safety concerns when carrying out their duties. For example, Waste management staff have received numerous negative comments, which may be perceived as threats from residents, activists, advocates and the general public. Staff have been videotaped with postings on social media platforms such as Twitter and Facebook. Staff have been called repeatedly at all hours on their cell phone. In one instance a staff member was assaulted during clean up, resulting in injuries to the worker and charges being laid by Hamilton Police Service. As a result, the injured employee has yet to return to work.

There is a steady increase of incidents involving the Hamilton Fire Department and the Hamilton Police Service. Where emergency service response is needed, the City will respond swiftly with staff health and safety supports. Healthy and Safe Communities Department staff are better able to flag resident health and safety concerns to the appropriate support services for timely resolution.

The professional skillset required of Housing Service's Outreach staff facilitates mitigation of challenging behaviours, circumstances and establishment of positive rapport. Staff have been trained in non-violent crisis intervention, work only in pairs and are in constant communication with each other.

Budgetary Implications

Costs vary site to site; while staff time is not itemized by site, typical contractor costs for waste management average $15 K. Across all encampments, average monthly security costs have been approximately $23 K from October 2020 to July 2021.

Licensing and By-law Services

Council may direct Licensing and Bylaw Services (LBS) to enforce 7 days a week, inclusive of evenings and weekends. To oversee and coordinate the MLE officer response for encampments 7 days a week LBS requires 1 temporary FTE By-law Clerk at a cost of $26, 162 and 1 temporary FTE MLE Officer at a cost of $30, 795 from the date of Council approval to December 31, 2021.These staff will assist in the collection of

weekly stats on complaints received, locations of encampments, determine priority locations in collaboration with others on the Encampment Response Team, provide status updates as to the step each encampment site is in throughout the City. MLE Officers will be attending encampment sites in pairs, and one additional temporary FTE MLE Officer will allow for a timely proactive and reactive response to each encampment site 7 days a week. The Bylaw Clerk will provide administrative support to the MLE Officers and will ensure all tracking, scheduling, monitoring, entering areas of concern, preparation of orders, and dispatch to this team 7 days a week. The total cost would be $56, 958.

Emergency Services Responses

The Hamilton Fire Department has attended to an increasing number of incidents involving encampments and individuals experiencing homelessness over the last three years (54 incidents in 2019, 82 incidents in 2020, and 101 incidents to date in 2021). The majority of incidents in 2021 to date have involved burning (controlled) and property fires/explosion.

Hamilton Paramedic Service responded to 55 encampment related calls in four parks from October 1, 2020 to August 31, 2021. There has been a steady increase in paramedic service response to encampments in City parks in 2021, ranging from two in January to 15 in August.

The Hamilton Police Service indicated there were 502 events from October 1, 2020 to August 31, 2021 related to six known encampment locations, but not necessarily due to the presence of an encampment. These incidents include events related to trespassing, assist (ambulance & fire), and other events requiring police service response (i.e. assault, harassment, protests, etc.)

Government Outreach

There remains an ongoing need to align provincial health and housing and homelessness investments to enable service managers to provide permanent housing with supports for high acuity chronically homeless individuals living in shelters and encampments. Strategic investment and partnership between Ontario Health West and City of Hamilton can demonstrably reduce chronic homelessness in Hamilton and the reliance on emergency hospital resources for those with the most complex, co-occurring needs.

Staff are actively pursuing funding opportunities from higher levels of government to address these needs. Specifically, the Ministry of Health (Ontario), Associate Minister of Mental Health and Addictions and the Ministry of Municipal Affairs and Housing (Ontario) in addition to the equivalent Ministries federally such as Health, Housing,

Infrastructure and Communities, and Families, Children and Social Development. Staff have proposed a pilot project to the Government of Ontario in order to address the needs of high-acuity individuals in Hamilton, this pilot outlines the resources required to take immediate action.

The proposed pilot would include 40 new units of supportive housing to address the needs of higher acuity individuals and continuing existing outreach activities will address needs in a new and improved way. The total funding necessary to undertake this development is $2,440,000. The request for on-going provincial operational funding is $1,940,000.

Staff have been using forums like the Association of Municipalities of Ontario (AMO), Federation of Canadian Municipalities (FCM) and Ontario Big City Mayors, of which Hamilton is a member, to further advocacy and align objectives in voicing our concerns about the lack of funding from higher levels of government to address these immediate needs. AMO, FCM and Ontario Big City Mayors are focused on improving supports for mental health. Ontario Big City Mayors has provided recommendations to support and complement the Province's Road to Wellness plan which seeks to improve mental health and addictions services across Ontario. The proposed recommendations and desire to collaborate demonstrate the need for municipalities to work with other levels of government and local service providers to ensure residents can access the help they need, where and when they need it.

APPENDICES AND SCHEDULES ATTACHED

None

TAB 5

City of Hamilton
EMERGENCY & COMMUNITY SERVICES COMMITTEE REVISED

Meeting #: 21-009
Date: September 09, 2021
Time: 1:30 p.m.
Location: Due to the COVID-19 and the Closure of City Hall (CC)
All electronic meetings can be viewed at:
City's Website: https://www.hamilton.ca/council-committee/council-committee-meetings/meetings-and-agendas
City's YouTube Channel: https://www.youtube.com/user/InsideCityofHamilton or Cable 14

Tamara Bates, Legislative Coordinator (905) 546-2424 ext. 4102

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1. **CEREMONIAL ACTIVITIES**

2. **APPROVAL OF AGENDA**

(Added Items, if applicable, will be noted with *)

3. **DECLARATIONS OF INTEREST**

4. **APPROVAL OF MINUTES OF PREVIOUS MEETING**

4.1 July 8, 2021

5. **COMMUNICATIONS**

5.1 Robin McKee, Sir John A. Macdonald Society, regarding petition not to remove the statue of Sir John A. Macdonald from Gore Park

6. **DELEGATION REQUESTS**

6.1 Linda Maloney, respecting statue of Sir John A. Macdonald (for a future meeting)

6.2 Tom Cooper, Hamilton Roundtable for Poverty Reduction, respecting recent community forums related to extreme heat in Hamilton (for a future meeting)

6.3 Stephane Cox and Sharon Crowe, Hamilton Community Legal Clinic, regarding revocation of the Encampment Protocol (for today's meeting)

6.4 Dr. Jill Wiwcharuk, Hamilton Social Medicine Response Team, regarding encampments (for today's meeting)

6.5 Marcie McIleen, Keeping Six, respecting encampments (for today's meeting)

7. **CONSENT ITEMS**

7.1 Automatic Mechanical Cardio Pulmonary Resuscitation (CPR) Devices (HSC21028) (City Wide)

7.2 Single-Source Paramedic Service Linen Supply (HSC21029) (City Wide)

7.3 Purchase of New Stair Chair Conveyance Equipment (HSC21030) (City Wide)

8. STAFF PRESENTATIONS

8.1 Harmonizing Eligibility Requirements for Subsidy Programs (HSC21026) (City Wide)

9. PUBLIC HEARINGS / DELEGATIONS

10. DISCUSSION ITEMS

10.1 Service Manager Consents for CityHousing Hamilton's Development Reset (HSC20055(a)) (Wards 2 and 4) (Outstanding Business List Item)

10.2 Replacement for the Ontario Works Scheduler (HSC21022) (City Wide)

*10.3 Municipal Affairs and Housing Social Services Relief Fund Phase 4 and Canada-Ontario Community Housing Initiative (HSC20036(b)) (City Wide)

*10.4 Encampment Response Update (PED21188/HSC20038(c)) (City Wide)

11. MOTIONS

12. NOTICES OF MOTION

*12.1 Youth Violent Crimes

13. GENERAL INFORMATION / OTHER BUSINESS

13.1 Amendments to the Outstanding Business List

13.1.a Items Considered Complete and to be Removed

13.1.a.a Service Manager Consents for CityHousing Hamilton Development Reset

Item on OBL: 20-I

Addressed as Item 10.1 on today's agenda

14. PRIVATE AND CONFIDENTIAL

15. ADJOURNMENT

TAB 6

City of Hamilton

CITY COUNCIL
REVISED

21-018
Wednesday, October 13, 2021 at 9:30 A.M.
Due to the COVID-19 and the Closure of City Hall (CC)
All electronic meetings can be viewed at:
City's Website: https://www.hamilton.ca/council-committee/council-committee-meetings/meetings-and-agendas
City's YouTube Channel: https://www.youtube.com/user/InsideCityofHamilton or Cable 14

Call to Order

1. APPROVAL OF AGENDA

(Added Items, if applicable, will be noted with *)

2. DECLARATIONS OF INTEREST

3. CEREMONIAL ACTIVITIES

3.1 2021 Trillium Awards

4. APPROVAL OF MINUTES OF PREVIOUS MEETING

4.1 September 29, 2021

5. COMMUNICATIONS

5.1 Correspondence from York Region requesting support for their resolution respecting preventing impacts of violence towards York Region paramedics.

Recommendation: Be received.

5.2 Correspondence from the City of Kingston requesting support for their resolution respecting a National Child Care Program.

Recommendation: Be received.

5.3 Correspondence from the Honourable Steve Clark, Minister of Municipal Affairs and Housing respecting the expiry of Temporary Regulations (130/20 and 131/20) Limiting Municipal Authority to Regulate Construction Noise.

Recommendation: Be received and referred to the General Manager of Planning and Economic Development for appropriate action.

5.4 Correspondence from the Town of Caledon in support of the City of Hamilton's resolution respecting Noise Concerns and Request for Expiry of Extended Construction Hours.

Recommendation: Be received.

5.5 Correspondence from Gord Baker respecting low speed limits.

Recommendation: Be received.

5.6 Correspondence respecting Heritage Permit Application HP2021-033, under Part IV of the Ontario Heritage Act for the relocation of 398 Wilson Street East, Ancaster (PED21196) (Ward 12):

5.6.a Sandra Starr

5.6.b Heather Bull

*5.6.c Gail Moffatt

*5.6.d Cindi Watson

*5.6.e John Allan

*5.6.f Darren Earl

*5.6.g David and Donna Molnar

*5.6.h Aimee Frketich

*5.6.i WJ Burtch

*5.6.j Honor Hughes

*5.6.k R. H. Baker

*5.6.l Bob Maton, President, Ancaster Village Heritage Community Inc.

*5.6.m Robin Larin

*5.6.n David Wallis

*5.6.o Andrea Connor

*5.6.p Jim MacLeod

*5.6.q Sandra Starr

*5.6.r David Starr

*5.6.s Patrick DeNardis

*5.6.t Graham and Linda Clements

*5.6.u Rosa Beraldo

*5.6.v Pat Nash

*5.6.w John Chaffey

*5.6.x Michael Weyman

*5.6.y Janice Currie

*5.6.z Robert Maton, President, Ancaster Village Heritage Community

*5.6.aa Brad Kuhn

*5.6.ab Jennifer Davis

*5.6.ac Lisa Cole

Recommendation: Be received and referred to the consideration of Item 5(b) of Planning Committee Report 21-015.

5.7 Correspondence requesting the End of Encampment Evictions:

5.7.a	Ani Chenier	
5.7.b	Kelsea McCready	
5.7.c	Alison Cupido	
5.7.d	Lee Skinner	
5.7.e	Daya Williams	
5.7.f	Sheryl Kyorkis	
5.7.g	Dan Ashworth	
5.7.h	Sarah Pegg	
5.7.i	Jess Maurice	
5.7.j	Allie Blumas	
5.7.k	Miles Oreskovic	
5.7.l	Ameil Joseph	
5.7.m	Briar von der Kall	
5.7.n	Alex Ramsay	
5.7.o	Melissa Folk	
5.7.p	Emma Croll-Baehre	
5.7.q	Zeina Hassan	
5.7.r	Rowa Mohamed	
5.7.s	Alissa Harvey	
5.7.t	Dina Catalucci	
5.7.u	Arianne Di Nardo	
5.7.v	Glenn Davies	
5.7.w	Elizabeth Catalucci	
5.7.x	Hiva Nematollahi	
5.7.y	Will Allen	
5.7.z	Sarah Dawson	
5.7.aa	Daisy Martindale	
5.7.ab	Gabriel Baribeau	
5.7.ac	Brenna Inglis	
5.7.ad	Clara MacKinnon	
5.7.ae	Allison Burda	
5.7.af	Harlee Mackenzie	
5.7.ag	Jonathan Jaeger-Dumont	
5.7.ah	Elle Klassen	

5.7.ai	Michael Schnittker
5.7.aj	Meredith Park
5.7.ak	Victoria Iles
5.7.al	Shanze Yoell
5.7.am	Sonali Menezes
5.7.an	Linnea Siggelkow
5.7.ao	Michelle Cordeiro
5.7.ap	Miranda Clayton
5.7.aq	Maggie Martineau
5.7.ar	Lia Hamelin
5.7.as	Haley Reap
5.7.at	James Lambert
5.7.au	Hollie Pocsai
5.7.av	Ayda Ghaffari
5.7.aw	Julia Schuurman
5.7.ax	Laura Carpenter
5.7.ay	Oliver Knutton
5.7.az	Liana Shaw
5.7.ba	Layla El-Dakhakhni
5.7.bb	Adrian Lee
5.7.bc	Laura Palumbo
5.7.bd	Mariel Rutherford
5.7.be	Vic Wojciechowska
5.7.bf	Ayeza Tahir
5.7.bg	Laura Sorbara
5.7.bh	Neve Doyle-Davis
5.7.bi	Lauren Glegg
5.7.bj	Ahmed Abdoulrazig
5.7.bk	Nick de Koning
5.7.bl	Sidney Drmay
5.7.bm	Trina Hetherington
5.7.bn	Jess Glegg
5.7.bo	Connor Bennett
5.7.bp	Nathan Todd
5.7.bq	Eric Kapteyn

5.7.br	Daniel Empringham
5.7.bs	Maryssa Barras
5.7.bt	Talia Hooper
5.7.bu	Rose Allain
5.7.bv	Catherine Skewes-Donaldson
5.7.bw	Emily Lauzon
5.7.bx	Deanna Allain
5.7.by	Amrit Randay
5.7.bz	Karen Huynh
5.7.ca	Annette Paiement
5.7.cb	Sebastian James
5.7.cc	Emily O'Halloran
5.7.cd	Shawna Stewart
5.7.ce	Julia Karpiuk
5.7.cf	India Morrish
5.7.cg	Francesca Morreale
5.7.ch	Sidney Szijarto
5.7.ci	Trish Holmes
5.7.cj	Brit Clarke
5.7.ck	Cam Heres
5.7.cl	Melissa Abaya-Ramos
5.7.cm	Courtney Darling
5.7.cn	Emma Rockwood
5.7.co	Maddie Brockbank
5.7.cp	Kate Melville
5.7.cq	Erin Yusek
5.7.cr	Kelsey Burns
5.7.cs	Ryan Riddell
5.7.ct	Grace Moran
5.7.cu	Clara Vuillier-Devillers
5.7.cv	Brooke Koslowski
5.7.cw	Tom Flood
5.7.cx	Kiera Boult
5.7.cy	Rebecca Katz

5.7.cz LeeAnna Moran

5.7.da Heather Gibson

5.7.db Andrea Kirkconnell

*5.7.dc Vince Soliveri

*5.7.dd Emily Hamel

*5.7.de Bethany Kenyon

*5.7.df Megan Myke

*5.7.dg Thomas Catchpole

*5.7.dh Leilani Rocha

*5.7.di Blake Bristol

*5.7.dj Alexandra Rideout

*5.7.dk Emrys MacLeod

*5.7.dl Molly Orr

*5.7.dm Genevieve Marrin

*5.7.dn Carly Billings

*5.7.do Nicole Mossop

*5.7.dp Camden Driedger

*5.7.dq Daniel Voloshin

*5.7.dr Phoebe Underhill

*5.7.ds Emily Jackson

*5.7.dt Candence Underhill

*5.7.du Jut Anta

*5.7.dv Jaime Land

*5.7.dw Carla Compagnoni

*5.7.dx Daniela Oliveira

*5.7.dy Shane Cabral

*5.7.dz Danica Evering

*5.7.ea Sierra Smith

*5.7.eb Vania Pagniello

*5.7.ec Melissa Robertson

*5.7.ed Austin Ruffo

*5.7.ee Arwen Ballentine

*5.7.ef Alexandra Henderson

*5.7.eg Olivia Bozzo

*5.7.eh Matt Carson

*5.7.ei Andrea Phair

*5.7.ej Tyler Mason

*5.7.ek Clara Rebello

*5.7.el Emily Jewer

*5.7.em Nicole Levaque

*5.7.en Katherine Walker-Jones

*5.7.eo Stevie Garnett

*5.7.ep Julia McGregor

*5.7.eq Olivia Mancini

*5.7.er Jocelyn Froese

*5.7.es Laura Katz

*5.7.et Kayla Crabtree

*5.7.eu Aisha Yusuf

*5.7.ev Matthew Crabtree

*5.7.ew Hamilton Harm Reduction Coalition

*5.7.ex Student Overdose Prevention and Education Network

*5.7.ey Alex Berze

*5.7.ez Emily Hart

*5.7.fa Sarah Jama

*5.7.fb Rebecca Morris-Miller

*5.7.fc Alisha Atri

*5.7.fd Austin Boyes

*5.7.fe Ester Chow

*5.7.ff Ian Walker

*5.7.fg Ryan Tse

*5.7.fh Anvita Gupta

*5.7.fi Claire Guyatt

*5.7.fj Janice Mancini

*5.7.fk Ben Robinson

*5.7.fl Ashley Sperry

*5.7.fm Elise Durie

*5.7.fn Stephen McCormcik

*5.7.fo Julio Rendeiro

*5.7.fp Paige Guyatt

*5.7.fq Olivia Hopen

*5.7.fr Sonjia McEachin

*5.7.fs Rachel Chaplow

*5.7.ft Josh Mitchell

*5.7.fu Hailey Dittrich

*5.7.fv Debbie Finn

*5.7.fw Tashiya Brown

*5.7.fx Hayley Pettis

*5.7.fy Mina Linklater

*5.7.fz Mitchell German

*5.7.ga Claudia Spadafora

*5.7.gb Anika Anand

*5.7.gc Erica Love-Jones

*5.7.gd Melanie Vair

*5.7.ge Alisa Gayle

*5.7.gf Joanna Aswani

*5.7.gg Karli Murdy

*5.7.gh Thomas Lewington

*5.7.gi Laura Konyndyk

*5.7.gj Emunah Woolf

*5.7.gk Amrit Randay

*5.7.gl Brandi Matthews

*5.7.gm Megan George

*5.7.gn Krista Browne

*5.7.go Natalie Hayes

*5.7.gp Spencer Blackwood

Recommendation: Be received.

5.8 Correspondence from the Ministry of Environment, Conservation and Parks respecting the amendments to the Conservation Authorities Act made in 2019/2020.

Recommendation: Be received.

*5.9 Correspondence from the Ministry of Northern Development, Mines, Natural Resources and Forestry respecting proposed amendments to the Crown Forest Sustainability Act, 1994, Professional Foresters Act, 2000 and the Public Lands Act,

Ministry of Northern Development, Mines, Natural Resources and Forestry included in the Supporting People and Businesses Act, 2021.
Recommendation: Be received and referred to the General Managers of Planning and Development and Public Works for appropriate action.

*5.10 Correspondence from Carlo Silvestri respecting ZAC-20-033, 1411, 1415 Upper Wellington St., Planning Committee meeting October 5, 2021, 9:30 a.m.

Recommendation: Be received and referred to the consideration of Item 7 of Planning Committee Report 21-015.

*5.11 Correspondence from the Ministry of the Environment, Conservation and Parks respecting EA Modernization: Clarifying the authority to change the classes of projects that follow a class environmental assessment process.

Recommendation: Be received and referred to the General Managers of Planning and Economic Development and Public Works for appropriate action.

6. COMMITTEE REPORTS

6.1 Public Works Committee Report 21-014 - October 4, 2021

6.2 Planning Committee Report 21-015 - October 5, 2021

6.3 General Issues Committee Report 21-019 - October 6, 2021

6.4 Audit, Finance and Administration Committee Report 21-015 - October 7, 2021

6.5 Emergency and Community Services Committee Report 21-010 - October 7, 2021

6.6 STAFF REPORTS

6.6.a Encampment Response Update (PED21188(a)/HSC20038(d)/LS21039) (City Wide)

7. MOTIONS

8. NOTICES OF MOTIONS

*8.1 “Rent Ready” Program

9. STATEMENT BY MEMBERS (non-debatable)

10. COUNCIL COMMUNICATION UPDATES

10.1 September 24, 2021 to October 7, 2021

11. PRIVATE AND CONFIDENTIAL

11.1 Closed Session Minutes - September 29, 2021

Pursuant to Section 9.1, Sub-section (b) and (f) of the City's Procedural By-law 21-021, as amended and Section 239(2), Sub-section (b) and (f) of *Ontario Municipal Act, 2001*, as amended, personal matters about an identifiable individual, including City or a local board employees and advice that is subject to solicitor-client privilege, including communications necessary for that purpose.

11.2 Grey Cup Update (PED18234(e)) (City Wide)

Pursuant to Section 9.1, Sub-section (k) of the City's Procedural By-law 21-021, as amended and Section 239(2), Sub-section (k) of *Ontario Municipal Act, 2001*, as amended, A position, plan, procedure, criteria or instruction to be applied to any negotiations carried on or to be carried on by or on behalf of the municipality or local board.

12. BY-LAWS AND CONFIRMING BY-LAW

12.1 171

To Amend By-law No. 01-218, as amended,

Being a By-law To Regulate On-Street Parking
Schedule 8 – No Parking
Schedule 12 – Permit Parking
Schedule 13 – No Stopping

Ward 3, 13

12.2 172

To Amend Zoning By-law No. 05-200, as Amended by By-law No. 18-232, Respecting Lands located at 90 Garner Road East (Formerly 70 Garner Road East), Ancaster

Ward 12

12.3 173

To Adopt:
Official Plan Amendment No. 30 to the Rural Hamilton Official Plan
Respecting:
Updates and Modifications to the Rural Hamilton Official Plan
City-Wide

12.4 174

To Adopt:
Official Plan Amendment No. 155 to the Urban Hamilton Official Plan
Respecting:
Updates and Modifications to the Urban Hamilton Official Plan
City-Wide

12.5 175

To amend Zoning By-law No. 05-200 with respect to lands located at 1411 and 1415 Upper Wellington Street, Hamilton

Ward 7

12.6 176

To Rename a Portion of Woodworth Drive, from West of Elgin Place to Calvin Street, and Calvin Street to Hatton Drive, to Woodworth Drive West, in the Former Town of Ancaster
Ward: 12

12.7 177

To Rename William Street to Vinegar Hill, in Waterdown, in the Former Town of Flamborough
Ward: 15

12.8 178

To Rename William Street to William Terrace North, in Freelton, in the Former Town of Flamborough
Ward: 13

12.9 179

To Rename Union Street to Pine Terrace Lane, in Lynden, in the Former Town of Flamborough
Ward: 12

12.10 180

To Rename a Portion of Sleepy Hollow Court, from the Existing Road Median to the Northerly End, to Sleepy Hollow Court North, in the Former Town of Dundas
Ward: 13

12.11 181

To Rename Margaret Street to Cheryl Lynn Lane, in Lynden, in the Former Town of Flamborough
Ward: 12

12.12 182

To Rename Bayview Avenue to Bayview Court North, in Greensville, in the Former Town of Flamborough

Ward: 13

12.13 183

To Amend Zoning By-law No. 87-57
Respecting Modifications and Updates to General Provisions and Administration in the former Town of Ancaster Zoning By-law
Ward: 12

12.14 184

To Amend Zoning By-law 3581-86 (Dundas)
Respecting Modifications and Updates to Administration, Enforcement and Penalties and a portion of the lands located at Part of 194 Pleasant Avenue
Ward: 11

12.15 185

To Amend Zoning By-law No. 90-145-Z (Flamborough), Respecting Modifications and Updates to Administration and Enforcement (Flamborough)
Ward: 15

12.16 186

To Amend Zoning By-law No. 464 (Glanbrook)
Respecting Modifications and Updates to Administration (Glanbrook)
Ward: 11

12.17 187

To Amend Zoning By-law No. 6593
Respecting Modifications and Updates to Administration and Violation in the former City of Hamilton Zoning By-law
Ward: 11

12.18 188

To Amend Zoning By-law 3692-92 (Stoney Creek)
Respecting Modifications and Updates to Administration and Enforcement and lands located at 57, 61, 63, 67 and 71 East Street
Ward: 11

12.19 189

To Amend By-law 05-200 Respecting Modifications and Updates to certain Definitions, General Provisions, Parking, Open Space and Parks Zones, Industrial Zones, Commercial and Mixed Use Zones, Transit Oriented Corridor Zones, Rural Zones, Utility Zones, Waterfront Zones, Special Exceptions, Holding Provisions and Mapping Changes for the City of Hamilton
Wards: City Wide

12.20 190

To Establish City of Hamilton Land
Described as Part 6 on Plan 62R-15449 and Parts 1, 2, 3, and 4 on Plan 62R-21611, save and except Parts 10, and 11 on Plan 62R-12459, Part 5 on Plan 62R-21611, Part 1 on Plan 62R-21136, and Parts 1 and 2 on Plan 62R-18932 as part of Aeropark Boulevard
Ward: 11

12.21 191

To Establish City of Hamilton Land
Described as Parts 3, 10, and 11 on Plan 62R-12459
as Part of Glanair Drive
Ward: 11

12.22 192

To Establish City of Hamilton Land
Described as Parts 3, 6, 9, 10, 12, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 38, 39, 40 and 41, Parts on Plan 62R-21643 as Part of Leavitt Boulevard.

To Establish City of Hamilton Land
Described as Parts 15, 16 and 19 on Plan 62R-21643 as part of the existing Dundas Street East
Ward: 15

12.23 193

Removal of Part Lot Control Respecting Lots 3 to 7 on Registered Plan No. 62M-1257, municipally known as 12, 16, 20, 24 and 28 Toffee Trail, Stoney Creek.
Ward: 5

12.24 194

To Rename a Portion of Woodworth Drive, from East of Elgin Place to Calvin Street, to Woodworth Drive East, in the Former Town of Ancaster
Ward: 12

12.25 195

To Amend By-law No. 01-218, as amended,
Being a By-law To Regulate On-Street Parking
Ward: 3, 7, 8, 9, 13

12.26 196

To Confirm Proceedings of Council

13. ADJOURNMENT

TAB 7

CITY OF HAMILTON

N O T I C E OF M O T I O N

EMERGENCY AND COMMUNITY SERVICES COMMITTEE: December 9, 2021

MOVED BY COUNCILLOR N. NANN……..…..……..……...

Comprehensive, Human-rights Based, Health-focused Housing Solutions for Residents Living Encamped across Hamilton

WHEREAS, the reality of unhoused residents living in encampments is a persistent reality across the City of Hamilton;

WHEREAS, these encampments have become increasingly visible throughout the pandemic;

WHEREAS, the number of unhoused residents who have been living encamped in Hamilton ranges between 80 to 140 people;

WHEREAS, encampments will persist until the City of Hamilton develops and implements a strategy to eliminate homelessness that addresses the unique health needs experienced by those who are encamped;

WHEREAS, the City's Housing & Homelessness Strategy is rooted in a solution-focused, person-centred approach and recognizes that best practices for solutions are the result of direct participation of those with lived experience of being unhoused;

WHEREAS, the largest gap in addressing the unique needs of many of those residents who have no other option than to live encamped rests in the lack of comprehensive, coordinated housing and health-based resources with a disproportionate impact on unhoused indigenous people, those unhoused residents living with disabilities, and those unhoused residents of other equity-seeking group that continue to face culture, structural and systemic barriers in accessing appropriate supportive housing; and

WHEREAS, an enforcement led response to the existence of encampments on city property does not solve homelessness, nor result in healing.

THEREFORE, BE IT RESOLVED:

(a) That City staff be directed to host solution-focused planning session(s) made up of representatives from the health sector, housing service providers, organizations that provide frontline support to the unhoused, people with lived

experiences of being unhoused and living in encampments, and other community stakeholders be convened to identify comprehensive, human-rights based, health-focused housing solutions to directly address the needs of those 80 to 140 unhoused residents living encamped in Hamilton;

(b) That any costs associated in hosting and facilitating the planning session(s) be covered through the existing Housing Services budget; and

(c) That staff report back the recommendations of these planning session(s) for Council's consideration to the Emergency Community Services Committee.

TAB 8

CITY OF HAMILTON

M O T I O N

Planning Committee: March 22, 2022

MOVED BY COUNCILLOR J. FARR ……..……..……

SECONDED BY COUNCILLOR ……..……

Enhanced Parks By-law - Encampment Enforcement

WHEREAS, on August 9, 2021, City Council voted to return to enforcing the prohibition of camping in our City parks and public places and through our Parks By-law. A prohibition no different than most other municipalities across the Province and by-law confirmed as "valid" in a 2021 Superior Court decision;

WHEREAS, the number of encampments more than doubled from approximately 20 to over 40 following the August 9, 2021 resolution, with many encampments entrenched in public parks for months.

WHEREAS, on September 15, 2021, City Council received Report PED21188/HSC20038(c), Encampment Response Update attached hereto as Appendix 'A', which outlined the Encampment Process implemented by City Staff;

WHEREAS, City Council is concerned that persons continue to camp in City parks in contravention of the Parks By-law and for extended periods in Hamilton while other neighbouring municipalities enforce the same by-law as a priority and within a few hours and few days. Like Hamilton, many of these municipalities include outreach assistance and safer options to encamped individuals as part of their enforcement process; and

WHEREAS, City Council believes Hamilton should not be the only City with a Parks By-law enforcement process that often results in both an increase in the number of encampments and an open-ended duration for encampments in parks or public spaces and should therefore facilitate the implementation of the Encampment Process to incorporate more precise timelines and direction into the Process consistent with similar processes implemented in other Ontario municipalities;

THEREFORE, BE IT RESOLVED:

That staff be directed to:

(i) complete their activities under the Encampment Process, including notifying the Hamilton Police Service that a Trespass Notice has been issued, within 12 to 72 hours after staff receive the first complaint regarding unauthorized camping in a City park or public place;

(ii) enforce the Encampment Process 7 days per week; and

(iii) report any staffing feasibility/service levels impacts to Council at their March 30, 2022 meeting.

Attachments:

Appendix ‘A’ - PED21188/HSC20038(c), Encampment Response Update

TAB 8a

INFORMATION REPORT

TO:	Chair and Members Emergency and Community Services Committee
COMMITTEE DATE:	September 9, 2021
SUBJECT/REPORT NO:	Encampment Response Update (PED21188/HSC20038(c)) (City Wide)
WARD(S) AFFECTED:	City Wide
PREPARED BY:	Monica Ciriello (905) 546-2424 Ext. 5809 Edward John (905) 546-2424 Ext. 4860
SUBMITTED BY: **SIGNATURE:**	Jason Thorne General Manager Planning and Economic Development Department
SUBMITTED BY: **SIGNATURE:**	Grace Mater General Manger Healthy and Safe Communities Department

COUNCIL DIRECTION

At its August 9, 2021 meeting, Council approved the repealing of the By-law Enforcement Protocol that permitted some individuals to camp in public spaces for up to 14 days. Further to that decision and the three-week winddown associated with it, as of August 30, 2021, the City returned to pre-protocol enforcement of City by-laws that prohibit camping on City property, including park areas.

INFORMATION

The COVID-19 pandemic highlighted and exacerbated ongoing systemic challenges and inequities across Canada as it relates to housing and homelessness. This has been demonstrated by the rise in, and visibility of, unsheltered homelessness and encampments throughout many Canadian cities. Person-centred strategies and

approaches are required to address urgent issues associated with supporting residents experiencing homelessness and living in encampments, while supporting long-term adequate housing solutions and broader community needs.

Encampment Process

With the repealing of the By-law Enforcement Protocol, staff will proceed with the following Encampment Process:

Step one
Complaints are received by Municipal Law Enforcement (MLE) regarding structures/tents in parks, road allowance and private property.

Step two
MLE attends, determines if there is a violation of a City By-law including the Parks Bylaw, seeks voluntary compliance and notifies Housing Outreach.

Step three
Housing Focused Street Outreach attends site and carries out the following:

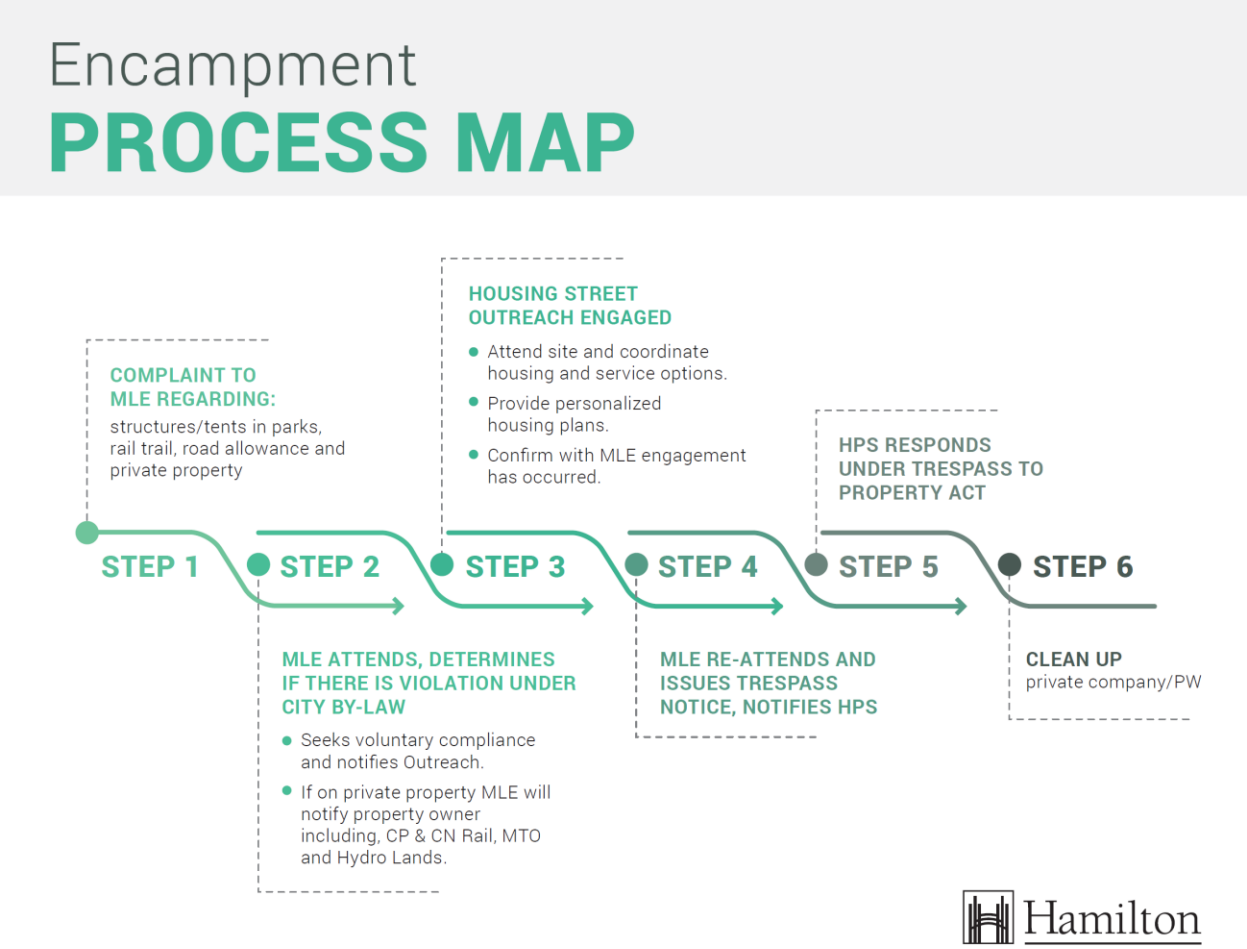
- Work from Housing Focused Street Outreach framework and within the context of Hamilton's Homeless Coordinated Access System
- Support individuals, families and groups, in order to promote connection to shelter, housing and the achievement of their optimal health and well-being
- Collaborative development of housing and service plans
- Assist individuals with obtaining necessary documents needed to obtain housing, including the completion of supportive and subsidized housing applications
- Collaborate and co-ordinate services with appropriate community and health agencies
- Crisis intervention
- Provide a summary of these actions (omitting any privileged and confidential information) in the form of an encampment assessment checklist to MLE pursuant to their request

Step four
MLE re-attends and issues a verbal trespass notice and notifies Hamilton Police Service (HPS).

Step five
Hamilton Police Service responds under the *Trespass to Property Act*, R.S.O. 1990, c. T.21

Step six

Park and Waste Divisions are contacted to coordinate a clean up.
Table 1



Encampment Response

The City of Hamilton's Licensing and Bylaw Services Division will be the first point of contact for complaints regarding structures and tents in parks, road allowances and private property. MLE Officers will attend to determine if there is a City Bylaw, including the Parks By-law 01-291 violation, which prohibits camping on City property, including park areas. MLE Officers will be responding to complaints proactively Monday to Friday and reactively on weekends along with other COVID-19 By-law and Provincial Regulation priorities. MLE Officers will attend, provide education and seek voluntary compliance under the City Bylaw, ticketing those who are unsheltered will not be a course of action. If determined to be private property, MLE Officers will notify the property owner, including CP & CN Rail and MTO. If voluntary compliance is not

achieved, MLE Officers will reach out to the Street Outreach team within the Housing Services Division and the Social Navigator Program.
The Housing Focused Street Outreach team will, if not already, attend the site and engage with those individuals currently unsheltered. Outreach will endeavor to provide an update summary of the site including identifying potential opportunities for connection to services and housing for those individuals, assess their needs and update MLE of the actions that have occurred.

MLE Officers will re-attend the location and, a verbal trespass notice would be issued to those contravening the bylaw. MLE will contact the Hamilton Police Service as the *Trespass to Property Act*, R.S.O. 1990, c. T.21 is a Provincial Act enforced by HPS. The City will continue to collaborate with HPS and the Social Navigator with regard to the service pathway. The last step will be to contact the Public Works Department (Parks, Streets, Waste Management) to coordinate a clean up.

Following the Council decision to repeal the By-law Enforcement Protocol, the City of Hamilton's Housing Services Division remains focused on supporting individuals experiencing homelessness in securing safe and affordable housing, by continuing to take an individualized approach to connect them to available supports.

Housing Services' Housing Focused Street Outreach Team connects with unsheltered individuals, regardless of their circumstances, to assess their immediate needs and housing preferences. The team completes common consent and intake forms for individuals not yet on the City's By-Name List (BNL), supports with benefit applications, unit viewings, harm reduction supplies, connections and referrals. As part of the City's homeless-servicing system, Outreach uses a shared system-wide database to stay connected to residents in encampments and outside of encampments in areas such as alleys, vacant lands, etc. Outreach services are provided to unsheltered residents across the geographic area of Hamilton Monday to Friday from 8:00 a.m. to 8:00 p.m. and Saturday and Sunday from 8:00 a.m. to 4:00 p.m. On a daily basis, the team undertakes progressive engagement to offer shelter or other available (and appropriate) space, works with individuals to find safe and supportive housing options, and works to address any barriers including a referral to our health partners.

During the COVID-19 pandemic, emergency shelter capacity has been expanded; however, occupancy pressures exist, particularly for women. Challenges remain in the access to available beds and in a number of instances capacity is not available. For example, length of stay in shelters has increased significantly during the pandemic and, with factors such as unaffordable costs of rent, housing availability has not kept pace with demand. Longer stays impact shelter bed turnover frequency, thus reducing the capacity of shelters to serve a higher volume of individuals. Outbreak status, availability of appropriate supports, staff turnover, shortages and burnout further impact the responsiveness of the system. When a move from encampment to emergency shelter

occurs, the City of Hamilton recognizes that this remains a temporary measure of accommodation until safe, secure and adequate housing is secured.
For individuals for whom emergency shelters are not an option, Housing Services' Outreach Team supports connection to health partners, works to address issues related to service restrictions, and continues progressive engagement towards accepting housing assistance. The City of Hamilton funds numerous agencies to assist in the housing of homeless individuals through funding streams such as the Federal Reaching Home program. City staff monitor, advise and assist these agencies in meeting predetermined targets through the homeless-serving sector's coordinated access system. From January 2020 to present, approximately 440 individuals and families have been housed by agencies funded by the City. Of the approximately 440 households housed, this includes people who have been unsheltered at one point during that time period. Since March 2020, more than 70 individuals were housed directly from encampments.

Outreach staff engage with every individual from a rights-based approach, ensuring dignity and confidentiality is maintained. On an ongoing basis, both Housing Services and agency staff work from a person-centred approach to engage with individuals in order to refer and make connections to appropriate support and resources. Referrals may include Intensive Case Management, Rapid Rehousing, Transitional or permanent supportive housing programs, in addition to housing affordability benefits, depending on individuals' needs, preferences and available resources. Increased engagement for the direct purpose of assessing effectiveness of approaches and appropriateness of available resources will continue to inform potential changes or adaptations to service and supports over time.

Coming Together to End Homelessness: Hamilton's Systems Planning Framework outlines a strategic local approach to preventing and ending homelessness, which must account for the systemic over-representation of Indigenous persons experiencing homelessness. The City is committed to ongoing coordination with Hamilton's Urban Indigenous Community to ensure that approaches to service coordination and provision are culturally appropriate, safe and built on principles of relationship, trust and informed consent. This includes ongoing discussion to achieve equitable access to resources including, for example, housing affordability benefits as they become available to support unsheltered individuals who identify as Indigenous. Through ongoing dialogue with the Indigenous community, the City aims to ensure appropriate referrals are consistently made from mainstream supports to Indigenous agencies, including at intake by City outreach staff.

The City continues to commit to permanent housing solutions by implementing increased prioritization of those in encampments for permanent housing and intensive case management support programs while continuing multi-sectoral discussions to enhance permanent housing with supports options. From September to December

2021, Housing Services Division, together with partner agencies, will undertake a housing campaign to maximize resources and collaboration to house 250 households experiencing homelessness.

Health and Safety Concerns

Due to the vulnerability and transience of encampment populations, health and safety concerns are present for both residents and City staff. COVID-19 exposure, verbal and sometimes physical aggressions have been noted at various sites. MLE Officers are not trained in outreach or mental health engagement techniques and therefore cannot offer support to address health and safety for encampment residents. This fact extends to include staff themselves, who navigate a challenging array of health and safety concerns when carrying out their duties. For example, Waste management staff have received numerous negative comments, which may be perceived as threats from residents, activists, advocates and the general public. Staff have been videotaped with postings on social media platforms such as Twitter and Facebook. Staff have been called repeatedly at all hours on their cell phone. In one instance a staff member was assaulted during clean up, resulting in injuries to the worker and charges being laid by Hamilton Police Service. As a result, the injured employee has yet to return to work.

There is a steady increase of incidents involving the Hamilton Fire Department and the Hamilton Police Service. Where emergency service response is needed, the City will respond swiftly with staff health and safety supports. Healthy and Safe Communities Department staff are better able to flag resident health and safety concerns to the appropriate support services for timely resolution.

The professional skillset required of Housing Service's Outreach staff facilitates mitigation of challenging behaviours, circumstances and establishment of positive rapport. Staff have been trained in non-violent crisis intervention, work only in pairs and are in constant communication with each other.

Budgetary Implications

Costs vary site to site; while staff time is not itemized by site, typical contractor costs for waste management average $15 K. Across all encampments, average monthly security costs have been approximately $23 K from October 2020 to July 2021.

Licensing and By-law Services

Council may direct Licensing and Bylaw Services (LBS) to enforce 7 days a week, inclusive of evenings and weekends. To oversee and coordinate the MLE officer response for encampments 7 days a week LBS requires 1 temporary FTE By-law Clerk at a cost of $26, 162 and 1 temporary FTE MLE Officer at a cost of $30, 795 from the

date of Council approval to December 31, 2021.These staff will assist in the collection of weekly stats on complaints received, locations of encampments, determine priority locations in collaboration with others on the Encampment Response Team, provide status updates as to the step each encampment site is in throughout the City. MLE Officers will be attending encampment sites in pairs, and one additional temporary FTE MLE Officer will allow for a timely proactive and reactive response to each encampment site 7 days a week. The Bylaw Clerk will provide administrative support to the MLE Officers and will ensure all tracking, scheduling, monitoring, entering areas of concern, preparation of orders, and dispatch to this team 7 days a week. The total cost would be $56, 958.

Emergency Services Responses

The Hamilton Fire Department has attended to an increasing number of incidents involving encampments and individuals experiencing homelessness over the last three years (54 incidents in 2019, 82 incidents in 2020, and 101 incidents to date in 2021). The majority of incidents in 2021 to date have involved burning (controlled) and property fires/explosion.

Hamilton Paramedic Service responded to 55 encampment related calls in four parks from October 1, 2020 to August 31, 2021. There has been a steady increase in paramedic service response to encampments in City parks in 2021, ranging from two in January to 15 in August.

The Hamilton Police Service indicated there were 502 events from October 1, 2020 to August 31, 2021 related to six known encampment locations, but not necessarily due to the presence of an encampment. These incidents include events related to trespassing, assist (ambulance & fire), and other events requiring police service response (i.e. assault, harassment, protests, etc.)

Government Outreach

There remains an ongoing need to align provincial health and housing and homelessness investments to enable service managers to provide permanent housing with supports for high acuity chronically homeless individuals living in shelters and encampments. Strategic investment and partnership between Ontario Health West and City of Hamilton can demonstrably reduce chronic homelessness in Hamilton and the reliance on emergency hospital resources for those with the most complex, co-occurring needs.

Staff are actively pursuing funding opportunities from higher levels of government to address these needs. Specifically, the Ministry of Health (Ontario), Associate Minister of Mental Health and Addictions and the Ministry of Municipal Affairs and Housing

(Ontario) in addition to the equivalent Ministries federally such as Health, Housing, Infrastructure and Communities, and Families, Children and Social Development. Staff have proposed a pilot project to the Government of Ontario in order to address the needs of high-acuity individuals in Hamilton, this pilot outlines the resources required to take immediate action.

The proposed pilot would include 40 new units of supportive housing to address the needs of higher acuity individuals and continuing existing outreach activities will address needs in a new and improved way. The total funding necessary to undertake this development is $2,440,000. The request for on-going provincial operational funding is $1,940,000.

Staff have been using forums like the Association of Municipalities of Ontario (AMO), Federation of Canadian Municipalities (FCM) and Ontario Big City Mayors, of which Hamilton is a member, to further advocacy and align objectives in voicing our concerns about the lack of funding from higher levels of government to address these immediate needs. AMO, FCM and Ontario Big City Mayors are focused on improving supports for mental health. Ontario Big City Mayors has provided recommendations to support and complement the Province's Road to Wellness plan which seeks to improve mental health and addictions services across Ontario. The proposed recommendations and desire to collaborate demonstrate the need for municipalities to work with other levels of government and local service providers to ensure residents can access the help they need, where and when they need it.

APPENDICES AND SCHEDULES ATTACHED

None

TAB 9

GENERAL ISSUES COMMITTEE
MINUTES 23-017

9:30 a.m.
May 17, 2023
Council Chambers, City Hall, 2nd Floor
71 Main Street West, Hamilton, Ontario

Present: Mayor A. Horwath
Deputy Mayor E. Pauls (Chair)
Councillors J. Beattie, C. Cassar, B. Clark, M. Francis, T. Hwang, T. Jackson, C. Kroetsch, T. McMeekin, N. Nann, M. Spadafora, M. Tadeson, A. Wilson, M. Wilson

Absent: Councillor J. P. Danko – Personal

THE FOLLOWING ITEMS WERE REFERRED TO COUNCIL FOR CONSIDERATION:

1. Proposed Encampment Protocol (HSC20036(f) / PED21188(c)) (Item 8.1)

(i) (A. Wilson/Nann)
That sub-section (e) of Report HSC20036(f) / PED21188(c), respecting Proposed Encampment Protocol, ***be amended***, with the inclusion of a new sub-section (f), as follows:

(e) That staff be directed to work with stakeholders to:
- i. Address washrooms, showers, and access to drinking water;
- ii. Integrate of peer and Indigenous supports into encampment response;
- iii. ***Develop a task force or committee, comprised of City staff, community stakeholders, and people with lived experience to advise on the development and policy of encampment response and appeals process;***
- iv. Report back to the General Issues Committee with recommendations and required resourcing; and,

(f) That prior to May 24, 2023 Council meeting staff incorporate - a process to inform residents of nearby compliant sites in the case of any enforcement measures (voluntary compliance notices, etc.), ensuring no residents are facing enforcement measures without being made aware of sanctioned and permitted sites where they can go - into the Proposed

Encampment Protocol attached as Appendix "A" to Report HSC20038(f) / PED21188(c).

Result: Vote on Sub-Section (e) and (f) of Report HSC20036(f) / PED21188(c), respecting Proposed Encampment Protocol, as *Amended* CARRIED by a vote of 12 to 2, as follows:

Absent	-	Mayor Andrea Horwath	
Yes	-	Ward 1	Councillor Maureen Wilson
Yes	-	Ward 2	Councillor Cameron Kroetsch
Yes	-	Ward 3	Councillor Nrinder Nann
Yes	-	Ward 4	Councillor Tammy Hwang
No	-	Ward 5	Councillor Matt Francis
No	-	Ward 6	Councillor Tom Jackson
Yes	-	Ward 7	Councillor Esther Pauls
Absent	-	Ward 8	Councillor J. P. Danko
Yes	-	Ward 9	Councillor Brad Clark
Yes	-	Ward 10	Councillor Jeff Beattie
Yes	-	Ward 11	Councillor Mark Tadeson
Yes	-	Ward 12	Councillor Craig Cassar
Yes	-	Ward 13	Councillor Alex Wilson
Yes	-	Ward 14	Councillor Mike Spadafora
Yes	-	Ward 15	Councillor Ted McMeekin

(ii) (Kroetsch/A. Wilson)

That sub-section (c) to Report HSC20036(f) / PED21188(c), respecting Proposed Encampment Protocol, ***be amended***, as follows:

(c) That, ~~***following Council ratification,***~~ staff be directed to make the Proposed Encampment Protocol attached as Appendix "A" to Report HSC20038(f) / PED21188(c) available for public comment ***(including written comments) until June 30, 2023***, ~~***and that staff monitor the implementation of the protocol,***~~ and that staff report back with a final recommended protocol at the General Issues Committee on August 2023.

Result: Vote on Sub-Section (c) of Report HSC20036(f) / PED21188(c), respecting Proposed Encampment Protocol, as *Amended* CARRIED by a vote of 13 to 1, as follows:

Yes	-	Mayor Andrea Horwath	
Yes	-	Ward 1	Councillor Maureen Wilson
Yes	-	Ward 2	Councillor Cameron Kroetsch
Yes	-	Ward 3	Councillor Nrinder Nann
Yes	-	Ward 4	Councillor Tammy Hwang
Yes	-	Ward 5	Councillor Matt Francis

Yes	-	Ward 6	Councillor Tom Jackson
Yes	-	Ward 7	Councillor Esther Pauls
Absent	-	Ward 8	Councillor J. P. Danko
Yes	-	Ward 9	Councillor Brad Clark
No	-	Ward 10	Councillor Jeff Beattie
Yes	-	Ward 11	Councillor Mark Tadeson
Absent	-	Ward 12	Councillor Craig Cassar
Yes	-	Ward 13	Councillor Alex Wilson
Yes	-	Ward 14	Councillor Mike Spadafora
Yes	-	Ward 15	Councillor Ted McMeekin

(iii) (A. Wilson/M. Wilson)

(d) That staff be directed to conduct a scan of jurisdictions that currently operate sanctioned encampments and further research/consultation as required and bring back options regarding operating models, parameters and criteria for site identification and potential sites with the goal of incorporating sanctioned sites into a new encampment protocol once site(s) and operating model are approved by Council;

Result: Vote on Sub-Section (d) of Report HSC20036(f) / PED21188(c), respecting Proposed Encampment Protocol, CARRIED by a vote of 8 to 5, as follows:

Yes	-	Mayor Andrea Horwath	
Yes	-	Ward 1	Councillor Maureen Wilson
Yes	-	Ward 2	Councillor Cameron Kroetsch
Yes	-	Ward 3	Councillor Nrinder Nann
Yes	-	Ward 4	Councillor Tammy Hwang
No	-	Ward 5	Councillor Matt Francis
No	-	Ward 6	Councillor Tom Jackson
No	-	Ward 7	Councillor Esther Pauls
Absent	-	Ward 8	Councillor J. P. Danko
No	-	Ward 9	Councillor Brad Clark
Absent	-	Ward 10	Councillor Jeff Beattie
Yes	-	Ward 11	Councillor Mark Tadeson
Absent	-	Ward 12	Councillor Craig Cassar
Yes	-	Ward 13	Councillor Alex Wilson
No	-	Ward 14	Councillor Mike Spadafora
Yes	-	Ward 15	Councillor Ted McMeekin

2. Dundas Business Improvement Area (BIA) Revised Board of Management (PED23109) (Ward 13) (Item 9.1)

(A. Wilson/Hwang)
That the following individuals be appointed to the Dundas Business Improvement Area (BIA) Board of Management for the 2022-2026 term:

(a) Jennifer Hayes, Jax Sweet Shoppe;
(b) Lily Zoghaib, Urban Vine;
(c) Dave Maciulis, Red Door Cucina;
(d) Melanie Barlow, Dundas Community Services;
(e) Donna Cole, The Kitchen Witch.

Result: MOTION, CARRIED by a vote of 13 to 0, as follows:

Yes	-	Mayor Andrea Horwath	
Yes	-	Ward 1	Councillor Maureen Wilson
Yes	-	Ward 2	Councillor Cameron Kroetsch
Yes	-	Ward 3	Councillor Nrinder Nann
Yes	-	Ward 4	Councillor Tammy Hwang
Yes	-	Ward 5	Councillor Matt Francis
Yes	-	Ward 6	Councillor Tom Jackson
Yes	-	Ward 7	Councillor Esther Pauls
Absent	-	Ward 8	Councillor J. P. Danko
Yes	-	Ward 9	Councillor Brad Clark
Absent	-	Ward 10	Councillor Jeff Beattie
Yes	-	Ward 11	Councillor Mark Tadeson
Absent	-	Ward 12	Councillor Craig Cassar
Yes	-	Ward 13	Councillor Alex Wilson
Yes	-	Ward 14	Councillor Mike Spadafora
Yes	-	Ward 15	Councillor Ted McMeekin

3. Dundas Business Improvement Area (BIA) Proposed Budget and Schedule of Payments (PED23110) (Ward 13) (Item 10.1)

(A. Wilson/M. Wilson)
(a) That the 2023 Operating Budget for the Dundas Business Improvement Area, attached as Appendix “A” to Report PED23110, in the amount of $268,214.00 be approved;

(b) That the levy portion of the Operating Budget for the Dundas Business Improvement Area (BIA) in the amount of $178,880.00 be approved;

(c) That the General Manager of Finance and Corporate Services be hereby authorized and directed to prepare the requisite By-law pursuant to

Section 208, The *Municipal Act, 2001*, to levy the 2023 Budget as referenced in Recommendation of Report PED23110; and,

(d) That the following schedule of payments for 2023 Operating Budget for the Dundas Business Improvement Area (BIA) be approved:

(i)	February	$89,440.00
(ii)	June	$89,440.00

Note: Assessment appeals may be deducted from the levy payments.

Result: MOTION, CARRIED by a vote of 13 to 0, as follows:

Yes	-	Mayor Andrea Horwath	
Yes	-	Ward 1	Councillor Maureen Wilson
Yes	-	Ward 2	Councillor Cameron Kroetsch
Yes	-	Ward 3	Councillor Nrinder Nann
Yes	-	Ward 4	Councillor Tammy Hwang
Yes	-	Ward 5	Councillor Matt Francis
Yes	-	Ward 6	Councillor Tom Jackson
Yes	-	Ward 7	Councillor Esther Pauls
Absent	-	Ward 8	Councillor J. P. Danko
Yes	-	Ward 9	Councillor Brad Clark
Absent	-	Ward 10	Councillor Jeff Beattie
Yes	-	Ward 11	Councillor Mark Tadeson
Absent	-	Ward 12	Councillor Craig Cassar
Yes	-	Ward 13	Councillor Alex Wilson
Yes	-	Ward 14	Councillor Mike Spadafora
Yes	-	Ward 15	Councillor Ted McMeekin

4. Airport Sub-Committee Report 23-001 - April 27, 2023 (Item 10.2)

(Hwang/Tadeson)

(a) Appointment of Chair and Vice-Chair (Item 1)

That Councillor M. Tadeson be appointed as Co-Chair of the Airport Sub Committee on a rotating basis for the term of 2022-2026.

(b) 2023-2024 John C. Munro Hamilton International Airport – City of Hamilton Joint Marketing Incentives (PED23121) (City Wide) (Item 10.1)

That the City of Hamilton approve and allocate $100K, from the Airport Joint Marketing Reserve Fund No. 112217 as the City's contribution to the 2023-2024 John C. Munro Hamilton International Airport – City of Hamilton Joint Marketing Initiatives outlined in Report PED23121.

(c) Airport Lease – Status Update (PED19084(g)) (City Wide) (Item 14.1)

That Report PED19084(g) and Appendix 'A' to Report PED19084(g), respecting Airport Lease – Status Update, be received and remain confidential.

Result: MOTION, CARRIED by a vote of 13 to 0, as follows:

Yes	-	Mayor Andrea Horwath	
Yes	-	Ward 1	Councillor Maureen Wilson
Yes	-	Ward 2	Councillor Cameron Kroetsch
Yes	-	Ward 3	Councillor Nrinder Nann
Yes	-	Ward 4	Councillor Tammy Hwang
Yes	-	Ward 5	Councillor Matt Francis
Yes	-	Ward 6	Councillor Tom Jackson
Yes	-	Ward 7	Councillor Esther Pauls
Absent	-	Ward 8	Councillor J. P. Danko
Yes	-	Ward 9	Councillor Brad Clark
Absent	-	Ward 10	Councillor Jeff Beattie
Yes	-	Ward 11	Councillor Mark Tadeson
Absent	-	Ward 12	Councillor Craig Cassar
Yes	-	Ward 13	Councillor Alex Wilson
Yes	-	Ward 14	Councillor Mike Spadafora
Yes	-	Ward 15	Councillor Ted McMeekin

5. 2023 Tax Policies and Area Rating (FCS23049) (City Wide) (Item 10.3)

(Nann/Jackson)

(a) That the following optional property classes be continued for the 2023 taxation year:

(i) Parking Lot and Vacant Land;
(ii) Large Industrial;

(b) That, the following final tax ratios be established for the 2023 taxation year:

(i)	Residential	1.0000
(ii)	Multi-Residential	2.2174
(iii)	New Multi-Residential	1.0000
(iv)	Commercial	1.9800
(v)	Parking Lot and Vacant Land	1.9800
(vi)	Industrial	3.1025
(vii)	Large Industrial	3.6381
(viii)	Pipeline	1.7947

(ix)	Farm	0.1767
(x)	Managed Forest	0.2500
(xi)	Landfills	2.9696

(c) That the following tax reductions be established for the 2023 taxation year:

(i)	Farmland awaiting development (1st Subclass)	25%
(ii)	Farmland awaiting development (2nd Subclass)	0%
(iii)	Excess land Subclass (Residual Commercial)	0%
(iv)	Excess land Subclass (Residual Industrial)	0%
(v)	Vacant land Subclass (Residual Industrial)	0%
(vi)	Excess land Subclass (Large Industrial)	0%

(d) That the Deferral of Tax Increases for Seniors and Low Income Persons with Disabilities Program (Deferral of Tax Increases Program) be continued for the 2023 taxation year;

(e) That the Full Tax Deferral Program for Seniors and Low Income Persons with Disabilities Program (Full Tax Deferral Program) be continued for the 2023 taxation year;

(f) That the Seniors' (65+) Tax Rebate Program be continued for the 2023 taxation year;

(g) That the 40% Tax Rebate for eligible charities and similar organizations be continued for the 2023 taxation year;

(h) That, for the 2023 taxation year, the Area Rated Levies be approved as identified in Appendix "A" to Report FCS23049, "2023 Tax Policies and Area Rating", attached hereto; and,

(i) That the City Solicitor be authorized and directed to prepare all necessary by-laws, for Council approval, for the purposes of establishing the tax policies and tax rates for the 2023 taxation year.

Result: MOTION, CARRIED by a vote of 12 to 0, as follows:

Yes	-	Mayor Andrea Horwath	
Yes	-	Ward 1	Councillor Maureen Wilson
Yes	-	Ward 2	Councillor Cameron Kroetsch
Yes	-	Ward 3	Councillor Nrinder Nann
Yes	-	Ward 4	Councillor Tammy Hwang
Absent	-	Ward 5	Councillor Matt Francis
Yes	-	Ward 6	Councillor Tom Jackson
Yes	-	Ward 7	Councillor Esther Pauls
Absent	-	Ward 8	Councillor J. P. Danko

Yes	-	Ward 9	Councillor Brad Clark
Absent	-	Ward 10	Councillor Jeff Beattie
Yes	-	Ward 11	Councillor Mark Tadeson
Absent	-	Ward 12	Councillor Craig Cassar
Yes	-	Ward 13	Councillor Alex Wilson
Yes	-	Ward 14	Councillor Mike Spadafora
Yes	-	Ward 15	Councillor Ted McMeekin

6. Pier 8 Animation Q4 2023 (PED23116) (City Wide) (Item 10.4)

(Kroetsch/Hwang)

(a) That up to $125,000, to be funded from the Economic Development Initiatives Capital Project 3621708900, be approved, to support special public programming and animation of Pier 8 during the month of November 2023; and,

(b) That the General Manager of Planning and Economic Development be authorized to enter into the necessary agreements to execute the special programming and animation, including securing a temporary art installation.

Result: MOTION, CARRIED by a vote of 11 to 0, as follows:

Yes	-	Mayor Andrea Horwath	
Yes	-	Ward 1	Councillor Maureen Wilson
Yes	-	Ward 2	Councillor Cameron Kroetsch
Yes	-	Ward 3	Councillor Nrinder Nann
Yes	-	Ward 4	Councillor Tammy Hwang
Absent	-	Ward 5	Councillor Matt Francis
Yes	-	Ward 6	Councillor Tom Jackson
Yes	-	Ward 7	Councillor Esther Pauls
Absent	-	Ward 8	Councillor J. P. Danko
Yes	-	Ward 9	Councillor Brad Clark
Absent	-	Ward 10	Councillor Jeff Beattie
Yes	-	Ward 11	Councillor Mark Tadeson
Absent	-	Ward 12	Councillor Craig Cassar
Yes	-	Ward 13	Councillor Alex Wilson
Yes	-	Ward 14	Councillor Mike Spadafora
Conflict	-	Ward 15	Councillor Ted McMeekin

7. Advisory Committee for Persons with Disabilities (ACPD) Report 23-005 - May 9, 2023 (Item 10.5)

(Tadeson/A. Wilson)

(a) Advisory Committee for Persons with Disabilities' "Ability First" Accessibility Fair, September 28, 2023 (Item 12.2)

WHEREAS, the Advisory Committee for Persons with Disabilities has received permission to begin organizing the “Ability First” Accessibility Fair annually;

WHEREAS, the date of the 2023 “Ability First” Accessibility Fair is scheduled for September 28th;

WHEREAS, the proposed budget for “Ability First” is an upset limit of $5811.67 to be funded from the Advisory Committee for Persons with Disabilities’ reserve; and,

WHEREAS, in order to organize and promote the event, Advisory Committee for Persons with Disabilities’ members and volunteers will be required to contact City of Hamilton staff, outside agencies and media to arrange attendance, but will exclude official media releases which will still need to be approved by Committee and Council.

THEREFORE, BE IT RESOLVED:

(i) That the Advisory Committee for Persons with Disabilities “Ability First” Accessibility Fair, to be held on Thursday September the 28th, 2023 on the Forecourt of City Hall, be approved;

(ii) That the Advisory Committee for Persons with Disabilities “Ability First” Accessibility Fair budget with an upset limit of $5811.67, attached as Appendix “A” to the Advisory Committee for Persons with Disabilities Report 23-005, to be funded from the ACPD Reserve Fund (#112212), be approved; and

(iii) That the Advisory Committee for Persons with Disabilities’ members and volunteers be permitted to contact City of Hamilton staff (when appropriate and available), outside agencies and media in order to organize, promote and arrange attendance to the event.

Result: MOTION, CARRIED by a vote of 12 to 0, as follows:

Yes	-	Mayor Andrea Horwath	
Yes	-	Ward 1	Councillor Maureen Wilson
Yes	-	Ward 2	Councillor Cameron Kroetsch
Yes	-	Ward 3	Councillor Nrinder Nann
Yes	-	Ward 4	Councillor Tammy Hwang
Absent	-	Ward 5	Councillor Matt Francis
Yes	-	Ward 6	Councillor Tom Jackson
Yes	-	Ward 7	Councillor Esther Pauls
Absent	-	Ward 8	Councillor J. P. Danko

Yes	-	Ward 9	Councillor Brad Clark
Absent	-	Ward 10	Councillor Jeff Beattie
Yes	-	Ward 11	Councillor Mark Tadeson
Absent	-	Ward 12	Councillor Craig Cassar
Yes	-	Ward 13	Councillor Alex Wilson
Yes	-	Ward 14	Councillor Mike Spadafora
Yes	-	Ward 15	Councillor Ted McMeekin

8. Facility Naming Sub-Committee Report 23-001 - May 11, 2023 (Added Item 10.6)

(M. Wilson/A. Wilson)

(a) Appointment of Chair and Vice-Chair (Item 1)

(i) That Councillor C. Cassar be appointed as Chair of the Facility Naming Sub-Committee for the 2022-2026 term.

(ii) That Councillor M. Francis be appointed as Vice-Chair of the Facility Naming Sub-Committee for the 2022-2026 term.

(b) Renaming of Ryerson Recreation Centre (HSC23031) (Ward 1) (Added Item 10.2)

(i) That the Ryerson Recreation Centre at 251 Duke Street be renamed “Kanétskare” (pronounced Ga-nét-sga-re, a Mohawk term meaning Bay or Inlet) Recreation Centre as it meets the guidelines as set out in Section 4(b)(i) of the City of Hamilton Municipal Property and Building Naming Policy;

(ii) That a budget of $20K funded from the City’s Tax Stabilization Reserve, (110046) be established for costs associated with the removal, repair, preparation and installation of new facility signage at the 251 Duke Street site;

(iii) That the Mayor and City Clerk be authorized and directed to execute any required agreement(s) and ancillary documents, with such terms and conditions in a form satisfactory to the City Solicitor; and,

(iv) That the renaming of Ryerson Recreation Centre to Kanétskare Recreation Centre be considered complete and removed from the Facility Naming Sub Committee Outstanding Business List.

Result: MOTION, CARRIED by a vote of 13 to 0, as follows:

Yes	-	Mayor Andrea Horwath

Yes	-	Ward 1	Councillor Maureen Wilson
Yes	-	Ward 2	Councillor Cameron Kroetsch
Yes	-	Ward 3	Councillor Nrinder Nann
Yes	-	Ward 4	Councillor Tammy Hwang
Yes	-	Ward 5	Councillor Matt Francis
Yes	-	Ward 6	Councillor Tom Jackson
Yes	-	Ward 7	Councillor Esther Pauls
Absent	-	Ward 8	Councillor J. P. Danko
Yes	-	Ward 9	Councillor Brad Clark
Absent	-	Ward 10	Councillor Jeff Beattie
Yes	-	Ward 11	Councillor Mark Tadeson
Absent	-	Ward 12	Councillor Craig Cassar
Yes	-	Ward 13	Councillor Alex Wilson
Yes	-	Ward 14	Councillor Mike Spadafora
Yes	-	Ward 15	Councillor Ted McMeekin

9. Advocate Registry for Homelessness (Added Item 11.1)

(Francis/Hwang)
WHEREAS, the compassionate nature of advocates and Council members compels us to seek innovative solutions to address the challenges faced by individuals experiencing homelessness;

WHEREAS, recognizing Council members play a vital role in leading by example and demonstrating compassion for individuals experiencing homelessness, this too will be extended to members of Council to participate if desired

WHEREAS, the voluntary nature of the registry allows participants the flexibility to opt out of the program at any time, ensuring that it respects the preferences and needs of both hosts and houseless individuals;

WHEREAS, the creation of a registry aligns with our city's commitment to foster a compassionate and inclusive community that values the dignity and well-being of all its residents;

WHEREAS, the registry program offers a practical and cost-effective approach to expanding available housing options for individuals experiencing homelessness;

WHEREAS, other municipalities like Oshawa have championed community led programs like Spirit in Service Sponsorship Program that is modelled after Refugee Sponsorship Programs and providing an opportunity for residents to contribute to solution building;

THEREFORE BE IT RESOLVED:

That staff be directed to determine the feasibility, financial impacts to the municipality, and potential liability of a registry for advocates, members of Council, and residents to voluntarily add their name to host a person experiencing homelessness as identified by housing support staff, and report back to the General Issues Committee.

Result: MOTION, CARRIED by a vote of 10 to 3, as follows:

Yes	-	Mayor Andrea Horwath	
No	-	Ward 1	Councillor Maureen Wilson
No	-	Ward 2	Councillor Cameron Kroetsch
Yes	-	Ward 3	Councillor Nrinder Nann
Yes	-	Ward 4	Councillor Tammy Hwang
Yes	-	Ward 5	Councillor Matt Francis
Yes	-	Ward 6	Councillor Tom Jackson
Yes	-	Ward 7	Councillor Esther Pauls
Absent	-	Ward 8	Councillor J. P. Danko
Yes	-	Ward 9	Councillor Brad Clark
Absent	-	Ward 10	Councillor Jeff Beattie
Yes	-	Ward 11	Councillor Mark Tadeson
Absent	-	Ward 12	Councillor Craig Cassar
No	-	Ward 13	Councillor Alex Wilson
Yes	-	Ward 14	Councillor Mike Spadafora
Yes	-	Ward 15	Councillor Ted McMeekin

10. Encampment Litigation Update (LS20023(g)) (City Wide) – REVISED (Item 14.1)

(Kroetsch/Spadafora)
That Report LS20023(g), respecting Encampment Litigation Report, be received and remain confidential.

CARRIED

11. Safety and Security at City Hall (No Copy) (Added Item 14.2)

(Hwang/Clark)
That the verbal update respecting Safety and Security at City Hall, be received and remain confidential.

CARRIED

FOR INFORMATION:

(a) APPROVAL OF AGENDA (Item 2)

The Committee Clerk advised of the following changes to the agenda:

5. COMMUNICATIONS

5.1 Correspondence respecting Item 8.1, Proposed Encampment Protocol (HSC20036(f) / PED21188(c)) (Item 8.1), from the following individual:

(b) Keeping Six and HAMSMaRT

Recommendation: Be received and referred to the consideration of Item 8.1.

6. DELEGATION REQUESTS

6.2 Delegation Requests respecting Item 8.1, Proposed Encampment Protocol (HSC20036(f) / PED21188(c)), from the from the following individuals (For today's meeting):

(a) Gessie Stearns (In Person)

(b) Lisa Nussey (In Person)

(c) Jammy Lo, Keeping Six (In Person)

(d) Leon Blaze (In Person)

10. DISCUSSION ITEMS

10.6 Facility Naming Sub-Committee Report 23-001 - May 11, 2023

14. PRIVATE AND CONFIDENTIAL

14.1 Encampment Litigation Update (LS20023(g)) (City Wide) – REVISED

14.2 Safety and Security at City Hall (No Copy)

(Francis/Hwang)
That the agenda for the May 17, 2023 General Issues Committee meeting, be approved, as amended.

Result: MOTION, CARRIED by a vote of 12 to 0, as follows:

Yes	-	Mayor Andrea Horwath	
Yes	-	Ward 1	Councillor Maureen Wilson
Yes	-	Ward 2	Councillor Cameron Kroetsch
Absent	-	Ward 3	Councillor Nrinder Nann

Yes	-	Ward 4	Councillor Tammy Hwang
Yes	-	Ward 5	Councillor Matt Francis
Absent	-	Ward 6	Councillor Tom Jackson
Yes	-	Ward 7	Councillor Esther Pauls
Absent	-	Ward 8	Councillor J. P. Danko
Yes	-	Ward 9	Councillor Brad Clark
Yes	-	Ward 10	Councillor Jeff Beattie
Yes	-	Ward 11	Councillor Mark Tadeson
Yes	-	Ward 12	Councillor Craig Cassar
Absent	-	Ward 13	Councillor Alex Wilson
Yes	-	Ward 14	Councillor Mike Spadafora
Yes	-	Ward 15	Councillor Ted McMeekin

(b) DECLARATIONS OF INTEREST (Item 3)

Councillor T. McMeekin declared a non-disqualifying interest, however, opted to vote with a conflict to Report PED23116, respecting Pier 8 Animation Q4 2023 as his daughter is employed by the City of Hamilton as an animator.

(c) APPROVAL OF MINUTES OF PREVIOUS MEETINGS (Item 4)

(Francis/Spadafora)
That the following Minutes of the General Issues Committee be approved, as presented:

(i) May 3, 2023 (Item 4.1)
(ii) May 5, 2023 – Special GIC (Item 4.2)

Result: MOTION, CARRIED by a vote of 12 to 0, as follows:

Yes	-	Mayor Andrea Horwath	
Yes	-	Ward 1	Councillor Maureen Wilson
Yes	-	Ward 2	Councillor Cameron Kroetsch
Absent	-	Ward 3	Councillor Nrinder Nann
Yes	-	Ward 4	Councillor Tammy Hwang
Yes	-	Ward 5	Councillor Matt Francis
Absent	-	Ward 6	Councillor Tom Jackson
Yes	-	Ward 7	Councillor Esther Pauls
Absent	-	Ward 8	Councillor J. P. Danko
Yes	-	Ward 9	Councillor Brad Clark
Yes	-	Ward 10	Councillor Jeff Beattie
Yes	-	Ward 11	Councillor Mark Tadeson
Yes	-	Ward 12	Councillor Craig Cassar
Absent	-	Ward 13	Councillor Alex Wilson
Yes	-	Ward 14	Councillor Mike Spadafora
Yes	-	Ward 15	Councillor Ted McMeekin

(d) COMMUNICATIONS (Item 5)

(M. Wilson/Horwath)
That the following Communications Items, be approved, as presented:

(i) Correspondence respecting Item 8.1, Report HSC20036(f) / PED21188(c), Proposed Encampment Protocol, from the following individuals (Item 5.1):

(1) Brooke Beney (Item 5.1(a))
(2) Keeping Six and HAMSMaRT (Added Item 5.1(b))

Recommendation: Be received and referred to consideration of Item 8.1.

(ii) Correspondence from Grant Bivol, Clerk, Niagara Peninsula Conservation Authority (NPCA) respecting the Financial Statements of the NPCA for the year ended December 31, 2022 (Item 5.2).

Recommendation: Be received.

Result: MOTION, CARRIED by a vote of 12 to 0, as follows:

Yes	-	Mayor Andrea Horwath	
Yes	-	Ward 1	Councillor Maureen Wilson
Yes	-	Ward 2	Councillor Cameron Kroetsch
Absent	-	Ward 3	Councillor Nrinder Nann
Yes	-	Ward 4	Councillor Tammy Hwang
Yes	-	Ward 5	Councillor Matt Francis
Absent	-	Ward 6	Councillor Tom Jackson
Yes	-	Ward 7	Councillor Esther Pauls
Absent	-	Ward 8	Councillor J. P. Danko
Yes	-	Ward 9	Councillor Brad Clark
Yes	-	Ward 10	Councillor Jeff Beattie
Yes	-	Ward 11	Councillor Mark Tadeson
Yes	-	Ward 12	Councillor Craig Cassar
Absent	-	Ward 13	Councillor Alex Wilson
Yes	-	Ward 14	Councillor Mike Spadafora
Yes	-	Ward 15	Councillor Ted McMeekin

(e) DELEGATION REQUESTS (Item 6)

(i) Hafeez Hussain, respecting more about my experience on Unconscious Bias and EDI and how as a resident it is hard to navigate the city of Hamilton to address these matters to management (Virtually) (For a future meeting) (Item 6.1)

(Nann/Clark)
That the delegation request from Hafeez Hussain, respecting more about my experience on Unconscious Bias and EDI and how as a resident it is hard to navigate the city of Hamilton to address these matters to management, be approved for a future meeting.

Result: MOTION, CARRIED by a vote of 13 to 0, as follows:

Yes	-	Mayor Andrea Horwath	
Yes	-	Ward 1	Councillor Maureen Wilson
Yes	-	Ward 2	Councillor Cameron Kroetsch
Yes	-	Ward 3	Councillor Nrinder Nann
Yes	-	Ward 4	Councillor Tammy Hwang
Yes	-	Ward 5	Councillor Matt Francis
Absent	-	Ward 6	Councillor Tom Jackson
Yes	-	Ward 7	Councillor Esther Pauls
Absent	-	Ward 8	Councillor J. P. Danko
Yes	-	Ward 9	Councillor Brad Clark
Yes	-	Ward 10	Councillor Jeff Beattie
Yes	-	Ward 11	Councillor Mark Tadeson
Yes	-	Ward 12	Councillor Craig Cassar
Absent	-	Ward 13	Councillor Alex Wilson
Yes	-	Ward 14	Councillor Mike Spadafora
Yes	-	Ward 15	Councillor Ted McMeekin

(Kroetsch/Francis)

(ii) That the following Delegation requests respecting Item 8.1, Proposed Encampment Protocol (HSC20036(f) / PED21188(c)) (For today's meeting), be approved, as follows:

(1) Gessie Stearns (In Person) (Added Item 6.2(a))

(2) Lisa Nussey, HAMSMaRT (In Person) (Added Item 6.2(b))

(3) Jammy Lo, Keeping Six (In Person) (Added Item 6.2(c))

(4) Leon Blaze (In Person) (Added Item 6.2(d))

Result: MOTION, CARRIED by a vote of 13 to 0, as follows:

Yes	-	Mayor Andrea Horwath	
Yes	-	Ward 1	Councillor Maureen Wilson
Yes	-	Ward 2	Councillor Cameron Kroetsch
Yes	-	Ward 3	Councillor Nrinder Nann
Yes	-	Ward 4	Councillor Tammy Hwang
Yes	-	Ward 5	Councillor Matt Francis
Absent	-	Ward 6	Councillor Tom Jackson
Yes	-	Ward 7	Councillor Esther Pauls
Absent	-	Ward 8	Councillor J. P. Danko
Yes	-	Ward 9	Councillor Brad Clark
Yes	-	Ward 10	Councillor Jeff Beattie
Yes	-	Ward 11	Councillor Mark Tadeson
Yes	-	Ward 12	Councillor Craig Cassar
Absent	-	Ward 13	Councillor Alex Wilson
Yes	-	Ward 14	Councillor Mike Spadafora
Yes	-	Ward 15	Councillor Ted McMeekin

(f) DELEGATIONS (Item 7)

(i) Delegations respecting Item 8.1, Proposed Encampment Protocol (HSC20036(f) / PED21188(c)) (Added Item 7.1):

The following Delegates addressed the Committee respecting Item 8.1, Proposed Encampment Protocol (HSC20036(f) / PED21188(c)):

(1) Gessie Stearns (In Person) (Added Item 7.1(a))

(2) Lisa Nussey, HAMSMaRT (Added Item 7.1(b))

(3) Jammy Lo, Keeping Six (In Person) (Added Item 7.1(c))

(4) Leon Blaze (In Person) (Added Item 7.1(d))

(Hwang/Francis)
That the following Delegations, respecting Item 8.1, Proposed Encampment Protocol (HSC20036(f) / PED21188(c)), be received:

(1) Gessie Stearns (In Person) (Added Item 7.1(a))

(2) Lisa Nussey, HAMSMaRT (Added Item 7.1(b))

(3) Jammy Lo, Keeping Six (In Person) (Added Item 7.1(c))

(4) Leon Blaze (In Person) (Added Item 7.1(d))

Result: MOTION, CARRIED by a vote of 15 to 0, as follows:

Yes	-	Mayor Andrea Horwath	
Yes	-	Ward 1	Councillor Maureen Wilson
Yes	-	Ward 2	Councillor Cameron Kroetsch
Yes	-	Ward 3	Councillor Nrinder Nann
Yes	-	Ward 4	Councillor Tammy Hwang
Yes	-	Ward 5	Councillor Matt Francis
Yes	-	Ward 6	Councillor Tom Jackson
Yes	-	Ward 7	Councillor Esther Pauls
Absent	-	Ward 8	Councillor J. P. Danko
Yes	-	Ward 9	Councillor Brad Clark
Yes	-	Ward 10	Councillor Jeff Beattie
Yes	-	Ward 11	Councillor Mark Tadeson
Yes	-	Ward 12	Councillor Craig Cassar
Yes	-	Ward 13	Councillor Alex Wilson
Yes	-	Ward 14	Councillor Mike Spadafora
Yes	-	Ward 15	Councillor Ted McMeekin

(g) STAFF PRESENTATIONS (Item 8)

(i) Proposed Encampment Protocol (HSC20036(f) / PED21188(c)) (Item 8.1)

Angela Burden, General Manager, Healthy and Safe Communities introduced Michelle Baird, Director, Housing Services Division; and Monica Ciriello, Director, Licensing and By-law Services who addressed the Committee with a presentation respecting Report HSC20036(f) / PED21188(c), Proposed Encampment Protocol.

(M. Wilson/Kroetsch)
That the General Issues Committee recess for 40 minutes until 1:30 pm.

Result: MOTION, CARRIED by a vote of 13 to 1, as follows:

Yes	-	Mayor Andrea Horwath	
Yes	-	Ward 1	Councillor Maureen Wilson
Yes	-	Ward 2	Councillor Cameron Kroetsch
Yes	-	Ward 3	Councillor Nrinder Nann
Yes	-	Ward 4	Councillor Tammy Hwang
Yes	-	Ward 5	Councillor Matt Francis
Yes	-	Ward 6	Councillor Tom Jackson
Yes	-	Ward 7	Councillor Esther Pauls
Absent	-	Ward 8	Councillor J. P. Danko
No	-	Ward 9	Councillor Brad Clark
Yes	-	Ward 10	Councillor Jeff Beattie

Yes	-	Ward 11	Councillor Mark Tadeson
Yes	-	Ward 12	Councillor Craig Cassar
Yes	-	Ward 13	Councillor Alex Wilson
Absent	-	Ward 14	Councillor Mike Spadafora
Yes	-	Ward 15	Councillor Ted McMeekin

(Cassar/Clark)
That the staff presentation respecting Report HSC20036(f) / PED21188(c), Proposed Encampment Protocol, be received.

Result: MOTION, CARRIED by a vote of 15 to 0, as follows:

Yes	-	Mayor Andrea Horwath	
Yes	-	Ward 1	Councillor Maureen Wilson
Yes	-	Ward 2	Councillor Cameron Kroetsch
Yes	-	Ward 3	Councillor Nrinder Nann
Yes	-	Ward 4	Councillor Tammy Hwang
Yes	-	Ward 5	Councillor Matt Francis
Yes	-	Ward 6	Councillor Tom Jackson
Yes	-	Ward 7	Councillor Esther Pauls
Absent	-	Ward 8	Councillor J. P. Danko
Yes	-	Ward 9	Councillor Brad Clark
Yes	-	Ward 10	Councillor Jeff Beattie
Yes	-	Ward 11	Councillor Mark Tadeson
Yes	-	Ward 12	Councillor Craig Cassar
Yes	-	Ward 13	Councillor Alex Wilson
Yes	-	Ward 14	Councillor Mike Spadafora
Yes	-	Ward 15	Councillor Ted McMeekin

(Horwath/Hwang)

(a) That Council adopt the Proposed Encampment Protocol attached as Appendix “A” to Report HSC20038(f) / PED21188(c) and that staff be directed to implement the Proposed Encampment Protocol upon Council ratification on May 24, 2023.

(b) That the staff and budget resources for the Coordination Response Team previously approved through Report HSC20038(e) / PED21188(b) be allocated to the implementation of the Proposed Encampment Protocol attached as Appendix “A” to Report HSC20038(f) / PED21188(c).

(c) That, following Council ratification, staff be directed to make the Proposed Encampment Protocol attached as Appendix “A” to Report HSC20038(f) / PED21188(c) available for public comment, and that staff monitor the implementation of the protocol, and that

staff report back with a final recommended protocol at the General Issues Committee on August 2023.

(d) That staff be directed to conduct a scan of jurisdictions that currently operate sanctioned encampments and further research/consultation as required and bring back options regarding operating models, parameters and criteria for site identification and potential sites with the goal of incorporating sanctioned sites into the new encampment protocol once site(s) and operating model are approved by Council; and,

(e) That staff be directed to work with stakeholders to address washrooms, showers, and access to drinking water, as well as integration of peer and Indigenous supports into encampment response, and report back to the General Issues Committee with recommendations and required resourcing.

Upon request, Committee considered the sub-sections of Report HSC20036(f) / PED21188(c), Proposed Encampment Protocol separately, as follows:

(M. Wilson/Horwath)

(a) That Council adopt the Proposed Encampment Protocol attached as Appendix “A” to Report HSC20038(f) / PED21188(c) and that staff be directed to implement the Proposed Encampment Protocol upon Council ratification on May 24, 2023.

Result: Vote on Sub-Section (a) of Report HSC20036(f) / PED21188(c), respecting Proposed Encampment Protocol, DEFEATED by a vote of 3 to 10, as follows:

Yes	-	Mayor Andrea Horwath	
Yes	-	Ward 1	Councillor Maureen Wilson
No	-	Ward 2	Councillor Cameron Kroetsch
No	-	Ward 3	Councillor Nrinder Nann
No	-	Ward 4	Councillor Tammy Hwang
No	-	Ward 5	Councillor Matt Francis
No	-	Ward 6	Councillor Tom Jackson
Absent	-	Ward 7	Councillor Esther Pauls
Absent	-	Ward 8	Councillor J. P. Danko
No	-	Ward 9	Councillor Brad Clark
No	-	Ward 10	Councillor Jeff Beattie
Yes	-	Ward 11	Councillor Mark Tadeson
Absent	-	Ward 12	Councillor Craig Cassar
No	-	Ward 13	Councillor Alex Wilson
No	-	Ward 14	Councillor Mike Spadafora

No	-	Ward 15	Councillor Ted McMeekin

(b) That the staff and budget resources for the Coordination Response Team previously approved through Report HSC20038(e) / PED21188(b) be allocated to the implementation of the Proposed Encampment Protocol attached as Appendix "A" to Report HSC20038(f) / PED21188(c).

Result: Vote on Sub-Section (b) of Report HSC20036(f) / PED21188(c), respecting Proposed Encampment Protocol, DEFEATED by a vote of 2 to 11, as follows:

Yes	-	Mayor Andrea Horwath	
Yes	-	Ward 1	Councillor Maureen Wilson
No	-	Ward 2	Councillor Cameron Kroetsch
No	-	Ward 3	Councillor Nrinder Nann
No	-	Ward 4	Councillor Tammy Hwang
No	-	Ward 5	Councillor Matt Francis
No	-	Ward 6	Councillor Tom Jackson
Absent	-	Ward 7	Councillor Esther Pauls
Absent	-	Ward 8	Councillor J. P. Danko
No	-	Ward 9	Councillor Brad Clark
No	-	Ward 10	Councillor Jeff Beattie
No	-	Ward 11	Councillor Mark Tadeson
Absent	-	Ward 12	Councillor Craig Cassar
No	-	Ward 13	Councillor Alex Wilson
No	-	Ward 14	Councillor Mike Spadafora
No	-	Ward 15	Councillor Ted McMeekin

For further disposition of this matter, refer to Item 1.

(Kroetsch/A. Wilson)
That the General Issues Committee meeting of May 17, 2023, be extended past the 5:30 pm curfew, up to an additional 60 minutes.

Result: MOTION, CARRIED by a vote of 13 to 0, as follows:

Yes	-	Mayor Andrea Horwath	
Yes	-	Ward 1	Councillor Maureen Wilson
Yes	-	Ward 2	Councillor Cameron Kroetsch
Yes	-	Ward 3	Councillor Nrinder Nann
Yes	-	Ward 4	Councillor Tammy Hwang
Absent	-	Ward 5	Councillor Matt Francis
Yes	-	Ward 6	Councillor Tom Jackson
Yes	-	Ward 7	Councillor Esther Pauls
Absent	-	Ward 8	Councillor J. P. Danko

Yes	-	Ward 9	Councillor Brad Clark
Absent	-	Ward 10	Councillor Jeff Beattie
Yes	-	Ward 11	Councillor Mark Tadeson
Yes	-	Ward 12	Councillor Craig Cassar
Yes	-	Ward 13	Councillor Alex Wilson
Yes	-	Ward 14	Councillor Mike Spadafora
Yes	-	Ward 15	Councillor Ted McMeekin

(h) GENERAL INFORMATION / OTHER BUSINESS (Item 13)

(i) Amendment to the Outstanding Business List (Item 13.1):

(A. Wilson/Hwang)
That the amendments to the Outstanding Business List, be approved, as follows:

(a) Items Considered Complete and Needing to be Removed (Item 13.1(a)):

Encampment Pilot Evaluation (HSC20038(e) / PED21188(b)) (City Wide)
OBL Item: 2023-E
Added: February 1, 2023 at GIC (Item 10.4)
Completed: May 17, 2023 at GIC (Item 8.1)

Result: MOTION, CARRIED by a vote of 12 to 0, as follows:

Yes	-	Mayor Andrea Horwath	
Yes	-	Ward 1	Councillor Maureen Wilson
Yes	-	Ward 2	Councillor Cameron Kroetsch
Yes	-	Ward 3	Councillor Nrinder Nann
Yes	-	Ward 4	Councillor Tammy Hwang
Absent	-	Ward 5	Councillor Matt Francis
Absent	-	Ward 6	Councillor Tom Jackson
Yes	-	Ward 7	Councillor Esther Pauls
Absent	-	Ward 8	Councillor J. P. Danko
Yes	-	Ward 9	Councillor Brad Clark
Absent	-	Ward 10	Councillor Jeff Beattie
Yes	-	Ward 11	Councillor Mark Tadeson
Yes	-	Ward 12	Councillor Craig Cassar
Yes	-	Ward 13	Councillor Alex Wilson
Yes	-	Ward 14	Councillor Mike Spadafora
Yes	-	Ward 15	Councillor Ted McMeekin

(i) PRIVATE & CONFIDENTIAL (Item 14)

(A. Wilson/Hwang)
Pursuant to Section 9.3, Sub-sections (a), (b), (e), (f) and (k) of the City's Procedural By-law 21-021, as amended, and Section 239(2), Sub-sections (a), (b), (e), (f) and (k) of the *Ontario Municipal Act, 2001*, as amended, as the subject matter pertains to the security of the property of the City or a local board; personal matters about an identifiable individual, including City or local board employees; litigation or potential litigation, including matters before administrative tribunals, affecting the municipality or local board; advice that is subject to solicitor-client privilege, including communications necessary for that purpose; and a position, plan, procedure, criteria or instruction to be applied to any negotiations carried on or to be carried on by or on behalf of the municipality or local board.

Result: MOTION, CARRIED by a vote of 12 to 0, as follows:

Yes	-	Mayor Andrea Horwath	
Yes	-	Ward 1	Councillor Maureen Wilson
Yes	-	Ward 2	Councillor Cameron Kroetsch
Absent	-	Ward 3	Councillor Nrinder Nann
Yes	-	Ward 4	Councillor Tammy Hwang
Absent	-	Ward 5	Councillor Matt Francis
Yes	-	Ward 6	Councillor Tom Jackson
Yes	-	Ward 7	Councillor Esther Pauls
Absent	-	Ward 8	Councillor J. P. Danko
Yes	-	Ward 9	Councillor Brad Clark
Absent	-	Ward 10	Councillor Jeff Beattie
Yes	-	Ward 11	Councillor Mark Tadeson
Yes	-	Ward 12	Councillor Craig Cassar
Yes	-	Ward 13	Councillor Alex Wilson
Yes	-	Ward 14	Councillor Mike Spadafora
Yes	-	Ward 15	Councillor Ted McMeekin

(i) Encampment Litigation Update (LS20023(g)) (City Wide) – REVISED (Item 14.1)

For disposition of this matter, refer to Item 10.

(ii) Safety and Security at City Hall (No Copy) (Added Item 14.2)

For disposition of this matter, refer to Item 11.

(j) ADJOURNMENT (Item 15)

(Spadafora/Jackson)
That there being no further business, the General Issues Committee be adjourned at 6:21 p.m.

CARRIED

Respectfully submitted,

_____
Deputy Mayor Esther Pauls
Chair, General Issues Committee

_____
Angela McRae
Legislative Coordinator
Office of the City Clerk

TAB 10

City of Hamilton

CITY COUNCIL AGENDA

23-010
Wednesday, May 24, 2023 at 9:30 A.M.
Council Chambers
Hamilton City Hall
71 Main Street West

Call to Order

1. APPROVAL OF AGENDA

(Added Items, if applicable, will be noted with *)

2. DECLARATIONS OF INTEREST

3. CEREMONIAL ACTIVITIES

4. APPROVAL OF MINUTES OF PREVIOUS MEETING

4.1 May 10, 2023

5. COMMUNICATIONS

5.1 Correspondence from the Township of Armour requesting support for their resolution raising awareness about the loopholes in current regulations regarding water aerodromes that allow proponents to build massive docks and boathouses without municipal

consultation, approval or adherence to bylaws and regulations.

Recommendation: Be received.

5.2 Correspondence from Robert Burke respecting vacant property tax administration.

Recommendation: Be received and referred to the General Manager of Finance and Corporate Services for appropriate action.

5.3 Correspondence from the County of Prince Edward requesting support for their resolution urging the province to pause proposed changes to the Provincial Planning Statement (PPS).

Recommendation: Be received.

5.4 Correspondence from the Town of Fort Frances requesting support for their resolution respecting the Opioid Crisis.

Recommendation: Be received.

5.5 Correspondence from the City of Cambridge requesting support for their resolution requesting that the Ontario Government permit municipalities to locate an Automated Speed Enforcement systems (ASE) permanently or temporarily on any roadway under the

jurisdiction of municipalities and as determined by municipalities, and not be restricted to only community safety zones and school safety zones.

Recommendation: Be received.

5.6 Correspondence from the Municipality of Tweed requesting support for their resolution respecting Bell-Hydro Infrastructure.

Recommendation: Be received.

5.7 Correspondence from the Citizens of Flamborough/City of Hamilton Action Committee respecting Soil Dumping at 1771 Highway 5 West, Flamborough "Waterdown Garden Supplies".

Recommendation: Be received and referred to the General Managers of Planning and Economic Development and Public Works for appropriate action.

5.8 Correspondence from Peter Vander Klippe respecting Urgent Action Needed: Resist Urban Boundary Expansion and Prioritize Sustainable Urban Planning.

Recommendation: Be received and referred to the General Manager of Planning and Economic Development for appropriate action.

5.9 Correspondence from Adeola Egbeyemi respecting the implementation of a maximum heat bylaw.

Recommendation: Be received and referred to the consideration of Item 1 of the Public Health Committee Report 23-005.

5.10 Correspondence from the Ministry of the Environment, Conservation and Parks respecting the Highway 6/Hanlon Expressway Midblock Interchange (GWP 3059-20-00) 2022 Annual Compliance Report (EA File No. TC-CE-02).

Recommendation: Be received.

5.11 Correspondence from Adam Pacey respecting prioritizing growth within our pre-2022 boundaries.

Recommendation: Be received and referred to the General Manager of Planning and Economic Development for appropriate action.

5.12 Correspondence from Lyn Folkes in support of the much more progressive growth strategy of our current Hamilton Council

Recommendation: Be received and referred to the General Manager of Planning and Economic Development for appropriate action.

5.13 Correspondence from alPHa respecting the Resolutions for Consideration at the June 13, 2023 Annual General Meeting.

Recommendation: Be received.

5.14 Correspondence respecting the Proposed Encampment Protocol

a. Warren Woermke

b. Paul Vicari

c. Michelle Hruschka

d. Ted Pudney

Recommendation: Be received and referred to the consideration of Item 1 of the General Issues Committee Report 23-017.

6. COMMITTEE REPORTS

6.1 Hamilton Police Services Board Selection Committee Report 23-001 - May 8, 2023

6.2 Selection Committee for Agencies, Boards and Sub-Committees Report 23-002, May 9, 2023

6.3 Public Health Committee (Special) Report 23-006 - May 15, 2023

6.4 Public Works Committee Report 23-007 - May 15, 2023

6.5 Planning Committee Report 23-008 - May 16, 2023

6.6 General Issues Committee Report 23-017 - May 17, 2023

6.7 Audit, Finance and Administration Committee Report 23-008 - May 18, 2023

6.8 Emergency and Community Services Committee Report 23-007 - May 18, 2023

6.9 CityHousing Hamilton Shareholder Report 23-002 - May 23, 2023

7. MOTIONS

7.1 City of Hamilton Representatives at the 2023 alPHa Conference and Annual General Meeting

8. NOTICES OF MOTIONS

9. STATEMENT BY MEMBERS (non-debatable)

10. COUNCIL COMMUNICATION UPDATES

10.1 May 5, 2023 to May 18, 2023

11. PRIVATE AND CONFIDENTIAL

11.1 Labour Relations Update (no copy)

Pursuant to Section 9.3, Sub-sections (b) and (d) of the City's Procedural By-law 21-021, as amended, and Section 239(2), Sub-sections (b) and (d) of the *Ontario Municipal Act*, 2001, as amended, as the subject matter pertains to personal matters about an identifiable individual, including City or local board employees and labour relations or employee negotiations.

12. BY-LAWS AND CONFIRMING BY-LAW

12.1 084

To Amend By-law No. 01-218, as amended, Being a By-law To Regulate On-Street Parking
Schedule 8 – No Parking

Schedule 12 – Permit

Schedule 13 – No Stopping
Ward: 1,2,12,14

12.2 085

To Amend City of Hamilton By-law 01-215, being a By-law to Regulate Traffic, to Add Additional Community Safety Zones in Hamilton
Schedule 34: Designated Community Safety Zones
Ward: City Wide

12.3 086

To Establish City of Hamilton Land described as Block 111 on Plan 62M-1073, Save and Except Parts 1 and 2 on Plan 62R-21881, as Part of Watershore Drive
Ward: City Wide

12.4 087

To Amend By-law R00-054, the Regional Municipality of Hamilton-Wentworth Conservation By-law (as amended by By-law 10-013, By-law 14-213, and By-law 17-094)
Ward: City Wide

12.5 088

To Amend By-law 14-212, To Promote the Conservation and Sustainable Use of Woodlands on Private Property within the Urban Boundary of the City of Hamilton

Ward: City Wide

12.6 089

To Set Optional Property Classes Within the City of Hamilton for the Year 2023

Ward: City Wide

12.7 090

To Establish Tax Ratios and Tax Reductions for the Year 2023
Ward: City Wide

12.8 091

To Set and Levy the Rates of Taxation for the Year 2023

Ward: City Wide

12.9 092

To Levy a Special Charge Upon the Rateable Property in the Business Improvement Areas for the Year 2023

Ward: City Wide

12.10 093

To Amend Zoning By-law No. 05-200 with Respect to Lands Located at 4 and 10 Trinity Church Road, Hamilton

Ward: 6

12.11 094

To Adopt Official Plan Amendment No. 38 to the Rural Hamilton Official Plan Respecting 127 Freelton Road, Flamborough

Ward: 13

12.12 095

To Amend Zoning By-law No. 05-200 Respecting Lands Located at 127 Freelton Road, Flamborough

ZAC-23-002

Ward: 13

12.14 097

To Confirm the Proceedings of City Council

13. ADJOURNMENT

TAB 11

OUR WARD 3 NEWS FOR OCTOBER 14TH, 2021

OCTOBER 14, 2021

NRINDER NANN
CITY COUNCILLOR | WARD 3

Dear Neighbour,

I hope you had a chance to rest and reflect on what you are grateful for this past long weekend. I was grateful for a weekend with my family, walking in forests, admiring mushrooms, feathers on the ground, the changing leaves, the sparkle of water, and all the gifts nature offers.

I couldn’t help but connect those precious moments to the critical and important decision facing Council about urban boundary expansion, the need to preserve farmland and protect environmentally rich and sensitive areas from development. The special General Issues Committee focused on growth related development has been rescheduled for Tuesday, November 9th at 9:30am.

Below are this week’s updates from Council, engagement opportunities and vaccine clinic locations in #OurWard3.

Yours in Community,

Nrinder Nann
Ward 3 City Councillor



Encampment Response Update

Yesterday at Council we received an update on a recent application for a Superior Court injunction that would stop the enforcement of some encampments in Hamilton.

Enforcement doesn't solve homelessness, only housing does.

In fact, more people are living in encampments today than there were in August before the previous Encampment Protocol was repealed by the majority of Council during an at the whim meeting. We have more sites with more tents than before. And yesterday, staff confirmed there is

in fact not enough shelter beds, supports nor housing to safely transition each person currently living in tents. There remains a chronic shortage for women, non-binary and trans residents for emergency housing. And forcing residents living in encampments to move from site to site impairs their health, breaks trust with outreach workers working to address their needs, and literally shortens their life expectancy.

No one wants encampments. Everyone deserves a safe and dignified place to live. And, we need each level of government to invest and work together with our social housing partners to eradicate homelessness. We also need the provincial government to unlock the COVID-19 specific surplus of $5B to help adequately address the health needs of those living in tents.

My focus is on solutions and working directly to address and understand the root causes of homelessness in our communities. It's important that we all talk about it with our families, children and neighbours. The recent release of the book, Shelter: Homelessness in Our Community is an important new resource that addresses these layers. The Ward 3 team is eagerly working on a virtual community reading and discussion for us to share, learn and build community together. If you want to help us plan the event, email us at ward3@hamilton.ca.

In the meantime,you can request to borrow a copy from the Hamilton Public Library via both ebook and in print at the Barton Branch or Book Mobile.

Free Mums Show 2021 at the Gage Park Greenhouses - October 22 to 31, 2021

TAB 12

City of Hamilton
GENERAL ISSUES COMMITTEE
REVISED

Meeting #: 21-027
Date: December 08, 2021
Time: 9:30 a.m.
Location: Due to the COVID-19 and the Closure of City Hall (CC)
All electronic meetings can be viewed at:
City's Website: https://www.hamilton.ca/council-committee/council-committee-meetings/meetings-and-agendas
City's YouTube Channel: https://www.youtube.com/user/InsideCityofHamilton or Cable 14

Stephanie Paparella, Legislative Coordinator (905) 546-2424 ext. 3993

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1. CEREMONIAL ACTIVITIES

2. APPROVAL OF AGENDA

(Added Items, if applicable, will be noted with *)

3. DECLARATIONS OF INTEREST

4. APPROVAL OF MINUTES OF PREVIOUS MEETINGS

4.1 November 9, 2021 - Special GIC

4.2 November 17, 2021

4.3 November 19, 2021 - Special GIC

5. COMMUNICATIONS

*5.1 Correspondence from Richard McKinnon, respecting Item 8.2 - Hamilton's Corporate-Wide Climate Change Update

Recommendation: Be received and referred to consideration of Item 8.2.

*5.2 Correspondence from Hollie Pocsai, respecting the Encampment Matter - J. C. Beemer Park

Recommendation: Be received.

*5.3 Correspondence from Eshan Merali respecting the Encampment Matter - J.C. Beamer Park

Recommendation: Be received.

*5.4 Correspondence from Eshran Merali respecting Item 10.10 - Report CM19006(g), Hate Prevention, Mitigation and Community Initiatives Action Plan

Recommendation: Be received and referred to consideration of Item 10.10.

*5.5 Correspondence from Rose Janson and Family respecting Item 10.10 - Report CM19006(g), Hate Prevention, Mitigation and Community Initiatives Action Plan

Recommendation: Be received and referred to consideration of Item 10.10.

*5.6 Correspondence from Gary Warner respecting the Encampment Matter - J.C. Beamer Park

Recommendation: Be received.

*5.7 Correspondence from Katherine Walker Jones, respecting Report CMO19006(g) - Hate Prevention, Mitigation and Community Initiatives Action Plan

Recommendation: Be received and referred to consideration of Item 10.10.

*5.8 Correspondence from Kevin Intini, respecting Item 8.2 - Hamilton's Corporate-Wide Climate Change Update

Recommendation: Be received and referred to consideration of Item 8.2.

*5.9 Correspondence from Lia Hamelin, respecting Item 10.10 - Report CM19006(g), Hate Prevention, Mitigation and Community Initiatives Action Plan

Recommendation: Be received and referred to consideration of Item 10.10.

*5.10 Correspondence from Sarah Dawson respecting the Encampment Matter - J. C. Beamer Park

Recommendation: Be received.

*5.11 Correspondence from Katie Sullivan, respecting Item 10.10 - Report CM19006(g), Hate Prevention, Mitigation and Community Initiatives Action Plan

Recommendation: Be received and referred to consideration of Item 10.10.

*5.12 Correspondence from Alex Wilson and Zoe Green, Action 13, respecting Item 8.2 - Hamilton's Corporate-Wide Climate Change Update

Recommendation: Be received and referred to consideration of Item 8.2.

*5.13 Correspondence from Ian Graham, respecting Item 8.2 - Hamilton's Corporate-Wide Climate Change Update 2021

6. DELEGATION REQUESTS

6.1 Cameron Kroetsch (Chair), Rebecca Banky (Chair-Elect), LGBTQ Advisory Committee, respecting Changes to the Code of Conduct for Advisory Committees

(For the January 17, 2022 Special GIC)

6.2 Bianca Caramento, Bay Area Climate Change Council, respecting Item 8.2 - Hamilton's Corporate-Wide Climate Change Update 2021

(For the December 8, 2021 GIC)

*6.3 Ian Borsuk, Environment Hamilton, respecting Item 8.2 - Hamilton's Corporate-Wide Climate Change Update 2021

(For the December 8, 2021 GIC)

*6.4 Don McLean, respecting Item 8.2 - Hamilton's Corporate-Wide Climate Change Update 2021

(For the December 8, 2021 GIC)

*6.5 Ian Graham, Copetown Institute on Climate Response, respecting Item 8.2 - Hamilton's Corporate-Wide Climate Change Update 2021

(For the December 8, 2021 GIC)

*6.6 Dr. James S. Quinn, respecting Item 8.2 - Hamilton's Corporate-Wide Climate Change Update 2021

(For the December 8, 2021 GIC)

*6.7 David Carson, respecting Item 8.2 - Hamilton's Corporate-Wide Climate Change Update 2021

(For the December 8, 2021 GIC)

*6.8 James Lambert respecting the Encampment Matter - J. C. Beamer Park

(For the December 8, 2021 GIC)

*6.9 Merima Menzildzic respecting the Encampment Matter - J. C. Beamer Park

(For the December 8, 2021 GIC)

*6.10 Joanna Aitcheson respecting Report CM19006(g) - Hate Prevention, Mitigation and Community Initiatives Action Plan

(For the December 8, 2021 GIC)

*6.11 Kojo Damptey, Hamilton Center for Civic Inclusion, respecting Report CM19006(g) - Hate Prevention, Mitigation and Community Initiatives Action Plan; and, the Encampment Matter - J.C. Beamer Park

*6.12 Video Submissions respecting Item 8.2 - Hamilton's Corporate-Wide Climate Change Update 2021

*6.12.a Grant Linney, Climate Change Reality Canada

*6.12.b Neil Woodley

*6.12.c Miriam Sager

7. CONSENT ITEMS

7.1 Ottawa Street Business Improvement Area (BIA) Revised Board of Management (PED21229) (Wards 3 and 4)

7.2 Downtown Hamilton Business Improvement Area (BIA) Revised Board of Management (PED21232) (Ward 2)

7.3 2021 S&P Global Ratings Credit Rating Review (FCS21109) (City Wide)

8. STAFF PRESENTATIONS

8.1 COVID-19 Verbal Update (no copy)

8.2 Hamilton's Corporate-Wide Climate Change Update 2021 (CMO19008(b)/HSC19073(b)) (City Wide)

9. PUBLIC HEARINGS / DELEGATIONS

9.1 David Carter, Innovation Factory, respecting Item 10.1 - Report PED21204, Innovation Factory and Synapse Life Sciences Consortium Request for Funding Renewal

10. DISCUSSION ITEMS

10.1 Innovation Factory and Synapse Life Sciences Consortium Request for Funding Renewal (PED21204) (City Wide)

10.2 2022 Budget Submission – Advisory Committee for Persons with Disabilities (HUR21012) (City Wide)

10.3 Multi-Purpose Community Hub for Diverse and Marginalized Communities (HSC21045) (City Wide)

10.4 Use of City Resources During an Election (FCS21113) (City Wide)

10.5 Concession Street Business Improvement Area (BIA) Proposed Budget and Schedule of Payments for 2022 (PED21225) (Ward 7)

10.6 Dundas Business Improvement Area (BIA) Proposed Budget and Schedule of Payments for 2022 (PED21226) (Ward 13)

10.7 Ottawa Street Business Improvement Area (BIA) Proposed Budget and Schedule of Payments for 2022 (PED21228) (Wards 3 and 4)

10.8 International Village Business Improvement Area (BIA) Proposed Budget and Schedule of Payments for 2022 (PED21227) (Ward 2)

10.9 Arts Advisory Commission Budget Submission (PED21218) (City Wide)

10.10 Hate Prevention, Mitigation and Community Initiatives Action Plan (CM19006(g)) (City Wide)

10.11 Support for the National Council of Canadian Muslims brought forward by the NCCM recommendations in Motion 6.2 (CM21015) (City Wide)

10.12 Business Improvement Area Advisory Committee Report 21-020, November 9, 2021

10.13 Proposal for the Adaptive Re-Use of Balfour House/Chedoke Estate (PED19168(b)) (Ward 14)

*10.14 2022 Tax Supported User Fees (FCS21115) (City Wide)

*10.15 Non-Union Compensation Sub-Committee Report 21-001, December 3, 2021

*10.16 Red Hill Valley Parkway Inquiry Update (LS19036(g)) City Wide)

11. MOTIONS

12. NOTICES OF MOTION

13. GENERAL INFORMATION / OTHER BUSINESS

13.1 Amendments to the Outstanding Business List

13.1.a Items to be removed:

13.1.a.a Innovation Factory Request for Funding Renewal Option

Addressed on this agenda as Item 10.1.

*13.1.a.b Synapse Life Sciences Consortium Finding Update

Addressed as Item 10.1 on this agenda.

13.1.a.c Multi-Purpose Community Hub for Diverse & Marginalized Communities – Business Case

Addressed on this agenda as Item 10.3.

13.1.a.d Hate Prevention and Mitigation Update

Addressed on today's agenda as Item 10.10.

13.1.a.e NCCM Recommendations brought forward by the National Council of Canadian Muslims – Recommendation 59

Addressed on this agenda as Item 10.11.

13.1.a.f Adaptive Reuse Project at Balfour House/Chedoke Estate by The Cardus Institute

Addressed on this agenda as Item 10.13.

13.1.a.g Land Needs Assessment and the Municipal Comprehensive Review Survey Results

Addressed at the November 19, 2021 GIC - Reports PED17010(m), PED17010(n), and PED17010(o).

13.1.a.h Land Needed to Accommodate Growth to 2051

Addressed at the November 19, 2021 GIC - Reports PED17010(m), PED17010(n), and PED17010(o).

13.1.a.i GRIDS 2 and Municipal Comprehensive Review – Employment Land Review

Addressed at the November 19, 2021 GIC - Reports PED17010(m), PED17010(n), and PED17010(o).

13.1.a.j GRIDS and Municipal Comprehensive Review - Consultation Update and Evaluation Framework and Phasing Principles

Addressed at the November 19, 2021 GIC - Reports PED17010(m), PED17010(n), and PED17010(o).

13.1.a.k Discontinuation of Water Billing Services by Alectra Utilities

Alectra representatives attended at the November 17, 2021 GIC meeting.

13.1.a.l 2020 Property and Liability Insurance Renewal Report (LS20010)

Addressed at as Item 10.8 at the August 9, 2021 GIC - Report LS21029.

13.1.a.m Options for Resolving the Parking Issues at the Carluke Cemetery

Was addressed as Item 14.2 at the October 5, 2021 Planning Committee - Report PED21171.

13.1.b Proposed New Due Dates:

13.1.b.a Update on Request for Information – Downtown Parking Structure (PED16105 and PED15183)

Current Due Date: December 8, 2021

Proposed New Due Date: April 6, 2022

13.1.b.b Corporate Strategic Growth Initiatives – Annual Update

Current Due Date: November 17, 2021

Proposed New Due Date: March 23, 2022

13.1.b.c Revenue Enhancement Opportunities at the John C. Munro International Airport

Current Due Date: September 22, 2021

Proposed New Due Date: March 23, 2022

13.1.b.d Potential Solutions to the Chedoke Creek Matter

Current Due Date: December 8, 2021

Proposed New Due Date: January 12, 2022

13.1.b.e Airport Employment Growth District (AEGD) Wastewater Servicing Update and Capacity Allocation Policy

Current Due Date: November 3, 2021

Proposed New Due Date: February 2, 2022

13.1.b.f Mayor's Task Force on Economic Recovery

Current Due Date: December 8, 2021

Proposed New Due Date: January 12, 2022

13.1.b.g Recommendations related to the implementation of the Municipal Accommodation Tax and the updated Hamilton Tourism Strategy 2021

Current Due Date: November 17, 2021

Proposed New Due Date: January 12, 2022

13.1.b.h ACPD Environmental Working Group Plan

Current Due Date: December 8, 2021

Proposed New Due Date: March 23, 2022

13.1.b.i Protection of Privacy

Current Due Date: November 17, 2021

Proposed New Due Date: February 16, 2022

13.1.b.j Downtown Entertainment Precinct Master Agreement – Municipal Capital Facility Agreement By-Laws

Current Due Date: December 8, 2021

Proposed New Due Date: February 16, 2022

13.1.b.k Considerations to Implement a Vacant Home Tax in Hamilton (FCS21017(a) / PED21114)

Current Due Date: December 8, 2021

Proposed New Due Date: January 12, 2022

13.1.b.l Community Benefits Protocol

Current Due Date: Deferred at the June 16, 2021 GIC

Proposed New Due Date: March 23, 2022

*13.1.b.m Draft City of Hamilton Public Engagement Policy

Current Due Date: May 4, 2022

Proposed New Due Date: June 15, 2022

13.1.c Items to be referred to another Standing Committee:

13.1.c.a Draft Official Plan Amendment (OPA), as part of the Municipal Comprehensive Review

To be referred to the Planning Committee.

*13.2 J.C. Beemer Park Verbal Overview

14. PRIVATE AND CONFIDENTIAL

14.1 Closed Session Minutes - November 17, 2021

Pursuant to Section 9.1, Sub-sections (f) and (k) of the City's Procedural By-law 21-021 and Section 239(2), Sub-sections (f) and (k) of the *Ontario Municipal Act*, 2001, as amended, as the subject matter pertains to advice that is subject to solicitor-client privilege, including communications necessary for that purpose; and, a position, plan, procedure, criteria or instruction to be applied to any negotiations carried on or to be carried on by or on behalf of the municipality or local board.

14.2 Closed Session Minutes - November 19, 2021

Pursuant to Section 9.1, Sub-sections (e) and (f) of the City's Procedural By-law 21-021 and Section 239(2), Sub-sections (e) and (f) of the *Ontario Municipal Act*, 2001, as amended, as the subject matter pertains to litigation or potential litigation, including matters before administrative tribunals, affecting the municipality or local board; and, advice that is subject to solicitor-client privilege, including communications necessary for that purpose.

14.3 Canadian Union of Public Employees Local 5167 (Macassa/ Wentworth Lodges), Ratification of Collective Agreement (HUR21014) (City Wide)

Pursuant to Section 9.1, Sub-section (d) of the City's Procedural By-law 21-021 and Section 239(2), Sub-section (d) of the *Ontario Municipal Act*, 2001, as amended, as the subject matter pertains to labour relations or employee negotiations.

14.4 Investigation Update (AUD21012) (City Wide)

Pursuant to Section 9.1, Sub-sections (b), (d) and (e) of the City's Procedural By-law 21-021 and Section 239(2), Sub-sections (b), (d) and (e) of the *Ontario Municipal Act*, 2001, as amended, as the subject matter pertains to personal matters about an identifiable individual, including municipal or local board employees; labour relations or employee negotiations; and, litigation or potential litigation, including matters before administrative tribunals, affecting the municipality or local board.

14.5 Litigation Update – Property Damage Claim (LS21028) (City Wide)

Pursuant to Section 9.1, Sub-sections (b), (e), (f) and (k) of the City's Procedural By-law 21-021 and Section 239(2), Sub-sections (b), (e), (f) and (k) of the *Ontario Municipal Act*, 2001, as amended, as the subject matter pertains to personal matters about an identifiable individual, including municipal or local board employees; litigation or potential litigation, including matters before administrative tribunals, affecting the municipality or local

board; advice that is subject to solicitor-client privilege, including communications necessary for that purpose; and, a position, plan, procedure, criteria or instruction to be applied to any negotiations carried on or to be carried on by or on behalf of the municipality or local board.

14.6 Disposition Strategy – Portion of the Wentworth Lodge Lands (PED19138) (Ward 13)

Deferred from the August 12, 2019 GIC.

Pursuant to Section 9.1, Sub-sections (c), and (k) of the City's Procedural By-law 21-021 and Section 239(2), Sub-sections (c) and (k) of the *Ontario Municipal Act*, 2001, as amended, as the subject matter pertains to a proposed or pending acquisition or disposition of land by the municipality or local board; and, a position, plan, procedure, criteria or instruction to be applied to any negotiations carried on or to be carried on by or on behalf of the municipality or local board.

*14.7 Red Hill Valley Parkway Inquiry Update (LS19036(h)) (City Wide)

15. ADJOURNMENT

TAB 13

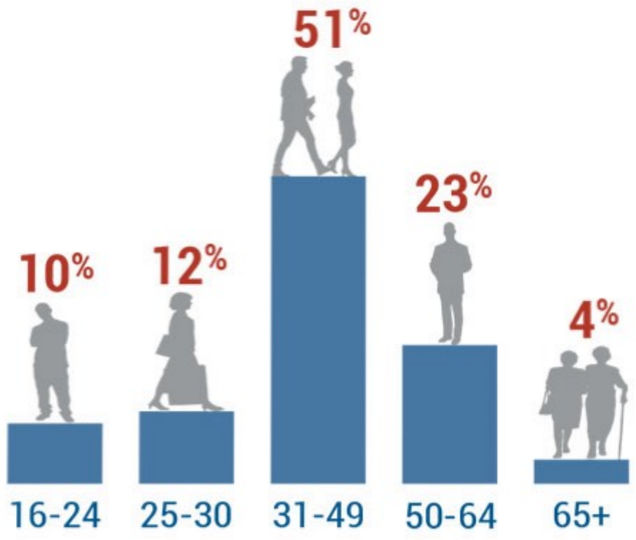
DID YOU HAVE ANY FAMILY MEMBERS OR ANYONE ELSE WHO STAYED WITH YOU LAST NIGHT?



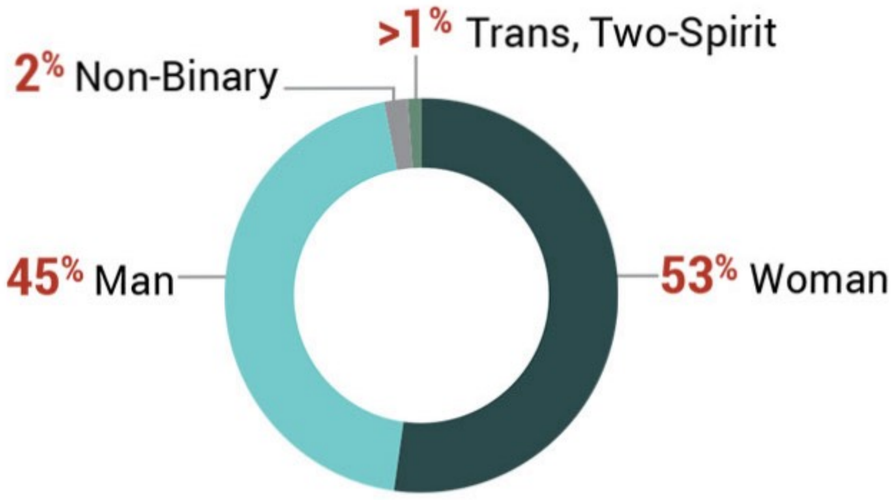
WHERE DID YOU STAY LAST NIGHT?



AGE



GENDER IDENTITY



INDIGENOUS ANCESTRY



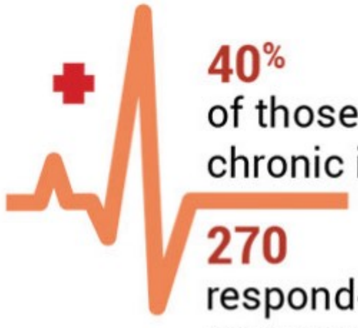
23% identified as Indigenous or as having Indigenous ancestry

IMPACTS OF COVID



77 number of people who report that their most recent housing loss is related to the COVID-19 pandemic

HEALTH



40% of those surveyed reported having a chronic illness or health condition.

270 respondents had been to an emergency room (ER) in the last 12 months, with a cumulative total of 787 ER visits

TOP 3 REASONS FOR MOST RECENT HOUSING LOSS



- Not enough income
- Landlord/tenant conflict
- Unfit/unsafe housing conditions

TOP 5 BARRIERS TO FINDING HOUSING



- Rent too high
- Low income
- No income assistance
- Poor Housing Conditions
- Discrimination

HOMELESS FOR 6 MONTHS OR MORE IN THE PAST YEAR

304 People



TAB 14

2022 PiTC Results Infographic Description

Did you have any family members or anyone else who stayed with you last night?

- None / single: 431
- Family: 94
- Partner: 8
- Other adult: 12

Where did you stay last night?

- Emergency Shelter: 298
- Hotel/motel - City funded: 68
- Unsheltered: 60
- Transitional shelter / housing: 52
- Encampment 35
- Someone else's place: 15
- Other - non permanent: 17

Age

- 16-24: 10%
- 25-30: 12%
- 31-49: 51%
- 50-64: 23%
- 65+: 4%

Gender Identity

- Woman: 53%
- Man: 45%
- Non-binary:2%
- Trans, Two-spirit:1%

Indigenous Ancestory

- 23% Identified as Indigenous or having Indigenous ancestory

Impacts of COVID

- 77 people who report that their most recent housing loss is related to the COVID-19 pandemic

Health

- 40% of those surveyed reported having a chronic illness or health condition
- 270 respondents had been to an emergency room in the last 12 months, with a cumulative total of 787 ER visits.

Top 3 reasons for most recent housing loss

- Not enough income
- Landlord/tenant conflict
- Unfit/unsafe housing conditions

Top 5 barriers to find housing

- Rent to high
- Low income
- No income assistance
- Poor housing conditions
- Discrimination

Homeless for 6 months or more in the past year

- 304 People

TAB 15

City of Hamilton

Point in Time Connection Results 2021

Housing Services Division – April 2022

The 2021 Point in Time Connection (PiTC), a joint planning effort with City of Hamilton's Housing Services Division and the Coalition of Hamilton Indigenous Leadership (CHIL), was made possible through the support of a wide range of community partners who assisted greatly in its planning and implementation. The Housing Services Division would like to specifically acknowledge and thank every single survey participant whose contributions allow us to more deeply examine the impact of our ongoing work to end homelessness.

The partnership with, and leadership of, CHIL remain central in efforts to prioritize Indigenous led solutions to homelessness. Recommendations from the Indigenous community guide efforts to ensure that the PiTC is conducted in a way that is safe and culturally appropriate, acknowledging autonomy and self-determination as key pillars of engagement.

For the first time, Hamilton's PiTC was led on the ground exclusively by community partners and City staff without the support of volunteers; these efforts were critical in prioritizing the health and safety of all involved throughout the survey week. Building on this initiative, we continue to strive to centre the voices of unhoused residents to work toward ensuring that their needs are directly prioritized in approaches taken and decisions made in the context of local planning, policy and investment.

Land Acknowledgment

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 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.

Coming Together to End Homelessness: Hamilton's Systems Planning Framework outlines our strategic local approach to preventing and ending homelessness, which must account for the systemic over-representation of Indigenous persons experiencing homelessness. The Housing Services Division is committed to ongoing coordination with urban Indigenous leadership to ensure that approaches to service coordination and provision are culturally appropriate, safe and built on principles of relationship, trust and informed consent.

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Summary and Key Findings

Hamilton's most recent PiTC survey of individuals experiencing homelessness in the city highlights a shift in the demographic profile of those experiencing homelessness, identifies key barriers to maintaining or obtaining housing, and shows specific groups are overrepresented in their experience of homelessness.

Held November 15 to 19, 2021, and jointly planned by the City's Housing Services Division and CHIL, it is the third nationally-coordinated Point-in-Time Count since 2016. The information collected complements existing local efforts to collect and report on key data on the state of homelessness and helps to ensure available resources are used as efficiently and effectively as possible to prevent and end homelessness.

Service staff from community-based social service organizations conducted 545 surveys over the five-day period at emergency shelters, drop-in programs, community agencies, and in unsheltered locations to better understand the needs of people experiencing homelessness in our community.

Results of the survey highlight:

- the overrepresentation of Indigenous peoples, as 23% of all respondents identified as Indigenous or as having Indigenous ancestry;
- a shift in the demographic profile of those experiencing homelessness throughout the COVID-19 pandemic, including an increase in the percentage of respondents who identify as a woman (53%), which was higher than in 2018 (32%) and 2016 (28%);
- key barriers to maintaining or obtaining housing, such as impacts from the COVID-19 pandemic, housing affordability, low income/low income assistance, landlord/tenant conflict, poor housing conditions and discrimination;
- a majority of respondents reported they had most recently stayed in an emergency shelter or a City funded hotel/motel; and,
- the 2021 PiTC engaged a larger number of people staying in outdoor unsheltered locations and encampments (95) compared to 2016 and 2018 (In 2016, 34 survey respondents were unsheltered and/or in encampments compared to 25 survey respondents in 2018).

In keeping with the principles of Indigenous data sovereignty, as directed by the Indigenous Community Advisory Board (ICAB), CHIL has led the analysis of Indigenous respondent data and the City of Hamilton has not and will not use this data without the approval of the ICAB. Housing Services Division continues to prioritize collaborative work with local Indigenous leadership to develop connections to housing and supports

that are culturally appropriate, rooted in the spirit and actions of reconciliation that recognize the values of autonomy and self-determination.

Snapshot of Homelessness in Hamilton on November 19, 2021

- Shelters were at 93% capacity during the period of November 15-19, 2021
- 748: the number of unique individuals that stayed in an emergency shelter during the period of November 15-19, 2021
- 1426: total number of people on the City of Hamilton's By-Name List on November 12, 2022

Introduction

From November 15 to 19, 2021 the City of Hamilton participated in Everyone Counts, the third nationally coordinated Point-in-Time Count in Canada. Completion of the PiTC fulfilled requirements of both the Federal government's Reaching Home: Canada's Homelessness Strategy and the Ontario Ministry of Municipal Affairs and Housing.

Point-in-Time Counts have historically been used to help communities better understand the nature and extent of homelessness and the circumstances of the people experiencing homelessness, while providing information to help shape ongoing system and service responses. Point-in-Time Counts can assist in identifying how many people in a community experience homelessness at any given time; however, it is not an exhaustive count. Through the accompanying survey, the initiative provides information on the demographics and service needs of the local population experiencing homelessness.

545 surveys were completed during the week at emergency shelters, provincially administered Violence Against Women shelters, drop-in programs, community agencies, and in unsheltered locations including encampments. An Indigenous led magnet event was also held in Beasley Park on November 17, 2021 to provide an opportunity for Indigenous community members to be surveyed by Indigenous surveyors.

COVID-19 Context

Investments specifically targeted towards housing-focused interventions in Hamilton to prevent and end people's experience of homelessness total approximately $25 M annually in regular funding. In addition, since the beginning of the COVID-19 pandemic, the City has sustained an emergency response across the homelessness-serving system directing more than $60 M in additional pandemic response funds. These funds ensured for a responsive and flexible response throughout the evolving demands of the pandemic.

Through the pandemic, additional investments have enabled the temporary expansion of shelter space across the system from 341 beds up to 548 beds at the highest point plus additional overflow space, as well as a new temporary women's shelter. In addition, these investments supported the expansion of the City's Housing Focused Street Outreach team and have also enabled community drop-in programs to expand and

maintain services for vulnerable residents, including: meals, showers, harm reduction supplies, and overnight access to drop-in services. These investments and the dedicated efforts of agency staff provided additional settings and opportunities for engagement through the PiTC.

Overview of Homelessness in Hamilton

Sheltered Homelessness

Emergency shelters are a critical first-line response to ensure people experiencing homelessness have a safe place to stay while they pursue stable housing. The City's outreach staff work on a daily basis to engage individuals experiencing unsheltered homelessness to offer shelter space and work with them to find safer, humane, and supportive housing options.

There has been growing pressure within the shelter system throughout the course of the pandemic. In 2020, emergency shelter average length of stay increased 18% and the women's system was particularly over-capacity. From 2020 to 2021 there has been an increasing trend in number of unique individuals accessing shelters by month.

Figure 1: Unique Individuals in Shelter by Month

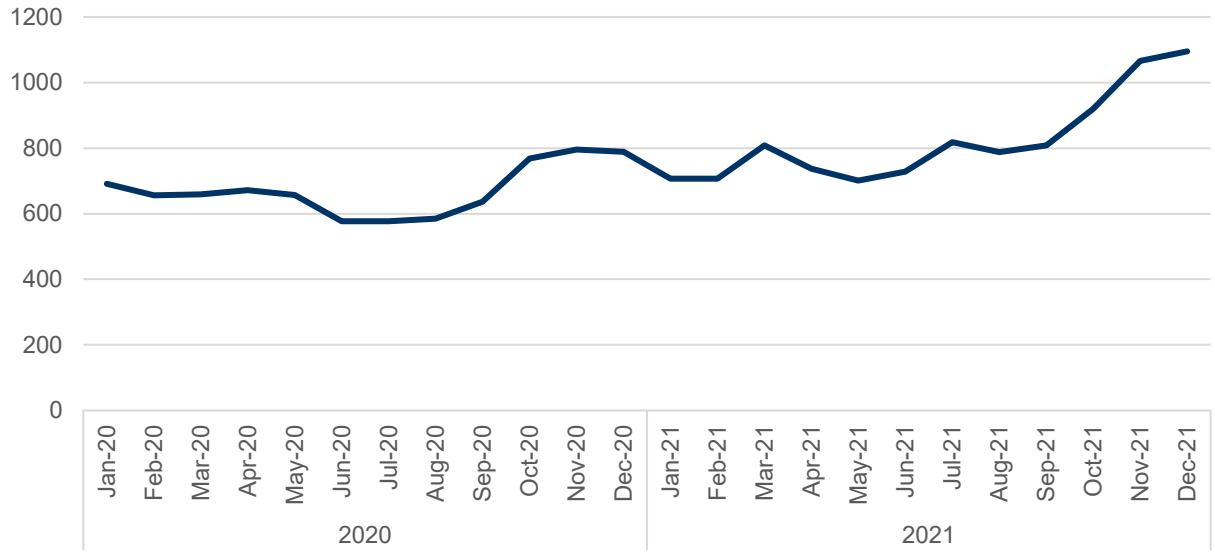


Figure 2: Monthly Shelter Bed Usage and Max Capacity by Month

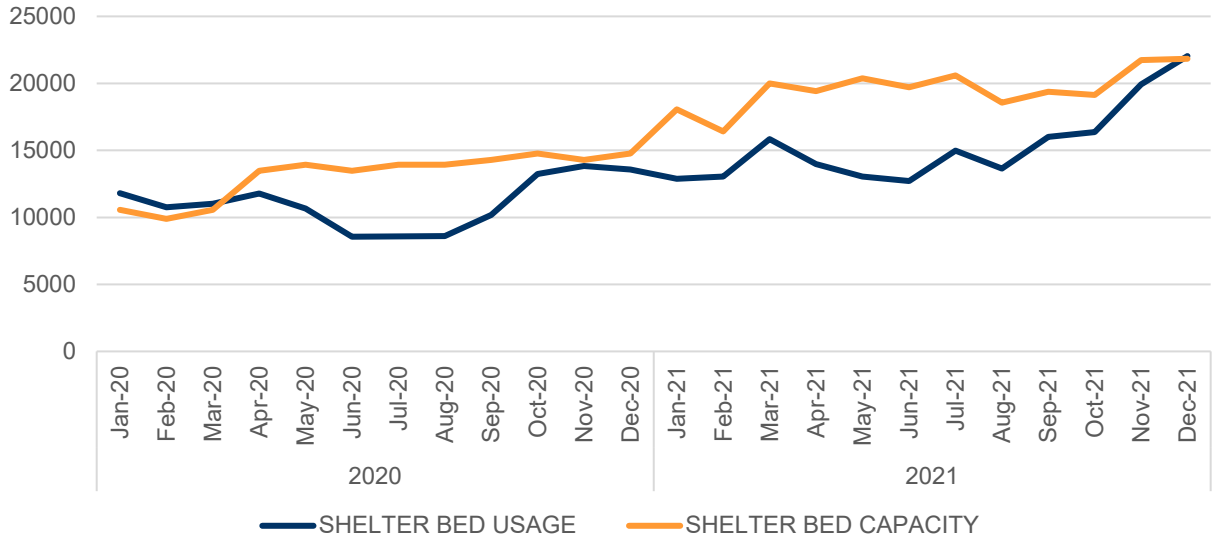
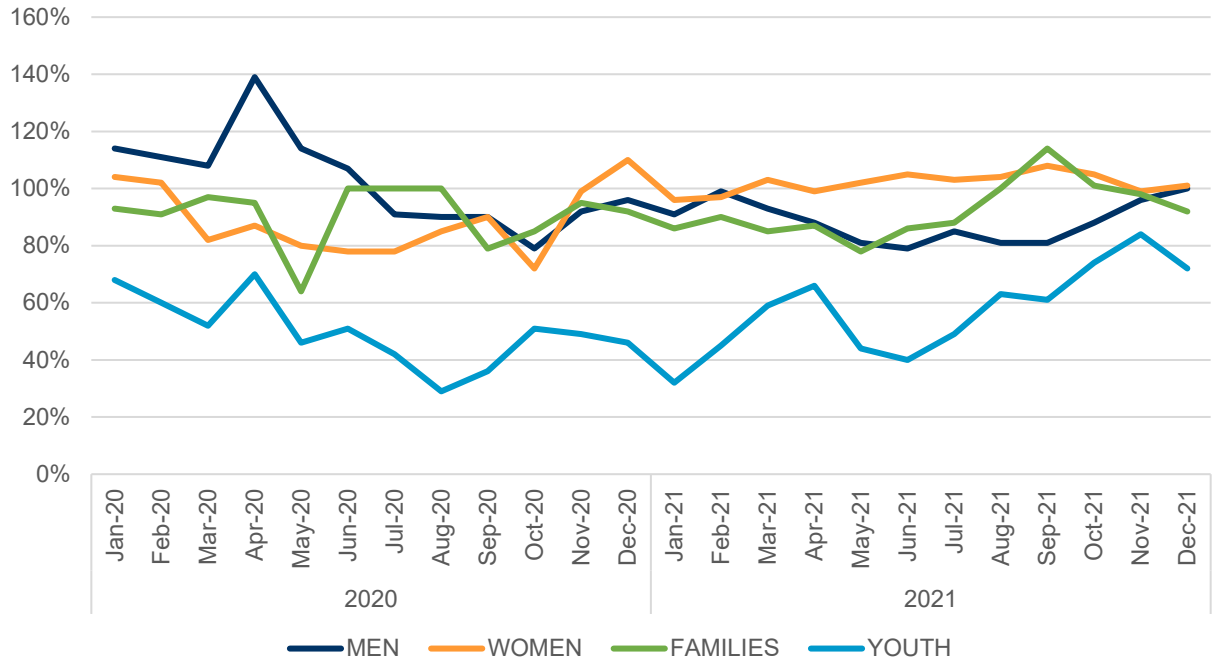


Figure 3: Shelter Occupancy by Sector and Month



Unsheltered Homelessness

During the week of the PiTC (Nov. 15-19, 2021), the City's Housing Focused Street Outreach team reported that there were approximately 90 unique individuals staying in unsheltered locations, including encampments. The rise in, and visibility of, unsheltered

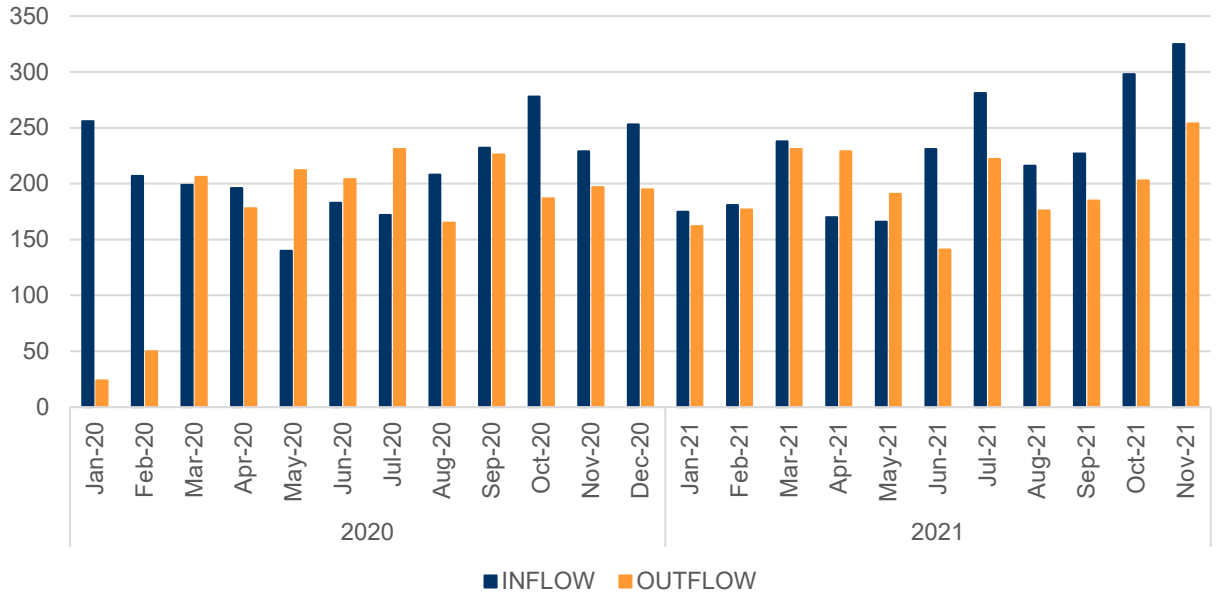
homelessness and encampments throughout many Canadian cities continues to demonstrate how the COVID-19 pandemic persists in exacerbating ongoing systemic challenges and inequities as it relates to housing and homelessness. While the City has worked to develop new strategies and approaches to address these issues locally, unsheltered homelessness remains a persistent reality in Hamilton along with structural barriers to accessing adequate housing and supports.

Shelter System Flow Data

Inflow and outflow are two of the most important measures for monitoring progress towards the goal of ending homelessness. The goal towards ending homelessness is to see outflow exceed inflow. When this happens, it means that more people are exiting from homelessness than are entering the homeless-serving system. As of the end of November 2021, there have been two months where outflow exceeds inflow. In 2020, there were four months where outflow exceeded inflow. Note that outflow data was limited for the first two months of 2020.

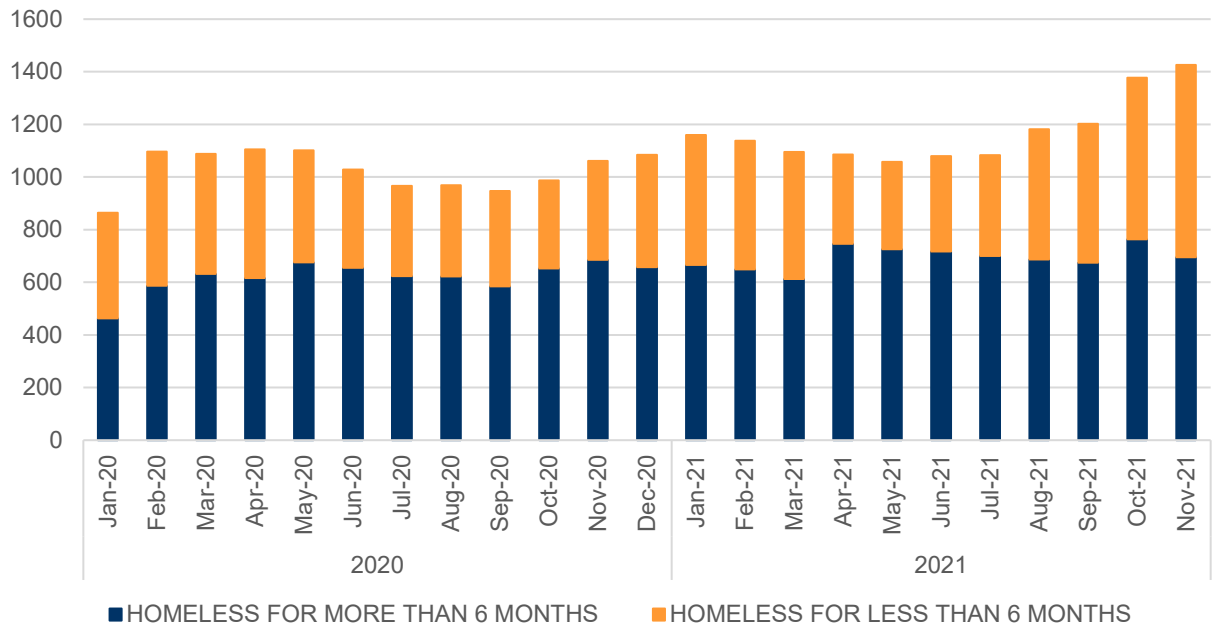
INFLOW	OUTFLOW
Represents the number of individuals: • newly identified as homeless, • returned to homelessness from housing, • returned to homelessness from inactive status.	Represents the number of individuals: • who have moved from housing to housed, • those who have moved to inactive status (meaning they have not interacted with the homeless-serving system for 90+ days).

Figure 4: Individuals (shelter stayers) entering (inflow) or exiting (outflow) homelessness by month



The number of people actively experiencing homelessness is based on data collected by homeless-serving shelters through the Homeless Individuals and Families Information System (HIFIS). Individuals on the By Name List (BNL) who have been engaged only through Outreach and Drop-in programs are not included in this depiction at this time as we look to improve our data reporting.

Figure 5: Individuals (shelter stayers) experiencing homelessness for less than six months and more than six months, by month



Methodology

The nationally coordinated Point-in-Time Count approach includes a set of core standards for the methodology that guide how the counts are conducted in participating communities across Canada. The core standards, identified by Federal and Provincial governments, identify common screening and survey questions that are asked in all participating communities. The approach does give some flexibility for communities to adapt methodology, and Hamilton's survey design and implementation was guided by local partners, including consultation with Indigenous partners through CHIL.

Given the COVID-19 pandemic, adaptations to methodology were made available to communities to support the implementation of Point-in-Time Counts to reduce risks and burden on participants and staff in the homeless serving sector. Adaptations to the 2021 PiTC included:

- expansion of surveying timeline to five days, creating additional flexibility to participate and complete surveys, while avoiding large gatherings to reduce the risk of infection and community spread of COVID-19;
- no additional assessment tool included for 2021, as the survey consisted of only the core anonymous questions;
- 24-hour online survey submission, completed through the Homeless Individuals and Families Information System (HIFIS);
- no additional community volunteers recruited - surveying was conducted exclusively by community social-service agency and City of Hamilton staff;
- full training module completed online; and,
- focus on sheltered sites (emergency shelter, drop in, etc.) and a targeted approach to connect with unsheltered individuals and families in the community in known locations through the City's Housing Focused Street Outreach team, alongside partners from local Indigenous housing organizations.

As in 2016 and 2018, an Indigenous led magnet event was held during the week to provide an opportunity for Indigenous community members to be surveyed by Indigenous surveyors. All survey participants of the PiTC were provided a $15 gift card honorarium upon completion of the survey.

While a number of strategic decisions allowed for increased engagement through the PiTC, there remains limitations in the methodology. In the 2018 PiTC, Hamilton had expanded survey sites to include additional drop-in programs focused on youth, as well as including the Central Library location as a survey site. As a result of enhanced COVID-19 health and safety regulations and limitations on volunteer recruitment, staff were unable to include these additional spaces and build upon learnings and reflections from these survey sites in 2018.

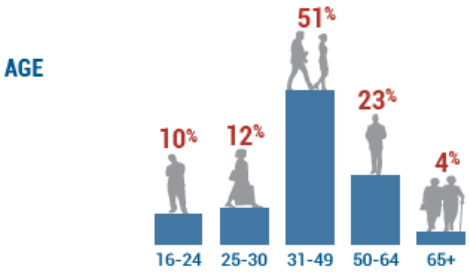
Snapshot

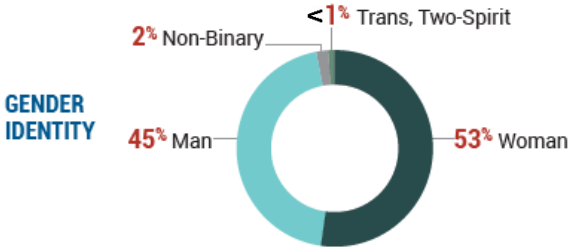
Comparison and analysis of detailed results across multiple PiTC initiatives remains a challenge given the varying contextual factors from year to year. Between PiTC initiatives, the Housing Services Division has worked with community partners to strengthen local reporting on key data related to the state of homelessness and actions towards preventing and ending it. As a part of these broader efforts, the PiTC remains a valuable tool to further support evidence-informed action and improvement within Hamilton's Housing and Homelessness Serving System.

A total of 545 individuals completed voluntary surveys during the 2021 Hamilton Point in Time Connection. Here is a snapshot of the survey results:









INDIGENOUS ANCESTRY

23% identified as Indigenous or as having Indigenous ancestry

IMPACTS OF COVID

77 number of people who report that their most recent housing loss is related to the COVID-19 pandemic

HEALTH

40% of those surveyed reported having a chronic illness or health condition.

270 respondents had been to an emergency room (ER) in the last 12 months, with a cumulative total of 787 ER visits

TOP 3 REASONS FOR MOST RECENT HOUSING LOSS

- Not enough income
- Landlord/tenant conflict
- Unfit/unsafe housing conditions

TOP 5 BARRIERS TO FINDING HOUSING

- Rent too high
- Low income
- No income assistance
- Poor Housing Conditions
- Discrimination

HOMELESS FOR 6 MONTHS OR MORE IN THE PAST YEAR

304 People

Survey Participation

The following chart provides a summary of where the 545 survey respondents reported staying the night before completing the survey:

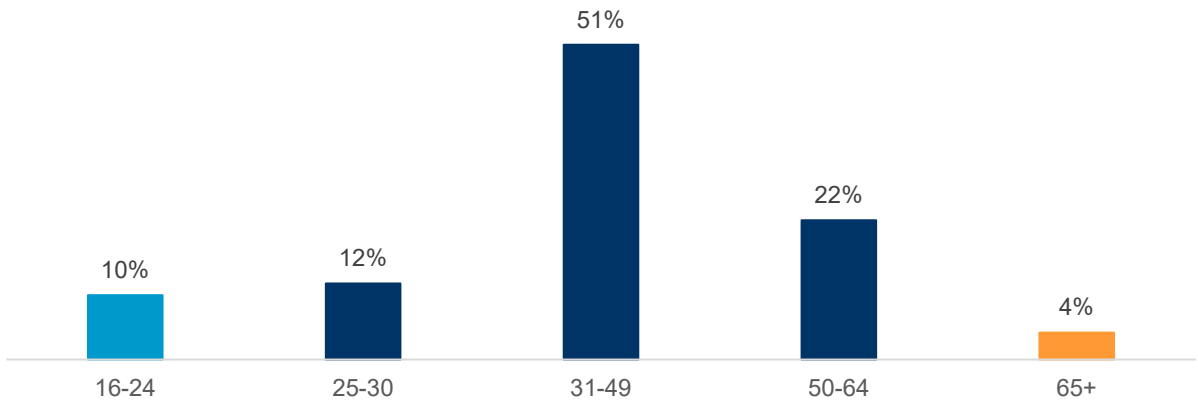
Location	Total	Description
Emergency Shelters	366 (67%)	An emergency shelter, hotel or motel, and domestic violence shelters for emergency accommodation.
Unsheltered	61 (11%)	An unsheltered location in a public space, such as a park, vehicle, or other place not intended for human habitation.
Encampment	35 (6%)	A group of tents, makeshift shelters, or other long-term outdoor settlements.
Couch Surfing	15 (3%)	Staying with a friend, family member, or stranger.
Transitional Housing	52 (10%)	Housing which is a temporary type of accommodation meant to bridge the gap from homelessness to permanent housing.
Motel / Hotel (Self-funded)	1 (0.2%)	Staying in a motel / hotel that was paid for by the individual or family.
Location undetermined	15 (3%)	Location was not reported.

Profile of Respondents Experiencing Homelessness

Age

The average age of respondents was 35 years. Respondents ranged in age from 16 being the youngest and 79 as the oldest. Most respondents (73%) were between the ages of 31 and 64.

Figure 6: Age of Respondents



Gender Identity

A key demographic shift in 2021 results was the percentage of respondents who identified as a woman (53%), which was higher than in 2018 (32%) and 2016 (28%). There are contributing factors to keep in mind when considering this shift in respondent profile, including intentional adaptations to methodology, and where surveys were administered in 2021 in comparison to previous years.

Although not required, Hamilton continues to include people who may be experiencing "hidden homelessness" into the PiTC survey. This has been a standing recommendation by our community to ensure that we better represent populations who may typically not be as highly represented in the mainstream emergency shelter system. Enhanced gender-specific responses during COVID-19, including an expanded emergency shelter system and enhanced drop in locations, along with the option to complete surveys 24 hours a day through the entire duration of the initiative may have also contributed to a shift in response rate.

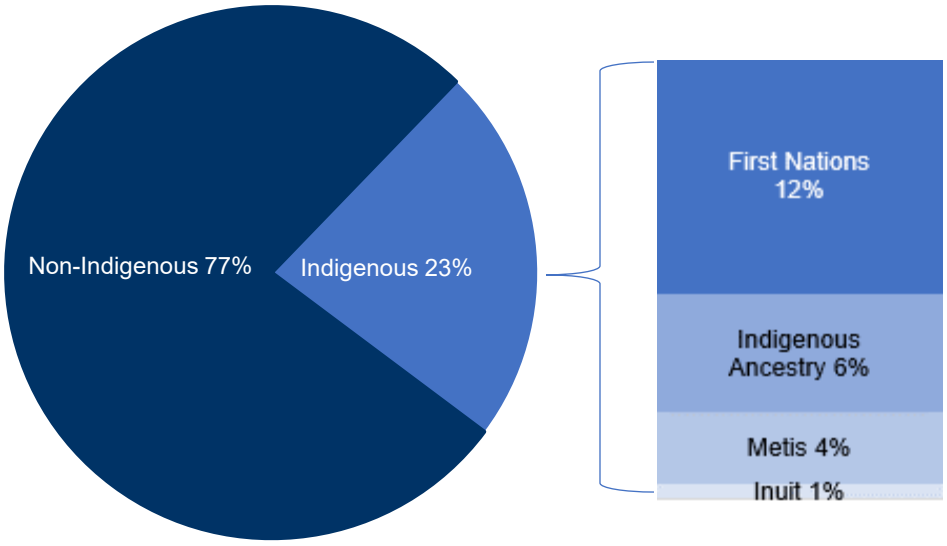
Table 1: Gender Identity of Respondents

Gender	Percentage
Woman	53%
Man	45%
Non-Binary	2%
Trans, Two-Spirit	<1%

Indigenous Identity

In 2021, the PiTC continues to highlight the overrepresentation of Indigenous persons experiencing homelessness in Hamilton (23% of all respondents). A full analysis of Indigenous respondent data can be found in Appendix "B" to Report HSC22021 - 2021 Point in Time Count (Hamilton, Ontario): Indigenous Responses, submitted by CHIL and approved by the ICAB.

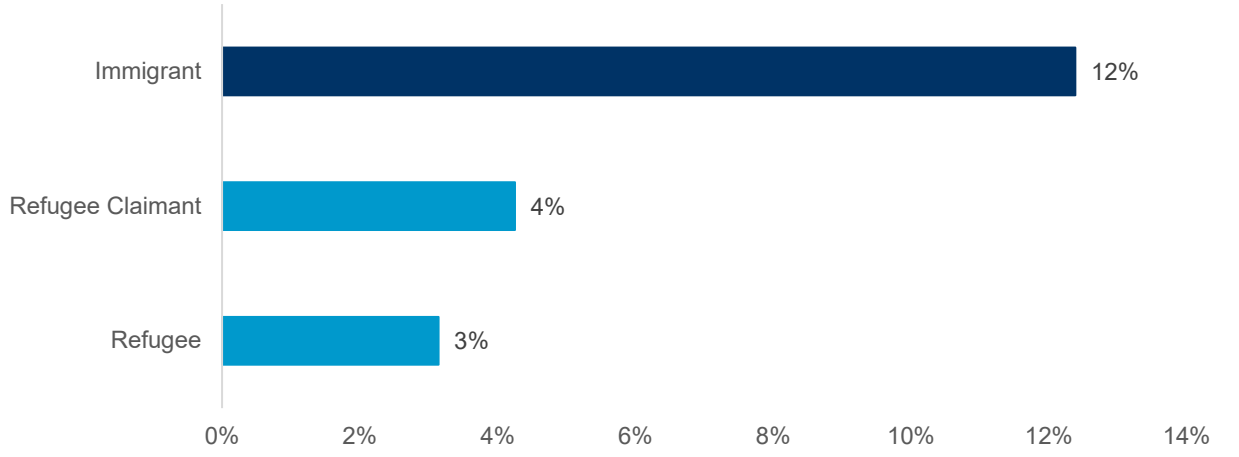
Figure 7: Indigenous Identity of Respondents



Migration to Canada

One-fifth of respondents identified as an immigrant or refugee. A total of 91% reported having been in Canada for one year or more, and 9% reported being in Canada for less than six months.

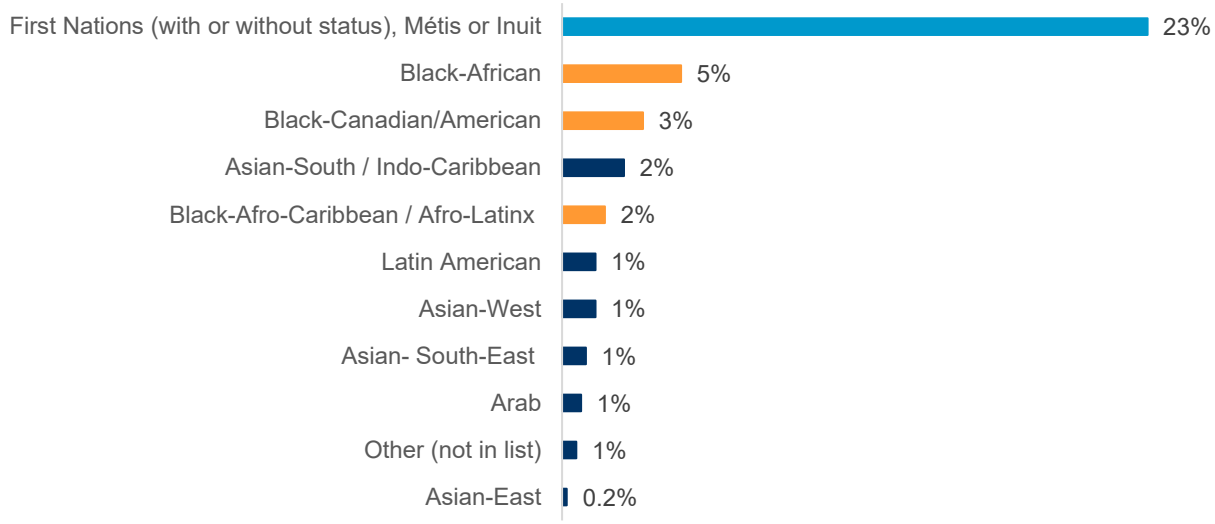
Figure 8: Respondents Migration to Canada



Racial Identity

In 2021, 39% of respondents identified as members of racialized groups, with the largest percentage identifying as First Nations (with or without status), Métis or Inuit (23%). Also, 10% of respondents identified as Black.

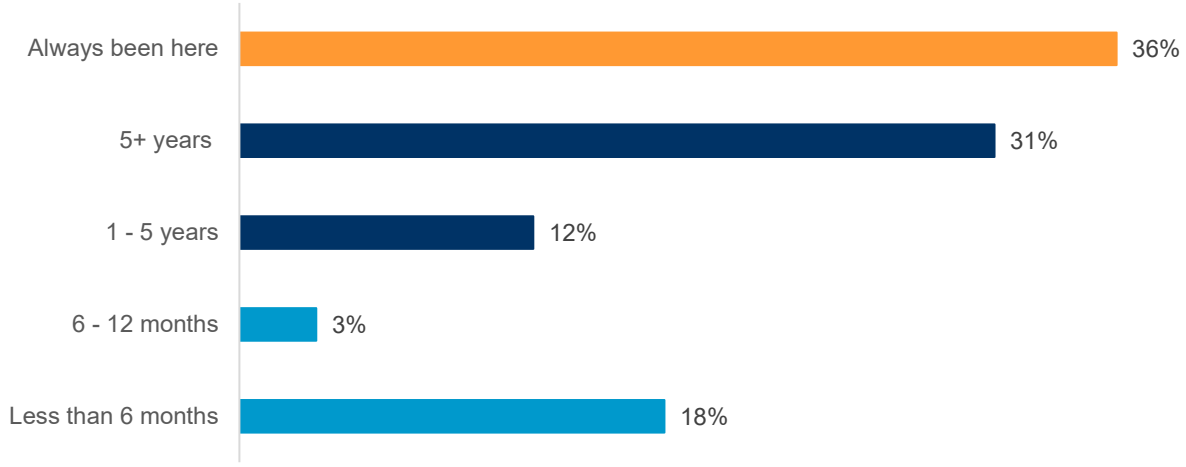
Figure 9: Racial Identity of Respondents



Length of Time in Hamilton

A total of 79% of respondents identified having been in Hamilton for one year or more, including those who reported as always been in Hamilton (36%). 21% of individuals reported being in Hamilton for less than one year.

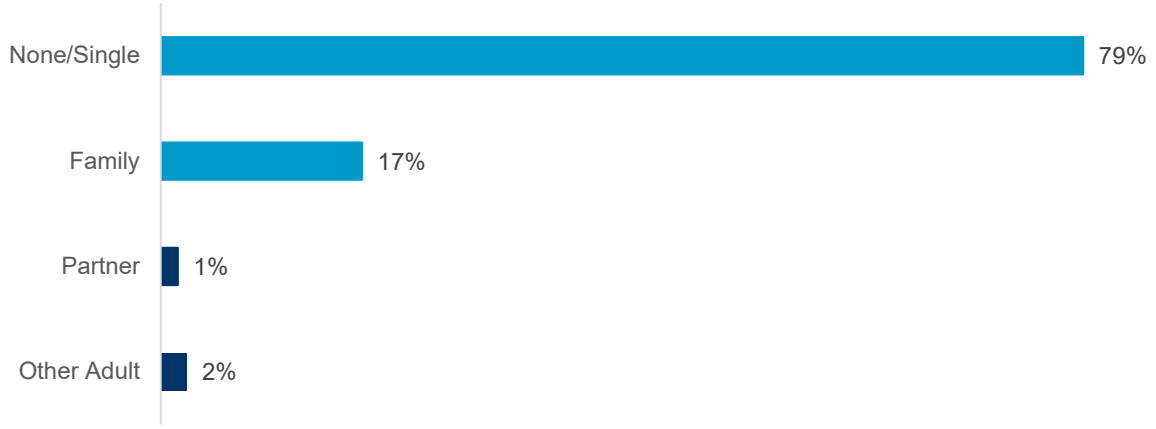
Figure 10: Respondents Length of Time in Hamilton



Family Homelessness

The majority of respondents identified that they were staying alone when surveyed (79%); 21% reported that they had either a partner, other adults or non-adult dependents staying with them that night.

Figure 11: Persons Staying with Respondent on Night of PiTC Survey



Sexual Identity

A total of 10% of respondents identified as 2SLGBTQ+ (Two-spirit, lesbian, gay, bisexual, transgender, queer, questioning, + refers to sexual and gender identities not represented in the acronym). Of those who identified as 2SLGBTQ+ (50), 16% (9) were youth between the ages of 16 and 24.

Figure 12: Sexual Identity of Respondents

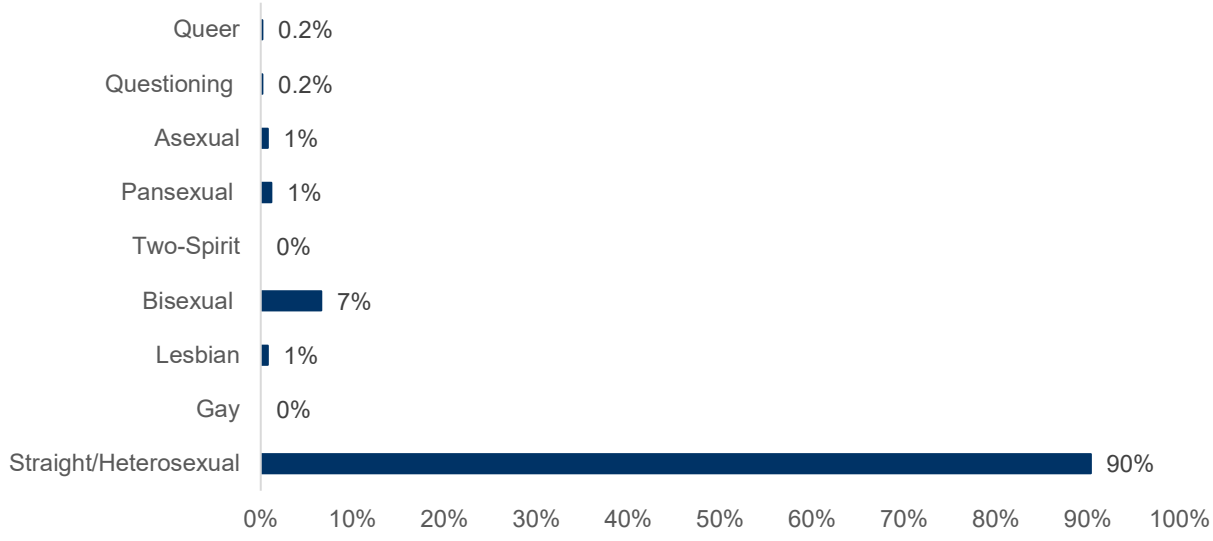
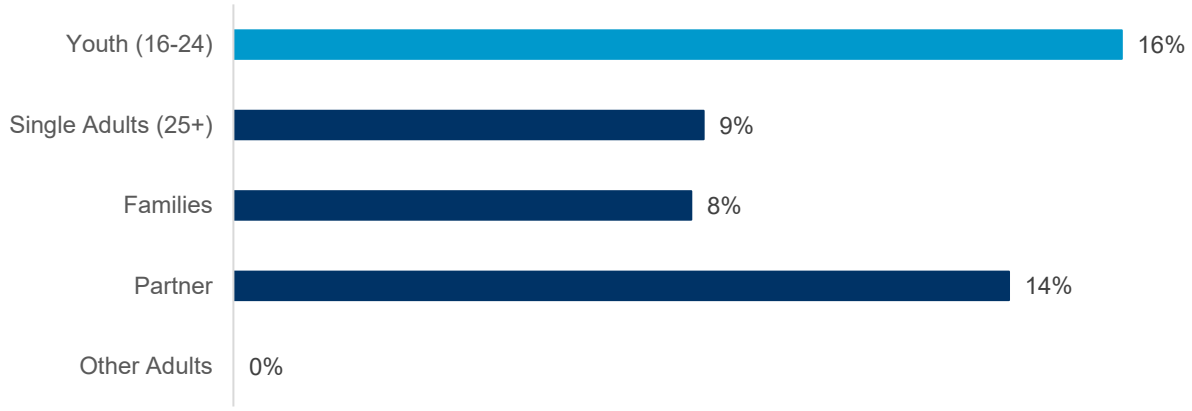


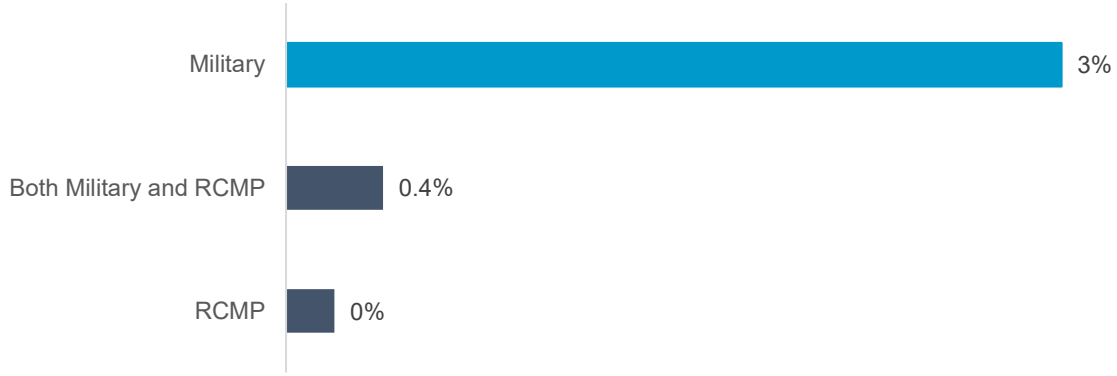
Figure 13: Respondents Identifying as 2SLGBTQ+ by Surveyed Group



Veteran Homelessness

In 2021, 3% of all respondents experiencing homelessness reported having served in the Canadian Military or RCMP.

Figure 14: Respondents Reporting Ever Serviced in the Military or RCMP



Health

Respondents were asked if they had any of the following types of health challenges:

- mental health issue [diagnosed or undiagnosed] (e.g. depression, PTSD, bipolar disorder),
- substance use issue (e.g. tobacco, alcohol, opiates),
- illness or medical condition (e.g. diabetes, arthritis, TB, HIV),
- physical limitation (e.g. challenges with mobility, physical abilities or dexterity),
- learning or cognitive limitations (e.g. dyslexia, autism spectrum disorder, or as a result of ADHD or an acquired brain injury).

A total of 457 respondents identified having at least one health challenge. More than half of respondents indicated having a health challenge relating to mental health (60%)

and substance use (59%). A total of 40% of those surveyed reported having a chronic illness or health condition.

Figure 15: Health Challenges Identified by Respondents



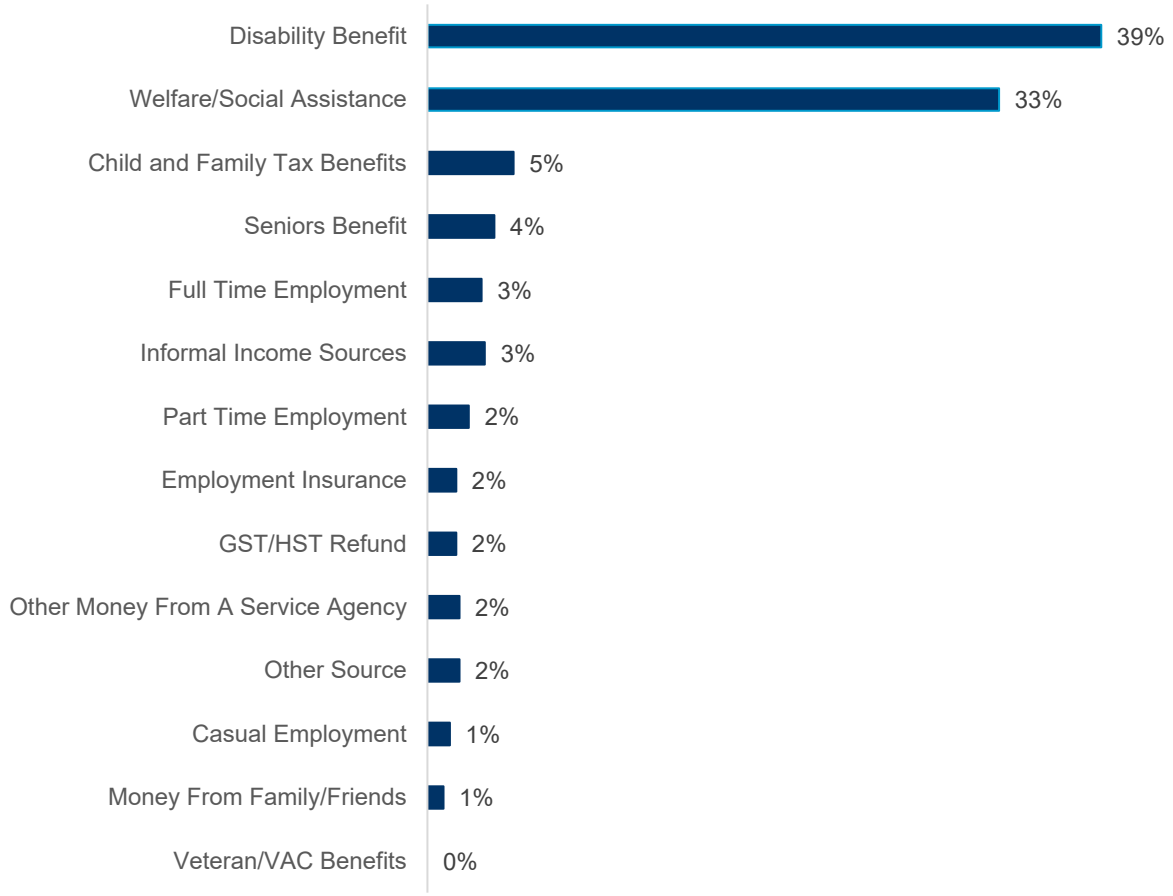
Figure 16: Multiple Types of Health Challenges Identified by Respondents



Sources of Income

The majority of respondents (87%) reported having at least one source of income. The most common sources of income reported in 2021 were disability benefit (39%) and welfare/social assistance (33%). All other sources of income were reported by less than 5% of respondents.

Figure 17: Respondents Source of Income

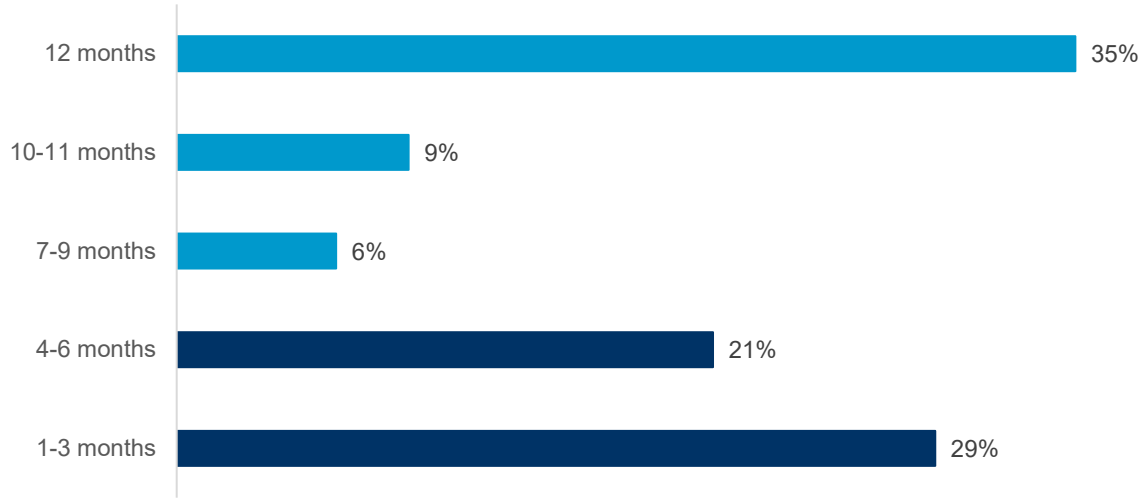


Homelessness History

Length of Homelessness in Past Year

The average reported length of homelessness in the past year was seven months. For the purposes of coordinated point-in-time counts, the federal definition of chronic homelessness is experiencing homelessness for six months or more in the past year. A total of 50% of respondents reported being homeless for more than six months over the past year. 65% of both youth and families identified as being homeless for less than six months in the past year. 57% of single adults identified as being homeless for more than six months in the last year.

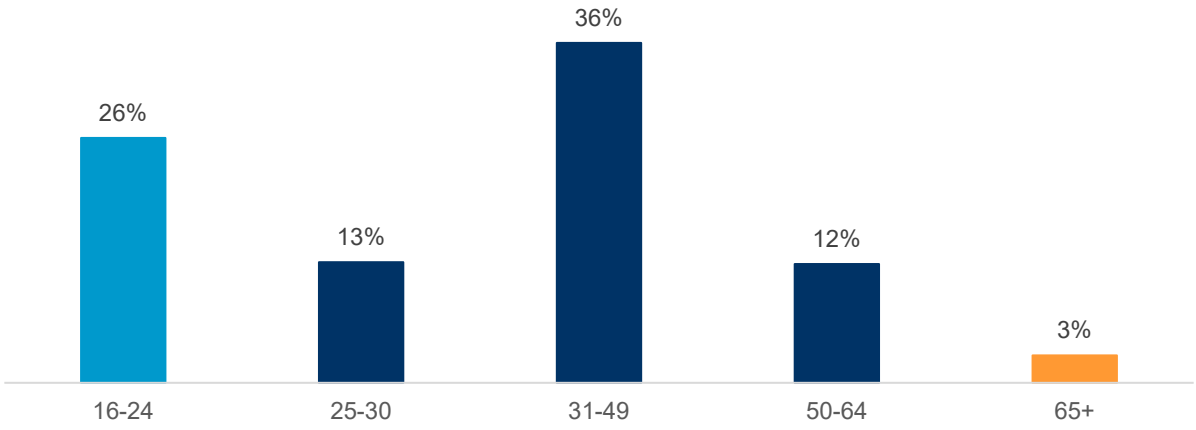
Figure 18: Length of Homelessness in the Past Year



Age of First Homeless Experience

Respondents were asked how old they were the first time they experienced homelessness. A total of 26% of respondents reported being between 16-24 years old the first time they experienced homelessness; 61% were between the ages of 25 and 64.

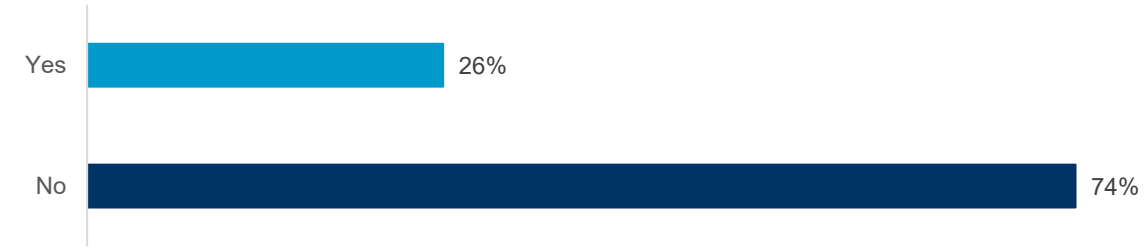
Figure 19: Respondents Age of First Homeless Experience



Experience with Foster Care

A total of 26% of respondents indicated that they had previous experience being in foster care or a youth group home.

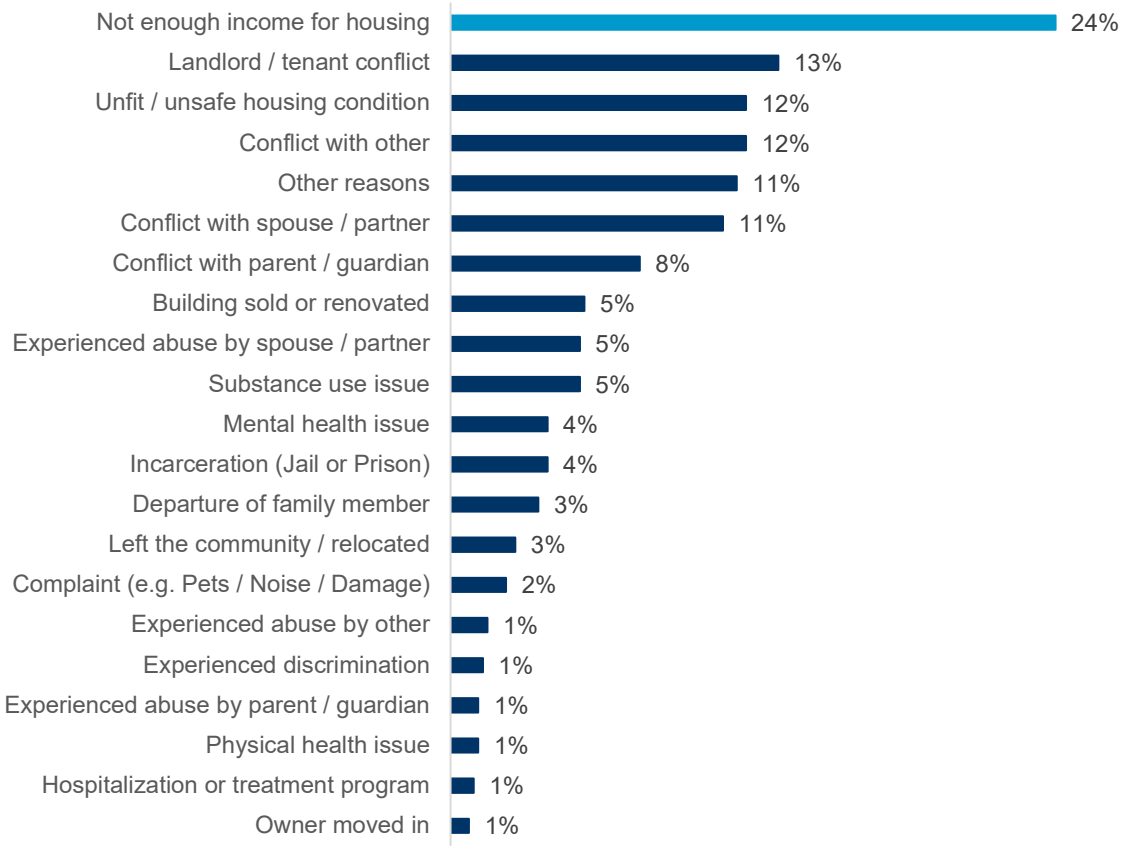
Figure 20: Respondents with Foster Care Experience



Reasons for Homelessness/Housing Loss

When asked what is necessary to maintain and/or find new housing, respondents consistently and clearly identified the need for enhanced income supports and spoke to ongoing challenges with housing affordability. The top reasons for most recent housing loss identified included: not enough income; landlord/tenant conflict; unfit/unsafe housing conditions and conflict with someone other than spouse/partner or parent/guardian.

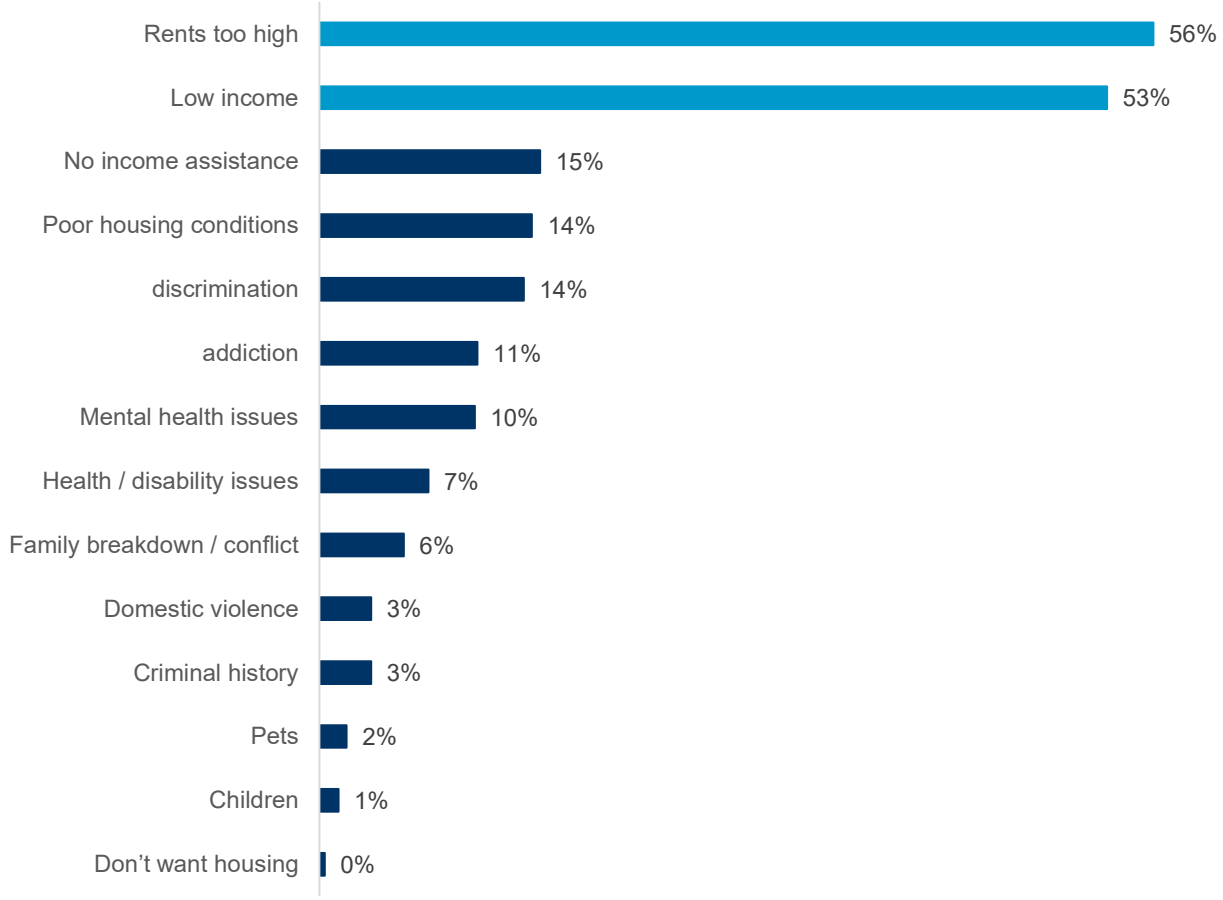
Figure 21: Respondents Reasons for Homelessness



Barriers to Finding Housing

The top barriers and challenges to finding new housing identified by respondents include: rents too high; low income; no income assistance; poor housing conditions; and, discrimination. Additionally, 67 respondents identified having a low credit score as a barrier as well.

Figure 22: Respondents Barriers to Finding Housing

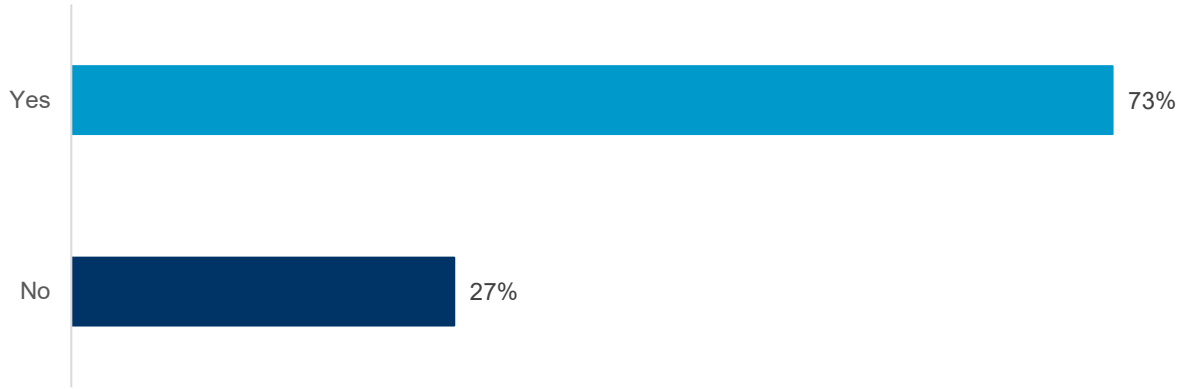


Service Use Patterns

Shelter Use in the Last Year

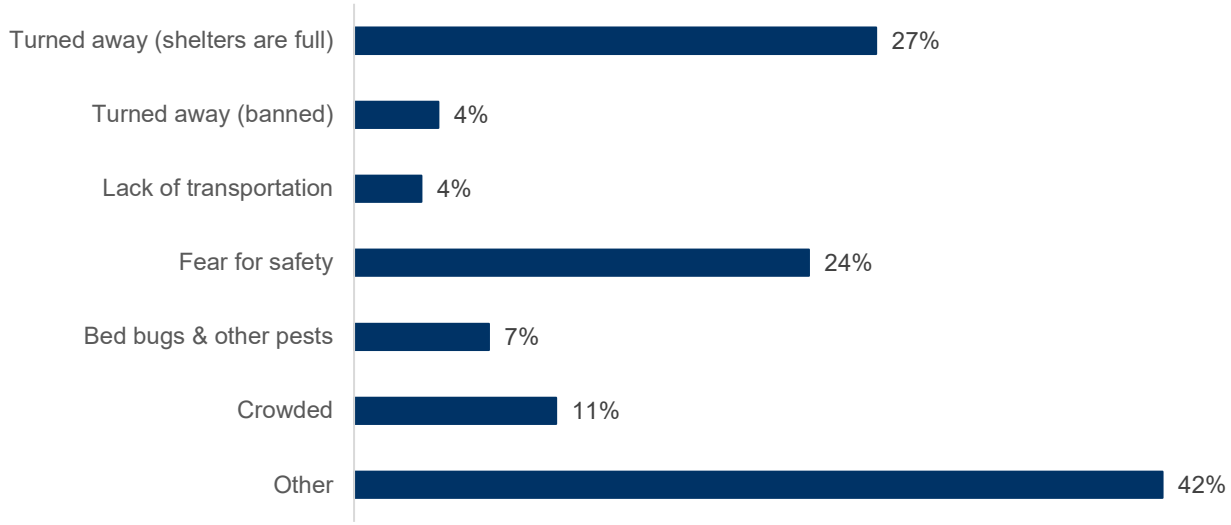
When asked if they have stayed in a shelter in the last year (including emergency and extreme weather shelters), 73% of respondents reported that they had.

Figure 23: Respondents Reporting Staying in Shelter in the Last Year



When individuals were asked about why they decided not to stay in a homeless shelter in the last year, 27% reported that they were turned away because the shelter was full, 24% feared for their safety in a shelter, and 11% expressed concerns about crowding.

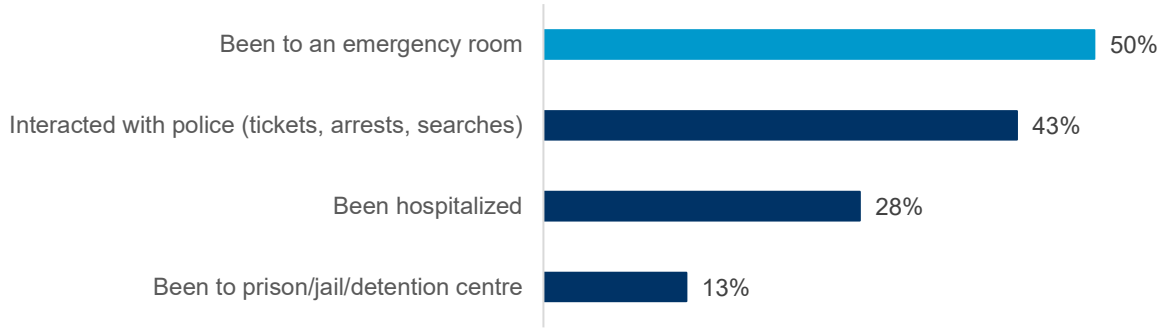
Figure 24: Respondents Reporting Staying in Shelter in the Last Year



Interaction with the Health Care & Criminal Justice System

A total of 270 respondents (50%) reported that they had been to an emergency room (ER) in the last 12 months, with a cumulative total of 787 ER visits. Approximately 61% of those who visited the ER in the last year had been there more than once.

Figure 25: Respondents Interaction with the Health Care and Criminal Justice System



Conclusion and Next Steps

The PiTC remains an important local initiative and a demonstration of Hamilton's commitment to work collaboratively to prevent and end homelessness. As Service System Manager and Designated Community Entity for the provincial and federal funding respectively, the Housing Services Division remains committed to working in partnership with urban Indigenous leadership to build a coordinated housing and homeless-serving system in deep collaboration with community partners to ensure everyone in Hamilton has a home.

In addition, enhanced gender-specific responses and housing options for women, trans-feminine, trans-masculine and non-binary adults remain an important local priority. The Housing Services Division continues to consult with the sector planning tables including the Women's Housing Planning Collaborative, the Street Youth Planning Collaborative and the membership of the Men's Emergency Services Coordination Committee. Through this ongoing engagement and collaboration, it is our goal to continue to share the results and further analysis of the PiTC, while discussing next steps to further centre the voices of unhoused residents in our collective responses.

In the ongoing development and adaptation of systems-level responses, it remains essential that people with living/lived experience are empowered to inform services and hold the homelessness-serving system accountable for delivering on its promise of housing and supports. A distinct focus on Indigenous rights should be prioritized in these efforts, guided by the obligation to respect, protect and fulfil the distinct rights of Indigenous peoples through engagement with unhoused residents. Underpinning further strategic coordination efforts remains the collective obligation to ensure that people experiencing homelessness have access to long-term, adequate housing that meets their needs.

Appendix A: 2021 PiTC Survey

SCREENING TOOL

Hello, my name is _____ and I'm a volunteer for the **Hamilton** Point in Time Connection – a housing needs survey. We are conducting a survey to provide better programs and services to people experiencing homelessness. The survey takes about 10 minutes to complete.

- **Participation is voluntary** and **your name will not be recorded –** participation will not affect the services you receive.
- You can choose to **skip any question** or to **stop the interview at any time**.
- Results will contribute to the understanding of homelessness across Canada, and will help with research to improve services.

A. Have you answered this survey already this week?
[YES: Thank and tally] **[NO: Go to B]**

B. Are you willing to participate in the survey?
[YES: Go to C] **[NO: Thank and tally]**

C. Where did you stay last night? [DO NOT READ CATEGORIES – circle response]

a. DECLINE TO ANSWER b. OWN APARTMENT / HOUSE	**[THANK & END SURVEY]**
c. SOMEONE ELSE'S PLACE d. MOTEL/HOTEL (SELF-FUNDED) e. HOSPITAL f. TREATMENT CENTRE g. JAIL, PRISON, REMAND CENTRE	**C1. Do you have access to a permanent residence where you can safely stay as long as you want?** a. Yes **[THANK & END]** b. No (not permanent AND/OR not safe) **[BEGIN SURVEY]** c. Don't Know **[BEGIN SURVEY]** d. Decline to answer **[THANK & END]**
h. HOMELESS SHELTER (EMERGENCY, FAMILY OR DOMESTIC VIOLENCE SHELTER) i. HOTEL/MOTEL (FUNDED BY CITY OR HOMELESS PROGRAM) j. TRANSITIONAL SHELTER/HOUSING k. UNSHELTERED IN A PUBLIC SPACE (E.G. STREET, PARK, BUS SHELTER, FOREST OR ABANDONED BUILDING) l. ENCAMPMENT (E.G. GROUP OF TENTS, MAKESHIFT SHELTERS OR LONG-TERM OUTDOOR SETTLEMENT) m. VEHICLE (CAR, VAN, RV, TRUCK, BOAT) n. UNSURE: INDICATE PROBABLE LOCATION _____	**[BEGIN SURVEY]**

- You will receive a $15 gift card as a thank you for your participation.

Survey Number: _____

Location: _____ **Time: _____AM/PM**

Interviewer: _____ **Contact #: _____**

BEGIN SURVEY

1. **Did you have any family members or anyone else who stayed with you last night?** [Indicate survey number for partners. Check all that apply]

☐ NONE ☐ PARTNER - Survey #: ___ ___ ___ ___					☐ OTHER (Can include other family or friends) ☐ DECLINE TO ANSWER			
☐ CHILD(REN)/DEPENDENT(S)	1	2	3	4	5	6	7	8
[indicate gender and age for each] GENDER								
AGE								

2. **How old are you? [OR] What year were you born?** [If unsure, ask for best estimate]

○ AGE _____**OR** YEAR BORN _____	○ DON'T KNOW	○ DECLINE TO ANSWER

➔ **For this survey, "homelessness" means any time when you have been without a permanent and secure place to live, including sleeping in shelters, on the streets, or living temporarily with others without having your own permanent housing (e.g. couch surfing).**

3. **How old were you the first time you experienced homelessness?**

○ AGE_____	○ DON'T KNOW	○ DECLINE TO ANSWER

4. **In total, for *how <u>much time</u>* have you experienced homelessness over the PAST YEAR (the last 12 months)?** [Does not need to be exact. Best estimate.]

○ LENGTH _____ DAYS | WEEKS | MONTHS	○ DON'T KNOW	○ DECLINE TO ANSWER

5. **Have you stayed in a homeless shelter in the past year? For example,** (*COMMUNITY NOTE: Include examples of emergency shelters and extreme weather shelters for interviewers to provide*).

○ YES	○ NO	○ DON'T KNOW	○ DECLINE TO ANSWER

5B➔ If not, what are the main reasons? [Do not read categories; select all that apply)

☐ TURNED AWAY (SHELTERS ARE FULL) ☐ TURNED AWAY (BANNED) ☐ LACK OF TRANSPORTATION	☐ FEAR FOR SAFETY ☐ BED BUGS & OTHER PESTS ☐ CROWDED	☐ OTHER: _____ ☐ DON'T KNOW ☐ DECLINE TO ANSWER

6. Did you come to Canada as an immigrant, refugee or a refugee claimant (i.e. applied for refugee status after coming to Canada)?

○ YES, IMMIGRANT ---------->	**If YES:** **How long have you been in Canada?**
○ YES, REFUGEE---------->	○ LENGTH: _____ DAYS | WEEKS | MONTHS | YEARS
○ YES, REFUGEE CLAIMANT--------->	OR DATE: _____/_____/_____ DAY / MONTH / YEAR
○ NO	○ DON'T KNOW
○ DON'T KNOW	○ DECLINE TO ANSWER
○ DECLINE TO ANSWER	

7. How long have you been in Hamilton?

○ LENGTH _____ DAYS / WEEKS / MONTHS / YEARS	○ ALWAYS BEEN HERE ○ DON'T KNOW ○ DECLINE TO ANSWER
↳ **Where did you live before you came here?**	○ CITY: _____ | PROVINCE/TERRITORY/COUNTRY: _____ ○ DECLINE TO ANSWER

8a. Do you identify as First Nations (with or without status), Métis, or Inuit, or do you have North American Indigenous ancestry? [If yes, please specify]

○ YES, FIRST NATIONS	○ YES, MÉTIS	○ NO	○ DECLINE TO ANSWER
○ YES, INUIT	○ YES, INDIGENOUS ANCESTRY	○ DON'T KNOW	

8b. In *addition* to your response in the question above, do you identify with any of the racialized identities listed below? [Show or Read list. Select all that apply]

☐ ARAB (e.g., Syrian, Egyptian, Yemeni)	☐ BLACK-AFRO-CARIBBEAN OR AFRO-LATINX (e.g., Jamaican, Haitian, Afro-Brazilian)
☐ ASIAN-EAST (e.g., Chinese, Korean, Japanese)	☐ LATIN AMERICAN (e.g., Brazilian, Mexican, Chilean, Cuban)
☐ ASIAN- SOUTH-EAST (e.g., Filipino, Vietnamese, Cambodian, Malaysian, Laotian)	☐ WHITE (e.g. European, French, Ukrainian, Euro-Latinx)
☐ ASIAN-SOUTH OR INDO-CARIBBEAN (e.g., Indian, Pakistani, Sri Lankan, Indo-Guyanese, Indo-Trinidadian)	☐ NOT LISTED (PLEASE SPECIFY): _____
☐ ASIAN-WEST (e.g., Iranian, Afghan)	☐ IDENTIFY AS INDIGENOUS ONLY
☐ BLACK-CANADIAN/AMERICAN	☐ DON'T KNOW
☐ BLACK-AFRICAN (e.g., Ghanaian, Ethiopian, Nigerian)	☐ DECLINE TO ANSWER

9. Have you ever served in the Canadian Military or RCMP?
[Military includes Canadian Navy, Army, or Air Force]

○ YES, MILITARY	○ BOTH MILITARY AND RCMP	○ DON'T KNOW
○ YES, RCMP	○ NO	○ DECLINE TO ANSWER

10. As a child or youth, were you ever in foster care or in a youth group home (*COMMUNITY NOTE: include any other Provincial child welfare programs*)? [Note: This question applies specifically to child welfare programs.]

○ YES	○ NO	○ DON'T KNOW	○ DECLINE TO ANSWER

11. Do you identify as having any of the following health challenges at this time:

ILLNESS OR MEDICAL CONDITION [e.g. diabetes, arthritis, TB, HIV]	○ YES	○ NO	○ DON'T KNOW	○ DECLINE TO ANSWER

PHYSICAL LIMITATION [e.g. challenges with mobility, physical abilities or dexterity]	○ YES	○ NO	○ DON'T KNOW	○ DECLINE TO ANSWER
LEARNING OR COGNITIVE LIMITATIONS [e.g. dyslexia, autism spectrum disorder, or as a result of ADHD or an acquired brain injury]	○ YES	○ NO	○ DON'T KNOW	○ DECLINE TO ANSWER
MENTAL HEALTH ISSUE [diagnosed/undiagnosed] [e.g. depression, Post traumatic stress disorder (PTSD), bipolar disorder]]	○ YES	○ NO	○ DON'T KNOW	○ DECLINE TO ANSWER
SUBSTANCE USE ISSUE [e.g. tobacco, alcohol, opiates]	○ YES	○ NO	○ DON'T KNOW	○ DECLINE TO ANSWER

12. What gender do you identify with? [Show list.]

○ WOMAN	○ TRANS WOMAN	○ NOT LISTED: _____
○ MAN	○ TRANS MAN	
○ TWO-SPIRIT	○ NON-BINARY (GENDERQUEER)	○ DON'T KNOW
		○ DECLINE TO ANSWER

13. How do you describe your sexual orientation, for example straight, gay, lesbian? [Show list.]

○ GAY	○ BISEXUAL	○ ASEXUAL	○ NOT LISTED: _____
○ LESBIAN	○ TWO-SPIRIT	○ QUESTIONING	○ DON'T KNOW
○ STRAIGHT/HETEROSEXUAL	○ PANSEXUAL	○ QUEER	○ DECLINE TO ANSWER

14a. What happened that caused you to lose your housing most recently?

[Do not read the options. Check all that apply. "Housing" does not include temporary arrangements (e.g., couch surfing) or shelter stays. Follow up for the reason if the respondent says "eviction" or that they "chose to leave".]

A: HOUSING AND FINANCIAL ISSUES	B: INTERPERSONAL AND FAMILY ISSUES	C: HEALTH OR CORRECTIONS
☐ NOT ENOUGH INCOME FOR HOUSING (E.G. LOSS OF BENEFIT, INCOME, OR JOB)	☐ EXPERIENCED DISCRIMINATION	☐ PHYSICAL HEALTH ISSUE
☐ UNFIT/UNSAFE HOUSING CONDITION	☐ CONFLICT WITH: SPOUSE / PARTNER	☐ MENTAL HEALTH ISSUE
☐ BUILDING SOLD OR RENNOVATED (RENOVICTION)	☐ CONFLICT WITH: PARENT / GUARDIAN	☐ SUBSTANCE USE ISSUE
☐ OWNER MOVED IN	☐ CONFLICT WITH: OTHER (_____)	☐ HOSPITALIZATION OR TREATMENT PROGRAM
☐ LANDLORD/TENANT CONFLICT	☐ EXPERIENCED ABUSE BY: SPOUSE / PARTNER	☐ INCARCERATION (JAIL OR PRISON)
☐ COMPLAINT (E.G. PETS/NOISE/DAMAGE)	☐ EXPERIENCED ABUSE BY: PARENT / GUARDIAN	
☐ LEFT THE COMMUNITY/RELOCATED	☐ EXPERIENCED ABUSE BY: OTHER (_____)	
	☐ DEPARTURE OF FAMILY MEMBER	

☐ OTHER REASON: _____ ☐ DON'T KNOW ☐ DECLINE TO ANSWER

14b. Was your most recent housing loss related to the COVID-19 pandemic?

○ YES ○ NO ○ DON'T KNOW ○ DECLINE TO ANSWER

14c. How long ago did that happen (that you lost your housing most recently)? (Best estimate)

○ LENGTH _____ DAYS | WEEKS | MONTHS | YEARS ○ DON'T KNOW ○ DECLINE TO ANSWER

15. What are your sources of income? [Reminder that this survey is anonymous. **Read list** and check all that apply.]

☐ FULL TIME EMPLOYMENT	☐ EMPLOYMENT INSURANCE	☐ CHILD AND FAMILY TAX BENEFITS
☐ PART TIME EMPLOYMENT	☐ DISABILITY BENEFIT [Name of PROV. DISABILITY BENEFIT]	☐ GST/HST REFUND
☐ CASUAL EMPLOYMENT (E.G. CONTRACT WORK)	☐ SENIORS BENEFITS (E.G. CPP/OAS/GIS)	☐ OTHER MONEY FROM A SERVICE AGENCY
☐ INFORMAL INCOME SOURCES (E.G. BOTTLE RETURNS, PANHANDLING)	☐ WELFARE/SOCIAL ASSISTANCE [Prov. Benefit]	☐ OTHER SOURCE: _____
☐ MONEY FROM FAMILY/FRIENDS	☐ VETERAN/VAC BENEFITS	☐ NO INCOME
		☐ DON'T KNOW
		☐ DECLINE TO ANSWER

16. In the past year (12 months) have you: [Ask respondents to give their best estimate]

BEEN TO AN EMERGENCY ROOM ---------->	Y ____ N____	# _____ *Times*
BEEN HOSPITALIZED ---------->	Y ____ N____	# _____ *Times*
→DAYS YOU HAVE SPENT HOSPITALIZED		_____ *Days Total*
INTERACTED WITH POLICE (*Tickets, arrests, searches)* ---------->	Y ____ N____	# _____ *Times*
BEEN TO PRISON/JAIL ---------->	Y ____ N____	# _____ *Times*
→DAYS YOU HAVE SPENT IN PRISON/JAIL		_____ *Days Total*

17. What challenges or problems have you experienced when trying to find housing? [Select all that apply]

☐ LOW INCOME	☐ MENTAL HEALTH ISSUES	☐ DISCRIMINATION
☐ NO INCOME ASSISTANCE	☐ ADDICTION	☐ DON'T WANT HOUSING
☐ RENTS TOO HIGH	☐ FAMILY BREAKDOWN/CONFLICT	☐ OTHER: _____
☐ POOR HOUSING CONDITIONS	☐ CRIMINAL HISTORY	☐ NO BARRIERS TO HOUSING
☐ DOMESTIC VIOLENCE	☐ PETS	☐ DECLINE TO ANSWER
☐ HEALTH/DISABILITY ISSUES	☐ CHILDREN	

----------END OF SURVEY – PROVIDE GIFT CARD----------

TAB 16

2021 POINT IN TIME COUNT

(Hamilton, Ontario)

INDIGENOUS RESPONSES

Submitted: April 15th, 2022

Approved by: Indigenous Community Advisory Board - Hamilton

Submitted by: Coalition of Hamilton Indigenous Leadership
Victoria Bomberry, Indigenous Data and Policy Analyst
Cindy Sue McCormack, Executive Director

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About the Coalition of Hamilton Indigenous Leadership

Formerly known as the Hamilton Executive Directors Aboriginal Coalition, the Coalition of Hamilton Indigenous Leadership is a collaborative of Indigenous leaders representing six Indigenous agencies in Hamilton, Ontario. The Coalition of Hamilton Indigenous Leadership (CHIL) is represented by the Hamilton Regional Indian Centre, De dwa da dehs nyes Aboriginal Health Centre, Sacajawea Non-Profit Housing Inc., the Native Women's Centre, Niagara Peninsula Aboriginal Area Management Board, and Ontario Aboriginal Housing Services.

The Executive Director (or Designate) of each member agency sits on the CHIL Board of Directors and contributes to achieving CHIL's vision, mission, and values.

Our vision is a vibrant, healthy, inclusive, and culturally safe community.

Our mission is to increase equitable access to services and programs for Indigenous community members of Hamilton.

Our values are informed by the Seven Grandfather teachings as we strive to live and work with Ka'nikonhrí:yo (the Haudenosaunee concept of a "Good Mind").

Reaching Home: Canada's National Homelessness Strategy

The Coalition of Hamilton Indigenous Leadership works to address Indigenous homelessness in Hamilton and is funded by Employment and Social Development Canada through Reaching Home: Canada's National Homelessness Strategy. Through Reaching Home, CHIL acts as the Indigenous Community Entity for Hamilton and is responsible for administering and managing the Indigenous stream of Reaching Home funding in our community.

Indigenous Community Advisory Board

In working to address Indigenous experiences of homelessness in Hamilton, CHIL is supported by the Indigenous Community Advisory Board (ICAB). The ICAB is made up of Indigenous identifying community members living in the city of Hamilton who draw from their lived, personal, and professional experiences to guide a community-wide and wholistic response to Indigenous experiences of homelessness in Hamilton.

Some of the ICAB's key responsibilities include:

- Gathering relevant information related to Indigenous homelessness to identify community priorities to address Indigenous homelessness in Hamilton
- Assessing and recommending projects for funding to the Indigenous Community Entity (CHIL)
- Supporting the Indigenous Community Entity (CHIL) to plan and coordinate a community-wide effort to prevent and address Indigenous homelessness
- Developing terms of reference and other policies and procedures central to fulfilling the responsibilities of the Indigenous Community Advisory Board

2021 Point in Time Survey Key Findings (Hamilton, ON)

Indigenous Peoples continue to be overrepresented among community members experiencing homelessness in Hamilton. Among the general population, 2% of Hamilton residents identify as Indigenous or having Indigenous ancestry[1]. However, among community members experiencing homelessness in Hamilton and participating in the 2021 Point in Time Connection survey, 23% identify as Indigenous or having Indigenous ancestry.

Gender Identity

Among Indigenous respondents to Hamilton's 2021 Point in Time survey, 55% identify as women, 40% identify as men, 1% identify as Two-Spirit, and 4% identify as Non-Binary/Gender Queer.

Age Groups

The majority of Indigenous respondents to the 2021 PIT survey are middle aged. Eighty percent of Indigenous respondents indicated they were between the ages of thirty-one and sixty-four.

Shelter Use

Eighty percent of respondents reported having stayed in a homelessness shelter within the past year. When asked where they had stayed the night before completing the survey, thirty-seven percent of Indigenous respondents reported they had stayed in a homeless shelter.

Hamilton is Home

Among Indigenous respondents, 44% reported always living in Hamilton. An additional twenty-eight percent (28%) reported having lived in Hamilton for five or more years.

First Experiences of Homelessness

More than one in three Indigenous respondents to the survey indicated having first experienced homelessness on or before their 25th birthday.

Foster Care and/or Youth Group Home Experiences

Experiences of having been in foster care or a youth group home are prevalent among Indigenous respondents. Forty-two percent of Indigenous respondents reported having been in foster care or a youth group home as a child or youth.

COVID-19 and Housing Loss

Approximately one in seven Indigenous respondents related their most recent housing loss to the COVID-19 pandemic. Other common reasons identified by Indigenous respondents for their most recent housing loss included "Unfit or unsafe housing conditions", "Not enough income" and "Conflict with spouse/partner".

Income

The three most common sources of income reported by Indigenous respondents included Disability benefit (provincial), Welfare/social assistance (provincial), and Informal sources (such as bottle returns, panhandling, friends, and family).

[1] Statistics Canada. Census Profile, 2016 Census. Hamilton, Ontario, Canada.

Background

The Point in Time (PIT) survey initiative is conducted in urban communities across lands occupied by Canada. Over a pre-established period of time, homeless-serving frontline workers and/or community volunteers connect with and survey community members currently experiencing homelessness. Point in Time surveys provide as a *snapshot* of homelessness in a community, which helps to articulate each community's unique homeless priorities and context. The PIT survey initiative also provides common data points to compare experiences of homelessness across all participating communities.

The 2021 Point in Time survey in Hamilton Ontario was led by the City of Hamilton – Housing Services Division alongside community partner the Coalition of Hamilton Indigenous Leadership (CHIL). The 2021 PIT survey marked the third execution of the survey and was carried out over the week of November 15th through 19th, 2021 and conducted at various locations in Hamilton's downtown area.

Point in Time surveys are completed by community members currently experiencing homelessness. In Hamilton, a total of five hundred and forty-five surveys were completed during the 2021 Point in Time initiative. Of the five hundred and forty-five PIT surveys completed in Hamilton, one hundred and twenty-three community members completing the PIT survey identified as Indigenous or having Indigenous ancestry, representing 23% of 2021 PIT survey respondents.

Indigenous Homelessness

In attempting to understand the experiences and causes of homelessness on lands occupied by Canada, it is critically important to disentangle the homeless experiences, causes, and needs of Indigenous Peoples. The roots of Indigenous experiences of homelessness stretch back to colonization through historical and ongoing social and economic policies and practices that have sought to dispossess, disempower, and disadvantage Indigenous Peoples. As articulated by Métis scholar Jesse Thistle (2017) and now acknowledged in Reaching Home: Canada's National Homelessness Strategy, Indigenous experiences of homelessness are distinct from those of non-Indigenous Peoples and therefore, require resources, programs, and supports that recognize and respond to the unique needs of Indigenous community members.

Since 2015, local Indigenous leaders in Hamilton have successfully demonstrated the need for methodologies rooted in Indigenous Ways of Knowing to help PIT initiatives better capture Indigenous experiences of homelessness in Hamilton.

Indigenous Magnet Event Background

In 2015, the Indigenous Community Entity[2] for addressing homelessness in Hamilton developed and led "All We Need is Community" an urban Aboriginal homelessness survey to connect with Indigenous community members experiencing homelessness. Guided by the principle "For Indigenous, by Indigenous", the Indigenous Magnet event brought together Indigenous volunteers, Indigenous frontline workers, and local Indigenous leaders to provide a highly visible and culturally safe space for Indigenous community members experiencing homelessness to share their experiences of homelessness in Hamilton. The 2015 urban Aboriginal homelessness survey interviewed three hundred and sixty-two people in

[2] The Social Planning and Research Council of Hamilton acted as the Indigenous Community Entity for Hamilton's federal homelessness funding from 2004 through 2020. The Coalition of Hamilton Indigenous Leadership became the Indigenous Community Entity for Hamilton's Federal homelessness funding on April 1st, 2020.

Hamilton's downtown area, of which seventy-six community members identified as currently experiencing homelessness in Hamilton[3]. Among the seventy-six community members experiencing homelessness, thirty-six identified as Aboriginal or having Aboriginal ancestry, representing 47% of those surveyed and experiencing homelessness[3]. A 2016 mainstream initiative to enumerate homelessness in Hamilton, reported 28% of community members experiencing homelessness identified as Aboriginal or having Aboriginal ancestry[4]. The 2015 urban Aboriginal survey data demonstrated to local leaders that Indigenous experiences of homelessness were not being fully captured through mainstream data collection efforts and required Indigenous-led initiatives.

The 2021 Point in Time – Indigenous Magnet event was led by CHIL and built upon the principles and methodologies of "All We Need is Community" 2015 Urban Aboriginal homelessness survey. The 2021 Indigenous Magnet event was an outdoor gathering held at Beasley Park on November 17th, 2021, from 11:00 a.m. until 7:00 p.m. In addition to completing a survey, community members were invited to enjoy a traditional meal, participate in drumming and singing, connect with Indigenous homelessness programs and services, as well as speak with cultural advisors throughout the event. A giveaway of supplies (socks, hats, gloves, toiletries, etc.) and traditional medicines was also provided.

Of the five hundred and forty-five surveys completed during the week-long 2021 PIT initiative, fifty-eight were completed during the one-day Indigenous Magnet event.

COVID-19

In regard to the COVID-19 pandemic, the 2015 Indigenous Magnet event observed Hamilton Public Health guidelines and restrictions throughout planning and implementation. During the Indigenous Magnet event, public outdoor gatherings were permissible in Hamilton. In addition to providing various pandemic supplies (such as hand sanitizers and masks), the Indigenous Magnet event also included an on-site "GO-VAXX" bus. The GO-VAXX bus is a mobile COVID-19 vaccine clinic fully equipped and staffed to safely administer COVID-19 vaccinations. Community members participating in the Indigenous Magnet event who wished to receive a COVID-19 vaccination were able to do so throughout the event. Receiving a vaccination was optional and not in any way tied to the PIT survey or Indigenous Magnet event activities and giveaways.

Methodology and Methods

The Point in Time survey in Hamilton is part of a coordinated enumeration of homelessness across lands occupied by Canada. As a multi-community initiative, the PIT survey methodology is guided by core standards that allow for data comparisons across communities. There is also flexibility in PIT survey methodology that support local leaders in selecting survey methods that best need their community's homelessness context. Hamilton's PIT incorporates Indigenous methodologies through the co-planning of the PIT survey initiative as well as the Indigenous-led design and execution of the Indigenous Magnet

[3] Social Planning and Research Council of Hamilton. (2015). *All we need is community: Urban Aboriginal homelessness survey.* Hamilton: Social Planning and Research Council of Hamilton.

[4] City of Hamilton. (2022, April 07). *Point in Time Connection*. Retrieved from City of Hamilton: https://www.hamilton.ca/social-services/housing/point-in-time-connection

event. The Indigenous Magnet event is guided by the "For Indigenous, by Indigenous" principle, which prioritizes Indigenous methods of community engagement.

The Indigenous Magnet event engages Indigenous principles of reciprocation to provide space for Indigenous community members to feast, gather, socialize, and to complete the PIT survey. The Indigenous Magnet event in Hamilton is an extension of homelessness programs, resources, and supports for Indigenous community members, which are rooted in local Indigenous Knowledges and cultures. By having Indigenous frontline workers as well as traditional medicines, foods, and giveaways available, the Indigenous Magnet event creates a safe and welcoming environment for community members to self-identify as Indigenous without fear of judgement or discrimination.

The location of the Indigenous Magnet event is selected for high accessibility (geographic location and physical space of the gathering) to lower barriers to participation and engagement. Although the Indigenous Magnet event seeks to connect with Indigenous community members specifically, all community members experiencing homelessness are welcome to take part.

Indigenous Identity

All 2021 Point in Time Connection participants in Hamilton were asked if they identify as First Nations (with or without status), Métis, or Inuit, or having North American Indigenous ancestry. This report reflects the responses of those who self-identified "Yes" to this question.

Limitations

There are important considerations to keep in mind when examining and attempting to interpret Point in Time data. The PIT survey initiative is *not* a comprehensive survey of all community members experiencing homelessness within a community. The PIT survey provides a *snapshot* of homelessness, which provides important local data to help leaders better identify and address the unique experiences of homelessness in a community.

Survey Locations

In Hamilton, the PIT survey was conducted entirely in the downtown area. The 2021 PIT survey was not conducted in any Hamilton suburbs due to the lack of response from these areas during the 2018 PIT survey initiative.

Hamilton's 2021 PIT surveys were conducted at Emergency Shelters (including extreme weather shelters and COVID-related sites), Violence Against Women Shelters, Transitional Housing as well as other locations such as drop-in centres, encampments, and the Indigenous Magnet event.

Hidden Homelessness

Not all community members experiencing or at-risk of homelessness access the homelessness supports available in community. The experiences of people who do not access community supports are referred to as *hidden homeless*. People experiencing hidden homelessness are more likely to leverage their personal support networks (for example, staying with family and friends) instead of staying in shelter or accessing homelessness support programs. As the majority of survey sites for the 2021 Point in Time Count in Hamilton were sites of community homelessness programs and services (such as homeless shelters, drop-in centres, and encampments), the experiences of community members experiencing hidden homelessness in Hamilton may not be well captured in this dataset.

Two-Spirit and Non-Binary (Gender Queer) Participation

The homelessness experiences and needs of Indigenous community members who identify as Two-Spirit, Non-Binary or Gender Queer may not be fully represented in 2021 PIT survey data. Among the one hundred twenty-three Indigenous-identifying 2021 PIT respondents, five also identified as Two-Spirit, Non-Binary/Gender Queer.

Findings

The findings presented here represent 2021 PIT respondents who self-identified as Indigenous or having Indigenous ancestry. Indigenous identity was gathered by asking respondents if they identified as First Nations (with or without status), Métis or Inuit, or if they identified as having North American Indigenous ancestry.

A comparison of responses between Indigenous and non-Indigenous community members experiencing homelessness in Hamilton will be provided in a separate report.

The response rates among Indigeous youth[5] (n=17) as well as those identifying as Two-Spirit or Non-Binary/Gender Queer (n=5) must also considered in interpreting these findings.

Demographics

While not comprehensive of all Indigenous community members experiencing homelessness, the 2021 PIT survey data offers useful *snapshots* of Indigenous experiences of homelessness in Hamilton. The 2021 PIT data provides important context to experiences and risks of homelessness in Hamilton for community leadership and service providers.

Gender

Among Indigenous 2021 PIT respondents, sixty-nine identified their gender as women, representing 55% of Indigenous respondents. Forty-nine Indigenous respondents identified their gender as men, representing forty percent of Indigenous respondents. One Indigenous identifying 2021 PIT survey respondent also identified their gender as Two-Spirit and four Indigenous identifying respondents also identified their gender as Non-Binary/Gender Queer.

[5] For the purposes of this report, Indigenous youth are 2021 PIT respondents who self-identified as Indigenous and identified as being 30 years old or younger.

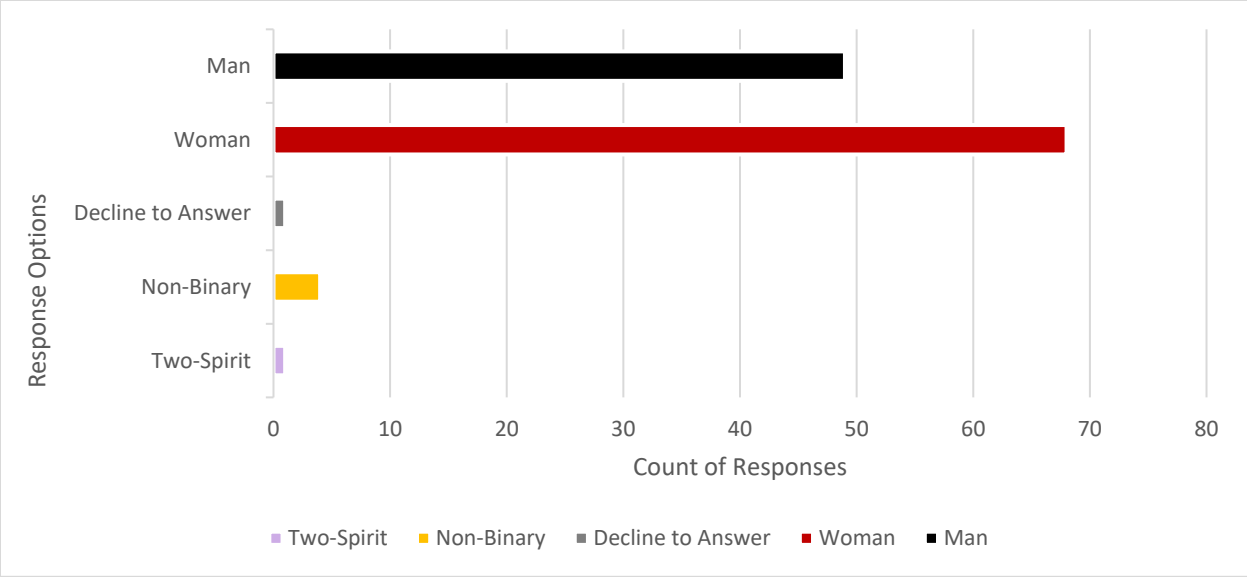


Figure 1. Gender Identity of Indigenous Respondents, 2021 Point in Time Survey (Hamilton, Ontario).

Age[6]

The majority of Indigenous respondents to Hamilton's 2021 PIT survey reported being middle-aged. Ninety-nine Indigenous survey respondents reported being between the ages of 31 years old and 64 years old, representing 80% of Indigenous respondents. Seventeen Indigenous respondents reported being under the age of 31, representing fourteen percent (14%) of Indigenous respondents. One Indigenous survey respondent reported being over the age of 65 years old.

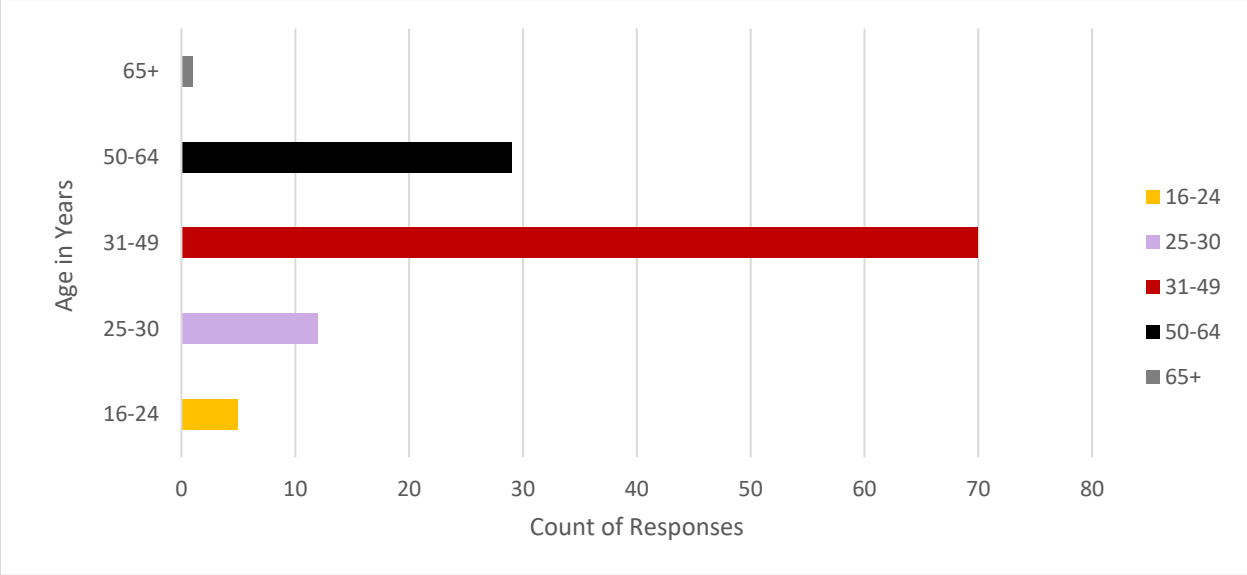


Figure 2. Age of Indigenous Respondents, 2021 Point in Time Survey (Hamilton, Ontario).

[6] *Among Indigenous respondents, there were six responses to this question that were unclear or blank and have not been included in* Figure 2. Age of Indigenous Respondents, 2021 Point in Time Survey (Hamilton, Ontario).

The pattern of age distribution among all Indigenous survey respondents is consistent across genders. Among Indigenous women who participated in Hamilton's 2021 Point in Time survey, 85% were between 31 and 64 years old. A similar proportion (80%) of Indigenous men were also between the ages of 31 and 64 years old.

Child and Youth Experiences of Homelessness

Among the one hundred and twenty-three Indigenous 2021 PIT respondents, fifty-one reported having first experienced homelessness before the age of 31 years old, representing 41% of Indigenous respondents.

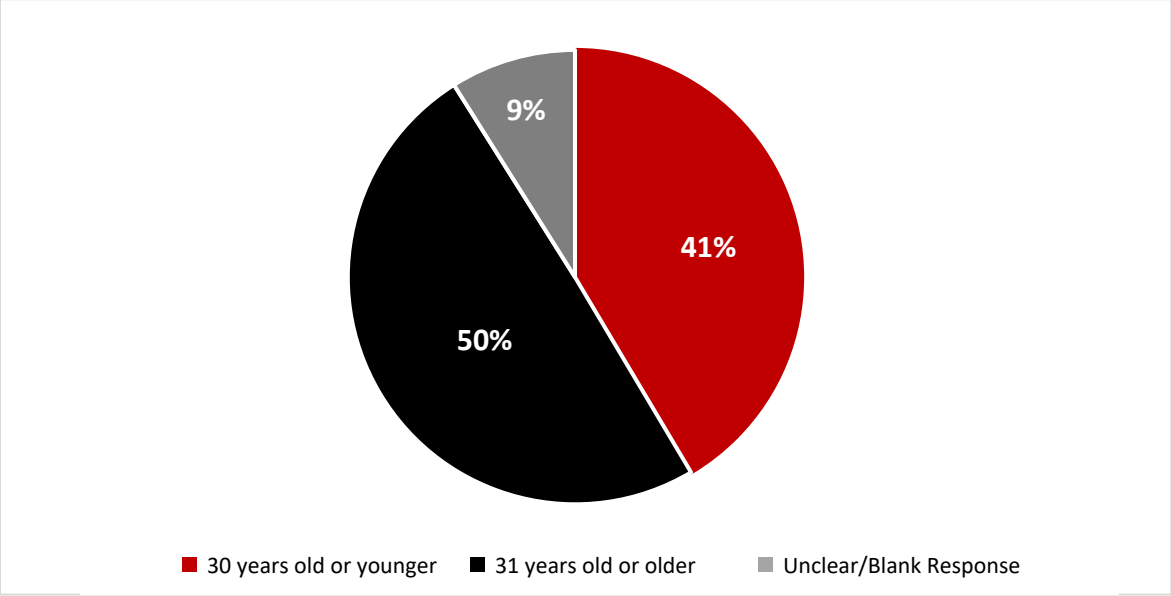


Figure 3. Age of First Experience of Homelessness - Indigenous Respondents, 2021 Point in Time Survey (Hamilton, Ontario).

Experiences of Foster Care or Youth Group Homes

Experiences with foster care or youth group home are prevalent among Indigenous community members responding to the 2021 PIT survey in Hamilton. Fifty-two Indigenous respondents reported having been in foster care or a youth group home as a child or youth, representing forty-two percent (42%) of Indigenous respondents.

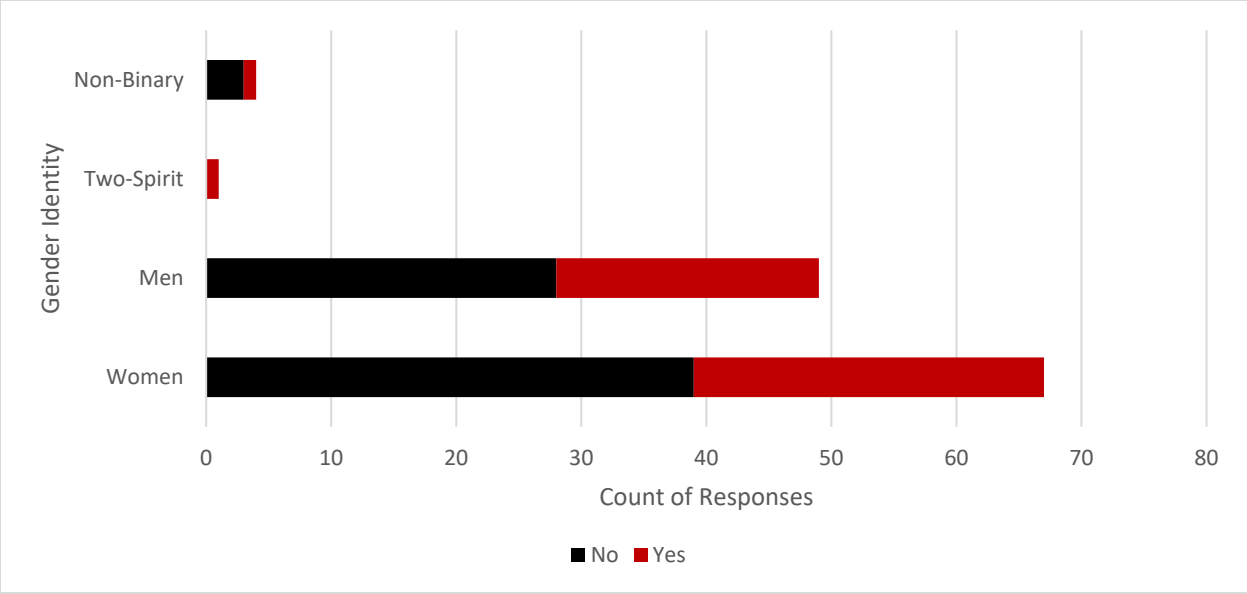


Figure 4. Experiences of Foster Care or Youth Group Home by Gender - Indigenous Respondents, 2021 Point in Time Survey (Hamilton, Ontario).

Among Indigenous women experiencing homelessness in Hamilton (n=68), twenty-eight reported having stayed in foster care or a youth group home. Among Indigenous men experiencing homelessness in Hamilton (n=49), 21 reported having lived in foster care or a youth group home.

Length of Homelessness

The 2021 Point in Time survey also asked respondents the total length of time they had been homeless over the past year. This does not necessarily mean community members experienced homelessness uninterrupted. Rather, responses indicate how much total time over the course of the past year they experienced homelessness. For example, a respondent may have experienced homelessness for three weeks, found housing for a few months but returned to homelessness.

Among all Indigenous respondents, ninety indicated they had experienced homelessness for more than six months of the past year, representing seventy-three percent (73%) of Indigenous respondents. The proportion of Indigenous participants experiencing homelessness for more than half of the past year is consistent across genders. Among Indigenous women responding to the 2021 Point in Time survey, seventy-eight percent (78%) reported having experienced homelessness for more than 6 months within the past year. Similarly, sixty-nine percent (69%) of Indigenous men respondents to the survey reported experiencing homelessness for more than half of the past year.

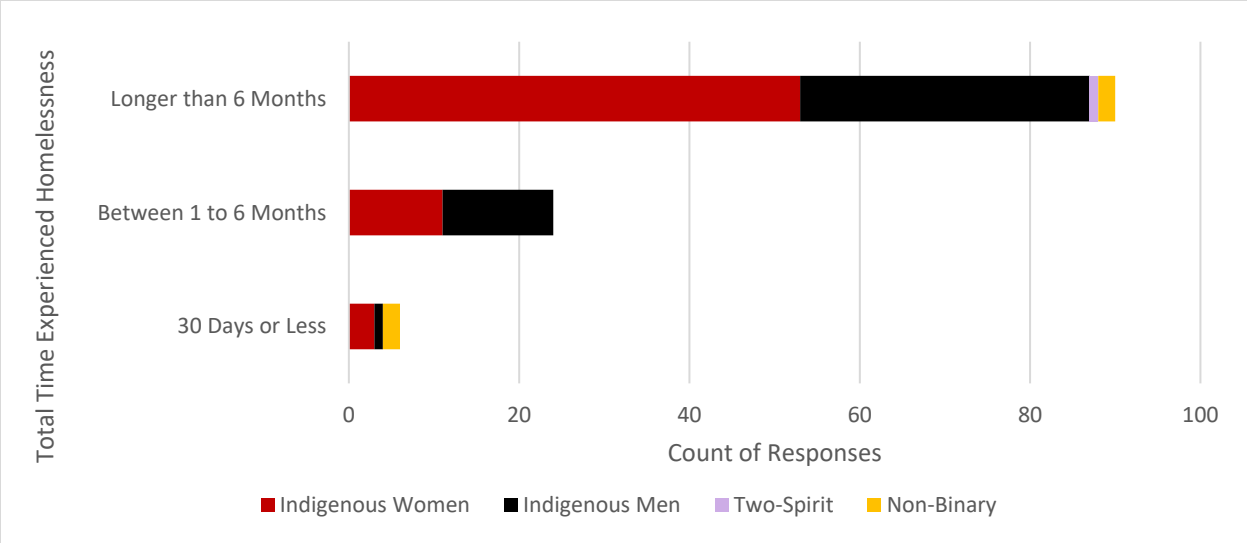


Figure 5. Total Time Experienced Homelessness Within Past Year - Indigenous Respondents, 2021 Point in Time Survey (Hamilton, Ontario).

This pattern of experiencing homelessness in Hamilton for the majority of the past year repeats across all age groups of Indigenous respondents. Among Indigenous youth[7] PIT survey responses (n=17), eighty-two percent (82%) reported having experienced a total of six or more months of the past year homeless. Among Indigenous adult survey respondents (n=99), eighty-one percent (81%) had experienced homelessness for a total of six (6) months or longer within the past year.

Length of Time in Hamilton[8]

Of Indigenous respondents, 54 reported having always lived in Hamilton, representing forty-four percent (44%) of Indigenous respondents. Seventeen Indigenous-identifying respondents reported they have lived in Hamilton for less than a year, representing fourteen percent (14%) of Indigenous survey respondents. Eleven Indigenous respondents reported living in Hamilton for more than one year but less than 5 years, representing nine percent (9%) of Indigenous-identifying respondents. Thirty-four Indigenous respondents reported having lived in Hamilton for five or more years, representing twenty-eight percent (28%) of Indigenous respondents.

[7] This report utilizes the Indigenous youth age range observed by the federal government, which identifies Indigenous youth as being between the ages of 15 and 30 years of age

[8] Among Indigenous respondents, seven responses to this question were unclear or blank and have not been included in Figure 6. Length of Time in Hamilton - Indigenous Respondents, 2021 Point in Time Survey (Hamilton, Ontario)

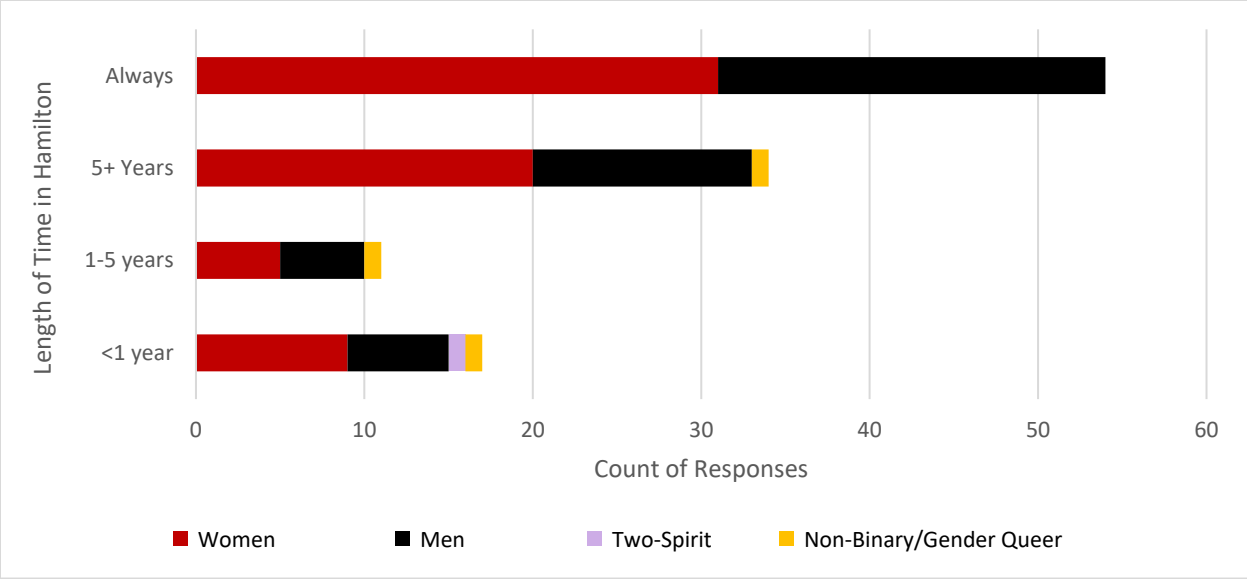


Figure 6. Length of Time in Hamilton - Indigenous Respondents, 2021 Point in Time Survey (Hamilton, Ontario).

Indigenous Youth Experiencing Homelessness in Hamilton

In total, 17 Indigenous youth participated in the 2021 Point in Time survey in Hamilton. The gender breakdown of Indigenous youth participating in the 2021 PIT survey included 18% of Indigenous youth identifying as Non-Binary/Gender Queer, with an equal proportion (41%) of Indigenous youth experiencing homelessness who identify as women and men.

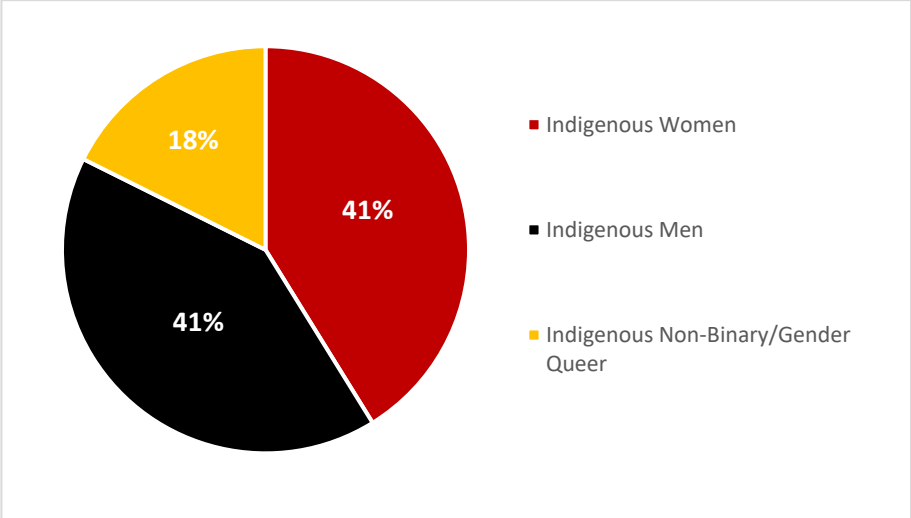


Figure 7. Gender Identity of Indigenous Youth Respondents, 2021 Point in Time Survey (Hamilton, Ontario).

Shelter System Use

The majority of Indigenous respondents have stayed in a homelessness shelter (emergency, family, or domestic violence shelter) in the past year. Of Indigenous respondents, one hundred and one reported having stayed in a homeless shelter within the past year, representing eighty-two percent (82%) of Indigenous respondents.

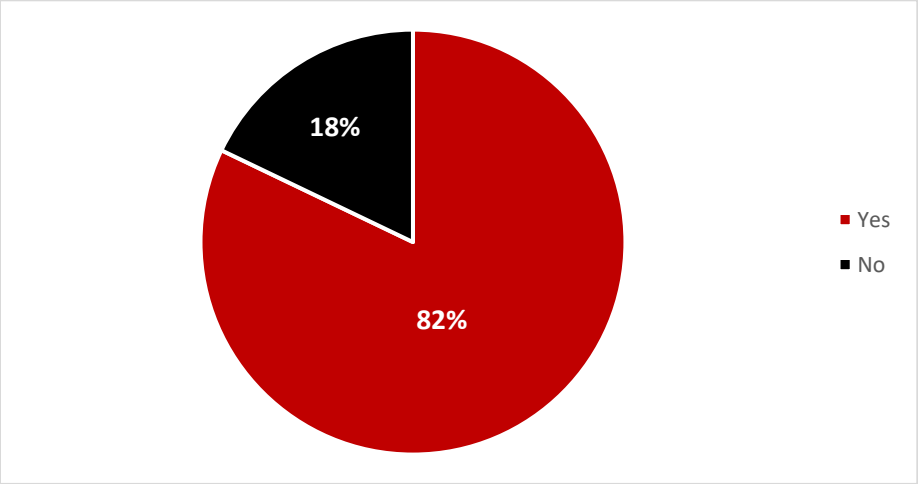


Figure 8. Shelter System Usage - Indigenous Respondents, 2021 Point in Time Survey (Hamilton, Ontario).

When asked where they had stayed the night before participating in Hamilton's 2021 PIT survey, Indigenous responses included Unsheltered Public Spaces (street, park, bus shelter, etc.), Transitional Housing, a city-funded hotel or motel, an encampment site, or someone else's place. One respondent identified sleeping in their vehicle the night before participating in the survey. No respondent (Indigenous or non-Indigenous) identified having stayed in a hospital, treatment centre, or jail/prison the previous night.

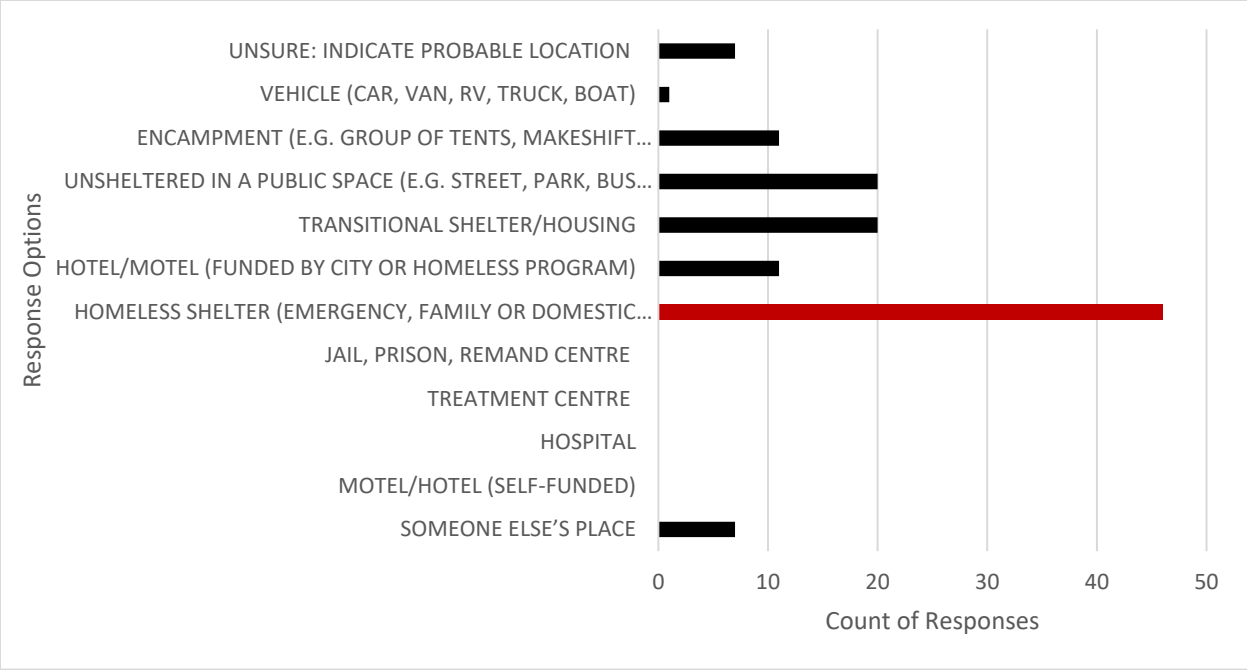


Figure 9. "Where did you stay last night?" - Indigenous Respondents, 2021 Point in Time Survey (Hamilton, Ontario). The most common response is highlighted in red.

Of Indigenous community members who are experiencing homelessness but chose not to stay in a homeless shelter last year (n=22), twenty-one provided one or more reasons why they chose not to stay in shelter. The most common reason Indigenous community members experiencing homelessness chose not to stay in a homeless shelter was due to safety concerns. Other reasons Indigenous community members experiencing homelessness chose not to stay in shelter included being turned away from the shelter due to lack of available beds, having lack of transportation to reach a shelter, concerns over pests, and feeling "crowded" in homeless shelters.

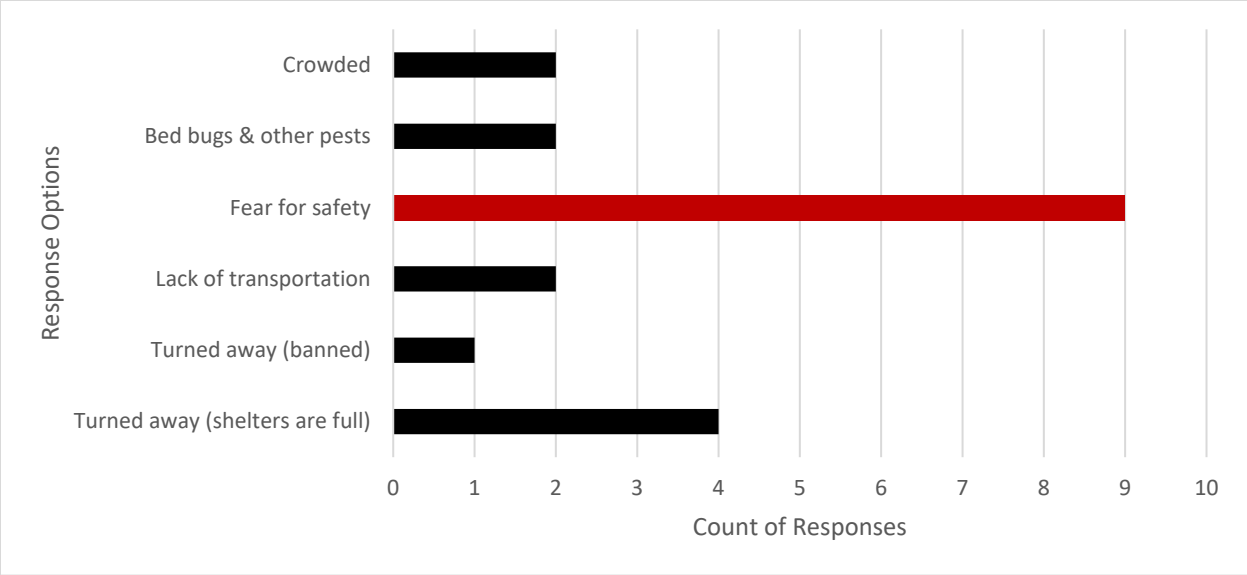


Figure 10. Reasons for Not Staying in Shelter - Indigenous Respondents, 2021 Point in Time Survey (Hamilton, Ontario). The most common response is highlighted in red.

Health Challenges

Response options to health challenges faced were multiple choice, allowing respondents to indicate the total health issues or challenges experienced. The most prominent health challenge reported by Indigenous 2021 PIT respondents is substance abuse (including tobacco, alcohol, or opiates).

Among Indigenous respondents, ninety-two reported experiencing substance use issues, representing seventy-five percent (75%) of Indigenous survey respondents. Hamilton's 2021 PIT survey data also indicates a high proportion of Indigenous respondents are experiencing mental health issues (including depression, post traumatic stress disorder and bipolar disorder. Eighty-three Indigenous respondents reported managing a diagnosed or undiagnosed mental health issue, representing sixty-seven percent (67%) of Indigenous respondents. Fifty-seven Indigenous respondents indicated managing an illness or medical condition, such as diabetes, arthritis, tuberculosis, or HIV, representing forty-six percent (46%) of Indigenous respondents. An equal proportion (46%) of Indigenous respondents reported having learning or cognitive limitations, such as dyslexia, autism spectrum disorder, or as a result of ADHD or an acquired brain injury. Forty-two Indigenous respondents reported experiencing a physical limitation (such as challenges with mobility, physical abilities and/or dexterity), representing thirty-four percent (34%) of Indigenous survey respondents.

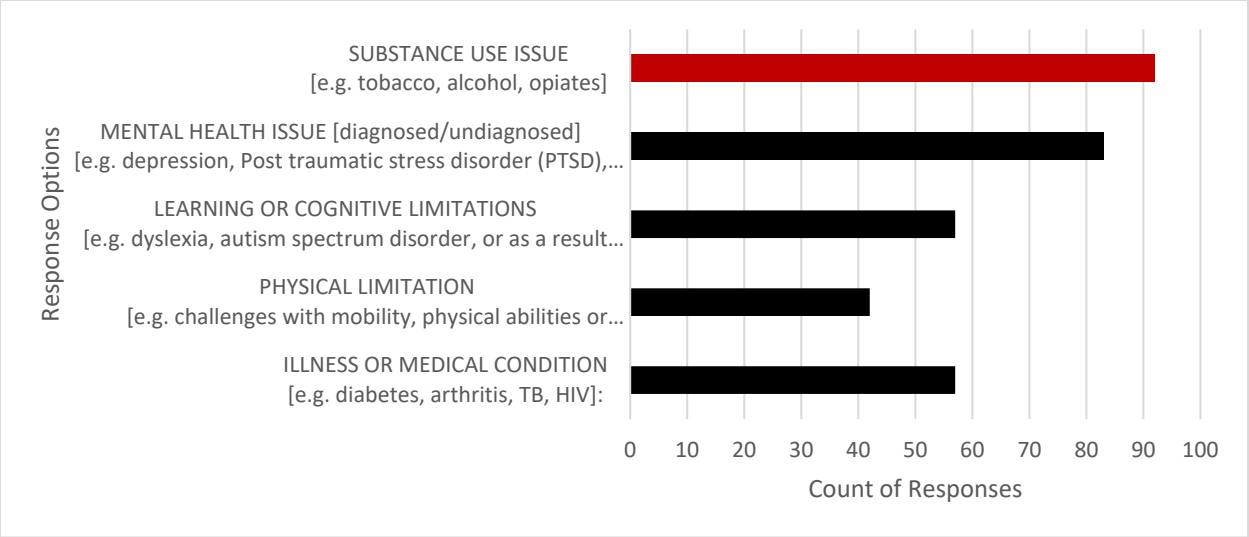


Figure 11. Health Challenges - Indigenous Respondents, 2021 Point in Time Survey (Hamilton, Ontario). The most common response is highlighted in red.

Causes of Most Recent Housing Loss

Of Indigenous-identifying respondents to the 2021 Point in Time survey (n=123), one hundred and twenty (120) provided one or more reasons for their most recent loss of housing. Respondents were able to provide multiple reasons for their most recent loss of housing. The most common reasons given by Indigenous community members experiencing homelessness in Hamilton for their most recent loss of housing included: “Not having enough income for housing”, “Unfit or unsafe housing conditions”, “Landlord/tenant conflict”, “Conflict with spouse”, “Conflict with: Other” (someone other than a parent, partner/spouse, or guardian).

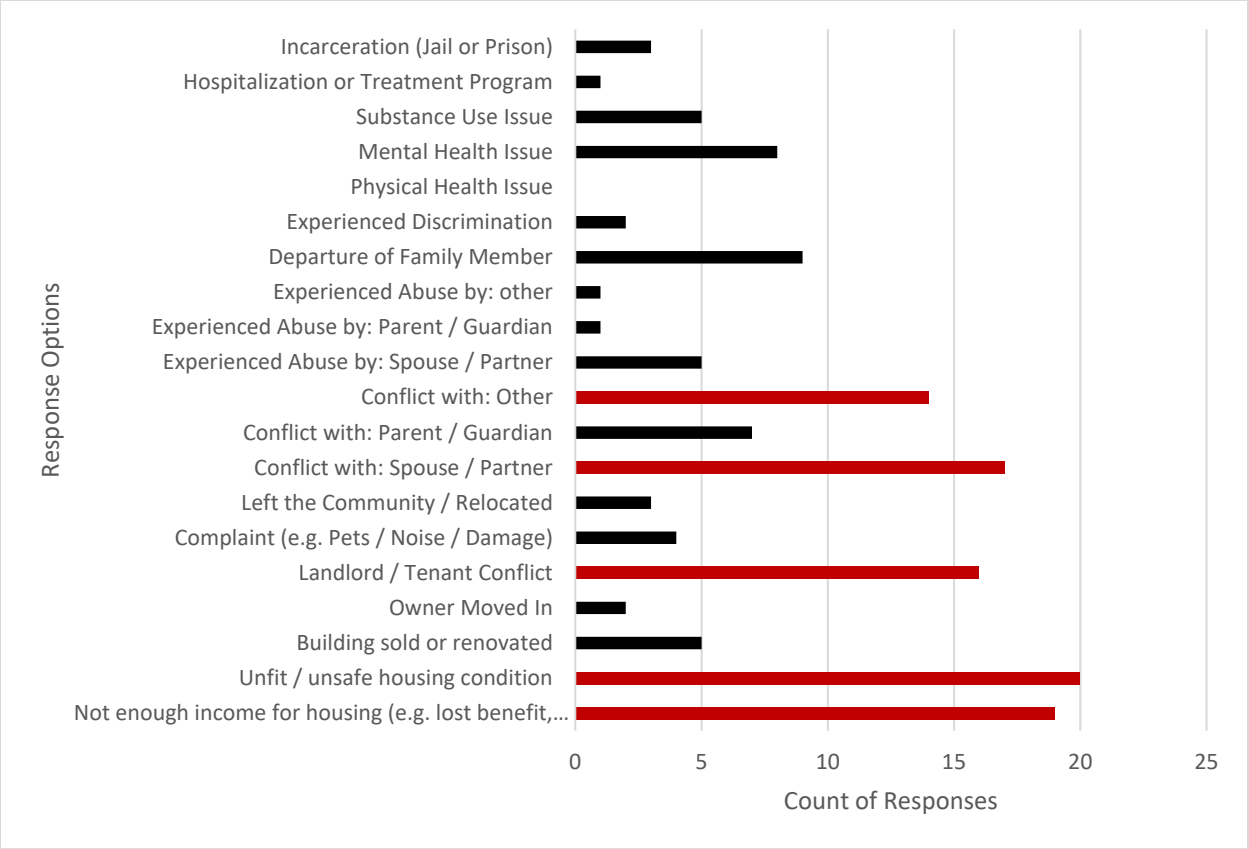


Figure 12. Causes of Most Recent Housing Loss - Indigenous Respondents, 2021 Point in Time Survey (Hamilton, Ontario). The five most common responses are highlighted in red.

Challenges Experienced in Finding Housing

Indigenous respondents to the 2021 PIT survey indicated the cost of housing in Hamilton posed the most common barrier to exiting homelessness. Among Indigenous survey respondents (n=123), one hundred and fifteen Indigenous community members identified one or more challenges or problems encountered in trying to find housing. The fives most commonly reported challenges to finding housing identified by Indigenous community members are “Rent being too high”, “Having low income”, “Poor housing conditions”, “Discrimination”, and “Addiction”.

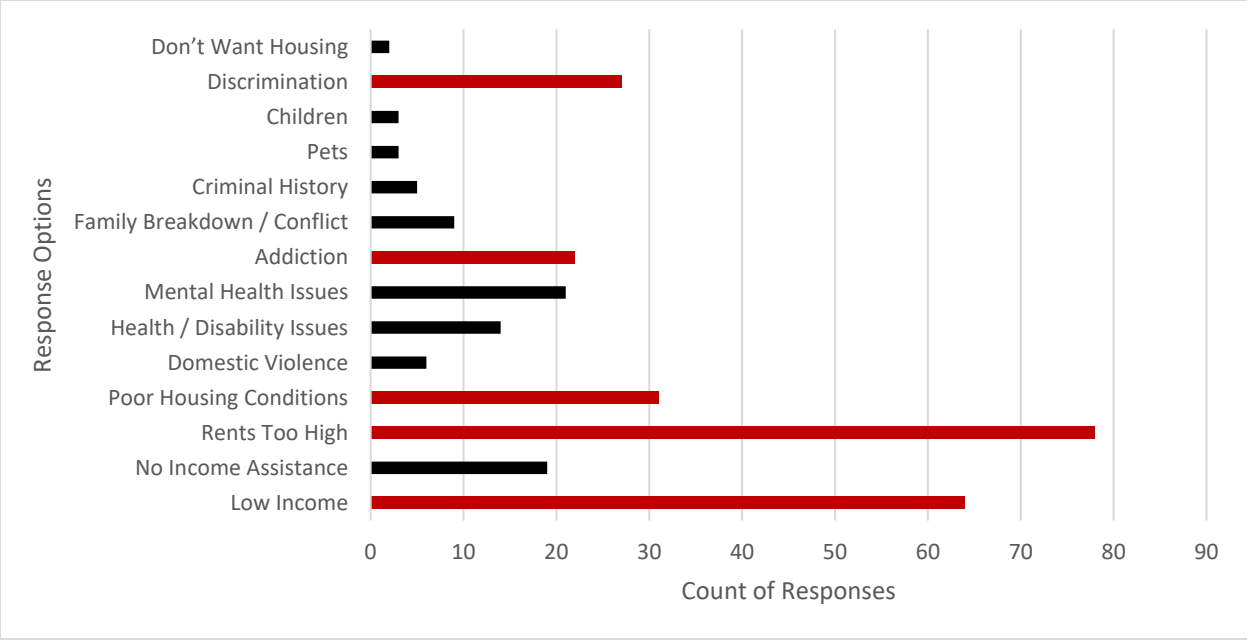


Figure 13. Challenges Experienced in Trying to Find Housing - Indigenous Respondents, 2021 Point in Time Survey (Hamilton, Ontario). The five most common responses are highlighted in red.

COVID-19

Seventeen Indigenous PIT respondents related their most recent housing loss to the COVID-19 pandemic, representing fourteen percent (14%) of Indigenous survey respondents. Of Indigenous community respondents who related their most recent housing to the pandemic (n=17), 82% were between the ages of 31 and 64 years old.

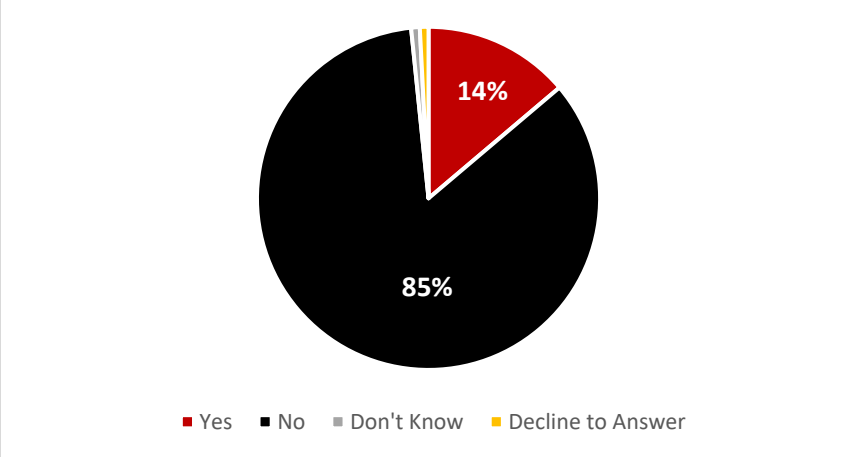


Figure 14. "Was your most recent housing loss related to the COVID-19 pandemic?" - Indigenous Respondents, 2021 Point in Time Count (Hamilton, Ontario).

Income Sources

Sixty-nine Indigenous PIT respondents reported receiving Disability Benefits (provincial) as a source of income, representing fifty-six percent (56%) of Indigenous respondents. Thirty-six Indigenous respondents reported receiving Welfare/social assistance (provincial) as a source of income, representing twenty-nine percent (29%) of Indigenous respondents of Indigenous respondents.

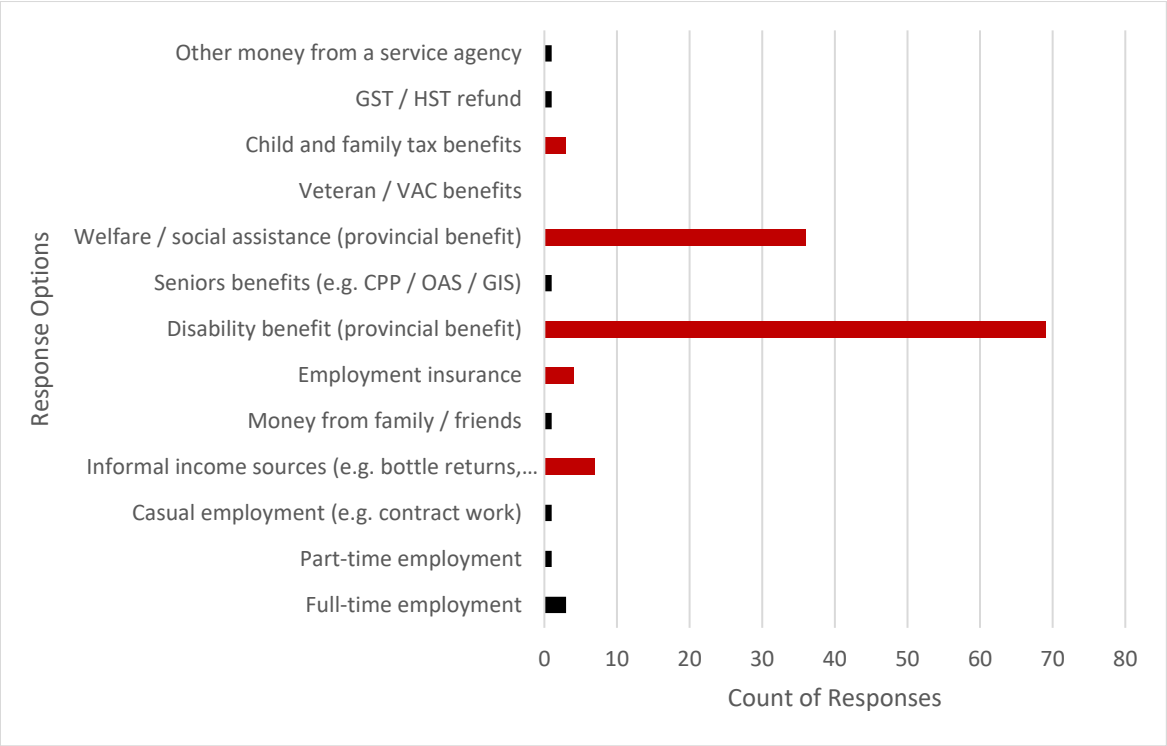


Figure 15. Sources of Income - Indigenous Respondents, 2021 Point in Time Survey (Hamilton, Ontario). The five most common responses are highlighted in red.

Appendices

Appendix A – Indigenous Magnet Event Promo Card



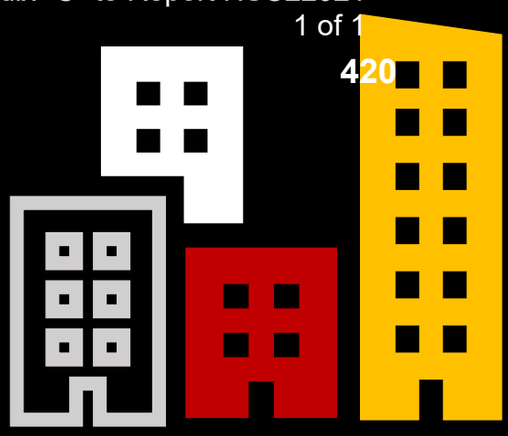


Appendix B – 2021 Point in Time Survey (Hamilton, Ontario)

TAB 17

2021 POINT IN TIME SURVEY (Hamilton, Ontario)

The 2021 Point in Time (PIT) survey for Hamilton was led by the City of Hamilton – Housing Services Division and the Coalition of Hamilton Indigenous Leadership. Each PIT survey was completed by a community member currently experiencing homelessness in Hamilton.



INDIGENOUS RESPONDENTS

*The responses shared in this infographic represent 2021 PIT respondents who self-identified as Indigenous or having Indigenous ancestry.**

Indigenous Peoples continue to be overrepresented among community members experiencing homelessness in Hamilton. Of Hamilton's general population, 2% of residents identify as Indigenous or having Indigenous ancestry. Among community members responding to Hamilton's 2021 PIT survey, 23% self-identified as Indigenous or having Indigenous ancestry.

545

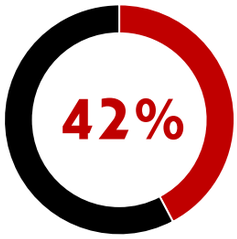
SURVEYS WERE COMPLETED DURING HAMILTON'S 2021 POINT IN TIME CONNECTION SURVEY INITIATIVE.

123 **OF 2021 PIT SURVEY RESPONDENTS IDENTIFIED AS INDIGENOUS OR HAVING INDIGENOUS ANCESTRY.**

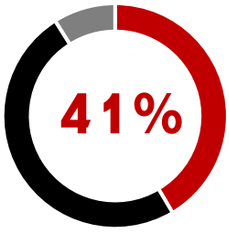
OF THE 123 INDIGENOUS IDENTIFIED RESPONDENTS:

- **68** Identified as **WOMEN**
- **49** Identified as **MEN**
- **5** Identified as **TWO-SPIRIT or NON-BINARY**

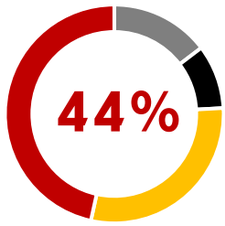
As a child or youth, were you ever in foster care or in a youth group home?



How old were you the first time you experienced homelessness?



How long have you been in Hamilton?



Top 5 reported sources of income:

1. Disability benefit
2. Welfare/social assistance
3. Informal income (e.g., bottle returns, panhandling, family)
4. Employment (full or part-time)
5. Employment insurance

Top 5 reported causes for most recent loss of housing:

1. Unfit/unsafe housing condition
2. Not enough income for housing
3. Conflict with Spouse/Partner
4. Landlord/tenant conflict
5. Conflict with other

Top 5 challenges or experienced when trying to find housing:

1. Rent too high
2. Low Income
3. Poor Housing Conditions
4. Discrimination
5. Addiction

Coalition of Hamilton Indigenous Leadership

Hamilton

The 2021 Point in Time survey for Hamilton, Ontario was conducted during the week of November 15th through 19th. All 2021 PIT survey respondents in Hamilton were asked if they self-identified as First Nations (with or without status), Métis or Inuit or if they identified as having North American Indigenous ancestry.

For comments and questions about this infographic, please contact the Coalition of Hamilton Indigenous Leadership at communications@chileadership.com

TAB 145

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

APPLICATION UNDER RULE 14.05 OF THE *RULES OF CIVIL PROCEDURE*

RESPONSE TO REQUEST TO ADMIT

In response to your request to admit dated May 31, 2023, the respondent:

1. Admits the truth of facts numbers N/A – none requested.

2. Admits the authenticity of the following documents, subject to the qualification that the Respondent's response is made with respect to the documents appended to the Applicant's May 31, 2023 Request to Admit only, and not the hyperlinks contained in the Applicant's May 31, 2023 Request to Admit, as it is not possible to admit the authenticity of a hyperlink:

   (a) 1

   (b) 2a

(c) 2b[1]

(d) 2c

(e) 2d

(f) page 1 of Document Number 3 (excerpt from City of Hamilton Emergency & Community Services Committee Agenda Addendum, Meeting 20-004, July 13, 2020),

(g) pages 2-4 of Document Number 3 (written delegation 6.2, “Dr. Jill Wiwcharuk and Dr. Tim O’Shea, Hamilton Social Medicine Response Team, respecting the City’s strategy about homeless encampments”);

(h) pages 5-8 of Document Number 3, (first four pages of “written delegation 6.3, Jody Ans and Lisa Nussey, Keeping Six, respecting request that the City re-evaluate and change its approach to encampments”);

(i) pages 9-46 of Document Number 3 (pages 5-42 of written delegation 6.3, Jody Ans and Lisa Nussey, Keeping Six, respecting request that the City re-evaluate and change its approach to encampments”) *only insofar as the Respondent admits that this is the document provided by the delegates Jody Ans and Lisa Nussey, Keeping Six, with their written delegation; the Respondent is not able to admit the authenticity of the document*

[1] The Respondent notes that the hyperlink provided and the document contained in the Index are different documents. The admission of authenticity is made with respect to the document only.

"Understanding Encampments of People Experiencing Homelessness and Community Responses" (see para. 6(a) below);

(j) pages 47-49 of Document Number 3 (first three pages of "written delegation 6.4, Sharon Crowe, Nadine Watson, and Wade Poziomka, Hamilton Community Legal Clinic, respecting Dismantlement of Homeless Encampments");

(k) pages 50-96 of Document Number 3 (pages 4-46 of "written delegation 6.4, Sharon Crowe, Nadine Watson, and Wade Poziomka, Hamilton Community Legal Clinic, respecting Dismantlement of Homeless Encampments") *only insofar as the Respondent admits that these are documents provided by the delegates Sharon Crowe, Nadine Watson, and Wade Poziomka, Hamilton Community Legal Clinic, with their written delegation; the Respondent is not able to admit the authenticity of the untitled document appearing at pages 50-56 of Document Number 3 and the document titled "A National Protocol for Homeless Encampments in Canada" appearing at pages 57-96 of Document Number 3 (see para. 6(b) below);*

(l) pages 1-3 of Document Number 5, being the City of Hamilton Emergency & Community Services Committee Revised Agenda, Meeting 21-009, September 9, 2021. *Note, no video was enclosed the Applicants' Request to Admit. See para. 6(c) below.*

(m) Pages 1-24 of Document Number 6, being the City of Hamilton General Issues Committee Minutes, Meeting 23-017, May 17, 2023. *Note, no video was enclosed the Applicants' Request to Admit. See para. 6(d) below.*

(n) 7

(o) 8

(p) 8a

(q) 9

(r) pages 1-4 of Document Number 10, being the City of Hamilton City Council Agenda, Meeting 23-010, May 24, 2023. *Note, no video was enclosed the Applicants' Request to Admit. See para. 6(e) below.*

(s) 11

(t) Pages 1-7 of Document Number 12, being the City of Hamilton General Issues Committee Revised Agenda, Meeting 21-027, December 8, 2021. *Note, the subheading preceding Document Number 11 states "Statements from City Councillors Regarding Encampments." For clarity, Document Number 12 does not contain any statements and thus, none are admitted.*

(u) 13

(v) 14[2]

(w) 15

(x) 16

(y) 17

3. Denies the truth of facts numbers N/A - none requested.

4. Denies the authenticity of documents numbers: See paragraph 6 below.

5. Refuses to admit the truth of facts numbers

(a) N/A – none requested.

6. Refuses to admit the authenticity of documents numbers:

(a) pages 9-46 of Document Number 3 (pages 5-42 of written delegation 6.3, Jody Ans and Lisa Nussey, Keeping Six, respecting request that the City re-evaluate and change its approach to encampments"): the Respondent is not able to admit the authenticity of the document "Understanding Encampments of People Experiencing Homelessness and Community Responses" as the Respondent has not been provided with, and is thus unable to verify, the original source of this document;

[2] The Respondent notes that the hyperlink provided and the document contained in the Index are different documents. The admission of authenticity is made with respect to the document only.

(b) pages 50-96 of Document Number 3 (pages 4-46 of "written delegation 6.4, Sharon Crowe, Nadine Watson, and Wade Poziomka, Hamilton Community Legal Clinic, respecting Dismantlement of Homeless Encampments"): the Respondent is not able to admit the authenticity of the untitled document appearing at pages 50-56 of Document Number 3 and the document titled "A National Protocol for Homeless Encampments in Canada" appearing at pages 57-96 of Document Number 3 as the Respondent has not been provided with, and is thus unable to verify, the original source of these documents;

(c) Document Number 5, City of Hamilton, Emergency and Community Services Committee, September 9, 2021 video recording: no video recording was included with the Request to Admit.

(d) Document Number 9, "video recording at recording at: https://pub-hamilton.escribemeetings.com/Players/ISIStandAlonePlayer.aspx?Id=1d954544-be89-4959-a370-abd5ccfcd269": no video recording was included with the Request to Admit.

(e) Document Number 10, "recording found at recording found at: https://pub-hamilton.escribemeetings.com/Meeting.aspx?Id=a6132950-b909-48b1-93a5-d4371a05273b&Agenda=Agenda&lang=English&Item=37&Tab=attachments": no recording was included with the Request to Admit.

June 20, 2023

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Court File No. CV-21-00077187-0000

KRISTEN HEEGSMA et al. - and - CITY OF HAMILTON

Applicants Respondent

ONTARIO
SUPERIOR COURT OF JUSTICE

PROCEEDING COMMENCED AT HAMILTON

RESPONSE TO REQUEST TO ADMIT

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Ashley Wilson: awilson@kastnerlam.com

TAB 146

Court File No. CV-21-00077187-0000

ONTARIO

SUPERIOR COURT OF JUSTICE

BETWEEN:

KRISTEN HEEGSMA, DARRIN MARCHAND, GORD SMYTH, MARIO MUSCATO, SHAWN ARNOLD, BRADLEY CALDWELL, CHRISTINE DELOREY, GLENN 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

REQUEST TO ADMIT

YOU ARE REQUESTED TO ADMIT, for the purposes of this proceeding only, the truth (see rule 51.01 of the Rules of Civil Procedure) of the following facts from the following documents:

Homelessness Dashboard: Data on Homeless Population, Including Shelter Use, Availability and Capacity (Tabs 1a and b):

1. In January of 2020:
    a. the total homeless population was 864; and
    b. there were 220 beds available for men, 46 beds available for women, 20 rooms available for families, 21 beds available for youth, for a total of 287 beds available, and a total of 20 rooms available.
2. In February of 2020:
    a. the total homeless population was 1,096; and
    b. there were 193 beds available for men, 46 beds available for women, 20 rooms available for families, 21 beds available for youth, for a total of 260 beds available, and a total of 20 rooms available.
3. In March of 2020:
    a. the total homeless population was 1,088; and
    b. there were 219 beds available for men, 46 beds available for women, 20 rooms available for families, 21 beds available for youth, for a total of 286 beds available, and a total of 20 rooms available.

4. In April of 2020:
    a. the total homeless population was 1,105; and
    b. there were 150 beds available for men, 46 beds available for women, 20 rooms available for families, 21 beds available for youth, for a total of 217 beds available, and a total of 87 rooms available.
5. In May of 2020:
    a. the total homeless population was 1,102; and
    b. there were 127 beds available for men, 46 beds available for women, 20 rooms available for families, 21 beds available for youth, for a total of 194 beds available, and a total of 63 rooms available.
6. In June of 2020:
    a. the total homeless population was 1,028; and
    b. there were 127 beds available for men, 46 beds available for women, 20 rooms available for families, 21 beds available for youth, for a total of 194 beds available, and a total of 63 rooms available.
7. In July of 2020:
    a. the total homeless population was 967; and
    b. there were 127 beds available for men, 46 beds available for women, 20 rooms available for families, 21 beds available for youth, for a total of 194 beds available, and a total of 67 rooms available.
8. In August of 2020:
    a. the total homeless population was 969; and
    b. there were 127 beds available for men, 38 beds available for women, 20 rooms available for families, 21 beds available for youth, for a total of 186 beds available, and a total of 82 rooms available.
9. In September of 2020:
    a. the total homeless population was 947; and
    b. there were 115 beds available for men, 38 beds available for women, 20 rooms available for families, 21 beds available for youth, for a total of 174 beds available, and a total of 147 rooms available.
10. In October of 2020:
    a. the total homeless population was 987; and
    b. there were 142 beds available for men, 26 beds available for women, 20 rooms available for families, 13 beds available for youth, for a total of 181 beds available, and a total of 152 rooms available.
11. In November of 2020:
    a. the total homeless population was 1,061; and
    b. there were 186 beds available for men, 26 beds available for women, 20 rooms available for families, 13 beds available for youth, for a total of 225 beds available, and a total of 149 rooms available.

12. In December of 2020:

    a. the total homeless population was 1,084; and

    b. there were 186 beds available for men, 26 beds available for women, 20 rooms available for families, 13 beds available for youth, for a total of 225 beds available, and a total of 143 rooms available.

13. In January of 2021:

    a. the total homeless population was 1,160; and

    b. there were 196 beds available for men, 26 beds available for women, 20 rooms available for families, 13 beds available for youth, for a total of 235 beds available, and a total of 177 rooms available.

14. In February of 2021:

    a. the total homeless population was 1,138; and

    b. there were 223 beds available for men, 26 beds available for women, 20 rooms available for families, 13 beds available for youth, for a total of 262 beds available, and a total of 178 rooms available.

15. In March of 2021:

    a. the total homeless population was 1,095; and

    b. there were 223 beds available for men, 26 beds available for women, 20 rooms available for families, 13 beds available for youth, for a total of 262 beds available, and a total of 198 rooms available.

16. In April of 2021:

    a. the total homeless population was 1,086; and

    b. there were 223 beds available for men, 26 beds available for women, 20 rooms available for families, 13 beds available for youth, for a total of 262 beds available, and a total of 199 rooms available.

17. In May of 2021:

    a. the total homeless population was 1,058; and

    b. there were 223 beds available for men, 26 beds available for women, 20 rooms available for families, 13 beds available for youth, for a total of 262 beds available, and a total of 178 rooms available.

18. In June of 2021:

    a. the total homeless population was 1,079; and

    b. there were 223 beds available for men, 26 beds available for women, 20 rooms available for families, 13 beds available for youth, for a total of 262 beds available, and a total of 183 rooms available.

19. In July of 2021:

    a. the total homeless population was 1,083; and

    b. there were 209 beds available for men, 26 beds available for women, 20 rooms available for families, 13 beds available for youth, for a total of 248 beds available, and a total of 169 rooms available.

20. In August of 2021:

    a. the total homeless population was 1,182; and

    b. there were 210 beds available for men, 26 beds available for women, 20 rooms available for families, 13 beds available for youth, for a total of 249 beds available, and a total of 177 rooms available.

21. In September of 2021:

    a. the total homeless population was 1,202; and

    b. there were 218 beds available for men, 26 beds available for women, 20 rooms available for families, 13 beds available for youth, for a total of 257 beds available, and a total of 185 rooms available.

22. In October of 2021:

    a. the total homeless population was 1,380; and

    b. there were 219 beds available for men, 41 beds available for women, 20 rooms available for families, 13 beds available for youth, for a total of 273 beds available, and a total of 218 rooms available.

23. In November of 2021:

    a. the total homeless population was 1,426; and

    b. there were 238 beds available for men, 41 beds available for women, 20 rooms available for family, 13 beds available for youth, for a total of 292 beds available, and a total of 235 rooms available.

24. In December of 2021:

    a. the total homeless population was 1,541; and

    b. there were 239 beds available for men, 41 beds available for women, 20 rooms available for families, 13 beds available for youth, for a total of 293 beds available, and a total of 218 rooms available.

25. In January of 2022:

    a. the total homeless population was 1,594; and

    b. there were 245 beds available for men, 41 beds available for women, 20 rooms available for families, 21 beds available for youth, for a total of 307 beds available, and a total of 268 rooms available.

26. In February of 2022:

    a. the total homeless population was 1,523.

    b. there were 212 beds available for men, 41 beds available for women, 20 rooms available for families, 21 beds available for youth, for a total of 274 beds available, and a total of 281 rooms available.

27. In March of 2022:

    a. the total homeless population was 1,596; and

    b. there were 212 beds available for men, 96 beds available for women, 20 rooms available for families, 21 beds available for youth, for a total of 329 beds available, and a total of 210 rooms available.

28. In April of 2022:

    a. the total homeless population was 1,735; and

    b. there were 154 beds available for men, 104 beds available for women, 20 rooms available for families, 21 beds available for youth, for a total of 279 beds available, and a total of 201 rooms available.

29. In May of 2022:

    a. the total homeless population was 1,673; and

    b. there were 154 beds available for men, 104 beds available for women, 20 rooms available for families, 21 beds available for youth, for a total of 279 beds available, and a total of 220 rooms available.

30. In June of 2022:

    a. the total homeless population was 1,539; and

    b. there were 193 beds available for men, 104 beds available for women, 20 rooms available for families, 21 beds available for youth, for a total of 318 beds available, and a total of 158 rooms available.

31. In July of 2022:

    a. the total homeless population was 1,494; and

    b. there were 193 beds available for men, 104 beds available for women, 20 rooms available for families, 21 beds available for youth, for a total of 318 beds available, and a total of 157 rooms available.

32. In August of 2022:

    a. the total homeless population was 1,476; and

    b. there were 212 beds available for men, 104 beds available for women, 20 rooms available for families, 21 beds available for youth, for a total of 337 beds available, and a total of 155 rooms available.

33. In September of 2022:

    a. the total homeless population was 1,531; and

    b. there were 212 beds available for men, 104 beds available for women, 20 rooms available for families, 21 beds available for youth, for a total of 337 beds available, and a total of 124 rooms available.

34. In October of 2022:

    a. the total homeless population was 1,569; and

    b. there were 212 beds available for men, 104 beds available for women, 20 rooms available for families, 21 beds available for youth, for a total of 337 beds available, and a total of 100 rooms available.

35. In November of 2022:

    a. the total homeless population was 1,670; and

    b. there were 201 beds available for men, 107 beds available for women, 20 rooms available for families, 21 beds available for youth, for a total of 329 beds available, and a total of 100 rooms available.

36. In December of 2022:
    a. the total homeless population was 1,536; and
    b. there were 198 beds available for men, 109 beds available for women, 20 rooms available for families, 21 beds available for youth, for a total of 328 beds available, and a total of 62 rooms available.
37. In January of 2023:
    a. the total homeless population was 1,545; and
    b. there were 198 beds available for men, 109 beds available for women, 20 rooms available for families, 21 beds available for youth, for a total of 328 beds available, and a total of 62 rooms available.
38. In February of 2023:
    a. the total homeless population was 1,465; and
    b. there were 198 beds available for men, 109 beds available for women, 20 rooms available for families, 21 beds available for youth, for a total of 328 beds available, and a total of 62 rooms available.
39. In March of 2023:
    a. the total homeless population was 1,571; and
    b. there were 198 beds available for men, 81 beds available for women, 20 rooms available for families, 21 beds available for youth, for a total of 300 beds available, and a total of 62 rooms available.
40. In April of 2023:
    a. the total homeless population was 1615; and
    b. there were 198 beds available for men, 65 beds available for women, 20 rooms available for families, 21 beds available for youth, for a total of 284 beds available, and a total of 62 rooms available.
41. In May of 2023:
    a. the total homeless population was 1650; and
    b. there were 198 beds available for men, 46 beds available for women, 20 rooms available for families, 21 beds available for youth, for a total of 265 beds available, and a total of 62 rooms available.
42. In June of 2023:
    a. the total homeless population was 1,732; and
    b. there were 198 beds available for men, 66 beds available for women, 20 rooms available for families, 21 beds available for youth, for a total of 285 beds available, and a total of 62 rooms available.

Point In Time Connection Survey Data

City of Hamilton, 2022 Homelessness Point in Time Count (Tab 2)

1. In 2022, from November 15-19, the City of Hamilton participated in the *Point in Time Connection* received completed 545 surveys at emergency shelters, drop-in programs, community agencies, and in unsheltered locations.

2. When asked “Did you have any family members or anyone else who stayed with you last night?”, survey participants responded as follows: 431 participants did not stay with anyone, 94 stayed with family, 8 stayed with a partner, and 12 stayed with an ‘Other adult’.
3. When asked “Where did you stay last night?”, survey participants responded as follows: 298 participants stayed at an emergency shelter, 68 stayed in a city funded hotel/motel, 60 were unsheltered, 52 stayed in transitional shelter/housing, 35 stayed in an encampment, 15 stayed at someone else’s place, and 17 answered ‘other - non permanent’.
4. Survey participants identified their ages as follows: 10% were between the ages of 16-24, 12% were between 25-30, 51% were between 31-49, 23% were between 50-64, and 4% were 65 and older.
5. Survey participants identified their gender indity as follows: 53% identified as women, 45% as men, 2% as non-binary, and 1% as trans or Two-Spirit.
6. 23% of survey participants identified as Indigenous or as having Indigenous ancestry.
7. 77 survey participants reported that their most recent housing loss was related to the COVID-19 pandemic.
8. 40% of survey participants reported having a chronic illness or health condition.
9. 270 survey participants reported having been to an emergency room in the last 12 months, with a cumulative total of 787 emergency room visits.
10. The top three reasons for most recent housing loss reported by survey participants were: not enough income, landlord/tenant conflict, and unfit/unsafe housing conditions.
11. The top five barriers to finding housing reported by survey participants were: rent too high, low income, no income assistance, poor housing conditions, and discrimination.
12. 304 survey participants reported being homeless for six months or more within the past year.

City of Hamilton, 2021 Point in Time Connection Results (Tab 3)

13. One fifth of the survey participants identified as an immigrant or refugee.
14. Of the survey participants, 12% identified as immigrants, 4% as refugee claimants, and 3% as refugees.
15. Of the survey participants, 10% identified as Black.
16. Of the 545 survey participants, 457 identified having at least one health challenge.
17. Of the survey participants, 60% indicated that they have a challenge relating to mental health.
18. Of the survey participants, 59% indicated having a challenge with substance use.
19. Of the survey participants, 40% reported having a chronic illness or health condition.
20. Of the survey participants, 39% reported having an illness or medical condition.
21. Of the survey participants, 34% reported having learning or cognitive limitations.
22. Of the survey participants, 33% reported having a physical limitation.
23. Of the survey participants, 39% reported that they receive disability benefits.
24. Of the survey participants, 10% identified as 2SLGBTQ+.
25. Of the survey participants, 73% reported staying in a shelter in the last year, 27% reported that they had not stayed in a shelter in the last year.

26. Of the survey participants who had not stayed in a shelter in the last year, 27% reported that they were turned away because the shelter was full, 24% feared for their safety in a shelter, and 11% expressed concerns about crowding.

City of Hamilton, 2021 Point in Time Count Indigenous Responses (Tab 4)

27. Of the 123 Indigenous survey respondents, 92 reported experiencing substance use issues.
28. Of the 123 Indigenous survey respondents, 83 reported managing a diagnosed or undiagnosed mental health issue.
29. Of the 123 Indigenous survey respondents, 57 reported managing an illness or medical condition such as diabetes, arthritis, tuberculosis, or HIV.
30. Of the 123 Indigenous survey respondents, 57 reported having learning or cognitive limitations such a dyslexia, autism spectrum disorder, ADHD, or an acquired brain injury.
31. Of the 123 Indigenous survey respondents, 42 reported experiencing a physical limitation, such as challenges with mobility, physical abilities and/or dexterity.
32. Of the 123 Indigenous survey respondents, 69 reported receiving provincial disability benefits as a source of income.
33. Of the 123 Indigenous survey respondents, 49 identified as men, 69 identified as women, 1 identified as Two-Spirit, and 4 identified as Non-Binary/Gender Queer.
34. Of the 123 Indigenous survey respondents, 99 reported being between the ages of 31 and 64 years old, 17 reported being under the age of 31, and 1 reported being over the age of 65.
35. Of the 17 Indigenous youth survey respondents, 18% identified as Non-Binary/Gender Queer.
36. Of the 123 Indigenous survey respondents, 82% reported having stayed in a shelter in the last year, 18% reported that they had not stayed in a shelter in the last year.
37. Of the 22 Indigenous survey respondents who did not stay in a shelter in the past year, 21 provided one or more reasons why they chose not to stay in shelter. 9 reported fearing for their safety, 4 reported that they were turned away because the shelter was full, 2 reported concerns about bed bugs and other pests, 2 reported concerns about crowding, 2 reported a lack of transportation, 1 reported that they were turned away because they were banned.

City of Hamilton, 2021 Point in Time Infographic – Indigenous Respondents (Tab 5)

38. Of Hamilton's general population, 2% of residents identify as Indigenous or having Indigenous ancestry.
39. Among the 545 individuals responding to Hamilton's 2021 Point in Time survey, 23% self-identified as Indigenous or having Indigenous ancestry.
40. Of the 123 Indigenous survey respondents, 68 identified as women, 49 identified as men, and 5 identified as two spirit or non-binary.
41. When asked "As a child or youth, were you ever in foster care or in a youth group home?", 42% of survey respondents responded yes.
42. When asked "How old were you the first time you experienced homelessness?", 41% or survey respondents said they were 30 years old or younger.
43. When asked "How long have you been in Hamilton?", 44% of survey respondents reported that they had "always been here".

44. The top five sources of income reported by survey respondents were: disability benefit, welfare/social assistance, informal income (e.g., bottle returns, panhandling, family), employment (full or part time), and employment insurance.

45. The top five causes for most recent loss of housing reported by survey respondents were: unfit/unsafe housing condition, not enough income for housing, conflict with spouse/partner, landlord/tenant conflict, and conflict with other.

46. The top five challenges or experiences when trying to find housing reported by survey respondents were: rent being too high, low income, poor housing conditions, discrimination, and addiction.

Attached to this request is a copy of each of the documents referred to above.

YOU MUST RESPOND TO THIS REQUEST by serving a response to request to admit in Form 51B prescribed by the Rules of Civil Procedure WITHIN TWENTY DAYS after this request is served on you. If you fail to do so, you will be deemed to admit, for the purposes of this proceeding only, the truth of the facts and the authenticity of the documents set out above.

August 1, 2023

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Tel: (905) 540-8208
Email: bevin.shores@gowlingwlg.com

Lawyer for the Respondent

TAB 1a

Scale of Homelessness

Open Hamilton
Private Organization

Summary

Number of individuals experiencing homelessness in Hamilton and their length of homelessness.

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MONTH_YEAR	HOMELESS_FOR_MORE_SIX_MONTHS	HOMELESS_FOR_LESS_SIX_MONTHS	TOTAL_HOMELESS
1/31/2020, 12:00 AM	463	401	864
2/28/2020, 12:00 AM	587	509	1,096
3/31/2020, 12:00 AM	632	456	1,088
4/30/2020, 12:00 AM	616	489	1,105
5/31/2020, 12:00 AM	676	426	1,102
6/30/2020, 12:00 AM	655	373	1,028
7/31/2020, 12:00 AM	624	343	967
8/31/2020, 12:00 AM	622	347	969
9/30/2020, 12:00 AM	585	362	947
10/31/2020, 12:00 AM	653	334	987
11/30/2020, 12:00 AM	685	376	1,061
12/31/2020, 12:00 AM	657	427	1,084
1/31/2021, 12:00 AM	666	494	1,160
2/28/2021, 12:00 AM	649	489	1,138
3/31/2021, 12:00 AM	612	483	1,095
4/30/2021, 12:00 AM	746	340	1,086

Scale of Homelessness

Open Hamilton
Private Organization

Summary

Number of individuals experiencing homelessness in Hamilton and their length of homelessness.

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MONTH_YEAR	HOMELESS_FOR_MORE_SIX_MONTHS	HOMELESS_FOR_LESS_SIX_MONTHS	TOTAL_HOMELESS
5/31/2021, 12:00 AM	726	332	1,058
6/30/2021, 12:00 AM	717	362	1,079
7/31/2021, 12:00 AM	700	383	1,083
8/31/2021, 12:00 AM	687	495	1,182
9/30/2021, 12:00 AM	674	528	1,202
10/31/2021, 12:00 AM	763	617	1,380
11/30/2021, 12:00 AM	695	731	1,426
12/31/2021, 12:00 AM	632	909	1,541
1/31/2022, 12:00 AM	889	705	1,594
2/28/2022, 12:00 AM	803	720	1,523
3/31/2022, 12:00 AM	795	801	1,596
4/30/2022, 12:00 AM	326	1,409	1,735
5/31/2022, 12:00 AM	370	1,303	1,673
6/30/2022, 12:00 AM	373	1,166	1,539
7/31/2022, 12:00 AM	367	1,127	1,494
8/30/2022, 12:00 AM	395	1,081	1,476
9/30/2022, 12:00 AM	390	1,141	1,531

Scale of Homelessness

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Private Organization

Summary

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MONTH_YEAR	HOMELESS_FOR_MORE_SIX_MONTHS	HOMELESS_FOR_LESS_SIX_MONTHS	TOTAL_HOMELESS
11/30/2021, 12:00 AM	695	731	1,426
12/31/2021, 12:00 AM	632	909	1,541
1/31/2022, 12:00 AM	889	705	1,594
2/28/2022, 12:00 AM	803	720	1,523
3/31/2022, 12:00 AM	795	801	1,596
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5/31/2022, 12:00 AM	370	1,303	1,673
6/30/2022, 12:00 AM	373	1,166	1,539
7/31/2022, 12:00 AM	367	1,127	1,494
8/30/2022, 12:00 AM	395	1,081	1,476
9/30/2022, 12:00 AM	390	1,141	1,531
10/31/2022, 12:00 AM	409	1,160	1,569
11/30/2022, 12:00 AM	542	1,128	1,670
12/31/2022, 12:00 AM	488	1,048	1,536
1/31/2023, 12:00 AM	494	1,051	1,545
2/28/2023, 12:00 AM	476	989	1,465
3/31/2023, 12:00 AM	556	1,015	1,571
4/30/2023, 12:00 AM	591	1,024	1,615

TAB 1b

Shelter Beds Available

Open Hamilton
Private Organization

Summary

Total number of shelter beds or rooms available on the last day of the month.

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MONTH_YEAR	MEN_BEDS	WOMEN_BEDS	FAMILY_ROOMS	YOUTH_BEDS	TOTAL_BEDS	TOTAL_ROOMS
1/31/2020, 12:00 AM	220	46	20	21	287	20
2/28/2020, 12:00 AM	193	46	20	21	260	20
3/31/2020, 12:00 AM	219	46	20	21	286	20
4/30/2020, 12:00 AM	150	46	20	21	217	87
5/31/2020, 12:00 AM	127	46	20	21	194	63
6/30/2020, 12:00 AM	127	46	20	21	194	63
7/31/2020, 12:00 AM	127	46	20	21	194	67
8/31/2020, 12:00 AM	127	38	20	21	186	82
9/30/2020, 12:00 AM	115	38	20	21	174	147
10/31/2020, 12:00 AM	142	26	20	13	181	152
11/30/2020, 12:00 AM	186	26	20	13	225	149
12/31/2020, 12:00 AM	186	26	20	13	225	143
1/31/2021, 12:00 AM	196	26	20	13	235	177
2/28/2021, 12:00 AM	223	26	20	13	262	178
3/31/2021, 12:00 AM	223	26	20	13	262	198
4/30/2021, 12:00 AM	223	26	20	13	262	199
5/31/2021, 12:00 AM	223	26	20	13	262	178
6/30/2021, 12:00 AM	223	26	20	13	262	183

Shelter Beds Available

Open Hamilton
Private Organization

Summary

Total number of shelter beds or rooms available on the last day of the month.

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MONTH_YEAR	MEN_BEDS	WOMEN_BEDS	FAMILY_ROOMS	YOUTH_BEDS	TOTAL_BEDS	TOTAL_ROOMS
7/31/2021, 12:00 AM	209	26	20	13	248	169
8/31/2021, 12:00 AM	210	26	20	13	249	177
9/30/2021, 12:00 AM	218	26	20	13	257	185
10/31/2021, 12:00 AM	219	41	20	13	273	218
11/30/2021, 12:00 AM	238	41	20	13	292	235
12/31/2021, 12:00 AM	239	41	20	13	293	218
1/31/2022, 12:00 AM	245	41	20	21	307	268
2/28/2022, 12:00 AM	212	41	20	21	274	281
3/31/2022, 12:00 AM	212	96	20	21	329	210
4/30/2022, 12:00 AM	154	104	20	21	279	201
5/31/2022, 12:00 AM	154	104	20	21	279	220
6/30/2022, 12:00 AM	193	104	20	21	318	158
7/31/2022, 12:00 AM	193	104	20	21	318	157
8/30/2022, 12:00 AM	212	104	20	21	337	155
9/30/2022, 12:00 AM	212	104	20	21	337	124
10/31/2022, 12:00 AM	212	104	20	21	337	100
11/30/2022, 12:00 AM	201	107	20	21	329	100

Shelter Beds Available

Open Hamilton
Private Organization

Summary

Total number of shelter beds or rooms available on the last day of the month.

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MONTH_YEAR	MEN_BEDS	WOMEN_BEDS	FAMILY_ROOMS	YOUTH_BEDS	TOTAL_BEDS	TOTAL_ROOMS
11/30/2021, 12:00 AM	238	41	20	13	292	235
12/31/2021, 12:00 AM	239	41	20	13	293	218
1/31/2022, 12:00 AM	245	41	20	21	307	268
2/28/2022, 12:00 AM	212	41	20	21	274	281
3/31/2022, 12:00 AM	212	96	20	21	329	210
4/30/2022, 12:00 AM	154	104	20	21	279	201
5/31/2022, 12:00 AM	154	104	20	21	279	220
6/30/2022, 12:00 AM	193	104	20	21	318	158
7/31/2022, 12:00 AM	193	104	20	21	318	157
8/30/2022, 12:00 AM	212	104	20	21	337	155
9/30/2022, 12:00 AM	212	104	20	21	337	124
10/31/2022, 12:00 AM	212	104	20	21	337	100
11/30/2022, 12:00 AM	201	107	20	21	329	100
12/31/2022, 12:00 AM	198	109	20	21	328	62
1/31/2023, 12:00 AM	198	109	20	21	328	62
2/28/2023, 12:00 AM	198	109	20	21	328	62
3/31/2023, 12:00 AM	198	81	20	21	300	62
4/30/2023, 12:00 AM	198	65	20	21	284	62

TAB 2

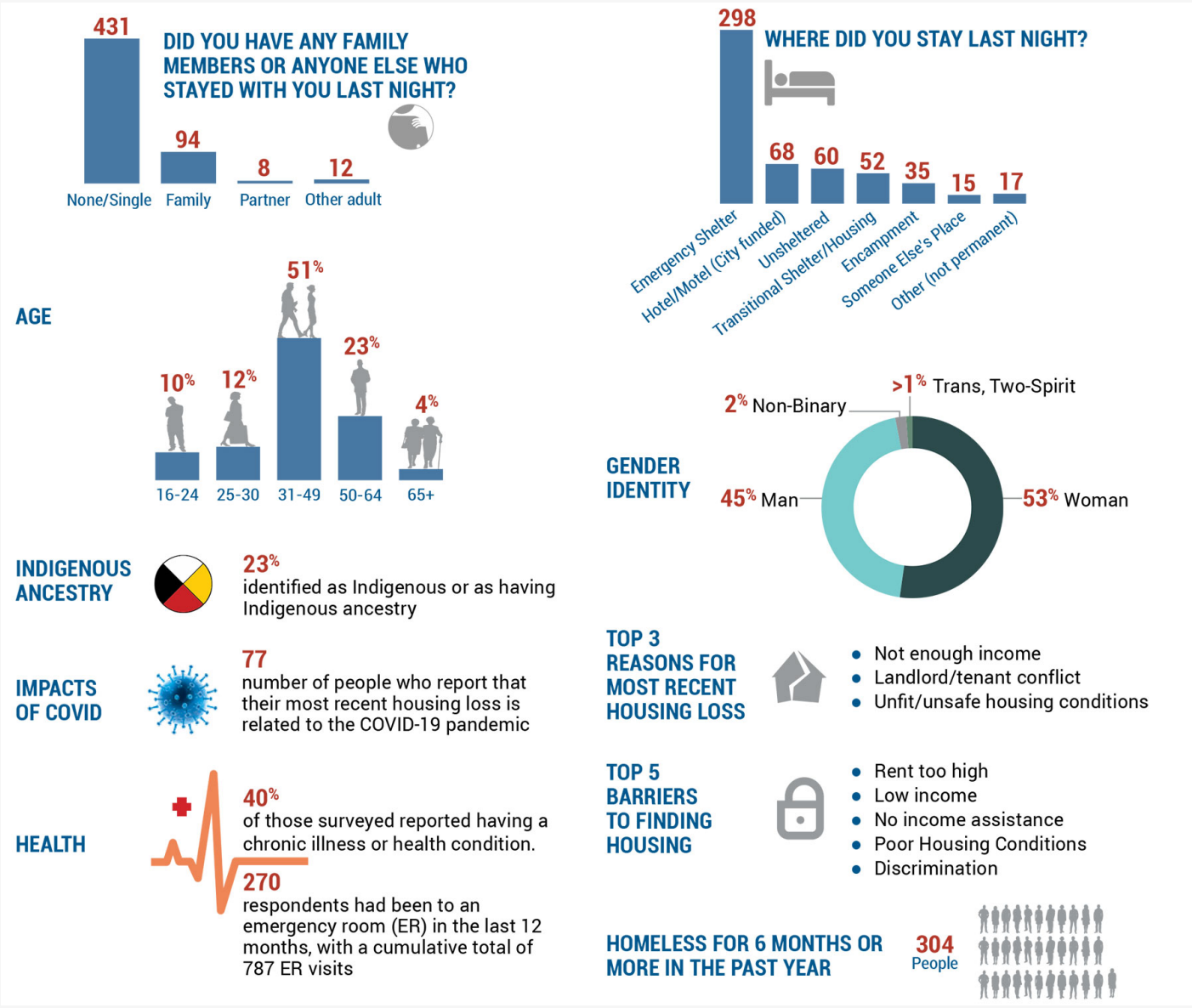
HOMELESSNESS

POINT IN TIME CONNECTION

From November 15 to 19, the City of Hamilton joined communities across Canada in participating in Everyone Counts: the third nationally coordinated Point-in-Time Count in Canada. This initiative, referred to locally as the Point in Time Connection, is a joint planning effort with City of Hamilton's Housing Services Division and the local Indigenous community through the Coalition of Hamilton Indigenous Leadership (CHIL).

During the initiative, staff from community-based social services organizations conducted surveys, hearing directly from unhoused residents, to better understand the needs of people experiencing homelessness in our community. 545 surveys were completed during the week at emergency shelters, drop-in programs, community agencies, and in unsheltered locations. Indigenous led magnet event was also held in Beasley Park on November 17 to provide an opportunity for Indigenous community members to be surveyed by Indigenous surveyors.

2022 POINT IN TIME CONNECTION RESULTS



2022 PiTC Results Infographic Description +

The goal of Hamilton's homeless-serving System is to connect people to the housing resources that will best meet their needs to access long-term sustainable housing. The system follows the principles of housing first and relies on person-centred data to facilitate the housing process.Point in Time Connection data helps to ensure available resources are leveraged as efficiently and effectively as possible to prevent and end homelessness.

- **City of Hamilton Point in Time Connection Results - 2021 (PDF, 1.09 MB)**
  In keeping with the principles of Indigenous data sovereignty, as directed by the Indigenous Community Advisory Board (ICAB), CHIL will continue to lead the analysis of Indigenous respondent data and the City of Hamilton will not use this data without the approval of the ICAB. See below for the full analysis of Indigenous respondent data, completed by CHIL and approved by the ICAB:
- **2021 Point in Time Count Indigenous Responses – Hamilton (PDF, 1.15 MB)**
- **2021 PiT Infographic - Indigenous Respondents (PDF, 800.43 KB)**

Coalition of Hamilton Indigenous Leadership

↗ BACKGROUND

- Completion of the PiTC fulfilled requirements of both the Federal government's Reaching Home: Canada's Homelessness Strategy and the Ontario Ministry of Municipal Affairs and Housing.
- The 2021 PiTC complements existing local efforts to collect and report on key data on the state of homelessness to inform homelessness prevention and reduction efforts.

- Hamilton was the second community in Ontario to undertake homelessness enumeration in 2016 and one of the first to put in place a Coordinated Access system underpinned by a By-Name Priority List.
- Hamilton's PiTC was initially planned for April 2020, however was subsequently postponed by the City of Hamilton and CHIL due to COVID-19 response and impacts, and to await further direction from Federal and Provincial Governments.
- Unlike in previous years, no additional volunteers were recruited to support the surveying. The 2021 PiTC survey was conducted over the course of the week of November 15-19, 2021 in order to: ease the burden on agency staff working to complete the surveys and provide essential services in the community; to enable more time to safely connect with individuals and families in a variety of settings; and to avoid large gatherings to reduce the risk of infection and community spread of COVID-19 within these settings.

2018 Point in Time Connection +

2016 Point in Time Connection +

Date modified: October 31, 2022

‹ Housing & Shelter

Preventing & Ending Homelessness

Cathedral Temporary Shelter

City of Hamilton Encampment Response

Emergency Shelters & Drop-ins

Hamilton's Homelessness Ending Strategy

Housing & Homelessness Action Plan

Housing Stability & Rent Ready Benefits

Point in Time Connection

Resources for Homeless-serving partners

Resources for Individuals at Risk of and Experiencing Homelessness

Contact Us

Homelessness Policy & Programs

Call 905-546-2424 ext. 4666

Email **homelesspolicyprograms@hamilton.ca**

RELATED PAGES

TAB 3

City of Hamilton

Point in Time Connection Results 2021

Housing Services Division – April 2022

The 2021 Point in Time Connection (PiTC), a joint planning effort with City of Hamilton's Housing Services Division and the Coalition of Hamilton Indigenous Leadership (CHIL), was made possible through the support of a wide range of community partners who assisted greatly in its planning and implementation. The Housing Services Division would like to specifically acknowledge and thank every single survey participant whose contributions allow us to more deeply examine the impact of our ongoing work to end homelessness.

The partnership with, and leadership of, CHIL remain central in efforts to prioritize Indigenous led solutions to homelessness. Recommendations from the Indigenous community guide efforts to ensure that the PiTC is conducted in a way that is safe and culturally appropriate, acknowledging autonomy and self-determination as key pillars of engagement.

For the first time, Hamilton's PiTC was led on the ground exclusively by community partners and City staff without the support of volunteers; these efforts were critical in prioritizing the health and safety of all involved throughout the survey week. Building on this initiative, we continue to strive to centre the voices of unhoused residents to work toward ensuring that their needs are directly prioritized in approaches taken and decisions made in the context of local planning, policy and investment.

Land Acknowledgment

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 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.

Coming Together to End Homelessness: Hamilton's Systems Planning Framework outlines our strategic local approach to preventing and ending homelessness, which must account for the systemic over-representation of Indigenous persons experiencing homelessness. The Housing Services Division is committed to ongoing coordination with urban Indigenous leadership to ensure that approaches to service coordination and provision are culturally appropriate, safe and built on principles of relationship, trust and informed consent.

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Summary and Key Findings

Hamilton's most recent PiTC survey of individuals experiencing homelessness in the city highlights a shift in the demographic profile of those experiencing homelessness, identifies key barriers to maintaining or obtaining housing, and shows specific groups are overrepresented in their experience of homelessness.

Held November 15 to 19, 2021, and jointly planned by the City's Housing Services Division and CHIL, it is the third nationally-coordinated Point-in-Time Count since 2016. The information collected complements existing local efforts to collect and report on key data on the state of homelessness and helps to ensure available resources are used as efficiently and effectively as possible to prevent and end homelessness.

Service staff from community-based social service organizations conducted 545 surveys over the five-day period at emergency shelters, drop-in programs, community agencies, and in unsheltered locations to better understand the needs of people experiencing homelessness in our community.

Results of the survey highlight:

- the overrepresentation of Indigenous peoples, as 23% of all respondents identified as Indigenous or as having Indigenous ancestry;
- a shift in the demographic profile of those experiencing homelessness throughout the COVID-19 pandemic, including an increase in the percentage of respondents who identify as a woman (53%), which was higher than in 2018 (32%) and 2016 (28%);
- key barriers to maintaining or obtaining housing, such as impacts from the COVID-19 pandemic, housing affordability, low income/low income assistance, landlord/tenant conflict, poor housing conditions and discrimination;
- a majority of respondents reported they had most recently stayed in an emergency shelter or a City funded hotel/motel; and,
- the 2021 PiTC engaged a larger number of people staying in outdoor unsheltered locations and encampments (95) compared to 2016 and 2018 (In 2016, 34 survey respondents were unsheltered and/or in encampments compared to 25 survey respondents in 2018).

In keeping with the principles of Indigenous data sovereignty, as directed by the Indigenous Community Advisory Board (ICAB), CHIL has led the analysis of Indigenous respondent data and the City of Hamilton has not and will not use this data without the approval of the ICAB. Housing Services Division continues to prioritize collaborative work with local Indigenous leadership to develop connections to housing and supports

that are culturally appropriate, rooted in the spirit and actions of reconciliation that recognize the values of autonomy and self-determination.

Snapshot of Homelessness in Hamilton on November 19, 2021

- Shelters were at 93% capacity during the period of November 15-19, 2021
- 748: the number of unique individuals that stayed in an emergency shelter during the period of November 15-19, 2021
- 1426: total number of people on the City of Hamilton's By-Name List on November 12, 2022

Introduction

From November 15 to 19, 2021 the City of Hamilton participated in Everyone Counts, the third nationally coordinated Point-in-Time Count in Canada. Completion of the PiTC fulfilled requirements of both the Federal government's Reaching Home: Canada's Homelessness Strategy and the Ontario Ministry of Municipal Affairs and Housing.

Point-in-Time Counts have historically been used to help communities better understand the nature and extent of homelessness and the circumstances of the people experiencing homelessness, while providing information to help shape ongoing system and service responses. Point-in-Time Counts can assist in identifying how many people in a community experience homelessness at any given time; however, it is not an exhaustive count. Through the accompanying survey, the initiative provides information on the demographics and service needs of the local population experiencing homelessness.

545 surveys were completed during the week at emergency shelters, provincially administered Violence Against Women shelters, drop-in programs, community agencies, and in unsheltered locations including encampments. An Indigenous led magnet event was also held in Beasley Park on November 17, 2021 to provide an opportunity for Indigenous community members to be surveyed by Indigenous surveyors.

COVID-19 Context

Investments specifically targeted towards housing-focused interventions in Hamilton to prevent and end people's experience of homelessness total approximately $25 M annually in regular funding. In addition, since the beginning of the COVID-19 pandemic, the City has sustained an emergency response across the homelessness-serving system directing more than $60 M in additional pandemic response funds. These funds ensured for a responsive and flexible response throughout the evolving demands of the pandemic.

Through the pandemic, additional investments have enabled the temporary expansion of shelter space across the system from 341 beds up to 548 beds at the highest point plus additional overflow space, as well as a new temporary women's shelter. In addition, these investments supported the expansion of the City's Housing Focused Street Outreach team and have also enabled community drop-in programs to expand and

maintain services for vulnerable residents, including: meals, showers, harm reduction supplies, and overnight access to drop-in services. These investments and the dedicated efforts of agency staff provided additional settings and opportunities for engagement through the PiTC.

Overview of Homelessness in Hamilton

Sheltered Homelessness

Emergency shelters are a critical first-line response to ensure people experiencing homelessness have a safe place to stay while they pursue stable housing. The City's outreach staff work on a daily basis to engage individuals experiencing unsheltered homelessness to offer shelter space and work with them to find safer, humane, and supportive housing options.

There has been growing pressure within the shelter system throughout the course of the pandemic. In 2020, emergency shelter average length of stay increased 18% and the women's system was particularly over-capacity. From 2020 to 2021 there has been an increasing trend in number of unique individuals accessing shelters by month.

Figure 1: Unique Individuals in Shelter by Month

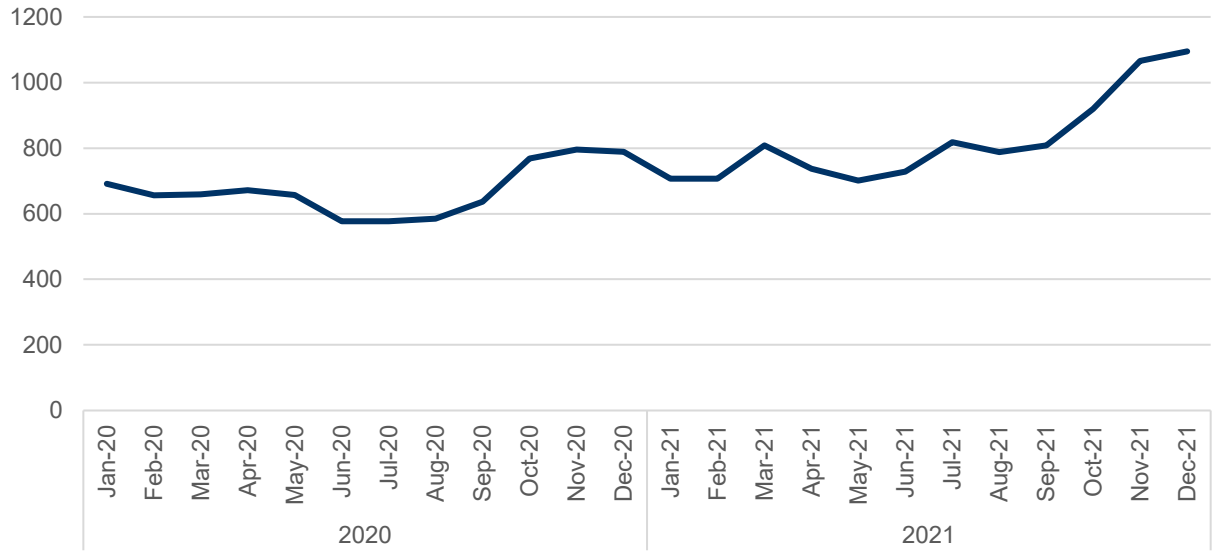


Figure 2: Monthly Shelter Bed Usage and Max Capacity by Month

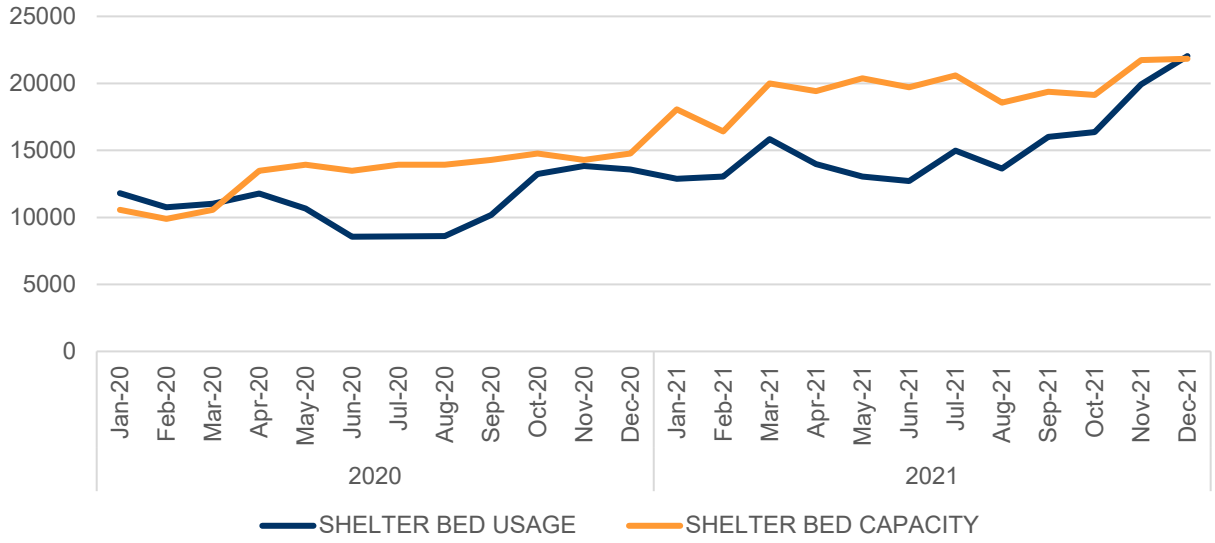
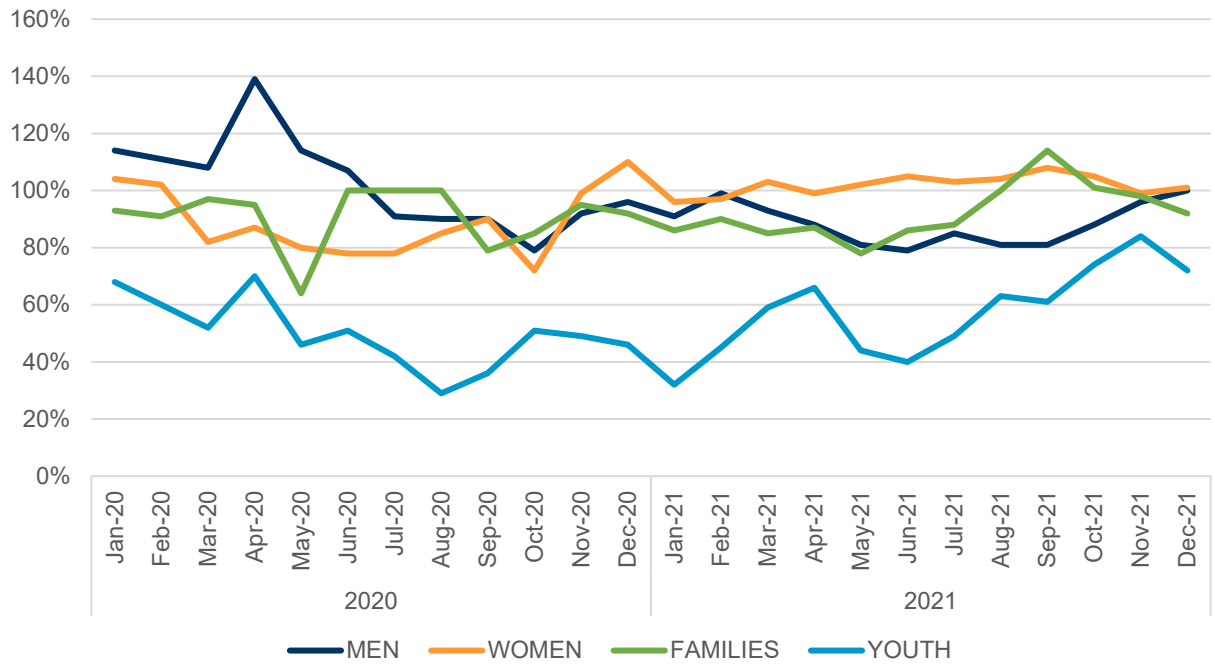


Figure 3: Shelter Occupancy by Sector and Month



Unsheltered Homelessness

During the week of the PiTC (Nov. 15-19, 2021), the City's Housing Focused Street Outreach team reported that there were approximately 90 unique individuals staying in unsheltered locations, including encampments. The rise in, and visibility of, unsheltered

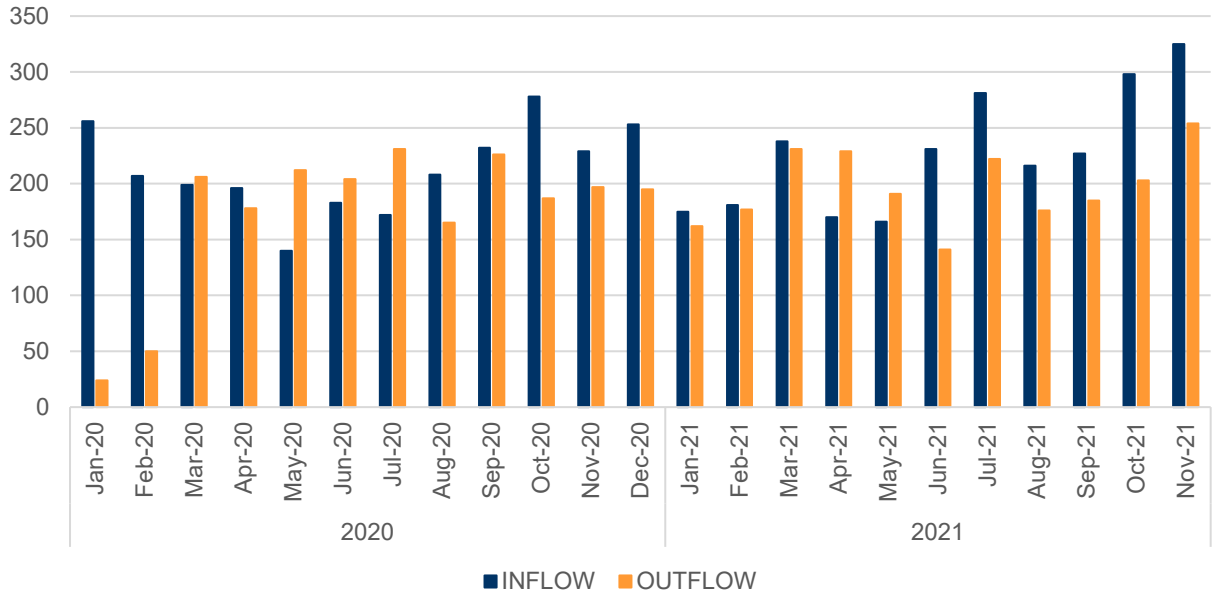
homelessness and encampments throughout many Canadian cities continues to demonstrate how the COVID-19 pandemic persists in exacerbating ongoing systemic challenges and inequities as it relates to housing and homelessness. While the City has worked to develop new strategies and approaches to address these issues locally, unsheltered homelessness remains a persistent reality in Hamilton along with structural barriers to accessing adequate housing and supports.

Shelter System Flow Data

Inflow and outflow are two of the most important measures for monitoring progress towards the goal of ending homelessness. The goal towards ending homelessness is to see outflow exceed inflow. When this happens, it means that more people are exiting from homelessness than are entering the homeless-serving system. As of the end of November 2021, there have been two months where outflow exceeds inflow. In 2020, there were four months where outflow exceeded inflow. Note that outflow data was limited for the first two months of 2020.

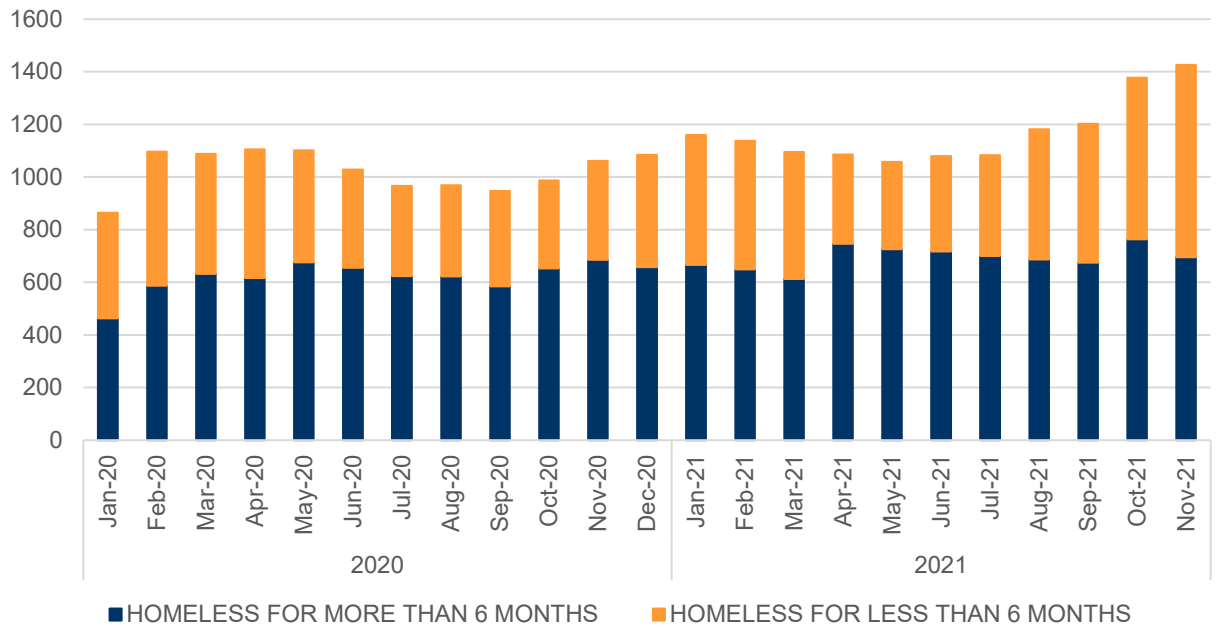
INFLOW	OUTFLOW
Represents the number of individuals: • newly identified as homeless, • returned to homelessness from housing, • returned to homelessness from inactive status.	Represents the number of individuals: • who have moved from housing to housed, • those who have moved to inactive status (meaning they have not interacted with the homeless-serving system for 90+ days).

Figure 4: Individuals (shelter stayers) entering (inflow) or exiting (outflow) homelessness by month



The number of people actively experiencing homelessness is based on data collected by homeless-serving shelters through the Homeless Individuals and Families Information System (HIFIS). Individuals on the By Name List (BNL) who have been engaged only through Outreach and Drop-in programs are not included in this depiction at this time as we look to improve our data reporting.

Figure 5: Individuals (shelter stayers) experiencing homelessness for less than six months and more than six months, by month



Methodology

The nationally coordinated Point-in-Time Count approach includes a set of core standards for the methodology that guide how the counts are conducted in participating communities across Canada. The core standards, identified by Federal and Provincial governments, identify common screening and survey questions that are asked in all participating communities. The approach does give some flexibility for communities to adapt methodology, and Hamilton's survey design and implementation was guided by local partners, including consultation with Indigenous partners through CHIL.

Given the COVID-19 pandemic, adaptations to methodology were made available to communities to support the implementation of Point-in-Time Counts to reduce risks and burden on participants and staff in the homeless serving sector. Adaptations to the 2021 PiTC included:

- expansion of surveying timeline to five days, creating additional flexibility to participate and complete surveys, while avoiding large gatherings to reduce the risk of infection and community spread of COVID-19;
- no additional assessment tool included for 2021, as the survey consisted of only the core anonymous questions;
- 24-hour online survey submission, completed through the Homeless Individuals and Families Information System (HIFIS);
- no additional community volunteers recruited - surveying was conducted exclusively by community social-service agency and City of Hamilton staff;
- full training module completed online; and,
- focus on sheltered sites (emergency shelter, drop in, etc.) and a targeted approach to connect with unsheltered individuals and families in the community in known locations through the City's Housing Focused Street Outreach team, alongside partners from local Indigenous housing organizations.

As in 2016 and 2018, an Indigenous led magnet event was held during the week to provide an opportunity for Indigenous community members to be surveyed by Indigenous surveyors. All survey participants of the PiTC were provided a $15 gift card honorarium upon completion of the survey.

While a number of strategic decisions allowed for increased engagement through the PiTC, there remains limitations in the methodology. In the 2018 PiTC, Hamilton had expanded survey sites to include additional drop-in programs focused on youth, as well as including the Central Library location as a survey site. As a result of enhanced COVID-19 health and safety regulations and limitations on volunteer recruitment, staff were unable to include these additional spaces and build upon learnings and reflections from these survey sites in 2018.

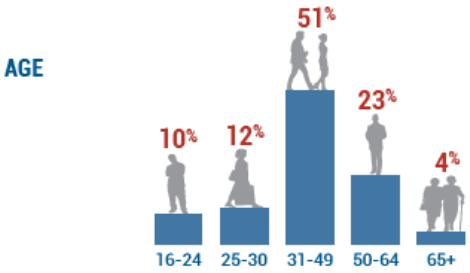
Snapshot

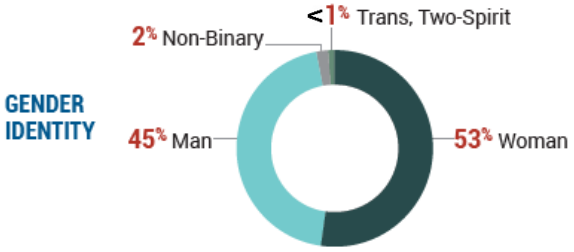
Comparison and analysis of detailed results across multiple PiTC initiatives remains a challenge given the varying contextual factors from year to year. Between PiTC initiatives, the Housing Services Division has worked with community partners to strengthen local reporting on key data related to the state of homelessness and actions towards preventing and ending it. As a part of these broader efforts, the PiTC remains a valuable tool to further support evidence-informed action and improvement within Hamilton's Housing and Homelessness Serving System.

A total of 545 individuals completed voluntary surveys during the 2021 Hamilton Point in Time Connection. Here is a snapshot of the survey results:









INDIGENOUS ANCESTRY

23% identified as Indigenous or as having Indigenous ancestry

IMPACTS OF COVID

77 number of people who report that their most recent housing loss is related to the COVID-19 pandemic

HEALTH

40% of those surveyed reported having a chronic illness or health condition.

270 respondents had been to an emergency room (ER) in the last 12 months, with a cumulative total of 787 ER visits

TOP 3 REASONS FOR MOST RECENT HOUSING LOSS

- Not enough income
- Landlord/tenant conflict
- Unfit/unsafe housing conditions

TOP 5 BARRIERS TO FINDING HOUSING

- Rent too high
- Low income
- No income assistance
- Poor Housing Conditions
- Discrimination

HOMELESS FOR 6 MONTHS OR MORE IN THE PAST YEAR

304 People

Survey Participation

The following chart provides a summary of where the 545 survey respondents reported staying the night before completing the survey:

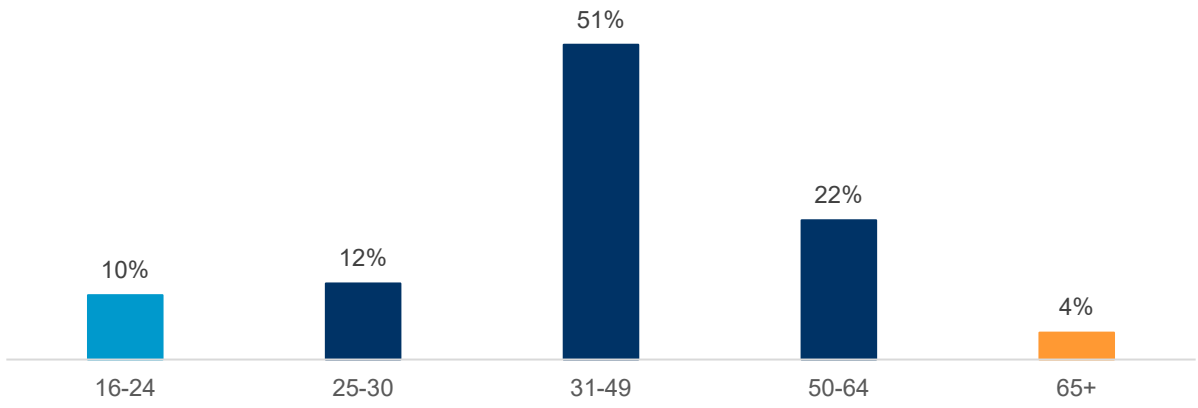
Location	Total	Description
Emergency Shelters	366 (67%)	An emergency shelter, hotel or motel, and domestic violence shelters for emergency accommodation.
Unsheltered	61 (11%)	An unsheltered location in a public space, such as a park, vehicle, or other place not intended for human habitation.
Encampment	35 (6%)	A group of tents, makeshift shelters, or other long-term outdoor settlements.
Couch Surfing	15 (3%)	Staying with a friend, family member, or stranger.
Transitional Housing	52 (10%)	Housing which is a temporary type of accommodation meant to bridge the gap from homelessness to permanent housing.
Motel / Hotel (Self-funded)	1 (0.2%)	Staying in a motel / hotel that was paid for by the individual or family.
Location undetermined	15 (3%)	Location was not reported.

Profile of Respondents Experiencing Homelessness

Age

The average age of respondents was 35 years. Respondents ranged in age from 16 being the youngest and 79 as the oldest. Most respondents (73%) were between the ages of 31 and 64.

Figure 6: Age of Respondents



Gender Identity

A key demographic shift in 2021 results was the percentage of respondents who identified as a woman (53%), which was higher than in 2018 (32%) and 2016 (28%). There are contributing factors to keep in mind when considering this shift in respondent profile, including intentional adaptations to methodology, and where surveys were administered in 2021 in comparison to previous years.

Although not required, Hamilton continues to include people who may be experiencing "hidden homelessness" into the PiTC survey. This has been a standing recommendation by our community to ensure that we better represent populations who may typically not be as highly represented in the mainstream emergency shelter system. Enhanced gender-specific responses during COVID-19, including an expanded emergency shelter system and enhanced drop in locations, along with the option to complete surveys 24 hours a day through the entire duration of the initiative may have also contributed to a shift in response rate.

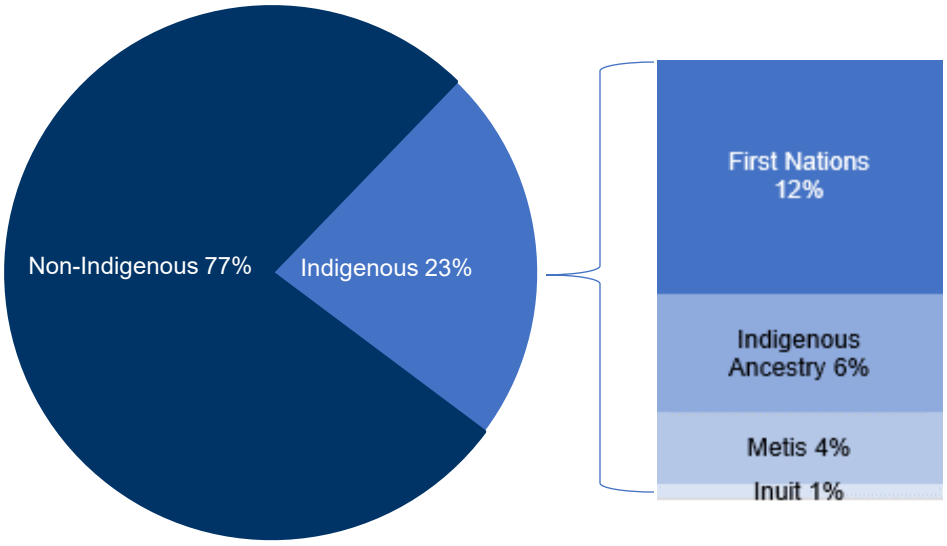
Table 1: Gender Identity of Respondents

Gender	Percentage
Woman	53%
Man	45%
Non-Binary	2%
Trans, Two-Spirit	<1%

Indigenous Identity

In 2021, the PiTC continues to highlight the overrepresentation of Indigenous persons experiencing homelessness in Hamilton (23% of all respondents). A full analysis of Indigenous respondent data can be found in Appendix "B" to Report HSC22021 - 2021 Point in Time Count (Hamilton, Ontario): Indigenous Responses, submitted by CHIL and approved by the ICAB.

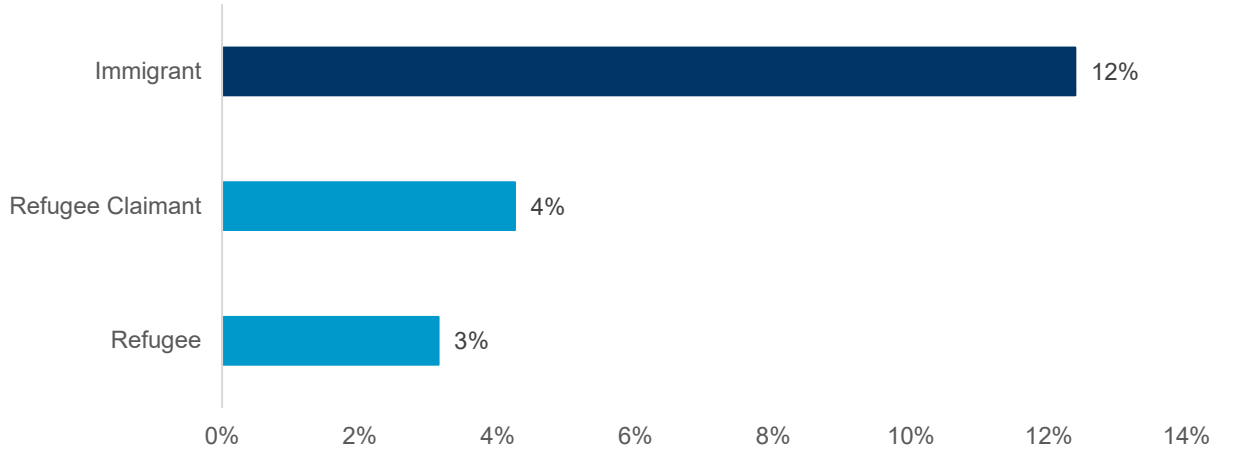
Figure 7: Indigenous Identity of Respondents



Migration to Canada

One-fifth of respondents identified as an immigrant or refugee. A total of 91% reported having been in Canada for one year or more, and 9% reported being in Canada for less than six months.

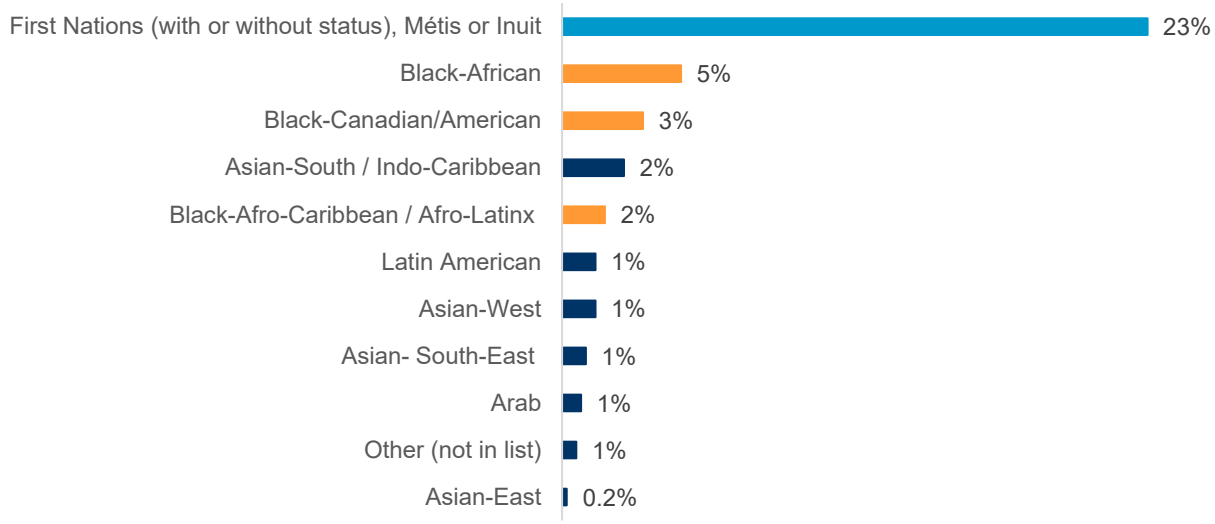
Figure 8: Respondents Migration to Canada



Racial Identity

In 2021, 39% of respondents identified as members of racialized groups, with the largest percentage identifying as First Nations (with or without status), Métis or Inuit (23%). Also, 10% of respondents identified as Black.

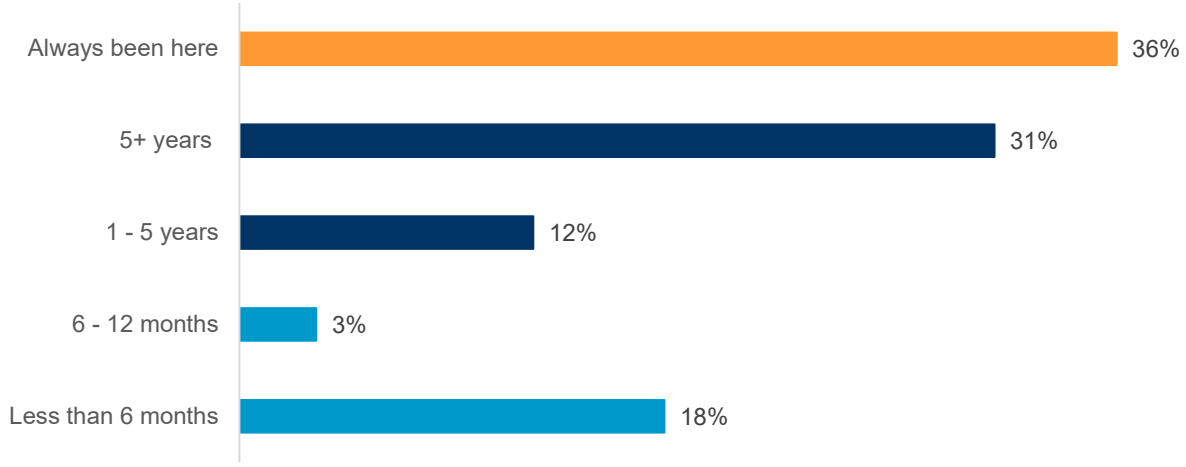
Figure 9: Racial Identity of Respondents



Length of Time in Hamilton

A total of 79% of respondents identified having been in Hamilton for one year or more, including those who reported as always been in Hamilton (36%). 21% of individuals reported being in Hamilton for less than one year.

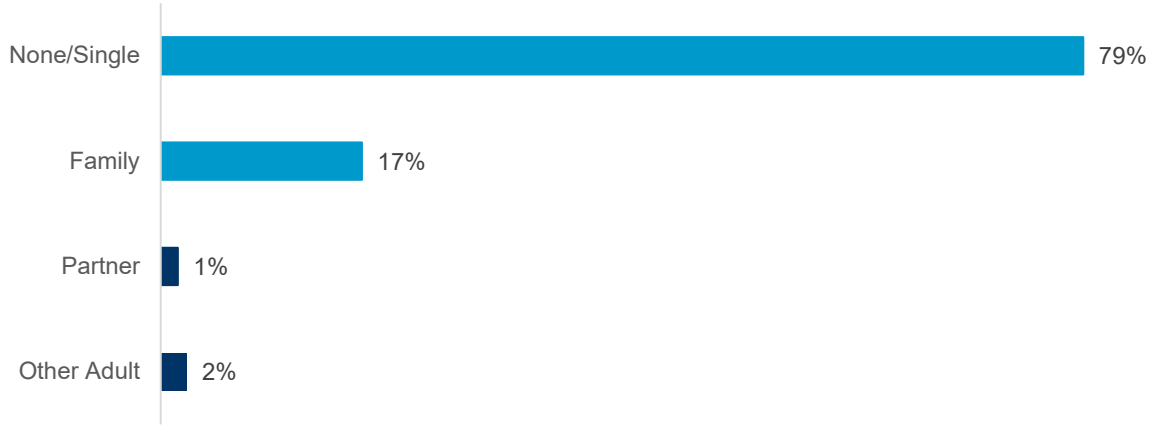
Figure 10: Respondents Length of Time in Hamilton



Family Homelessness

The majority of respondents identified that they were staying alone when surveyed (79%); 21% reported that they had either a partner, other adults or non-adult dependents staying with them that night.

Figure 11: Persons Staying with Respondent on Night of PiTC Survey



Sexual Identity

A total of 10% of respondents identified as 2SLGBTQ+ (Two-spirit, lesbian, gay, bisexual, transgender, queer, questioning, + refers to sexual and gender identities not represented in the acronym). Of those who identified as 2SLGBTQ+ (50), 16% (9) were youth between the ages of 16 and 24.

Figure 12: Sexual Identity of Respondents

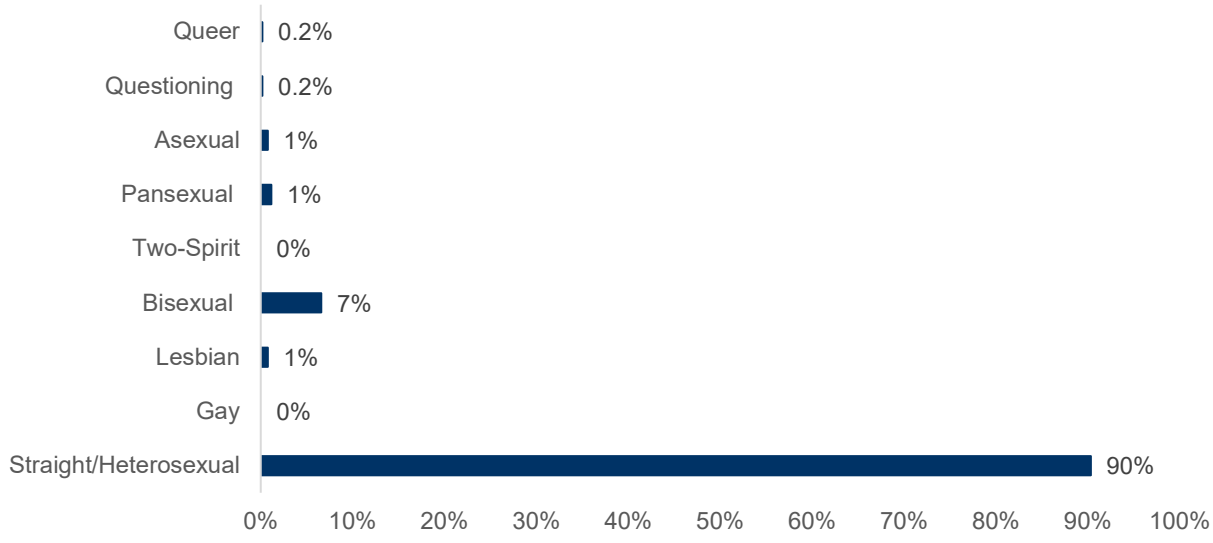
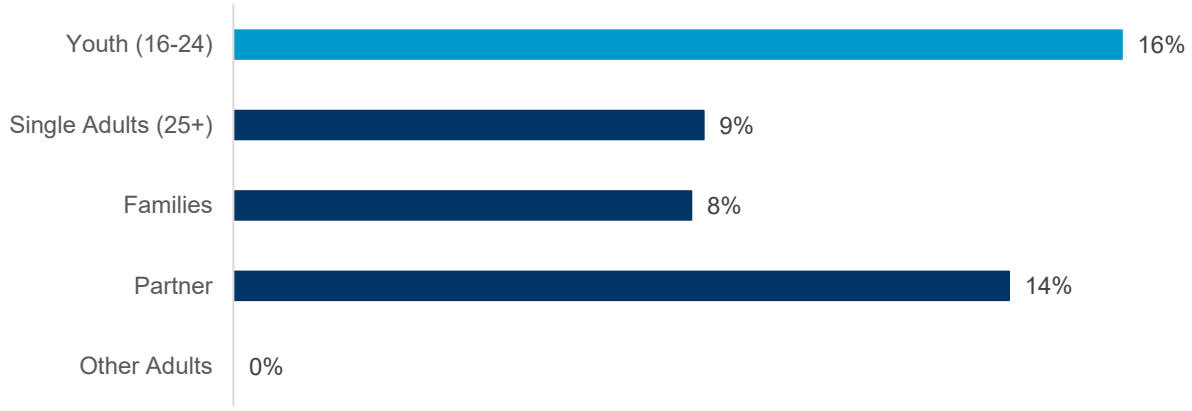


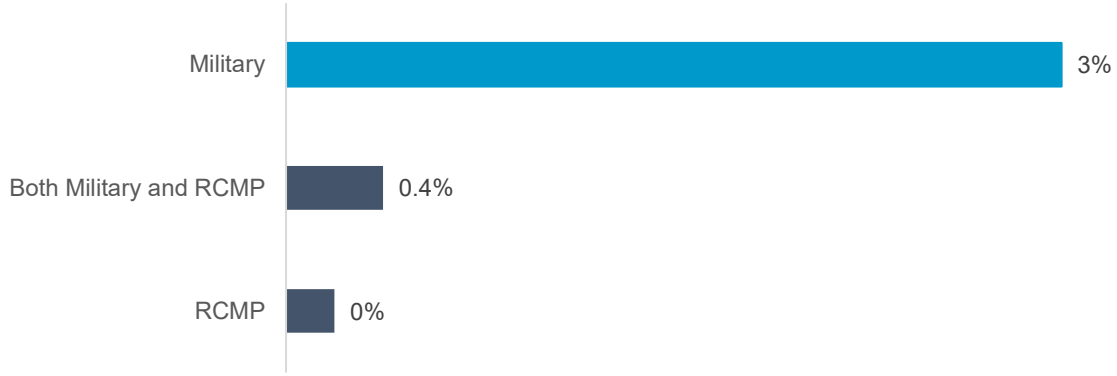
Figure 13: Respondents Identifying as 2SLGBTQ+ by Surveyed Group



Veteran Homelessness

In 2021, 3% of all respondents experiencing homelessness reported having served in the Canadian Military or RCMP.

Figure 14: Respondents Reporting Ever Serviced in the Military or RCMP



Health

Respondents were asked if they had any of the following types of health challenges:

- mental health issue [diagnosed or undiagnosed] (e.g. depression, PTSD, bipolar disorder),
- substance use issue (e.g. tobacco, alcohol, opiates),
- illness or medical condition (e.g. diabetes, arthritis, TB, HIV),
- physical limitation (e.g. challenges with mobility, physical abilities or dexterity),
- learning or cognitive limitations (e.g. dyslexia, autism spectrum disorder, or as a result of ADHD or an acquired brain injury).

A total of 457 respondents identified having at least one health challenge. More than half of respondents indicated having a health challenge relating to mental health (60%)

and substance use (59%). A total of 40% of those surveyed reported having a chronic illness or health condition.

Figure 15: Health Challenges Identified by Respondents



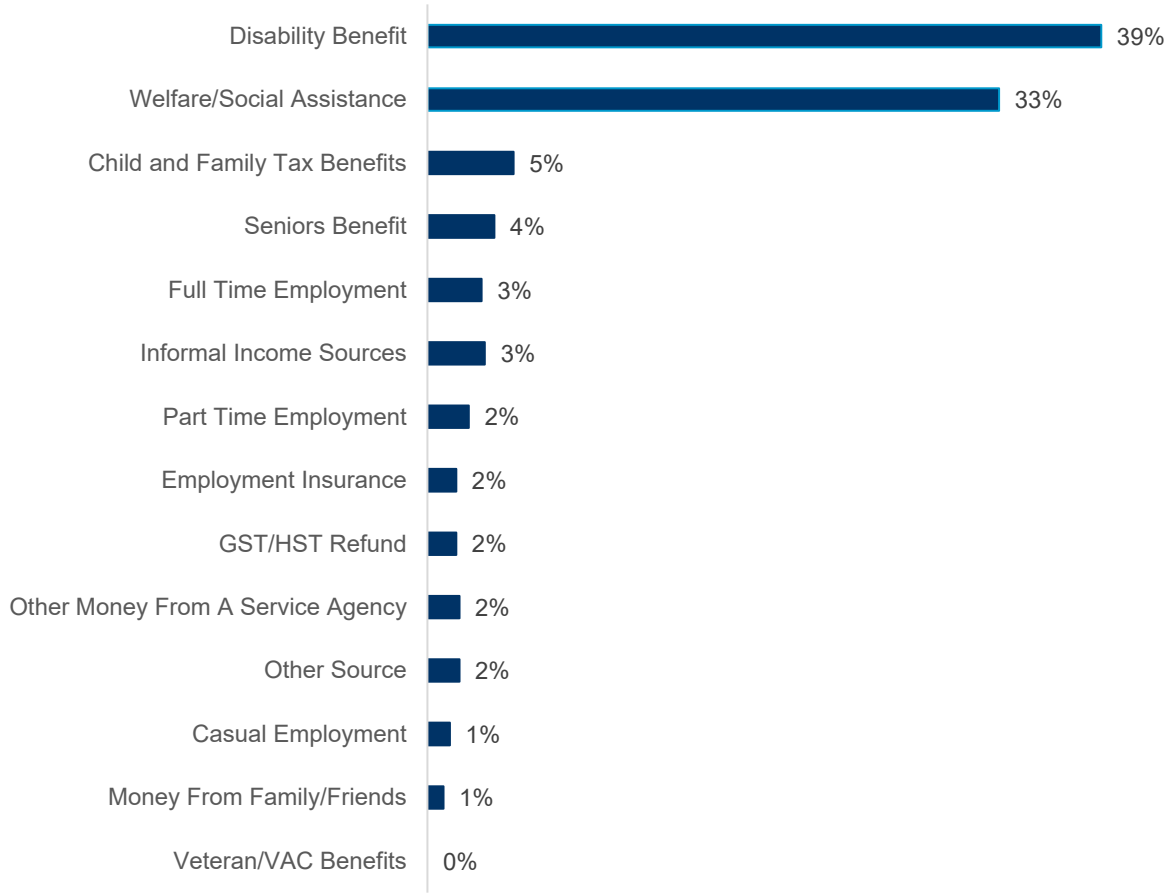
Figure 16: Multiple Types of Health Challenges Identified by Respondents



Sources of Income

The majority of respondents (87%) reported having at least one source of income. The most common sources of income reported in 2021 were disability benefit (39%) and welfare/social assistance (33%). All other sources of income were reported by less than 5% of respondents.

Figure 17: Respondents Source of Income

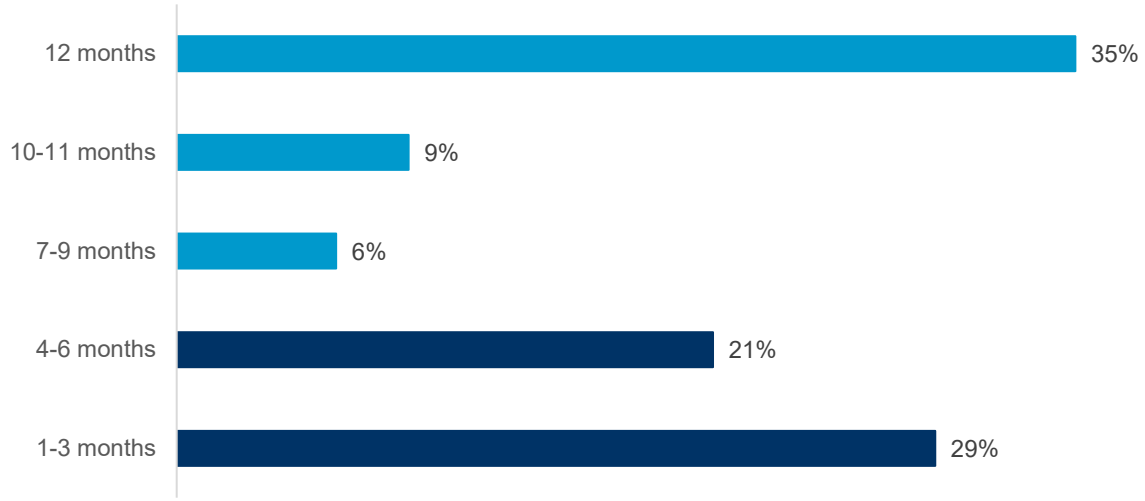


Homelessness History

Length of Homelessness in Past Year

The average reported length of homelessness in the past year was seven months. For the purposes of coordinated point-in-time counts, the federal definition of chronic homelessness is experiencing homelessness for six months or more in the past year. A total of 50% of respondents reported being homeless for more than six months over the past year. 65% of both youth and families identified as being homeless for less than six months in the past year. 57% of single adults identified as being homeless for more than six months in the last year.

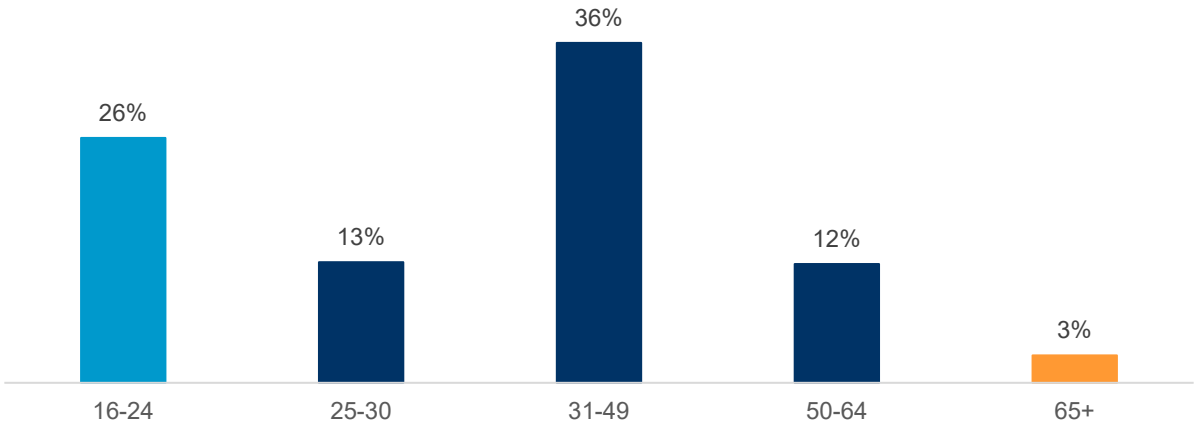
Figure 18: Length of Homelessness in the Past Year



Age of First Homeless Experience

Respondents were asked how old they were the first time they experienced homelessness. A total of 26% of respondents reported being between 16-24 years old the first time they experienced homelessness; 61% were between the ages of 25 and 64.

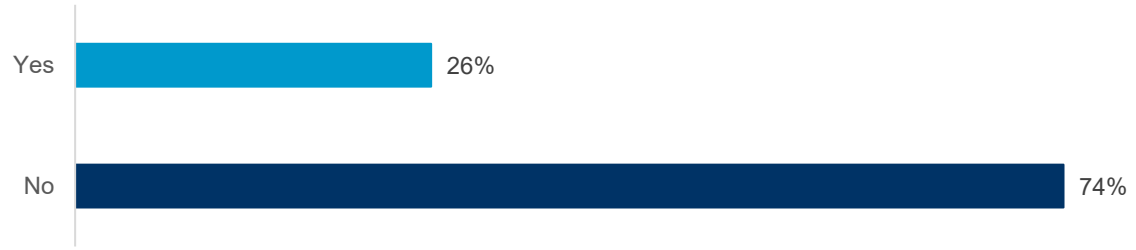
Figure 19: Respondents Age of First Homeless Experience



Experience with Foster Care

A total of 26% of respondents indicated that they had previous experience being in foster care or a youth group home.

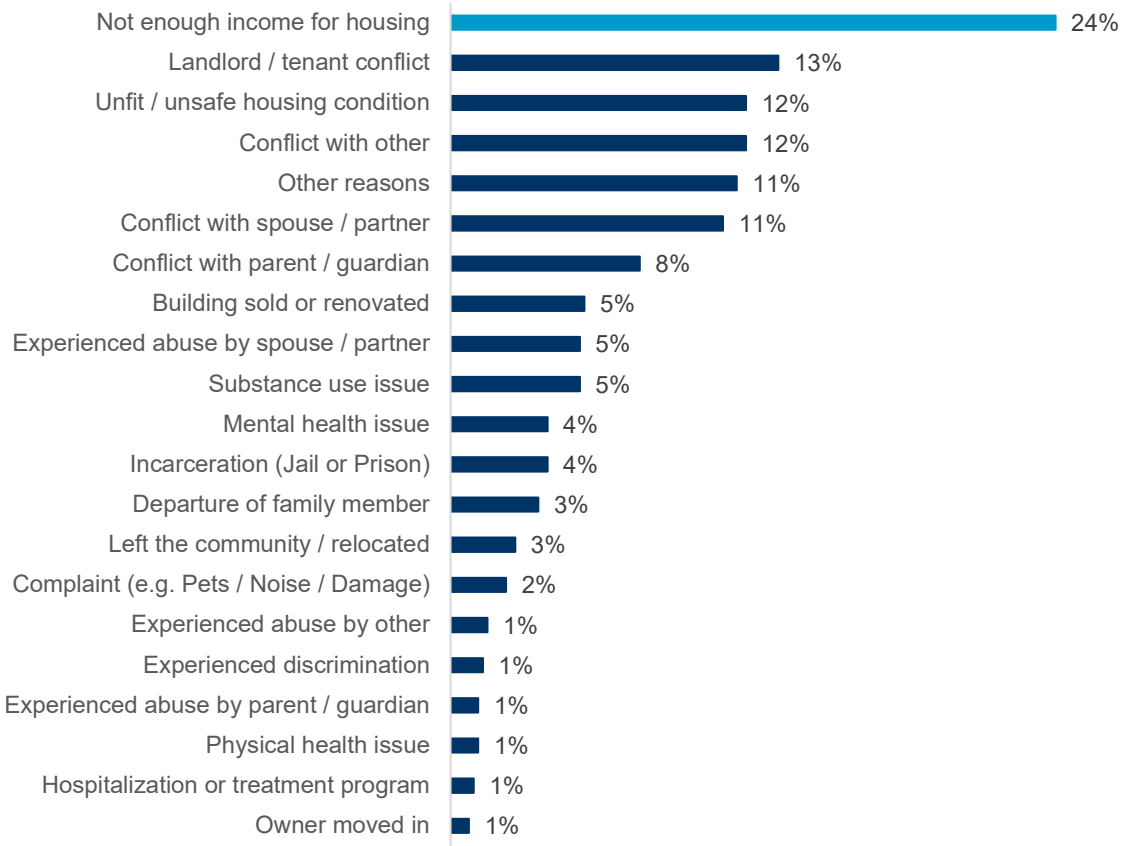
Figure 20: Respondents with Foster Care Experience



Reasons for Homelessness/Housing Loss

When asked what is necessary to maintain and/or find new housing, respondents consistently and clearly identified the need for enhanced income supports and spoke to ongoing challenges with housing affordability. The top reasons for most recent housing loss identified included: not enough income; landlord/tenant conflict; unfit/unsafe housing conditions and conflict with someone other than spouse/partner or parent/guardian.

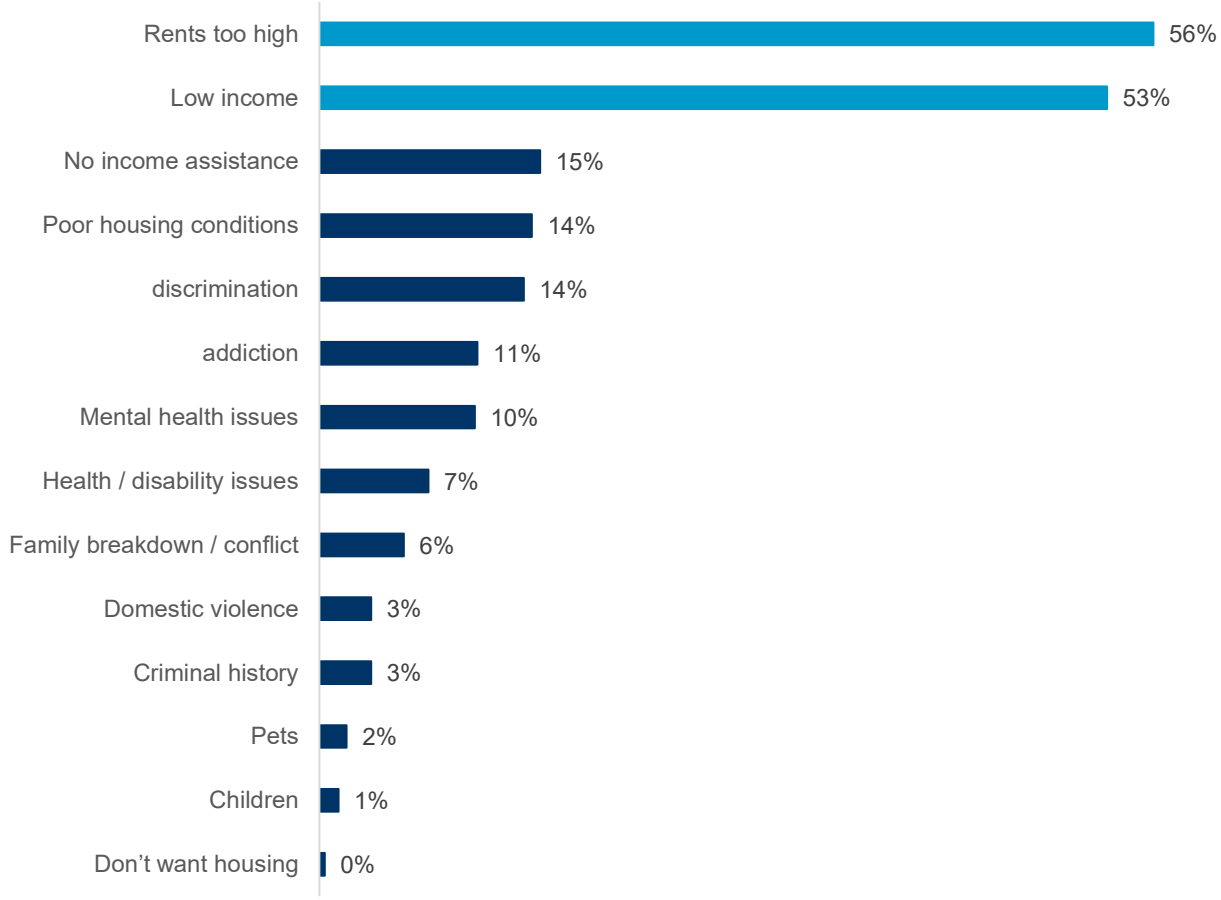
Figure 21: Respondents Reasons for Homelessness



Barriers to Finding Housing

The top barriers and challenges to finding new housing identified by respondents include: rents too high; low income; no income assistance; poor housing conditions; and, discrimination. Additionally, 67 respondents identified having a low credit score as a barrier as well.

Figure 22: Respondents Barriers to Finding Housing

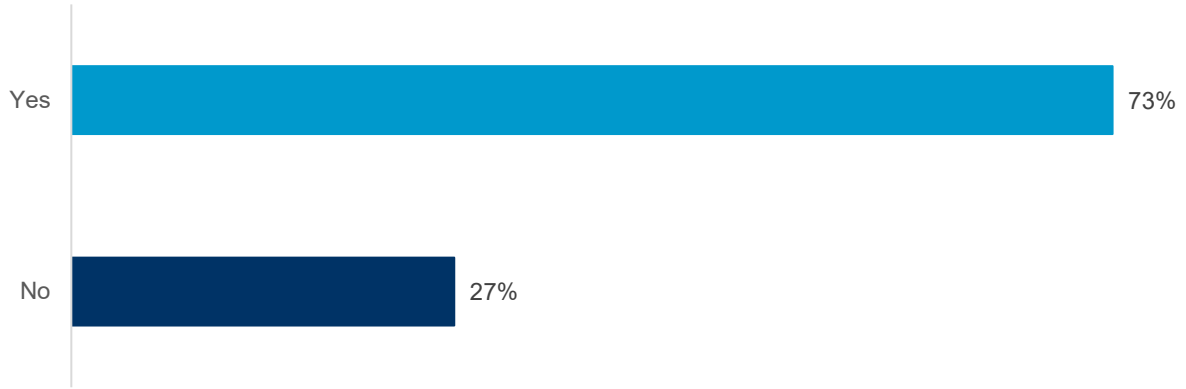


Service Use Patterns

Shelter Use in the Last Year

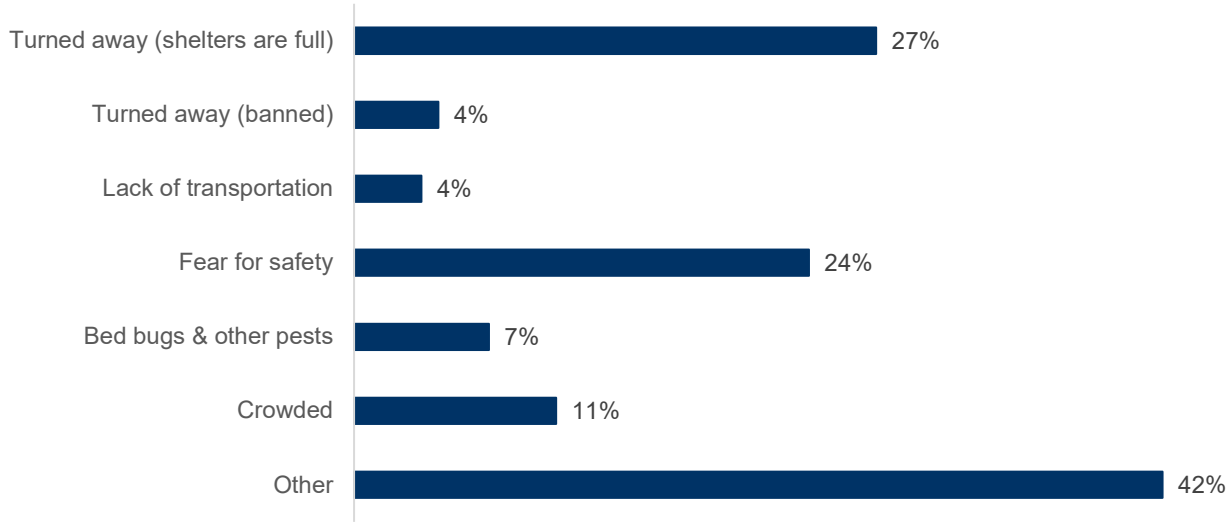
When asked if they have stayed in a shelter in the last year (including emergency and extreme weather shelters), 73% of respondents reported that they had.

Figure 23: Respondents Reporting Staying in Shelter in the Last Year



When individuals were asked about why they decided not to stay in a homeless shelter in the last year, 27% reported that they were turned away because the shelter was full, 24% feared for their safety in a shelter, and 11% expressed concerns about crowding.

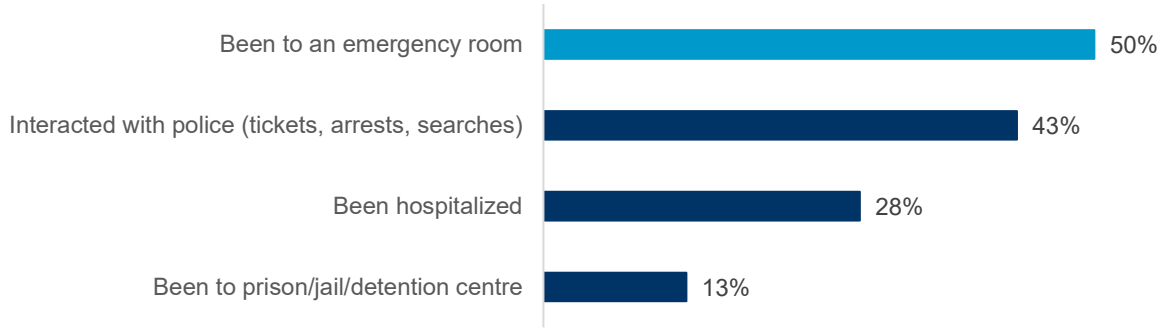
Figure 24: Respondents Reporting Staying in Shelter in the Last Year



Interaction with the Health Care & Criminal Justice System

A total of 270 respondents (50%) reported that they had been to an emergency room (ER) in the last 12 months, with a cumulative total of 787 ER visits. Approximately 61% of those who visited the ER in the last year had been there more than once.

Figure 25: Respondents Interaction with the Health Care and Criminal Justice System



Conclusion and Next Steps

The PiTC remains an important local initiative and a demonstration of Hamilton's commitment to work collaboratively to prevent and end homelessness. As Service System Manager and Designated Community Entity for the provincial and federal funding respectively, the Housing Services Division remains committed to working in partnership with urban Indigenous leadership to build a coordinated housing and homeless-serving system in deep collaboration with community partners to ensure everyone in Hamilton has a home.

In addition, enhanced gender-specific responses and housing options for women, trans-feminine, trans-masculine and non-binary adults remain an important local priority. The Housing Services Division continues to consult with the sector planning tables including the Women's Housing Planning Collaborative, the Street Youth Planning Collaborative and the membership of the Men's Emergency Services Coordination Committee. Through this ongoing engagement and collaboration, it is our goal to continue to share the results and further analysis of the PiTC, while discussing next steps to further centre the voices of unhoused residents in our collective responses.

In the ongoing development and adaptation of systems-level responses, it remains essential that people with living/lived experience are empowered to inform services and hold the homelessness-serving system accountable for delivering on its promise of housing and supports. A distinct focus on Indigenous rights should be prioritized in these efforts, guided by the obligation to respect, protect and fulfil the distinct rights of Indigenous peoples through engagement with unhoused residents. Underpinning further strategic coordination efforts remains the collective obligation to ensure that people experiencing homelessness have access to long-term, adequate housing that meets their needs.

Appendix A: 2021 PiTC Survey

SCREENING TOOL

Hello, my name is _____ and I'm a volunteer for the **Hamilton** Point in Time Connection – a housing needs survey. We are conducting a survey to provide better programs and services to people experiencing homelessness. The survey takes about 10 minutes to complete.

- **Participation is voluntary** and **your name will not be recorded –** participation will not affect the services you receive.
- You can choose to **skip any question** or to **stop the interview at any time**.
- Results will contribute to the understanding of homelessness across Canada, and will help with research to improve services.

A. Have you answered this survey already this week?
[YES: Thank and tally] **[NO: Go to B]**

B. Are you willing to participate in the survey?
[YES: Go to C] **[NO: Thank and tally]**

C. Where did you stay last night? [DO NOT READ CATEGORIES – circle response]

a. DECLINE TO ANSWER b. OWN APARTMENT / HOUSE	**[THANK & END SURVEY]**
c. SOMEONE ELSE'S PLACE d. MOTEL/HOTEL (SELF-FUNDED) e. HOSPITAL f. TREATMENT CENTRE g. JAIL, PRISON, REMAND CENTRE	**C1. Do you have access to a permanent residence where you can safely stay as long as you want?** a. Yes **[THANK & END]** b. No (not permanent AND/OR not safe) **[BEGIN SURVEY]** c. Don't Know **[BEGIN SURVEY]** d. Decline to answer **[THANK & END]**
h. HOMELESS SHELTER (EMERGENCY, FAMILY OR DOMESTIC VIOLENCE SHELTER) i. HOTEL/MOTEL (FUNDED BY CITY OR HOMELESS PROGRAM) j. TRANSITIONAL SHELTER/HOUSING k. UNSHELTERED IN A PUBLIC SPACE (E.G. STREET, PARK, BUS SHELTER, FOREST OR ABANDONED BUILDING) l. ENCAMPMENT (E.G. GROUP OF TENTS, MAKESHIFT SHELTERS OR LONG-TERM OUTDOOR SETTLEMENT) m. VEHICLE (CAR, VAN, RV, TRUCK, BOAT) n. UNSURE: INDICATE PROBABLE LOCATION _____	**[BEGIN SURVEY]**

- You will receive a $15 gift card as a thank you for your participation.

Survey Number: _____

Location: _____ **Time: _____AM/PM**

Interviewer: _____ **Contact #: _____**

BEGIN SURVEY

1. **Did you have any family members or anyone else who stayed with you last night?** [Indicate survey number for partners. Check all that apply]

☐ NONE ☐ PARTNER - Survey #: ___ ___ ___ ___					☐ OTHER (Can include other family or friends) ☐ DECLINE TO ANSWER			
☐ CHILD(REN)/DEPENDENT(S)	1	2	3	4	5	6	7	8
[indicate gender and age for each] GENDER								
AGE								

2. **How old are you? [OR] What year were you born?** [If unsure, ask for best estimate]

○ AGE _____**OR** YEAR BORN _____	○ DON'T KNOW	○ DECLINE TO ANSWER

➔ **For this survey, "homelessness" means any time when you have been without a permanent and secure place to live, including sleeping in shelters, on the streets, or living temporarily with others without having your own permanent housing (e.g. couch surfing).**

3. **How old were you the first time you experienced homelessness?**

○ AGE_____	○ DON'T KNOW	○ DECLINE TO ANSWER

4. **In total, for *how <u>much time</u>* have you experienced homelessness over the PAST YEAR (the last 12 months)?** [Does not need to be exact. Best estimate.]

○ LENGTH _____ DAYS | WEEKS | MONTHS	○ DON'T KNOW	○ DECLINE TO ANSWER

5. **Have you stayed in a homeless shelter in the past year? For example,** (*COMMUNITY NOTE: Include examples of emergency shelters and extreme weather shelters for interviewers to provide*).

○ YES	○ NO	○ DON'T KNOW	○ DECLINE TO ANSWER

5B➔ If not, what are the main reasons? [Do not read categories; select all that apply)

☐ TURNED AWAY (SHELTERS ARE FULL) ☐ TURNED AWAY (BANNED) ☐ LACK OF TRANSPORTATION	☐ FEAR FOR SAFETY ☐ BED BUGS & OTHER PESTS ☐ CROWDED	☐ OTHER: _____ ☐ DON'T KNOW ☐ DECLINE TO ANSWER

6. Did you come to Canada as an immigrant, refugee or a refugee claimant (i.e. applied for refugee status after coming to Canada)?

○ YES, IMMIGRANT ---------->	**If YES:** **How long have you been in Canada?**
○ YES, REFUGEE---------->	○ LENGTH: _____ DAYS | WEEKS | MONTHS | YEARS
○ YES, REFUGEE CLAIMANT--------->	OR DATE: _____/_____/_____ DAY / MONTH / YEAR
○ NO	○ DON'T KNOW
○ DON'T KNOW	○ DECLINE TO ANSWER
○ DECLINE TO ANSWER	

7. How long have you been in Hamilton?

○ LENGTH _____ DAYS / WEEKS / MONTHS / YEARS	○ ALWAYS BEEN HERE ○ DON'T KNOW ○ DECLINE TO ANSWER
↳ **Where did you live before you came here?**	○ CITY: _____ | PROVINCE/TERRITORY/COUNTRY: _____ ○ DECLINE TO ANSWER

8a. Do you identify as First Nations (with or without status), Métis, or Inuit, or do you have North American Indigenous ancestry? [If yes, please specify]

○ YES, FIRST NATIONS	○ YES, MÉTIS	○ NO	○ DECLINE TO ANSWER
○ YES, INUIT	○ YES, INDIGENOUS ANCESTRY	○ DON'T KNOW	

8b. In *addition* to your response in the question above, do you identify with any of the racialized identities listed below? [Show or Read list. Select all that apply]

☐ ARAB (e.g., Syrian, Egyptian, Yemeni)	☐ BLACK-AFRO-CARIBBEAN OR AFRO-LATINX (e.g., Jamaican, Haitian, Afro-Brazilian)
☐ ASIAN-EAST (e.g., Chinese, Korean, Japanese)	☐ LATIN AMERICAN (e.g., Brazilian, Mexican, Chilean, Cuban)
☐ ASIAN- SOUTH-EAST (e.g., Filipino, Vietnamese, Cambodian, Malaysian, Laotian)	☐ WHITE (e.g. European, French, Ukrainian, Euro-Latinx)
☐ ASIAN-SOUTH OR INDO-CARIBBEAN (e.g., Indian, Pakistani, Sri Lankan, Indo-Guyanese, Indo-Trinidadian)	☐ NOT LISTED (PLEASE SPECIFY): _____
☐ ASIAN-WEST (e.g., Iranian, Afghan)	☐ IDENTIFY AS INDIGENOUS ONLY
☐ BLACK-CANADIAN/AMERICAN	☐ DON'T KNOW
☐ BLACK-AFRICAN (e.g., Ghanaian, Ethiopian, Nigerian)	☐ DECLINE TO ANSWER

9. Have you ever served in the Canadian Military or RCMP?
[Military includes Canadian Navy, Army, or Air Force]

○ YES, MILITARY	○ BOTH MILITARY AND RCMP	○ DON'T KNOW
○ YES, RCMP	○ NO	○ DECLINE TO ANSWER

10. As a child or youth, were you ever in foster care or in a youth group home (*COMMUNITY NOTE: include any other Provincial child welfare programs*)? [Note: This question applies specifically to child welfare programs.]

○ YES	○ NO	○ DON'T KNOW	○ DECLINE TO ANSWER

11. Do you identify as having any of the following health challenges at this time:

ILLNESS OR MEDICAL CONDITION [e.g. diabetes, arthritis, TB, HIV]	○ YES	○ NO	○ DON'T KNOW	○ DECLINE TO ANSWER

PHYSICAL LIMITATION [e.g. challenges with mobility, physical abilities or dexterity]	○ YES	○ NO	○ DON'T KNOW	○ DECLINE TO ANSWER
LEARNING OR COGNITIVE LIMITATIONS [e.g. dyslexia, autism spectrum disorder, or as a result of ADHD or an acquired brain injury]	○ YES	○ NO	○ DON'T KNOW	○ DECLINE TO ANSWER
MENTAL HEALTH ISSUE [diagnosed/undiagnosed] [e.g. depression, Post traumatic stress disorder (PTSD), bipolar disorder]]	○ YES	○ NO	○ DON'T KNOW	○ DECLINE TO ANSWER
SUBSTANCE USE ISSUE [e.g. tobacco, alcohol, opiates]	○ YES	○ NO	○ DON'T KNOW	○ DECLINE TO ANSWER

12. What gender do you identify with? [Show list.]

○ WOMAN	○ TRANS WOMAN	○ NOT LISTED: _____
○ MAN	○ TRANS MAN	
○ TWO-SPIRIT	○ NON-BINARY (GENDERQUEER)	○ DON'T KNOW
		○ DECLINE TO ANSWER

13. How do you describe your sexual orientation, for example straight, gay, lesbian? [Show list.]

○ GAY	○ BISEXUAL	○ ASEXUAL	○ NOT LISTED: _____
○ LESBIAN	○ TWO-SPIRIT	○ QUESTIONING	○ DON'T KNOW
○ STRAIGHT/HETEROSEXUAL	○ PANSEXUAL	○ QUEER	○ DECLINE TO ANSWER

14a. What happened that caused you to lose your housing most recently?

[Do not read the options. Check all that apply. "Housing" does not include temporary arrangements (e.g., couch surfing) or shelter stays. Follow up for the reason if the respondent says "eviction" or that they "chose to leave".]

A: HOUSING AND FINANCIAL ISSUES	B: INTERPERSONAL AND FAMILY ISSUES	C: HEALTH OR CORRECTIONS
☐ NOT ENOUGH INCOME FOR HOUSING (E.G. LOSS OF BENEFIT, INCOME, OR JOB)	☐ EXPERIENCED DISCRIMINATION	☐ PHYSICAL HEALTH ISSUE
☐ UNFIT/UNSAFE HOUSING CONDITION	☐ CONFLICT WITH: SPOUSE / PARTNER	☐ MENTAL HEALTH ISSUE
☐ BUILDING SOLD OR RENNOVATED (RENOVICTION)	☐ CONFLICT WITH: PARENT / GUARDIAN	☐ SUBSTANCE USE ISSUE
☐ OWNER MOVED IN	☐ CONFLICT WITH: OTHER (_____)	☐ HOSPITALIZATION OR TREATMENT PROGRAM
☐ LANDLORD/TENANT CONFLICT	☐ EXPERIENCED ABUSE BY: SPOUSE / PARTNER	☐ INCARCERATION (JAIL OR PRISON)
☐ COMPLAINT (E.G. PETS/NOISE/DAMAGE)	☐ EXPERIENCED ABUSE BY: PARENT / GUARDIAN	
☐ LEFT THE COMMUNITY/RELOCATED	☐ EXPERIENCED ABUSE BY: OTHER (_____)	
	☐ DEPARTURE OF FAMILY MEMBER	

☐ OTHER REASON: _____ ☐ DON'T KNOW ☐ DECLINE TO ANSWER

14b. Was your most recent housing loss related to the COVID-19 pandemic?

○ YES ○ NO ○ DON'T KNOW ○ DECLINE TO ANSWER

14c. How long ago did that happen (that you lost your housing most recently)? (Best estimate)

○ LENGTH _____ DAYS | WEEKS | MONTHS | YEARS ○ DON'T KNOW ○ DECLINE TO ANSWER

15. What are your sources of income? [Reminder that this survey is anonymous. **Read list** and check all that apply.]

☐ FULL TIME EMPLOYMENT	☐ EMPLOYMENT INSURANCE	☐ CHILD AND FAMILY TAX BENEFITS
☐ PART TIME EMPLOYMENT	☐ DISABILITY BENEFIT [Name of PROV. DISABILITY BENEFIT]	☐ GST/HST REFUND
☐ CASUAL EMPLOYMENT (E.G. CONTRACT WORK)	☐ SENIORS BENEFITS (E.G. CPP/OAS/GIS)	☐ OTHER MONEY FROM A SERVICE AGENCY
☐ INFORMAL INCOME SOURCES (E.G. BOTTLE RETURNS, PANHANDLING)	☐ WELFARE/SOCIAL ASSISTANCE [Prov. Benefit]	☐ OTHER SOURCE: _____
☐ MONEY FROM FAMILY/FRIENDS	☐ VETERAN/VAC BENEFITS	☐ NO INCOME
		☐ DON'T KNOW
		☐ DECLINE TO ANSWER

16. In the past year (12 months) have you: [Ask respondents to give their best estimate]

BEEN TO AN EMERGENCY ROOM ---------->	Y ____ N____	# _____ *Times*
BEEN HOSPITALIZED ---------->	Y ____ N____	# _____ *Times*
→DAYS YOU HAVE SPENT HOSPITALIZED		_____ *Days Total*
INTERACTED WITH POLICE (*Tickets, arrests, searches)* ---------->	Y ____ N____	# _____ *Times*
BEEN TO PRISON/JAIL ---------->	Y ____ N____	# _____ *Times*
→DAYS YOU HAVE SPENT IN PRISON/JAIL		_____ *Days Total*

17. What challenges or problems have you experienced when trying to find housing? [Select all that apply]

☐ LOW INCOME	☐ MENTAL HEALTH ISSUES	☐ DISCRIMINATION
☐ NO INCOME ASSISTANCE	☐ ADDICTION	☐ DON'T WANT HOUSING
☐ RENTS TOO HIGH	☐ FAMILY BREAKDOWN/CONFLICT	☐ OTHER: _____
☐ POOR HOUSING CONDITIONS	☐ CRIMINAL HISTORY	☐ NO BARRIERS TO HOUSING
☐ DOMESTIC VIOLENCE	☐ PETS	☐ DECLINE TO ANSWER
☐ HEALTH/DISABILITY ISSUES	☐ CHILDREN	

----------END OF SURVEY – PROVIDE GIFT CARD----------

TAB 4

2021 POINT IN TIME COUNT

(Hamilton, Ontario)

INDIGENOUS RESPONSES

Submitted: April 15th, 2022

Approved by: Indigenous Community Advisory Board - Hamilton

Submitted by: Coalition of Hamilton Indigenous Leadership
Victoria Bomberry, Indigenous Data and Policy Analyst
Cindy Sue McCormack, Executive Director

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About the Coalition of Hamilton Indigenous Leadership

Formerly known as the Hamilton Executive Directors Aboriginal Coalition, the Coalition of Hamilton Indigenous Leadership is a collaborative of Indigenous leaders representing six Indigenous agencies in Hamilton, Ontario. The Coalition of Hamilton Indigenous Leadership (CHIL) is represented by the Hamilton Regional Indian Centre, De dwa da dehs nyes Aboriginal Health Centre, Sacajawea Non-Profit Housing Inc., the Native Women's Centre, Niagara Peninsula Aboriginal Area Management Board, and Ontario Aboriginal Housing Services.

The Executive Director (or Designate) of each member agency sits on the CHIL Board of Directors and contributes to achieving CHIL's vision, mission, and values.

Our vision is a vibrant, healthy, inclusive, and culturally safe community.

Our mission is to increase equitable access to services and programs for Indigenous community members of Hamilton.

Our values are informed by the Seven Grandfather teachings as we strive to live and work with Ka'nikonhrí:yo (the Haudenosaunee concept of a "Good Mind").

Reaching Home: Canada's National Homelessness Strategy

The Coalition of Hamilton Indigenous Leadership works to address Indigenous homelessness in Hamilton and is funded by Employment and Social Development Canada through Reaching Home: Canada's National Homelessness Strategy. Through Reaching Home, CHIL acts as the Indigenous Community Entity for Hamilton and is responsible for administering and managing the Indigenous stream of Reaching Home funding in our community.

Indigenous Community Advisory Board

In working to address Indigenous experiences of homelessness in Hamilton, CHIL is supported by the Indigenous Community Advisory Board (ICAB). The ICAB is made up of Indigenous identifying community members living in the city of Hamilton who draw from their lived, personal, and professional experiences to guide a community-wide and wholistic response to Indigenous experiences of homelessness in Hamilton.

Some of the ICAB's key responsibilities include:

- Gathering relevant information related to Indigenous homelessness to identify community priorities to address Indigenous homelessness in Hamilton
- Assessing and recommending projects for funding to the Indigenous Community Entity (CHIL)
- Supporting the Indigenous Community Entity (CHIL) to plan and coordinate a community-wide effort to prevent and address Indigenous homelessness
- Developing terms of reference and other policies and procedures central to fulfilling the responsibilities of the Indigenous Community Advisory Board

2021 Point in Time Survey Key Findings (Hamilton, ON)

Indigenous Peoples continue to be overrepresented among community members experiencing homelessness in Hamilton. Among the general population, 2% of Hamilton residents identify as Indigenous or having Indigenous ancestry[1]. However, among community members experiencing homelessness in Hamilton and participating in the 2021 Point in Time Connection survey, 23% identify as Indigenous or having Indigenous ancestry.

Gender Identity

Among Indigenous respondents to Hamilton's 2021 Point in Time survey, 55% identify as women, 40% identify as men, 1% identify as Two-Spirit, and 4% identify as Non-Binary/Gender Queer.

Age Groups

The majority of Indigenous respondents to the 2021 PIT survey are middle aged. Eighty percent of Indigenous respondents indicated they were between the ages of thirty-one and sixty-four.

Shelter Use

Eighty percent of respondents reported having stayed in a homelessness shelter within the past year. When asked where they had stayed the night before completing the survey, thirty-seven percent of Indigenous respondents reported they had stayed in a homeless shelter.

Hamilton is Home

Among Indigenous respondents, 44% reported always living in Hamilton. An additional twenty-eight percent (28%) reported having lived in Hamilton for five or more years.

First Experiences of Homelessness

More than one in three Indigenous respondents to the survey indicated having first experienced homelessness on or before their 25th birthday.

Foster Care and/or Youth Group Home Experiences

Experiences of having been in foster care or a youth group home are prevalent among Indigenous respondents. Forty-two percent of Indigenous respondents reported having been in foster care or a youth group home as a child or youth.

COVID-19 and Housing Loss

Approximately one in seven Indigenous respondents related their most recent housing loss to the COVID-19 pandemic. Other common reasons identified by Indigenous respondents for their most recent housing loss included "Unfit or unsafe housing conditions", "Not enough income" and "Conflict with spouse/partner".

Income

The three most common sources of income reported by Indigenous respondents included Disability benefit (provincial), Welfare/social assistance (provincial), and Informal sources (such as bottle returns, panhandling, friends, and family).

[1] Statistics Canada. Census Profile, 2016 Census. Hamilton, Ontario, Canada.

Background

The Point in Time (PIT) survey initiative is conducted in urban communities across lands occupied by Canada. Over a pre-established period of time, homeless-serving frontline workers and/or community volunteers connect with and survey community members currently experiencing homelessness. Point in Time surveys provide as a *snapshot* of homelessness in a community, which helps to articulate each community's unique homeless priorities and context. The PIT survey initiative also provides common data points to compare experiences of homelessness across all participating communities.

The 2021 Point in Time survey in Hamilton Ontario was led by the City of Hamilton – Housing Services Division alongside community partner the Coalition of Hamilton Indigenous Leadership (CHIL). The 2021 PIT survey marked the third execution of the survey and was carried out over the week of November 15th through 19th, 2021 and conducted at various locations in Hamilton's downtown area.

Point in Time surveys are completed by community members currently experiencing homelessness. In Hamilton, a total of five hundred and forty-five surveys were completed during the 2021 Point in Time initiative. Of the five hundred and forty-five PIT surveys completed in Hamilton, one hundred and twenty-three community members completing the PIT survey identified as Indigenous or having Indigenous ancestry, representing 23% of 2021 PIT survey respondents.

Indigenous Homelessness

In attempting to understand the experiences and causes of homelessness on lands occupied by Canada, it is critically important to disentangle the homeless experiences, causes, and needs of Indigenous Peoples. The roots of Indigenous experiences of homelessness stretch back to colonization through historical and ongoing social and economic policies and practices that have sought to dispossess, disempower, and disadvantage Indigenous Peoples. As articulated by Métis scholar Jesse Thistle (2017) and now acknowledged in Reaching Home: Canada's National Homelessness Strategy, Indigenous experiences of homelessness are distinct from those of non-Indigenous Peoples and therefore, require resources, programs, and supports that recognize and respond to the unique needs of Indigenous community members.

Since 2015, local Indigenous leaders in Hamilton have successfully demonstrated the need for methodologies rooted in Indigenous Ways of Knowing to help PIT initiatives better capture Indigenous experiences of homelessness in Hamilton.

Indigenous Magnet Event Background

In 2015, the Indigenous Community Entity[2] for addressing homelessness in Hamilton developed and led "All We Need is Community" an urban Aboriginal homelessness survey to connect with Indigenous community members experiencing homelessness. Guided by the principle "For Indigenous, by Indigenous", the Indigenous Magnet event brought together Indigenous volunteers, Indigenous frontline workers, and local Indigenous leaders to provide a highly visible and culturally safe space for Indigenous community members experiencing homelessness to share their experiences of homelessness in Hamilton. The 2015 urban Aboriginal homelessness survey interviewed three hundred and sixty-two people in

[2] The Social Planning and Research Council of Hamilton acted as the Indigenous Community Entity for Hamilton's federal homelessness funding from 2004 through 2020. The Coalition of Hamilton Indigenous Leadership became the Indigenous Community Entity for Hamilton's Federal homelessness funding on April 1st, 2020.

Hamilton's downtown area, of which seventy-six community members identified as currently experiencing homelessness in Hamilton[3]. Among the seventy-six community members experiencing homelessness, thirty-six identified as Aboriginal or having Aboriginal ancestry, representing 47% of those surveyed and experiencing homelessness[3]. A 2016 mainstream initiative to enumerate homelessness in Hamilton, reported 28% of community members experiencing homelessness identified as Aboriginal or having Aboriginal ancestry[4]. The 2015 urban Aboriginal survey data demonstrated to local leaders that Indigenous experiences of homelessness were not being fully captured through mainstream data collection efforts and required Indigenous-led initiatives.

The 2021 Point in Time – Indigenous Magnet event was led by CHIL and built upon the principles and methodologies of "All We Need is Community" 2015 Urban Aboriginal homelessness survey. The 2021 Indigenous Magnet event was an outdoor gathering held at Beasley Park on November 17th, 2021, from 11:00 a.m. until 7:00 p.m. In addition to completing a survey, community members were invited to enjoy a traditional meal, participate in drumming and singing, connect with Indigenous homelessness programs and services, as well as speak with cultural advisors throughout the event. A giveaway of supplies (socks, hats, gloves, toiletries, etc.) and traditional medicines was also provided.

Of the five hundred and forty-five surveys completed during the week-long 2021 PIT initiative, fifty-eight were completed during the one-day Indigenous Magnet event.

COVID-19

In regard to the COVID-19 pandemic, the 2015 Indigenous Magnet event observed Hamilton Public Health guidelines and restrictions throughout planning and implementation. During the Indigenous Magnet event, public outdoor gatherings were permissible in Hamilton. In addition to providing various pandemic supplies (such as hand sanitizers and masks), the Indigenous Magnet event also included an on-site "GO-VAXX" bus. The GO-VAXX bus is a mobile COVID-19 vaccine clinic fully equipped and staffed to safely administer COVID-19 vaccinations. Community members participating in the Indigenous Magnet event who wished to receive a COVID-19 vaccination were able to do so throughout the event. Receiving a vaccination was optional and not in any way tied to the PIT survey or Indigenous Magnet event activities and giveaways.

Methodology and Methods

The Point in Time survey in Hamilton is part of a coordinated enumeration of homelessness across lands occupied by Canada. As a multi-community initiative, the PIT survey methodology is guided by core standards that allow for data comparisons across communities. There is also flexibility in PIT survey methodology that support local leaders in selecting survey methods that best need their community's homelessness context. Hamilton's PIT incorporates Indigenous methodologies through the co-planning of the PIT survey initiative as well as the Indigenous-led design and execution of the Indigenous Magnet

[3] Social Planning and Research Council of Hamilton. (2015). *All we need is community: Urban Aboriginal homelessness survey.* Hamilton: Social Planning and Research Council of Hamilton.

[4] City of Hamilton. (2022, April 07). *Point in Time Connection*. Retrieved from City of Hamilton: https://www.hamilton.ca/social-services/housing/point-in-time-connection

event. The Indigenous Magnet event is guided by the "For Indigenous, by Indigenous" principle, which prioritizes Indigenous methods of community engagement.

The Indigenous Magnet event engages Indigenous principles of reciprocation to provide space for Indigenous community members to feast, gather, socialize, and to complete the PIT survey. The Indigenous Magnet event in Hamilton is an extension of homelessness programs, resources, and supports for Indigenous community members, which are rooted in local Indigenous Knowledges and cultures. By having Indigenous frontline workers as well as traditional medicines, foods, and giveaways available, the Indigenous Magnet event creates a safe and welcoming environment for community members to self-identify as Indigenous without fear of judgement or discrimination.

The location of the Indigenous Magnet event is selected for high accessibility (geographic location and physical space of the gathering) to lower barriers to participation and engagement. Although the Indigenous Magnet event seeks to connect with Indigenous community members specifically, all community members experiencing homelessness are welcome to take part.

Indigenous Identity

All 2021 Point in Time Connection participants in Hamilton were asked if they identify as First Nations (with or without status), Métis, or Inuit, or having North American Indigenous ancestry. This report reflects the responses of those who self-identified "Yes" to this question.

Limitations

There are important considerations to keep in mind when examining and attempting to interpret Point in Time data. The PIT survey initiative is *not* a comprehensive survey of all community members experiencing homelessness within a community. The PIT survey provides a *snapshot* of homelessness, which provides important local data to help leaders better identify and address the unique experiences of homelessness in a community.

Survey Locations

In Hamilton, the PIT survey was conducted entirely in the downtown area. The 2021 PIT survey was not conducted in any Hamilton suburbs due to the lack of response from these areas during the 2018 PIT survey initiative.

Hamilton's 2021 PIT surveys were conducted at Emergency Shelters (including extreme weather shelters and COVID-related sites), Violence Against Women Shelters, Transitional Housing as well as other locations such as drop-in centres, encampments, and the Indigenous Magnet event.

Hidden Homelessness

Not all community members experiencing or at-risk of homelessness access the homelessness supports available in community. The experiences of people who do not access community supports are referred to as *hidden homeless*. People experiencing hidden homelessness are more likely to leverage their personal support networks (for example, staying with family and friends) instead of staying in shelter or accessing homelessness support programs. As the majority of survey sites for the 2021 Point in Time Count in Hamilton were sites of community homelessness programs and services (such as homeless shelters, drop-in centres, and encampments), the experiences of community members experiencing hidden homelessness in Hamilton may not be well captured in this dataset.

Two-Spirit and Non-Binary (Gender Queer) Participation

The homelessness experiences and needs of Indigenous community members who identify as Two-Spirit, Non-Binary or Gender Queer may not be fully represented in 2021 PIT survey data. Among the one hundred twenty-three Indigenous-identifying 2021 PIT respondents, five also identified as Two-Spirit, Non-Binary/Gender Queer.

Findings

The findings presented here represent 2021 PIT respondents who self-identified as Indigenous or having Indigenous ancestry. Indigenous identity was gathered by asking respondents if they identified as First Nations (with or without status), Métis or Inuit, or if they identified as having North American Indigenous ancestry.

A comparison of responses between Indigenous and non-Indigenous community members experiencing homelessness in Hamilton will be provided in a separate report.

The response rates among Indigeous youth[5] (n=17) as well as those identifying as Two-Spirit or Non-Binary/Gender Queer (n=5) must also considered in interpreting these findings.

Demographics

While not comprehensive of all Indigenous community members experiencing homelessness, the 2021 PIT survey data offers useful *snapshots* of Indigenous experiences of homelessness in Hamilton. The 2021 PIT data provides important context to experiences and risks of homelessness in Hamilton for community leadership and service providers.

Gender

Among Indigenous 2021 PIT respondents, sixty-nine identified their gender as women, representing 55% of Indigenous respondents. Forty-nine Indigenous respondents identified their gender as men, representing forty percent of Indigenous respondents. One Indigenous identifying 2021 PIT survey respondent also identified their gender as Two-Spirit and four Indigenous identifying respondents also identified their gender as Non-Binary/Gender Queer.

[5] For the purposes of this report, Indigenous youth are 2021 PIT respondents who self-identified as Indigenous and identified as being 30 years old or younger.

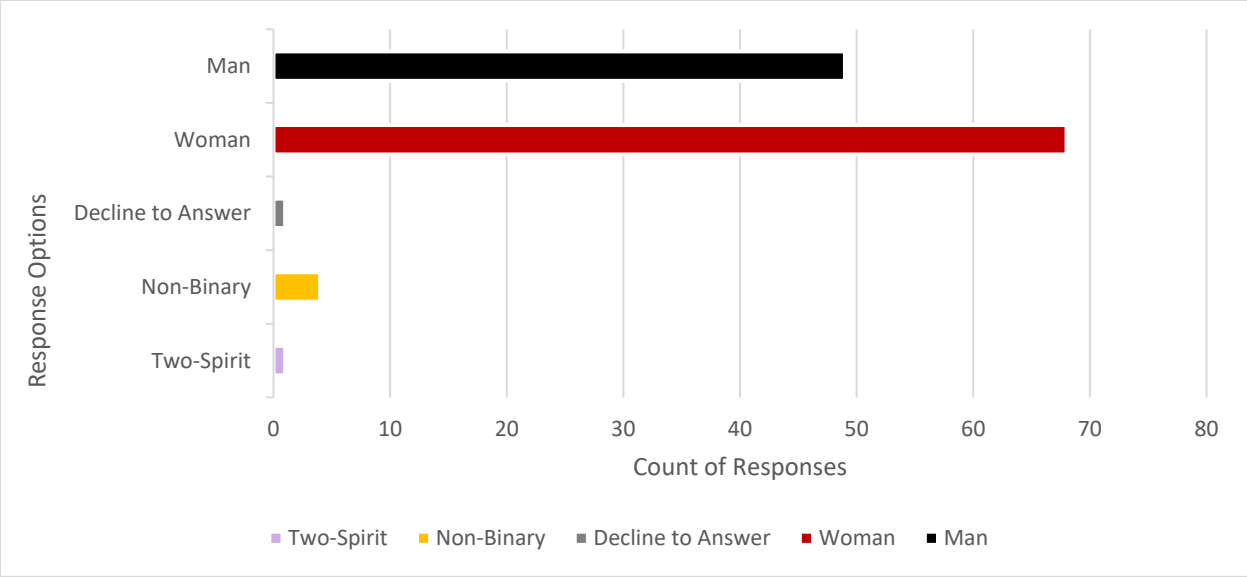


Figure 1. Gender Identity of Indigenous Respondents, 2021 Point in Time Survey (Hamilton, Ontario).

Age[6]

The majority of Indigenous respondents to Hamilton's 2021 PIT survey reported being middle-aged. Ninety-nine Indigenous survey respondents reported being between the ages of 31 years old and 64 years old, representing 80% of Indigenous respondents. Seventeen Indigenous respondents reported being under the age of 31, representing fourteen percent (14%) of Indigenous respondents. One Indigenous survey respondent reported being over the age of 65 years old.

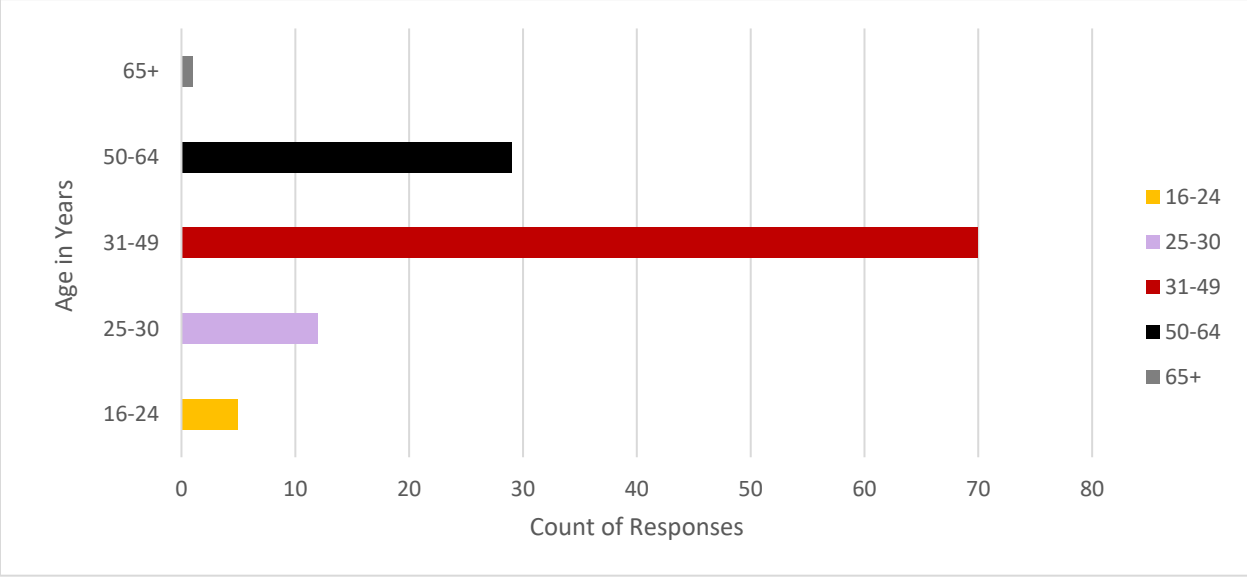


Figure 2. Age of Indigenous Respondents, 2021 Point in Time Survey (Hamilton, Ontario).

[6] *Among Indigenous respondents, there were six responses to this question that were unclear or blank and have not been included in* Figure 2. Age of Indigenous Respondents, 2021 Point in Time Survey (Hamilton, Ontario).

The pattern of age distribution among all Indigenous survey respondents is consistent across genders. Among Indigenous women who participated in Hamilton's 2021 Point in Time survey, 85% were between 31 and 64 years old. A similar proportion (80%) of Indigenous men were also between the ages of 31 and 64 years old.

Child and Youth Experiences of Homelessness

Among the one hundred and twenty-three Indigenous 2021 PIT respondents, fifty-one reported having first experienced homelessness before the age of 31 years old, representing 41% of Indigenous respondents.

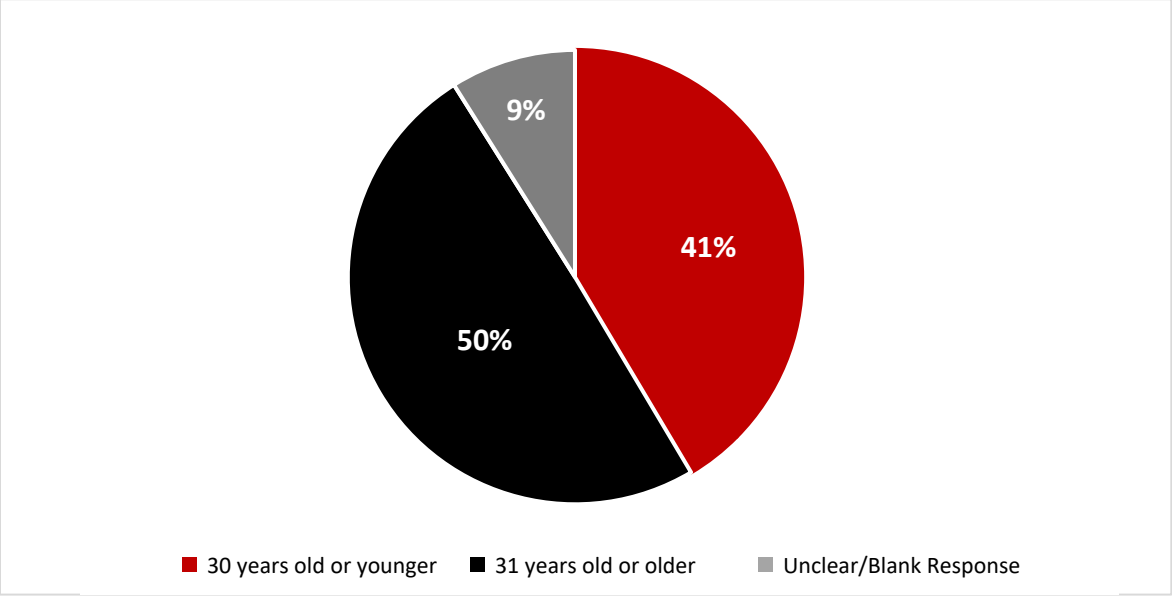


Figure 3. Age of First Experience of Homelessness - Indigenous Respondents, 2021 Point in Time Survey (Hamilton, Ontario).

Experiences of Foster Care or Youth Group Homes

Experiences with foster care or youth group home are prevalent among Indigenous community members responding to the 2021 PIT survey in Hamilton. Fifty-two Indigenous respondents reported having been in foster care or a youth group home as a child or youth, representing forty-two percent (42%) of Indigenous respondents.

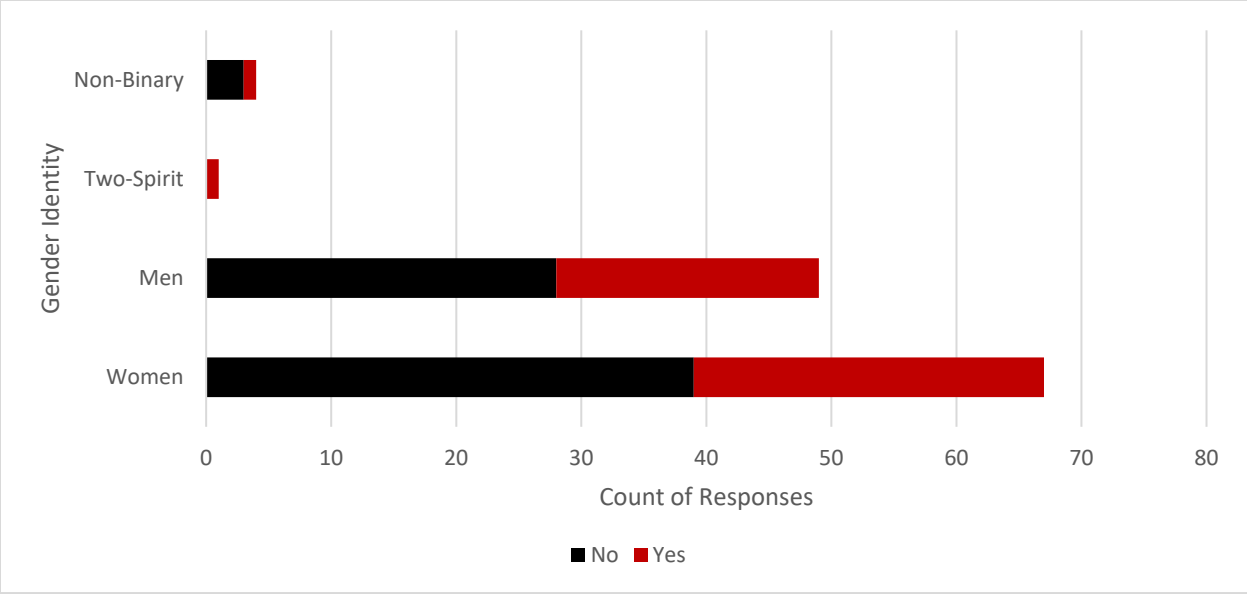


Figure 4. Experiences of Foster Care or Youth Group Home by Gender - Indigenous Respondents, 2021 Point in Time Survey (Hamilton, Ontario).

Among Indigenous women experiencing homelessness in Hamilton (n=68), twenty-eight reported having stayed in foster care or a youth group home. Among Indigenous men experiencing homelessness in Hamilton (n=49), 21 reported having lived in foster care or a youth group home.

Length of Homelessness

The 2021 Point in Time survey also asked respondents the total length of time they had been homeless over the past year. This does not necessarily mean community members experienced homelessness uninterrupted. Rather, responses indicate how much total time over the course of the past year they experienced homelessness. For example, a respondent may have experienced homelessness for three weeks, found housing for a few months but returned to homelessness.

Among all Indigenous respondents, ninety indicated they had experienced homelessness for more than six months of the past year, representing seventy-three percent (73%) of Indigenous respondents. The proportion of Indigenous participants experiencing homelessness for more than half of the past year is consistent across genders. Among Indigenous women responding to the 2021 Point in Time survey, seventy-eight percent (78%) reported having experienced homelessness for more than 6 months within the past year. Similarly, sixty-nine percent (69%) of Indigenous men respondents to the survey reported experiencing homelessness for more than half of the past year.

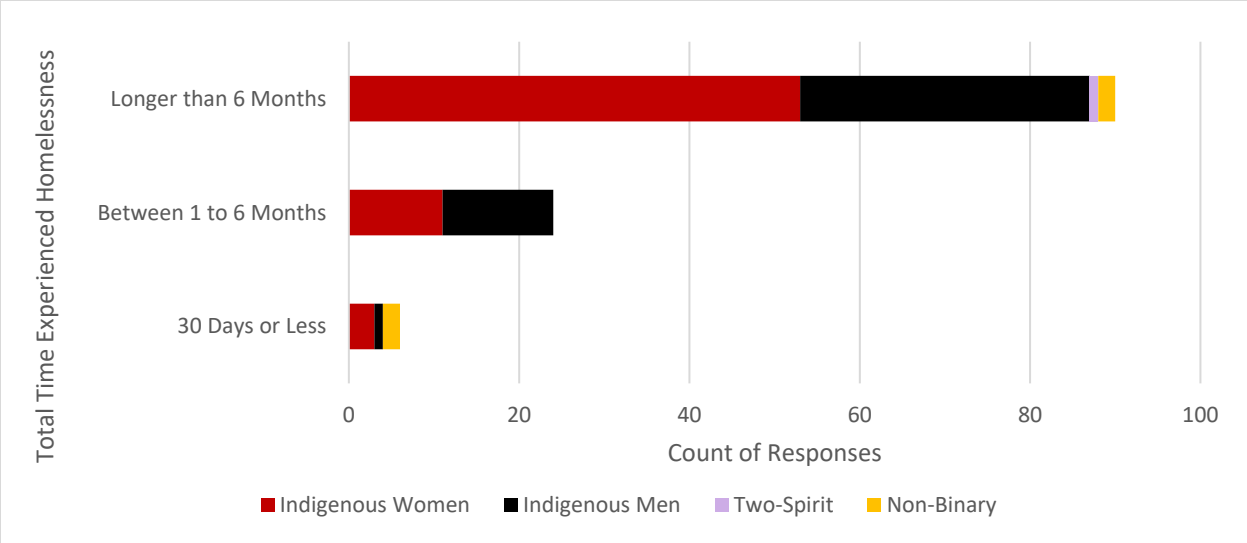


Figure 5. Total Time Experienced Homelessness Within Past Year - Indigenous Respondents, 2021 Point in Time Survey (Hamilton, Ontario).

This pattern of experiencing homelessness in Hamilton for the majority of the past year repeats across all age groups of Indigenous respondents. Among Indigenous youth[7] PIT survey responses (n=17), eighty-two percent (82%) reported having experienced a total of six or more months of the past year homeless. Among Indigenous adult survey respondents (n=99), eighty-one percent (81%) had experienced homelessness for a total of six (6) months or longer within the past year.

Length of Time in Hamilton[8]

Of Indigenous respondents, 54 reported having always lived in Hamilton, representing forty-four percent (44%) of Indigenous respondents. Seventeen Indigenous-identifying respondents reported they have lived in Hamilton for less than a year, representing fourteen percent (14%) of Indigenous survey respondents. Eleven Indigenous respondents reported living in Hamilton for more than one year but less than 5 years, representing nine percent (9%) of Indigenous-identifying respondents. Thirty-four Indigenous respondents reported having lived in Hamilton for five or more years, representing twenty-eight percent (28%) of Indigenous respondents.

[7] This report utilizes the Indigenous youth age range observed by the federal government, which identifies Indigenous youth as being between the ages of 15 and 30 years of age

[8] Among Indigenous respondents, seven responses to this question were unclear or blank and have not been included in Figure 6. Length of Time in Hamilton - Indigenous Respondents, 2021 Point in Time Survey (Hamilton, Ontario)

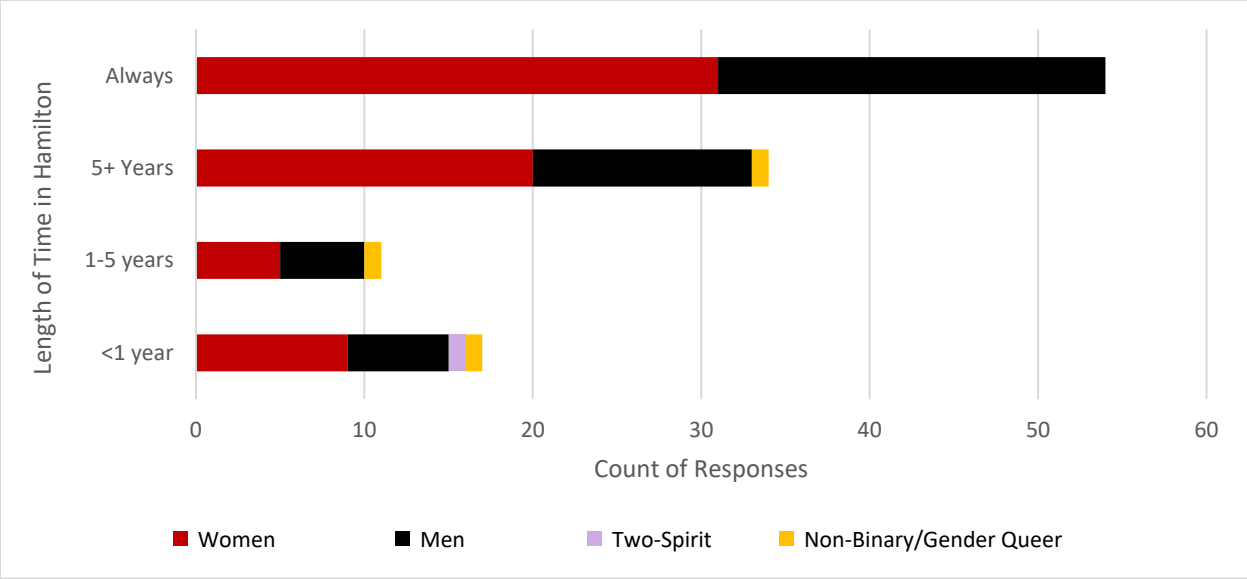


Figure 6. Length of Time in Hamilton - Indigenous Respondents, 2021 Point in Time Survey (Hamilton, Ontario).

Indigenous Youth Experiencing Homelessness in Hamilton

In total, 17 Indigenous youth participated in the 2021 Point in Time survey in Hamilton. The gender breakdown of Indigenous youth participating in the 2021 PIT survey included 18% of Indigenous youth identifying as Non-Binary/Gender Queer, with an equal proportion (41%) of Indigenous youth experiencing homelessness who identify as women and men.

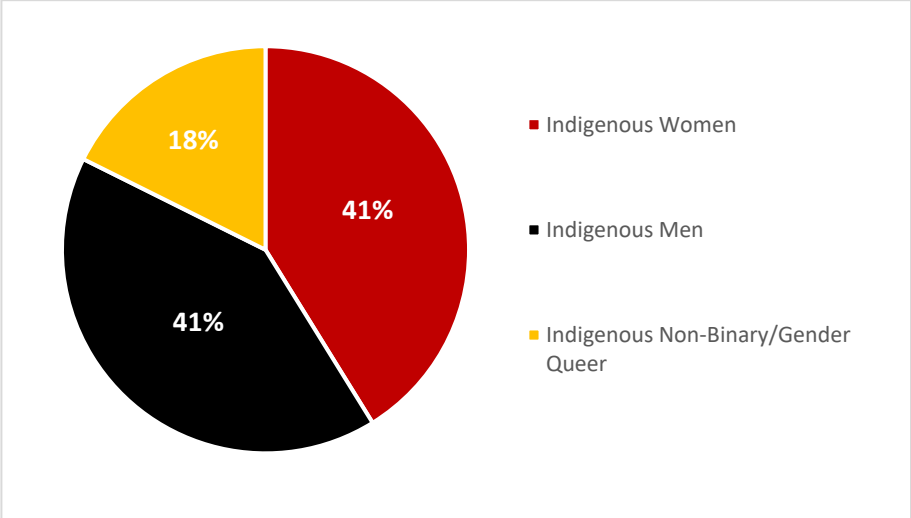


Figure 7. Gender Identity of Indigenous Youth Respondents, 2021 Point in Time Survey (Hamilton, Ontario).

Shelter System Use

The majority of Indigenous respondents have stayed in a homelessness shelter (emergency, family, or domestic violence shelter) in the past year. Of Indigenous respondents, one hundred and one reported having stayed in a homeless shelter within the past year, representing eighty-two percent (82%) of Indigenous respondents.

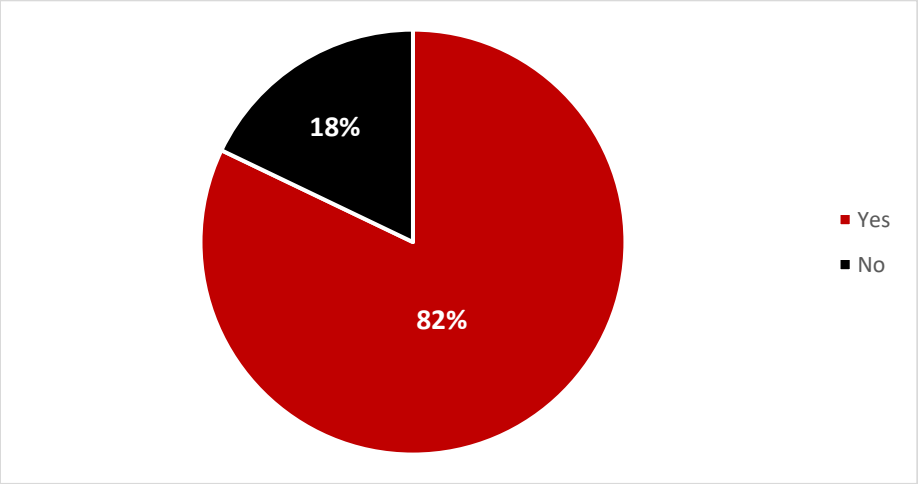


Figure 8. Shelter System Usage - Indigenous Respondents, 2021 Point in Time Survey (Hamilton, Ontario).

When asked where they had stayed the night before participating in Hamilton's 2021 PIT survey, Indigenous responses included Unsheltered Public Spaces (street, park, bus shelter, etc.), Transitional Housing, a city-funded hotel or motel, an encampment site, or someone else's place. One respondent identified sleeping in their vehicle the night before participating in the survey. No respondent (Indigenous or non-Indigenous) identified having stayed in a hospital, treatment centre, or jail/prison the previous night.

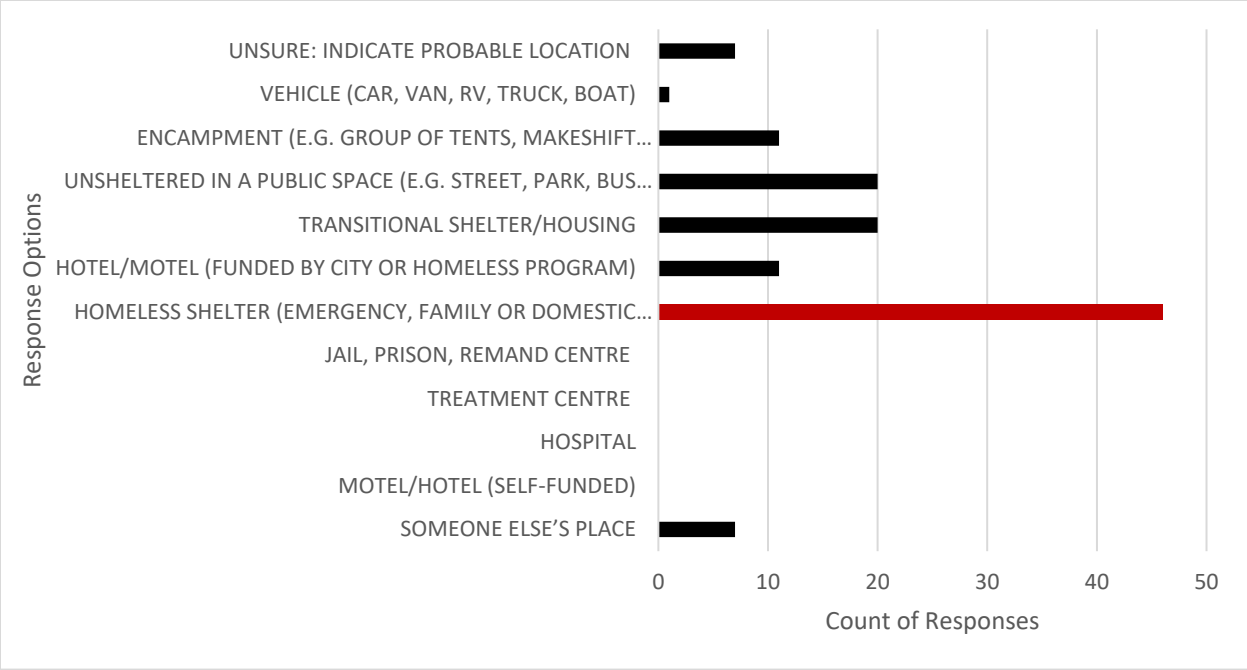


Figure 9. "Where did you stay last night?" - Indigenous Respondents, 2021 Point in Time Survey (Hamilton, Ontario). The most common response is highlighted in red.

Of Indigenous community members who are experiencing homelessness but chose not to stay in a homeless shelter last year (n=22), twenty-one provided one or more reasons why they chose not to stay in shelter. The most common reason Indigenous community members experiencing homelessness chose not to stay in a homeless shelter was due to safety concerns. Other reasons Indigenous community members experiencing homelessness chose not to stay in shelter included being turned away from the shelter due to lack of available beds, having lack of transportation to reach a shelter, concerns over pests, and feeling "crowded" in homeless shelters.

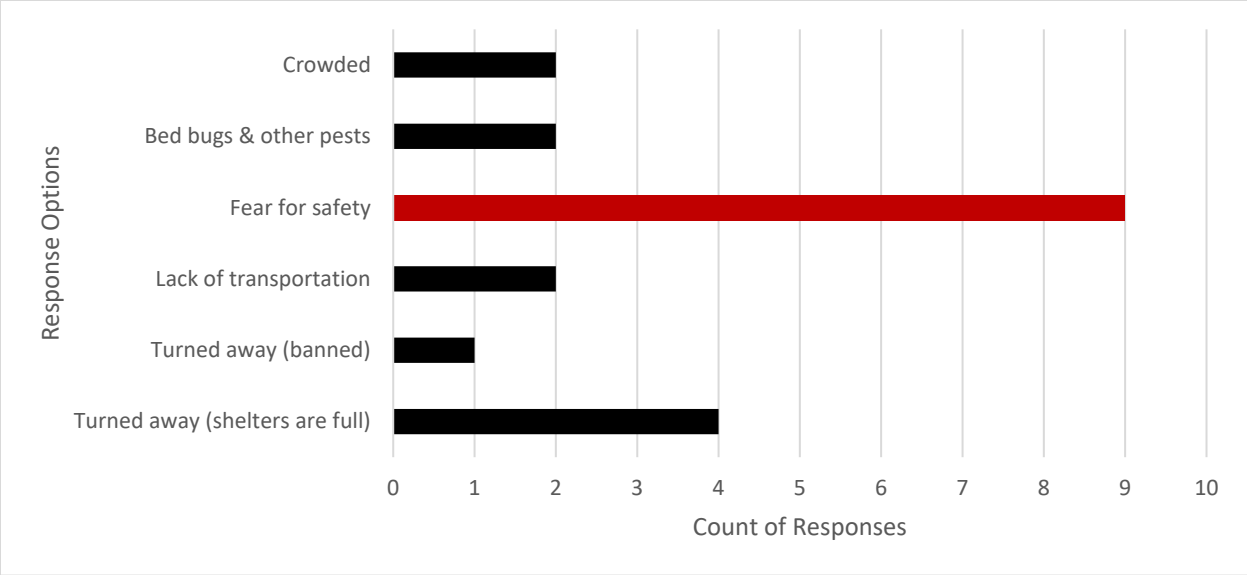


Figure 10. Reasons for Not Staying in Shelter - Indigenous Respondents, 2021 Point in Time Survey (Hamilton, Ontario). The most common response is highlighted in red.

Health Challenges

Response options to health challenges faced were multiple choice, allowing respondents to indicate the total health issues or challenges experienced. The most prominent health challenge reported by Indigenous 2021 PIT respondents is substance abuse (including tobacco, alcohol, or opiates).

Among Indigenous respondents, ninety-two reported experiencing substance use issues, representing seventy-five percent (75%) of Indigenous survey respondents. Hamilton's 2021 PIT survey data also indicates a high proportion of Indigenous respondents are experiencing mental health issues (including depression, post traumatic stress disorder and bipolar disorder. Eighty-three Indigenous respondents reported managing a diagnosed or undiagnosed mental health issue, representing sixty-seven percent (67%) of Indigenous respondents. Fifty-seven Indigenous respondents indicated managing an illness or medical condition, such as diabetes, arthritis, tuberculosis, or HIV, representing forty-six percent (46%) of Indigenous respondents. An equal proportion (46%) of Indigenous respondents reported having learning or cognitive limitations, such as dyslexia, autism spectrum disorder, or as a result of ADHD or an acquired brain injury. Forty-two Indigenous respondents reported experiencing a physical limitation (such as challenges with mobility, physical abilities and/or dexterity), representing thirty-four percent (34%) of Indigenous survey respondents.

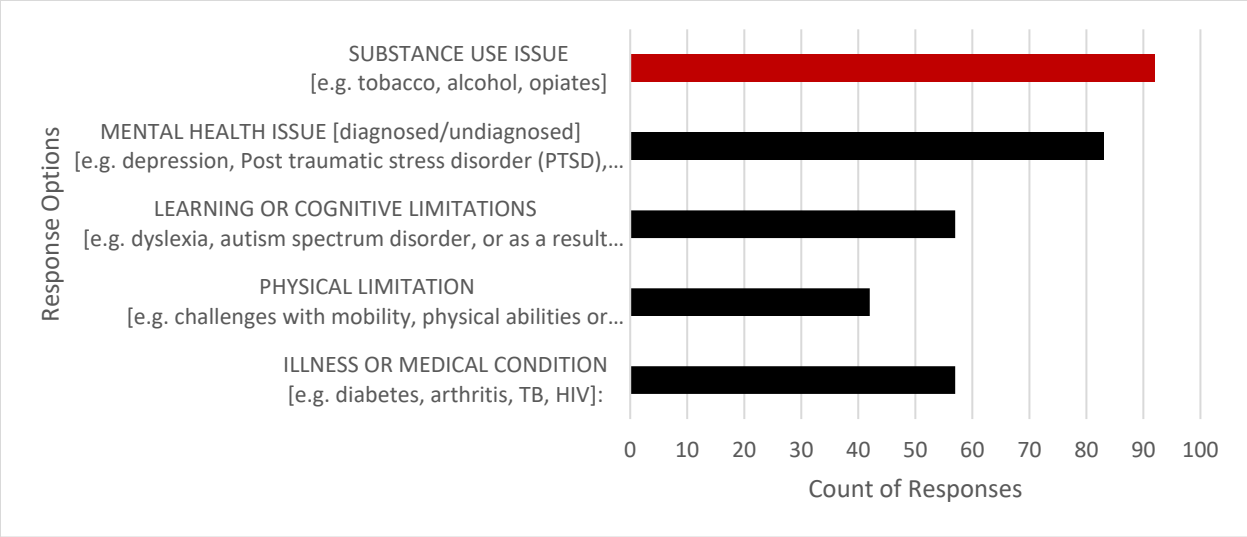


Figure 11. Health Challenges - Indigenous Respondents, 2021 Point in Time Survey (Hamilton, Ontario). The most common response is highlighted in red.

Causes of Most Recent Housing Loss

Of Indigenous-identifying respondents to the 2021 Point in Time survey (n=123), one hundred and twenty (120) provided one or more reasons for their most recent loss of housing. Respondents were able to provide multiple reasons for their most recent loss of housing. The most common reasons given by Indigenous community members experiencing homelessness in Hamilton for their most recent loss of housing included: “Not having enough income for housing”, “Unfit or unsafe housing conditions”, “Landlord/tenant conflict”, “Conflict with spouse”, “Conflict with: Other” (someone other than a parent, partner/spouse, or guardian).

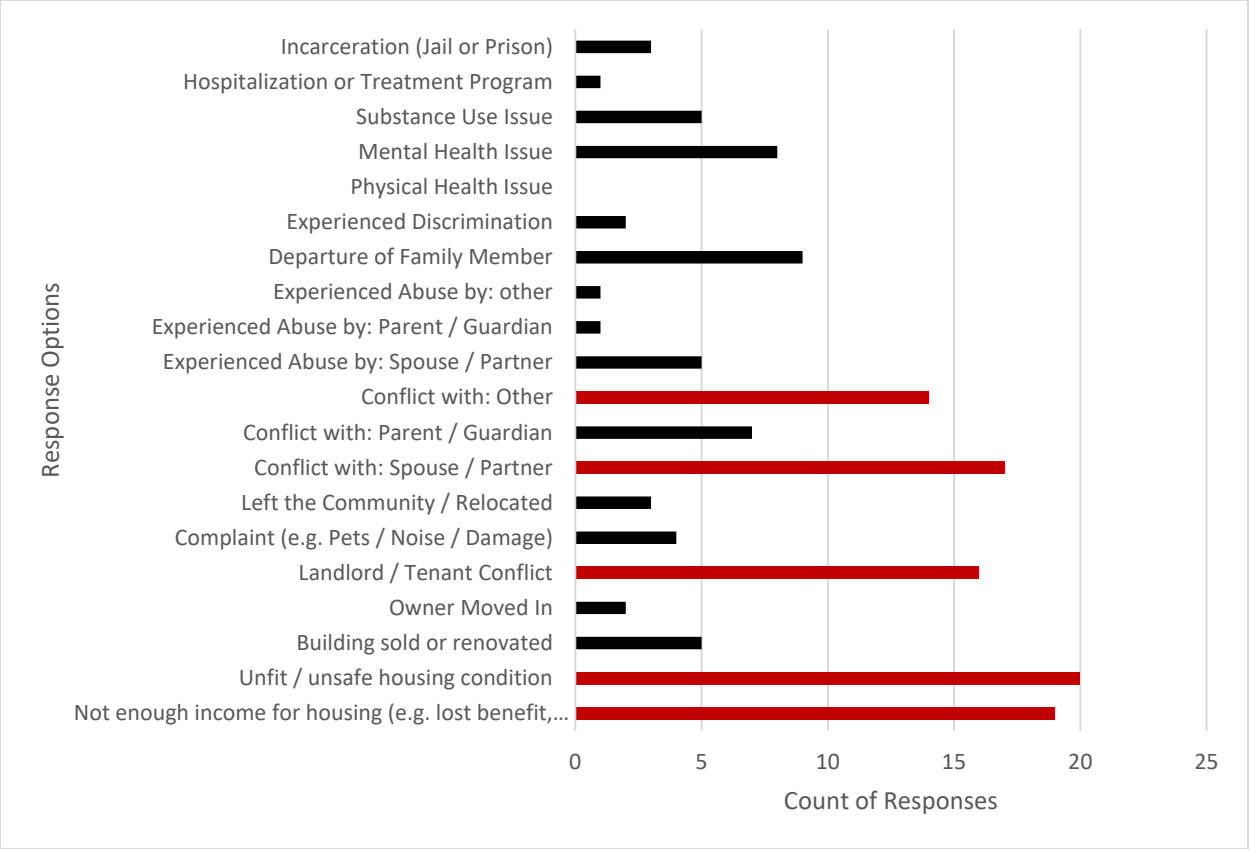


Figure 12. Causes of Most Recent Housing Loss - Indigenous Respondents, 2021 Point in Time Survey (Hamilton, Ontario). The five most common responses are highlighted in red.

Challenges Experienced in Finding Housing

Indigenous respondents to the 2021 PIT survey indicated the cost of housing in Hamilton posed the most common barrier to exiting homelessness. Among Indigenous survey respondents (n=123), one hundred and fifteen Indigenous community members identified one or more challenges or problems encountered in trying to find housing. The fives most commonly reported challenges to finding housing identified by Indigenous community members are “Rent being too high”, “Having low income”, “Poor housing conditions”, “Discrimination”, and “Addiction”.

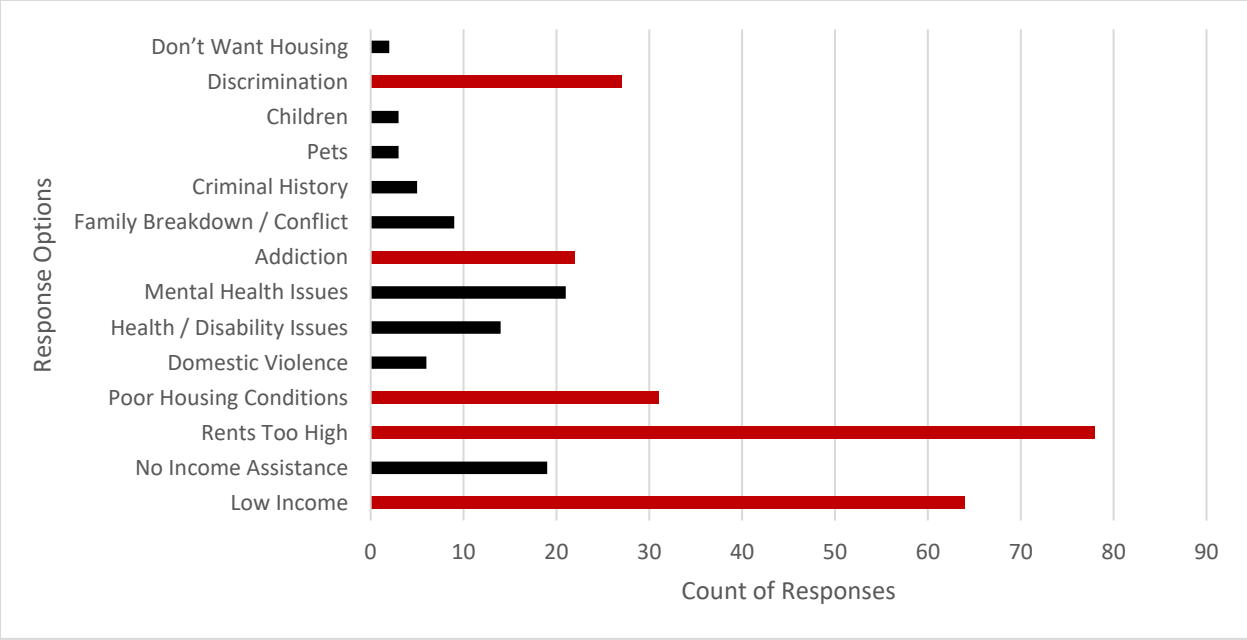


Figure 13. Challenges Experienced in Trying to Find Housing - Indigenous Respondents, 2021 Point in Time Survey (Hamilton, Ontario). The five most common responses are highlighted in red.

COVID-19

Seventeen Indigenous PIT respondents related their most recent housing loss to the COVID-19 pandemic, representing fourteen percent (14%) of Indigenous survey respondents. Of Indigenous community respondents who related their most recent housing to the pandemic (n=17), 82% were between the ages of 31 and 64 years old.

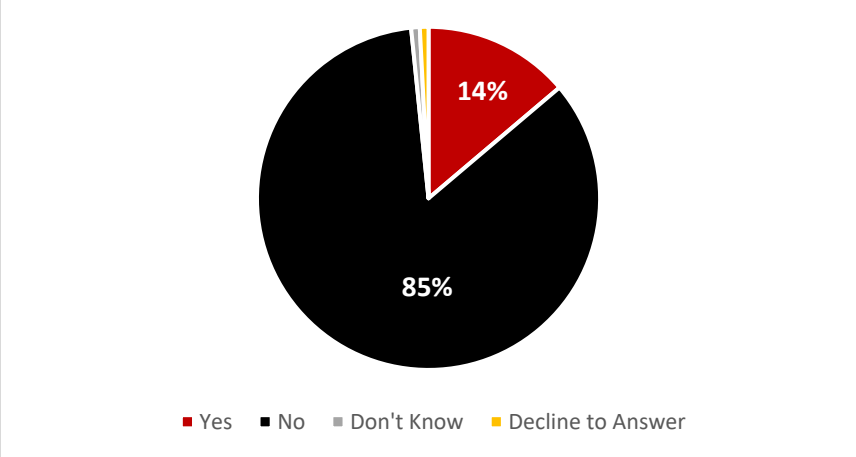


Figure 14. "Was your most recent housing loss related to the COVID-19 pandemic?" - Indigenous Respondents, 2021 Point in Time Count (Hamilton, Ontario).

Income Sources

Sixty-nine Indigenous PIT respondents reported receiving Disability Benefits (provincial) as a source of income, representing fifty-six percent (56%) of Indigenous respondents. Thirty-six Indigenous respondents reported receiving Welfare/social assistance (provincial) as a source of income, representing twenty-nine percent (29%) of Indigenous respondents of Indigenous respondents.

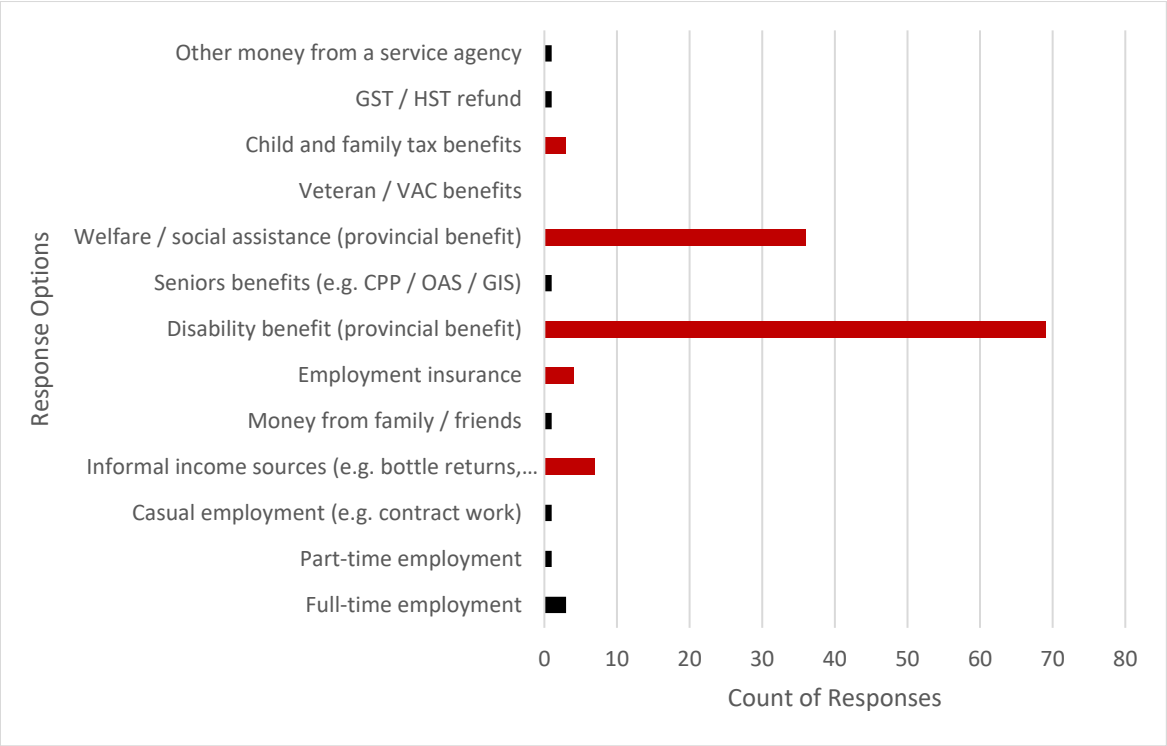


Figure 15. Sources of Income - Indigenous Respondents, 2021 Point in Time Survey (Hamilton, Ontario). The five most common responses are highlighted in red.

Appendices

Appendix A – Indigenous Magnet Event Promo Card



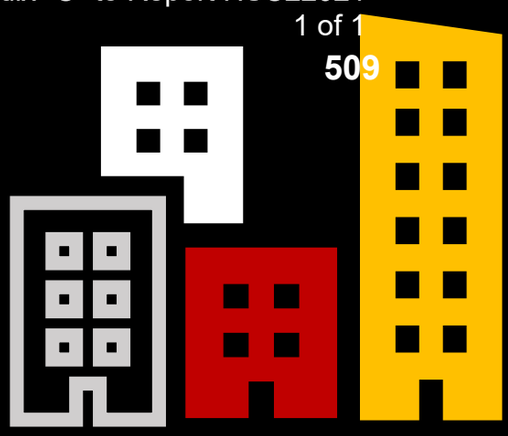


Appendix B – 2021 Point in Time Survey (Hamilton, Ontario)

TAB 5

2021 POINT IN TIME SURVEY (Hamilton, Ontario)

The 2021 Point in Time (PIT) survey for Hamilton was led by the City of Hamilton – Housing Services Division and the Coalition of Hamilton Indigenous Leadership. Each PIT survey was completed by a community member currently experiencing homelessness in Hamilton.



INDIGENOUS RESPONDENTS

*The responses shared in this infographic represent 2021 PIT respondents who self-identified as Indigenous or having Indigenous ancestry.**

Indigenous Peoples continue to be overrepresented among community members experiencing homelessness in Hamilton. Of Hamilton's general population, 2% of residents identify as Indigenous or having Indigenous ancestry. Among community members responding to Hamilton's 2021 PIT survey, 23% self-identified as Indigenous or having Indigenous ancestry.

545

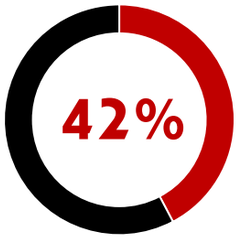
SURVEYS WERE COMPLETED DURING HAMILTON'S 2021 POINT IN TIME CONNECTION SURVEY INITIATIVE.

123 **OF 2021 PIT SURVEY RESPONDENTS IDENTIFIED AS INDIGENOUS OR HAVING INDIGENOUS ANCESTRY.**

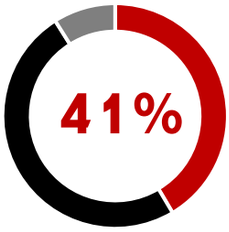
OF THE 123 INDIGENOUS IDENTIFIED RESPONDENTS:

- **68** Identified as **WOMEN**
- **49** Identified as **MEN**
- **5** Identified as **TWO-SPIRIT or NON-BINARY**

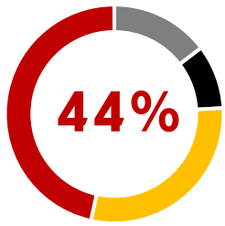
As a child or youth, were you ever in foster care or in a youth group home?



How old were you the first time you experienced homelessness?



How long have you been in Hamilton?



Top 5 reported sources of income:

1. Disability benefit
2. Welfare/social assistance
3. Informal income (e.g., bottle returns, panhandling, family)
4. Employment (full or part-time)
5. Employment insurance

Top 5 reported causes for most recent loss of housing:

1. Unfit/unsafe housing condition
2. Not enough income for housing
3. Conflict with Spouse/Partner
4. Landlord/tenant conflict
5. Conflict with other

Top 5 challenges or experienced when trying to find housing:

1. Rent too high
2. Low Income
3. Poor Housing Conditions
4. Discrimination
5. Addiction

Coalition of Hamilton Indigenous Leadership

Hamilton

The 2021 Point in Time survey for Hamilton, Ontario was conducted during the week of November 15th through 19th. All 2021 PIT survey respondents in Hamilton were asked if they self-identified as First Nations (with or without status), Métis or Inuit or if they identified as having North American Indigenous ancestry.

For comments and questions about this infographic, please contact the Coalition of Hamilton Indigenous Leadership at communications@chileadership.com

TAB 147

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

APPLICATION UNDER RULE 14.05 OF THE *RULES OF CIVIL PROCEDURE*

RESPONSE TO REQUEST TO ADMIT

In response to the Applicants' Request to Admit dated August 1, 2023 (received August 3, 2023), the Respondent:

1. Admits the truth of facts numbers:

   (a) Under the Heading "Point In Time Connection Survey Data," the Respondent admits facts number 1, 2, 3, 4, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46.

2. Admits the authenticity of the following documents: N/A – none requested.

3. Denies the truth of facts numbers: None. See paragraphs 1 above and 5 below.

4. Denies the authenticity of documents numbers: N/A – none requested.

5. Refuses to admit the truth of facts numbers:

(a) Under the heading “Homelessness Dashboard: Data on Homeless Population, Including Shelter Use, Availability and Capacity (Tabs 1a and b)”: The Respondent refuses to admit facts numbers 1 through 42 for the following reasons:

(i) The Homelessness Dashboard data regarding “Scale of Homelessness” (erroneously referred to as “Data on Homeless Population” in the Request to Admit) does not quantify and does not purport to quantify the “homeless population” in the City of Hamilton. The data in the “TOTAL_HOMELESS” column of the “Scale of Homelessness” table correlates to the number of “Current Individuals Actively Homeless” displayed on the Homelessness Dashboard for that month. The term “Actively Homeless” refers to individuals who were experiencing homelessness at the end of the month, and includes individuals who have accessed the homeless-serving system at least one time in the past three months. This is expressly stated within the “Data Notes” that accompany the Homelessness Dashboard (see, e.g., Tab 1 of the Respondent’s Response to Request to Admit dated May 25, 2023). The homeless-serving system includes shelters, drop-ins, street outreach, transitional housing, and case management programs. One person who may

have accessed any or all of these supports in the past three months will be counted as one individual who is “Actively Homeless” during the applicable reporting period. The number of “Current Individuals Actively Homeless” does not indicate the number of people seeking shelter. As well, the number of “Current Individuals Actively Homeless” does not indicate that those “actively homeless” people are all experiencing homelessness at the same time. Further, the information from which the “TOTAL_HOMELESS” data is drawn is based on the self-report of people who access the homeless-serving system, as recorded in the City’s Homeless Individuals and Families Information System (“HIFIS”). People who access the homeless-serving system may provide inconsistent information, or may decline to provide their information, and may therefore be counted more than once. The foregoing is provided for explanation purposes, and should not be taken as exhaustive of or in any way limiting the City’s evidence on this topic.

(ii) The Homelessness Dashboard data regarding “Shelter Beds Available” quantifies the total number of shelter beds *or rooms* available at the last day of the applicable month. Some rooms contain more than one bed. The number of rooms available are in addition to the number of beds available. Therefore, the figures in the “TOTAL_BEDS” column of the “Shelter Beds Available” table do not reflect the total number of beds available in the City-funded shelter

system. The number of shelter beds available in the City-funded shelter system at the end of a given month would be the total number of beds in the "TOTAL_BEDS" column *plus* the total number of beds available within the rooms in the "TOTAL_ROOMS" column. The Respondent will provide separately the number of beds available within the rooms in the "TOTAL_ROOMS" column on the "Shelter Beds Available" table.

(1) It should also be noted that the "Shelter Beds Available" data does not exhaustively record the number of shelter beds available within the City of Hamilton. The "Shelter Beds Available" data tracks shelter beds and rooms available in the City-funded emergency shelter system. For example, the City provides partial funding for Violence Against Women's (VAW) shelters for women escaping violence, which are managed through the Ministry of Children's and Community Social Services (MCCSS); however the beds available through those shelters are not included in the number of beds in the emergency women's sector. As well, any shelter beds available through charities or non-City funded sources are not counted in the "Shelter Beds Available" data.

(b) Under the heading "Point In Time Connection Survey Data," the Respondent refuses to admit:

(i) fact number 5 (under the subheading “City of Hamilton, 2022 Homelessness Point in Time Count (Tab 2)”), for the reason that survey participants identified their gender identity as “>1%” as trans or Two-Spirit, not “1%” as stated in the Request to Admit. The Respondent admits that survey participants identified their gender identity as follows: 53% identified as women, 45% as men, 2% as non-binary, and >1% as trans or Two-Spirit.

(ii) Fact number 33 (under the subheading “City of Hamilton, 2021 Point in Time Count Indigenous Responses (Tab 4)”), for the reason that of the 123 Indigenous survey respondents, 68 identified as women; not 69. The Respondent acknowledges that the 2021 Point in Time Count Indigenous Responses report states that “69” respondents identified as women, however that is an inadvertent error. The City admits that of the 123 Indigenous survey respondents, 68 identified as women, 49 identified as men, and 5 identified as two spirit or non-binary. One person declined to answer.

6. Refuses to admit the authenticity of documents numbers: N/A – none requested.

August 23, 2023

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Court File No. CV-21-00077187-0000

KRISTEN HEEGSMA et al. - and - CITY OF HAMILTON

Applicants Respondent

ONTARIO
SUPERIOR COURT OF JUSTICE

PROCEEDING COMMENCED AT HAMILTON

RESPONSE TO REQUEST TO ADMIT

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TAB 148

Court File No. CV-21-00077187-0000

Form 51A
Courts of Justice Act

REQUEST TO ADMIT

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, GLENN 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

YOU ARE REQUESTED TO ADMIT, for the purposes of this proceeding only, the authenticity (see rule 51.01 of the *Rules of Civil Procedure*) of the following facts:

1. **City of Hamilton, Information Report: Encampment Response Update (PED21188/HSC20038(c)) (City Wide), September 9, 2021 Tab 1** (filestream.ashx (escribemeetings.com)

YOU ARE REQUESTED TO ADMIT, for the purposes of this proceeding only, the truth and authenticity (see rule 51.01 of the *Rules of Civil Procedure*) of the following facts:

2. **City of Hamilton, Healthy and Safe Communities Department (Housing Services Division), Planning and Economic Development Department (Licensing and By-Law Services Division), and Public Works Department (Environmental Services Division): May 15, 2024 Encampment Observation**

Report (HSC24020/PED24080/ PW24030) (City Wide), Tab 2 (Report HSC24020/PED24080 (escribemeetings.com):

The following statement, at page 9, paragraph 5:

"With less required movement of people living unsheltered throughout the city as a result of compliant spaces being available, there are several compliant sites that have had a stable group of individuals living there. This has allowed Housing Focused Street Outreach and other frontline providers to build effective rapport with the same individuals over a longer period of time, leading to more successful outcomes. Both Outreach staff and individuals living unsheltered noted that having a place to stay for longer periods of time was very beneficial, especially when compared to approaches used in the past that required ongoing movement to new areas."

The following statement, at pages 14-15, paragraph 5:

"The issue of homelessness and related issues of addiction and mental health continue to cause pressures across the housing and homelessness system and beyond. These are multi-faceted complex issues, and the continuously growing needs are pressuring the capacity of the existing systems. In addition, the issues are challenging and cross- departmental in nature, often extending beyond city departments. This is demanding work and has an impact on the City staff working on these issues. Despite the challenges there are opportunities for us, as a City, to have a positive impact with time. The encampment protocol is not a solution to homelessness, it continues to be a means to manage the crisis within our City providing some stability and options for people experiencing homelessness, however, continued commitment to more solution focused measures is needed in accompaniment with the protocol."

Attached to this request is a copy of each of the documents referred to above.

YOU MUST RESPOND TO THIS REQUEST by serving a response to request to admit in Form 51B prescribed by the Rules of Civil Procedure WITHIN TWENTY DAYS after this request is served on you. If you fail to do so, you will be deemed to admit, for the purposes of this proceeding only, the truth of the facts and the authenticity of the documents set out above.

June 7, 2024

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TAB DESCRIPTION

1 **City of Hamilton, Information Report: Encampment Response Update (PED21188/HSC20038(c)) (City Wide), September 9, 2021** (filestream.ashx (escribemeetings.com)

2 **City of Hamilton, Healthy and Safe Communities Department (Housing Services Division), Planning and Economic Development Department (Licensing and By-Law Services Division), and Public Works Department (Environmental Services Division): May 15, 2024 Encampment Observation Report (HSC24020/PED24080/ PW24030) (City Wide),** Report HSC24020/PED24080 (escribemeetings.com)

TAB 1

INFORMATION REPORT

TO:	Chair and Members Emergency and Community Services Committee
COMMITTEE DATE:	September 9, 2021
SUBJECT/REPORT NO:	Encampment Response Update (PED21188/HSC20038(c)) (City Wide)
WARD(S) AFFECTED:	City Wide
PREPARED BY:	Monica Ciriello (905) 546-2424 Ext. 5809 Edward John (905) 546-2424 Ext. 4860
SUBMITTED BY: **SIGNATURE:**	Jason Thorne General Manager Planning and Economic Development Department
SUBMITTED BY: **SIGNATURE:**	Grace Mater General Manger Healthy and Safe Communities Department

COUNCIL DIRECTION

At its August 9, 2021 meeting, Council approved the repealing of the By-law Enforcement Protocol that permitted some individuals to camp in public spaces for up to 14 days. Further to that decision and the three-week winddown associated with it, as of August 30, 2021, the City returned to pre-protocol enforcement of City by-laws that prohibit camping on City property, including park areas.

INFORMATION

The COVID-19 pandemic highlighted and exacerbated ongoing systemic challenges and inequities across Canada as it relates to housing and homelessness. This has been demonstrated by the rise in, and visibility of, unsheltered homelessness and encampments throughout many Canadian cities. Person-centred strategies and approaches are required to address urgent issues associated with supporting residents

experiencing homelessness and living in encampments, while supporting long-term adequate housing solutions and broader community needs.

Encampment Process

With the repealing of the By-law Enforcement Protocol, staff will proceed with the following Encampment Process:

Step one
Complaints are received by Municipal Law Enforcement (MLE) regarding structures/tents in parks, road allowance and private property.

Step two
MLE attends, determines if there is a violation of a City By-law including the Parks Bylaw, seeks voluntary compliance and notifies Housing Outreach.

Step three
Housing Focused Street Outreach attends site and carries out the following:

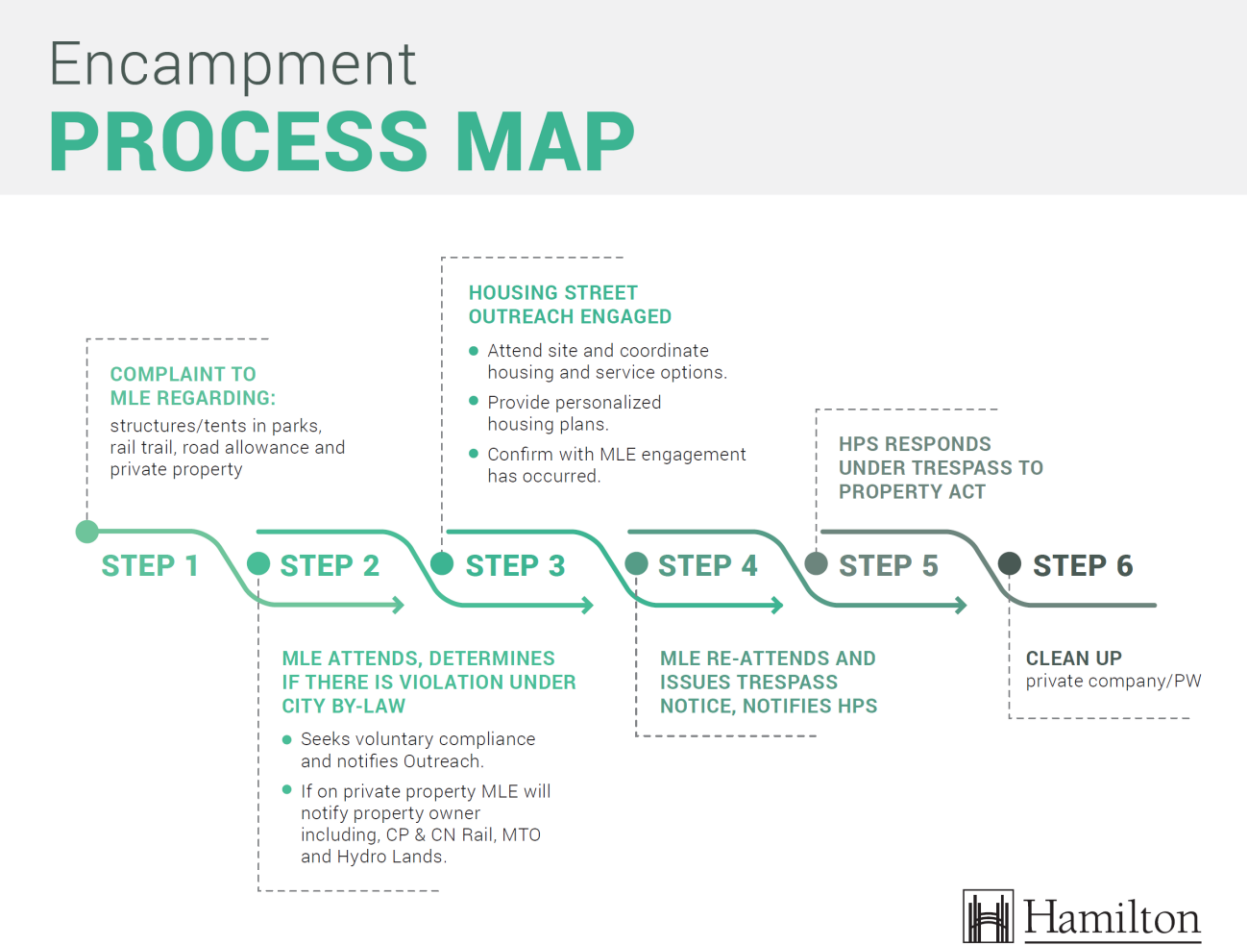
- Work from Housing Focused Street Outreach framework and within the context of Hamilton's Homeless Coordinated Access System
- Support individuals, families and groups, in order to promote connection to shelter, housing and the achievement of their optimal health and well-being
- Collaborative development of housing and service plans
- Assist individuals with obtaining necessary documents needed to obtain housing, including the completion of supportive and subsidized housing applications
- Collaborate and co-ordinate services with appropriate community and health agencies
- Crisis intervention
- Provide a summary of these actions (omitting any privileged and confidential information) in the form of an encampment assessment checklist to MLE pursuant to their request

Step four
MLE re-attends and issues a verbal trespass notice and notifies Hamilton Police Service (HPS).

Step five
Hamilton Police Service responds under the *Trespass to Property Act*, R.S.O. 1990, c. T.21

Step six
Park and Waste Divisions are contacted to coordinate a clean up.

Table 1



Encampment Response

The City of Hamilton's Licensing and Bylaw Services Division will be the first point of contact for complaints regarding structures and tents in parks, road allowances and private property. MLE Officers will attend to determine if there is a City Bylaw, including the Parks By-law 01-291 violation, which prohibits camping on City property, including park areas. MLE Officers will be responding to complaints proactively Monday to Friday and reactively on weekends along with other COVID-19 By-law and Provincial Regulation priorities. MLE Officers will attend, provide education and seek voluntary compliance under the City Bylaw, ticketing those who are unsheltered will not be a course of action. If determined to be private property, MLE Officers will notify the property owner, including CP & CN Rail and MTO. If voluntary compliance is not achieved, MLE Officers will reach out to the Street Outreach team within the Housing Services Division and the Social Navigator Program.

The Housing Focused Street Outreach team will, if not already, attend the site and engage with those individuals currently unsheltered. Outreach will endeavor to provide an update summary of the site including identifying potential opportunities for connection to services and housing for those individuals, assess their needs and update MLE of the actions that have occurred.

MLE Officers will re-attend the location and, a verbal trespass notice would be issued to those contravening the bylaw. MLE will contact the Hamilton Police Service as the *Trespass to Property Act*, R.S.O. 1990, c. T.21 is a Provincial Act enforced by HPS. The City will continue to collaborate with HPS and the Social Navigator with regard to the service pathway. The last step will be to contact the Public Works Department (Parks, Streets, Waste Management) to coordinate a clean up.

Following the Council decision to repeal the By-law Enforcement Protocol, the City of Hamilton's Housing Services Division remains focused on supporting individuals experiencing homelessness in securing safe and affordable housing, by continuing to take an individualized approach to connect them to available supports.

Housing Services' Housing Focused Street Outreach Team connects with unsheltered individuals, regardless of their circumstances, to assess their immediate needs and housing preferences. The team completes common consent and intake forms for individuals not yet on the City's By-Name List (BNL), supports with benefit applications, unit viewings, harm reduction supplies, connections and referrals. As part of the City's homeless-servicing system, Outreach uses a shared system-wide database to stay connected to residents in encampments and outside of encampments in areas such as alleys, vacant lands, etc. Outreach services are provided to unsheltered residents across the geographic area of Hamilton Monday to Friday from 8:00 a.m. to 8:00 p.m. and Saturday and Sunday from 8:00 a.m. to 4:00 p.m. On a daily basis, the team undertakes progressive engagement to offer shelter or other available (and appropriate) space, works with individuals to find safe and supportive housing options, and works to address any barriers including a referral to our health partners.

During the COVID-19 pandemic, emergency shelter capacity has been expanded; however, occupancy pressures exist, particularly for women. Challenges remain in the access to available beds and in a number of instances capacity is not available. For example, length of stay in shelters has increased significantly during the pandemic and, with factors such as unaffordable costs of rent, housing availability has not kept pace with demand. Longer stays impact shelter bed turnover frequency, thus reducing the capacity of shelters to serve a higher volume of individuals. Outbreak status, availability of appropriate supports, staff turnover, shortages and burnout further impact the responsiveness of the system. When a move from encampment to emergency shelter occurs, the City of Hamilton recognizes that this remains a temporary measure of accommodation until safe, secure and adequate housing is secured.

For individuals for whom emergency shelters are not an option, Housing Services' Outreach Team supports connection to health partners, works to address issues related to service restrictions, and continues progressive engagement towards accepting housing assistance. The City of Hamilton funds numerous agencies to assist in the housing of homeless individuals through funding streams such as the Federal Reaching Home program. City staff monitor, advise and assist these agencies in meeting predetermined targets through the homeless-serving sector's coordinated access system. From January 2020 to present, approximately 440 individuals and families have been housed by agencies funded by the City. Of the approximately 440 households housed, this includes people who have been unsheltered at one point during that time period. Since March 2020, more than 70 individuals were housed directly from encampments.

Outreach staff engage with every individual from a rights-based approach, ensuring dignity and confidentiality is maintained. On an ongoing basis, both Housing Services and agency staff work from a person-centred approach to engage with individuals in order to refer and make connections to appropriate support and resources. Referrals may include Intensive Case Management, Rapid Rehousing, Transitional or permanent supportive housing programs, in addition to housing affordability benefits, depending on individuals' needs, preferences and available resources. Increased engagement for the direct purpose of assessing effectiveness of approaches and appropriateness of available resources will continue to inform potential changes or adaptations to service and supports over time.

Coming Together to End Homelessness: Hamilton's Systems Planning Framework outlines a strategic local approach to preventing and ending homelessness, which must account for the systemic over-representation of Indigenous persons experiencing homelessness. The City is committed to ongoing coordination with Hamilton's Urban Indigenous Community to ensure that approaches to service coordination and provision are culturally appropriate, safe and built on principles of relationship, trust and informed consent. This includes ongoing discussion to achieve equitable access to resources including, for example, housing affordability benefits as they become available to support unsheltered individuals who identify as Indigenous. Through ongoing dialogue with the Indigenous community, the City aims to ensure appropriate referrals are consistently made from mainstream supports to Indigenous agencies, including at intake by City outreach staff.

The City continues to commit to permanent housing solutions by implementing increased prioritization of those in encampments for permanent housing and intensive case management support programs while continuing multi-sectoral discussions to enhance permanent housing with supports options. From September to December 2021, Housing Services Division, together with partner agencies, will undertake a

housing campaign to maximize resources and collaboration to house 250 households experiencing homelessness.

Health and Safety Concerns

Due to the vulnerability and transience of encampment populations, health and safety concerns are present for both residents and City staff. COVID-19 exposure, verbal and sometimes physical aggressions have been noted at various sites. MLE Officers are not trained in outreach or mental health engagement techniques and therefore cannot offer support to address health and safety for encampment residents. This fact extends to include staff themselves, who navigate a challenging array of health and safety concerns when carrying out their duties. For example, Waste management staff have received numerous negative comments, which may be perceived as threats from residents, activists, advocates and the general public. Staff have been videotaped with postings on social media platforms such as Twitter and Facebook. Staff have been called repeatedly at all hours on their cell phone. In one instance a staff member was assaulted during clean up, resulting in injuries to the worker and charges being laid by Hamilton Police Service. As a result, the injured employee has yet to return to work.

There is a steady increase of incidents involving the Hamilton Fire Department and the Hamilton Police Service. Where emergency service response is needed, the City will respond swiftly with staff health and safety supports. Healthy and Safe Communities Department staff are better able to flag resident health and safety concerns to the appropriate support services for timely resolution.

The professional skillset required of Housing Service's Outreach staff facilitates mitigation of challenging behaviours, circumstances and establishment of positive rapport. Staff have been trained in non-violent crisis intervention, work only in pairs and are in constant communication with each other.

Budgetary Implications

Costs vary site to site; while staff time is not itemized by site, typical contractor costs for waste management average $15 K. Across all encampments, average monthly security costs have been approximately $23 K from October 2020 to July 2021.

Licensing and By-law Services

Council may direct Licensing and Bylaw Services (LBS) to enforce 7 days a week, inclusive of evenings and weekends. To oversee and coordinate the MLE officer response for encampments 7 days a week LBS requires 1 temporary FTE By-law Clerk at a cost of $26, 162 and 1 temporary FTE MLE Officer at a cost of $30, 795 from the date of Council approval to December 31, 2021.These staff will assist in the collection of

weekly stats on complaints received, locations of encampments, determine priority locations in collaboration with others on the Encampment Response Team, provide status updates as to the step each encampment site is in throughout the City. MLE Officers will be attending encampment sites in pairs, and one additional temporary FTE MLE Officer will allow for a timely proactive and reactive response to each encampment site 7 days a week. The Bylaw Clerk will provide administrative support to the MLE Officers and will ensure all tracking, scheduling, monitoring, entering areas of concern, preparation of orders, and dispatch to this team 7 days a week. The total cost would be $56, 958.

Emergency Services Responses

The Hamilton Fire Department has attended to an increasing number of incidents involving encampments and individuals experiencing homelessness over the last three years (54 incidents in 2019, 82 incidents in 2020, and 101 incidents to date in 2021). The majority of incidents in 2021 to date have involved burning (controlled) and property fires/explosion.

Hamilton Paramedic Service responded to 55 encampment related calls in four parks from October 1, 2020 to August 31, 2021. There has been a steady increase in paramedic service response to encampments in City parks in 2021, ranging from two in January to 15 in August.

The Hamilton Police Service indicated there were 502 events from October 1, 2020 to August 31, 2021 related to six known encampment locations, but not necessarily due to the presence of an encampment. These incidents include events related to trespassing, assist (ambulance & fire), and other events requiring police service response (i.e. assault, harassment, protests, etc.)

Government Outreach

There remains an ongoing need to align provincial health and housing and homelessness investments to enable service managers to provide permanent housing with supports for high acuity chronically homeless individuals living in shelters and encampments. Strategic investment and partnership between Ontario Health West and City of Hamilton can demonstrably reduce chronic homelessness in Hamilton and the reliance on emergency hospital resources for those with the most complex, co-occurring needs.

Staff are actively pursuing funding opportunities from higher levels of government to address these needs. Specifically, the Ministry of Health (Ontario), Associate Minister of Mental Health and Addictions and the Ministry of Municipal Affairs and Housing (Ontario) in addition to the equivalent Ministries federally such as Health, Housing,

Infrastructure and Communities, and Families, Children and Social Development. Staff have proposed a pilot project to the Government of Ontario in order to address the needs of high-acuity individuals in Hamilton, this pilot outlines the resources required to take immediate action.

The proposed pilot would include 40 new units of supportive housing to address the needs of higher acuity individuals and continuing existing outreach activities will address needs in a new and improved way. The total funding necessary to undertake this development is $2,440,000. The request for on-going provincial operational funding is $1,940,000.

Staff have been using forums like the Association of Municipalities of Ontario (AMO), Federation of Canadian Municipalities (FCM) and Ontario Big City Mayors, of which Hamilton is a member, to further advocacy and align objectives in voicing our concerns about the lack of funding from higher levels of government to address these immediate needs. AMO, FCM and Ontario Big City Mayors are focused on improving supports for mental health. Ontario Big City Mayors has provided recommendations to support and complement the Province's Road to Wellness plan which seeks to improve mental health and addictions services across Ontario. The proposed recommendations and desire to collaborate demonstrate the need for municipalities to work with other levels of government and local service providers to ensure residents can access the help they need, where and when they need it.

APPENDICES AND SCHEDULES ATTACHED

None

TAB 2

CITY OF HAMILTON

HEALTHY AND SAFE COMMUNITIES DEPARTMENT
Housing Services Division
and
PLANNING AND ECONOMIC DEVELOPMENT DEPARTMENT
Licensing and By-law Services Division
and
PUBLIC WORKS DEPARTMENT
Environmental Services Division

TO:	Mayor and Members General Issues Committee
COMMITTEE DATE:	May 15, 2024
SUBJECT/REPORT NO:	Encampment Observation Report (HSC24020/PED24080/ PW24030) (City Wide)
WARD(S) AFFECTED:	City Wide
PREPARED BY:	Mike Jones (905) 546-2424 Ext.3824
SUBMITTED BY: **SIGNATURE:**	Michelle Baird Director, Housing Services Division Healthy and Safe Communities Department Michelle Baird
SUBMITTED BY: **SIGNATURE:**	Dan Smith Acting Director, Licensing and Bylaw Services Planning and Economic Development Department
SUBMITTED BY: **SIGNATURE:**	Cynthia Graham Director, Environmental Services Public Works Department C. Graham

RECOMMENDATIONS

(a) The Encampment Protocol (Appendix “A” in Report HSC20038(g)) be modified to remove the following provision from Section D, indicating the removal of encampments, temporary shelters, or tents “on or within 50 metres of the Hamilton Alliance for Tiny Shelters model site. For the purpose of this site the full length of the Strachan Linear Park, Bay Street North to Ferguson Street North, will be considered the site.”

(b) That the Housing Services Division report back with recommendations on how to address the needs of individuals who are unhoused and any additional service gaps highlighted in this report.

EXECUTIVE SUMMARY

This report provides an overview of the findings associated with implementing the Encampment Response protocol. The Encampment Protocol represents a concerted effort to mitigate the challenges faced by individuals living unsheltered and address concerns raised by the broader community.

Since its ratification in August 2023, the Protocol has undergone several phases of response, from initial ground truthing efforts (i.e., using maps to determine a site's compliance before confirming in-person) aimed to delineate compliant and non-compliant areas, followed by ongoing outreach efforts by Housing Focused Street Outreach to make individuals aware of the protocol's requirements and available resources.

The City has effectively established a housing-led approach that prioritizes supportive outreach over punitive measures, yet several challenges persist, such as difficulties in enforcing compliance timelines, managing garbage and debris at encampment sites, and seasonal considerations regarding the implementation of the protocol.

Overall, the implementation of the protocol has provided greater transparency and clarity regarding the processes used by the City in responding to encampments in the community and has been an effective tool in balancing the needs of individuals living unsheltered with the broader community's needs. However, sustained efforts focused on permanent, humane, cost-effective solutions is needed to address the systemic multifaceted challenges faced by individuals living unsheltered. To this end, Housing Services Division will be proposing several recommendations in Report HSC23021(b) aimed at responding to some of the concerns outlined in this report with the ultimate goal of ending chronic homelessness in Hamilton.

Alternatives for Consideration – N/A

FINANCIAL – STAFFING – LEGAL IMPLICATIONS

Financial: N/A

Staffing: N/A

Legal: N/A

HISTORICAL BACKGROUND

On March 23, 2023, staff presented information report HSC23021, Ending Chronic Homelessness, identifying interventions that were successful as well as needed investments to make progress on resolving chronic homelessness in Hamilton.

On May 17, 2023, staff recommended that Council adopt a Proposed Encampment Protocol (HSC20038(f)/PED21188(c)) in the interim, while a period of public comment occurred until June 30, 2023, to obtain public comment around the concept of sanctioned sites and to conduct a jurisdictional scan.

In addition, to respond to concerns related to basic needs supports and the need to integrate frontline stakeholders and people with lived experience into the encampment response, Council directed staff to provide access to washrooms, showers, clean drinking water, as well as integrate Indigenous and peer supports into its encampment response program. Further, staff were asked to develop a task force or committee comprised of City staff, community stakeholders, and people with lived experience to advise on the development of an encampment response policy and appeals process.

The period of public comment resulted in significant feedback on the draft Protocol, including 11,943 visitors to the Engage Hamilton website who contributed 15,965 individual comments, as well as approximately 2,000 attendees at three in-person community engagement sessions. Once the period of public comment closed, it was recommended that the City make the necessary changes and provide a final recommended Protocol to Council in August 2023.

On August 18, 2023, Council adopted and ratified an Encampment Protocol in Encampment Response Update – August 2023 (HSC23066), identifying approaches, processes, and service levels associated with responding to encampments in the City. In addition, Council provided necessary resources in staffing and equipment to support the implementation of the Protocol. While a broad approach involving sanctioned sites was not recommended by Staff due to its prohibitive costs better utilized in prevention efforts and/or housing, Council also approved a two-year Hamilton Alliance for Tiny Shelters pilot for up to 25 tiny homes on City lands at no cost to the City.

On September 6, 2023, staff followed up on the Ending Chronic Homelessness report with HSC23041 – Addressing the needs of Unsheltered Individuals and those Relying on Hamilton’s Emergency Shelter System. This recommended several investments to address capacity challenges in the shelter system, including providing additional space for those living encamped. These items were referred to Budget 2024 and subsequently approved as part of the budget process.

POLICY IMPLICATIONS AND LEGISLATED REQUIREMENTS

N/A

RELEVANT CONSULTATION

Several consultations were conducted and were the basis for analysing the implementation of the Encampment Protocol.

Housing Focused Street Outreach consulted with internal divisions including Municipal Law Enforcement, Parks Section, Parking Enforcement, and Hamilton Fire Department, as well as Hamilton Police Services. In addition, an open-ended questionnaire was sent to several community partners who comprise the Encampment Liaison Committee, including Keeping Six, St. Matthew's House, HAMSMRT, and Hamilton Regional Indian Centre.

People living in encampments throughout the City were also consulted from March 7-12, 2024.

Housing Focused Street Outreach staff consulted with nearby municipalities that are considering adopting a Protocol to direct encampment-related work in Guelph and Toronto, to compare approaches and findings. The consultation helped to inform the analysis below.

ANALYSIS AND RATIONALE FOR RECOMMENDATION

While this report focuses on the impacts of unsheltered homelessness in the City of Hamilton, it is important to note that increasing levels of unsheltered homelessness is being experienced in communities across Canada. With increased costs of housing and rental prices, inflation with stagnant wages, as well as insufficient income from supports such as Ontario Works and Ontario Disability Support Program, it is exceedingly difficult for low-income households, particularly singles, to access suitable and appropriate housing. Adding to the precarity being experienced, in Hamilton and across Canada, emergency shelter capacities are also being met and chronically exceeded across sectors, particularly for adult men, resulting in overflow into hotel spaces.

With both housing and emergency shelter largely inaccessible, and with more individuals entering into unsheltered homelessness, the constellation of existing supports is unable to meet the growing demand. More people are confronted with the reality of living in an encampment, a lifestyle that contributes to worsened physical and mental health outcomes and often associated with increased substance use.

Limited coordination and accountability to-date from Federal and Provincial levels of government has further complicated efforts to address the issue. Nonetheless, there is

still a need to address unsheltered homelessness at a community level to ensure individuals living outside do so with dignity, while also meeting the needs of the broader community. As such, the Encampment Protocol was adopted to provide transparency and expectations around the City's approach to encampment response, and to balance the needs of everyone in the community.

To evaluate how the Protocol is being implemented, several consultations were conducted, including with people with lived experience, community partners, and members of the Coordinated Response Team, who have provided ongoing oversight throughout implementation to various aspects of the program through ongoing collaboration and coordination, to calibrate how supports are best utilized to achieve the maximum impact. Given the volume of responses from the community (particularly from concerned citizens, Business Improvement Areas, and local businesses) to the unsheltered inbox, their voice is also represented in the following analysis. The recommendations being made reflect all the feedback received.

The following section of the report will provide context around the implementation of the Protocol, and review feedback received from the consultations conducted, including both what was achieved, as well as challenges.

Volume of Requests and Approach to Communication

Since the establishment of the Encampment Protocol in August 2023 until April 15, 2024, Housing Focused Street Outreach has been contacted 3825 times (including follow-ups and repeated contact) via its unsheltered email, as well as hundreds more times by voicemail. The majority of complaints or service requests received by Housing Focused Street Outreach are initiated by concerned citizens (70%) and include requests for additional supports onsite, reporting of encampments, and requests for removal as per the terms of the Protocol, yet several other internal and external sources have also contacted Housing Focused Street Outreach regarding encampment-related concerns or requests.

With a high volume of complaints and service requests received by Housing Focused Street Outreach via email and voicemail, the ability of Housing Focused Street Outreach to respond to each request without a dedicated staffing complement has not been possible. As a result, complainants have not received personalized responses, leading to a lack of clarity and significant frustration. As part of a concerted effort to respond to complaints and requests, and to improve transparency with the public, Housing Focused Street Outreach has established a Program Secretary tasked with responding to inquiries, and the team has developed several new approaches to managing the inflow of complaints and service requests to its unsheltered mailbox and voicemail.

Enforcement-related Complaints and Requests for Service

Since implementation of the Protocol, the overall number of complaints and service requests has gradually declined, peaking at 860 in September 2023 before gradually declining to 328 in March 2024. There has also been a gradual decrease in the reporting of and requests to enforce encampments, which totalled a high of 526 in September 2023 before dropping to 130 in February 2024. This suggests that the efforts of Housing Focused Street Outreach and its partners has been successful in working with individuals living unsheltered to access compliant spaces.

While the complaints and requests for service regarding encampments have decreased month-over-month since the Protocol was established, from 897 in September 2023 to 328 in March 2024, it increased substantially in April 2024 to 481 complaints and requests for service. With warmer weather anticipated in the upcoming months it is expected that the total number of complaints and service requests related to encampments will increase to, or higher than the levels experienced in September 2023.This will place an additional strain on resources as staff attempt to address the community's concerns and suggestions.

Coordination amongst Partners and Stakeholders

Implementation of the Encampment Protocol requires significant effort and expertise from several teams. The Coordinated Response Team - made up of staff from Housing Focused Street Outreach, Municipal Law Enforcement, Parks Section, Parking Enforcement, Corporate Security, Hamilton Fire Department, and Hamilton Police Services - meet three times weekly to strategize around approaches to sites with acute challenges, coordinate encampment response through the City, and address issues via new, innovative approaches that build upon previous experiences. On a daily basis, several divisions are involved in ongoing coordination of frontline efforts to ensure sites are effectively engaged and when necessary, escalated to the appropriate parties who work together to enforce. To ensure the frontline work is well-coordinated, significant administrative work is needed to ensure all incoming communications are logged, new sites are identified and prioritized effectively, with frontline information (i.e., site visits, interactions/engagement with individuals living in encampments, enforcement actions, site clean-ups) about new and existing sites updated across teams within shared repositories on a daily basis. These interactions are the backbone of implementation, and this collaboration has been noted by all partners as being necessary and successful.

In terms of external partnerships, Housing Focused Street Outreach held an initial meeting in February 2024 with community stakeholders and persons with lived experience of homelessness to develop a Terms of Reference that outlines the purpose, values, objectives, and scope of the work. Due to the cybersecurity incident, timelines have been impacted and a next meeting is being rescheduled for May 2024.

Housing Focused Street Outreach will conduct ongoing research with individuals living unsheltered to establish appropriate baselines and to ensure there is ongoing evaluation of the community's needs that also correspond with the program's objectives. This will also provide staff with an opportunity to develop and track more reliable equity-based indicators to assess the impacts on people disproportionally impacted by unsheltered homelessness, which can be used to inform new partnerships and approaches to service.

Service Levels

As per the guidelines established in the Encampment Protocol, Housing Focused Street Outreach (Housing Services Division), Municipal Law Enforcement (Licensing and Bylaw), and Parks Section (Public Works) have service levels associated with their response to encampments. While other divisions (i.e., Parking enforcement, Hamilton Fire Department), and partners (i.e., Hamilton Police Services) are involved via the Coordinated Response Team, they do not have service levels guiding their response.

As of April 15, 2024, Housing Focused Street Outreach has received and visited 472 sites within the scope of the Encampment Protocol. Of the sites with a defined outcome, Housing Focused Street Outreach met its service level of attending and escalating each identified site with 72 hours 89% of the time and escalates 96% of sites to Municipal Law Enforcement within a week of being identified.

Due to the cybersecurity incident, there has been a significant loss of historical data related to Municipal Law Enforcement's service levels. Broadly, given the staffing levels available (i.e., a Municipal Law Enforcement Supervisor and two Municipal Law Enforcement Officers), there have been significant challenges in meeting the defined service level, and Municipal Law Enforcement would require additional staffing, as well as the support of additional Hamilton Police Encampment Engagement team staff to avoid enforcement bottlenecks.

While there are service levels identified within the Encampment Protocol defining clean-ups and site maintenance, Parks Section simultaneously manages routine garbage pickup, ad hoc clean-ups resulting from enforcement actions, as well as complaints and/or service requests, making it challenging to track each specific type of request. Additional mechanisms to track and identify work requests are under development.

Housing-Led Approach

The goal of a housing-led approach is for Housing Focused Street Outreach to be the first point of contact for individuals living unsheltered on public property, to establish rapport and work towards connecting them with services and supports that maintain their well-being, and to only escalate sites with potential compliance concerns to Municipal Law Enforcement (i.e., sites with no clear compliance issues would not be

escalated to Municipal Law Enforcement for investigation). To date, this has been effective during the implementation of the Encampment Protocol, and individuals living unsheltered reported having less or little interaction with Municipal Law Enforcement and Hamilton Police since the Protocol had been established.

Under the existing approach of having compliant spaces available for access, 50% of individuals living unsheltered felt the current approach was working for them. When comparing to a similar survey done in 2022, at a time when there was a 12–72-hour bylaw required individuals living unsheltered to move frequently to new locations, only 10% believed that approach was working for them.

To aide in continuous improvement of service to individuals living unsheltered, Housing Focused Street Outreach has developed several new processes to assist in triaging of complaints and requests, data analysis, and reporting. The new approaches will be used to collect more reliable, accurate systems data from outreach staff to assist with site prioritization and better define the work being completed by outreach staff. Housing Focused Street Outreach is also in the process of adding three (3) peer support workers who will be funded to support rapport-building, harm reduction, and site remediation.

Distance Away from Schools and Childcare Facilities

During the consultation period in summer 2023, and prior to the ratification of the Encampment Protocol, there was significant feedback provided by the public related to the proximity of encampments to places frequented by toddlers and school-aged children. As a result, in the final version of the Protocol the distances were extended from 50-metres to 100-metres away from schools and childcare facilities. This has been successful, with sites being identified near a school of childcare facility dropping from 12% in September 2023, to none in March 2023.

Number of Encampments Per Cluster

The Protocol provides direction regarding number of tents permitted in a cluster and distances between clusters. From the experiences of staff, corroborated through the experiences of a majority of individuals living unsheltered, as well as the complaints data, this has been a successful provision within the Protocol. While enforcement is based upon a five-tent limit, it is common for sites to include tents that are not inhabited, and instead used for storage of food and personal items, which adds to the size of a site. Largely, when sites exceed a manageable number of tents, i.e., approximately five tents, there is a clear increase in the number of associated complaints and concerns with the site.

At a community level, an increase in tents at a site is generally associated with an increase in complaints related to garbage and debris in a concentrated area, more combustibles, violence and use of weapons, and reports of feeling intimidated by the

number of people. In addition, individuals living in encampments also reported concerns with larger sites, included theft, lack of privacy, and varying and at times conflicting lifestyles and goals amongst the people living there.

Additional Protocol Considerations

While the intent of the Protocol is to balance the needs of individuals living unsheltered and the broader community, there were additional considerations made by internal staff and people with lived experience regarding potential changes that would add to the Protocol, as well as modify, and remove existing clauses.

One change to the Encampment Protocol being recommended is the following from Section D, indicating the removal of encampments, temporary shelters, or tents “on or within 50 metres of the Hamilton Alliance for Tiny Shelters model site. For the purpose of this site the full length of the Strachan Linear Park, Bay Street North to Ferguson Street North, will be considered the site.” It has since been confirmed that this area will not be used for the Hamilton Alliance for Tiny Homes pilot project, and to reflect this update, this provision should be removed from the Protocol.

For other potential changes, given that the Protocol has not been implemented for a full year yet and understanding that the warmer months have higher rates of people living unsheltered, more information is required to better understand the impacts of the Protocol prior to recommending any changes. In addition, before a recommendation(s) is made, each consideration would require a comprehensive policy and risk analysis of associated impacts. See Appendix “A” for a detailed list of considerations.

Compliant Spaces

With less required movement of people living unsheltered throughout the city as a result of compliant spaces being available, there are several compliant sites that have had a stable group of individuals living there. This has allowed Housing Focused Street Outreach and other frontline providers to build effective rapport with the same individuals over a longer period of time, leading to more successful outcomes. Both Outreach staff and individuals living unsheltered noted that having a place to stay for longer periods of time was very beneficial, especially when compared to approaches used in the past that required ongoing movement to new areas. However, this approach has been problematic for some neighbours and local businesses nearby who report concerns with an ongoing encampment presence nearby, particularly when there are presenting concerns around health and safety, namely garbage, debris, and waste.

In terms of frequented areas of the city, as expected given the proximity to services and supports, Ward 2 (34%), Ward 3 (29%), Ward 5 (9%), Ward 1 (9%), and Ward 4 (7%) have had the most newly identified encampments in non-compliant spaces, while all other Wards have had less than 5% of the total number of new encampments identified.

In general, the significant majority of encampments are in the lower City. Given the concentration of encampments in lower City wards, it is anticipated that this may lead to an increase in sites with numerical non-compliance (i.e., five or more tents, lack of distance between clusters), geographically non-compliant sites (i.e., proximity to), and more tents within escarpment areas during warmer weather months when historically more people live outside.

Safety Concerns

Concerned citizens and local businesses have detailed several health and safety issues in their complaints to Housing Focused Street Outreach, such as light posts being compromised for electricity, human waste exposure, and personal safety concerns. Businesses have detailed that the presence of encampments has negatively impacted their operations. This has led to significant frustration amongst all parties.

Several encampment residents who were interviewed also expressed concerns for their safety, sharing instances where their presence had resulted in confrontation from neighbours and youth.

Enforcement Challenges

The consistent enforcement of sites has been impacted by a lack of staffing available to manage the responsibilities of the portfolio. Currently, there are two Hamilton Police Services Encampment Engagement Team officers responsible for attending all site visits with Municipal Law Enforcement officers, coordinating and leading private property enforcement and the enforcement of sites on public property. With a high number of non-compliant sites resulting from the disbandment of larger sites like Woodlands Park and City Hall, and in using a hands-off approach to enforcement, the time required to enforce requires more resources than currently allocated.

Since Hamilton Police's Encampment Engagement Team was established in September 2023, the team has attended 441 encampment site visits. Some of these visits are supporting the issuing of 419 Trespass Notices by Municipal Law Enforcement Officers. In addition, Hamilton Police Service's Encampment Engagement team has spent a total of 248 hours enforcing previously issued notices. This does not include time spent assisting other agencies and enforcing encampments on private property.

Contributing to the time spent enforcing previously issued notices are several locations within the city that are often habitually occupied by encampments. Some examples include MacNab St S and Hunter St W, Jackson St W and MacNab St S, Vine between Park and York, and the Hamilton Convention Centre alcoves on King St W. Given the proximity of these sites/areas to community resources and services that meet the basic needs of individuals living unsheltered, these sites quickly re-establish after enforcement has occurred with new occupants, triggering a new round of engagement

and enforcement. In addition, other street-related concerns not related to encampments are often grouped under the heading of encampments, including loitering and illegal dumping or garbage. These issues, although not related to encampments and more frequently associated with mental health and substance abuse issues, are brought to the attention of the City via the unsheltered inbox These sites are also resource-intensive for Municipal Law Enforcement and Housing Focused Street Outreach to assess and address.

Recreational Vehicles and Trailers

Since the Encampment Protocol was adopted by Council, a growing number of locations throughout the city have been occupied by individuals inhabiting within Recreational Vehicles (RVs) and trailers. Many of the RVs and trailers being inhabited also have had additional semi-permanent structures built into them. With existing Parks Bylaws already governing the use of RVs and trailers, particularly for habitation, as well as several other Parking-related violations, the use of these vehicles in this manner is not compliant and there are no designated areas for free parking of Recreational Vehicles or trailers on public lands in the City of Hamilton.

To support this work, the City's Parking Enforcement team has joined the Coordinated Response Team to provide best practices related to managing these concerns, and in coordination with Housing Focused Street Outreach, has allowed for Outreach staff to visit individuals to ensure they are provided with additional options and resources prior to enforcement.

Fire and Combustibles

The use of fire pits and other combustibles by individuals who are unsheltered to maintain warmth during colder months has resulted in several complaints and concerns from neighbours of sites who feel at risk. The Hamilton Fire Department has been actively engaged with incidents related to encampments, categorized into those necessitating emergency response and those that do not. The main types of incidents responded to include burning complaints, rubbish fires, and calls for medical assistance. In January 2023, burning complaints were the predominant response call-type, numbering 31 responses. During such responses, fire-related situations are promptly extinguished, and encampment occupants are reminded of the open-air burning by-law.

The Hamilton Fire Department, in collaboration with the Housing Focused Outreach team, developed a printed resource to increase fire safety awareness and support educating people living unsheltered. Approximately 800 of these two-sided, non-destructible flyers were distributed to resource centres and the City's Encampment Response Team in early 2024. In addition, in January 2024 a representative from the Hamilton Fire Department joined the City's Coordinated Response Team to provide ongoing support and best practices related to coordination and risk mitigation at sites.

An important aspect to note is that application of the Ontario Fire Code principally pertains to buildings and structures but does not apply to tents smaller than 30m² used for camping, personal, or non-commercial purposes. Additionally, the Fire Department is not licensed to remove or transport hazardous materials (including propane cylinders). As such, there is currently no defined process for removal of flammable or combustible materials.

Washroom Access

The need for access to washrooms was echoed by several individuals living in encampments who want the option of using facilities nearby, as well as community partners who provide frontline service. Housing Focused Street Outreach has received several complaints from members of the community reporting human waste requiring clean up or wanting portable washrooms at compliant sites.

To address some of the concerns, two washroom programs were established at central locations within the city and are available on a 24/7 basis. Individuals encamped near washroom programs (i.e., JC Beemer, Corktown Park) report it as one of the reasons they stay nearby but given logistical concerns in counting users of the washrooms who are experiencing homelessness, staff were unable to identify the frequency individuals access the 24/7 washrooms.

In September 2023, shower programs were also established within two locations within the City, Norman Pinky Lewis Recreational Centre, and Bennetto Community Centre. Previously, the City operated a shower program at Eastwood Arena, but due to low uptake (33 visitors over 15 weeks), the program was moved to Bennetto in January 2024, which has seen a mild increase in uptake (6 per week, vs 2 per week). In contrast, Norman Pinky Lewis has seen an average of 14 individuals experiencing homelessness utilize the service each week. More work is required to better understand barriers to service use.

Garbage and Debris Pickup

Housing Focused Street Outreach received several complaints describing parks as being unusable due to the presence of garbage and debris. As individuals move to compliant sites and stay in a single place for longer periods of time, they often accumulate more items at the site, particularly during colder weather months. As a result, the number of complaints related to garbage and debris has maintained at the same level (67-80 requests per month), despite a significant decrease to the number of sites and overall complaints and requests for service.

To facilitate clean-ups at sites across the city, the Parks Section has created a schedule to assist in managing garbage and debris pickup at encampments. To ensure adequate coverage, larger sites that may contain more than one cluster or are currently non-

compliant with five or more tents are attended to every other day given the level of need, while smaller sites are visited at least once a week.

Managing clean-ups throughout the city can be challenging given that there are ongoing ad hoc requests made of Parks section staff, sometimes related to sites being vacated or recently vacated. As such, a consistent, planned schedules for all sites is not possible. In the meantime, all known encampment sites visited by Parks section are offered garbage bags to help mitigate the spread of garbage and debris, and staff coordinate with individual(s) at the site to detail the location to leave bagged garbage, and approximate time of next pickup.

Additionally, there have been concerns about garbage/debris on private property associated with encampments, which is presently not within the City's scope of work. To alleviate the burden on members of the public to clean up after garbage/debris has been left on their property, Public Works is bringing forward a recommendation report in May 2024 to suggest an approach to address and mitigate these concerns.

Special Events

Throughout the year, the City of Hamilton, and its partners host community events on public lands across the city. As part of holding events the Special Events Advisory Committee (SEAT) reviews the operational details to ensure the health and safety of participants and City assets (parks, roads). Occasionally, some of the 350+ events held each year are planned in spaces already occupied by encampments in a compliant location.

With no specific clause in the Encampment Protocol delineating a process for managing co-location and given the mental health impacts of moving individuals from their compliant space, individual(s) in residing in compliant locations will not be moved as a result of an upcoming or planned event. As encampments move throughout the City, particularly in the summer months, this can lead to tensions and challenges amongst event organizers and City staff that are managed on a case-by-case basis.

Barriers to Housing and Emergency Shelter

Without identified outflow from encampments into indoor spaces such as emergency shelter, temporary or transitional housing, or permanent housing, encampments are likely to maintain or increase in total.

Individual(s) living unsheltered reported several barriers to emergency shelter, including a lack of pet-friendly and couples' spaces, harm reduction friendly policies, privacy concerns, and requirements to leave and return to secure a bed every day, that precluded them from wanting to access the service. When asked if they would consider accessing spaces in the emergency shelter system more suitable to their needs (i.e.,

some of the barriers to access were potentially reduced), 71% were interested. To reflect this need, Housing Services division continues to explore various program models aimed at providing more inclusive service.

To address the impacts of colder weather and increasing need, in 2023-24 Housing Services Division introduced a number of services and supports aimed at providing greater access to warm, indoor spaces, particularly for individuals who are less likely to access traditional service models and may spend time in encampments. Services offered included the warming bus which operated in cold-weather months overnight and was staffed by two outreach employees, extended hours at resource centres and libraries for individuals looking for immediate respite from colder weather, 45 overnight spaces at Willow's Place, and 50 warming spaces at Good Shepherd Cathedral. Given the benefits associated with the City's Winter Response Strategy and the ongoing need for indoor space, particularly for hardest-to-reach populations, these services have been extended until November 30, 2024. An investment in resources within the Family Shelter system allowed for additional support services for clients in this sector.

Housing also continues to be difficult to acquire for individuals living in encampments, especially those who may require supports that assist in their transition. While many of the individuals living outside had connected with housing workers and were on the Access to Housing waitlist, many still felt unsupported, and shared little to no hope in acquiring housing. While the Encampment Protocol has been developed to provide clarity and balance the needs of individuals living unsheltered and the broader community, and with the knowledge that other approaches (i.e., sanctioned sites) have been considered that would provide temporary relief at high costs, the goal is to use resources towards permanent, humane, cost-effective solutions such as housing. To this end, Housing Service Division has identified resources and strategies that would effectively end chronic homelessness in Hamilton and will be bringing a report with actionable recommendations for Council to consider in June 2024.

To ensure individuals are able to stay in their housing, the City of Hamilton is currently implementing the expanded Tenant Support Program as approved by City Council to help stop vulnerable tenants being displaced and possibly entering into the homelessness serving system. This expanded program includes a partnership with the Hamilton Community Legal Clinic to provide legal support for tenants facing displacement through N-13 and N-12 notices. Additional supports as part of this program are outreach services to tenants through ACORN Hamilton and housing plans and support for tenants who do need to be displaced because of legitimate renovations through the Housing Help Centre Hamilton and Area.

The issue of homelessness and related issues of addiction and mental health continue to cause pressures across the housing and homelessness system and beyond. These are multi-faceted complex issues, and the continuously growing needs are pressuring the capacity of the existing systems. In addition, the issues are challenging and cross-

departmental in nature, often extending beyond city departments. This is demanding work and has an impact on the City staff working on these issues.

Despite the challenges there are opportunities for us, as a City, to have a positive impact with time. The encampment protocol is not a solution to homelessness, it continues to be a means to manage the crisis within our City providing some stability and options for people experiencing homelessness, however, continued commitment to more solution focused measures is needed in accompaniment with the protocol.

ALTERNATIVES FOR CONSIDERATION

N/A

APPENDICES AND SCHEDULES ATTACHED

Appendix “A” to Report HSC24020/PED24080/PW24030 – Additional Encampment Protocol Considerations

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

Request to Admit dated June 6, 2024

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TAB 149

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,
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ASHLEY MACDONALD, COREY MONAHAN, MISTY MARSHALL,
SHERRI OGDEN, JAHMAL PIERRE, LINSLEY GREAVES and PATRICK WARD

Applicants

and

CITY OF HAMILTON

Respondent

APPLICATION UNDER RULE 14.05 OF THE *RULES OF CIVIL PROCEDURE*

RESPONSE TO REQUEST TO ADMIT

In response to the Applicants' Request to Admit dated May 21, 2024 (received May 22, 2024), the Respondent:

1. Admits the truth of facts numbers: None.

2. Admits the authenticity of the following documents: N/A – none requested.

3. Denies the truth of facts numbers: 1, 2, 3, 4, 5, 6, 7, 8, 9.

4. Denies the authenticity of documents numbers: N/A – none requested.

5. Refuses to admit the truth of facts numbers: None. See response at paragraph #3 above.

6. Refuses to admit the authenticity of documents numbers: N/A – none requested.

June 7, 2024

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Court File No. CV-21-00077187-0000

KRISTEN HEEGSMA et al. - and - CITY OF HAMILTON

Applicants Respondent

ONTARIO
SUPERIOR COURT OF JUSTICE

PROCEEDING COMMENCED AT HAMILTON

RESPONSE TO REQUEST TO ADMIT

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File No. H227899

TAB 150

Court File No. CV-21-00077187-0000

Form 51A
Courts of Justice Act

REQUEST TO ADMIT

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, GLENN 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

YOU ARE REQUESTED TO ADMIT, for the purposes of this proceeding only, the authenticity (see Rule 51.01 of the *Rules of Civil Procedure*) of the following documents:

1. **City of Hamilton, Healthy and Safe Communities Department, Housing Services Division, June 19, 2024* "Reducing Homelessness and Managing Encampments (HSC24027) (City Wide), Tab 1**

   Microsoft Word - HSC24027 - Reducing Homelessness and Managing Encampments Report (escribemeetings.com)

   *mistakenly dated June 19, 2023

2. **City of Hamilton, Healthy and Safe Communities Department, Housing Services Division, Appendix A to Report HSC24027, Tab 2**

filestream.ashx (escribemeetings.com)

YOU ARE REQUESTED TO ADMIT, for the purposes of this proceeding only, the truth (see Rule 51.01 of the *Rules of Civil Procedure*) of the following facts:

3. **City of Hamilton, Healthy and Safe Communities Department, Housing Services Division, June 19, 2024* "Reducing Homelessness and Managing Encampments (HSC24027) (City Wide), Tab 1**

   Microsoft Word - HSC24027 - Reducing Homelessness and Managing Encampments Report (escribemeetings.com)

   The following statement, at page 5, paragraph 1:

   "We know that the shelter system is consistently at 99-100% occupancy with many individuals and families being turned away each night. While we continue to provide 52 hotels rooms (or 208 beds) as overflow, this paired with the current capacity of 345 permanent and 20 temporary shelter beds does not come close to meeting the needs of the roughly 1592 people experiencing homelessness in the City."

   * mistakenly dated June 19, 2023

Attached to this request is a copy of each of the documents referred to above.

YOU MUST RESPOND TO THIS REQUEST by serving a response to request to admit in Form 51B prescribed by the Rules of Civil Procedure WITHIN TWENTY DAYS after this request is served on you. If you fail to do so, you will be deemed to admit, for the purposes of this proceeding only, the truth of the facts and the authenticity of the documents set out above.

June 25, 2024

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INDEX

TAB DESCRIPTION

1 **City of Hamilton, Healthy and Safe Communities Department (Housing Services Division), Planning and Economic Development Department (Licensing and By-Law Services Division), and Public Works Department (Environmental Services Division): May 15, 2024 Encampment Observation Report (HSC24020/PED24080/ PW24030) (City Wide),** Report HSC24020/PED24080 (escribemeetings.com)

TAB 1

CITY OF HAMILTON

HEALTHY AND SAFE COMMUNITIES DEPARTMENT
Housing Services Division
and
PLANNING AND ECONOMIC DEVELOPMENT DEPARTMENT
Licensing and By-law Services Division
and
PUBLIC WORKS DEPARTMENT
Environmental Services Division

TO:	Mayor and Members General Issues Committee
COMMITTEE DATE:	May 15, 2024
SUBJECT/REPORT NO:	Encampment Observation Report (HSC24020/PED24080/ PW24030) (City Wide)
WARD(S) AFFECTED:	City Wide
PREPARED BY:	Mike Jones (905) 546-2424 Ext.3824
SUBMITTED BY: **SIGNATURE:**	Michelle Baird Director, Housing Services Division Healthy and Safe Communities Department Michelle Baird
SUBMITTED BY: **SIGNATURE:**	Dan Smith Acting Director, Licensing and Bylaw Services Planning and Economic Development Department
SUBMITTED BY: **SIGNATURE:**	Cynthia Graham Director, Environmental Services Public Works Department C. Graham

RECOMMENDATIONS

(a) The Encampment Protocol (Appendix “A” in Report HSC20038(g)) be modified to remove the following provision from Section D, indicating the removal of encampments, temporary shelters, or tents “on or within 50 metres of the Hamilton Alliance for Tiny Shelters model site. For the purpose of this site the full length of the Strachan Linear Park, Bay Street North to Ferguson Street North, will be considered the site.”

(b) That the Housing Services Division report back with recommendations on how to address the needs of individuals who are unhoused and any additional service gaps highlighted in this report.

EXECUTIVE SUMMARY

This report provides an overview of the findings associated with implementing the Encampment Response protocol. The Encampment Protocol represents a concerted effort to mitigate the challenges faced by individuals living unsheltered and address concerns raised by the broader community.

Since its ratification in August 2023, the Protocol has undergone several phases of response, from initial ground truthing efforts (i.e., using maps to determine a site's compliance before confirming in-person) aimed to delineate compliant and non-compliant areas, followed by ongoing outreach efforts by Housing Focused Street Outreach to make individuals aware of the protocol's requirements and available resources.

The City has effectively established a housing-led approach that prioritizes supportive outreach over punitive measures, yet several challenges persist, such as difficulties in enforcing compliance timelines, managing garbage and debris at encampment sites, and seasonal considerations regarding the implementation of the protocol.

Overall, the implementation of the protocol has provided greater transparency and clarity regarding the processes used by the City in responding to encampments in the community and has been an effective tool in balancing the needs of individuals living unsheltered with the broader community's needs. However, sustained efforts focused on permanent, humane, cost-effective solutions is needed to address the systemic multifaceted challenges faced by individuals living unsheltered. To this end, Housing Services Division will be proposing several recommendations in Report HSC23021(b) aimed at responding to some of the concerns outlined in this report with the ultimate goal of ending chronic homelessness in Hamilton.

Alternatives for Consideration – N/A

FINANCIAL – STAFFING – LEGAL IMPLICATIONS

Financial: N/A

Staffing: N/A

Legal: N/A

HISTORICAL BACKGROUND

On March 23, 2023, staff presented information report HSC23021, Ending Chronic Homelessness, identifying interventions that were successful as well as needed investments to make progress on resolving chronic homelessness in Hamilton.

On May 17, 2023, staff recommended that Council adopt a Proposed Encampment Protocol (HSC20038(f)/PED21188(c)) in the interim, while a period of public comment occurred until June 30, 2023, to obtain public comment around the concept of sanctioned sites and to conduct a jurisdictional scan.

In addition, to respond to concerns related to basic needs supports and the need to integrate frontline stakeholders and people with lived experience into the encampment response, Council directed staff to provide access to washrooms, showers, clean drinking water, as well as integrate Indigenous and peer supports into its encampment response program. Further, staff were asked to develop a task force or committee comprised of City staff, community stakeholders, and people with lived experience to advise on the development of an encampment response policy and appeals process.

The period of public comment resulted in significant feedback on the draft Protocol, including 11,943 visitors to the Engage Hamilton website who contributed 15,965 individual comments, as well as approximately 2,000 attendees at three in-person community engagement sessions. Once the period of public comment closed, it was recommended that the City make the necessary changes and provide a final recommended Protocol to Council in August 2023.

On August 18, 2023, Council adopted and ratified an Encampment Protocol in Encampment Response Update – August 2023 (HSC23066), identifying approaches, processes, and service levels associated with responding to encampments in the City. In addition, Council provided necessary resources in staffing and equipment to support the implementation of the Protocol. While a broad approach involving sanctioned sites was not recommended by Staff due to its prohibitive costs better utilized in prevention efforts and/or housing, Council also approved a two-year Hamilton Alliance for Tiny Shelters pilot for up to 25 tiny homes on City lands at no cost to the City.

On September 6, 2023, staff followed up on the Ending Chronic Homelessness report with HSC23041 – Addressing the needs of Unsheltered Individuals and those Relying on Hamilton’s Emergency Shelter System. This recommended several investments to address capacity challenges in the shelter system, including providing additional space for those living encamped. These items were referred to Budget 2024 and subsequently approved as part of the budget process.

POLICY IMPLICATIONS AND LEGISLATED REQUIREMENTS

N/A

RELEVANT CONSULTATION

Several consultations were conducted and were the basis for analysing the implementation of the Encampment Protocol.

Housing Focused Street Outreach consulted with internal divisions including Municipal Law Enforcement, Parks Section, Parking Enforcement, and Hamilton Fire Department, as well as Hamilton Police Services. In addition, an open-ended questionnaire was sent to several community partners who comprise the Encampment Liaison Committee, including Keeping Six, St. Matthew's House, HAMSMRT, and Hamilton Regional Indian Centre.

People living in encampments throughout the City were also consulted from March 7-12, 2024.

Housing Focused Street Outreach staff consulted with nearby municipalities that are considering adopting a Protocol to direct encampment-related work in Guelph and Toronto, to compare approaches and findings. The consultation helped to inform the analysis below.

ANALYSIS AND RATIONALE FOR RECOMMENDATION

While this report focuses on the impacts of unsheltered homelessness in the City of Hamilton, it is important to note that increasing levels of unsheltered homelessness is being experienced in communities across Canada. With increased costs of housing and rental prices, inflation with stagnant wages, as well as insufficient income from supports such as Ontario Works and Ontario Disability Support Program, it is exceedingly difficult for low-income households, particularly singles, to access suitable and appropriate housing. Adding to the precarity being experienced, in Hamilton and across Canada, emergency shelter capacities are also being met and chronically exceeded across sectors, particularly for adult men, resulting in overflow into hotel spaces.

With both housing and emergency shelter largely inaccessible, and with more individuals entering into unsheltered homelessness, the constellation of existing supports is unable to meet the growing demand. More people are confronted with the reality of living in an encampment, a lifestyle that contributes to worsened physical and mental health outcomes and often associated with increased substance use.

Limited coordination and accountability to-date from Federal and Provincial levels of government has further complicated efforts to address the issue. Nonetheless, there is

still a need to address unsheltered homelessness at a community level to ensure individuals living outside do so with dignity, while also meeting the needs of the broader community. As such, the Encampment Protocol was adopted to provide transparency and expectations around the City's approach to encampment response, and to balance the needs of everyone in the community.

To evaluate how the Protocol is being implemented, several consultations were conducted, including with people with lived experience, community partners, and members of the Coordinated Response Team, who have provided ongoing oversight throughout implementation to various aspects of the program through ongoing collaboration and coordination, to calibrate how supports are best utilized to achieve the maximum impact. Given the volume of responses from the community (particularly from concerned citizens, Business Improvement Areas, and local businesses) to the unsheltered inbox, their voice is also represented in the following analysis. The recommendations being made reflect all the feedback received.

The following section of the report will provide context around the implementation of the Protocol, and review feedback received from the consultations conducted, including both what was achieved, as well as challenges.

Volume of Requests and Approach to Communication

Since the establishment of the Encampment Protocol in August 2023 until April 15, 2024, Housing Focused Street Outreach has been contacted 3825 times (including follow-ups and repeated contact) via its unsheltered email, as well as hundreds more times by voicemail. The majority of complaints or service requests received by Housing Focused Street Outreach are initiated by concerned citizens (70%) and include requests for additional supports onsite, reporting of encampments, and requests for removal as per the terms of the Protocol, yet several other internal and external sources have also contacted Housing Focused Street Outreach regarding encampment-related concerns or requests.

With a high volume of complaints and service requests received by Housing Focused Street Outreach via email and voicemail, the ability of Housing Focused Street Outreach to respond to each request without a dedicated staffing complement has not been possible. As a result, complainants have not received personalized responses, leading to a lack of clarity and significant frustration. As part of a concerted effort to respond to complaints and requests, and to improve transparency with the public, Housing Focused Street Outreach has established a Program Secretary tasked with responding to inquiries, and the team has developed several new approaches to managing the inflow of complaints and service requests to its unsheltered mailbox and voicemail.

Enforcement-related Complaints and Requests for Service

Since implementation of the Protocol, the overall number of complaints and service requests has gradually declined, peaking at 860 in September 2023 before gradually declining to 328 in March 2024. There has also been a gradual decrease in the reporting of and requests to enforce encampments, which totalled a high of 526 in September 2023 before dropping to 130 in February 2024. This suggests that the efforts of Housing Focused Street Outreach and its partners has been successful in working with individuals living unsheltered to access compliant spaces.

While the complaints and requests for service regarding encampments have decreased month-over-month since the Protocol was established, from 897 in September 2023 to 328 in March 2024, it increased substantially in April 2024 to 481 complaints and requests for service. With warmer weather anticipated in the upcoming months it is expected that the total number of complaints and service requests related to encampments will increase to, or higher than the levels experienced in September 2023.This will place an additional strain on resources as staff attempt to address the community's concerns and suggestions.

Coordination amongst Partners and Stakeholders

Implementation of the Encampment Protocol requires significant effort and expertise from several teams. The Coordinated Response Team - made up of staff from Housing Focused Street Outreach, Municipal Law Enforcement, Parks Section, Parking Enforcement, Corporate Security, Hamilton Fire Department, and Hamilton Police Services - meet three times weekly to strategize around approaches to sites with acute challenges, coordinate encampment response through the City, and address issues via new, innovative approaches that build upon previous experiences. On a daily basis, several divisions are involved in ongoing coordination of frontline efforts to ensure sites are effectively engaged and when necessary, escalated to the appropriate parties who work together to enforce. To ensure the frontline work is well-coordinated, significant administrative work is needed to ensure all incoming communications are logged, new sites are identified and prioritized effectively, with frontline information (i.e., site visits, interactions/engagement with individuals living in encampments, enforcement actions, site clean-ups) about new and existing sites updated across teams within shared repositories on a daily basis. These interactions are the backbone of implementation, and this collaboration has been noted by all partners as being necessary and successful.

In terms of external partnerships, Housing Focused Street Outreach held an initial meeting in February 2024 with community stakeholders and persons with lived experience of homelessness to develop a Terms of Reference that outlines the purpose, values, objectives, and scope of the work. Due to the cybersecurity incident, timelines have been impacted and a next meeting is being rescheduled for May 2024.

Housing Focused Street Outreach will conduct ongoing research with individuals living unsheltered to establish appropriate baselines and to ensure there is ongoing evaluation of the community's needs that also correspond with the program's objectives. This will also provide staff with an opportunity to develop and track more reliable equity-based indicators to assess the impacts on people disproportionally impacted by unsheltered homelessness, which can be used to inform new partnerships and approaches to service.

Service Levels

As per the guidelines established in the Encampment Protocol, Housing Focused Street Outreach (Housing Services Division), Municipal Law Enforcement (Licensing and Bylaw), and Parks Section (Public Works) have service levels associated with their response to encampments. While other divisions (i.e., Parking enforcement, Hamilton Fire Department), and partners (i.e., Hamilton Police Services) are involved via the Coordinated Response Team, they do not have service levels guiding their response.

As of April 15, 2024, Housing Focused Street Outreach has received and visited 472 sites within the scope of the Encampment Protocol. Of the sites with a defined outcome, Housing Focused Street Outreach met its service level of attending and escalating each identified site with 72 hours 89% of the time and escalates 96% of sites to Municipal Law Enforcement within a week of being identified.

Due to the cybersecurity incident, there has been a significant loss of historical data related to Municipal Law Enforcement's service levels. Broadly, given the staffing levels available (i.e., a Municipal Law Enforcement Supervisor and two Municipal Law Enforcement Officers), there have been significant challenges in meeting the defined service level, and Municipal Law Enforcement would require additional staffing, as well as the support of additional Hamilton Police Encampment Engagement team staff to avoid enforcement bottlenecks.

While there are service levels identified within the Encampment Protocol defining clean-ups and site maintenance, Parks Section simultaneously manages routine garbage pickup, ad hoc clean-ups resulting from enforcement actions, as well as complaints and/or service requests, making it challenging to track each specific type of request. Additional mechanisms to track and identify work requests are under development.

Housing-Led Approach

The goal of a housing-led approach is for Housing Focused Street Outreach to be the first point of contact for individuals living unsheltered on public property, to establish rapport and work towards connecting them with services and supports that maintain their well-being, and to only escalate sites with potential compliance concerns to Municipal Law Enforcement (i.e., sites with no clear compliance issues would not be

escalated to Municipal Law Enforcement for investigation). To date, this has been effective during the implementation of the Encampment Protocol, and individuals living unsheltered reported having less or little interaction with Municipal Law Enforcement and Hamilton Police since the Protocol had been established.

Under the existing approach of having compliant spaces available for access, 50% of individuals living unsheltered felt the current approach was working for them. When comparing to a similar survey done in 2022, at a time when there was a 12–72-hour bylaw required individuals living unsheltered to move frequently to new locations, only 10% believed that approach was working for them.

To aide in continuous improvement of service to individuals living unsheltered, Housing Focused Street Outreach has developed several new processes to assist in triaging of complaints and requests, data analysis, and reporting. The new approaches will be used to collect more reliable, accurate systems data from outreach staff to assist with site prioritization and better define the work being completed by outreach staff. Housing Focused Street Outreach is also in the process of adding three (3) peer support workers who will be funded to support rapport-building, harm reduction, and site remediation.

Distance Away from Schools and Childcare Facilities

During the consultation period in summer 2023, and prior to the ratification of the Encampment Protocol, there was significant feedback provided by the public related to the proximity of encampments to places frequented by toddlers and school-aged children. As a result, in the final version of the Protocol the distances were extended from 50-metres to 100-metres away from schools and childcare facilities. This has been successful, with sites being identified near a school of childcare facility dropping from 12% in September 2023, to none in March 2023.

Number of Encampments Per Cluster

The Protocol provides direction regarding number of tents permitted in a cluster and distances between clusters. From the experiences of staff, corroborated through the experiences of a majority of individuals living unsheltered, as well as the complaints data, this has been a successful provision within the Protocol. While enforcement is based upon a five-tent limit, it is common for sites to include tents that are not inhabited, and instead used for storage of food and personal items, which adds to the size of a site. Largely, when sites exceed a manageable number of tents, i.e., approximately five tents, there is a clear increase in the number of associated complaints and concerns with the site.

At a community level, an increase in tents at a site is generally associated with an increase in complaints related to garbage and debris in a concentrated area, more combustibles, violence and use of weapons, and reports of feeling intimidated by the

number of people. In addition, individuals living in encampments also reported concerns with larger sites, included theft, lack of privacy, and varying and at times conflicting lifestyles and goals amongst the people living there.

Additional Protocol Considerations

While the intent of the Protocol is to balance the needs of individuals living unsheltered and the broader community, there were additional considerations made by internal staff and people with lived experience regarding potential changes that would add to the Protocol, as well as modify, and remove existing clauses.

One change to the Encampment Protocol being recommended is the following from Section D, indicating the removal of encampments, temporary shelters, or tents “on or within 50 metres of the Hamilton Alliance for Tiny Shelters model site. For the purpose of this site the full length of the Strachan Linear Park, Bay Street North to Ferguson Street North, will be considered the site.” It has since been confirmed that this area will not be used for the Hamilton Alliance for Tiny Homes pilot project, and to reflect this update, this provision should be removed from the Protocol.

For other potential changes, given that the Protocol has not been implemented for a full year yet and understanding that the warmer months have higher rates of people living unsheltered, more information is required to better understand the impacts of the Protocol prior to recommending any changes. In addition, before a recommendation(s) is made, each consideration would require a comprehensive policy and risk analysis of associated impacts. See Appendix “A” for a detailed list of considerations.

Compliant Spaces

With less required movement of people living unsheltered throughout the city as a result of compliant spaces being available, there are several compliant sites that have had a stable group of individuals living there. This has allowed Housing Focused Street Outreach and other frontline providers to build effective rapport with the same individuals over a longer period of time, leading to more successful outcomes. Both Outreach staff and individuals living unsheltered noted that having a place to stay for longer periods of time was very beneficial, especially when compared to approaches used in the past that required ongoing movement to new areas. However, this approach has been problematic for some neighbours and local businesses nearby who report concerns with an ongoing encampment presence nearby, particularly when there are presenting concerns around health and safety, namely garbage, debris, and waste.

In terms of frequented areas of the city, as expected given the proximity to services and supports, Ward 2 (34%), Ward 3 (29%), Ward 5 (9%), Ward 1 (9%), and Ward 4 (7%) have had the most newly identified encampments in non-compliant spaces, while all other Wards have had less than 5% of the total number of new encampments identified.

In general, the significant majority of encampments are in the lower City. Given the concentration of encampments in lower City wards, it is anticipated that this may lead to an increase in sites with numerical non-compliance (i.e., five or more tents, lack of distance between clusters), geographically non-compliant sites (i.e., proximity to), and more tents within escarpment areas during warmer weather months when historically more people live outside.

Safety Concerns

Concerned citizens and local businesses have detailed several health and safety issues in their complaints to Housing Focused Street Outreach, such as light posts being compromised for electricity, human waste exposure, and personal safety concerns. Businesses have detailed that the presence of encampments has negatively impacted their operations. This has led to significant frustration amongst all parties.

Several encampment residents who were interviewed also expressed concerns for their safety, sharing instances where their presence had resulted in confrontation from neighbours and youth.

Enforcement Challenges

The consistent enforcement of sites has been impacted by a lack of staffing available to manage the responsibilities of the portfolio. Currently, there are two Hamilton Police Services Encampment Engagement Team officers responsible for attending all site visits with Municipal Law Enforcement officers, coordinating and leading private property enforcement and the enforcement of sites on public property. With a high number of non-compliant sites resulting from the disbandment of larger sites like Woodlands Park and City Hall, and in using a hands-off approach to enforcement, the time required to enforce requires more resources than currently allocated.

Since Hamilton Police's Encampment Engagement Team was established in September 2023, the team has attended 441 encampment site visits. Some of these visits are supporting the issuing of 419 Trespass Notices by Municipal Law Enforcement Officers. In addition, Hamilton Police Service's Encampment Engagement team has spent a total of 248 hours enforcing previously issued notices. This does not include time spent assisting other agencies and enforcing encampments on private property.

Contributing to the time spent enforcing previously issued notices are several locations within the city that are often habitually occupied by encampments. Some examples include MacNab St S and Hunter St W, Jackson St W and MacNab St S, Vine between Park and York, and the Hamilton Convention Centre alcoves on King St W. Given the proximity of these sites/areas to community resources and services that meet the basic needs of individuals living unsheltered, these sites quickly re-establish after enforcement has occurred with new occupants, triggering a new round of engagement

and enforcement. In addition, other street-related concerns not related to encampments are often grouped under the heading of encampments, including loitering and illegal dumping or garbage. These issues, although not related to encampments and more frequently associated with mental health and substance abuse issues, are brought to the attention of the City via the unsheltered inbox These sites are also resource-intensive for Municipal Law Enforcement and Housing Focused Street Outreach to assess and address.

Recreational Vehicles and Trailers

Since the Encampment Protocol was adopted by Council, a growing number of locations throughout the city have been occupied by individuals inhabiting within Recreational Vehicles (RVs) and trailers. Many of the RVs and trailers being inhabited also have had additional semi-permanent structures built into them. With existing Parks Bylaws already governing the use of RVs and trailers, particularly for habitation, as well as several other Parking-related violations, the use of these vehicles in this manner is not compliant and there are no designated areas for free parking of Recreational Vehicles or trailers on public lands in the City of Hamilton.

To support this work, the City's Parking Enforcement team has joined the Coordinated Response Team to provide best practices related to managing these concerns, and in coordination with Housing Focused Street Outreach, has allowed for Outreach staff to visit individuals to ensure they are provided with additional options and resources prior to enforcement.

Fire and Combustibles

The use of fire pits and other combustibles by individuals who are unsheltered to maintain warmth during colder months has resulted in several complaints and concerns from neighbours of sites who feel at risk. The Hamilton Fire Department has been actively engaged with incidents related to encampments, categorized into those necessitating emergency response and those that do not. The main types of incidents responded to include burning complaints, rubbish fires, and calls for medical assistance. In January 2023, burning complaints were the predominant response call-type, numbering 31 responses. During such responses, fire-related situations are promptly extinguished, and encampment occupants are reminded of the open-air burning by-law.

The Hamilton Fire Department, in collaboration with the Housing Focused Outreach team, developed a printed resource to increase fire safety awareness and support educating people living unsheltered. Approximately 800 of these two-sided, non-destructible flyers were distributed to resource centres and the City's Encampment Response Team in early 2024. In addition, in January 2024 a representative from the Hamilton Fire Department joined the City's Coordinated Response Team to provide ongoing support and best practices related to coordination and risk mitigation at sites.

An important aspect to note is that application of the Ontario Fire Code principally pertains to buildings and structures but does not apply to tents smaller than 30m² used for camping, personal, or non-commercial purposes. Additionally, the Fire Department is not licensed to remove or transport hazardous materials (including propane cylinders). As such, there is currently no defined process for removal of flammable or combustible materials.

Washroom Access

The need for access to washrooms was echoed by several individuals living in encampments who want the option of using facilities nearby, as well as community partners who provide frontline service. Housing Focused Street Outreach has received several complaints from members of the community reporting human waste requiring clean up or wanting portable washrooms at compliant sites.

To address some of the concerns, two washroom programs were established at central locations within the city and are available on a 24/7 basis. Individuals encamped near washroom programs (i.e., JC Beemer, Corktown Park) report it as one of the reasons they stay nearby but given logistical concerns in counting users of the washrooms who are experiencing homelessness, staff were unable to identify the frequency individuals access the 24/7 washrooms.

In September 2023, shower programs were also established within two locations within the City, Norman Pinky Lewis Recreational Centre, and Bennetto Community Centre. Previously, the City operated a shower program at Eastwood Arena, but due to low uptake (33 visitors over 15 weeks), the program was moved to Bennetto in January 2024, which has seen a mild increase in uptake (6 per week, vs 2 per week). In contrast, Norman Pinky Lewis has seen an average of 14 individuals experiencing homelessness utilize the service each week. More work is required to better understand barriers to service use.

Garbage and Debris Pickup

Housing Focused Street Outreach received several complaints describing parks as being unusable due to the presence of garbage and debris. As individuals move to compliant sites and stay in a single place for longer periods of time, they often accumulate more items at the site, particularly during colder weather months. As a result, the number of complaints related to garbage and debris has maintained at the same level (67-80 requests per month), despite a significant decrease to the number of sites and overall complaints and requests for service.

To facilitate clean-ups at sites across the city, the Parks Section has created a schedule to assist in managing garbage and debris pickup at encampments. To ensure adequate coverage, larger sites that may contain more than one cluster or are currently non-

compliant with five or more tents are attended to every other day given the level of need, while smaller sites are visited at least once a week.

Managing clean-ups throughout the city can be challenging given that there are ongoing ad hoc requests made of Parks section staff, sometimes related to sites being vacated or recently vacated. As such, a consistent, planned schedules for all sites is not possible. In the meantime, all known encampment sites visited by Parks section are offered garbage bags to help mitigate the spread of garbage and debris, and staff coordinate with individual(s) at the site to detail the location to leave bagged garbage, and approximate time of next pickup.

Additionally, there have been concerns about garbage/debris on private property associated with encampments, which is presently not within the City's scope of work. To alleviate the burden on members of the public to clean up after garbage/debris has been left on their property, Public Works is bringing forward a recommendation report in May 2024 to suggest an approach to address and mitigate these concerns.

Special Events

Throughout the year, the City of Hamilton, and its partners host community events on public lands across the city. As part of holding events the Special Events Advisory Committee (SEAT) reviews the operational details to ensure the health and safety of participants and City assets (parks, roads). Occasionally, some of the 350+ events held each year are planned in spaces already occupied by encampments in a compliant location.

With no specific clause in the Encampment Protocol delineating a process for managing co-location and given the mental health impacts of moving individuals from their compliant space, individual(s) in residing in compliant locations will not be moved as a result of an upcoming or planned event. As encampments move throughout the City, particularly in the summer months, this can lead to tensions and challenges amongst event organizers and City staff that are managed on a case-by-case basis.

Barriers to Housing and Emergency Shelter

Without identified outflow from encampments into indoor spaces such as emergency shelter, temporary or transitional housing, or permanent housing, encampments are likely to maintain or increase in total.

Individual(s) living unsheltered reported several barriers to emergency shelter, including a lack of pet-friendly and couples' spaces, harm reduction friendly policies, privacy concerns, and requirements to leave and return to secure a bed every day, that precluded them from wanting to access the service. When asked if they would consider accessing spaces in the emergency shelter system more suitable to their needs (i.e.,

some of the barriers to access were potentially reduced), 71% were interested. To reflect this need, Housing Services division continues to explore various program models aimed at providing more inclusive service.

To address the impacts of colder weather and increasing need, in 2023-24 Housing Services Division introduced a number of services and supports aimed at providing greater access to warm, indoor spaces, particularly for individuals who are less likely to access traditional service models and may spend time in encampments. Services offered included the warming bus which operated in cold-weather months overnight and was staffed by two outreach employees, extended hours at resource centres and libraries for individuals looking for immediate respite from colder weather, 45 overnight spaces at Willow's Place, and 50 warming spaces at Good Shepherd Cathedral. Given the benefits associated with the City's Winter Response Strategy and the ongoing need for indoor space, particularly for hardest-to-reach populations, these services have been extended until November 30, 2024. An investment in resources within the Family Shelter system allowed for additional support services for clients in this sector.

Housing also continues to be difficult to acquire for individuals living in encampments, especially those who may require supports that assist in their transition. While many of the individuals living outside had connected with housing workers and were on the Access to Housing waitlist, many still felt unsupported, and shared little to no hope in acquiring housing. While the Encampment Protocol has been developed to provide clarity and balance the needs of individuals living unsheltered and the broader community, and with the knowledge that other approaches (i.e., sanctioned sites) have been considered that would provide temporary relief at high costs, the goal is to use resources towards permanent, humane, cost-effective solutions such as housing. To this end, Housing Service Division has identified resources and strategies that would effectively end chronic homelessness in Hamilton and will be bringing a report with actionable recommendations for Council to consider in June 2024.

To ensure individuals are able to stay in their housing, the City of Hamilton is currently implementing the expanded Tenant Support Program as approved by City Council to help stop vulnerable tenants being displaced and possibly entering into the homelessness serving system. This expanded program includes a partnership with the Hamilton Community Legal Clinic to provide legal support for tenants facing displacement through N-13 and N-12 notices. Additional supports as part of this program are outreach services to tenants through ACORN Hamilton and housing plans and support for tenants who do need to be displaced because of legitimate renovations through the Housing Help Centre Hamilton and Area.

The issue of homelessness and related issues of addiction and mental health continue to cause pressures across the housing and homelessness system and beyond. These are multi-faceted complex issues, and the continuously growing needs are pressuring the capacity of the existing systems. In addition, the issues are challenging and cross-

departmental in nature, often extending beyond city departments. This is demanding work and has an impact on the City staff working on these issues.

Despite the challenges there are opportunities for us, as a City, to have a positive impact with time. The encampment protocol is not a solution to homelessness, it continues to be a means to manage the crisis within our City providing some stability and options for people experiencing homelessness, however, continued commitment to more solution focused measures is needed in accompaniment with the protocol.

ALTERNATIVES FOR CONSIDERATION

N/A

APPENDICES AND SCHEDULES ATTACHED

Appendix “A” to Report HSC24020/PED24080/PW24030 – Additional Encampment Protocol Considerations

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

Request to Admit dated June 24, 2024

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TAB 151

Court File No. CV-21-77187

ONTARIO
SUPERIOR COURT OF JUSTICE

B E T W E E N:

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SHERRI OGDEN, JAHMAL PIERRE, LINSLEY GREAVES and PATRICK WARD

Applicants

and

CITY OF HAMILTON

Respondent

APPLICATION UNDER RULE 14.05 OF THE *RULES OF CIVIL PROCEDURE*

RESPONSE TO REQUEST TO ADMIT

In response to the Applicants' Request to Admit dated June 7, 2024, the Respondent:

1. Admits the truth of facts numbers: None.

2. Admits the authenticity of the following documents: 1.

3. Denies the truth of facts numbers: 2.

4. Denies the authenticity of documents numbers: None.

5. Refuses to admit the truth of facts numbers: None. See response at paragraph #3 above.

6. Refuses to admit the authenticity of documents numbers: None. See response at paragraph #2 above.

June 26, 2024

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Court File No. CV-21-00077187-0000

KRISTEN HEEGSMA et al. - and - CITY OF HAMILTON

Applicants Respondent

ONTARIO
SUPERIOR COURT OF JUSTICE

PROCEEDING COMMENCED AT HAMILTON

RESPONSE TO REQUEST TO ADMIT

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File No. H227899

TAB 152

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

APPLICATION UNDER RULE 14.05 OF THE *RULES OF CIVIL PROCEDURE*

RESPONSE TO REQUEST TO ADMIT

In response to the Applicants' Request to Admit dated June 25, 2024, the Respondent:

1. Admits the truth of facts numbers: None.

2. Admits the authenticity of documents numbers: See paragraph 6 below.

3. Denies the truth of facts numbers: 3.

4. Denies the authenticity of documents numbers: See paragraph 6 below.

5. Refuses to admit the truth of facts numbers: None.

6. Refuses to admit the authenticity of documents numbers 1 and 2:

(a) Document 1: The Respondent refuses to admit the authenticity of the “City of Hamilton, Healthy and Safe Communities Department, Housing Services Division, June 19, 2024* “Reducing Homelessness and Managing Encampments (HSC24027) (City Wide), Tab 1 Microsoft Word - HSC24027 - Reducing Homelessness and Managing Encampments Report (escribemeetings.com)” in the form presented in the Applicants’ June 25, 2024 Request to Admit, as it is not possible to admit the authenticity of a hyper-link.

The Respondent admits the authenticity of the preserved copy of report entitled “Reducing Homelessness and Managing Encampments (HSC24027)” which was accessed at and preserved from the web ad-dress https://pub-hamilton.escribemeetings.com/filestream.ashx?DocumentId=412632

on July 15, 2025, and which is attached as Tab 1 to this Response to Request to Admit.

(b) Document 2: The Respondent refuses to admit the authenticity of the “City of Hamilton, Healthy and Safe Communities Department, Housing Services Division, Appendix A to Report HSC24027, Tab 2 filestream.ashx (escribemeetings.com)” in the form presented in the Applicants’ June 25, 2024 Request to Admit, as it is not possible to admit the authenticity of a hyper-link.

The Respondent admits the authenticity of the preserved copy of the document titled “Appendix “A” to Report HSC24027” which was accessed at and preserved from the web address https://pub-hamilton.escribemeetings.com/filestream.ashx?DocumentId=412633

on July 15, 2025, and which is attached as Tab 2 to this Response to Request to Admit.

July 15, 2024

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Counsel to the Applicants

TAB 1

CITY OF HAMILTON
Healthy and Safe Communities Department
Housing Services Division

TO:	Chair and Members General Issues Committee
COMMITTEE DATE:	June 19, 2023
SUBJECT/REPORT NO:	Reducing Homelessness and Managing Encampments (HSC24027) (City Wide)
WARD(S) AFFECTED:	City Wide
PREPARED BY:	Shannon Honsberger Danielle Blake Rob Mastroianni
SUBMITTED BY:	Michelle Baird Director, Housing Services Division Healthy and Safe Communities Department
SIGNATURE:	

RECOMMENDATIONS

(a) That staff report back with the results of a call for information on the feasibility and costs associated with creating new shelter beds with 25% being pet friendly, in the following bed numbers: Men's singles: 110, Women's singles: 50, Couple's: 55.

(b) That Council approve enhancements to the homeless-serving system for an approximate cost of $1,556,000 between August 1 and December 31, 2024, to be funded first from any available government funding, then from any 2024 Housing Services Division surplus, then from any 2024, Healthy and Safe Communities Departmental Surplus, and lastly from any 2024, Corporate Surplus or any source deemed appropriate by the General Manager of Corporate Services; and that those enhancements are as follows:

(i) approximately $940,000 be added to enhance existing shelter operator contracts by 25% to rectify historic underfunding;

(ii) approximately $266,000 in additional funding to enhance the Hamilton Regional Indian Centre's indigenous drop-in program;

(iii) approximately $210,000 to enhance Rapid Rehousing and Intensive Case Management supports to improve outflow from shelters into permanent housing;

(iv) approximately $40,000 be approved for one full-time equivalent for Housing Service Division to provide tax filing support for those experiencing homelessness; and

(v) approximately $100,000 to be provided to housing landlords for exceptional unit damage as a result of housing an individual from City-funded case management programs.

(c) That staff be directed to prepare a motion to amend the Encampment Protocol to mitigate impacts on those living in and around encampments as outlined in Appendix “A”, which was approved by Council on August 18, 2023, including:

(i) removing the following provision from Section D, indicating the removal of encampments, temporary shelters, or tents “on or within 50 metres of the Hamilton Alliance for Tiny Shelters model site. For the purpose of this site the full length of the Strachan Linear Park, Bay Street North to Ferguson Street North, will be considered the site.”;

(ii) adding an exclusion from allowing encampments, temporary shelters, or tents for the full length of the Strachan Linear Park, Bay Street North to Ferguson Street North until further park development options can be explored;

(iii) Establishing a minimum distance of 100m for additional sensitive uses, specifically around funeral homes and long-term care residencies as well as spaces that are designed and programmed for children as an amendment to the encampment protocol;

(iv) Amending the requirement to keep 5 metres from sidewalks during the winter months to be a full year requirement, and to include walkways and pathways in this requirement; and

(v) Establishing a minimum 25m distance from active construction sites

(d) That Council approve additional investments into encampment management, for an approximate cost of $286,000 between August 1 and December 31, 2024, to be funded first from any available government funding, then from any 2024, Housing Services Division surplus, then from any 2024, Healthy and Safe Communities Departmental Surplus, and lastly from any 2024, Corporate Surplus or any source deemed appropriate by the General Manager of

Corporate Services; and that those enhancements are as follows:

(i) approximately $108,000 be approved to increase Housing-Focused Street Outreach support;

(ii) One permanent FTE to provide program coordination, at an approximate cost of $48,000;

(iii) Make permanent one Community Services Program Analyst FTE supporting the Housing Focused Outreach Team, at an approximate cost of $42,500;

(iv) approximately $130,000 to provide two Social Navigator Paramedic by Hamilton Paramedic Service; and

(e) That the following items be referred to the 2025 municipal tax operating budget for an annual cost of $4,186,000

(i) approximately $2,255,000 be added to enhance existing shelter operator contracts by 25% to rectify historic underfunding;

(ii) approximately $400,000 for ongoing operations of the Hamilton Regional Indian Centre's indigenous drop-in program;

(iii) approximately $500,000 for enhanced Rapid Rehousing and Intensive Case Management supports to improve outflow from shelters into permanent housing;

(iv) approximately $90,000 for one permanent full-time equivalent for Housing Service Division to provide tax filing support for those experiencing homelessness;

(v) approximately $250,000 for exceptional unit damage because of housing an individual from City-funded case management programs;

(vi) approximately $266,000 for increased Housing-Focused Outreach support;

(vii) One permanent FTE to provide program coordination, at an approximate cost of $115,000;

(viii) Make permanent one Community Services Program Analyst FTE supporting the Housing Focused Outreach Team, at an approximate cost of $100,000;

(ix) approximately $310,000 to provide enhancements for two Social Navigator Paramedics by Hamilton Paramedic Service; and

(f) That the appropriate General Managers of Public Works and the Healthy and Safe Communities Department or their designate be directed and authorized, on behalf of the City of Hamilton, to enter into, execute and administer all agreements and documents necessary to implement recommendations (a) and (b), inclusive of all sub-sections, outlined above on terms and conditions satisfactory to the respective General Manager or their designate and in a form satisfactory to the City Solicitor.

(g) That two Outstanding Business items be removed from the list including:

(i) A 2023 OBL item respecting increasing beds in Residential Care Facilities

(ii) A 2023 OBL Item respecting reporting back on a proposed investment ratio for Housing Services Division

EXECUTIVE SUMMARY

This report follows Report HSC240020/PED24080/PW24030, Encampment Observation Report, to provide recommendations on how the City may reduce instances of acute and chronic homelessness in the community and reduce impacts of encampments on neighbourhoods. This work is rooted within the housing continuum, with recommendations to better connect those covered under the encampment protocol to emergency shelter and outflow supports, and subsequently into more permanent housing solutions as governed by the Housing and Homelessness Action Plan and Housing Sustainability Investment Roadmap.

The high rates of homelessness in Hamilton are a shared issue influenced and intensified by the failure to increase Ontario Works and Ontario Disability Support Program rates; rising inflation, interest rates, and the cost of living; an influx of refugee claimants and asylum seekers; and an extreme shortage of affordable and deeply affordable housing options exacerbated by bad faith renovictions. As the Service Manager for Hamilton, staff continue to assess whether enhancements are needed to manage demand, but also advocate with government partners and prioritize investment into homelessness prevention and outflow supports.

That said, Hamilton’s response to the homelessness crisis is improving. The most recent data shows that vacancy in CityHousing Hamilton units decreased from 9% in March 2023 to 5.5% in April 2024, and is on track to a target of 2% vacancy by the end of the year. CityHousing Hamilton has also completed 66% of repairs that were funded by Council, and is on track to complete these repairs by November. There has also been successes in homelessness services, like the reduction of family hotel stays from 400 in 2023 to 87 days in 2024. This is largely due to the concerted efforts of community partners, City investments, and forward-thinking policy decisions. Work

continues to implement the interventions approved as part of Report HSC23041: Addressing the Needs of Unsheltered Individuals and those Relying on Hamilton's Emergency Shelter System (HSC23041), and those approved in Budget 2024. Despite some successes, the demand for services continues to be larger than the available or approved resources and the number of encampments in Hamilton continues to be high. We know that the shelter system is consistently at 99-100% occupancy with many individuals and families being turned away each night. While we continue to provide 52 hotels rooms (or 208 beds) as overflow, this paired with the current capacity of 345 permanent and 20 temporary shelter beds does not come close to meeting the needs of the roughly 1592 people experiencing homelessness in the City. The need for shelter spaces is not easily quantifiable, as there is no accepted model of need per capita, and Hamilton has several social and econonomic factors that increase our need compared to other similar sized cities. Also contributing to a lack of shelter outflow is a shortage in available Long Term Care beds, limiting options for seniors experiencing homelessness. To improve our sector's ability to respond to the continued homelessness crisis and reduce the resulting impacts on other areas of the City, staff are recommending a variety of investments into encampment management, the shelter system, and outflow supports. This is intended to improve the rate at which individuals and families can be served within the emergency system and enter permanent housing, thereby reducing the prevalence of encampments in Hamilton.

Recommendations to reduce instances of homelessness include:

- Conducting a Call for Information to assess the costs associated with expanding the shelter system.
    - This recommendation would seek information from shelter operators the costs associated with adding 110 single men, 50 single women, and 55 couple spaces with 25% being pet friendly, to right-size the shelter capacity and close known service gaps for pet owners and couples. Staff will return with this information, as well as any additional resources needed to support that expansion including staff resources as well as potential investments into outflow supports like rent supplements.

- Approving a one-time adjustment of shelter operating costs by 25%
    - This is in recognition of historic underfunding across the last two decades and is intended to bring operations to a more appropriate baseline. The 2023 approval for cost-of-living adjustments would continue and better support funding adjustments.

- Enhance funding for Indigenous drop-in spaces, an important support for connecting individuals with culturally appropriate programs
    - funding for a portion of this program expired in March 31, 2024 despite this program being a critical support and entry point for unhoused indigenous people in Hamilton.

- A 10% funding increase to case management programs to expand caseloads as well as improve the quality of supports provided.

- Improving access to and prioritization of unhoused individuals on the Access to Housing Waitlist
    - Staff are recommending one Housing Services Clerk to help clients file their taxes, an identified barrier to completing an Access to Housing application.
    - Within current complement, staff will be reviewing the prioritization of homeless individuals on the waitlist to increase the rate of offers being provided to individuals on the By-Name-List. Any changes to the process would be brought to Council for approval.

- Beginning a Landlord Engagement program whereby staff can support landlords that house individuals out of homelessness.
    - As part of this program, staff are recommending providing up to $250,000 in financial aid to landlords experiencing excessive unit damage.

Recommendations to mininimize unintentional consequences of encampments include:

- A variety of updates to the Encampment Protocol, as shown in Appendix “A” to Report HSC24027, including
    - Including a minimum distance of 100 metres around funeral homes, long-term care facilities and spaces that are designed and programmed for children as an amendment to the encampment protocol; in recognition of family members attending these locations, as well as a minimum distance around construction sites of 25m for the safety of those living encamped.
    - Extending the requirement of a minimum distance from sidewalks of 5m during winter to accommodate snow clearance to be a full year requirement to address concerns around walkways and sidewalks.

- Increased resourcing for the Housing-Focused Outreach Team to
    - better resource winter response programs and address rising encampment numbers in the warmer months.
    - Create a permanent program coordinator to coordinate inquiries from the public, internal stakeholders and members of Council.

- Increase services to those living in encampments and those around encampments through:
    - Enhancing the Social Navigation Program provided by Hamilton Paramedic Services and Hamilton Police Services. This program provides short-term intensive case management, including assessments, connection to experts,

point-of-care testing and wound care to improve the health outcomes of those living unsheltered.

Recommendations to remove items from the Outstanding Business List include:

- Expanding Residential Care Facilities
    - Residential Care Facility subsidies are funded through provincial funding which is currently fully expended with no anticipated increase. Further, there are consistently vacancies in the program based on low demand. Staff do not recommend spending further funding on a program that may not get utilized
- Housing Investment Ratio
    - Staff researched this area further and have not found reliable data to inform a recommendation to Council. Without reliable data, staff are not able to recommend an evidence-based approach and recommend continuing efforts to promote prevention of homelessness and outflow supports with the eventual goal of reducing funds directed towards emergency supports in accordance with decreasing demand in the community.

In addition, staff are recommending one confidential item to be considered in closed session. The closed session recommendation pertains to staff recommendation to make the Community Services Program Analyst a permanent position. This position supports data collection and analysis for the encamped population to inform management of encampments and improving services for those living unsheltered.

With these investments, as well as continued quality improvement work within the Division, we can create capacity within shelter and housing supports to accommodate more of those living in encampments, accelerate and improve housing outcomes for those already in receipt of emergency supports, and reduce the impacts of encampments on those living or working nearby.

Alternatives for Consideration – Page 14

FINANCIAL – STAFFING – LEGAL IMPLICATIONS

Financial: There are financial implications to recommendations (c) and (e). Most are prorated in 2024 to begin funding in August 2024, however the Hamilton Regional Indian Centre is prorated to April, as there was previously available funding that concluded March 31, 2024.

Recommendation	2024 Cost (approximate)	Annualized Cost (approximate)
Closed session recommendation (a)	$42,000	$100,000

Recommendation	2024 Cost (approximate)	Annualized Cost (approximate)
(c)(ii) Shelter operating costs	$940,000	$2,255,000
(c)(iii) HRIC Drop-In	$266,000	$400,000
(c)(iv) Case management	$210,000	$500,000
(c)(v) Tax Filing Resourcing	$40,000	$90,000
(c)(vi) Unit Repairs	$100,000	$250,000
(e)(i) Housing Focused Outreach Resourcing	$108,000	$266,000
(e)(ii) Program Coordination	$48,000	$115,000
(e)(iv) Social Navigators	$130,000	$310,000
Total	$1,884,000	$4,286,000

Staffing: Staff recommend 3 additional permanent FTEs, one each for data collection, tax filing, and program coordination. The remaining work would be completed within existing complement or as an enhancement to an existing contract.

Legal: support is needed to develop and review contracts.

HISTORICAL BACKGROUND

On March 23, 2023, the Ending Chronic Homelessness Report (HSC23021) was received by Council. The report provides an outline of the comprehensive approach and investments required to end chronic homelessness in Hamilton. A performance update on Q1 and Q2 was provided to council on November 16, 2023 (HSC23076).

The Housing Sustainability and Investment Roadmap (HSIR) was published in April 2023 and updated in November 2023. This roadmap builds upon the Housing and Homelessness Action Plan. On April 19, 2023, the General Issues committee approved report HSC23028/FCS23055/PED23099 Housing Sustainability and Investment Roadmap to guide affordable housing issues cross-departmentally.

August 14, 2023, the report Addressing the Needs of Unsheltered Individuals and those Relying on Hamilton's Emergency Shelter System (HSC23041) was presented to Council. The report identified that the number of individuals living unsheltered and the number of individuals who are homeless continues to rise in Hamilton and the shelter system continues to be over capacity. This report included recommendations to continue funding shelter overflow beds for families and make investments into shelter bed expansion and homelessness prevention.

On August 18, 2023, Council adopted and ratified an Encampment Protocol in Encampment Response Update – August 2023 (HSC23066), identifying approaches, processes, and service levels associated with responding to encampments in the City. In addition, Council provided necessary resources in staffing and equipment to support the implementation of the Protocol. While a broad approach involving sanctioned sites was not recommended by Staff due to its prohibitive costs better utilized in prevention efforts and/or housing, Council also approved a two-year Hamilton Alliance for Tiny Shelters pilot for up to 25 tiny homes on City lands at no cost to the City. The City was asked to provide a location, and while the City continues to work with HATS to secure a location, none has yet been agreed upon.

The Annual Winter Response Strategy (HSC23012) was approved by Council in September 2023 and an amendment was made in March 2024 (HSC23012(a)) to extend the response from April 2024 until December 1, 2024, as it has been demonstrated that the need for services in the community continues beyond the winter season.

The Encampment Observation Report (HSC24020 / PED24080 / PW24030) was presented to General issues Committee on May 17, 2024 which detailed information around the first eight months of using the Encampment Protocol. It also recommended returning to Council with recommendations on how to reduce homelessness, and staff were directed to include recommendations on reducing the impact of encampments on neighbourhoods.

The Housing and Homelessness Action Plan (HHAP) was published in 2013 and updated in 2020 demonstrating Hamilton's commitment to ending homelessness. In 2019, the Coming Together to End Homelessness report was published, which provides an outline of Hamilton's strategy to end homelessness.

RELEVANT CONSULTATION

In July 2022, The Social Planning and Research Council of Hamilton released a key findings report, *Hamilton Post-Pandemic Emergency Shelter Size Review* for the City of Hamilton. This was included as Appendix "A" to Report HSC23041. The preparation of this report included interviews and focus groups with agencies providing shelter services, outreach, diversion, and prevention, and/or drop-in services. Qualitative data was also gathered in consultation with partners from Indigenous-led agencies, youth, women's, men's and family services as well as service providers that provide outreach services to shelter clients and unsheltered populations. This report includes recommendations for prioritization of additional supports in the shelter system including prioritizing the Indigenous community, safe and deeply affordable housing with supports, staff recruitment and retention, and an increase in emergency shelter responses particularly for the Indigenous, women's and family sectors.

The November 2023 Report HSC23076, Ending Chronic Homelessness Performance Update, included performance results that had been provided, reviewed, or confirmed by representatives from the individual reporting programs through multiple engagement sessions and data collection points. At that time a full list of the reporting and engagement opportunities was included as Appendix “B” to Report HSC23076.

In November 2023, the Homelessness Policy and Programs team from the City of Hamilton’s Housing Services Division hosted an event entitled *Coming Back Together to End Homelessness*, bringing together community partners from across the homeless-serving sector, healthcare, settlement services, social housing providers, and people with living experience to learn from each other, collaborate, and to discuss opportunities for greater impact in ending homelessness. Discussions highlighted strengths of the sector, areas for improvement and acknowledgement of the existing challenges and limitations experienced in the sector.

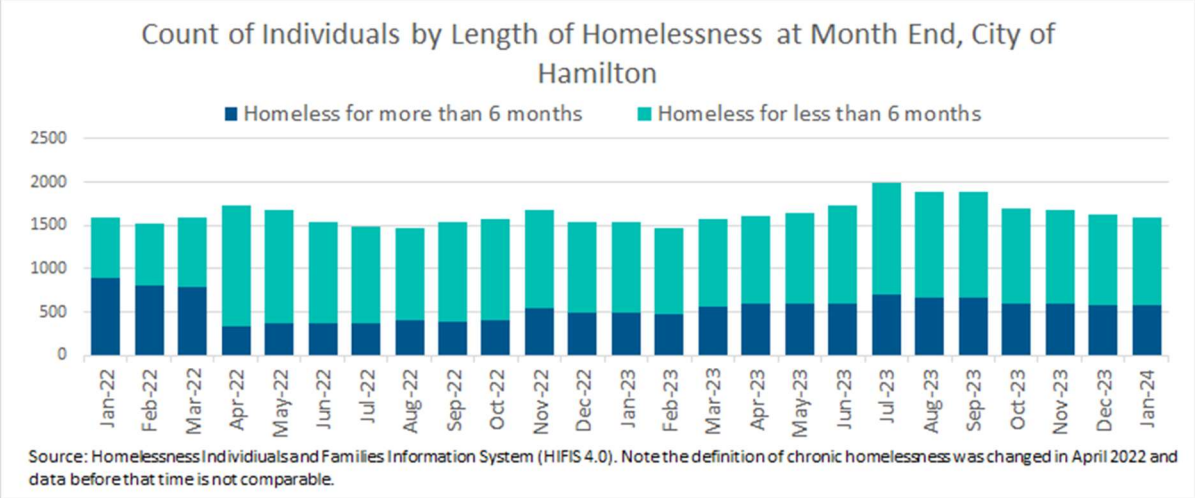
Since the establishment of the Encampment Protocol in August 2023, the operation of a centralized inbox allows staff to respond quickly to community correspondence and monitor community perspectives. Concerned citizens make up 31% of the correspondence with the Housing Focused Street Outreach team, the other categories include Municipal Law Enforcement (15%), Public Works (12%), Councillor’s Offices (11%), the City’s Contact Centre (10%), as well as other groups in less significant numbers such as Hamilton Police, Business Improvement Areas, schools and hospitals.

Staff also worked closely across Planning and Economic Development, Public Works, and Healthy and Safe Communities to determine areas for improvement.

ANALYSIS AND RATIONALE FOR RECOMMENDATION

While the data availability has been hampered by the cyber-security incident, staff do have trend-level data up until January, as well as informal data collected through weekly visits to encampments that has informed the recommendations within this report. Figure 1 shows population count across the last two years, divided by length of homelessness.

Figure 1: Count of Individuals by Length of Homelessness at Months End[1]



An important factor in this graph is the proportion of individuals experiencing homelessness for more than 6 months. These individuals are often of higher acuity, and in need of more services to become "rent-ready" and successful in maintaining their housing. As such, they are often clients within the Rapid Rehousing and Intensive Case Management programs. There has been between 500 and 700 individuals in that category across 2023. To ensure that more individuals gain access to these supports, staff recommend increasing funding to these programs to increase the caseload capacity and improve service.

Figure 2: Approximate Demographics of Those Living Unsheltered

Current Approximate Total Number of Individuals Living Unsheltered in Hamilton: **205**					
Demographic Breakdown:					
Couples		Singles (Males)		Singles (Females)	
41 (*82 individuals)*		84		39	
Couples with Pets	Couples without Pets	Single Males with Pets	Single Males w/o pets	Single Females with Pets	Single Females without Pets

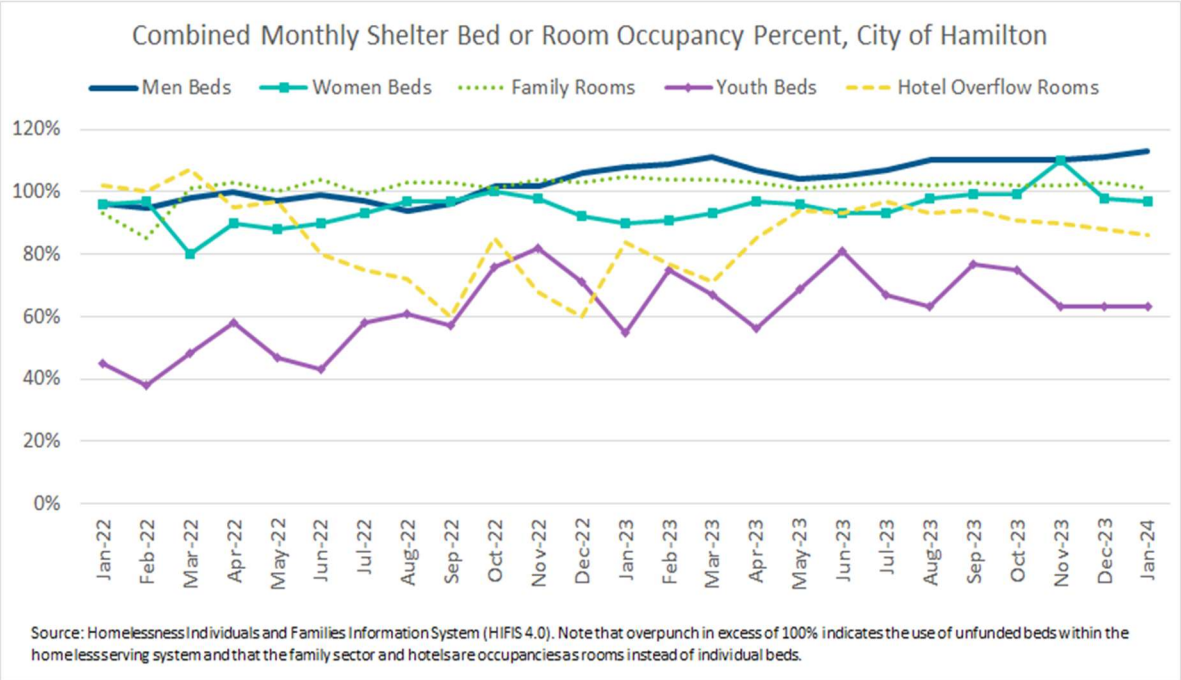
[1] Note: the increase in the total count of individuals increasing in the summer of 2023 was a result of changes in data reporting. The count of individuals is consistently approximately 1600.

11 *16 dogs total*	30	19 *20 dogs total*	65	9 *18 dogs total* *6 cats total*	30
Total People with Pets: 50 (18 individuals, 11 couples) **Total Pets:** 60 (54 dogs, 6 cats)					

Further, Housing-Focused Outreach staff maintain an informal count of individuals living in encampments. There are currently over 90 encampment sites with over 200 individuals. While there will always be individuals who prefer to live outside, there are individuals who would shelter within City-funded programs if there were appropriate spaces. However, city-funded shelters are consistently at, or over, capacity (Figure 3). In addition to these capacity pressures, there are gaps in service for individuals with pets and couples without children. Because there is no space for those who are unwilling to access shelter separately from their partners, these individuals often chose to live in encampments. Without additional resources in these targeted areas, encampments are likely to persist. As such, staff used peak encampment population numbers, plus 10%, from last summer to develop the number of new shelter beds to consider funding through the recommended Call for Information.

Drop-in programs are funded, in part, to capture individuals who are not otherwise sheltered. However, a critical drop-in program serving the indigenous population recently lost some of their funding and had to downsize their program. To rectify this, for an already over-represented group within the homeless population, staff recommend the City fund the gap.

Figure 3: Combined Monthly Shelter Bed or Room Occupancy Percent

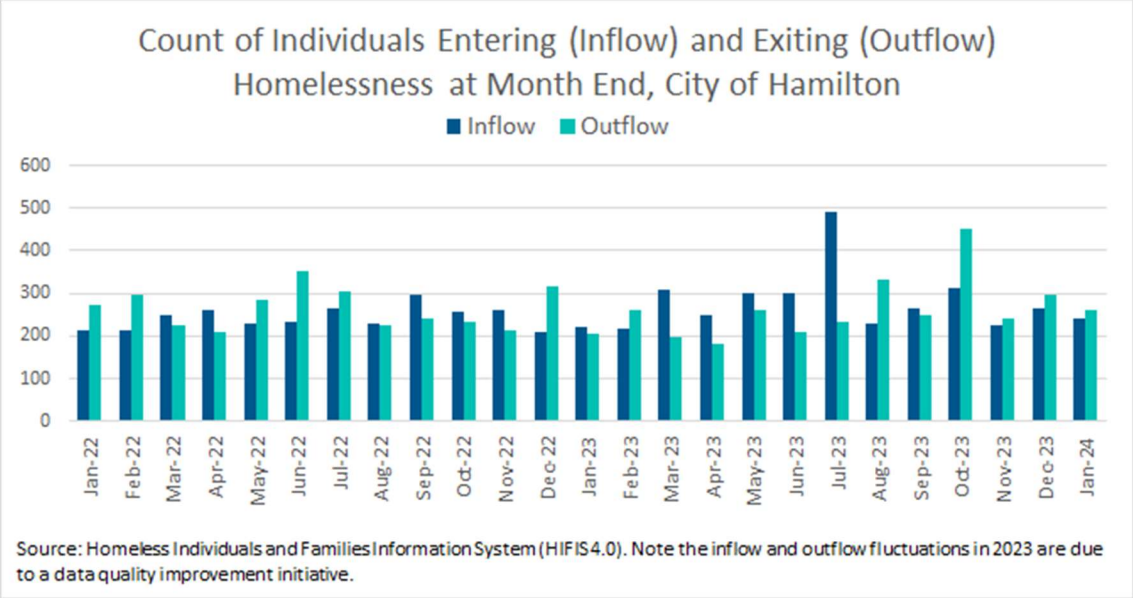


Source: Homelessness Individuals and Families Information System (HIFIS 4.0). Note that overpunch in excess of 100% indicates the use of unfunded beds within the homelessserving system and that the family sector and hotelsare occupanciesas rooms instead of individual beds.

In tandem with the high demand for services, shelter operators are been chronically underfunded. As part of Budget 2023, Council approved an ongoing cost-of-living adjustment for all City-Funded shelters. While this assuages issues of continued underfunding, it does not resolve the cumulative effect over the past several years. Staff are recommending a percentage increase to all shelter contracts to reestablish more appropriate funding levels. This percentage rate is based on the percentage of total operating costs that operators augment through other funding sources such as donations. This other funding ranges between approximately 12 and 35% of their total operating costs.

Inflow and Outflow are the terms used to describe those entering and exiting the emergency support system. Figure 4 depicts the rate of inflow and outflow, including an increase to inflow between February and July 2023. This aligns with the observed increase in encampments over last summer. However, outflow numbers improve from August onward as population numbers decreased. Investments into prevention of inflow and accelerated outflow is how the City can reduce overall reliance on the emergency system. Some factors which influence inflow remain outside of the City's control, however, including the rate of asylum seekers and refugee claimants that choose to settle in Hamilton.

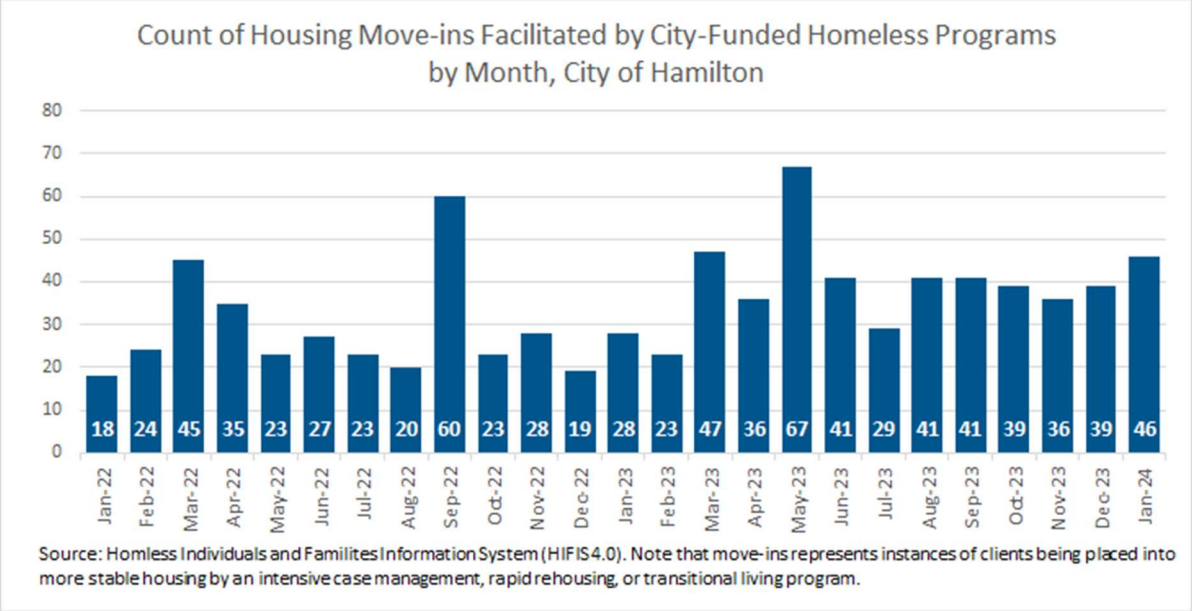
Figure 4: Count of Individuals Entering and Exiting Homelessness at Month End



Source: Homeless Individuals and Families Information System (HIFIS 4.0). Note the inflow and outflow fluctuations in 2023 are due to a data quality improvement initiative.

In addition, Hamilton is improving the rate at which individuals are housed through City-funded programs. Figure 5 shows the number of individuals moved into housing that was facilitated by City programs. In 2022, the City averaged 28.75 'move-in's' per month and increased that to an average of 38.9 in 2023. This may be attributed, in part, to the opening of Dorothy Day Place in May 2023. However, removing outlier months of 60 move-ins or more, the averages still show an increase to outflow in 2023 (25.9 and 36.4, respectively).

Figure 5: Count of Housing Move-Ins Facilitated by City-Funded Homeless Programs by Month



Source: Homless Individuals and Familites Information System (HIFIS 4.0). Note that move-ins represents instances of clients being placed into more stable housing by an intensive case management, rapid rehousing, or transitional living program.

Despite these improvements at the population level, the effects of further investment will take time to realize. During that time, encampments will continue across the City. To better manage any impacts to those living in or around encampments and those working nearby, staff recommend several improvements in alignment with program design needs and community concerns.

Inquiry	Mitigation
Reporting an encampement (27% of inquiries)	Increase the Housing Focused Street Outreach complement to support anticipated increased encampment numbers during the summer, and support winter response programs during the winter months.
Feelings of intimidation and lack of safety (25%)	Implementing minimum distances from walkways and pathways, and maintaining a minimum distance from roads throughout the year (instead of only during snow plowing season). Establishing a minimum distance from funeral homes, long-term care homes and spaces that are designed and programmed for children.
Requesting Enforcement (19%)	Staff do not recommend changing the enforcement approach
Waste & Debris (15% of inquiries)	Collection of waste is already in place and occurring daily in some places. Staff do not recommend a change to this process.
Healthy and Safety of those living unsheltered	Increase the Social Navigator Program with two additional Paramedics to better connect those living

(11%)	unsheltered with healthcare, and provide onsite supports like wound care, point-in-care assessments, and harm reduction supplies. Establishing a minimum distance from construction sites to ensure individuals are a safe distance from active work

The Community Services Program Analyst supports analysis of encampment correspondence, as well as data collection from encampment residents. This enables Housing Services to continue to optimize the application of the Encampment Protocol and better connect individuals to emergency supports. Due to the prevalence of encampments, and the anticipated continuation of encampments, staff recommend making this position permanent. In addition, staff recommend an additional permanent FTE in Housing Services Division to coordinate responses to community inquiries.

ALTERNATIVES FOR CONSIDERATION

Additional amendments may be considered for the Encampment Protocol including:

1. A setback from private property line. While staff recognize the need to limit impacts to private property, increasing the setback beyond 5m would restrict smaller downtown compliant sites.
2. Limiting to five tents in parks, regardless of size. Staff do not recommend this approach as it would be very limiting and not an equitable approach across the city.
3. Exclude tents from all parks with construction. This is also not recommended as it would close all parks for any type of construction and reduce the number of compliant sites.

APPENDICES AND SCHEDULES ATTACHED

Appendix “A” to Report HSC24027 – Proposed Updates to the Encampment Protocol

TAB 2

Encampment Protocol – with Amendments

A) Shared Principles

When engaging in encampment response, all staff in a frontline capacity will use the same philosophical approach. In all interactions with people who are living unsheltered, staff will engage utilizing a human-centered, housing first, health-focused, rights-based approach. All actions will be guided by a commitment to upholding the human rights and human dignity of all individuals living in encampments, temporary shelters, or tents. Staff will also work to build rapport through mutual respect, effective communication, empathy, and by maintaining transparency around the expectations of individuals living in encampments, temporary shelters, or tents and City staff.

It is vital that all actions taken in the Protocol are grounded in the understanding that housing is a fundamental human need, and that people in our community deserve housing and homelessness responses that are based on intentional planning and good evidence and that have measurable positive impacts and outcomes. Working to provide permanent housing for all is critical and will require an ongoing commitment from the City, community, and other levels of government to find innovative, meaningful solutions.

B) Complaints and Service Request Information:

Individuals in the community who encounter an active or abandoned encampment, temporary shelter, or tent, or someone who is living unsheltered, and/or have questions or concerns about an encampment, should contact the Coordinated Response Team led by Housing Focused Street Outreach by email at unsheltered@hamilton.ca or by phone at 905-546-2828.

Any contacts made with other internal City divisions or through other City channels regarding encampments, temporary shelters, or tents will also be forwarded to Housing Focused Street Outreach for first response.

C) Alignment to Housing Resources and Supports

In establishing a housing-focused approach to interacting with individuals living unsheltered and/or in encampments, all individuals will be given an opportunity to complete a Vulnerability Index – Service Prioritization Decision Assistance Tool (VI-SPDAT)

In the context of individuals living in encampments, temporary shelters, or tents, the Vulnerability Index – Service Prioritization Decision Assistance Tool is a triage tool, with a series of questions asked by Housing Focused Street Outreach staff to individuals who are experiencing homelessness. The assessment tool is used to support conversations where staff learn about an individual's housing situation, needs, and strengths to help build a plan to achieve stable housing. It is also used to inform additional supports that may be needed and/or help prioritize housing interventions

within Hamilton's Homeless-serving System likely to be most beneficial to support an individual's needs, preferences, and long-term housing outcomes.

There is no requirement for anyone who is living in an encampment, temporary shelter, or tent to complete the Vulnerability Index – Service Prioritization Decision Assistance Tool and it will have no bearing on whether they are able to stay in a particular location or for a specific duration of time. The assessment tool will only be used to help connect individuals experiencing homelessness to housing resources and supports.

D) Prohibited Areas for Erecting Encampments, Temporary Shelters, or Tents

In order to provide for the availability of space for temporary shelter in parks, persons without shelter or being homeless will be able to establish an encampment through erecting a temporary shelter for themselves and also be able group together with other such persons' temporary shelters. However, the encampment or cluster of shelters must not exceed five tents or similar temporary shelters, and there must be at least 50 meters separating the encampment or cluster from other encampments or clusters of shelters. Further, the balancing of public and private interests while allowing for temporary shelter will require encampments or clusters not be located:

- On or within 100 meters of a school or children daycare centre
- On or within 100 meters of a playground, pool, waterpark, or any spray pad
- On or within 50 metres of any lake, beach, pond, watercourse or other body of water, or a dock
- Within 10 meters of any private property line
- Within 100 meters of a funeral home
- Within 100 meters of a long-term care facility
- Within 25 meters of an active construction site
- On or within 5 meters of any transit stop or a highway and specifically including a sidewalk, boulevard, or bridge or tunnel being part of such highway.
- On or within 5 meters of any property with an environmental or heritage designation
- On or within 50 meters of any sports fields, inclusive of but not limited to, skateboard parks, fitness amenities, golf courses, ball diamonds, soccer pitches, tennis courts, or any other sports or multi-use courts, as well as stadiums, dugouts, stages, and bleachers.
- On any fenced-in, off-leash dog area
- On any cemetery, including its roads, lanes and paths for travel within the cemetery
- On any community garden and including any garden shed or greenhouse
- On or within 5 metres of any pathway, walkway, sidewalk, or parking lot or on or under any bridge, including pedestrian access points to such areas and structures
- On or within any designated fire route, or the entrance to or exit from a designated fire route, or located so as the block any fire hydrant

- On or within any entrance, exit or a doorway to a building or structure, and including, without limiting the generality of the foregoing, an area adjacent to such entrances or exits required in the event of fire or emergency
- On or within any accessibility entrance or ramp or located in a way that blocks access to such entrances or ramps.
- On or within any area identified susceptible to flooding, erosion, slope instability, or other environmental hazards that presents a risk to health and safety.
- Further no temporary shelter or tent will be placed against, or under, or be attached or tied to any building or permanent structure. All shelters or tents must be freestanding.

E) Campfire and Barbecue Use

Section 14 of By-Law 01-219, the Parks By-Law, which regulates campfires and barbecues in City Parks; as well as By-Law No. 02-283, the Open Air Burning By-Law, which regulates open-air burning within the City, shall be complied with and will be enforced.

F) Maximum Personal Space Allotment(s)

The total area for a single tent and all its associated belongings cannot exceed beyond a 3-metre-by-3-metre area, or 9-metres-squared, and the total area for five tents within a cluster cannot exceed beyond a total area of 45-metres-squared. The following chart identifies space limits by number of temporary shelters or tents:

Number of Temporary Shelters/Tents within Encampment Cluster	Maximum Total Space Allotment (metres)
One	9m²
Two	18m²
Three	27m²
Four	36m²
Five	45m²

Any items located outside of the allotted personal space area will be subject to removal by City staff.

G) Encampment Response Processes

Given that there are several circumstances that require a unique response from the Coordinated Response Team, the following guidelines have been established to direct responses to people living in encampments, and their temporary shelters, or tents:

A) When an encampment, temporary shelter, or tent is located on public property, and not within a prohibited area, as defined by this Protocol:

1. Within 72 hours after receiving a complaint or request for service (unless exceptional circumstances exist), Housing Focused Street Outreach staff will engage with the individual(s) living within an encampment, temporary shelter, or tent to better understand their needs and connect them with internal and community supports, including housing-focused case management; referral into the emergency shelter system; referrals to health agencies, social assistance supports, and specialized outreach supports; and any other relevant supports available that would improve an individual's health and wellbeing.

2. If no health and safety issues are observed by Housing Focused Street Outreach (see Section J, 'Health and Safety' for further detail on specific circumstances or factors), and the encampment, temporary shelter, or tent complies with the prohibitions and locations outlined in this Protocol, individuals will be allowed to maintain and occupy temporary such shelter for the duration of the Protocol, as defined by City Council. Housing Focused Street Outreach will continue to engage with the individual(s) on an ongoing basis to provide supports and referrals as needed and work towards goals in individualized housing plans.

3. Only if a substantial change in circumstances is observed by Housing Focused Street Outreach in subsequent visits to the encampment, temporary shelter, or tent, such as new significant health or safety issues, will Hamilton Police Services be asked to attend to support any response. Hamilton Police Services will attend encampments within the normal course of responding to emergencies and other policing duties, and Housing Focused Street Outreach and other City partners will work cooperatively with Hamilton Police Services if a concern related to health and safety is identified at an encampment.

4. Any items or circumstances that are of clear and immediate risk to the individuals living in an encampment or neighbouring encampments or the broader public will result in a call for immediate emergency response. Hamilton Police Service Encampment Engagement Officers will attend the location and conduct a risk assessment when requested and as required.

B) When an encampment, temporary shelter, or tent is located on public property, within a <u>prohibited</u> area, as defined by this Protocol:

1. Within 72 hours after receiving a complaint or request for service (unless exceptional circumstances exist), Housing Focused Street Outreach staff will engage with individual(s) living within an encampment, temporary shelter, or tent to better understand their needs and connect them with internal and community supports, including housing-focused case management; referral into the emergency shelter system; referrals to health agencies, social assistance

supports, and specialized outreach supports; and any other relevant supports available that would improve an individual's health and wellbeing. Housing Focused Street Outreach will have available information about possible suitable and compliant sites and will consider the needs and choices of the individual and collaborate with the individual(s) living within an encampment, temporary shelter, or tent, to identify a more suitable area that meets the conditions noted within this Protocol.

2. If after visiting an encampment, temporary shelter, or tent, Housing Focused Street Outreach staff observe the encampment, temporary shelter, or tent to be in a prohibited area, as defined by this Protocol, Housing Focused Street Outreach will contact Municipal Law Enforcement within 72 hours of receiving the initial complaint, and Municipal Law Enforcement will respond to the within four (4) business days.

3. Municipal Law Enforcement Officers will visit the site within four business days and confirm whether the encampment, temporary shelter, or tent is in a prohibited area. If so, Municipal Law Enforcement Officers will notify the individual(s) living at the location via a Notice of Trespass and verbally, if possible, that they are in a prohibited area, and that they will be required to move from the existing location.

4. Municipal Law Enforcement Officers will determine compliance timelines depending on the presenting circumstances, for the issuance of notices or actions to be taken in respect to the encampment, temporary shelter, or tent, within a maximum of four (4) total days from the issuance of notice, unless exceptional circumstances exist. For example, if the Municipal Law Enforcement Officers observes a significant health or safety issue for the individual due to placing a shelter on a highway the Municipal Law Enforcement Officers will take more urgent action to require compliance or remediate the concern and may seek Hamilton Police Services support. If there are few or no immediate health, safety, or other concerns due to encampment or its location within a prohibited area, Municipal Law Enforcement Officers will allow for more time, up to a maximum of four (4) total days, unless exceptional circumstances exist, to engage with the individuals in an encampment, temporary shelter, or tent around supports and next steps.

5. After a Trespass Notice has been served and prior to an area being cleared, Housing Focused Street Outreach's will continue to engage with individual(s) at the location to identify alternate sheltering options and attempt to address any barriers to shelter or housing, such as lack of identification or item storage.

6. If the duration of time provided by a Trespass Notice expires and individual(s) at the site has not moved voluntarily and are unwilling to move, Municipal Law Enforcement Officers will notify Hamilton Police Services Encampment

Engagement Officers. Hamilton Police Services will be available to support and assist the Municipal Law Enforcement Officers, operational plan, and/or the individual(s) living at the encampment, temporary shelter, or tent to vacate the prohibited area.

7. Hamilton Police Services Encampment Engagement Officers will interact with individuals in encampments, temporary shelters, or tents at the request of Housing Focused Street Outreach and/or Municipal Law Enforcement, in a supportive capacity. Otherwise, their level of intervention will be dictated by their own internal policies and the circumstances at a given encampment, temporary shelter, or tent site.

8. Parks staff will coordinate the clean-up, to be completed either by Parks staff, Roads staff, or the contractor, depending on the location, within 72 hours, with discretion for extenuating circumstances such as inclement weather.

C) When an encampment, temporary shelter, or tent is located on public property, is not located in a prohibited area, but health and safety concerns are identified:

1. If Housing Focused Street Outreach identify or confirm a health or safety issue at an encampment, temporary shelter, or tent, and depending on circumstances, will address or may collaborate with appropriate partners to address the health and safety concerns identified.

2. If the health and safety concern is considered serious and/or imminent (e.g., exposed electrical wiring, accumulation of discarded needles, use of propane tanks and other combustible materials, possession of weapons) as identified by Housing Focused Street Outreach or Hamilton Police Services Encampment Engagement Officers, Hamilton Police Services will follow appropriate policing responses required in the circumstances. In addition, they will communicate with the Coordinated Response Team and prioritize working with community partners to address any remaining safety concern. These partners may include Hamilton Fire Department, Hamilton Public Health's Community Points program, Hamilton Parks, or any other parties deemed necessary to address the observed health and safety concerns.

3. All items determined by Hamilton Police Services and/or partners to be a serious risk to the health and safety of individual(s) living at the encampment, temporary shelter, or tent, as well as the public will be removed at the earliest opportunity.

4. If the encampment, temporary shelter, or tent is also in an area deemed to be prohibited based upon the provisions identified in Section D of this Protocol, and after health and/or safety issues placing Municipal Law Enforcement Officers at

risk have been removed, Municipal Law Enforcement Officers will initiate steps 4-9 in Encampment Response Process B – "*If an encampment is located on public property, in a prohibited area*."

5. If all serious health and/or safety issues have been removed or otherwise corrected, and the encampment, temporary shelter, or tent is not located in a prohibited area as designated in Section D of this Protocol, then the individual(s) will be permitted to remain where they are, in accordance with Encampment Response Process A.

H) Encampments on Private Property

Encampments, temporary shelters, or tents identified on private property are primarily the responsibility of the property owner. Where the owner has not provided consent, concerns of the owner are within Hamilton Police Services' jurisdiction and will be subject to ordinary enforcement procedures in accordance with applicable laws.

Hamilton Police Services may seek the assistance of Municipal Law Enforcement Officers as appropriate or required in the circumstances.

Provided the property owner permits, Housing Focused Street Outreach will engage with encampment, temporary shelter, or tent residents to identify alternate sheltering options and attempt to address any barriers to shelter or housing. Additionally, Housing Focused Street Outreach will work with individuals at the encampment, temporary shelter, or tent to provide supports and referrals as needed and work towards goals in individualized housing plans.

I) Process for Designating an Encampment, Temporary Shelter, or Tent as Abandoned

While Housing Focused Street Outreach is aware of many encampments, temporary shelters, and tents in the community, people living in encampments, temporary shelters, and tents may move to new locations and/or may abandon a previous site without Housing Focused Street Outreach's or other Coordinated Response Team partners' knowledge. Given that maintaining one's possessions while experiencing homelessness is vital to a human-rights based approach, staff will be cautious when deeming a site to be abandoned.

The following process will be followed regarding potentially abandoned sites on public property:

1. If Housing Focused Street Outreach have not interacted with anyone at a particular site and/or there has been observed inactivity for at least three (3) days, they will review the site with the Coordinated Response Team partners at

the nearest opportunity to confirm there has been no recent activity witnessed at the site.

2. If Coordinated Response Team partners (i.e., Municipal Law Enforcement, Hamilton Police Services, Parks) have not witnessed anyone at the site and/or can confirm that the former inhabitants of the site have moved elsewhere, Housing Focused Street Outreach will place a notice at the site in a conspicuous area informing potential residents that the site is due to be cleaned in three (3) days from the time of the notice being placed.

3. Within the three-day timeline, all reasonable attempts will be made by Housing Focused Street Outreach and/or other Coordinated Response Team partners to ensure that individuals known to be previously staying at a site have been made aware that their former site will be deemed abandoned and cleaned.

4. If no interaction has been made by Housing Focused Street Outreach with the former inhabitants at the site, no attempts have been made by the former inhabitants of the site to contact Housing Focused Street Outreach, and/or no other changes are observed at the site by the end of the allotted time, Housing Focused Street Outreach will provide approval to Parks Section to clean the site.

5. Parks staff will coordinate the clean-up, to be completed either by Parks staff, Roads staff, or the contractor, within 72 hours of approval, with discretion for extenuating circumstances such as inclement weather.

Clean-up and maintenance of encampments, temporary shelters, or tents previously on private property are the responsibility of the property owner.

J) Health and Safety

Defining specific health and safety issues is difficult and can be based upon several factors unique to a particular site or circumstance. Some examples include, exposed electrical wiring, accumulation of discarded needles, illegal activity, abuse, threats or violence against staff, HPS or other persons, improper use or storage of propane tanks and other flammable materials, and acts involving weapons. Health and safety issues may also be identified via complaints from the public and/or businesses in relation to the encampment, temporary shelter, or tent; for example regarding harassment, vandalism, and/or stolen personal property.

Housing Focused Street Outreach staff will notify Animal Services when a pet is encountered at an encampment site. Housing Focused Street Outreach staff will collaborate with appropriate parties including the pet owner to identify how to best support the pet and pet owner, including implementing strategies to reduce any potential harms to the pet owner, public, City staff and the animal.

Health and safety concerns existing for those living within or adjacent to an encampment, temporary shelter, or tent will be addressed in a reasonable and timely fashion, in good faith, on a case-by-case basis, prioritizing the seriousness of the concern and recognizing that there is a need to balance the needs of both the individual living in an encampment, temporary shelter, or tent and community members.

In situations where the need to intervene is less acute, the City may consult with additional internal and external partners to determine how to best balance the needs of individuals living encamped and community members.

If at any time City staff encounter someone in medical distress requiring immediate attention, witness violence, or believe violence to be imminent to people living in encampments, temporary shelters, or tents, staff, or community members, they will notify emergency medical, Hamilton Fire Department, or Hamilton Police Services, including members of the Hamilton Police Crisis Response Branch), to have the appropriate services dispatched. Additionally, City staff will leave the site irrespective of all procedures above, if their health and safety is currently being, or at risk of being threatened. To ensure safety of staff, the presence of Hamilton Police Services may be required while visiting the site.

K) Reporting

To provide ongoing accountability and transparency to the City’s encampment response program and the implementation of its encampment protocol, communication with Council and Ward Councillors regarding the Encampment Protocol will be through monthly, ongoing Information Reports to General Issues Committee and include data and trends, operational updates, and any continuous improvement measures implemented to further efforts toward providing ongoing accountability and transparency to the City’s encampment response program and the implementation of its encampment protocol. Where a Ward Councillor requests information regarding a specific encampment site within their ward, Housing Focused Street Outreach will provide an update as to whether the encampment has been deemed to be within a prohibited area. Reporting on the status of outreach or enforcement activities will be limited to the monthly Council reports.

L) Communicating Protocol to Residents of Encampments

An engagement strategy has been developed to update unsheltered individuals living in encampments about the Protocol as well as to communicate expectations of places within the City where encampments, temporary shelters, or tents can be erected.

The following approaches will be taken to build understanding of the Protocol:

- Housing Focused Street Outreach workers will have an information sheet outlining expectations of the Protocol, to be shared with unsheltered individuals when staff visit an encampment. Additionally, outreach staff will collaborate with individuals to understand their needs and choices in order to

identify suitable locations (compliant sites) within the City where the individual can set up a temporary shelter or tent.

- Information sheets will also be shared with external frontline service providers who manage drop-ins, emergency shelters, and other related services and programs providers in the community, which can be posted in their locations and also communicated to staff throughout these organizations.
- City partners who also engage in frontline response, i.e., Parks Section and Municipal Law Enforcement, will also be provided information sheets to share with unsheltered individuals within the City, and community partners upon request.
- The City will post the Encampment Protocol and information sheet on the City’s website for public access.

Court File No. CV-21-00077187-0000

KRISTEN HEEGSMA et al. - and - CITY OF HAMILTON

Applicants Respondent

ONTARIO
SUPERIOR COURT OF JUSTICE

PROCEEDING COMMENCED AT HAMILTON

RESPONSE TO REQUEST TO ADMIT

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File No. H227899

TAB 153

Court File No. CV-21-00077187-0000

Form 51A
Courts of Justice Act

REQUEST TO ADMIT

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, GLENN 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

YOU ARE REQUESTED TO ADMIT, for the purposes of this proceeding only, the truth of the following facts:

1. According to the 2021 Census of Population, the area of the City of Hamilton was 1,118.31 square kilometres.
2. According to the 2021 Census of Population, the population of the City of Hamilton was 569,353.
3. According to the 2021 Census of Population, based on 25% sample data, in the City of Hamilton 12,520 persons had Indigenous identity.

YOU ARE REQUESTED TO ADMIT, for the purposes of this proceeding only, the authenticity (see rule 51.01 of the *Rules of Civil Procedure*) of the following documents:

1. "Housing and Homeless Data Dashboard" (May 16, 2022)
2. "Homelessness – Data Notes" (August 25, 2024)

   (https://experience.arcgis.com/experience/3c7fd27e188b4ce0951d86d1a532be4a/page/Data-Notes/)
3. "Scale of Homelessness" (August 25, 2024)

   (https://open.hamilton.ca/datasets/0869417f4ab04937a9fa3acc770b3d12_22/explore)
4. "Shelter Beds Available" (August 25, 2024) (https://open.hamilton.ca/datasets/4bb655e968a246fd95332f447609120e_23/explore)
5. "Shelter Occupancy" (August 25, 2024) (https://open.hamilton.ca/datasets/0930c7d2f3d34780bfcc2027f394e9e5_24/explore)
6. "Average Market Rent" (August 25, 2024)

   (https://open.hamilton.ca/datasets/dd4a386981684aad83720b902e2247e5_26/explore)
7. "Addressing Needs of Unsheltered Individuals and those Relying on Hamilton's Emergency Shelter System" (HSC23041) (August 14, 2023)
8. "Encampment Observation Report" (HSC24020/PED24080/ PW24030) (May 15, 2024)
9. "Further Amended Appendix "A" to Report HSC20036(g)" (July 4, 2024)
10. "City Council Minutes 24-014" (July 12, 2024)
11. "Encampment Protocol Distance Proposals" (HSC24027(a)) (August 12, 2024)
12. "Appendix "A" to Report HSC24027(a)" (August 12, 2024)
13. "Appendix "B" to Report HSC24027(a)" (August 12, 2024)
14. "Hamilton's Emergency Shelter Standards" (September 2023)
15. "Service Restriction Policy for Emergency Shelters" (July 15, 2024)
16. "Emergency Shelters and Drop-ins" (August 25, 2024)

    (https://www.hamilton.ca/people-programs/housing-shelter/preventing-ending-homelessness/emergency-shelters-drop-ins#temporary-extended-services)

Attached to this request is a copy of each of the documents referred to above.

YOU MUST RESPOND TO THIS REQUEST by serving a response to request to admit in Form 51B prescribed by the Rules of Civil Procedure WITHIN TWENTY DAYS after this request is served on you. If you fail to do so, you will be deemed to admit, for the purposes of this proceeding only, the truth of the facts and the authenticity of the documents set out above.

August 26, 2024

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DOCUMENT 1

COMMUNICATION UPDATE

TO:	Mayor and Members City Council
DATE:	May 16, 2022
SUBJECT:	Housing and Homelessness Data Dashboard (City Wide)
WARD(S) AFFECTED:	City Wide
SUBMITTED BY: **SIGNATURE:**	Angela Burden General Manager Healthy and Safe Communities Department

On September 9, 2021, the Emergency and Community Services Committee directed:

> "That staff be requested to provide a comprehensive snapshot of housing and homelessness in Hamilton on a quarterly basis, outlining all programs that have been utilized and the different resources that are available in collaboration with partners in community, the shelter health network."

The first Housing and Homelessness Data Snapshot was prepared for the December 9, 2021 meeting of the Emergency and Community Services as Appendix "A" to Report HSC20020(d). The Housing Services Division (HSD) has since worked in collaboration with the City Manager's Officer to develop a public facing data dashboard. The dashboard will present housing and homelessness data in an interactive format to serve the following goals:

- Advance the City's data capabilities to support decision-making, performance management, and drive a culture of continuous improvement and innovation
- Build Trust and Confidence in City Government by ensuring City government information is readily available and accessible

Rationale for Establishing a Housing and Homelessness Data Dashboard

The dashboard format offers several advantages over static reports. The dashboard:

- Consolidates data on housing and homelessness and the City's response
- Allows Council, staff, community, and partners to track core metrics over time

- Creates transparency and clarity around the data the HSD is collecting and using to inform program decisions and system planning
- Supports greater public understanding of the work of the HSD as well as gaps in our community

Description of the Dashboard

As System Manager, the City works in partnership with urban Indigenous leadership to build a coordinated housing and homeless-serving system in deep collaboration with community partners to ensure everyone in Hamilton has a home. This goal is guided by the Council approved 10-year Housing and Homelessness Action Plan and Hamilton's Systems Planning Framework: Coming Together to End Homelessness.

The dashboard contains data about the state of homelessness and access to affordable housing. It is intended to support evidence-informed action and illustrate progress towards housing and homelessness goals within Hamilton's Housing and Homelessness Serving System. This data supports ongoing accountability to addressing immediate unmet housing needs while establishing permanent solutions to housing pressures.

The following metrics are included in the dashboard:

- Average market rent
- Active households on the Access to Housing waitlist
- Active households housed off the Access to Housing waitlist
- Inflow/Outflow to Homelessness
- Shelter Occupancy
- Shelter Bed Capacity
- Number of individuals experiencing homelessness for less than six months and more than six months
- Number of individuals housed through City-funded Homelessness Programs

Each metric is accompanied with a data note that defines how the data is collected, frequency of data collection, and how the data are used. Metrics included in this dashboard do not reflect the totality of work and investments undertaken through the Housing Services Division, community partners, and other levels of government. The dashboard will evolve as additional data needs and reporting capabilities are determined.

Launch of the Housing and Homelessness Data Dashboard

The dashboard will go live on the City website on May 17, 2022 at: www.hamilton.ca/housing-data. The dashboard will be updated on a quarterly basis.

Should you require further information please contact Senior Project Manager, Homeless Policy and Programs, Vanessa Parlette at (905) 546-2424 ext. 3863 or by email at vanessa.parlette@hamilton.ca.

DOCUMENT 2

Inflow/Outflow to Homelessness
Inflow and Outflow are two of the most important measures for monitoring progress towards our goal of ending homelessness. The goal is to see outflow exceed inflow. Whe
from homelessness than are entering the homeless-serving system.
Please note that in July 2023, there was an increase of clients captured in inflow that was the result of data cleaning efforts by Housing Services staff and led to reactivation of
160 cases. Trend should be interpreted with caution.

Inflow represents the number of individuals: newly identified as homeless, returned to homelessness from housing, returned to homelessness from inactive status during the
Outflow represents the number of individuals: who have moved from staying in shelter or unsheltered to housed and those who have moved to inactive status during the rep
Data depicted is collected by the homeless-serving system through HIFIS. Please note that as part of continuous quality improvement, we have changed the methodology for
before and after that date may not be directly comparable.

Shelter Bed or Room Occupancy
Data depicted represents the average percentage of available beds or rooms that were occupied within a specific period. Data depicted is collected through HIFIS and Housi
occupancy for family shelters and emergency hotels reflects rooms occupied instead of beds. Emergency hotel occupancy is underrepresented and the actual availability of h
space is lower than reported. A higher number of rooms are needed compared to the actual number of families served because large families require additional rooms that c
children) and rooms within the blocked reservation can be unavailable for repairs or turnover.

Shelter Bed or Room Capacity
Data depicted represents the total number of beds and rooms available on the last day of the month. This point of time is used as changes can occur daily for a variety of reas
total number of beds and rooms available are for city-funded beds only. Shelters may have other beds and rooms available that are not funded by the city and are included in
to as overflow beds within shelters). Beds and rooms combined represent the system capacity. As of March 2023 reporting of beds available to accommodate single people s
families seeking shelter together or emergency hotel overflow have been separated. This reporting has been updated to more accurately reflect the nature of room-based ser
of beds available or beds occupied within it). Historical reporting has been updated to reflect this change. Previous reporting estimated the number of beds available based
through HIFIS and Housing Services Internal Records.

Actively Homeless
Actively homeless refers to individuals who were experiencing homelessness at the end of the month. It includes individuals who have accessed the homeless-serving system
include individuals captured in outflow data. Please note that as part of continuous quality improvement, we have changed and improved our reporting for actively homeless

Number of individuals experiencing homelessness for less than six months and more than six months
This chart highlights the number of individuals experiencing homelessness in the city of Hamilton at the end of the month. It provides a breakdown of individuals who were ch
and those who were homeless for less than six months. Data depicted is collected by staff within the homeless-serving system through HIFIS. Please note that as part of contin
improved our reporting for actively homeless starting April 2022.

Chronically homeless: Individuals experiencing homelessness at the end of the month and who meet one of the two criteria below, as per the federal definition of chronic ho
• The individual has experienced at least six months (180 days) of homelessness over the past year
• The individual has recurrent experiences of homelessness over the past three years, with a total duration of at least 18 months (546 days).

Housed through City-funded Homelessness Programs
Housing Placements are defined as housing secured for unique individuals participating in a City-funded homelessness program: Intensive Case Management (ICM), Rapid R
continue to work towards including housing placements secured through Emergency Shelters, Outreach, and Drop-in programs.
Data depicted is collected through HIFIS and the Data Collection Tools submitted by funded housing programs to the City of Hamilton on a monthly basis. As data is submitte
depicted.

DOCUMENT 3

Hamilton

Scale of Homelessness

Open Hamilton
Private Organization

Summary

Number of individuals experiencing homelessness in Hamilton and their length of homelessness.

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MONTH_YEAR	HOMELESS_FOR_MORE_SIX_MONTHS	HOMELESS_FOR_LESS_SIX_MONTHS	TOTAL_HOMELESS
2020-01-31, 12:00 AM	463	401	864
2020-02-28, 12:00 AM	587	509	1,096
2020-03-31, 1:00 AM	632	456	1,088
2020-04-30, 1:00 AM	616	489	1,105
2020-05-31, 1:00 AM	676	426	1,102
2020-06-30, 1:00 AM	655	373	1,028
2020-07-31, 1:00 AM	624	343	967
2020-08-31, 1:00 AM	622	347	969
2020-09-30, 1:00 AM	585	362	947
2020-10-31, 1:00 AM	653	334	987
2020-11-30, 12:00 AM	685	376	1,061
2020-12-31, 12:00 AM	657	427	1,084
2021-01-31, 12:00 AM	666	494	1,160
2021-02-28, 12:00 AM	649	489	1,138
2021-03-31, 1:00 AM	612	483	1,095
2021-04-30, 1:00 AM	746	340	1,086
2021-05-31, 1:00 AM	726	332	1,058
2021-06-30, 1:00 AM	717	362	1,079
2021-07-31, 1:00 AM	700	383	1,083
2021-08-31, 1:00 AM	687	495	1,182
2021-09-30, 1:00 AM	674	528	1,202
2021-10-31, 1:00 AM	763	617	1,380
2021-11-30, 12:00 AM	695	731	1,426
2021-12-31, 12:00 AM	632	909	1,541
2022-01-31, 12:00 AM	889	705	1,594

Hamilton

Scale of Homelessness

Open Hamilton
Private Organization

Summary

Number of individuals experiencing homelessness in Hamilton and their length of homelessness.

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MONTH_YEAR	HOMELESS_FOR_MORE_SIX_MONTHS	HOMELESS_FOR_LESS_SIX_MONTHS	TOTAL_HOMELESS
2022-01-31, 12:00 AM	889	705	1,594
2022-02-28, 12:00 AM	803	720	1,523
2022-03-31, 1:00 AM	795	801	1,596
2022-04-30, 1:00 AM	326	1,409	1,735
2022-05-31, 1:00 AM	370	1,303	1,673
2022-06-30, 1:00 AM	373	1,166	1,539
2022-07-31, 1:00 AM	367	1,127	1,494
2022-08-30, 1:00 AM	395	1,081	1,476
2022-09-30, 1:00 AM	390	1,141	1,531
2022-10-31, 1:00 AM	409	1,160	1,569
2022-11-30, 12:00 AM	542	1,128	1,670
2022-12-31, 12:00 AM	488	1,048	1,536
2023-01-31, 12:00 AM	494	1,051	1,545
2023-02-28, 12:00 AM	476	989	1,465
2023-03-31, 1:00 AM	556	1,015	1,571
2023-04-30, 1:00 AM	591	1,024	1,615
2023-05-31, 1:00 AM	590	1,060	1,650
2023-06-30, 1:00 AM	587	1,145	1,732
2023-07-31, 1:00 AM	701	1,284	1,985
2023-08-31, 1:00 AM	660	1,221	1,881
2023-09-30, 1:00 AM	664	1,226	1,890
2023-10-31, 1:00 AM	597	1,096	1,693
2023-11-30, 12:00 AM	600	1,071	1,671
2023-12-31, 12:00 AM	583	1,050	1,633
2024-01-31, 12:00 AM	585	1,007	1,592

DOCUMENT 4

Hamilton

Shelter Beds Available

Open Hamilton
Private Organization

Summary

Total number of shelter beds or rooms available on the last day of the month.

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MONTH_YEAR	MEN_BEDS	WOMEN_BEDS	FAMILY_ROOMS	YOUTH_BEDS	EMERGENCY_HOTEL_OVERFLOW_ROOMS	TOTAL_BEDS	TOTAL_ROOMS
2020-01-31, 12:00 AM	220	46	20	21	0	287	20
2020-02-28, 12:00 AM	193	46	20	21	0	260	20
2020-03-31, 1:00 AM	219	46	20	21	0	286	20
2020-04-30, 1:00 AM	150	46	20	21	67	217	87
2020-05-31, 1:00 AM	127	46	20	21	43	194	63
2020-06-30, 1:00 AM	127	46	20	21	43	194	63
2020-07-31, 1:00 AM	127	46	20	21	47	194	67
2020-08-31, 1:00 AM	127	38	20	21	62	186	82
2020-09-30, 1:00 AM	115	38	20	21	127	174	147
2020-10-31, 1:00 AM	142	26	20	13	132	181	152
2020-11-30, 12:00 AM	186	26	20	13	129	225	149
2020-12-31, 12:00 AM	186	26	20	13	123	225	143
2021-01-31, 12:00 AM	196	26	20	13	157	235	177
2021-02-28, 12:00 AM	223	26	20	13	158	262	178
2021-03-31, 1:00 AM	223	26	20	13	178	262	198
2021-04-30, 1:00 AM	223	26	20	13	179	262	199
2021-05-31, 1:00 AM	223	26	20	13	158	262	178
2021-06-30, 1:00 AM	223	26	20	13	163	262	183
2021-07-31, 1:00 AM	209	26	20	13	149	248	169
2021-08-31, 1:00 AM	210	26	20	13	157	249	177
2021-09-30, 1:00 AM	218	26	20	13	165	257	185
2021-10-31, 1:00 AM	219	41	20	13	198	273	218
2021-11-30, 12:00 AM	238	41	20	13	215	292	235
2021-12-31, 12:00 AM	239	41	20	13	198	293	218
2022-01-31, 12:00 AM	245	41	20	21	248	307	268

Hamilton

Shelter Beds Available

Open Hamilton
Private Organization

Summary

Total number of shelter beds or rooms available on the last day of the month.

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MONTH_YEAR	MEN_BEDS	WOMEN_BEDS	FAMILY_ROOMS	YOUTH_BEDS	EMERGENCY_HOTEL_OVERFLOW_ROOMS	TOTAL_BEDS	TOTAL_ROOMS
2022-01-31, 12:00 AM	245	41	20	21	248	307	268
2022-02-28, 12:00 AM	212	41	20	21	261	274	281
2022-03-31, 1:00 AM	212	96	20	21	190	329	210
2022-04-30, 1:00 AM	154	104	20	21	181	279	201
2022-05-31, 1:00 AM	154	104	20	21	200	279	220
2022-06-30, 1:00 AM	193	104	20	21	138	318	158
2022-07-31, 1:00 AM	193	104	20	21	137	318	157
2022-08-30, 1:00 AM	212	104	20	21	135	337	155
2022-09-30, 1:00 AM	212	104	20	21	104	337	124
2022-10-31, 1:00 AM	212	104	20	21	80	337	100
2022-11-30, 12:00 AM	201	107	20	21	80	329	100
2022-12-31, 12:00 AM	198	109	20	21	42	328	62
2023-01-31, 12:00 AM	198	109	20	21	42	328	62
2023-02-28, 12:00 AM	198	109	20	21	42	328	62
2023-03-31, 1:00 AM	198	81	20	21	42	300	62
2023-04-30, 1:00 AM	198	65	20	21	52	284	72
2023-05-31, 1:00 AM	198	46	20	21	52	265	72
2023-06-30, 1:00 AM	198	66	20	21	52	285	72
2023-07-31, 1:00 AM	198	66	20	21	52	285	72
2023-08-31, 1:00 AM	198	66	20	21	52	285	72
2023-09-30, 1:00 AM	198	66	20	21	52	285	72
2023-10-31, 1:00 AM	198	66	20	21	52	285	72
2023-11-30, 12:00 AM	198	66	20	21	52	285	72
2023-12-31, 12:00 AM	243	66	20	21	52	320	72
2024-01-31, 12:00 AM	243	66	20	21	52	320	72

DOCUMENT 5

Hamilton

Shelter Occupancy

Open Hamilton
Private Organization

Summary

The percentage of available beds that were occupied within a specific period.

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MONTH_YEAR	PERCENT_MEN	PERCENT_WOMEN	PERCENT_FAMILIES	PERCENT_YOUTH	PERCENT_EMERGENCY
2020-01-31, 12:00 AM	1.14	1.04	0.93	0.68	
2020-02-28, 12:00 AM	1.11	1.02	0.91	0.6	
2020-03-31, 1:00 AM	1.08	0.82	0.97	0.52	
2020-04-30, 1:00 AM	1.39	0.87	0.95	0.7	0.44
2020-05-31, 1:00 AM	1.14	0.8	0.64	0.46	0.5
2020-06-30, 1:00 AM	1.07	0.78	1	0.51	0.34
2020-07-31, 1:00 AM	0.91	0.78	1	0.42	0.31
2020-08-31, 1:00 AM	0.9	0.85	1	0.29	0.33
2020-09-30, 1:00 AM	0.9	0.9	0.79	0.36	0.39
2020-10-31, 1:00 AM	0.79	0.72	0.85	0.51	0.72
2020-11-30, 12:00 AM	0.92	0.99	0.95	0.49	0.72
2020-12-31, 12:00 AM	0.96	1.1	0.92	0.46	0.62
2021-01-31, 12:00 AM	0.91	0.96	0.86	0.32	0.52
2021-02-28, 12:00 AM	0.99	0.97	0.9	0.45	0.6
2021-03-31, 1:00 AM	0.93	1.03	0.85	0.59	0.67
2021-04-30, 1:00 AM	0.88	0.99	0.87	0.66	0.54
2021-05-31, 1:00 AM	0.81	1.02	0.78	0.44	0.46
2021-06-30, 1:00 AM	0.79	1.05	0.86	0.4	0.47
2021-07-31, 1:00 AM	0.85	1.03	0.88	0.49	0.58
2021-08-31, 1:00 AM	0.81	1.04	1	0.63	0.73
2021-09-30, 1:00 AM	0.81	1.08	1.14	0.61	0.74
2021-10-31, 1:00 AM	0.88	1.05	1.01	0.74	0.79
2021-11-30, 12:00 AM	0.96	0.99	0.98	0.84	0.87
2021-12-31, 12:00 AM	1	1.01	0.92	0.72	1.05
2022-01-31, 12:00 AM	0.96	0.96	0.93	0.45	1.02

Hamilton

Shelter Occupancy

Open Hamilton
Private Organization

Summary

The percentage of available beds that were occupied within a specific period.

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MONTH_YEAR	PERCENT_MEN	PERCENT_WOMEN	PERCENT_FAMILIES	PERCENT_YOUTH	PERCENT_EMERGENCY
2022-01-31, 12:00 AM	0.96	0.96	0.93	0.45	1.02
2022-02-28, 12:00 AM	0.95	0.97	0.85	0.38	1
2022-03-31, 1:00 AM	0.98	0.8	1.01	0.48	1.07
2022-04-30, 1:00 AM	1	0.9	1.03	0.58	0.95
2022-05-31, 1:00 AM	0.97	0.88	1	0.47	0.97
2022-06-30, 1:00 AM	0.99	0.9	1.04	0.43	0.8
2022-07-31, 1:00 AM	0.97	0.93	0.99	0.58	0.75
2022-08-30, 1:00 AM	0.94	0.97	1.03	0.61	0.72
2022-09-30, 1:00 AM	0.96	0.97	1.03	0.57	0.6
2022-10-31, 1:00 AM	1.02	1	1.01	0.76	0.85
2022-11-30, 12:00 AM	1.02	0.98	1.04	0.82	0.68
2022-12-31, 12:00 AM	1.06	0.92	1.03	0.71	0.6
2023-01-31, 12:00 AM	1.08	0.9	1.05	0.55	0.84
2023-02-28, 12:00 AM	1.09	0.91	1.04	0.75	0.77
2023-03-31, 1:00 AM	1.11	0.93	1.04	0.67	0.71
2023-04-30, 1:00 AM	1.07	0.97	1.03	0.56	0.85
2023-05-31, 1:00 AM	1.04	0.96	1.01	0.69	0.94
2023-06-30, 1:00 AM	1.05	0.93	1.02	0.81	0.93
2023-07-31, 1:00 AM	1.07	0.93	1.03	0.67	0.97
2023-08-31, 1:00 AM	1.1	0.98	1.02	0.63	0.93
2023-09-30, 1:00 AM	1.1	0.99	1.03	0.77	0.94
2023-10-31, 1:00 AM	1.1	0.99	1.02	0.75	0.91
2023-11-30, 12:00 AM	1.1	1.1	1.02	0.63	0.9
2023-12-31, 12:00 AM	1.11	0.98	1.03	0.63	0.88
2024-01-31, 12:00 AM	1.13	0.97	1.01	0.63	0.86

DOCUMENT 6

Hamilton

Average Market Rent

Open Hamilton
Private Organization

Summary

Average rent price in the Hamilton market, as provided by Canadian Mortgage and Housing Corporation (CMHC).

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YEAR	HAMILTON	BACHELOR	ONE_BEDROOM	TWO_BEDROOM	THREE_BEDROOM
2016	901				
2017	944	632	845	1,030	1,129
2018	1,009	746	916	1,085	1,257
2019	1,055	814	963	1,130	1,283
2020	1,118	867	1,033	1,184	1,350
2021	1,190	915	1,095	1,271	1,479
2022	1,242	920	1,142	1,335	1,450

DOCUMENT 7

CITY OF HAMILTON
HEALTHY AND SAFE COMMUNITIES DEPARTMENT
Housing Services Division

TO:	Chair and Members General Issues Committee
COMMITTEE DATE:	August 14, 2023
SUBJECT/REPORT NO:	Addressing Needs of Unsheltered Individuals and those Relying on Hamilton's Emergency Shelter System (HSC23041) (City Wide)
WARD(S) AFFECTED:	City Wide
PREPARED BY:	Vanessa Parlette (905) 546-2424 Ext. 3863 Rob Mastroianni (905) 546-2424 Ext. 8035 Greg Witt (905) 546-2424 Ext. 4818
SUBMITTED BY: **SIGNATURE:**	Michelle Baird Director, Housing Services Division Healthy and Safe Communities Department Michelle Baird

RECOMMENDATION(S)

(a) That Council approve up to $5.6M in 2023 for the following in-year emergency response expenditures to address the immediate pressures experienced by unsheltered individuals and individuals requiring assistance from Hamilton's emergency shelter system funded through a combination of sources, deemed appropriate by the General Manager of Corporate Services, and to be confirmed through the 2023 year-end budget variance report beginning with additional Provincial or Federal Funding, City of Hamilton COVID-19 Reserve, or 2023 Corporate Surplus;

(i) $4.1M to continue providing shelter overflow in hotels in 2023 for families experiencing homelessness as reported in the April 2023 Budget Variance Report, FCS23063;

(ii) $600K to Indwell to provide high level supports from October 1, 2023 – March 31, 2024 for 24 units at City Housing Hamilton's - King William location in order to house individuals from encampments or the by name list as of Q4, 2023;

(iii) That up to $876K in expenditures to provide support for overnight drop in centres, beginning in December 2023 through March 2024 be referred to the discussion of the City's Winter Response in the report coming forward with the same name to the September 7, 2023 Emergency and Community Services Committee;

(b) That Council approve an in-year immediate commitment of a $2.3M conditional grant to Indwell Community Homes as the City's municipal contribution to enable construction at Acorn Flats to commence within 30 days of approval in order to build 20-25 units of permanent housing for families experiencing homelessness with occupancy by the end of 2024, funded from the Tax Stabilization Reserve (#110046);

(c) That the General Manager of the Healthy and Safe Communities Department or their designate be directed and authorized, on behalf of the City of Hamilton, to enter into, execute and administer all agreements and documents necessary to implement the purchases and grants outlined above on terms and conditions satisfactory to the General Manager of the Healthy and Safe Communities Department or their designate and in a form satisfactory to the City Solicitor;

(d) That up to $5.925M for 2024 emergency response expenditures be referred to the 2024 tax operating budget for Council consideration:to address the needs experienced by unsheltered individuals and individuals requiring assistance from Hamilton's emergency shelter system items;

(i) The continuation of shelter hotel overflow for families experiencing homelessness at an anticipated cost of $4.64M annually

(1) $4.45M for emergency hotel shelter overflow beds for families experiencing homeless.
(2) $190K to fund temporary mobile case management team supporting families experiencing homelessness who are housed in hotel overflow beds.

(ii) The continuation of 20 additional beds in the women's emergency shelter system, through 46 West South as a temporary emergency shelter (run by Good Shepherd Centre Hamilton), from April 1, 2024 to December 31, 2024 at a cost of $952K (annualized cost of $1.267M)

(iii) $333K to enhance diversion programs within shelters to prevent homelessness for an estimated 600 individuals

(e) That up to $2.3M be referred to the 2024 Tax Operating budget for Council consideration to support individuals experiencing homelessness in securing successful tenancies and prevent homelessness as referenced in the plan to end chronic homelessness and the Housing Sustainability and Investment Roadmap;

(i) $2M increase to the Municipal Housing Benefit equivalent to Rent-Geared-to-Income to end homelessness for an estimated 332 households, in order to reflect the commitment to support 500 households in this way through the HSIR.

(ii) Up to $1.2M to Indwell to provide continued high level supports for 24 units at City Housing Hamilton King William that will take individuals from encampments or the by name list until provincial commitment for these costs can be obtained.

(f) That expansion of the Housing Services Division's 2024 budgeted complement by 5.0 permanent FTEs to be referred to the 2024 Tax Operating Budget to support execution of recommendations (d) through (e), with annual cost in 2024 of approximately $502K;

(i) 2.0 FTEs, Emergency Shelter Case Managers, to support expanded shelter capacity at an annual cost in 2024 of approximately $199K for salaries, benefits and ancillary costs.

(ii) 3.0 FTEs, a Senior Project Manager, a Housing Support Worker, and a Housing Services Clerk, to design and administer programs offering permanent housing solutions at an annual cost in 2024 of approximately $303K

(g) That Council approve in principle the concept of an advance multi-year municipal commitment of $31M (e.g. $10.33M per year over 3 years) towards the creation of 200 units supportive housing in order to maximize opportunities for affordable housing providers to leverage provincial and federal funds for projects in development and that Housing Secretariat report back to Council in Q3 on financing options and recommended parameters by which Council would delegate decision making authority to staff to work with providers, identify highest impact projects and administer and allocate these funds to enable flexibility and nimble decision-making;

(h) That Council direct staff to explore an approach to subsidizing funding of up to 100 additional Residential Care Facility spaces to provide additional permanent

housing options for individuals requiring shelter and to report back to Council in Q4 2023 with opportunities and costs;

(i) That Council direct staff to assess Hamilton's current ratio of investment in emergency response compared with upstream housing interventions versus emergency response and propose a policy framework to guide City of Hamilton's future municipal investment in the housing sector to shift from emphasis on emergency response to homelessness prevention and permanent housing solutions that decrease reliance on emergency interventions; and,

(j) In recognition that funding of housing with supports is not within the municipal tax levy mandate or resources, that Council direct staff to work with the Mayor's office to pursue funding from upper levels of government for the $1.2M in operating costs for 2024 associated with Indwell King William, the $3.6M in annual operating costs for permanent housing at the Dorothy Day Centre and the $2.6M in annual operating costs for transitional housing at the YWCA currently subsidized by the municipality, which have no sustainable funding source, as well as other projects that require similar annual operating costs to provide the supportive housing capacity required to address local need;

EXECUTIVE SUMMARY

As the housing crisis continues, more individuals are living unsheltered and the number of individuals who are homeless continues to rise. Hamilton's shelter system has consistently been at or over-capacity since before the COVID-19 pandemic. The issue has worsened as a result of a severe lack of affordable housing, lingering bottlenecks from the COVID-19 pandemic, and long lengths of stay in the shelter system. While the problem at first glance may appear to be solved with building additional shelter capacity, it is important to recognize that emergency shelters currently absorb the greatest proportion of investment within Hamilton's homeless-serving sector and Hamilton invests more per capita in emergency shelters than many surrounding municipalities. The path forward for Hamilton is more permanent housing while continuing to provide emergency response to individuals who are homeless and/or living unsheltered.

In 2022, staff engaged the Social Planning and Research Council to conduct a review of post-pandemic emergency sheltering needs in Hamilton and provide recommendations. Many of these have already been initiated and/or recommended for consideration through the March 2023 Ending Chronic Homelessness Report and the April 2023 Housing Sustainability and Investment Roadmap Report. At the time of engaging the SPRC, consultant, the focus was determining how many additional beds in the emergency shelter system would be required post-pandemic. Context has since shifted to reflect a new reality growing encampments family homelessness, increased numbers

of refugee and asylum seekers arriving in Hamilton, and other critical social issues. Both emergency response and a focus on permanent housing solutions are required. There is significant risk to the health of our housing sector if we only respond to crises instead of also focusing efforts and investments upstream to create permanent housing solutions.

Staff from various teams and departments have worked together in this report to provide recommendations to address Hamilton's overburdened shelter system and growing homelessness issues and address basic needs of unsheltered individuals from a human-rights focus. The resulting focus in this report on permanent housing solutions reflects consensus from the June 2023 public engagement on Hamilton's approach to encampment response.

Some recommendations in this report require in-year decisions and it is recommended that where possible, investment decisions be referred to the 2024 budget process in order to provide Council the ability to consider all recommendations and prioritize accordingly. It it will not be feasible to invest in all recommendations due to availability of resources. Additionally, partnerships with and funding from upper levels of government are required to make progress on ending chronic homelessness.

Informed by The Social Planning and Research Council's 2022 review of post-pandemic emergency sheltering needs in Hamilton and recommendations, this report outlines a three-pronged approach.

- Prong one recommends continued investment in interim emergency response interventions, including hotel overflow spaces for families experiencing homelessness, temporary shelter beds for women, winter response, and diversion programs to meet immediate need of individuals experiencing homelessness and unsheltered individuals until new permanent solutions are established. In-year decisions are needed for continuing hotel shelter overflow spaces for families and winter response; the remaining recommended investments are referred to the 2024 budget.

- Prong two recommends investments in immediate housing solutions through various strategies, including portable housing benefits for individuals who are unsheltered and/or homeless be referred to the 2024 budget. One recommendation requires an in-year decision related to an immediate opportunity to provide 24 units of housing with supports at City Housing Hamilton's King William project to house individuals directly from encampments this fall; the remaining recommended investments are referred to the 2024 budget.

- Prong three recommends longer-term strategies and investment in creation of permanent supportive housing as described in the Housing Sustainability and Investment Roadmap, including:
    - One recommendation requires an in-year decision for the City to take advantage of an immediate opportunity to realize 20-25 units of permanent housing for families with occupancy by fall 2024 and provide a capital grant to Indwell for $2.3M to enable their Acorn Flats project to begin construction within 30 days of approval.
    - Creation of a new Housing reserve fund to facilitate an in-year multi-year municipal commitment towards the creation of 200 new supportive housing units. It is proposed allocate the $31M capital funding that would have otherwise been required to build new shelter beds instead to a three year, $10 M annual Housing Secretariat reserve fund as municipal contribution to enable leveraging of provincial and federal funding for capital construction of new permanent supportive housing and that the Secretariat and staff work to develop options and parameters for delegated authority for this fund, and report back to Council in Q3 2023 on options.
    - Exploring the opportunity to create supportive housing through existing but unfunded Residential Care Facility spaces. Currently operators have unfunded beds that could be used to create additional permanent or temporary capacity for housing. Staff will further investigate costs and opportunities and report back to council.

Need and demand will always be greater than available resources, prioritizing recommendations in alignment with available in-year and 2024 resources is exceedingly difficult. Looking ahead, we must establish a policy framework that includes a target ratio for investing in permanent housing solutions versus emergency response to reorient Hamilton's homeless-serving system around prevention and permanent housing options to move people out of homelessness.

Alternatives for Consideration – See Page 14

FINANCIAL – STAFFING – LEGAL IMPLICATIONS

Financial:

Staff are requesting that family shelter overflows and 24 units of high level support services continue in 2023 at a total projected cost of $4.4M to be funded in 2023, first from any new/additional Provincial or Federal Funding sources and if necessary, from available City of Hamilton COVID-19 Reserve and/or any 2023 Corporate Surplus'.

$876,000 will be recommended for the period of December 1, 2023 to March 31, 2024 to provide overnight drop in centres. This will be addressed in further detail in a forthcoming September 7, 2023 in the ECS Winter Response staff report. This results in a total potential additional cost of $5.3M in 2023 to be funded a combination of the following sources: new/additional Provincial or Federal Funding sources, City of Hamilton COVID-19 Reserve and/or 2023 Corporate Surplus'.

A one-time Grant is also being recommended to the Indwell Acorn Flats Project which will provide an additional 20-25 permanent units for families at a cost of $2.3M to be funded from the Unallocated Capital Levy Reserve in 2023/2024.

A report will also be forthcoming in Q3 from the Housing Secretariat addressing a multi-year municipal commitment of $31M ($10.33M over 3 years) towards the creation of 200 units of supportive housing by leveraging provincial and/or federal funding for projects in development as of this fall. The report will address financing options.

Staffing: Implementation of recommendations in this report will be referred to the 2024 tax operating budget process and require the addition of five permanent FTE within Housing Services Division's budgeted complement at a cost of approximately $502 K for salary and benefits in 2024: 2.0 Emergency Shelter Case Managers, 1.0 Housing Support Worker, 1.0 Housing Services Clerk, 1.0 Sr. Project Manager.

Legal: Legal Services support will be required in drafting any agreements and developing the terms of those agreements.

HISTORICAL BACKGROUND

On March 23, 2023, the Emergency and Community Services Committee approved Report HSC23021 Ending Chronic Homelessness, outlining a comprehensive approach and investments required to end chronic homelessness in Hamilton. In addition to identifying needs and related investments required for the homelessness serving system, this report included the need for additional capacity of 200 beds and 40 beds in the women's and family shelter system, at an estimated minimum of 5.7M annual operating costs and unknown capital costs, which were later costed by staff at a minimum of $31M capital costs for a new build.

On April 19, 2023, the General Issues Committee approved Report HSC23028/FCS23055/PED23099 Housing Sustainability Investment Roadmap to guide cross-departmental work related to affordable housing issues. This included eleven first year priorities, including the creation of 200 new supportive housing units and a

recommendation to provide a new municipal housing benefit to 500 households and approval of $1M to be invested through the provincial Homelessness Prevention Program to establish a new Housing Benefit for up to 166 households per year at $500/month/household.

POLICY IMPLICATIONS AND LEGISLATED REQUIREMENTS

On June 21, 2019 the federal government passed the National Housing Strategy Act, Bill C-97, which legislated the right to housing in Canada.

Purchasing Policy 4.11, Section 2 (b) Policy for Negotiations, requires Council Approval when a single source for the supply of a particular Good and/or Service is being recommended because it is more cost effective or beneficial for when the request has a cumulative value of $250,000.00 or greater.

RELEVANT CONSULTATION

In July 2022, the Housing Services Division contracted the Social Planning and Research Council of Hamilton (SPRC) to support a review of post-pandemic emergency sheltering needs and recommendations (Appendix "A" to Report HSC23041). These recommendations are outlined in the analysis section.

From October 2022 through January 2023, more than 180 individuals with experience using emergency shelters and drop-in programs were engaged to inform review and revision of Hamilton's Emergency Shelter Standards. A staff report will come forward in Q3 2023.

Further consultation with external stakeholders regarding Hamilton's overall strategy to prevent and end experiences of homelessness has included engagement with: Hamilton is Home, Coordinated Access Steering Committee (a group made up of senior leaders within the homeless-serving sector), Coalition of Hamilton's Indigenous Leadership, Community Safety and Wellbeing Plan stakeholders, Hamilton's Community Advisory Board, and stakeholders of the Housing Sustainability Investment Roadmap. Community partners continuously advocate for greater investment in permanent housing. Without more permanent housing options people in shelters and encampments have nowhere to go.

This report and recommendations were also informed by Encampment public Engagement sessions where permanent housing solutions emerged as a consensus theme.

Internal consultation was conducted with Finance and Procurement. Procurement supports the recommendations in this report

ANALYSIS AND RATIONALE FOR RECOMMENDATION

Emergency shelters are necessary to ensure people experiencing homelessness are safe and their basic needs are met while they pursue stable housing. However, an over-investment in emergency response services runs the risk of regressing to a place of managing homelessness rather than ending it. To accelerate progress toward ending homelessness, Hamilton must move boldly to invest in long-term permanent solutions to homelessness. This is the only way to avoid cycles of short-term measures that help people cope with homelessness, rather than address the root causes.

Emergency Shelters

Emergency shelters are designed to provide short-term shelter and housing supports, ideally for a duration less than 30 days. The City of Hamilton funds 9 shelters that currently offer 365 beds. The City also provides funding for hotel overflow for approximately 30 families because there is great need and no other options for families who find themselves without shelter (see Appendix "B" to Report HSC23041). Provincial Social Services Relief funding enabled the City to increase shelter capacity for all populations through hotel overflow during the pandemic, which brought shelter capacity to more than 600 beds at the peak of Covid-19 response (HSC20020(f). Although the number of beds within the system was significantly higher from March 2020 through December 2022, demand for emergency shelter increased proportionately and shelter occupancy remained at capacity or over-capacity during the same period.

In 2022, a total of 58% for all populations and 85% of families spent more than 30 nights in shelter. This means that almost 60% of all shelter stayers were in need of shelter and supports beyond the intended design of the emergency shelter system.

Persistent over-capacity and long stays in the emergency shelter system are a direct result of a lack of permanent housing options. Beds are occupied for longer periods, leading to bottlenecks and forcing others to be turned away due to lack of space.

The report completed by Social Planning and Research Council, commissioned by City of Hamilton in July 2022, emphasized the need to prioritize investments in Indigenous community supports, permanent housing, and prevention. Many existing actions towards those priorities are addressed in HSC23021 and HSC23028 and continue to be prioritized by ongoing collaboration through the homeless-serving system. The report also stated a need for an additional 40 beds in the women's shelter system and 50 units (200 beds) in the family shelter system due to ongoing overcapacity and high demand.

Preliminary estimates of capital costs for shelter expansion of this scale are approximately $31 M. This is based on the average cost of $500,000 per unit for new construction with an occupancy of four people per room, but actual costs could be higher. Ongoing operating costs are estimated at a minimum of $5.7 M annually. Actual operating costs could vary depending on site proposed, development plan, and program model. Given continued pressures in the emergency system and the critical need to focus on permanent housing solutions, the recommendation in this report is to instead invest this amount over the next three years in a new housing reserve fund administered by the Housing Secretariat that acts as municipal contribution to leverage provincial and federal funding for supportive housing projects that can be ready for occupancy in the next 18-26 months. With Council direction, staff will further investigate this opportunity and report back to Council on financial options and an implementation strategy consistent with the Housing Sustainability and Investment Roadmap.

Family homelessness has become a new and significant crisis within our City. Between January 1 and April 30, 2023 there have been 249 'turn-aways' from the Family Centre due to the program having no space available. Currently, we are provided hotel room for families and capped at supporting approximately 30 families. Due to overflow spaces being used consistently, providing these 30 beds translates to a budget pressure of $4.1 M in 2023 and $4.45 M anticipated in 2024. Council approval and levy funding is required to continue providing these hotel spaces. Contracts will otherwise be brough to an end.

Likewise, the women's shelter system has continually had to add capacity to meet demand before and throughout the pandemic. Bed capacity in January 2020 was 46 beds and at its peak in early 2023, bed capacity was 109 beds. With Cathedral closed as of May 19, 2023, overflow was established at West Avenue to offer 20 beds for women for a total of 66 in the women's system. Avenue is funded temporarily until March 2024.

These shelter capacity pressures may suggest a need for more shelter beds, however investments in shelter space alone are insufficient without significant investment in homelessness prevention and permanent housing solutions to prevent people from getting stuck in homelessness and in shelter. The City of Hamilton needs to develop an ideal ratio of investments in permanent housing solutions vs. immediate emergency supports.

Hamilton already has more shelter beds per 100,000 compared to peer communities. Hamilton's investment was substantially higher than peer communities in 2021, when Hamilton had 110.4 beds per 100,000 compared to a median of 39.2 due to expansion of use of hotel overflow (see Appendix "B" to Report HSC23041). This tells us that the solution is not to continue expansion of shelter beds. This was demonstrated during

COVID-19 response when shelter beds were increased to more than 600 spaces and were continually full. Any beds added to the system are likely to be filled while still seeing unmet demand.

Proposed Solution: A 3-Pronged Approach

The March 2023 Ending Chronic Homelessness and April 2023 Housing Sustainability and Investment Roadmap reports (HSC23021 and HSC23028) outlined actions that have already been initiated, including expanded prevention supports, Indigenous-led housing and homelessness solutions, enhanced case management programs, and new investments in affordable housing and housing subsidies. More investment is needed to respond to the levels of community need as evidenced by growing encampments and pressure on Hamilton's emergency shelter system.

Prong One – Continued Interim Investment in Emergency Response

To bridge the gap between now and when new permanent housing solutions are in place, continued funding for hotel overflow beds and the temporary women's emergency shelter located at 46 West Ave S (operated by Good Shepherd Centre Hamilton) are recommended through December 31, 2024.

If the funding for family hotel overflow is not approved in-year for 2023, capacity will need to be reduced immediately by 20 families (current capacity is 30 families) and capped at a maximum of 10 families, currently funded by provincial funding. As the program is partially funded by provincial programs, closing the remaining 10 beds and ending all hotel contracts would enable $1.8M of provincial funding to be reinvested in the system in other ways for families. As inflation and costs continue to rise, the expenses related to hotel overflow beds are expected to increase in 2024 but until permanent solutions like Acorn Flats and other similar initiatives are available, the City has limited opportunities for housing families experiencing homelessness. Staff will continue to review and report back on opportunities.

If the funding for overflow at West Avenue is not approved, 20 beds of expanded capacity in the women's system will need to be reduced as of April 1, 2024.

Research indicates that early prevention supports dramatically reduce public spending on homelessness. Diversion is a form of prevention that exists within shelters as an essential component to an effective emergency housing strategy. Enhanced investments in diversion programs will enable hiring fulltime staff roles and dedicated flex funds to engage in mediation, problem solving, and the identification of community and housing supports. It is estimated that approximately 25-30% of people who access the shelter system can be successfully diverted if provided the right supports. This

recommended enhancement is expected to prevent homelessness for up to 600 people per year.

Prong Two –Immediate Solutions to Preserve and Attain Affordable and Supportive Housing

Report HSC23021 in March 2023 outlined a need to establish a municipal housing benefit aligned with Rent-Geared-to-Income for an estimated 500 households to end their experience of homelessness. Portable housing benefits provide direct financial assistance to households rather than being tied to a housing unit. Allocating this benefit directly through homelessness support programs closes the affordability gap for people experiencing homelessness to find suitable stable housing on the private market.
In April 2023, Council approved report HSC23028 and the recommendation to allocate $1 M through the provincial Homelessness Prevention Program towards a municipal housing benefit for 166 households. Recommendation (e) in this report will support an additional 332 households to bring the total households served to the 500 range.

Through federal Rapid Housing Initiative funding, the City of Hamilton has invested in a new CityHousing Hamilton building that will offer 24 new units of housing at 257 King William. This building will be ready for occupancy in fall 2023. The recommendation for City investment of $600,000 in 2023 and the first quarter of 2024 ($1.2 M annually) in operational funding, while at the same time pursuing provincial commitment for these ongoing operating costs, will enable Indwell Community Homes and health partners to offer high intensity supports for individuals housed in these units, who may be coming from unsheltered homelessness or long-term periods of homelessness. This addresses a large need for housing with supports to help people exiting chronic homelessness to stabilize their housing and well-being.

Additionally, staff is proposing to explore how Residential Care Facilities can be used to expand the City's capacity to house individuals requiring minimal supports. By doing so, the City aims to increase its capacity to provide housing to more individuals on the By Name List, which is a list of individuals experiencing homelessness in the area. Here are some key points and potential benefits of this potential strategy:

- **Increased Capacity:** By subsidizing existing unsubsidized beds in Residential Care Facilities, the City can increase the overall housing capacity for individuals requiring minimal supports. This may lead to more vacant beds being utilized, thus reducing homelessness.
- **Support for Vulnerable Individuals:** Residential Care Facilities typically offer support services, which can be crucial for individuals with minimal support needs. This can improve the well-being and stability of those individuals and help them transition towards more independent living arrangements.

- **Reduced Homelessness:** By focusing on housing individuals only from the By Name List, the strategy targets those in most urgent need of housing and aims to reduce the number of people experiencing homelessness in the community.
- **Cost-Effectiveness:** Subsidizing existing beds might be more cost-effective than building new. It can also be a faster solution to provide housing for those in need.
- **Collaboration with Residential Care Facilities:** Involving Residential Care Facilities in the strategy can foster cooperation between public and private sectors, encouraging them to contribute to solving the homelessness issue in the community.

Exploring the use of unsubsidized Residential Care Facilities beds to house individuals from the By Name List, requiring minimal supports, is a promising strategy to address homelessness and reduce the number of people experiencing homelessness in the City. In addition to understanding resource requirements, proper planning, collaboration, and monitoring will be vital to the success of this initiative. Staff will report back to Council with an update on opportunities to implement this strategy.

Prong Three – Invest longer term in permanent supportive housing as described in the Housing Sustainability and Investment Roadmap

Lack of permanent supportive housing for individuals and families with the highest complexity of need remains one of the largest gaps within the homeless-serving system. Towards addressing this gap, the City of Hamilton has made a commitment through the Housing Sustainability Investment Roadmap to work with upper levels of government and community partners to establish 200 units of permanent supportive housing for people with the greatest complexity of need. Currently there are no known supportive housing resources in Hamilton that are dedicated to families and too few for all population groups.

City staff have engaged with non-profit housing providers through Hamilton is Home and the Housing Sustainability and Investment Roadmap to identify permanent supportive housing projects that could be constructed (or substantially constructed) within the next 36 months. Hamilton is Home has identified 418 possible units where the land is owned (or there is a path to ownership), and if project funding were identified, construction of the units could meet this 36-month timeline. The City has worked with planning division staff to determine that almost 200 of these units do not require re-zoning, and construction could begin with one year. Municipal funding is required to make these projects viable. To facilitate leveraging provincial and federal investments, this report recommends the Housing Secretariat report back on a financing strategy and parameters that would enable the allocation of $31 M municipal investment structured over three years, to ensure that viable projects can move forward quickly while optimizing cost-sharing between levels of government. Once constructed and operating,

these supportive housing units will reduce pressure on emergency shelters, hotel overflow, and emergency response to encampments.

This report also recommends the City take advantage of an immediate opportunity to realize 20-25 units of permanent housing for families with occupancy by fall 2024 and provide a capital grant for $2.3M to Indwell Community Homes for $2.3M. Though community consultation, Indwell's Acorn Flats project has been identified as both the most shovel-ready project that project that best leverages funding from other levels of government, $2.3M that Indwell has secured through the Federal Co-investment Fund Federal funding. Alternatives would require more time and be higher cost.

ALTERNATIVES FOR CONSIDERATION

Alternative A:

- Instead of allocating $31M to the Secretariat for a Housing Reserve Fund, Council could direct staff to initiate a Request for Proposals for expansion of shelter beds, 40 beds in the women's system and 200 beds (50 units) in the family system.

The benefit of this approach is that it would help meet expected continued high demand for emergency shelter beds. This would reduce the instances where someone may be turned away from shelter due to lack of space and minimize the need for continued investment in overflow.

Risks include failure to invest in permanent housing, leading to higher numbers of people in shelter with nowhere to go. Investments in prevention and housing subsidies will help offset this risk, though won't meet the depth or diversity of need. Additionally, even with expanded shelter beds in the system, there is always potential for demand to increase and lead to further need to contract new overflow shelters through hotels or alternate sites.

Alternative B:

- Allow contracts with hotel operators to expire and avoid $4M levy pressure associated with costs of hotel overflow program or direct staff to explore other options for this $6M investment(1.8M provincial funding). The total cost of hotels used to shelter families is $6M, however, a portion, $1.8M is derived from the provincial funding through the Homelessness Prevention Program.

Benefits include the opportunity to invest further upstream and prevent new homelessness. Risks include even less ability to meet the needs of families currently experiencing homelessness. We currently have nowhere for families to be housed.

APPENDICES AND SCHEDULES ATTACHED

Appendix "A" to Report HSC23041: Hamilton Post-Pandemic Emergency Shelter Size Review: Key Findings. SPRC, July 2022

Appendix "B" to Report HSC23041: Hamilton Emergency Shelter Data Trends

DOCUMENT 8

CITY OF HAMILTON

HEALTHY AND SAFE COMMUNITIES DEPARTMENT
Housing Services Division
and
PLANNING AND ECONOMIC DEVELOPMENT DEPARTMENT
Licensing and By-law Services Division
and
PUBLIC WORKS DEPARTMENT
Environmental Services Division

TO:	Mayor and Members General Issues Committee
COMMITTEE DATE:	May 15, 2024
SUBJECT/REPORT NO:	Encampment Observation Report (HSC24020/PED24080/ PW24030) (City Wide)
WARD(S) AFFECTED:	City Wide
PREPARED BY:	Mike Jones (905) 546-2424 Ext.3824
SUBMITTED BY: **SIGNATURE:**	Michelle Baird Director, Housing Services Division Healthy and Safe Communities Department Michelle Baird
SUBMITTED BY: **SIGNATURE:**	Dan Smith Acting Director, Licensing and Bylaw Services Planning and Economic Development Department
SUBMITTED BY: **SIGNATURE:**	Cynthia Graham Director, Environmental Services Public Works Department C. Graham

RECOMMENDATIONS

(a) The Encampment Protocol (Appendix “A” in Report HSC20038(g)) be modified to remove the following provision from Section D, indicating the removal of encampments, temporary shelters, or tents “on or within 50 metres of the Hamilton Alliance for Tiny Shelters model site. For the purpose of this site the full length of the Strachan Linear Park, Bay Street North to Ferguson Street North, will be considered the site.”

(b) That the Housing Services Division report back with recommendations on how to address the needs of individuals who are unhoused and any additional service gaps highlighted in this report.

EXECUTIVE SUMMARY

This report provides an overview of the findings associated with implementing the Encampment Response protocol. The Encampment Protocol represents a concerted effort to mitigate the challenges faced by individuals living unsheltered and address concerns raised by the broader community.

Since its ratification in August 2023, the Protocol has undergone several phases of response, from initial ground truthing efforts (i.e., using maps to determine a site's compliance before confirming in-person) aimed to delineate compliant and non-compliant areas, followed by ongoing outreach efforts by Housing Focused Street Outreach to make individuals aware of the protocol's requirements and available resources.

The City has effectively established a housing-led approach that prioritizes supportive outreach over punitive measures, yet several challenges persist, such as difficulties in enforcing compliance timelines, managing garbage and debris at encampment sites, and seasonal considerations regarding the implementation of the protocol.

Overall, the implementation of the protocol has provided greater transparency and clarity regarding the processes used by the City in responding to encampments in the community and has been an effective tool in balancing the needs of individuals living unsheltered with the broader community's needs. However, sustained efforts focused on permanent, humane, cost-effective solutions is needed to address the systemic multifaceted challenges faced by individuals living unsheltered. To this end, Housing Services Division will be proposing several recommendations in Report HSC23021(b) aimed at responding to some of the concerns outlined in this report with the ultimate goal of ending chronic homelessness in Hamilton.

Alternatives for Consideration – N/A

FINANCIAL – STAFFING – LEGAL IMPLICATIONS

Financial: N/A

Staffing: N/A

Legal: N/A

HISTORICAL BACKGROUND

On March 23, 2023, staff presented information report HSC23021, Ending Chronic Homelessness, identifying interventions that were successful as well as needed investments to make progress on resolving chronic homelessness in Hamilton.

On May 17, 2023, staff recommended that Council adopt a Proposed Encampment Protocol (HSC20038(f)/PED21188(c)) in the interim, while a period of public comment occurred until June 30, 2023, to obtain public comment around the concept of sanctioned sites and to conduct a jurisdictional scan.

In addition, to respond to concerns related to basic needs supports and the need to integrate frontline stakeholders and people with lived experience into the encampment response, Council directed staff to provide access to washrooms, showers, clean drinking water, as well as integrate Indigenous and peer supports into its encampment response program. Further, staff were asked to develop a task force or committee comprised of City staff, community stakeholders, and people with lived experience to advise on the development of an encampment response policy and appeals process.

The period of public comment resulted in significant feedback on the draft Protocol, including 11,943 visitors to the Engage Hamilton website who contributed 15,965 individual comments, as well as approximately 2,000 attendees at three in-person community engagement sessions. Once the period of public comment closed, it was recommended that the City make the necessary changes and provide a final recommended Protocol to Council in August 2023.

On August 18, 2023, Council adopted and ratified an Encampment Protocol in Encampment Response Update – August 2023 (HSC23066), identifying approaches, processes, and service levels associated with responding to encampments in the City. In addition, Council provided necessary resources in staffing and equipment to support the implementation of the Protocol. While a broad approach involving sanctioned sites was not recommended by Staff due to its prohibitive costs better utilized in prevention efforts and/or housing, Council also approved a two-year Hamilton Alliance for Tiny Shelters pilot for up to 25 tiny homes on City lands at no cost to the City.

On September 6, 2023, staff followed up on the Ending Chronic Homelessness report with HSC23041 – Addressing the needs of Unsheltered Individuals and those Relying on Hamilton's Emergency Shelter System. This recommended several investments to address capacity challenges in the shelter system, including providing additional space for those living encamped. These items were referred to Budget 2024 and subsequently approved as part of the budget process.

POLICY IMPLICATIONS AND LEGISLATED REQUIREMENTS

N/A

RELEVANT CONSULTATION

Several consultations were conducted and were the basis for analysing the implementation of the Encampment Protocol.

Housing Focused Street Outreach consulted with internal divisions including Municipal Law Enforcement, Parks Section, Parking Enforcement, and Hamilton Fire Department, as well as Hamilton Police Services. In addition, an open-ended questionnaire was sent to several community partners who comprise the Encampment Liaison Committee, including Keeping Six, St. Matthew's House, HAMSMRT, and Hamilton Regional Indian Centre.

People living in encampments throughout the City were also consulted from March 7-12, 2024.

Housing Focused Street Outreach staff consulted with nearby municipalities that are considering adopting a Protocol to direct encampment-related work in Guelph and Toronto, to compare approaches and findings. The consultation helped to inform the analysis below.

ANALYSIS AND RATIONALE FOR RECOMMENDATION

While this report focuses on the impacts of unsheltered homelessness in the City of Hamilton, it is important to note that increasing levels of unsheltered homelessness is being experienced in communities across Canada. With increased costs of housing and rental prices, inflation with stagnant wages, as well as insufficient income from supports such as Ontario Works and Ontario Disability Support Program, it is exceedingly difficult for low-income households, particularly singles, to access suitable and appropriate housing. Adding to the precarity being experienced, in Hamilton and across Canada, emergency shelter capacities are also being met and chronically exceeded across sectors, particularly for adult men, resulting in overflow into hotel spaces.

With both housing and emergency shelter largely inaccessible, and with more individuals entering into unsheltered homelessness, the constellation of existing supports is unable to meet the growing demand. More people are confronted with the reality of living in an encampment, a lifestyle that contributes to worsened physical and mental health outcomes and often associated with increased substance use.

Limited coordination and accountability to-date from Federal and Provincial levels of government has further complicated efforts to address the issue. Nonetheless, there is

still a need to address unsheltered homelessness at a community level to ensure individuals living outside do so with dignity, while also meeting the needs of the broader community. As such, the Encampment Protocol was adopted to provide transparency and expectations around the City's approach to encampment response, and to balance the needs of everyone in the community.

To evaluate how the Protocol is being implemented, several consultations were conducted, including with people with lived experience, community partners, and members of the Coordinated Response Team, who have provided ongoing oversight throughout implementation to various aspects of the program through ongoing collaboration and coordination, to calibrate how supports are best utilized to achieve the maximum impact. Given the volume of responses from the community (particularly from concerned citizens, Business Improvement Areas, and local businesses) to the unsheltered inbox, their voice is also represented in the following analysis. The recommendations being made reflect all the feedback received.

The following section of the report will provide context around the implementation of the Protocol, and review feedback received from the consultations conducted, including both what was achieved, as well as challenges.

Volume of Requests and Approach to Communication

Since the establishment of the Encampment Protocol in August 2023 until April 15, 2024, Housing Focused Street Outreach has been contacted 3825 times (including follow-ups and repeated contact) via its unsheltered email, as well as hundreds more times by voicemail. The majority of complaints or service requests received by Housing Focused Street Outreach are initiated by concerned citizens (70%) and include requests for additional supports onsite, reporting of encampments, and requests for removal as per the terms of the Protocol, yet several other internal and external sources have also contacted Housing Focused Street Outreach regarding encampment-related concerns or requests.

With a high volume of complaints and service requests received by Housing Focused Street Outreach via email and voicemail, the ability of Housing Focused Street Outreach to respond to each request without a dedicated staffing complement has not been possible. As a result, complainants have not received personalized responses, leading to a lack of clarity and significant frustration. As part of a concerted effort to respond to complaints and requests, and to improve transparency with the public, Housing Focused Street Outreach has established a Program Secretary tasked with responding to inquiries, and the team has developed several new approaches to managing the inflow of complaints and service requests to its unsheltered mailbox and voicemail.

Enforcement-related Complaints and Requests for Service

Since implementation of the Protocol, the overall number of complaints and service requests has gradually declined, peaking at 860 in September 2023 before gradually declining to 328 in March 2024. There has also been a gradual decrease in the reporting of and requests to enforce encampments, which totalled a high of 526 in September 2023 before dropping to 130 in February 2024. This suggests that the efforts of Housing Focused Street Outreach and its partners has been successful in working with individuals living unsheltered to access compliant spaces.

While the complaints and requests for service regarding encampments have decreased month-over-month since the Protocol was established, from 897 in September 2023 to 328 in March 2024, it increased substantially in April 2024 to 481 complaints and requests for service. With warmer weather anticipated in the upcoming months it is expected that the total number of complaints and service requests related to encampments will increase to, or higher than the levels experienced in September 2023.This will place an additional strain on resources as staff attempt to address the community's concerns and suggestions.

Coordination amongst Partners and Stakeholders

Implementation of the Encampment Protocol requires significant effort and expertise from several teams. The Coordinated Response Team - made up of staff from Housing Focused Street Outreach, Municipal Law Enforcement, Parks Section, Parking Enforcement, Corporate Security, Hamilton Fire Department, and Hamilton Police Services - meet three times weekly to strategize around approaches to sites with acute challenges, coordinate encampment response through the City, and address issues via new, innovative approaches that build upon previous experiences. On a daily basis, several divisions are involved in ongoing coordination of frontline efforts to ensure sites are effectively engaged and when necessary, escalated to the appropriate parties who work together to enforce. To ensure the frontline work is well-coordinated, significant administrative work is needed to ensure all incoming communications are logged, new sites are identified and prioritized effectively, with frontline information (i.e., site visits, interactions/engagement with individuals living in encampments, enforcement actions, site clean-ups) about new and existing sites updated across teams within shared repositories on a daily basis. These interactions are the backbone of implementation, and this collaboration has been noted by all partners as being necessary and successful.

In terms of external partnerships, Housing Focused Street Outreach held an initial meeting in February 2024 with community stakeholders and persons with lived experience of homelessness to develop a Terms of Reference that outlines the purpose, values, objectives, and scope of the work. Due to the cybersecurity incident, timelines have been impacted and a next meeting is being rescheduled for May 2024.

Housing Focused Street Outreach will conduct ongoing research with individuals living unsheltered to establish appropriate baselines and to ensure there is ongoing evaluation of the community's needs that also correspond with the program's objectives. This will also provide staff with an opportunity to develop and track more reliable equity-based indicators to assess the impacts on people disproportionally impacted by unsheltered homelessness, which can be used to inform new partnerships and approaches to service.

Service Levels

As per the guidelines established in the Encampment Protocol, Housing Focused Street Outreach (Housing Services Division), Municipal Law Enforcement (Licensing and Bylaw), and Parks Section (Public Works) have service levels associated with their response to encampments. While other divisions (i.e., Parking enforcement, Hamilton Fire Department), and partners (i.e., Hamilton Police Services) are involved via the Coordinated Response Team, they do not have service levels guiding their response.

As of April 15, 2024, Housing Focused Street Outreach has received and visited 472 sites within the scope of the Encampment Protocol. Of the sites with a defined outcome, Housing Focused Street Outreach met its service level of attending and escalating each identified site with 72 hours 89% of the time and escalates 96% of sites to Municipal Law Enforcement within a week of being identified.

Due to the cybersecurity incident, there has been a significant loss of historical data related to Municipal Law Enforcement's service levels. Broadly, given the staffing levels available (i.e., a Municipal Law Enforcement Supervisor and two Municipal Law Enforcement Officers), there have been significant challenges in meeting the defined service level, and Municipal Law Enforcement would require additional staffing, as well as the support of additional Hamilton Police Encampment Engagement team staff to avoid enforcement bottlenecks.

While there are service levels identified within the Encampment Protocol defining clean-ups and site maintenance, Parks Section simultaneously manages routine garbage pickup, ad hoc clean-ups resulting from enforcement actions, as well as complaints and/or service requests, making it challenging to track each specific type of request. Additional mechanisms to track and identify work requests are under development.

Housing-Led Approach

The goal of a housing-led approach is for Housing Focused Street Outreach to be the first point of contact for individuals living unsheltered on public property, to establish rapport and work towards connecting them with services and supports that maintain their well-being, and to only escalate sites with potential compliance concerns to Municipal Law Enforcement (i.e., sites with no clear compliance issues would not be

escalated to Municipal Law Enforcement for investigation). To date, this has been effective during the implementation of the Encampment Protocol, and individuals living unsheltered reported having less or little interaction with Municipal Law Enforcement and Hamilton Police since the Protocol had been established.

Under the existing approach of having compliant spaces available for access, 50% of individuals living unsheltered felt the current approach was working for them. When comparing to a similar survey done in 2022, at a time when there was a 12–72-hour bylaw required individuals living unsheltered to move frequently to new locations, only 10% believed that approach was working for them.

To aide in continuous improvement of service to individuals living unsheltered, Housing Focused Street Outreach has developed several new processes to assist in triaging of complaints and requests, data analysis, and reporting. The new approaches will be used to collect more reliable, accurate systems data from outreach staff to assist with site prioritization and better define the work being completed by outreach staff. Housing Focused Street Outreach is also in the process of adding three (3) peer support workers who will be funded to support rapport-building, harm reduction, and site remediation.

Distance Away from Schools and Childcare Facilities

During the consultation period in summer 2023, and prior to the ratification of the Encampment Protocol, there was significant feedback provided by the public related to the proximity of encampments to places frequented by toddlers and school-aged children. As a result, in the final version of the Protocol the distances were extended from 50-metres to 100-metres away from schools and childcare facilities. This has been successful, with sites being identified near a school of childcare facility dropping from 12% in September 2023, to none in March 2023.

Number of Encampments Per Cluster

The Protocol provides direction regarding number of tents permitted in a cluster and distances between clusters. From the experiences of staff, corroborated through the experiences of a majority of individuals living unsheltered, as well as the complaints data, this has been a successful provision within the Protocol. While enforcement is based upon a five-tent limit, it is common for sites to include tents that are not inhabited, and instead used for storage of food and personal items, which adds to the size of a site. Largely, when sites exceed a manageable number of tents, i.e., approximately five tents, there is a clear increase in the number of associated complaints and concerns with the site.

At a community level, an increase in tents at a site is generally associated with an increase in complaints related to garbage and debris in a concentrated area, more combustibles, violence and use of weapons, and reports of feeling intimidated by the

number of people. In addition, individuals living in encampments also reported concerns with larger sites, included theft, lack of privacy, and varying and at times conflicting lifestyles and goals amongst the people living there.

Additional Protocol Considerations

While the intent of the Protocol is to balance the needs of individuals living unsheltered and the broader community, there were additional considerations made by internal staff and people with lived experience regarding potential changes that would add to the Protocol, as well as modify, and remove existing clauses.

One change to the Encampment Protocol being recommended is the following from Section D, indicating the removal of encampments, temporary shelters, or tents “on or within 50 metres of the Hamilton Alliance for Tiny Shelters model site. For the purpose of this site the full length of the Strachan Linear Park, Bay Street North to Ferguson Street North, will be considered the site.” It has since been confirmed that this area will not be used for the Hamilton Alliance for Tiny Homes pilot project, and to reflect this update, this provision should be removed from the Protocol.

For other potential changes, given that the Protocol has not been implemented for a full year yet and understanding that the warmer months have higher rates of people living unsheltered, more information is required to better understand the impacts of the Protocol prior to recommending any changes. In addition, before a recommendation(s) is made, each consideration would require a comprehensive policy and risk analysis of associated impacts. See Appendix “A” for a detailed list of considerations.

Compliant Spaces

With less required movement of people living unsheltered throughout the city as a result of compliant spaces being available, there are several compliant sites that have had a stable group of individuals living there. This has allowed Housing Focused Street Outreach and other frontline providers to build effective rapport with the same individuals over a longer period of time, leading to more successful outcomes. Both Outreach staff and individuals living unsheltered noted that having a place to stay for longer periods of time was very beneficial, especially when compared to approaches used in the past that required ongoing movement to new areas. However, this approach has been problematic for some neighbours and local businesses nearby who report concerns with an ongoing encampment presence nearby, particularly when there are presenting concerns around health and safety, namely garbage, debris, and waste.

In terms of frequented areas of the city, as expected given the proximity to services and supports, Ward 2 (34%), Ward 3 (29%), Ward 5 (9%), Ward 1 (9%), and Ward 4 (7%) have had the most newly identified encampments in non-compliant spaces, while all other Wards have had less than 5% of the total number of new encampments identified.

In general, the significant majority of encampments are in the lower City. Given the concentration of encampments in lower City wards, it is anticipated that this may lead to an increase in sites with numerical non-compliance (i.e., five or more tents, lack of distance between clusters), geographically non-compliant sites (i.e., proximity to), and more tents within escarpment areas during warmer weather months when historically more people live outside.

Safety Concerns

Concerned citizens and local businesses have detailed several health and safety issues in their complaints to Housing Focused Street Outreach, such as light posts being compromised for electricity, human waste exposure, and personal safety concerns. Businesses have detailed that the presence of encampments has negatively impacted their operations. This has led to significant frustration amongst all parties.

Several encampment residents who were interviewed also expressed concerns for their safety, sharing instances where their presence had resulted in confrontation from neighbours and youth.

Enforcement Challenges

The consistent enforcement of sites has been impacted by a lack of staffing available to manage the responsibilities of the portfolio. Currently, there are two Hamilton Police Services Encampment Engagement Team officers responsible for attending all site visits with Municipal Law Enforcement officers, coordinating and leading private property enforcement and the enforcement of sites on public property. With a high number of non-compliant sites resulting from the disbandment of larger sites like Woodlands Park and City Hall, and in using a hands-off approach to enforcement, the time required to enforce requires more resources than currently allocated.

Since Hamilton Police's Encampment Engagement Team was established in September 2023, the team has attended 441 encampment site visits. Some of these visits are supporting the issuing of 419 Trespass Notices by Municipal Law Enforcement Officers. In addition, Hamilton Police Service's Encampment Engagement team has spent a total of 248 hours enforcing previously issued notices. This does not include time spent assisting other agencies and enforcing encampments on private property.

Contributing to the time spent enforcing previously issued notices are several locations within the city that are often habitually occupied by encampments. Some examples include MacNab St S and Hunter St W, Jackson St W and MacNab St S, Vine between Park and York, and the Hamilton Convention Centre alcoves on King St W. Given the proximity of these sites/areas to community resources and services that meet the basic needs of individuals living unsheltered, these sites quickly re-establish after enforcement has occurred with new occupants, triggering a new round of engagement

and enforcement. In addition, other street-related concerns not related to encampments are often grouped under the heading of encampments, including loitering and illegal dumping or garbage. These issues, although not related to encampments and more frequently associated with mental health and substance abuse issues, are brought to the attention of the City via the unsheltered inbox These sites are also resource-intensive for Municipal Law Enforcement and Housing Focused Street Outreach to assess and address.

Recreational Vehicles and Trailers

Since the Encampment Protocol was adopted by Council, a growing number of locations throughout the city have been occupied by individuals inhabiting within Recreational Vehicles (RVs) and trailers. Many of the RVs and trailers being inhabited also have had additional semi-permanent structures built into them. With existing Parks Bylaws already governing the use of RVs and trailers, particularly for habitation, as well as several other Parking-related violations, the use of these vehicles in this manner is not compliant and there are no designated areas for free parking of Recreational Vehicles or trailers on public lands in the City of Hamilton.

To support this work, the City's Parking Enforcement team has joined the Coordinated Response Team to provide best practices related to managing these concerns, and in coordination with Housing Focused Street Outreach, has allowed for Outreach staff to visit individuals to ensure they are provided with additional options and resources prior to enforcement.

Fire and Combustibles

The use of fire pits and other combustibles by individuals who are unsheltered to maintain warmth during colder months has resulted in several complaints and concerns from neighbours of sites who feel at risk. The Hamilton Fire Department has been actively engaged with incidents related to encampments, categorized into those necessitating emergency response and those that do not. The main types of incidents responded to include burning complaints, rubbish fires, and calls for medical assistance. In January 2023, burning complaints were the predominant response call-type, numbering 31 responses. During such responses, fire-related situations are promptly extinguished, and encampment occupants are reminded of the open-air burning by-law.

The Hamilton Fire Department, in collaboration with the Housing Focused Outreach team, developed a printed resource to increase fire safety awareness and support educating people living unsheltered. Approximately 800 of these two-sided, non-destructible flyers were distributed to resource centres and the City's Encampment Response Team in early 2024. In addition, in January 2024 a representative from the Hamilton Fire Department joined the City's Coordinated Response Team to provide ongoing support and best practices related to coordination and risk mitigation at sites.

An important aspect to note is that application of the Ontario Fire Code principally pertains to buildings and structures but does not apply to tents smaller than 30m² used for camping, personal, or non-commercial purposes. Additionally, the Fire Department is not licensed to remove or transport hazardous materials (including propane cylinders). As such, there is currently no defined process for removal of flammable or combustible materials.

Washroom Access

The need for access to washrooms was echoed by several individuals living in encampments who want the option of using facilities nearby, as well as community partners who provide frontline service. Housing Focused Street Outreach has received several complaints from members of the community reporting human waste requiring clean up or wanting portable washrooms at compliant sites.

To address some of the concerns, two washroom programs were established at central locations within the city and are available on a 24/7 basis. Individuals encamped near washroom programs (i.e., JC Beemer, Corktown Park) report it as one of the reasons they stay nearby but given logistical concerns in counting users of the washrooms who are experiencing homelessness, staff were unable to identify the frequency individuals access the 24/7 washrooms.

In September 2023, shower programs were also established within two locations within the City, Norman Pinky Lewis Recreational Centre, and Bennetto Community Centre. Previously, the City operated a shower program at Eastwood Arena, but due to low uptake (33 visitors over 15 weeks), the program was moved to Bennetto in January 2024, which has seen a mild increase in uptake (6 per week, vs 2 per week). In contrast, Norman Pinky Lewis has seen an average of 14 individuals experiencing homelessness utilize the service each week. More work is required to better understand barriers to service use.

Garbage and Debris Pickup

Housing Focused Street Outreach received several complaints describing parks as being unusable due to the presence of garbage and debris. As individuals move to compliant sites and stay in a single place for longer periods of time, they often accumulate more items at the site, particularly during colder weather months. As a result, the number of complaints related to garbage and debris has maintained at the same level (67-80 requests per month), despite a significant decrease to the number of sites and overall complaints and requests for service.

To facilitate clean-ups at sites across the city, the Parks Section has created a schedule to assist in managing garbage and debris pickup at encampments. To ensure adequate coverage, larger sites that may contain more than one cluster or are currently non-

compliant with five or more tents are attended to every other day given the level of need, while smaller sites are visited at least once a week.

Managing clean-ups throughout the city can be challenging given that there are ongoing ad hoc requests made of Parks section staff, sometimes related to sites being vacated or recently vacated. As such, a consistent, planned schedules for all sites is not possible. In the meantime, all known encampment sites visited by Parks section are offered garbage bags to help mitigate the spread of garbage and debris, and staff coordinate with individual(s) at the site to detail the location to leave bagged garbage, and approximate time of next pickup.

Additionally, there have been concerns about garbage/debris on private property associated with encampments, which is presently not within the City's scope of work. To alleviate the burden on members of the public to clean up after garbage/debris has been left on their property, Public Works is bringing forward a recommendation report in May 2024 to suggest an approach to address and mitigate these concerns.

Special Events

Throughout the year, the City of Hamilton, and its partners host community events on public lands across the city. As part of holding events the Special Events Advisory Committee (SEAT) reviews the operational details to ensure the health and safety of participants and City assets (parks, roads). Occasionally, some of the 350+ events held each year are planned in spaces already occupied by encampments in a compliant location.

With no specific clause in the Encampment Protocol delineating a process for managing co-location and given the mental health impacts of moving individuals from their compliant space, individual(s) in residing in compliant locations will not be moved as a result of an upcoming or planned event. As encampments move throughout the City, particularly in the summer months, this can lead to tensions and challenges amongst event organizers and City staff that are managed on a case-by-case basis.

Barriers to Housing and Emergency Shelter

Without identified outflow from encampments into indoor spaces such as emergency shelter, temporary or transitional housing, or permanent housing, encampments are likely to maintain or increase in total.

Individual(s) living unsheltered reported several barriers to emergency shelter, including a lack of pet-friendly and couples' spaces, harm reduction friendly policies, privacy concerns, and requirements to leave and return to secure a bed every day, that precluded them from wanting to access the service. When asked if they would consider accessing spaces in the emergency shelter system more suitable to their needs (i.e.,

some of the barriers to access were potentially reduced), 71% were interested. To reflect this need, Housing Services division continues to explore various program models aimed at providing more inclusive service.

To address the impacts of colder weather and increasing need, in 2023-24 Housing Services Division introduced a number of services and supports aimed at providing greater access to warm, indoor spaces, particularly for individuals who are less likely to access traditional service models and may spend time in encampments. Services offered included the warming bus which operated in cold-weather months overnight and was staffed by two outreach employees, extended hours at resource centres and libraries for individuals looking for immediate respite from colder weather, 45 overnight spaces at Willow's Place, and 50 warming spaces at Good Shepherd Cathedral. Given the benefits associated with the City's Winter Response Strategy and the ongoing need for indoor space, particularly for hardest-to-reach populations, these services have been extended until November 30, 2024. An investment in resources within the Family Shelter system allowed for additional support services for clients in this sector.

Housing also continues to be difficult to acquire for individuals living in encampments, especially those who may require supports that assist in their transition. While many of the individuals living outside had connected with housing workers and were on the Access to Housing waitlist, many still felt unsupported, and shared little to no hope in acquiring housing. While the Encampment Protocol has been developed to provide clarity and balance the needs of individuals living unsheltered and the broader community, and with the knowledge that other approaches (i.e., sanctioned sites) have been considered that would provide temporary relief at high costs, the goal is to use resources towards permanent, humane, cost-effective solutions such as housing. To this end, Housing Service Division has identified resources and strategies that would effectively end chronic homelessness in Hamilton and will be bringing a report with actionable recommendations for Council to consider in June 2024.

To ensure individuals are able to stay in their housing, the City of Hamilton is currently implementing the expanded Tenant Support Program as approved by City Council to help stop vulnerable tenants being displaced and possibly entering into the homelessness serving system. This expanded program includes a partnership with the Hamilton Community Legal Clinic to provide legal support for tenants facing displacement through N-13 and N-12 notices. Additional supports as part of this program are outreach services to tenants through ACORN Hamilton and housing plans and support for tenants who do need to be displaced because of legitimate renovations through the Housing Help Centre Hamilton and Area.

The issue of homelessness and related issues of addiction and mental health continue to cause pressures across the housing and homelessness system and beyond. These are multi-faceted complex issues, and the continuously growing needs are pressuring the capacity of the existing systems. In addition, the issues are challenging and cross-

departmental in nature, often extending beyond city departments. This is demanding work and has an impact on the City staff working on these issues.

Despite the challenges there are opportunities for us, as a City, to have a positive impact with time. The encampment protocol is not a solution to homelessness, it continues to be a means to manage the crisis within our City providing some stability and options for people experiencing homelessness, however, continued commitment to more solution focused measures is needed in accompaniment with the protocol.

ALTERNATIVES FOR CONSIDERATION

N/A

APPENDICES AND SCHEDULES ATTACHED

Appendix “A” to Report HSC24020/PED24080/PW24030 – Additional Encampment Protocol Considerations

DOCUMENT 9

Encampment Protocol

A) Shared Principles

When engaging in encampment response, all staff in a frontline capacity will use the same philosophical approach. In all interactions with people who are living unsheltered, staff will engage utilizing a human-centered, housing first, health-focused, rights-based approach. All actions will be guided by a commitment to upholding the human rights and human dignity of all individuals living in encampments, temporary shelters, or tents. Staff will also work to build rapport through mutual respect, effective communication, empathy, and by maintaining transparency around the expectations of individuals living in encampments, temporary shelters, or tents and City staff.

It is vital that all actions taken in the Protocol are grounded in the understanding that housing is a fundamental human need, and that people in our community deserve housing and homelessness responses that are based on intentional planning and good evidence and that have measurable positive impacts and outcomes. Working to provide permanent housing for all is critical and will require an ongoing commitment from the City, community, and other levels of government to find innovative, meaningful solutions.

B) Complaints and Service Request Information:

Individuals in the community who encounter an active or abandoned encampment, temporary shelter, or tent, or someone who is living unsheltered, and/or have questions or concerns about an encampment, should contact the Coordinated Response Team led by Housing Focused Street Outreach by email at unsheltered@hamilton.ca or by phone at 905-546-2828.

Any contacts made with other internal City divisions or through other City channels regarding encampments, temporary shelters, or tents will also be forwarded to Housing Focused Street Outreach for first response.

C) Alignment to Housing Resources and Supports

In establishing a housing-focused approach to interacting with individuals living unsheltered and/or in encampments, all individuals will be given an opportunity to complete a Vulnerability Index – Service Prioritization Decision Assistance Tool (VI-SPDAT)

In the context of individuals living in encampments, temporary shelters, or tents, the Vulnerability Index – Service Prioritization Decision Assistance Tool is a triage tool, with a series of questions asked by Housing Focused Street Outreach staff to individuals who are experiencing homelessness. The assessment tool is used to support conversations where staff learn about an individual's housing situation, needs, and strengths to help build a plan to achieve stable housing. It is also used to inform additional supports that may be needed and/or help prioritize housing interventions within Hamilton's Homeless-serving System likely to be most beneficial to support an individual's needs, preferences, and long-term housing outcomes.

There is no requirement for anyone who is living in an encampment, temporary shelter, or tent to complete the Vulnerability Index – Service Prioritization Decision Assistance Tool and it will have no bearing on whether they are able to stay in a particular location or for a specific duration of time. The assessment tool will only be used to help connect individuals experiencing homelessness to housing resources and supports.

D) Prohibited Areas for Erecting Encampments, Temporary Shelters, or Tents

In order to provide for the availability of space for temporary shelter in parks, persons without shelter or being homeless will be able to establish an encampment through erecting a temporary shelter for themselves and also be able group together with other such persons' temporary shelters. However, the encampment or cluster of shelters must not exceed five tents or similar temporary shelters, and there must be at least 50 meters separating the encampment or cluster from other encampments or clusters of shelters. Further, the balancing of public and private interests while allowing for temporary shelter will require encampments or clusters not be located:

1. On or within 100 meters of a school or children daycare centre
2. ***Within 100 meters of spaces that are designed and programmed for children***
3. On or within 100 meters of a playground, pool, waterpark, or any spray pad
4. On or within 50 metres of any lake, beach, pond, watercourse or other body of water, or a dock
5. Within 10 meters of any private property line
6. ***Within 100 meters of a funeral home***
7. ***Within 100 meters of a long-term care facility***
8. ***Within 25 meters of an active construction site***
9. ~~***On or within 50 metres of the Hamilton Alliance for Tiny Shelters model site. For the purpose of this site the full length of the Strachan Linear Park, Bay Street North to Ferguson Street North, will be considered the site.***~~
9. On or within 5 meters of any transit stop or a highway and specifically including a sidewalk, boulevard, or bridge or tunnel being part of such highway
10. On or within 5 meters of any property with an environmental or heritage designation
11. On or within 50 meters of any sports fields, inclusive of but not limited to, skateboard parks, fitness amenities, golf courses, ball diamonds, soccer pitches, tennis courts, or any other sports or multi-use courts, as well as stadiums, dugouts, stages, and bleachers.
12. On any fenced-in, off-leash dog area
13. On any cemetery, including its roads, lanes and paths for travel within the cemetery
14. On any community garden and including any garden shed or greenhouse
15. On ***or within 5 metres of*** any pathway, sidewalk, or parking lot or on or under any bridge, including pedestrian access points to such areas and structures
16. On or within any designated fire route, or the entrance to or exit from a designated fire route, or located so as the block any fire hydrant

17. On or within any entrance, exit or a doorway to a building or structure, and including, without limiting the generality of the foregoing, an area adjacent to such entrances or exits required in the event of fire or emergency
18. On or within any accessibility entrance or ramp or located in a way that blocks access to such entrances or ramps.
19. On or within any area identified susceptible to flooding, erosion, slope instability, or other environmental hazards that presents a risk to health and safety.
20. ***On or within the full length of the Strachan Linear Park, Bay Street North to Ferguson Street North until further park development options can be explored.***
21. Further no temporary shelter or tent will be placed against, or under, or be attached or tied to any building or permanent structure. All shelters or tents must be freestanding.

E) Campfire and Barbecue Use

Section 14 of By-Law 01-219, the Parks By-Law, which regulates campfires and barbecues in City Parks; as well as By-Law No. 02-283, the Open Air Burning By-Law, which regulates open-air burning within the City, shall be complied with and will be enforced.

F) Maximum Personal Space Allotment(s)

The total area for a single tent and all its associated belongings cannot exceed beyond a 3-metre-by-3-metre area, or 9-metres-squared, and the total area for five tents within a cluster cannot exceed beyond a total area of 45-metres-squared. The following chart identifies space limits by number of temporary shelters or tents:

Number of Temporary Shelters/Tents within Encampment Cluster	Maximum Total Space Allotment (metres)
One	9m²
Two	18m²
Three	27m²
Four	36m²
Five	45m²

Any items located outside of the allotted personal space area will be subject to removal by City staff.

G) Encampment Response Processes

Given that there are several circumstances that require a unique response from the Coordinated Response Team, the following guidelines have been established to direct responses to people living in encampments, and their temporary shelters, or tents:

A) When an encampment, temporary shelter, or tent is located on public property, and not within a prohibited area, as defined by this Protocol:

1. Within 72 hours after receiving a complaint or request for service (unless exceptional circumstances exist), Housing Focused Street Outreach staff will

engage with the individual(s) living within an encampment, temporary shelter, or tent to better understand their needs and connect them with internal and community supports, including housing-focused case management; referral into the emergency shelter system; referrals to health agencies, social assistance supports, and specialized outreach supports; and any other relevant supports available that would improve an individual's health and wellbeing.

2. If no health and safety issues are observed by Housing Focused Street Outreach (see Section J, 'Health and Safety' for further detail on specific circumstances or factors), and the encampment, temporary shelter, or tent complies with the prohibitions and locations outlined in this Protocol, individuals will be allowed to maintain and occupy temporary such shelter for the duration of the Protocol, as defined by City Council. Housing Focused Street Outreach will continue to engage with the individual(s) on an ongoing basis to provide supports and referrals as needed and work towards goals in individualized housing plans.

3. Only if a substantial change in circumstances is observed by Housing Focused Street Outreach in subsequent visits to the encampment, temporary shelter, or tent, such as new significant health or safety issues, will Hamilton Police Services be asked to attend to support any response. Hamilton Police Services will attend encampments within the normal course of responding to emergencies and other policing duties, and Housing Focused Street Outreach and other City partners will work cooperatively with Hamilton Police Services if a concern related to health and safety is identified at an encampment.

4. Any items or circumstances that are of clear and immediate risk to the individuals living in an encampment or neighbouring encampments or the broader public will result in a call for immediate emergency response. Hamilton Police Service Encampment Engagement Officers will attend the location and conduct a risk assessment when requested and as required.

B) When an encampment, temporary shelter, or tent is located on public property, within a <u>prohibited</u> area, as defined by this Protocol:

1. Within 72 hours after receiving a complaint or request for service (unless exceptional circumstances exist), Housing Focused Street Outreach staff will engage with individual(s) living within an encampment, temporary shelter, or tent to better understand their needs and connect them with internal and community supports, including housing-focused case management; referral into the emergency shelter system; referrals to health agencies, social assistance supports, and specialized outreach supports; and any other relevant supports available that would improve an individual's health and wellbeing. Housing Focused Street Outreach will have available information about possible suitable and compliant sites and will consider the needs and choices of the individual and collaborate with the individual(s) living within an encampment, temporary shelter, or tent, to identify a more suitable area that meets the conditions noted within this Protocol.

2. If after visiting an encampment, temporary shelter, or tent, Housing Focused Street Outreach staff observe the encampment, temporary shelter, or tent to be in a prohibited area, as defined by this Protocol, Housing Focused Street Outreach will contact Municipal Law Enforcement within 72 hours of receiving the initial

complaint, and Municipal Law Enforcement will respond to the within four (4) business days.

3. Municipal Law Enforcement Officers will visit the site within four business days and confirm whether the encampment, temporary shelter, or tent is in a prohibited area. If so, Municipal Law Enforcement Officers will notify the individual(s) living at the location via a Notice of Trespass and verbally, if possible, that they are in a prohibited area, and that they will be required to move from the existing location.

4. Municipal Law Enforcement Officers will determine compliance timelines depending on the presenting circumstances, for the issuance of notices or actions to be taken in respect to the encampment, temporary shelter, or tent, within a maximum of four (4) total days from the issuance of notice, unless exceptional circumstances exist. For example, if the Municipal Law Enforcement Officers observes a significant health or safety issue for the individual due to placing a shelter on a highway the Municipal Law Enforcement Officers will take more urgent action to require compliance or remediate the concern and may seek Hamilton Police Services support. If there are few or no immediate health, safety, or other concerns due to encampment or its location within a prohibited area, Municipal Law Enforcement Officers will allow for more time, up to a maximum of four (4) total days, unless exceptional circumstances exist, to engage with the individuals in an encampment, temporary shelter, or tent around supports and next steps.

5. After a Trespass Notice has been served and prior to an area being cleared, Housing Focused Street Outreach's will continue to engage with individual(s) at the location to identify alternate sheltering options and attempt to address any barriers to shelter or housing, such as lack of identification or item storage.

6. If the duration of time provided by a Trespass Notice expires and individual(s) at the site has not moved voluntarily and are unwilling to move, Municipal Law Enforcement Officers will notify Hamilton Police Services Encampment Engagement Officers. Hamilton Police Services will be available to support and assist the Municipal Law Enforcement Officers, operational plan, and/or the individual(s) living at the encampment, temporary shelter, or tent to vacate the prohibited area.

7. Hamilton Police Services Encampment Engagement Officers will interact with individuals in encampments, temporary shelters, or tents at the request of Housing Focused Street Outreach and/or Municipal Law Enforcement, in a supportive capacity. Otherwise, their level of intervention will be dictated by their own internal policies and the circumstances at a given encampment, temporary shelter, or tent site.

8. Parks staff will coordinate the clean-up, to be completed either by Parks staff, Roads staff, or the contractor, depending on the location, within 72 hours, with discretion for extenuating circumstances such as inclement weather.

C) When an encampment, temporary shelter, or tent is located on public property, is not located in a prohibited area, but health and safety concerns are identified:

1. If Housing Focused Street Outreach identify or confirm a health or safety issue at an encampment, temporary shelter, or tent, and depending on circumstances, will address or may collaborate with appropriate partners to address the health and safety concerns identified.

2. If the health and safety concern is considered serious and/or imminent (e.g., exposed electrical wiring, accumulation of discarded needles, use of propane tanks and other combustible materials, possession of weapons) as identified by Housing Focused Street Outreach or Hamilton Police Services Encampment Engagement Officers, Hamilton Police Services will follow appropriate policing responses required in the circumstances. In addition, they will communicate with the Coordinated Response Team and prioritize working with community partners to address any remaining safety concern. These partners may include Hamilton Fire Department, Hamilton Public Health's Community Points program, Hamilton Parks, or any other parties deemed necessary to address the observed health and safety concerns.

3. All items determined by Hamilton Police Services and/or partners to be a serious risk to the health and safety of individual(s) living at the encampment, temporary shelter, or tent, as well as the public will be removed at the earliest opportunity.

4. If the encampment, temporary shelter, or tent is also in an area deemed to be prohibited based upon the provisions identified in Section D of this Protocol, and after health and/or safety issues placing Municipal Law Enforcement Officers at risk have been removed, Municipal Law Enforcement Officers will initiate steps 4-9 in Encampment Response Process B – "*If an encampment is located on public property, in a prohibited area*."

5. If all serious health and/or safety issues have been removed or otherwise corrected, and the encampment, temporary shelter, or tent is not located in a prohibited area as designated in Section D of this Protocol, then the individual(s) will be permitted to remain where they are, in accordance with Encampment Response Process A.

H) Encampments on Private Property

Encampments, temporary shelters, or tents identified on private property are primarily the responsibility of the property owner. Where the owner has not provided consent, concerns of the owner are within Hamilton Police Services' jurisdiction and will be subject to ordinary enforcement procedures in accordance with applicable laws. Hamilton Police Services may seek the assistance of Municipal Law Enforcement Officers as appropriate or required in the circumstances.
Provided the property owner permits, Housing Focused Street Outreach will engage with encampment, temporary shelter, or tent residents to identify alternate sheltering options and attempt to address any barriers to shelter or housing. Additionally, Housing Focused Street Outreach will work with individuals at the encampment, temporary shelter, or tent to provide supports and referrals as needed and work towards goals in individualized housing plans.

I) Process for Designating an Encampment, Temporary Shelter, or Tent as Abandoned

While Housing Focused Street Outreach is aware of many encampments, temporary shelters, and tents in the community, people living in encampments, temporary shelters, and tents may move to new locations and/or may abandon a previous site without Housing Focused Street Outreach's or other Coordinated Response Team partners' knowledge. Given that maintaining one's possessions while experiencing homelessness is vital to a human-rights based approach, staff will be cautious when deeming a site to be abandoned.

The following process will be followed regarding potentially abandoned sites on public property:

1. If Housing Focused Street Outreach have not interacted with anyone at a particular site and/or there has been observed inactivity for at least three (3) days, they will review the site with the Coordinated Response Team partners at the nearest opportunity to confirm there has been no recent activity witnessed at the site.

2. If Coordinated Response Team partners (i.e., Municipal Law Enforcement, Hamilton Police Services, Parks) have not witnessed anyone at the site and/or can confirm that the former inhabitants of the site have moved elsewhere, Housing Focused Street Outreach will place a notice at the site in a conspicuous area informing potential residents that the site is due to be cleaned in three (3) days from the time of the notice being placed.

3. Within the three-day timeline, all reasonable attempts will be made by Housing Focused Street Outreach and/or other Coordinated Response Team partners to ensure that individuals known to be previously staying at a site have been made aware that their former site will be deemed abandoned and cleaned.

4. If no interaction has been made by Housing Focused Street Outreach with the former inhabitants at the site, no attempts have been made by the former inhabitants of the site to contact Housing Focused Street Outreach, and/or no other changes are observed at the site by the end of the allotted time, Housing Focused Street Outreach will provide approval to Parks Section to clean the site.

5. Parks staff will coordinate the clean-up, to be completed either by Parks staff, Roads staff, or the contractor, within 72 hours of approval, with discretion for extenuating circumstances such as inclement weather.

Clean-up and maintenance of encampments, temporary shelters, or tents previously on private property are the responsibility of the property owner.

J) Health and Safety

Defining specific health and safety issues is difficult and can be based upon several factors unique to a particular site or circumstance. Some examples include, exposed electrical wiring, accumulation of discarded needles, illegal activity, abuse, threats or violence against staff, HPS or other persons, improper use or storage of propane tanks and other flammable materials, and acts involving weapons. Health and safety issues

may also be identified via complaints from the public and/or businesses in relation to the encampment, temporary shelter, or tent; for example regarding harassment, vandalism, and/or stolen personal property.

Housing Focused Street Outreach staff will notify Animal Services when a pet is encountered at an encampment site. Housing Focused Street Outreach staff will collaborate with appropriate parties including the pet owner to identify how to best support the pet and pet owner, including implementing strategies to reduce any potential harms to the pet owner, public, City staff and the animal.

Health and safety concerns existing for those living within or adjacent to an encampment, temporary shelter, or tent will be addressed in a reasonable and timely fashion, in good faith, on a case-by-case basis, prioritizing the seriousness of the concern and recognizing that there is a need to balance the needs of both the individual living in an encampment, temporary shelter, or tent and community members.

In situations where the need to intervene is less acute, the City may consult with additional internal and external partners to determine how to best balance the needs of individuals living encamped and community members.

If at any time City staff encounter someone in medical distress requiring immediate attention, witness violence, or believe violence to be imminent to people living in encampments, temporary shelters, or tents, staff, or community members, they will notify emergency medical, Hamilton Fire Department, or Hamilton Police Services, including members of the Hamilton Police Crisis Response Branch), to have the appropriate services dispatched. Additionally, City staff will leave the site irrespective of all procedures above, if their health and safety is currently being, or at risk of being threatened. To ensure safety of staff, the presence of Hamilton Police Services may be required while visiting the site.

K) Reporting

To provide ongoing accountability and transparency to the City's encampment response program and the implementation of its encampment protocol, communication with Council and Ward Councillors regarding the Encampment Protocol will be through monthly, ongoing Information Reports to General Issues Committee and include data and trends, operational updates, and any continuous improvement measures implemented to further efforts toward providing ongoing accountability and transparency to the City's encampment response program and the implementation of its encampment protocol. Where a Ward Councillor requests information regarding a specific encampment site within their ward, Housing Focused Street Outreach will provide an update as to whether the encampment has been deemed to be within a prohibited area. Reporting on the status of outreach or enforcement activities will be limited to the monthly Council reports.

L) Communicating Protocol to Residents of Encampments

An engagement strategy has been developed to update unsheltered individuals living in encampments about the Protocol as well as to communicate expectations of places within the City where encampments, temporary shelters, or tents can be erected. The following approaches will be taken to build understanding of the Protocol:

- Housing Focused Street Outreach workers will have an information sheet outlining expectations of the Protocol, to be shared with unsheltered individuals when staff visit an encampment. Additionally, outreach staff will collaborate with individuals to understand their needs and choices in order to identify suitable locations (compliant sites) within the City where the individual can set up a temporary shelter or tent.
- Information sheets will also be shared with external frontline service providers who manage drop-ins, emergency shelters, and other related services and programs providers in the community, which can be posted in their locations and also communicated to staff throughout these organizations.
- City partners who also engage in frontline response, i.e., Parks Section and Municipal Law Enforcement, will also be provided information sheets to share with unsheltered individuals within the City, and community partners upon request.
- The City will post the Encampment Protocol and information sheet on the City's website for public access.

DOCUMENT 10

CITY COUNCIL
MINUTES 24-014

9:30 a.m.
July 12, 2024
Council Chamber (Hybrid)
Hamilton City Hall
71 Main Street West

Present: Mayor A. Horwath
Deputy Mayor M. Francis
Councillors J. Beattie (virtually), C. Cassar, B. Clark (virtually), J.P. Danko, T. Jackson, C. Kroetsch, T. McMeekin, E. Pauls (virtually), M. Spadafora, M. Tadeson, T. Hwang, A. Wilson (virtually) and M. Wilson

Absent with Regrets: Councillor N. Nann – Personal

Mayor Horwath called the meeting to order and recognized that Council is meeting on the traditional territories of the Erie, Neutral, HuronWendat, 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. It was further acknowledged that this land is covered by the Between the Lakes Purchase, 1792, between the Crown and the Mississaugas of the Credit First Nation. The City of Hamilton is home to many Indigenous people from across Turtle Island (North America) and it was recognized that 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.

APPROVAL OF THE AGENDA

The Clerk advised Council of the following changes to the agenda:

5. COMMUNICATIONS

5.14 Correspondence from Sally Palmer, Chair, Hamilton Social Work Action Committee proposing a possible amendment to the motion respecting Request for the Association of Municipalities of Ontario (AMO) to Advocate to the Government of Ontario to Increase Ontario Disability Support Program (ODSP) and Ontario Works (OW) Rates in Ontario (Item 7.5)

Recommendation: Be received and referred to the consideration of Item 7.5

5.15 Correspondence from Hafeez Hussain respecting his speaking notes for his delegation at the July 8, 2024 General Issues Committee meeting.

Recommendation: Be received and referred to the consideration of Item (f)(i) of General Issues Committee Report 24-012.

5.16 Correspondence from Kimberly Moran, CEO, Ontario Medical Association and Colin Best, AMO President who are working collaboratively to advocate for a better healthcare system for Ontario's residents and communities.

Recommendation: Be received.

5.17 Correspondence from Mariewin Lorenzo, Hamilton Philippine Heritage Festival, Organizing Chair – Hamilton Fiesta Extravaganza respecting an invitation to the Hamilton Fiesta Extravaganza 2024 “Sining, Sayaw and Saya” (Art, Dance and Happiness) on July 27th and July 28th at Bayfront Park.

Recommendation: Be received.

5.18 Correspondence in response to the General Issues Committee's request to verify the account number in Item 8 of the General Issues Committee Report 24-012.

Recommendation: Be received and referred to the consideration of Item 8 of the General Issues Committee Report 24-012.

5.19 Correspondence from Rose Castelao Alvarez respecting supporting the Indigenous Seat Initiative.

Recommendation: Be received and referred to the consideration of Item (i)(i) of the General Issues Committee Report 24-012.

8. NOTICES OF MOTION

8.1 Amendment to Item 1 of the General Issues Committee 23-024, respecting Addressing Needs of Unsheltered Individuals and those Relying on Hamilton’s Emergency Shelter System (HSC23041) (City Wide)

8.2 Amendment to Item 6.3 of the Council Meeting 21-024, respecting Canada Mortgage and Housing Corporation (CMHC) Rapid Housing Initiative (RHI) Project Stream Funding, which was approved by Council on December 15, 2021

8.3 Furthering a Collaborative Path Between the City of Hamilton and Urban Indigenous residents as per the Council approved Urban Indigenous Strategy

11. PRIVATE AND CONFIDENTIAL

11.2 Correspondence from Lisa Shields, City Solicitor respecting a Confidential Legal Update regarding proceedings under the Endangered Species Act – Delsey Pond

Recommendation: Be received and referred to the consideration of Item 14 of General Issues Committee Report 24-012.

Pursuant to Section 9.3, Sub-section (f) of the City's Procedural By-law 21-021, as amended; and, Section 239(2), Sub-section (f) of the Ontario Municipal Act, 2001, as amended, as the subject matter pertains to advice that is subject to solicitor-client privilege, including communications necessary for that purpose.

12. BY-LAWS AND CONFIRMING BY-LAW

123 To Authorize the Signing of the Building Faster Fund Transfer Payment Agreement with the Ministry of Municipal Affairs and Housing and the City of Hamilton for the receipt of funds from the Province of Ontario Building Faster Fund
Ward: City Wide

124 Respecting Removal of Part Lot Control, Block 149, Registered Plan No. 62M-1051, municipally known as 205 Thames Way, Glanbrook
Ward: 11
PLC-23-007

125 Respecting Removal of Part Lot Control, Lots 89 to 102, Registered Plan No. 62M-1299, municipally known as 1 to 28 Cherry Blossom Heights, Hamilton
Ward: 8
PLC-24-005

126 Being a By-law to Allow the City to Enter into a Heritage Covenant or Easement Agreement with the Owner of the Lands municipally known as 84 York Boulevard in the City of Hamilton for Conservation of Heritage Attributes of a Structure known as Philpott Church
Ward: 2

127 A By-law to Amend By-law No. 07-170, a By-law to License and Regulate Various Businesses
Ward: City Wide

128 To Amend By-law No. 24-036, as amended by By-law No. 24-049, Being a By-law to Establish Certain 2024 User Fees and Charges for Services, Activities or the Use of Property
Ward: City Wide

129 To Adopt Official Plan Amendment No. 206 to the Urban Hamilton Official Plan respecting 101 Hunter Street East, Hamilton
Ward: 2

130 To Amend Zoning By-law No. 05-200, Respecting Lands Located at 101 Hunter Street East, in the City of Hamilton
ZAC-21-014
Ward: 2

131 To Adopt Official Plan Amendment No. 214 to the Urban Hamilton Official Plan Respecting 259 and 265 Wilson Street East (Ancaster)
Ward: 12

132 To Amend Zoning By-law No. 05-200 with Respect to Lands Located at 259 and 265 Wilson Street East, Ancaster
ZAC-24-013
Ward: 12

133 To Adopt Official Plan Amendment No. 217 to the Urban Hamilton Official Plan Respecting 365 Highway No. 8 (Stoney Creek)
Ward: 10

134 To Amend Zoning By-law No. 05-200 with Respect to Lands Located at 365 Highway No. 8, Stoney Creek
ZAC-24-011
Ward: 10

135 To Adopt Official Plan Amendment No. 218 to the Urban Hamilton Official Plan, Respecting Housekeeping Amendments and Strategic Updates
Ward: City Wide

136 To Adopt Official Plan Amendment No. 41 to the Rural Hamilton Official Plan, Respecting
Housekeeping Amendments and Strategic Updates
Ward: City Wide

137 To Amend Zoning By-law No. 05-200, Respecting Modifications and Updates to the Interpretation, Definitions, General Provisions, Parking, Industrial Zones, Commercial and Mixed Use Zones, Transit Oriented Corridor Zones, Rural Zones, Utility Zones, Waterfront Zones, Special Exceptions, Holding Provisions, Temporary Use Provisions, and Zoning Maps
CI-24-D
Ward: City Wide

138 To Amend Former City of Hamilton Zoning By-law No. 6593 Respecting Lands Located at 1126 Garth Street, Hamilton
CI-24
Ward: 14

139 To Amend By-law No. 12-094, being a By-law to Authorize the Borrowing of Monies by way of Bank Loans in the Principal Amounts of $38,000,000 and $14,740,000
Ward: City Wide

(Spadafora/Hwang)
That the agenda for the July 12, 2024 meeting of Council be approved, as amended.

Result: Motion CARRIED by a vote of 15 to 0, as follows:

YES - Ward 10 Councillor Jeff Beattie
YES - Ward 12 Councillor Craig Cassar
YES - Ward 9 Councillor Brad Clark
YES - Ward 8 Councillor John-Paul Danko
YES - Deputy Mayor - Ward 5 Councillor Matt Francis
YES - Mayor Andrea Horwath
YES - Ward 4 Councillor Tammy Hwang
YES - Ward 6 Councillor Tom Jackson
YES - Ward 2 Councillor Cameron Kroetsch
YES - Ward 15 Councillor Ted McMeekin
NOT PRESENT - Ward 3 Councillor Nrinder Nann
YES - Ward 7 Councillor Esther Pauls
YES - Ward 14 Councillor Mike Spadafora
YES - Ward 11 Councillor Mark Tadeson
YES - Ward 13 Councillor Alex Wilson
YES - Ward 1 Councillor Maureen Wilson

DECLARATIONS OF INTEREST

There were no declarations of interest.

APPROVAL OF MINUTES OF PREVIOUS MEETING

4.1 June 26, 2024

(Hwang/Kroetsch)
That the Minutes of the June 26, 2024 meeting of Council be approved, as presented.

Result: Motion CARRIED by a vote of 15 to 0, as follows:

YES - Ward 10 Councillor Jeff Beattie
YES - Ward 12 Councillor Craig Cassar
YES - Ward 9 Councillor Brad Clark
YES - Ward 8 Councillor John-Paul Danko
YES - Deputy Mayor - Ward 5 Councillor Matt Francis
YES - Mayor Andrea Horwath
YES - Ward 4 Councillor Tammy Hwang
YES - Ward 6 Councillor Tom Jackson
YES - Ward 2 Councillor Cameron Kroetsch

YES - Ward 15 Councillor Ted McMeekin
NOT PRESENT - Ward 3 Councillor Nrinder Nann
YES - Ward 7 Councillor Esther Pauls
YES - Ward 14 Councillor Mike Spadafora
YES - Ward 11 Councillor Mark Tadeson
YES - Ward 13 Councillor Alex Wilson
YES - Ward 1 Councillor Maureen Wilson

COMMUNICATIONS

(Francis/Tadeson)
That Council Communications 5.1 to 5.19 be approved, as ***amended***, as follows:

5.1 Correspondence from Prof Dr. Emir Ramic, Director of the Institute for Research of Genocide Canada respecting the 29th anniversary of the genocide in Srebrenica, the largest crime against humanity after the Holocaust in Europe.

Recommendation: Be received.

5.2 Correspondence from the Niagara Peninsula Conservation Authority respecting Report No. FA-29-24 RE: Water Quality Monitoring Program Summary Report for the Year 2023.

Recommendation: Be received.

5.3 Correspondence from the Town of Plympton-Wyoming in support of the City of Hamilton's resolution regarding the City of Hamilton being declared a paid-plasma free zone.

Recommendation: Be received.

5.4 Correspondence from Lauren MacKenzie respecting the Encampment Protocol: Private Property Line.

Recommendation: Be received and referred to the General Manager of Healthy and Safe Communities for appropriate action.

5.5 Correspondence from the Township of Otonabee-South Monaghan requesting support for their resolution respecting Regulations for the Importation and Safe Use of Lithium-ion Batteries.

Recommendation: Be received.

5.6 Correspondence from Durham Region requesting support for their resolution respecting Moving Towards a Sustainable Approach for Asylum Seekers and Refugees in Durham (2024-COW-24).

Recommendation: Be endorsed.

5.7 Correspondence from the City of St. Catherines requesting support for their resolution respecting Green Roads Pilot Project.

Recommendation: Be endorsed.

5.8 Correspondence from Lyn Folkes respecting the Restore Hamilton Plan.

Recommendation: Be received and referred to the General Manager of Planning and Economic Development for appropriate action.

5.9 Correspondence from Colin Best, President, Association of Municipalities of Ontario (AMO) respecting AMO Advocacy on Homelessness Encampments.

Recommendation: Be ***endorsed***.

5.10 Correspondence from the Ministry of Municipal Affairs and Housing respecting *Planning Act* and *Development Charges Act* Regulations related to the *Cutting Red Tape to Build More Homes Act, 2024* (Bill 185).

Recommendation: Be received and referred to the General Manager of Planning and Economic Development for appropriate action.

5.11 Correspondence from Jessica Myers resigning from the Hamilton Farmers' Market Board of Directors.

Recommendation: Be received and referred to the Selection Committee for Agencies, Boards and Sub-Committees to fill the vacancy on the Hamilton Farmers' Market Board of Directors.

5.12 Correspondence from Christa O'Connor, President, Ontario Coalition for Better Child Care and Fred Hahn, President, CUPE, Ontario Division respecting the 24th Annual Child Care Working and Early Childhood Educator Appreciation Day, October 24, 2024.

Recommendation: Be received.

5.13 Correspondence from the Treasury Board Secretariat, Office of the Associate Minister of Emergency Preparedness and Response respecting the modernization of the *Emergency Management and Civil Protection Act*.

Recommendation: Be received and referred to the Senior Leadership Team for appropriate action.

5.14 Correspondence from Sally Palmer, Chair, Hamilton Social Work Action Committee proposing a possible amendment to the motion respecting Request for the Association of Municipalities of Ontario (AMO) to Advocate to the Government of Ontario to Increase Ontario Disability Support Program (ODSP) and Ontario Works (OW) Rates in Ontario (Item 7.5)

Recommendation: Be received and referred to the consideration of Item 7.5

5.15 Correspondence from Hafeez Hussain respecting his speaking notes for his delegation at the July 8, 2024 General Issues Committee meeting.

Recommendation: Be received and referred to the consideration of Item (f)(i) of General Issues Committee Report 24-012.

5.16 Correspondence from Kimberly Moran, CEO, Ontario Medical Association and Colin Best, AMO President who are working collaboratively to advocate for a better healthcare system for Ontario's residents and communities.
Recommendation: Be received.

5.17 Correspondence from Mariewin Lorenzo, Hamilton Philippine Heritage Festival, Organizing Chair – Hamilton Fiesta Extravaganza respecting an invitation to the Hamilton Fiesta Extravaganza 2024 “Sining, Sayaw and Saya” (Art, Dance and Happiness) on July 27th and July 28th at Bayfront Park.

Recommendation: Be received.

5.18 Correspondence in response to the General Issues Committee's request to verify the account number in Item 8 of the General Issues Committee Report 24-012.

Recommendation: Be received and referred to the consideration of Item 8 of the General Issues Committee Report 24-012.

5.19 Correspondence from Rose Castelao Alvarez respecting supporting the Indigenous Seat Initiative.

Recommendation: Be received and referred to the consideration of Item (i)(i) of the General Issues Committee Report 24-012.

Result: Motion on the Communication Items, as A*mended*, CARRIED by a vote of 15 to 0, as follows:

YES - Ward 10 Councillor Jeff Beattie
YES - Ward 12 Councillor Craig Cassar
YES - Ward 9 Councillor Brad Clark
YES - Ward 8 Councillor John-Paul Danko
YES - Deputy Mayor - Ward 5 Councillor Matt Francis
YES - Mayor Andrea Horwath
YES - Ward 4 Councillor Tammy Hwang
YES - Ward 6 Councillor Tom Jackson
YES - Ward 2 Councillor Cameron Kroetsch
YES - Ward 15 Councillor Ted McMeekin
NOT PRESENT - Ward 3 Councillor Nrinder Nann
YES - Ward 7 Councillor Esther Pauls
YES - Ward 14 Councillor Mike Spadafora
YES - Ward 11 Councillor Mark Tadeson
YES - Ward 13 Councillor Alex Wilson
YES - Ward 1 Councillor Maureen Wilson

(Francis/Tadeson)
That Council move into Committee of the Whole for consideration of the Committee Reports.

Result: Motion CARRIED by a vote of 15 to 0, as follows:

YES - Ward 10 Councillor Jeff Beattie
YES - Ward 12 Councillor Craig Cassar
YES - Ward 9 Councillor Brad Clark
YES - Ward 8 Councillor John-Paul Danko
YES - Deputy Mayor - Ward 5 Councillor Matt Francis
YES - Mayor Andrea Horwath
YES - Ward 4 Councillor Tammy Hwang
YES - Ward 6 Councillor Tom Jackson
YES - Ward 2 Councillor Cameron Kroetsch
YES - Ward 15 Councillor Ted McMeekin
NOT PRESENT - Ward 3 Councillor Nrinder Nann
YES - Ward 7 Councillor Esther Pauls
YES - Ward 14 Councillor Mike Spadafora
YES - Ward 11 Councillor Mark Tadeson
YES - Ward 13 Councillor Alex Wilson
YES - Ward 1 Councillor Maureen Wilson

CITY OF HAMILTON INTEGRITY COMMISSIONER'S REPORT
DGB-HAMILTONICI-2024-04

(Cassar/Beattie)
That the City of Hamilton Integrity Commissioner's Report Regarding Citation: Frisina, Anthony (Re) – DGB-HamiltonICI-2024-04 dated June 28, 2024, be received and the recommendations contained therein be approved.

Result: Motion on the City of Hamilton Integrity Commissioner's Report Regarding Citation: Frisina, Anthony (Re) – DGB-HamiltonICI-2024-04 dated June 28, 2024, CARRIED by a vote of 15 to 0, as follows:

YES - Ward 10 Councillor Jeff Beattie
YES - Ward 12 Councillor Craig Cassar
YES - Ward 9 Councillor Brad Clark
YES - Ward 8 Councillor John-Paul Danko
YES - Deputy Mayor - Ward 5 Councillor Matt Francis
YES - Mayor Andrea Horwath
YES - Ward 4 Councillor Tammy Hwang
YES - Ward 6 Councillor Tom Jackson
YES - Ward 2 Councillor Cameron Kroetsch
YES - Ward 15 Councillor Ted McMeekin
NOT PRESENT - Ward 3 Councillor Nrinder Nann
YES - Ward 7 Councillor Esther Pauls
YES - Ward 14 Councillor Mike Spadafora
YES - Ward 11 Councillor Mark Tadeson
YES - Ward 13 Councillor Alex Wilson

YES - Ward 1 Councillor Maureen Wilson

GENERAL ISSUES COMMITTEE REPORT 24-012

(Francis/Tadeson)
That General Issues Committee Report 24-012, being the meeting held on Monday, July 8, 2024, be received and the recommendations contained therein, be approved.

(M. Wilson/McMeekin)
That Item (i)(i) respecting Representation by the Urban Indigenous Community at City Council (Item 11.2), be lifted from the Information Section and added as Item 15 of the General Issues Committee Report 24-012.

Result: Motion on Lifting Item (i)(i) and adding it as Item 15 of the General Issues Committee Report 24-012, CARRIED by a vote of 14 to 1, as follows:

YES - Ward 10 Councillor Jeff Beattie
YES - Ward 12 Councillor Craig Cassar
YES - Ward 9 Councillor Brad Clark
YES - Ward 8 Councillor John-Paul Danko
NO - Deputy Mayor - Ward 5 Councillor Matt Francis
YES - Mayor Andrea Horwath
YES - Ward 4 Councillor Tammy Hwang
YES - Ward 6 Councillor Tom Jackson
YES - Ward 2 Councillor Cameron Kroetsch
YES - Ward 15 Councillor Ted McMeekin
NOT PRESENT - Ward 3 Councillor Nrinder Nann
YES - Ward 7 Councillor Esther Pauls
YES - Ward 14 Councillor Mike Spadafora
YES - Ward 11 Councillor Mark Tadeson
YES - Ward 13 Councillor Alex Wilson
YES - Ward 1 Councillor Maureen Wilson

Item 15 was voted on separately, as follows:

15. Representation by the Urban Indigenous Community at City Council (Item 11.2)

WHEREAS City Council is currently made up of 15 Councillors and 1 Mayor, a total of 16 members;

WHEREAS members of the urban Indigenous community, represented by the Circle of Beads, have asked the City of Hamilton to support their request for the City to ask the Province of Ontario to have changes made to the *Municipal Act* to permit a member of Hamilton's urban Indigenous community to be a voting member of City Council;

WHEREAS the Circle of Beads has asked, while Council awaits word from the Province about that request, that it establish an interim advisory seat (non voting) on Council for a member of Hamilton's urban Indigenous community;

WHEREAS there are governance, legal, and other implications to honouring these requests that the municipality must fully explore before Council formally considers them;

WHEREAS First Nations in Canada have specific and distinct relationships with the Federal and Provincial levels of governments through the *Indian Act*;

WHEREAS according to the National Association of Friendship Centres, as of 2021, approximately 88% of Indigenous people in Ontario live in urban settings, which means that a majority of Indigenous peoples live their lives with no direct local representation with respect to the services they access most;

WHEREAS City Council approved the Urban Indigenous Strategy (UIS) presented to, endorsed, and fully supported by the General Issues Committee on July 8, 2019 and committed to "having a trusting relationship with Indigenous communities where we communicate and work together appropriately to address the unique needs and issues of Indigenous people";

WHEREAS, within the UIS, there was direct acknowledgement of ongoing and historical oppression including many unique barriers related to health, poverty, justice, employment, and intergenerational trauma;

WHEREAS City Council has made a commitment to supporting Indigenous rights and history;

WHEREAS Land Theme Action 8 in the UIS, a short term goal meant to be achieved by the City in 1-2 years, reads, "Understand how concepts such as the Doctrine of Discovery affect municipal decision making and develop tools to reform those processes";

WHEREAS the City of Halifax, Nova Scotia, after approving a motion to its Regional Council on October 23, 2023, is currently investigating and considering the development of an Indigenous council seat, specifically a Mi'kmaw seat; and

WHEREAS the Province of Nova Scotia has set a precedent by the addition of a Provincial seat in their legislature for a Mi'kmaw representative since 1992.

THEREFORE, BE IT RESOLVED:

(a) That City staff in the Indigenous Relations and Legal Services Divisions report back to a future General Issues Committee on recommendations and information related to the following:

    (i) The City's statutory responsibilities to Indigenous communities, the responsibilities of the Provincial and Federal governments, and an identification of any limitations in the *Municipal Act* and other legislation including an analysis that addresses the requests made by the Circle of Beads to Council on February 14 and June 19, 2024;

(ii) The outstanding actions in the Urban Indigenous Strategy (UIS) that include an identification of any ongoing work towards closer collaboration and involvement throughout the municipal decision making process as it relates to the urban Indigenous community and other Indigenous leaders and representative organizations; and

(iii) The ongoing work the City is doing with respect to Truth and Reconciliation best practices including a scan of the work being done by other municipalities across Canada and ongoing work through the Federation of Canadian Municipalities with respect to urban Indigenous communities and other Indigenous leaders and representative organizations.

Result: Motion on Item 15 of the General Issues Committee Report 24-012, DEFEATED by a vote of 7 to 8, as follows:

NO - Ward 10 Councillor Jeff Beattie
YES - Ward 12 Councillor Craig Cassar
NO - Ward 9 Councillor Brad Clark
NO - Ward 8 Councillor John-Paul Danko
NO - Deputy Mayor - Ward 5 Councillor Matt Francis
NO - Mayor Andrea Horwath
YES - Ward 4 Councillor Tammy Hwang
NO - Ward 6 Councillor Tom Jackson
YES - Ward 2 Councillor Cameron Kroetsch
YES - Ward 15 Councillor Ted McMeekin
NOT PRESENT - Ward 3 Councillor Nrinder Nann
NO - Ward 7 Councillor Esther Pauls
NO - Ward 14 Councillor Mike Spadafora
YES - Ward 11 Councillor Mark Tadeson
YES - Ward 13 Councillor Alex Wilson
YES - Ward 1 Councillor Maureen Wilson

The following ***friendly amendment***, was accepted by Council:

That Item 8, respecting the Pier 8 Development: Waterfront Shores Development Agreement, Greenway Strata Title, and Delegated Authority (PED23039(a)) (Ward 2) (Item 10.2), be ***amended*** to read as follows:

8. Pier 8 Development: Waterfront Shores Development Agreement, Greenway Strata Title, and Delegated Authority (PED23039(a)) (Ward 2) (Item 10.2)

(a) That staff be authorized to negotiate, complete and finalize any disposition, easements, conveyances, interface and other requisite agreements with Waterfront Shores Corporation, in whole or part of Blocks 12, 13 and 14 identified as the Greenway, as shown on Appendix “A” to General Issues Committee Report 24-012, consistent with the key terms and conditions as outlined in this Report PED23039(a) in order to dispose the sub-strata portion of the Greenway and to preserve the City’s ownership of the above grade portion of Blocks 12, 13 and 14 that includes both the surface portion to a

defined depth and the air portion, to be more specifically defined and more particularly described in reference plans, and on such terms and conditions satisfactory to the General Manager of the Planning and Economic Development Department or designate, in a form satisfactory to the City Solicitor;

(b) That staff be directed to credit Account No. 4411806107 with the net disposition proceeds from any sub-strata sale to Waterfront Shores Corporation;

(c) That staff be directed and authorized to fund all ***City*** costs associated with the agreements outlined in Recommendation (a) of Report PED23039(a) including any real estate and legal costs for each transaction from Account No. 4411806107, with real estate and legal costs credited to Account No. 55778-812036 (Real Estate – Admin Recovery);

(d) That staff be authorized and directed to complete and finalize any required amending agreements or agreements comprehended within the Development Agreement dated November 1, 2021, between the City of Hamilton and Waterfront Shores Corporation, on such terms and conditions satisfactory to the General Manager of the Planning and Economic Development Department or designate;

(e) That the General Manager of the Planning and Economic Development Department or designate be authorized to administer the Development Agreement dated November 1, 2021 between the City of Hamilton and Waterfront Shores Corporation and those other such agreements outlined in Recommendation (a) and Recommendation (d) of Report PED23039(a), provide any requisite consents, approvals, and notices in respect of any Agreements, including reviewing and responding to notices issued by Waterfront Shores Corporation and completing, providing and executing any requisite notices, consents, approvals, confirmations, extensions, or other administrative matters contained within the Development Agreement as may be amended as outlined in Recommendation (d) of Report PED23039(a), with such deemed reasonable and necessary to the satisfaction of the City Solicitor;

(f) That the City Solicitor be authorized to amend and waive terms and conditions on such terms as considered reasonable to complete such agreements with Waterfront Shores Corporation as outlined in Recommendation (a) and Recommendation (d) of Report PED23039(a);

(g) That the Mayor and the City Clerk be authorized and directed to execute any agreements with Waterfront Shores Corporation required to give effect to the Recommendations contained in this Report PED23039(a), with all such documents and agreements to be in a form satisfactory to the City Solicitor.

Item 9 (j) was voted on separately, as follows:

9. New Paramedic Facility: Central Reporting Station (HSC24028 / PW24037) (City Wide) (Item 10.3)

(j) That an increase to the Hamilton Paramedic Service operating budget to a maximum of $713 K including 1 permanent FTE in Corporate Facilities and Energy Management for a Facilities Maintenance Technician be approved in principle and included for consideration in the 2029 Tax Budget, related to the annual operating costs of maintaining the central reporting station;

Result: Motion on Item 9 (j) of the General Issues Committee Report 24-012, CARRIED by a vote of 14 to 1, as follows:

YES - Ward 10 Councillor Jeff Beattie
YES - Ward 12 Councillor Craig Cassar
NO - Ward 9 Councillor Brad Clark
YES - Ward 8 Councillor John-Paul Danko
YES - Deputy Mayor - Ward 5 Councillor Matt Francis
YES - Mayor Andrea Horwath
YES - Ward 4 Councillor Tammy Hwang
YES - Ward 6 Councillor Tom Jackson
YES - Ward 2 Councillor Cameron Kroetsch
YES - Ward 15 Councillor Ted McMeekin
NOT PRESENT - Ward 3 Councillor Nrinder Nann
YES - Ward 7 Councillor Esther Pauls
YES - Ward 14 Councillor Mike Spadafora
YES - Ward 11 Councillor Mark Tadeson
YES - Ward 13 Councillor Alex Wilson
YES - Ward 1 Councillor Maureen Wilson

Result: Motion on the balance of the General Issues Committee Report 24-012, CARRIED by a vote of 15 to 0, as follows:

YES - Ward 10 Councillor Jeff Beattie
YES - Ward 12 Councillor Craig Cassar
YES - Ward 9 Councillor Brad Clark
YES - Ward 8 Councillor John-Paul Danko
YES - Deputy Mayor - Ward 5 Councillor Matt Francis
YES - Mayor Andrea Horwath
YES - Ward 4 Councillor Tammy Hwang
YES - Ward 6 Councillor Tom Jackson
YES - Ward 2 Councillor Cameron Kroetsch
YES - Ward 15 Councillor Ted McMeekin
NOT PRESENT - Ward 3 Councillor Nrinder Nann
YES - Ward 7 Councillor Esther Pauls
YES - Ward 14 Councillor Mike Spadafora
YES - Ward 11 Councillor Mark Tadeson
YES - Ward 13 Councillor Alex Wilson
YES - Ward 1 Councillor Maureen Wilson

PLANNING COMMITTEE REPORT 24-010

(Cassar/Kroetsch)
That Planning Committee Report 24-010, being the meeting held on Tuesday, July 9, 2024, be received and the recommendations contained therein be approved.

(Cassar/Kroetsch)
That Item 7 of the Planning Committee Report 24-010, respecting Housekeeping Amendments and Strategic Updates to the Urban Hamilton Official Plan and Rural Hamilton Official Plan and Modifications and Updates to City of Hamilton Zoning By-law No. 05-200 and Former City of Hamilton Zoning By-law No. 6593 (PED24113), be ***amended***, to remove sub-section (b)(ii) and renumber the balance accordingly, as follows:

7. Housekeeping Amendments and Strategic Updates to the Urban Hamilton Official Plan and Rural Hamilton Official Plan and Modifications and Updates to City of Hamilton Zoning By-law 05-200 and Former City of Hamilton Zoning By-law No. 6593 (City Wide) (PED24113) (Item 10.3)

(b) That City Initiative CI-24-D – Housekeeping Amendments and Strategic Updates to City of Hamilton Zoning By-law No. 05-200 for modifications and updates, be APPROVED on the following basis:

(i) That the Draft By-law, attached as Appendix "C" to Report PED24113, which has been prepared in a form satisfactory to the City Solicitor, be enacted by Council;

~~***(ii) That the Draft By-law, attached as Appendix "D" to Report PED24113, which has been prepared in a form satisfactory to the City Solicitor, be enacted by Council;***~~

(ii) That the proposed changes in zoning will comply with the Urban Hamilton Official Plan upon approval of the Draft Urban Hamilton Official Plan Amendment No. XX, attached as Appendix "A" to Report PED24113;

(iii) That the proposed changes in zoning comply with the Rural Hamilton Official Plan;

(iv) That the proposed Zoning By-law Amendments are consistent with the Provincial Policy Statement, 2020 and conform to A Place to Grow: Growth Plan for the Greater Golden Horseshoe, 2019, as amended, and the Greenbelt Plan, 2017;

Result: *Amendment* to Item 7 of the Planning Committee Report 24-010, CARRIED, by a vote of 15 to 0, as follows:

YES - Ward 10 Councillor Jeff Beattie
YES - Ward 12 Councillor Craig Cassar
YES - Ward 9 Councillor Brad Clark
YES - Ward 8 Councillor John-Paul Danko
YES - Deputy Mayor - Ward 5 Councillor Matt Francis

YES - Mayor Andrea Horwath
YES - Ward 4 Councillor Tammy Hwang
YES - Ward 6 Councillor Tom Jackson
YES - Ward 2 Councillor Cameron Kroetsch
YES - Ward 15 Councillor Ted McMeekin
NOT PRESENT - Ward 3 Councillor Nrinder Nann
YES - Ward 7 Councillor Esther Pauls
YES - Ward 14 Councillor Mike Spadafora
YES - Ward 11 Councillor Mark Tadeson
YES - Ward 13 Councillor Alex Wilson
YES - Ward 1 Councillor Maureen Wilson

Result: Motion on the Planning Committee Report 24-010, *As Amended*, CARRIED, by a vote of 15 to 0, as follows:

YES - Ward 10 Councillor Jeff Beattie
YES - Ward 12 Councillor Craig Cassar
YES - Ward 9 Councillor Brad Clark
YES - Ward 8 Councillor John-Paul Danko
YES - Deputy Mayor - Ward 5 Councillor Matt Francis
YES - Mayor Andrea Horwath
YES - Ward 4 Councillor Tammy Hwang
YES - Ward 6 Councillor Tom Jackson
YES - Ward 2 Councillor Cameron Kroetsch
YES - Ward 15 Councillor Ted McMeekin
NOT PRESENT - Ward 3 Councillor Nrinder Nann
YES - Ward 7 Councillor Esther Pauls
YES - Ward 14 Councillor Mike Spadafora
YES - Ward 11 Councillor Mark Tadeson
YES - Ward 13 Councillor Alex Wilson
YES - Ward 1 Councillor Maureen Wilson

PUBLIC HEALTH COMMITTEE REPORT 24-006

(Francis/Tadeson)
That Public Health Committee Report 24-006, being the meeting held on Wednesday, July 10, 2024, be received and the recommendations contained therein, be approved.

Result: Motion on the Public Health Committee Report 24-006, CARRIED by a vote of 15 to 0, as follows:

YES - Ward 10 Councillor Jeff Beattie
YES - Ward 12 Councillor Craig Cassar
YES - Ward 9 Councillor Brad Clark
YES - Ward 8 Councillor John-Paul Danko
YES - Deputy Mayor - Ward 5 Councillor Matt Francis
YES - Mayor Andrea Horwath
YES - Ward 4 Councillor Tammy Hwang
YES - Ward 6 Councillor Tom Jackson
YES - Ward 2 Councillor Cameron Kroetsch

YES - Ward 15 Councillor Ted McMeekin
NOT PRESENT - Ward 3 Councillor Nrinder Nann
YES - Ward 7 Councillor Esther Pauls
YES - Ward 14 Councillor Mike Spadafora
YES - Ward 11 Councillor Mark Tadeson
YES - Ward 13 Councillor Alex Wilson
YES - Ward 1 Councillor Maureen Wilson

(Francis/Tadeson)
That Section 5.8(2) of the City's Procedural By-law 21-021, as Amended, which provides that a minimum of 2 days shall pass before the Report of a Standing Committee, the Selection Committee, or other Committee that reports directly to Council is presented to Council to provide adequate opportunity for review, be waived in order to consider the Public Works Committee Report 24-009 and Audit, Finance and Administration Committee Report 24-013.

Result: Motion CARRIED by a 2/3rds vote of 15 to 0, as follows:

YES - Ward 10 Councillor Jeff Beattie
YES - Ward 12 Councillor Craig Cassar
YES - Ward 9 Councillor Brad Clark
YES - Ward 8 Councillor John-Paul Danko
YES - Deputy Mayor - Ward 5 Councillor Matt Francis
YES - Mayor Andrea Horwath
YES - Ward 4 Councillor Tammy Hwang
YES - Ward 6 Councillor Tom Jackson
YES - Ward 2 Councillor Cameron Kroetsch
YES - Ward 15 Councillor Ted McMeekin
NOT PRESENT - Ward 3 Councillor Nrinder Nann
YES - Ward 7 Councillor Esther Pauls
YES - Ward 14 Councillor Mike Spadafora
YES - Ward 11 Councillor Mark Tadeson
YES - Ward 13 Councillor Alex Wilson
YES - Ward 1 Councillor Maureen Wilson

PUBLIC WORKS COMMITTEE REPORT 24-009

(Spadafora/Francis)
That Public Works Committee Report 24-009, being the meeting held on Wednesday, July 10, 2024, be received and the recommendations contained therein, be approved.

Result: Motion on the Public Works Committee Report 24-009, CARRIED by a vote of 15 to 0, as follows:

YES - Ward 10 Councillor Jeff Beattie
YES - Ward 12 Councillor Craig Cassar
YES - Ward 9 Councillor Brad Clark
YES - Ward 8 Councillor John-Paul Danko
YES - Deputy Mayor - Ward 5 Councillor Matt Francis
YES - Mayor Andrea Horwath

YES - Ward 4 Councillor Tammy Hwang
YES - Ward 6 Councillor Tom Jackson
YES - Ward 2 Councillor Cameron Kroetsch
YES - Ward 15 Councillor Ted McMeekin
NOT PRESENT - Ward 3 Councillor Nrinder Nann
YES - Ward 7 Councillor Esther Pauls
YES - Ward 14 Councillor Mike Spadafora
YES - Ward 11 Councillor Mark Tadeson
YES - Ward 13 Councillor Alex Wilson
YES - Ward 1 Councillor Maureen Wilson

AUDIT, FINANCE AND ADMINISTRATION COMMITTEE REPORT 24-013

(Hwang/Spadafora)
That Audit, Finance and Administration Committee Report 24-013, being the meeting held on Thursday, July 11, 2024, be received and the recommendations contained therein, be approved.

Result: Motion on the Audit, Finance and Administration Committee Report 24-013, CARRIED by a vote of 15 to 0, as follows:

YES - Ward 10 Councillor Jeff Beattie
YES - Ward 12 Councillor Craig Cassar
YES - Ward 9 Councillor Brad Clark
YES - Ward 8 Councillor John-Paul Danko
YES - Deputy Mayor - Ward 5 Councillor Matt Francis
YES - Mayor Andrea Horwath
YES - Ward 4 Councillor Tammy Hwang
YES - Ward 6 Councillor Tom Jackson
YES - Ward 2 Councillor Cameron Kroetsch
YES - Ward 15 Councillor Ted McMeekin
NOT PRESENT - Ward 3 Councillor Nrinder Nann
YES - Ward 7 Councillor Esther Pauls
YES - Ward 14 Councillor Mike Spadafora
YES - Ward 11 Councillor Mark Tadeson
YES - Ward 13 Councillor Alex Wilson
YES - Ward 1 Councillor Maureen Wilson

(Francis/Tadeson)
That Committee of the Whole rise as Council to report and confirm the actions taken in Committee of the Whole.

Result: Motion CARRIED by a vote of 14 to 0, as follows:

NOT PRESENT - Ward 10 Councillor Jeff Beattie
YES - Ward 12 Councillor Craig Cassar
YES - Ward 9 Councillor Brad Clark
YES - Ward 8 Councillor John-Paul Danko
YES - Deputy Mayor - Ward 5 Councillor Matt Francis
YES - Mayor Andrea Horwath

YES - Ward 4 Councillor Tammy Hwang
YES - Ward 6 Councillor Tom Jackson
YES - Ward 2 Councillor Cameron Kroetsch
YES - Ward 15 Councillor Ted McMeekin
NOT PRESENT - Ward 3 Councillor Nrinder Nann
YES - Ward 7 Councillor Esther Pauls
YES - Ward 14 Councillor Mike Spadafora
YES - Ward 11 Councillor Mark Tadeson
YES - Ward 13 Councillor Alex Wilson
YES - Ward 1 Councillor Maureen Wilson

MOTIONS

7.1 Sanctioned Encampment Site(s)

(Hwang/Tadeson)
WHEREAS, a sanctioned encampment site was discussed as a possible solution to manage encampments in the City of Hamilton at the June 19, 2024 General Issues Committee by delegates as well as the representatives from the Hamilton Police Service; and

WHEREAS, an amendment to the updated encampment protocol was added at the June 19th, 2024 General Issues Committee where staff will be evaluating the opportunity of increasing certain distances in specific cases; and that report will be presented at the August 2024 General Issues Committee meeting.

THEREFORE, BE IT RESOLVED:

(a) That staff be directed to report back to the General Issues Committee in August 2024, with an information report that identifies the resources required to integrate services and supports for individuals living unsheltered into a sanctioned encampment site or sites, including:

(i) a summary of the results of the previously completed jurisdictional scan and operating model analysis of sanctioned site options; and

(ii) a cost comparison of current encampment protocol spending coupled with cost estimates for sanctioned site options.

Result: Motion CARRIED by a vote of 14 to 0, as follows:

YES - Ward 10 Councillor Jeff Beattie
YES - Ward 12 Councillor Craig Cassar
YES - Ward 9 Councillor Brad Clark
YES - Ward 8 Councillor John-Paul Danko
YES - Deputy Mayor - Ward 5 Councillor Matt Francis
YES - Mayor Andrea Horwath
YES - Ward 4 Councillor Tammy Hwang
YES - Ward 6 Councillor Tom Jackson
YES - Ward 2 Councillor Cameron Kroetsch

YES - Ward 15 Councillor Ted McMeekin
NOT PRESENT - Ward 3 Councillor Nrinder Nann
YES - Ward 7 Councillor Esther Pauls
NOT PRESENT - Ward 14 Councillor Mike Spadafora
YES - Ward 11 Councillor Mark Tadeson
YES - Ward 13 Councillor Alex Wilson
YES - Ward 1 Councillor Maureen Wilson

7.2 Workers Arts and Heritage Centre Capital Updates and Repairs (Ward 2)

(Kroetsch/A. Wilson)
WHEREAS Workers Arts and Heritage Centre (WAHC), as a not-for-profit institution, does not have sufficient funding to take on emerging capital updates and repairs to the Hamilton Custom House, where they host their operations and programming;

WHEREAS the Hamilton Custom House was built between 1858 and 1860 and is one of the oldest remaining federal public buildings in Canada;

WHEREAS the Hamilton Custom House is a heritage-listed building of important historical and architectural significance to Ward 2 and the City of Hamilton, and is recognized as a heritage easement site through the Ontario Heritage Foundation;

WHEREAS Workers Arts and Heritage Centre is a museum that celebrates the history of workers and labour and is of important cultural and historical significance to Ward 2 and the City of Hamilton; and

WHEREAS Workers Arts and Heritage Centre staff obtained the following quotes and estimates for necessary capital updates and repairs:

- Heritage window pane repair by Lower City Joinery for $4,881.60
- River stone hardscaping on exterior of the building for $2,358.34
- Plaster restoration by Acanthus Heritage Plastering Inc. for $10,000
- Chain link fence replacement for $9,034.35
- LED lighting conversion by Christopher’s Electric for $3,725.71

THEREFORE, BE IT RESOLVED:

(a) That a grant up to $30,000 be allocated from the Ward 2 Capital Re-Investment Reserve #108052 to Workers Arts and Heritage Centre for costs associated with these necessary capital updates and repairs; and

(b) That the Mayor and City Clerk be authorized and directed to execute any required agreement(s) and ancillary documents, with such terms and conditions in a form satisfactory to the City Solicitor.

Result: Motion CARRIED by a vote of 14 to 1, as follows:

YES - Ward 10 Councillor Jeff Beattie
YES - Ward 12 Councillor Craig Cassar
YES - Ward 9 Councillor Brad Clark

NO - Ward 8 Councillor John-Paul Danko
YES - Deputy Mayor - Ward 5 Councillor Matt Francis
YES - Mayor Andrea Horwath
YES - Ward 4 Councillor Tammy Hwang
YES - Ward 6 Councillor Tom Jackson
YES - Ward 2 Councillor Cameron Kroetsch
YES - Ward 15 Councillor Ted McMeekin
NOT PRESENT - Ward 3 Councillor Nrinder Nann
YES - Ward 7 Councillor Esther Pauls
YES - Ward 14 Councillor Mike Spadafora
YES - Ward 11 Councillor Mark Tadeson
YES - Ward 13 Councillor Alex Wilson
YES - Ward 1 Councillor Maureen Wilson

Item 7.3, respecting an Amendment to Item 2 of the General Issues Committee Report 23-023, respecting Public Feedback and Recommendations for an Encampment Protocol and Sanctioned Sites (HSC20036(g)) (City Wide) - REVISED, which was approved by Council on August 18, 2023, was considered following the recess.

7.4 Funding to the Somali Community in Hamilton for Soccer Tournament Participation – 2024

(Kroetsch/Hwang)
WHEREAS, the Somali Community in Hamilton is a registered non-profit organization operating in Ward 3 and is committed to providing multi-ethnic and under-served communities with access to recreation, social services, and community engagement;

WHEREAS, the Somali Community Soccer team provides an opportunity for youth to engage in healthy, competitive sports and fosters community spirit and pride within and outside of Hamilton's Somali community;

WHEREAS, the Hamilton Stars Soccer team is participating in the annual Somali Week Soccer Tournament in Toronto this month where their talents and teamwork will be showcased on a larger stage;

WHEREAS, this annual tournament, held at Centennial Park Arena, brings together Somali soccer teams from across North America and aims to unite the Somali community and celebrate their history, culture, art, and performances, while also spreading the positive message of bringing youth together for good;

WHEREAS, to reduce the financial burden of transportation for the youth participating in the tournament and ensure their safety for four round trips to Toronto, the group is seeking to arrange bus transportation; and

WHEREAS, Ward 3 residents will be both playing in and volunteering to organize tournament logistics.

THEREFORE, BE IT RESOLVED:

(a) That $3,390 be allocated from the Ward 3 Non-Property Tax Revenue Account (3301609603) to the Somali Community in Hamilton; and

(b) That the Mayor and City Clerk be authorized and directed to execute any required agreement(s) and ancillary documents, with such terms and conditions in a form satisfactory to the City Solicitor.

Result: Motion CARRIED by a vote of 15 to 0, as follows:

YES - Ward 10 Councillor Jeff Beattie
YES - Ward 12 Councillor Craig Cassar
YES - Ward 9 Councillor Brad Clark
YES - Ward 8 Councillor John-Paul Danko
YES - Deputy Mayor - Ward 5 Councillor Matt Francis
YES - Mayor Andrea Horwath
YES - Ward 4 Councillor Tammy Hwang
YES - Ward 6 Councillor Tom Jackson
YES - Ward 2 Councillor Cameron Kroetsch
YES - Ward 15 Councillor Ted McMeekin
NOT PRESENT - Ward 3 Councillor Nrinder Nann
YES - Ward 7 Councillor Esther Pauls
YES - Ward 14 Councillor Mike Spadafora
YES - Ward 11 Councillor Mark Tadeson
YES - Ward 13 Councillor Alex Wilson
YES - Ward 1 Councillor Maureen Wilson

7.5 Request for the Association of Municipalities of Ontario (AMO) to Advocate to the Government of Ontario to Increase Ontario Disability Support Program (ODSP) and Ontario Works (OW) Rates in Ontario

(Hwang/Jackson)
WHEREAS, the Hamilton Social Work Action Committee delegated to the Emergency & Community Services Committee on June 20, 2024, to ask the City of Hamilton to encourage the Association of Municipalities of Ontario (AMO) to leverage its collective power to advocate to the Government of Ontario for it to significantly increase the rates for the Ontario Disability Support Program (ODSP) and Ontario Works (OW);

WHEREAS, about 500,000 Ontarians with disabilities rely on ODSP, with a maximum of $1,368 per month for a single person and about 445,000 Ontarians rely on Ontario Works, with a maximum of $733 per month for a single person, that the average ODSP or OW recipient is entitled to much less, when adjusting for inflation, than they did in the late 1990s;

WHEREAS, ODSP rates were frozen from 2018 to 2022 and that even with the indexation of ODSP rates, they remain lower than when they were frozen in 2018, whereas OW rates remain frozen since 2018, which resulted in a 15% decline in inflation-adjusted rates from 2018 to 2024;

WHEREAS, even with the rate of inflation increase for ODSP, the social assistance income of individuals with a disability is not only well below the poverty line but also below the deep income poverty threshold;

WHEREAS, current ODSP and OW rates are contributing to the housing precarity of recipients of social assistance, leading some to experience homelessness, thereby exacerbating existing disabilities and food insecurity, and that homelessness is a social, economic, and health crisis;

WHEREAS, AMO, through the 2024 Ontario budget preparation, advocated to the Ministry of Children, Community, and Social Services (MCCSS) to 1) increase provincial social assistance rates to adequate rates so people can pay rent and feed themselves and their families, 2) to provide base shelter amounts to unhoused people on ODSP and OW to help them get out of homelessness, 3) to increase amount of money individuals on OW can earn without impacts to monthly benefits, and 4) to increase cap on discretionary benefits administered by municipal system managers; and

WHEREAS, increasing the income of people with disabilities, and those experiencing deep poverty, supports the Council priority of Safe and Thriving Neighbourhoods (i.e. reducing chronic homelessness) and the Hamilton Community Safety and Well-being plan (i.e. housing and homelessness and access to income).

THEREFORE, BE IT RESOLVED:

(a) That staff be directed to draft a letter to the Association of Municipalities of Ontario (AMO) requesting, at its upcoming Annual General Meeting (AGM), that it advocate to the Government of Ontario to substantially increase the rates for Ontario Disability Support Program (ODSP) and Ontario Works (OW) to lift Ontarians living with disabilities out of deep poverty; and

(b) That a copy of this motion be sent to the Premier of Ontario (premier@ontario.ca), the Minister of Children, Community, and Social Services (MinisterMCCSS@ontario.ca), the Minister of Finance (minister.fin@ontario.ca), to the Association of Municipalities of Ontario (amo@amo.on.ca), and to the 443 municipalities of Ontario.

Result: Motion CARRIED by a vote of 15 to 0, as follows:

YES - Ward 10 Councillor Jeff Beattie
YES - Ward 12 Councillor Craig Cassar
YES - Ward 9 Councillor Brad Clark
YES - Ward 8 Councillor John-Paul Danko
YES - Deputy Mayor - Ward 5 Councillor Matt Francis
YES - Mayor Andrea Horwath
YES - Ward 4 Councillor Tammy Hwang
YES - Ward 6 Councillor Tom Jackson
YES - Ward 2 Councillor Cameron Kroetsch
YES - Ward 15 Councillor Ted McMeekin
NOT PRESENT - Ward 3 Councillor Nrinder Nann

YES - Ward 7 Councillor Esther Pauls
YES - Ward 14 Councillor Mike Spadafora
YES - Ward 11 Councillor Mark Tadeson
YES - Ward 13 Councillor Alex Wilson
YES - Ward 1 Councillor Maureen Wilson

7.6 Amendment to Item 1 of the General Issues Committee 23-024, respecting Addressing Needs of Unsheltered Individuals and those Relying on Hamilton's Emergency Shelter System (HSC23041) (City Wide) (formerly Item 8.1)

(a) (Kroetsch/Cassar)
That the Rules of Order be waived to allow for the introduction of a motion respecting an Amendment to Item 1 of the General Issues Committee 23-024, respecting Addressing Needs of Unsheltered Individuals and those Relying on Hamilton's Emergency Shelter System (HSC23041) (City Wide)

Result: Motion CARRIED by a 2/3rds vote of 15 to 0, as follows:

YES - Ward 10 Councillor Jeff Beattie
YES - Ward 12 Councillor Craig Cassar
YES - Ward 9 Councillor Brad Clark
YES - Ward 8 Councillor John-Paul Danko
YES - Deputy Mayor - Ward 5 Councillor Matt Francis
YES - Mayor Andrea Horwath
YES - Ward 4 Councillor Tammy Hwang
YES - Ward 6 Councillor Tom Jackson
YES - Ward 2 Councillor Cameron Kroetsch
YES - Ward 15 Councillor Ted McMeekin
NOT PRESENT - Ward 3 Councillor Nrinder Nann
YES - Ward 7 Councillor Esther Pauls
YES - Ward 14 Councillor Mike Spadafora
YES - Ward 11 Councillor Mark Tadeson
YES - Ward 13 Councillor Alex Wilson
YES - Ward 1 Councillor Maureen Wilson

(b) (Kroetsch/Cassar)
WHEREAS, at its meeting of September 6, 2023, City Council approved item 1(i)(e) (ii) of General Issues Committee Report 23-024, Addressing Needs of Unsheltered Individuals and those Relying on Hamilton's Emergency Shelter System (HSC23041), thereby authorizing up to $1.2M to Indwell to provide continued high level supports for 24 units at CityHousing Hamilton King William that will take individuals from encampments or the by name list. To be funded by the 2024 Tax Operating budget until provincial commitment for these costs can be obtained;

WHEREAS, the King William project capital costs were funded by the federal Rapid Housing Initiative and our funding agreement stipulates that the City of Hamilton is the applicant and CityHousing Hamilton is the intermediary to that funding and there can be no additional intermediaries to the agreement;

WHEREAS, Indwell has been named as the service provider for the housing supports but entering into a contract with an organization who is not an intermediary to the agreement breach the requirements under the Rapid Housing Initiative agreement; and

WHEREAS, the City may require flexibility in the level of acuity of residents housed in this project to manage risk within the building;

THEREFORE, BE IT RESOLVED:

That Item 1(i)(e)(ii) of the General Issues Committee Report 23-024, respecting Addressing Needs of Unsheltered Individuals and those Relying on Hamilton's Emergency Shelter System (HSC23041) (City Wide) be ***amended***, to read as follows:

1. Addressing Needs of Unsheltered Individuals and those Relying on Hamilton's Emergency Shelter System (HSC23041) (City Wide) (Item 8.1)

(e) That up to $2.3M be referred to the 2024 Tax Operating budget for Council consideration to support individuals experiencing homelessness in securing successful tenancies and prevent homelessness as referenced in the plan to end chronic homelessness and the Housing Sustainability and Investment Roadmap;

(ii) Up to $1.2M to ***~~Indwell~~ CityHousing Hamilton*** to provide ***~~continued high level supports~~ medium to high level permanent supportive housing*** for 24 units at City Housing Hamilton King William that will take individuals from encampments or the by name list until provincial commitment for these costs can be obtained, ***~~And that if the $1.2 M funding is approved by~~ within the 2024 Tax Operating budget ~~that its provision be~~ subject to the City and CityHousing Hamilton entering into an agreement for the provision of the funding with the following terms and conditions:***

(1) the term of the agreement for 2024 shall be from a start date determined by the GM and end on December 31, 2024 with an automatic yearly renewal contingent on approval of yearly funding by Council for a maximum of 39 renewals;

(2) that payments continue for the first quarter of each calendar year past the initial term and each renewal term until Council approves the budge for the subsequent renewal term and if funding is not approved the agreement terminates;

(3) such additional terms and conditions satisfactory to the General Manager of Healthy and Safe Communities in a form satisfactory to the City Solicitor; and

(4) that the General Manager of Healthy and Safe Communities be authorized to execute the agreement.

Result: Motion CARRIED by a vote of 15 to 0, as follows:

YES - Ward 10 Councillor Jeff Beattie
YES - Ward 12 Councillor Craig Cassar
YES - Ward 9 Councillor Brad Clark
YES - Ward 8 Councillor John-Paul Danko
YES - Deputy Mayor - Ward 5 Councillor Matt Francis
YES - Mayor Andrea Horwath
YES - Ward 4 Councillor Tammy Hwang
YES - Ward 6 Councillor Tom Jackson
YES - Ward 2 Councillor Cameron Kroetsch
YES - Ward 15 Councillor Ted McMeekin
NOT PRESENT - Ward 3 Councillor Nrinder Nann
YES - Ward 7 Councillor Esther Pauls
YES - Ward 14 Councillor Mike Spadafora
YES - Ward 11 Councillor Mark Tadeson
YES - Ward 13 Councillor Alex Wilson
YES - Ward 1 Councillor Maureen Wilson

7.7 Amendment to Item 6.3 of the Council Meeting 21-024, respecting Canada Mortgage and Housing Corporation (CMHC) Rapid Housing Initiative (RHI) Project Stream Funding, which was approved by Council on December 15, 2021 (formerly Item 8.2)

(a) (Kroetsch/Cassar)
That the Rules of Order be waived to allow for the introduction of a motion respecting an Amendment to Item 6.3 of the Council Meeting 21-024, respecting Canada Mortgage and Housing Corporation (CMHC) Rapid Housing Initiative (RHI) Project Stream Funding, which was approved by Council on December 15, 2021.

Result: Motion CARRIED by a 2/3rds vote of 15 to 0, as follows:

YES - Ward 10 Councillor Jeff Beattie
YES - Ward 12 Councillor Craig Cassar
YES - Ward 9 Councillor Brad Clark
YES - Ward 8 Councillor John-Paul Danko
YES - Deputy Mayor - Ward 5 Councillor Matt Francis
YES - Mayor Andrea Horwath
YES - Ward 4 Councillor Tammy Hwang
YES - Ward 6 Councillor Tom Jackson
YES - Ward 2 Councillor Cameron Kroetsch

YES - Ward 15 Councillor Ted McMeekin
NOT PRESENT - Ward 3 Councillor Nrinder Nann
YES - Ward 7 Councillor Esther Pauls
YES - Ward 14 Councillor Mike Spadafora
YES - Ward 11 Councillor Mark Tadeson
YES - Ward 13 Councillor Alex Wilson
YES - Ward 1 Councillor Maureen Wilson

(b) (Kroetsch/Cassar)

WHEREAS, Council on December 15, 2021 approved rent subsidy of $150K for 36 units created under the Rapid Housing Initiative Round II for the City's submitted projects with required program affordability period of 20 years to be included in the 2023 operating budget for Council deliberation and approval, through the motion dated December 15, 2021 respecting Canada Mortgage and Housing Corporation (CMHC) Rapid Housing Initiative (RHI) Project Stream Funding;

WHEREAS, Council on December 7, 2022 approved an amendment that repurposed subsidy approved for 49 units under Rapid Housing Initiative II, through report Emergency and Community Services report HSC20056(a), to support the rent subsidy for 36 units to created under the Rapid Housing Initiative Round II, for the City's submitted projects with required program affordability period of 20 years;

WHEREAS, rent subsidies for projects approved under the Rapid Housing Initiative II Project Stream was approved in the annual tax operating budget 2023 to be funded from the municipal levy;

WHEREAS, the King William project capital costs were funded by the federal Rapid Housing Initiative and our funding agreement stipulates that the affordability term required is 40 years; and

WHEREAS, the City requires approval to commit future annual budgets for the 40-year affordability term.

THEREFORE, BE IT RESOLVED:

That Item 6.3 of the Council Meeting 21-024, respecting Canada Mortgage and Housing Corporation (CMHC) Rapid Housing Initiative (RHI) Project Stream Funding, be ***amended***, to read as follows:

6.3 Canada Mortgage and Housing Corporation (CMHC) Rapid Housing Initiative (RHI) Project Stream Funding

(a) That the General Manager of the Healthy and Safe Communities Department, or designate, be directed to accept the Rapid Housing Initiative Project Stream Funding allocation in an amount of up to $10,305,844 for the creation of additional affordable housing units, providing the City's submitted projects are selected by CMHC's evaluation team for funding under the Project Stream;

(b) That the General Manager of the Healthy and Safe Communities Department, or designate, be authorized and directed to enter into the Rapid Housing Initiative Amending Letter dated December 6, 2021 with the Canada Mortgage and Housing Corporation (CMHC) to accept Rapid Housing Initiative Project Stream allocation in the amount of up to $10,305,844 for the creation of up to 36 affordable housing units, in a form satisfactory to the City Solicitor;

(c) That the General Manager of the Healthy and Safe Communities Department, or designate, be authorized and directed to administer projects selected through the Rapid Housing Initiative (RHI) Project Stream including: entering into any agreements and ancillary agreements on such terms as they consider appropriate; approving purchase orders; and taking other actions needed to ensure success, in a form satisfactory to the City Solicitor;

(d) That Housing Services Division be directed to managed project overrun costs for the projects selected under RHI-2 Project Stream, and funds required to cover overruns of the RHI-2 Project Stream projects be brought forward to Council for approval with a funding source identified;

(e) Pending CMHC's approval of the City's submitted projects for Project Stream Funding, Staff be directed to fund eligible Development Charges (DC), for approximately 12 units at an estimated cost of $231 K, from the Tax Stabilization Reserve 110046 or other Council approved funding sources; and

(f) That the Housing Services Division report back to the Emergency and Community Services Committee, upon receiving CMHC's approval of RHI-2 projects under Project Stream as appropriate, on the City's progress with the Rapid Housing Initiative including both the first and second round of funding; and

(g) That the City of Hamilton enter into agreements with RHI-2 projects under the Project Stream for the provision of funding rent subsidy with the following terms and conditions:

(i) the term of the agreement for 2024 shall be from a start date determined by the GM and end on December 31, 2024 with an automatic yearly renewal contingent on approval of yearly funding by Council for a maximum of 39 renewals;

(ii) that payments continue for the first quarter of each calendar year past the initial term and each renewal term until Council approves the budget for the subsequent renewal term and if funding is not approved the agreement terminates;

(iii) such additional terms and conditions satisfactory to the General Manager of Healthy and Safe Communities in a form satisfactory to the City Solicitor and that the General Manager of Healthy and Safe Communities be authorized to execute the agreement.

Result: Motion CARRIED by a vote of 15 to 0, as follows:

YES - Ward 10 Councillor Jeff Beattie
YES - Ward 12 Councillor Craig Cassar
YES - Ward 9 Councillor Brad Clark
YES - Ward 8 Councillor John-Paul Danko
YES - Deputy Mayor - Ward 5 Councillor Matt Francis
YES - Mayor Andrea Horwath
YES - Ward 4 Councillor Tammy Hwang
YES - Ward 6 Councillor Tom Jackson
YES - Ward 2 Councillor Cameron Kroetsch
YES - Ward 15 Councillor Ted McMeekin
NOT PRESENT - Ward 3 Councillor Nrinder Nann
YES - Ward 7 Councillor Esther Pauls
YES - Ward 14 Councillor Mike Spadafora
YES - Ward 11 Councillor Mark Tadeson
YES - Ward 13 Councillor Alex Wilson
YES - Ward 1 Councillor Maureen Wilson

7.8 Furthering a Collaborative Path Between the City of Hamilton and Urban Indigenous residents as per the Council approved Urban Indigenous Strategy (formerly Item 8.3)

(a) (Horwath/Spadafora)
That the Rules of Order be waived to allow for the introduction of a motion respecting Furthering a Collaborative Path Between the City of Hamilton and Urban Indigenous residents as per the Council approved Urban Indigenous Strategy.

Result: Motion CARRIED by a 2/3rds vote of 15 to 0, as follows:

YES - Ward 10 Councillor Jeff Beattie
YES - Ward 12 Councillor Craig Cassar
YES - Ward 9 Councillor Brad Clark
YES - Ward 8 Councillor John-Paul Danko
YES - Deputy Mayor - Ward 5 Councillor Matt Francis
YES - Mayor Andrea Horwath
YES - Ward 4 Councillor Tammy Hwang

YES - Ward 6 Councillor Tom Jackson
YES - Ward 2 Councillor Cameron Kroetsch
YES - Ward 15 Councillor Ted McMeekin
NOT PRESENT - Ward 3 Councillor Nrinder Nann
YES - Ward 7 Councillor Esther Pauls
YES - Ward 14 Councillor Mike Spadafora
YES - Ward 11 Councillor Mark Tadeson
YES - Ward 13 Councillor Alex Wilson
YES - Ward 1 Councillor Maureen Wilson

(b) (Horwath/McMeekin)

WHEREAS, Hamilton City Council's approved Urban Indigenous Strategy (UIS) makes a commitment to having a trusting relationship with Indigenous communities, where we communicate and work together appropriately to address the unique needs and issues of Indigenous people;

WHEREAS, Indigenous community organizations serving the Urban Indigenous residents of Hamilton have articulated, through various presentations and requests, the need for accelerated progress in the methods and processes to achieve the goals of the UIS;

WHEREAS, the UIS affirms that the City of Hamilton will "Improve meaningful consultation with Urban Indigenous residents and First Nations communities on municipal projects, plans and approvals"; and

WHEREAS, the City of Hamilton's UIS seeks to ensure that the City "Understand how concepts such as the "Doctrine of Discovery" affect municipal decision making and develop tools to reform those processes."

THEREFORE, BE IT RESOLVED:

(a) That the City of Hamilton's Indigenous Relations Division provide a presentation to a future General Issues Committee detailing the current status and progress on the Urban Indigenous Strategy (UIS) and its various components, including but not limited to those that improve meaningful consultation and participation of Indigenous peoples in municipal decision-making;

(b) That an updated scan of Truth and Reconciliation best practices currently being implemented in other Canadian municipalities and ongoing work being done through organizations like the Federation of Canadian Municipalities be completed; and

(c) That the City of Hamilton's Legal Services Division provides an overview of the statutory framework and responsibilities that exists at the Federal, Provincial and Municipal orders of Government, relating to the work detailed in the Urban Indigenous Strategy (UIS).

Result: Motion CARRIED by a vote of 15 to 0, as follows:

YES - Ward 10 Councillor Jeff Beattie
YES - Ward 12 Councillor Craig Cassar
YES - Ward 9 Councillor Brad Clark
YES - Ward 8 Councillor John-Paul Danko
YES - Deputy Mayor - Ward 5 Councillor Matt Francis
YES - Mayor Andrea Horwath
YES - Ward 4 Councillor Tammy Hwang
YES - Ward 6 Councillor Tom Jackson
YES - Ward 2 Councillor Cameron Kroetsch
YES - Ward 15 Councillor Ted McMeekin
NOT PRESENT - Ward 3 Councillor Nrinder Nann
YES - Ward 7 Councillor Esther Pauls
YES - Ward 14 Councillor Mike Spadafora
YES - Ward 11 Councillor Mark Tadeson
YES - Ward 13 Councillor Alex Wilson
YES - Ward 1 Councillor Maureen Wilson

(Tadeson/McMeekin)
That the Council meeting recess for 30 minutes until 1:00 p.m.

Result: Motion CARRIED by a vote of 15 to 0, as follows:

YES - Ward 10 Councillor Jeff Beattie
YES - Ward 12 Councillor Craig Cassar
YES - Ward 9 Councillor Brad Clark
YES - Ward 8 Councillor John-Paul Danko
YES - Deputy Mayor - Ward 5 Councillor Matt Francis
YES - Mayor Andrea Horwath
YES - Ward 4 Councillor Tammy Hwang
YES - Ward 6 Councillor Tom Jackson
YES - Ward 2 Councillor Cameron Kroetsch
YES - Ward 15 Councillor Ted McMeekin
NOT PRESENT - Ward 3 Councillor Nrinder Nann
YES - Ward 7 Councillor Esther Pauls
YES - Ward 14 Councillor Mike Spadafora
YES - Ward 11 Councillor Mark Tadeson
YES - Ward 13 Councillor Alex Wilson
YES - Ward 1 Councillor Maureen Wilson

The Council meeting reconvened at 1:02 p.m.

7.3 Amendment to Item 2 of the General Issues Committee Report 23-023, respecting Public Feedback and Recommendations for an Encampment Protocol and Sanctioned Sites (HSC20036(g)) (City Wide) - REVISED, which was approved by Council on August 18, 2023

(Danko/Spadafora)
WHEREAS, staff were directed to prepare a motion to amend the Encampment Protocol to mitigate impacts on those living in and around encampments as outlined in Appendix "A" to General Issues Committee Report 23-023 which was approved by Council on August 18, 2023, as per Item 8 (1) of General Issues Committee Report 24-011, including:

(i) removing the following provision from Section D, indicating the removal of encampments, temporary shelters, or tents "on or within 50 metres of the Hamilton Alliance for Tiny Shelters model site. For the purpose of this site the full length of the Strachan Linear Park, Bay Street North to Ferguson Street North, will be considered the site."

(ii) adding an exclusion from allowing encampments, temporary shelters, or tents for the full length of the Strachan Linear Park, Bay Street North to Ferguson Street North until further park development options can be explored;

(iii) Establishing a minimum distance of 100m for additional sensitive uses, specifically around funeral homes and long-term care residencies as well as spaces that are designed and programmed for children as an amendment to the encampment protocol;

(iv) Amending the requirement to keep 5 metres from sidewalks during the winter months to be a full year requirement, and to include walkways and pathways in this requirement; and

(v) Establishing a minimum 25m distance from active construction sites.

THEREFORE, BE IT RESOLVED:

That Item 2 of the of the General Issues Committee Report 23-023, respecting Public Feedback and Recommendations for an Encampment Protocol and Sanctioned Sites (HSC20036(g)) (City Wide) - REVISED, be ***amended***, as follows:

2. Public Feedback and Recommendations for an Encampment Protocol and Sanctioned Sites (HSC20036(g)) (City Wide) - REVISED (Item 8.2)

(a) That Council adopt the Proposed Encampment Protocol attached as ***further amended*** Appendix "A" to General Issues Committee Report 23-023;

Result: Motion CARRIED by a vote of 13 to 0, as follows:

YES - Ward 10 Councillor Jeff Beattie
YES - Ward 12 Councillor Craig Cassar
NOT PRESENT - Ward 9 Councillor Brad Clark
YES - Ward 8 Councillor John-Paul Danko
YES - Deputy Mayor - Ward 5 Councillor Matt Francis
YES - Mayor Andrea Horwath
YES - Ward 4 Councillor Tammy Hwang
YES - Ward 6 Councillor Tom Jackson
YES - Ward 2 Councillor Cameron Kroetsch
YES - Ward 15 Councillor Ted McMeekin
NOT PRESENT - Ward 3 Councillor Nrinder Nann
NOT PRESENT - Ward 7 Councillor Esther Pauls
YES - Ward 14 Councillor Mike Spadafora
YES - Ward 11 Councillor Mark Tadeson
YES - Ward 13 Councillor Alex Wilson
YES - Ward 1 Councillor Maureen Wilson

STATEMENTS BY MEMBERS

Members of Council used this opportunity to discuss matters of general interest.

COUNCIL COMMUNICATION UPDATES

(Francis/Tadeson)
That the listing of Council Communication Updates from June 21, 2024 to July 4, 2024, be received.

Result: Motion on the Council Communication Updates from June 21, 2024 to July 4, 2024 CARRIED by a vote of 13 to 0, as follows:

YES - Ward 10 Councillor Jeff Beattie
YES - Ward 12 Councillor Craig Cassar
NOT PRESENT - Ward 9 Councillor Brad Clark
YES - Ward 8 Councillor John-Paul Danko
YES - Deputy Mayor - Ward 5 Councillor Matt Francis
YES - Mayor Andrea Horwath
YES - Ward 4 Councillor Tammy Hwang
YES - Ward 6 Councillor Tom Jackson
YES - Ward 2 Councillor Cameron Kroetsch
YES - Ward 15 Councillor Ted McMeekin
NOT PRESENT - Ward 3 Councillor Nrinder Nann
NOT PRESENT - Ward 7 Councillor Esther Pauls
YES - Ward 14 Councillor Mike Spadafora
YES - Ward 11 Councillor Mark Tadeson
YES - Ward 13 Councillor Alex Wilson
YES - Ward 1 Councillor Maureen Wilson

PRIVATE AND CONFIDENTIAL

Council determined that discussion of Item 11.2 was not required in Closed Session; therefore, the matter was addressed in Open Session, as follows:

11.2 Correspondence from Lisa Shields, City Solicitor respecting a Confidential Legal Update regarding proceedings under the Endangered Species Act – Delsey Pond

(Cassar/Hwang)

(a) That the Correspondence from Lisa Shields, City Solicitor respecting a Confidential Legal Update regarding proceedings under the Endangered Species Act – Delsey Pond (Item 11.2), be received and referred to the consideration of Item 14 of the General Issues Committee Report 24-012; and

(b) That the Correspondence from Lisa Shields, City Solicitor respecting a Confidential Legal Update regarding proceedings under the Endangered Species Act – Delsey Pond (Item 11.2), remain confidential.

Result: Motion CARRIED by a vote of 13 to 0, as follows:

YES - Ward 10 Councillor Jeff Beattie
YES - Ward 12 Councillor Craig Cassar
NOT PRESENT - Ward 9 Councillor Brad Clark
YES - Ward 8 Councillor John-Paul Danko
YES - Deputy Mayor - Ward 5 Councillor Matt Francis
YES - Mayor Andrea Horwath
YES - Ward 4 Councillor Tammy Hwang
YES - Ward 6 Councillor Tom Jackson
YES - Ward 2 Councillor Cameron Kroetsch
YES - Ward 15 Councillor Ted McMeekin
NOT PRESENT - Ward 3 Councillor Nrinder Nann
NOT PRESENT - Ward 7 Councillor Esther Pauls
YES - Ward 14 Councillor Mike Spadafora
YES - Ward 11 Councillor Mark Tadeson
YES - Ward 13 Councillor Alex Wilson
YES - Ward 1 Councillor Maureen Wilson

(Tadeson/M. Wilson)
That Bryson Tan, Shannon Parker, Andy Potter and Kristen Davies of Deloitte LLP be permitted to attend the Closed Session portion of the Council Meeting respecting the Update on a Cyber Security Incident.

Result: Motion CARRIED by a vote of 13 to 0, as follows:

YES - Ward 10 Councillor Jeff Beattie
YES - Ward 12 Councillor Craig Cassar
NOT PRESENT - Ward 9 Councillor Brad Clark
YES - Ward 8 Councillor John-Paul Danko
YES - Deputy Mayor - Ward 5 Councillor Matt Francis

YES - Mayor Andrea Horwath
YES - Ward 4 Councillor Tammy Hwang
YES - Ward 6 Councillor Tom Jackson
YES - Ward 2 Councillor Cameron Kroetsch
YES - Ward 15 Councillor Ted McMeekin
NOT PRESENT - Ward 3 Councillor Nrinder Nann
NOT PRESENT - Ward 7 Councillor Esther Pauls
YES - Ward 14 Councillor Mike Spadafora
YES - Ward 11 Councillor Mark Tadeson
YES - Ward 13 Councillor Alex Wilson
YES - Ward 1 Councillor Maureen Wilson

(Cassar/Jackson)
That Council move into Closed Session at 1:32 p.m. to discuss Item 11.1 respecting an Update on a Cyber Security Incident pursuant to Section 9.3, Sub-sections (a) of the City's Procedural By-law 21-021, as amended; and, Section 239(2), Sub-sections (a) of the *Ontario Municipal Act, 2001*, as amended, as the subject matters pertain to the security of the property of the City or a local board.

Result: Motion CARRIED by a vote of 13 to 0, as follows:

YES - Ward 10 Councillor Jeff Beattie
YES - Ward 12 Councillor Craig Cassar
NOT PRESENT - Ward 9 Councillor Brad Clark
YES - Ward 8 Councillor John-Paul Danko
YES - Deputy Mayor - Ward 5 Councillor Matt Francis
YES - Mayor Andrea Horwath
YES - Ward 4 Councillor Tammy Hwang
YES - Ward 6 Councillor Tom Jackson
YES - Ward 2 Councillor Cameron Kroetsch
YES - Ward 15 Councillor Ted McMeekin
NOT PRESENT - Ward 3 Councillor Nrinder Nann
NOT PRESENT - Ward 7 Councillor Esther Pauls
YES - Ward 14 Councillor Mike Spadafora
YES - Ward 11 Councillor Mark Tadeson
YES - Ward 13 Councillor Alex Wilson
YES - Ward 1 Councillor Maureen Wilson

The Council meeting reconvened in Open Session at 2:21 p.m.

11.1 Update on a Cyber Security Incident

(Cassar/Tadeson)
That the Update on a Cyber Security Incident, be received and remain confidential.

Result: Motion CARRIED by a vote of 13 to 0, as follows:

YES - Ward 10 Councillor Jeff Beattie
YES - Ward 12 Councillor Craig Cassar
NOT PRESENT - Ward 9 Councillor Brad Clark

YES - Ward 8 Councillor John-Paul Danko
YES - Deputy Mayor - Ward 5 Councillor Matt Francis
YES - Mayor Andrea Horwath
YES - Ward 4 Councillor Tammy Hwang
YES - Ward 6 Councillor Tom Jackson
YES - Ward 2 Councillor Cameron Kroetsch
YES - Ward 15 Councillor Ted McMeekin
NOT PRESENT - Ward 3 Councillor Nrinder Nann
NOT PRESENT - Ward 7 Councillor Esther Pauls
YES - Ward 14 Councillor Mike Spadafora
YES - Ward 11 Councillor Mark Tadeson
YES - Ward 13 Councillor Alex Wilson
YES - Ward 1 Councillor Maureen Wilson

BY-LAWS AND CONFIRMING BY-LAW

(Francis/Tadeson)
That Bills No. 24-122 to No. 24-140 be passed, and that the Corporate Seal be affixed thereto, and that the By-laws, be numbered, be signed by the Mayor and the City Clerk to read as follows:

122 To Amend By-law No. 01-218, as amended, Being a By-law to Regulate On-Street Parking
Schedule 8 (No Parking Zones)
Schedule 13 (No Stopping Zones)
Ward: 11, 14

123 To Authorize the Signing of the Building Faster Fund Transfer Payment Agreement with the Ministry of Municipal Affairs and Housing and the City of Hamilton for the receipt of funds from the Province of Ontario Building Faster Fund
Ward: City Wide

124 Respecting Removal of Part Lot Control, Block 149, Registered Plan No. 62M-1051, municipally known as 205 Thames Way, Glanbrook
Ward: 11
PLC-23-007

125 Respecting Removal of Part Lot Control, Lots 89 to 102, Registered Plan No. 62M-1299, municipally known as 1 to 28 Cherry Blossom Heights, Hamilton
Ward: 8
PLC-24-005

126 Being a By-law to Allow the City to Enter into a Heritage Covenant or Easement Agreement with the Owner of the Lands municipally known as 84 York Boulevard in the City of Hamilton for Conservation of Heritage Attributes of a Structure known as Philpott Church
Ward: 2

127 A By-law to Amend By-law No. 07-170, a By-law to License and Regulate Various Businesses
Ward: City Wide

128 To Amend By-law No. 24-036, as amended by By-law No. 24-049, Being a By-law to Establish Certain 2024 User Fees and Charges for Services, Activities or the Use of Property
Ward: City Wide

129 To Adopt Official Plan Amendment No. 206 to the Urban Hamilton Official Plan respecting 101 Hunter Street East, Hamilton
Ward: 2

130 To Amend Zoning By-law No. 05-200, Respecting Lands Located at 101 Hunter Street East, in the City of Hamilton
ZAC-21-014
Ward: 2

131 To Adopt Official Plan Amendment No. 214 to the Urban Hamilton Official Plan Respecting 259 and 265 Wilson Street East (Ancaster)
Ward: 12

132 To Amend Zoning By-law No. 05-200 with Respect to Lands Located at 259 and 265 Wilson Street East, Ancaster
ZAC-24-013
Ward: 12

133 To Adopt Official Plan Amendment No. 217 to the Urban Hamilton Official Plan Respecting 365 Highway No. 8 (Stoney Creek)
Ward: 10

134 To Amend Zoning By-law No. 05-200 with Respect to Lands Located at 365 Highway No. 8, Stoney Creek
ZAC-24-011
Ward: 10

135 To Adopt Official Plan Amendment No. 218 to the Urban Hamilton Official Plan, Respecting Housekeeping Amendments and Strategic Updates
Ward: City Wide

136 To Adopt Official Plan Amendment No. 41 to the Rural Hamilton Official Plan, Respecting
Housekeeping Amendments and Strategic Updates
Ward: City Wide

137 To Amend Zoning By-law No. 05-200, Respecting Modifications and Updates to the Interpretation, Definitions, General Provisions, Parking, Industrial Zones, Commercial and Mixed Use Zones, Transit Oriented Corridor Zones, Rural Zones, Utility Zones, Waterfront Zones, Special Exceptions, Holding Provisions, Temporary Use Provisions, and Zoning Maps
CI-24-D
Ward: City Wide

138 To Amend Former City of Hamilton Zoning By-law No. 6593 Respecting Lands Located at 1126 Garth Street, Hamilton
CI-24
Ward: 14

139 To Amend By-law No. 12-094, being a By-law to Authorize the Borrowing of Monies by way of Bank Loans in the Principal Amounts of $38,000,000 and $14,740,000
Ward: City Wide

140 To Confirm the Proceedings of City Council

Result: Motion CARRIED by a vote of 13 to 0, as follows:

YES - Ward 10 Councillor Jeff Beattie
YES - Ward 12 Councillor Craig Cassar
NOT PRESENT - Ward 9 Councillor Brad Clark
YES - Ward 8 Councillor John-Paul Danko
YES - Deputy Mayor - Ward 5 Councillor Matt Francis
YES - Mayor Andrea Horwath
YES - Ward 4 Councillor Tammy Hwang
YES - Ward 6 Councillor Tom Jackson
YES - Ward 2 Councillor Cameron Kroetsch
YES - Ward 15 Councillor Ted McMeekin
NOT PRESENT - Ward 3 Councillor Nrinder Nann
NOT PRESENT - Ward 7 Councillor Esther Pauls
YES - Ward 14 Councillor Mike Spadafora
YES - Ward 11 Councillor Mark Tadeson
YES - Ward 13 Councillor Alex Wilson
YES - Ward 1 Councillor Maureen Wilson

(Tadeson/Hwang)
That, there being no further business, City Council be adjourned at 2:25 p.m.

Result: Motion CARRIED by a vote of 13 to 0, as follows:

YES - Ward 10 Councillor Jeff Beattie
YES - Ward 12 Councillor Craig Cassar
NOT PRESENT - Ward 9 Councillor Brad Clark
YES - Ward 8 Councillor John-Paul Danko
YES - Deputy Mayor - Ward 5 Councillor Matt Francis
YES - Mayor Andrea Horwath
YES - Ward 4 Councillor Tammy Hwang
YES - Ward 6 Councillor Tom Jackson
YES - Ward 2 Councillor Cameron Kroetsch
YES - Ward 15 Councillor Ted McMeekin
NOT PRESENT - Ward 3 Councillor Nrinder Nann
NOT PRESENT - Ward 7 Councillor Esther Pauls
YES - Ward 14 Councillor Mike Spadafora
YES - Ward 11 Councillor Mark Tadeson
YES - Ward 13 Councillor Alex Wilson

YES - Ward 1 Councillor Maureen Wilson

Respectfully submitted,

Mayor Andrea Horwath

Matthew Trennum
City Clerk

DOCUMENT 11

INFORMATION REPORT

TO:	Mayor and Members General Issues Committee
COMMITTEE DATE:	August 12, 2024
SUBJECT/REPORT NO:	Encampment Protocol Distance Proposals (HSC24027(a)) (City Wide)
WARD(S) AFFECTED:	City Wide
PREPARED BY:	Amanda Ciardullo (905) 546-2424 ext. 3824 Danielle Blake (905) 546-2424 ext. 3731
SUBMITTED BY: **SIGNATURE:**	Al Fletcher Acting Director, Housing Services Division Healthy and Safe Communities Department
SUBMITTED BY: **SIGNATURE:**	Cynthia Graham Director, Environmental Services Division Public Works Department
SUBMITTED BY: **SIGNATURE:**	Monica Ciriello Director, Licensing and Bylaw Enforcement Planning and Economic Development Department

INFORMATION

Hamilton continues to attempt to address a severe housing and homelessness challenge. Throughout Canada, there has been a noticeable rise in unsheltered homelessness and encampments since the onset of the COVID-19 pandemic. These encampments are indicative of broader issues, including a housing shortage, high demand for shelters surpassing availability, rising living expenses, insufficient income supports, and compounding social challenges such as drug toxicity and mental health issues. Staff believe that permanent, suitable, affordable, and supportive housing is the

solution to homelessness as encampments do not offer a sustainable, long-term resolution. While efforts towards securing permanent housing solutions are ongoing, it remains imperative to provide ongoing support to individuals residing in encampments, who are among the most vulnerable members of our community.

Currently, there are over 90 active encampment sites housing more than 200 individuals in Hamilton. Engagement with individuals with lived experience has revealed a common theme: while some individuals prefer to live outdoors, others would shelter within City of Hamilton funded programs if suitable spaces were available.

On August 18, 2023, Council approved an Encampment Protocol through Report HSC20036(g) identifying approaches, processes, and service levels associated with responding to encampments in the City of Hamilton. On July 12, 2024, Council approved amendments to the Encampment Protocol through Report HSC24027. Council approved Report HSC24027 including a motion for staff to review and report back on Encampment Protocol distance proposals with implications including any legal considerations on the following changes to distance requirements:

(i) Private Property Line minimum distance increase from 10 metres to 25 metres.
(ii) Construction Site minimum distance increase from 25 metres to 100 metres.
(iii) Funeral Home minimum distance change from classification of Funeral Home to Active Business.
(iv) Pathways minimum distance increase from 5 metres to 50 metres.
(v) Heritage Designation distance increase from 5 metres to 50 metres and add monuments & memorials to the classification.

In addition to the above Encampment Protocol distance proposals, staff were directed to report back to the General Issues Committee on City parks that have bona fide and active construction projects with a list of recommendations including but not limited to distancing, safety, and/or exemptions due to nature of the construction scope and tendered schedules to be considered for further amendments to the Encampment Protocol.

Additionally, these compliant spaces would be limited to the center of open areas within parks, increasing the visibility of encampments. Positioning encampments in the center of open spaces would further hinder event planning in parks, as events are typically held in these areas and would require relocating individuals to other compliant spaces for special events. Another significant finding is that some of the remaining compliant spaces under the proposed distance increases would place tents in unsafe locations, such as heavily wooded areas, posing safety risks for both individuals and staff.

Although encampments are not a sustainable, long-term solution for municipalities, it must be recognized that housing is a human right. Until permanent housing solutions are in place to support individuals living in encampments, municipalities need to act in the best interests of individuals experiencing homelessness and their communities to find other solutions.

The Encampment Protocol amendments that were approved by Council on July 12, 2024, through Report HSC24027, limited the number of compliant encampment spaces to 102 sites in the community. The Encampment Protocol distance proposals referred to staff for review found that through implementing all proposed distance increases would further limit the number of compliant encampment spaces to 29 sites in the community. Appendix "A" to Report HSC24027(a), Community Impact Analysis of Proposed Amendments to the Encampment Protocol, provides specific analysis on the number of compliant sites under each of the proposed increased distance requirements.

This analysis was completed through using an online mapping tool. Additional ground truthing will be necessary to confirm the viability of the sites.

The proposed increases in distance offsets for private property and pathways had the most significant impact on compliant sites. These changes would position compliant areas in the middle of open spaces affecting the usability of the park for the general public.

Figure 1 illustrates the impact of compliant sites in the community for encampments with all of the proposed distance increases.

Figure 1: Impact of Proposed Distance Increases

Impact of Proposed Distance Increases on Compliant Sites	
Proposed Distance Increase	**Number of Compliant Sites**
10 m to 25 m of a Private Property Line	52
5 m to 50 m from a Pathway	46
5 m to 50 m of a Military Monument	100

Proposed Distance Increase of 25 metres to 100 metres from a Construction Site

Specific data regarding active construction sites is not available or consistent over time. Construction projects are dynamic and subject to change, which can affect the locations and timelines associated with them. Therefore, any attempts to provide specific data on active constructions sites may not be feasible for this exercise due to the fluid nature of these projects. To further investigate this setback, a better understanding of the type of construction activity to be considered would be important, i.e., building construction, road construction, etc.

Proposed Distance Increase of 100 metres from any Active Business

Specific data regarding the impact of compliant sites within 100 metres of an active business was not able to be collected at this time. To further investigate this setback, a refinement of type of business would be important given active business could be those within Business Improvement Areas, home occupations, etc.

Proposed Distance Increase of 5 metres to 50 metres from a Property with a Heritage Designation and include Monuments and Memorials

Consultations with the Heritage Resource Management team have highlighted complexities in designating monuments or memorials within the City of Hamilton. These sites often hold diverse cultural and historical significance, which can lead to varying interpretations and disputes over their appropriate use and protection. While heritage designated businesses or cultural landscapes are more easily defined, memorials could include benches placed in memorial, trees planted for fallen soldiers, etc.

City Parks with Active Construction Projects

The current setback related to active park construction sites exists regulation which prohibits encampments from being located on or within 25 metres.

Staff propose that the Housing Focused Street Outreach team be involved in the early planning stages of construction projects on compliant sites to develop a coordinated response for assisting and potentially relocating affected individuals to safer, compliant sites that meet their needs. Appendix “B” to Report HSC24027(a) lists the parks in the City of Hamilton with scheduled construction projects.

APPENDICES AND SCHEDULES ATTACHED

Appendix “A” to Report HSC24027(a): Proposed Amendments to the Encampment

Appendix “B” to Report HSC24027(a): Park Construction Projects

DOCUMENT 12

Proposed Amendments to the Encampment Protocol

Total Compliant Sites as of June 2024 Amendments

Following the amendments to the Encampment Protocol approved in June 2024, 102 sites were determined to be compliant in the community. The table below details the approved amendments to the Encampment Protocol in June 2024.

Original Encampment Protocol Prohibited Areas:	Revised Encampment Protocol Prohibited Areas:
• **On or within 50 metres of the Hamilton Alliance for Tiny Shelters model site**. For the purpose of this site the full length of the Strachan Linear Park, Bay Street North to Ferguson Street North, will be considered the site.	• Encampments **are NOT to be located on or within** the full length of the Strachan Linear Park
• On any pathway, sidewalk, or parking lot or on or under any bridge, including pedestrian access points to such areas and structures.	• **On or within 5 metres of** any pathway, walkway, sidewalk, or parking lot or on or under any bridge including pedestrian access points to such areas and structures
• Original Encampment Protocol did not provide regulations for spaces that are designed and programmed for Children.	• **On or within 100 metres** of spaces that are designed and programmed for children
• Original Encampment Protocol did not provide regulations for sites regarding funeral homes.	• **On or within 100 metres** of a funeral home
• Original Encampment Protocol did not provide regulations for sites regarding long-term care facilities.	• **On or within 100 metres** of a long-term care facility
• Original Encampment Protocol did not provide regulations for sites regarding active construction.	• **On or within 25 metres** of an active construction site

Total Compliant Sites with all Proposed Increase Distance Amendments

Considering all the proposed increase distance amendments, the number of compliant sites would decrease to 29 in the community. The following table outlines the proposed increase in distances for the Encampment Protocol:

Current Encampment Protocol Distance Requirements:	Proposed Increased Distance Requirements:
• Private Property Line minimum distance **10 metres**	• Private Property Line minimum distance increase to **25 metres**
• Construction Site minimum distance of **25 metres**	• Construction Site minimum distance increase to **100 metres**
• Funeral Home minimum distance of **100 metres**	• Funeral Home minimum distance **change from classification of Funeral Home to Active Business**
• Pathways minimum distance of **5 metres**	• Pathways minimum distance increase to **50 metres**
• Property with a Heritage Designation minimum distance of **5 metres**	• Property with a Heritage Designation minimum distance increase to **50 metres and add Monuments and Memorials to the classification.**

The following information demonstrates the impact of each proposed distance increase on compliant sites within the community.

Proposed Distance Increase of 10 metres to 25 metres from a Private Property Line

The number of compliant sites will decrease 102 to 52 if the distance from a private property line is increased from 10 metres to 25 metres, which is second-largest reduction after increasing the distance requirement from a pathway. Analysis with the GIS team highlighted an important detail, this increase would place individuals in the center of the compliant sites, thereby increasing their visibility in the community. The figure below illustrates the impact further.



Proposed Distance Increase of 25 metres to 100 metres from a Construction Site

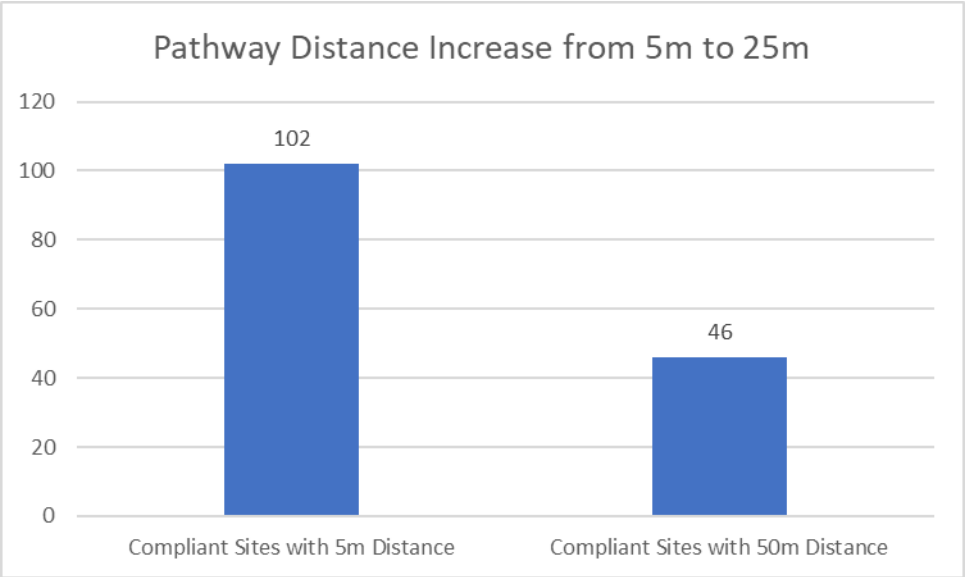
Specific data regarding active construction sites is not available or consistent over time. Construction projects are dynamic and subject to change, which can affect the locations and timelines associated with them. Therefore, any attempts to provide specific data on active constructions sites may not be feasible for this exercise due to the fluid nature of these projects.

Proposed Distance Increase of 100 metres from any Active Business

Specific data regarding the impact of compliant sites within 100 of an active business was not able to be collected at this time, however, further analysis of popular and compliant sites in the community suggests that most sites would be in compliance with this distance regulation.

Proposed Distance Increase of 5 metres to 50 metres from a Pathway

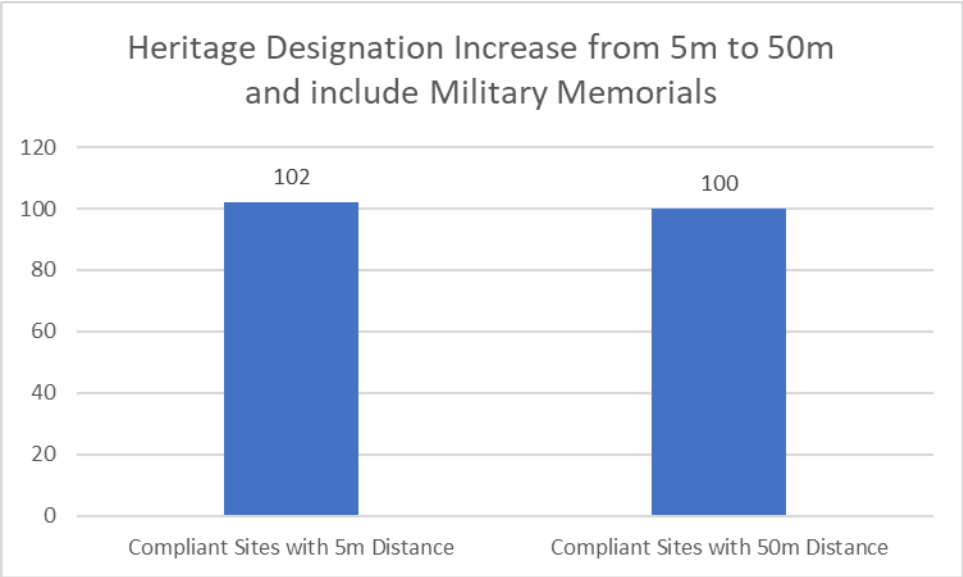
The number of compliant sites will decrease 102 to 46 if the distance from a private property line is increased from 5 metres to 50 metres. This is the largest reduction among all the proposed distance increases. The figure below illustrates this impact further.



Proposed Distance Increase of 5 metres to 50 metres from a Property with a Heritage Designation and include Monuments and Memorials

Consultations with the Heritage Resource Management team have highlighted complexities in designating monuments or memorials within the City. These sites often hold diverse cultural and historical significance, which can lead to varying interpretations and disputes over their appropriate use and protection.

In response to these challenges, staff have taken a collaborative approach, aligning proposed amendments with existing policies clarify guidelines specifically for Military Memorials in the community. Currently, there are 9 Military Memorials in Hamilton, and applying clear distance provisions on Military Memorials ensures transparency and consistency with the community. This approach safeguards temporary shelters during special events such as Remembrance Day ceremonies, respecting the significance of these memorials while maintaining practicality in urban planning and safety measures.



City Parks with Active Construction Projects

Staff are recommending that the current regulations related to Active Construction Sites in the Encampment Protocol remain unchanged for public safety. The existing regulation prohibits encampments from being located on or within 25 metres of any Active Construction Site. Given the scarcity of compliant sites and the fluid nature of construction projects, staff believe that increasing this regulation would further limit available compliant sites and create further challenges for individuals living in encampments.

Staff propose that the Housing Focused Street Outreach team be involved in the early planning stages of construction projects on compliant sites to develop a coordinated response for assisting and potentially relocating affected individuals to safer, compliant sites that meet their needs.

DOCUMENT 13

City Parks with Active Construction Projects

Staff are recommending that the current distance requirement related to Active Construction Sites in the Encampment Protocol remain unchanged for public safety. The existing protocol prohibits encampments from being located on or within 25 metres of any Active Construction Site. Given the scarcity of compliant sites and the fluid nature of construction projects, staff believe that increasing this distance requirement would further limit available compliant sites and create further challenges for individuals living in encampments.

Staff propose that the Housing Focused Street Outreach team be involved in the early planning stages of construction projects on compliant sites to develop a coordinated response for assisting and potentially relocating affected individuals to safer, compliant sites that meet their needs.

Current Parks with Scheduled Construction Projects				
Ward	Park and Project name	Scope	Limits of construction	Anticipated start of construction
1	Alexander Park	Skateboard Park construction	Around skateboard park	Construction forces are not on site at this time, but site remains fenced off.
1	Alexander Park	Field house construction	Park building	Fall 2024
2	Bayfront Park shoreline improvement	Reinforce shoreline protection	Around the edge of the shoreline	Fall 2024
2	Eastwood Park	Netting at baseball diamond	Northwest side, adjacent to path	Fall 2024
3	Woodlands Park	Spray pad	Building, spray pad area and construction entrance	Underway
3	Birge Park	Water service for natural ice rink and drinking fountain	Park entrance and fountain area	Fall 2024
3	Bishops Park	Drinking fountain installation	Entire park	Fall 2024
3	Lifesavers Park	Drinking fountain installation	Area around playground and servicing	Fall 2024
4	Globe Park – dog park	Shelter installation	Shelter area	Summer 2024
5	Jennie Florence Parker Sports	Pickleball court repair	Portions of the pickleball court	Underway, anticipated completion August.

	Park – Confederation Beach Park			
5	Confederation Beach Park	Boat launch removal	Shoreline and trail area at boat launch location	underway
5	Green Acres Park	Slope repair from erosion	Pathway area	Fall 2024
5	Glendale Park	Adjustment of assets that are on former school board lands	Entire park	Fall 2024
6	Mohawk Sports Park	Sport lighting replacement	Bernie Arbour sport lighting area	complete
6/7	Mountain Drive Park	Park master plan implementation and soil remediations	Westerly half of the park	Restriction fencing August 2024. Construction start spring 2025
7	Elmar Park	Playground replacement and rubber surfacing	Area around the playground	Fall 2024
7	Peace Memorial Park	Playground replacement and rubber surfacing	Area around the playground	Fall 2024
7	Alison Park	Playground replacement and rubber surfacing	Area around the playground	Fall 2024
7	Inch Park playground	Radically inclusive playground	Park entrance to play area	Fall 2024
7/8	Sam Lawrence Park	Phase 1 Master plan implementation. Walkway improvements	Walkways, western parking lot	Under construction
8	Newlands Park	Drinking fountain installation	On Newlands Road adjacent to park	Fall 2024
8	Burkholder Park	Playground replacement	Area around the playground	underway
8	William Bethune Park	Playground replacement	Area around the playground	Fall 2024
8	T. Melville Bailey	Playground replacement	Area around the playground	underway
8	Gourley Park	Park redevelopment		Fall 2024
8	Southam Park redevelopment	Full park redevelopment	Majority of the site	Spring 2025
10	Corman Park	Pathway construction	Entire path	Fall 2024/spring 2025
10	Hunter Park	Pathway and multi-use court reconstruction	Area around the court and extents of the path	Fall 2024/spring 2025

10	Ferris Park	Pathway and multi-use court reconstruction	Area around the court and extents of the path	Fall 2024/spring 2025
11	Kopperfield Park	Drainage improvement	50% of the park, around multi-use court	Fall 2024
10	Millen Road shoreline improvement	Reinforce shoreline protection	Road allowance	Fall 2024
10	McNeilly Road shoreline improvement	Reinforce shoreline protection	Road allowance	Fall 2024
12	Ancaster Heights	Playground replacement	Area around the playground	underway
12	Meadowlands Community Park	Sun shelter and drinking fountain	Around the spray pad area	Summer 2024
13	Valley Community Centre Park	Full park redevelopment	Full park	Late fall 2024
13	Millgrove Park	Playground and drainage improvement	Entire park	Fall 2024
13	Beverly Park	Pathway construction	Area around path	Late fall 2024/spring 2025
14	Scenic Woods Park	Playground and path replacement	Area around the playground and extents of the path	underway
14	Scenic Drive Park	Playground and path replacement	Area around the playground and extents of the path	underway
14	Freelton Park	Sport lighting removal	Around the baseball diamond and tennis court	Fall 2024
14	William McCullough	Baseball backstop	Area around the ball diamond	Fall 2024
14	Gilkson Park	Baseball backstop and path	Area around the ball diamond and path	underway
14	Mountview Park	Court and path	Area around the path and court	underway
15	Clear Skies Park	Full park development	Full park	Fall 2024
15	Smoky Hollow Park	Full park development	Full park	Fall 2024

DOCUMENT 14

Hamilton



Hamilton's

EMERGENCY SHELTER STANDARDS

September 2023

Hamilton's Emergency Shelter Standards

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   - 1.3. Writing the Standards
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     - 1.4.2. Role of Emergency Shelter Operators
     - 1.4.3. Role of Indigenous Partners and Community Leaders
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   - 1.5. Guiding Principles
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11.2. Related Documents



1. Introduction
1.1. Acknowledgments
1.2. Background
1.3. Writing the Standards
1.4. Local Homeless-Serving Sector
1.4.1. Role of the City
1.4.2. Role of Emergency Shelter Operators
1.4.3. Role of Indigenous Partners and Community Leaders
1.4.4. Role of People with Lived Experience
1.5. Guiding Principles
1.6. Key Terms and Definitions

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*

DOCUMENT 15

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.

DOCUMENT 16

HOMELESSNESS

Emergency Shelters & Drop-ins

< Housing & Shelter

Preventing & Ending Homelessness

REVIEW THE AVAILABLE

Emergency Shelters & Drop-ins

City of Hamilton Encampment Protocol

City of Hamilton Encampment Response

Emergency Shelters & Drop-ins

Former Cathedral Boys School

Hamilton's Homelessness Ending Strategy

Housing & Homelessness Action Plan

Point in Time Connection

Resources for Homeless-serving partners

Resources for Individuals at Risk of and Experiencing

Emergency & Violence Against | Emergency Drop-ins | Temporary Extended

As a result of the City of Hamilton's ongoing commitment to addressing capacity pressures in the homelessness serving system, service delivery for specific services initiated through the Winter Response Strategy have been temporarily extended.

The City, along with community partners, have committed to extending services which specifically added capacity for an additional temporary period of April 1, 2024 to November 30, 2024.

Daytime and Overnight Drop-in Spaces

To determine if there is available space at a specific location, please contact the number listed for that service.

Living Rock Ministries

50 daytime drop-in spaces for youth up to age 25*, all genders

30 Wilson St., Hamilton ↗

Call 905-528-7625

Monday to Friday, 8 am to 8 pm | Saturday & Sunday, 1 pm to 8 pm

Homelessness

Christ's Church Cathedral

50 daytime drop-in spaces, all genders

252 James St. N., Hamilton ↗

Operated by St. Matthew's

Call 905-523-5546 ext 232

9am to 4pm, 6 days a week

Good Shepherd Cathedral

50 overnight drop-in spaces serving cis men, Two Spirit, transgender and non-binary people

378 Main Street East, Hamilton ↗

Call 905-528-5877 ext 4245

8 pm to 8 am / 7 days a week

Willow's Place

45 overnight drop-in spaces, all women, trans- and non-binary people

196 Wentworth St. N., Hamilton ↗

Call 905-528-5100 press 8; then 3

24 hours a day / 7 days a week

YWCA Carole Anne's Place

40 overnight drop-in spaces, all women, trans- and non-binary people

75 MacNab St. S., ↗

Call 905-522-9922 ext 100

6 pm to 1 pm, nightly (enhanced from 10 pm to 1 pm)

Emergency Shelter Beds

Mission Services Men's Shelter

35 emergency shelter beds, all men

400 King Street E., Hamilton ↗

Call 905-528-7635

24 hours a day / 7 days a week

Salvation Army Booth Centre

10 emergency shelter beds, all men

94 York Blvd, Hamilton ↗

Call 905-527-1444

24 hours a day / 7 days a week

Note: These spaces will be available December 9, 2023.

Additional Resources

Service Restriction Policy for Emergency Shelters _(PDF, 169.83 KB)

Hamilton's Emergency Shelter Standards _(PDF, 1.67 MB)

Date modified: July 22, 2024

Was this information helpful?

Yes ✓ No ✕

Hamilton

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TAB 154

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

APPLICATION UNDER RULE 14.05 OF THE *RULES OF CIVIL PROCEDURE*

RESPONSE TO REQUEST TO ADMIT

In response to the Applicants' Request to Admit dated August 26, 2024, the Respondent, City of Hamilton:

1. Admits the truth of facts number:

None.

2. Admits the authenticity of documents number:

1, 2, 3 (save that the City is unable to confirm the date on which the copy of website information was made), 4 (save that the City is unable to confirm the date on which the copy of website information was made), 5 (save that the City is unable to confirm the date on which the copy of website information was made), 6 (save that the City is unable to confirm the date on

which the copy of website information was made), 9, 10, 11, 12, 13, 14 (save that this document does not appear to be a copy of the current version of Hamilton's Emergency Shelter Standards), 15 (save that this document does not appear to be a copy of the current version of the Service Restriction Policy for Emergency Shelters) and 16 (save that the City is unable to confirm the date on which the copy of website information was made).

3. Denies the truth of facts number:

N/A

4. Denies the authenticity of documents number:

N/A

5. Refuses to admit the truth of facts number **1, 2 and 3** for the following reasons:

1: The 2021 Census of Population sets out an area for the census division in which the City of Hamilton is located, which is not necessarily identical to the area of the City of Hamilton. Its accuracy is unclear and unknown. No admission is made.

2: The 2021 Census of Population data for the Hamilton census division is subject to numerous explicit caveats, including Footnote #1, which states that the total population count is purposely 'adjusted' from the actual data collected in order to ensure 'confidentiality'. It is not accurate. No admission is made.

3: The 2021 Census of Population data relating to individuals of Indigenous identity in the Hamilton census division is based on a partial sample and is in any event subject to the explicit caveat set out in Footnote #44, which states that it comprises an 'estimate' that is more affected than most census variables by 'incomplete enumeration'. It is not accurate. No admission is made.

6. Refuses to admit the authenticity of documents number:

7 (the document appears to be incomplete, missing Appendices A and B) and 8 (the document appears to be incomplete, missing Appendices A and B).

September 10, 2024

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Court File No. CV-21-00077187-0000

KRISTEN HEEGSMA et al. - and - CITY OF HAMILTON

Applicants Respondent

ONTARIO
SUPERIOR COURT OF JUSTICE

PROCEEDING COMMENCED AT HAMILTON

RESPONSE TO REQUEST TO ADMIT

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File No. H227899

TAB 155

Court File No. CV-21-00077187-0000

COURT OF APPEAL FOR ONTARIO

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Moving Parties / Applicants

-and-

CITY OF HAMILTON

Responding Party / Respondent

FACTUM OF THE MOVING PARTY/APPLICANTS

HEEGSMA ET AL.

November 5, 2024

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Lawyers for the Responding Party / Respondent

PART I – INTRODUCTION

1. The Applicants bring this motion pursuant to Rules 1.04., 26.01 and 26.02(c) to seek leave to amend the affidavits of Dr. Jill Wiwcharuk (dated June 7, 2024), Dr. Timothy O'Shea (dated June 7, 2024), Dr. Claire Bodkin (dated May 5, 2023), and Dr. Rachel Lamont (dated June 7, 2024), for the purposes of removing opinion evidence.

2. The affidavits speak to the Applicants' medical conditions and experiences in encampments, and are of central relevance to the Applicants' *Charter* challenge. The Applicants wish to put these statements into evidence to assist the Court.

PART II – SUMMARY OF THE FACTS

3. On June 15, 2022, the Applicants served a Fresh as Amended Notice of Application, which expanded the number of Applicants from five to nineteen, substantially revised both the relief sought and grounds for the Application and listed a much more extensive set of expert affidavits.

4. The Fresh as Amended Notice of Application included medical reports on behalf of ten Applicants from Dr. Wiwcharuk and Dr. O'Shea, who were treating physicians to those Applicants.

5. Dr. Wiwcharuk and Dr. O'Shea were physicians with the Hamilton Social Medicine Response Team (HAMSMaRT) and Shelter Health Network. Both HAMSMaRT and Shelter Health Network operate as a team practice, with several health care practitioners including physicians, psychiatrists, nurse practitioners, and social workers. Both organizations also work closely with several other community organizations who provide outreach to people who live in encampments, including harm reduction groups, social navigation paramedics, and drop-in programs.

6. Dr. Wiwcharuk wrote medical reports for eight Applicants in June 2022. Dr. O'Shea wrote medical reports for two Applicants in June 2022. At the time of authoring the reports, Dr. Wiwcharuk and Dr. O'Shea had been treating physicians for the respective Applicants. In addition, because the Applicants were patients of HAMSMaRT or the Shelter Health Network, Dr. Wiwcharuk and Dr. O'Shea had access to their medical records. They prepared reports detailing diagnoses, treatment and the Applicants' reports of their experiences in encampments. The reports were based on the Applicants' self-reporting, the doctors' knowledge of the Applicants, and a review of their medical records.

7. The Fresh as Amended Notice of Application also included a medical report from Dr. Bodkin on behalf of one Applicant. Dr. Bodkin is a physician with HAMSMaRT and an

emergency room physician. She saw the Applicant for a leg infection and referred him to hospital. Dr. Bodkin prepared a report detailing diagnoses, treatment, and the Applicants' reports of his experiences in encampments.

8. Dr. Lamont is a psychiatrist with HAMSMaRT and wrote medical reports for eight Applicants between May 2023 and April 2024. At the time of authoring the reports, Dr. Lamont was either a treating psychiatrist for the individual Applicant, or the Applicant was a patient of HAMSMaRT, giving Dr. Lamont access to their medical records. Dr. Lamont reviewed the medical records in the course of meeting with the Applicants and preparing the reports.

9. The Applicants did not provide a Form 53 for any of the reports and subsequent affidavits, as it was always the intention for the doctors to be fact witnesses only.

10. The Respondent has been in possession of the medical reports of Dr. Wiwcharuk and Dr. O'Shea since June 2022, when they were included in the Fresh as Amended Notice of Application.

11. On May 7, 2023, Counsel for the Applicants served the Respondent with the May 5, 2023 affidavit of Dr. Bodkin.

12. The Respondent objected to the number of expert witnesses adduced by the Applicants. On May 12, 2023, the Applicants brought a motion pursuant for leave pursuant to section 12 of the *Ontario Evidence Act* to adduce the affidavits of eight expert witnesses. The motion set out the specific expert witnesses that the Applicants wished to adduce.

13. The Respondent opposed the motion, which necessitated a hearing on October 30, 2023.

14. At the time of the hearing, the Respondents had been served with copies of the medical reports from Dr. Wiwcharuk, Dr. O'Shea and Dr. Bodkin.

15. On October 30, 2023, Justice Ramsay granted the Applicants' motion, with costs. The eight experts who were approved were identified, along with the basis for the approval.

16. On March 6, 2024, the Respondent was also served with all reports from Dr. Lamont, except for the April 9, 2024 report, which had not yet been prepared.

17. On June 7, 2024, the Applicants served the balance of their evidence, including the June 7, 2024 affidavits of Dr. Wiwcharuk, Dr. O'Shea, and Dr. Lamont. For clarity, the affidavits did not add a substantive content. Instead, the doctors affixed the reports previously disclosed as exhibits.

18. On August 1, 2024, the Respondent filed their affidavits. The Respondent sought to adduce one expert witness.

19. Cross Examinations started on August 14, 2024. In the midst of cross examinations, the Applicants discovered that the Respondent considered some of the content of the affidavits to contain improper opinion evidence. The parties attempted to resolve the dispute by exchanging proposed amendments, but were unable to reach a consensus on the content for removal. For clarity, the parties disagree on the extent of the content that should be removed.

PART III – ISSUES AND ARGUMENT

ISSUE

20. Should the Court grant leave under Rules 1.04(1), 1.05, 2.01(1), 25.11, 37.10 and 37.13 to amend the four medical fact witness affidavits?

ARGUMENT

The legal framework: Rules 1.04(1), 1.05, 2.01(1), 25.11, 37.10 and 37.13

21. Rule 1.04(1) allows for a liberal construction of the Rules to achieve the most just, expeditious and least expensive determination. A similar provision is found under Rule 1.05. Collectively, Rules 1.04(1), 1.05, 2.01(1), 25.11. 37.10 and 37.13 provide sufficient authority to make amendments to documents at various stages in the proceedings on such terms that are reasonable and just.

22. The Court should grant the amendment of the four medical fact affidavits to ensure that the Applicants are afforded an appropriate opportunity to establish the extent of the impact of the ban on encampments and encampment evictions. Amending the affidavits is the most reasonable, balanced and efficient approach for the following reasons:

a. the affiants are both properly considered fact witnesses and are necessary for this Court to have a fulsome evidentiary record of the Applicants' vulnerabilities, experiences and injuries; and

b. there is nominal, if any, prejudice to the Respondent if improper opinion content is removed. Conversely, the Applicants will be profoundly prejudiced should they be rendered unable to rely on the medical fact affidavits in their entirety.

The affiants are proper fact witnesses

20. The Applicants have led evidence with respect to their physical and mental health, and how their health has been impacted by the ban on encampments and encampment evictions. Some of the evidence consists of firsthand reports from the Applicants themselves. They have also adduced expert evidence regarding the various harms associated with bans on encampments and encampment evictions.

21. Lastly, the Applicants have adduced evidence from four medical fact physicians to speak to their individual experiences.

22. All four of the medical fact physicians previously or currently work for HAMSMaRT and Shelter Health Network. HAMSMaRT and Shelter Health Network are medical outreach organizations, which involves providing healthcare to individuals who are homeless in unconventional settings such as shelters, encampments, drop-in centres, and on the streets.[1]

25. Providing healthcare to individuals experiencing homelessness often involves gathering information from different sources over time, rather than an upfront linear chronology and reporting. Dr. Wiwcharuk explained how providing healthcare to this population differs from more traditional types of healthcare:

> "Because when you provide patient-centred care, you -- you do what is best for the patients given -- given the circumstances that are there and given the difficulties that they're facing. So you -- over time, you may get an entire medical -- you slowly develop the medical history over time. Classically, you might have the idea of a patient coming in and you have a 40-minute intake and you discuss all your past medical history with all previous reports, and that is a very privileged way of being able to access health care, and it's not the reality for the majority of people that are -- have significant mental health and addictions histories. So in my extensive practice working with people in these scenarios, I have found that I can absolutely get an accurate medical history over the time that I spend with them, and it might not all be in one specific time and it might be put together over time, but a medical opinion that is -- that is given from that is absolutely just as -- just as accurate as it would be if I had spent more time -- you know, if they were able to give me more time at the beginning of a session."[2]

[1]Transcript of the cross examination of Jill Wiwcharuk (August 16, 2024) [**"Wiwcharuk XE"**] p. 25, lines, 6-25 [**MR**, Tab 6, p. 104]

[2]Wiwcharuk XE, p. 29, line 5 – p. 30, line 5 [**MR**, Tab, 6 pp. 108].

26. The medical fact witnesses have sufficient personal knowledge, access to information and qualifications to comment on the Applicants' health.

a. Dr. Wiwcharuk

27. At the time of authoring the reports, Dr. Wiwcharuk had been a treating physician for each of the Applicants. To summarize, Dr. Wiwcharuk had known the Applicants as follows:

i. Cory Monahan: Since April 2020, by both Dr. Wiwcharuk and other doctors/health care practitioners since April 2020.[3]

ii. Cassandra Jordan: Through Shelter Health Network since October 2020, and individually November 2021, January 2022, and May 2022[4]

iii. Sherri Ogden: Through Shelter Health Network since 2010, and regularly since 2020. Dr. Wiwcharuk had treated Ms. Ogden "many times".[5]

iv. Patrick Ward: Regularly since late 2014.[6]

v. Jahmal Pierre: Three times since 2020 by Dr. Wiwcharuk and other doctors at Shelter Health Network.[7]

vi. Mario Muscato: Since 2019, several times a week.[8]

vii. Mysty Marshall: Several times since summer 2020.[9]

viii. Shawn Arnold: Sporadically since 2018, regularly in 2021[10]

28. Some of the Applicants had also been seen by Dr. Wiwcharuk's HAMSMaRT and Shelter Health Network colleagues. The information in the reports is based on her direct experience and observation, and/or credibly based on other sources of information such as the Applicants' medical records and

[3]Affidavit of Jill Wiwcharuk sworn June 7, 2024 ["**Wiwcharuk Affidavit**"] Exhibit A, p. 5 [**MR**, Tab 2, p. 17];
[4]Wiwcharuk Affidavit, Exhibit B, pp. 7,8 [**MR**, Tab 2, pp. 19, 20].
[5]Wiwcharuk Affidavit, Exhibit C, pp. 9,10 [**MR**, Tab 2, pp. 19, 20]; Wiwcharuk XE, p. 54, line 25 – p. 55, line 1[**MR**, Tab 6, pp. 133,134].
[6]Wiwcharuk Affidavit, Exhibit D, pp. 11, 12 [**MR**, Tab 2, pp. 23, 24]
[7]Wiwcharuk Affidavit, Exhibit E, p.13 [**MR**, Tab 2 ,p. 25]
[8]Wiwcharuk Affidavit, Exhibit F, p. 14 [**MR**, Tab 2, p. 26]
[9]Wiwcharuk Affidavit, Exhibit G, pp. 17,18 [**MR**, Tab 2, pp. 29,30]
[10]Wiwcharuk Affidavit, Exhibit H, p. 19 [**MR**, Tab 2, p. 31]

information provided by other organizations who supported the Applicants, such as harm reduction groups and paramedics with the Social Navigation program. Dr. Wiwcharuk relied on the different sources, or "circle of care", to credibly inform her assessment and treatment of the Applicants.[11]

29. Dr. Wiwcharuk also explained how she can make observations about medical conditions that are not disclosed by a patient during the course of assessment and treatment:

> "And when you -- when you see someone -- when someone walks in to say, "This is my concern," I look at that patient's concern and I also look at the whole person, every time they come to see me. So they -- they are here because they have a rash. I am there. I see the rash and I look at the whole person, and I see their past -- I see the mental health issues that they're struggling with, and I see all the social determinants of health that are causing poor health outcomes. I see that stuff as well. So that is part -- they're coming to us with one thing, because that is their concern, and as a doctor with the years of experience I have, I am looking at the whole person and I am seeing the background stuff. So yes, every time she came to see me, I would also see the fact that she had significant undiagnosed mental health issues.[12]

b. Dr. O'Shea

30. At the time of authoring the reports, Dr. O'Shea had been a treating physician for each of the Applicants. To summarize, Dr. O'Shea had seen the Applicants as follows:

i. Kristen Heegsma: once every two weeks since July 2021[13]

ii. Ammy Lewis: once every two weeks since July 2021[14]

31. Some of the Applicants had also been seen by his HAMSMaRT and Shelter Health Network colleagues. The information in the reports is based on his direct experience and observation, and credibly based on other sources of information such as the Applicants' medical records other

[11]Wiwcharuk Affidavit, Exhibit A, p. 2; Exhibit B, pp. 1– 2; Exhibit C; ; Exhibit D pp. 1- 2; Exhibit E, p. 1; Exhibit F pp. 1 – 3; Exhibit G pp. 1 – 2; Exhibit H pp. 1 - 2; [**MR** Tab 2, pp. 17,18; 19,20; 21,22; 23,24; 25; 26-28; 29,30; 31,32] Wiwcharuk XE, p. 13, line 23 - p. 14, line 3, p. 14, line 20 – p. 15, line 3, 6-25; p. 39, line 10-12, [**MR**, Tab 6, p. 92-94;118]; Transcript of the redirect examination of Jill Wiwcharuk (September 6, 2024) [**"Wiwcharuk Redirect"**] p. 31, line 1-15, [**MR**, Tab 7, p 178].
[12]Wiwcharuk XE, p. 55, line 18 – p. 56, line 12. [**MR** Tab 6, pp. 134,135]
[13]Affidavit of Timothy O'Shea sworn June 7, 2024, [**"O'Shea Affidavit"**] Exhibit A, p. 4. [**MR** Tab 3, p, 38]
[14]O'Shea Affidavit, Exhibit B, p. 7 [**MR** Tab 3, p 41]

physicians, pharmacy records, social services and shelter workers, and patient advocacy groups. In addition to patient reporting, these information sources are used to create a reliable medical record.[15]

c. Dr. Bodkin

32. At the time of authoring her report, Dr. Bodkin had known the Applicant Linsley Greaves for ten months, and had provided care to him on two occasions. She also assessed Mr. Greaves' tissue injury and infections in both feet. She referred Mr. Greaves to the emergency department, where he underwent an amputation of the left leg below the knee.[16]

33. Dr. Bodkin detailed her involvement with Mr. Greaves as follows:

> "And then I saw him and I did what I do as a physician who does primary care and does emergency medicine all the time, which is that I took a history, I did physical examination, and then I made an assessment and a diagnosis, and then I arranged for appropriate care, because it wasn't what I could provide in my outpatient clinic."[17]

d. Dr. Lamont

34. At the time of authoring her reports, Dr. Lamont had been the treating psychiatrist for several of the Applicants, for varying amounts of time. To summarize, Dr. Lamont had known the Applicants as follows:

i. Kristen Heegsma: Treating psychiatrist since November 2021.[18] She was able to confirm Ms. Heegsma's mental health diagnoses in the course of treatment.[19]

---

[15]Transcript of the cross examination Timothy O'Shea, (September 6, 2024) [**"O'Shea XE"**] p. 13, question 41 –p. 15. [**MR** Tab 8, pp. 200-202]
[16]Affidavit of Claire Bodkin (May 5, 2023), [**"Bodkin Affidavit"**], p. 1, para 3; [**MR** Tab 4, p. 46]; Bodkin Affidavit, Exhibit A [**MR** Tab 4, p. 49]
[17]Transcript of cross examination of Claire Bodkin (September 6, 2024) [**"Bodkin XE"**], p. 33, line 5 – p. 35, line 6 [**MR** Tab 9, pp. 266-268]
[18]Affidavit of Rachel Lamont (June 7, 2024) [**"Lamont Affidavit"**] Exhibit A, p. 5 [**MR** Tab 5, p. 55]
[19]Transcript of the cross examination of Rachel Lamont, (October 7, 2024) [**"Lamont XE"**] p. 34, line 24 – p. 35, line 10) [**MR** Tab 10, pp. 312, 313]

ii. Darrin Marchand: Treating psychiatrist since May 2023.[20]

iii. Shawn Arnold: Shortly before the December 2023 report for an assessment following a referral by outreach workers who were concerned about his well being[21] His presentation was consistent with the substance use disorders referenced in his records.[22]

iv. Cory Monahan: Shortly before the April 2024 report for an assessment and determined that his presentation was consistent with the diagnoses in his medical record.[23]

v. Ammy Lewis: Treating psychiatrist since October 2021, at least 40 times.[24]

vi. Sherri Ogden: Before the February 2024 report and was able to confirm the diagnoses in her medical record.[25]

vii. Jahmal (Jammy) Pierre: First knew her in the fall of 2021 when Ms. Pierre was a peer support worker with Keeping Six. She had been a patient of HAMSMaRT and was eventually referred to Dr. Lamont for support. Dr. Lamont was able to confirm the diagnoses in her medical record.[26]

viii. Linsley Greaves: Before the May 2023 report. Dr. Lamont was able to confirm the diagnoses in his medical record.[27]

35. Where Applicants presented with previous psychiatric diagnoses, Dr. Lamont undertook her own assessment in order to confirm same.[28]

36. Where incidents pre-dated Dr. Lamont's involvement, she assessed whether the Applicant's report and related medical records were consistent with what she would expect in the circumstances. For example, even though Dr. Lamont did not know Mr. Marchand when he was shot in 2021, she could reasonably conclude that the incident contributed to ongoing trauma symptoms.[29]

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[20]Lamont Affidavit, Exhibit B, p. 8 [**MR** Tab 5, p. 58]
[21]Lamont XE p. 64, lines 1-4 [**MR** Tab 10, p. 342]
[22]Lamont XE, p. 64, lines 22 – 25 [**MR** Tab 10, p. 342]
[23]Lamont XE, p. 75 lines 4 – 5; p. 76 line 2 – 5 [**MR** Tab 10, pp. 353-354]
[24]Lamont XE p. 85, line 25 – p. 86, line 1 [**MR** Tab 10, pp. 363-364]
[25]Lamont XE, p. 97, lines 2-4. [**MR** Tab 10, p. 375]
[26]Lamont XE, p. 108, lines 13-25, p. 109, line 23 – p. 110, line 1[**MR** Tab 10, pp. 386-388]
[27]Lamont XE, p. 121, line 24 – 25 [**MR** Tab 10, p. 399]
[28]Lamont XE, p. 35, line 7-10 [**MR** Tab 10, p. 313] p. 47, line 1-2 [**MR** Tab 10, p. 325]
[29]Lamont XE, p. 50, line 13-24 [**MR** Tab 10, p. 328]

37. Dr. Lamont went into further detail to explain how she was able to corroborate previous diagnoses of the Applicants. For example, Dr. Lamont described how she confirmed opiate use disorders for Shawn Arnold and Cory Monahan, despite only meeting them once:

> "…history of reported amounts of the use of opioids, the significant consequences he faced as a result of use of opioids, ongoing use despite cravings -- sorry, despite consequences, intense cravings, experiences of withdrawal when he doesn't use and escalating tolerance."[30]

38. Lastly, Dr. Lamont reviewed the medical records of each Applicant prior to their meeting:

> I did not specify in the letters; however, before every assessment that I completed of those individuals, I can confirm that I did review Clinical Connect, which is a centralized repository of hospital records for Southwestern Ontario, and reviewed any and all records available for each applicant contained within Clinical Connect. I also reviewed every applicant's Shelter Health Network electronic medical record and reviewed their Hamilton Social Medicine Response Team electronic medical record.[31]

Court's Interpretation of Treating Doctors as Fact Witnesses

39. The evidence of the four doctors is based on their direct experience and/or knowledge. In *Davies v The Corporation of the Municipality of Clarington*, the Court considered the scope of evidence allowed from a fact/participatory witness who is a treating doctor. The Court held at paras 36-37:

> "Having reviewed some of the reports of the treating doctors that the plaintiff wishes to call, I have come to the conclusion that many of these doctors are pure fact witnesses whose evidence falls clearly within the definition of a participatory witness. The plaintiff does not have to seek leave to call, as a participatory expert, any of the plaintiffs treating doctors to the extent their evidence relates to the history taken from

[30] Lamont XE, p. 136, line 24 – p. 137, line 23 [**MR** Tab 10, pp. 414-415]
[31] Lamont XE, p. 10, line 14 – 25 [**MR** Tab 10, p. 288]

the plaintiff; the treatment afforded the plaintiff; the diagnosis of the doctor; and the doctor's prognosis as revealed in his clinical notes."[32]

40. The Applicants acknowledge this Court's gatekeeper function with respect to opinion evidence, and can exclude any improper opinion evidence, or rule that the portion of such opinion evidence is not admissible or the truth of the contents.[33]

41. The medical fact witnesses have not gone beyond diagnoses, treatment and prognosis type evidence. In the alternative, should this Court determine that there are elements of improper opinion evidence in the affidavits, the Applicants have produced draft edits where potential opinion pieces are removed. As is stands, the parties disagree on the extent of content that is properly included in the affidavits.

42. Striking opinion portions from a physician's letter was adopted by the Court in *Paul v. Miller*,[34] where the Court found that the physician was likely a fact witness, with much of the affidavit potentially admissible as relevant facts. Where the parties could not agree on the portions of the affidavit were admissible as non-opinion evidence, the Court accepted arguments on admissibility on a paragraph-by-paragraph basis. Such is the request of the Applicants on this motion.

Potential for Prejudice to the Parties

43. The Respondent has had the content of the medical fact affidavits in its position for an extended period:

i. The reports of Dr. Wiwcharuk and Dr. O'Shea were first served in June 2022;
ii. The affidavit of Dr. Bodkin was first served in May 2023;

[32] Davies v The Corporation of the Municipality of Clarington, [Davies] 2016 ONSC 1079 paras 36 and 37.
[33] Westerhof v. Gee Estate, 2015 ONCA 206 (CanLII) at para 64.
[34] Paul v. Miller, 2022 NSSC 255 at para 3.

iii. The reports of Dr. Lamont (which subsequently became the exhibits to her affidavit) were served in March 2024, with the exception of the April 9, 2024 report, which was served on June 7, 2024.

44. The Respondent now objects to the portions of the of the medical fact affidavits. It first confirmed its objection while the August 2024 cross examinations were underway. In so doing, the Respondents unreasonably delayed their objection, thereby limiting the Applicants from taking more timely corrective steps outside of a formal motion.

45. In fact, the very issue of expert evidence was previously raised by the Respondent over a year ago. The Respondent's objection to the Applicants' attempt to adduce eight expert witnesses resulted in a motion. At the time of the October 30, 2023, motion, the Respondent already had copies of several of the medical reports against which it now seeks to object. Had the Respondent raised this matter at an earlier stage in the proceedings, the Applicants could have both amended the current medical reports and taken proactive steps to ensure that there were no similar issues with the subsequent medical reports.

46. The Applicants are comprised of low-income individuals who either were or continue to be homeless. As a collective, they have substantial disabilities, including mental health and substance use disabilities. They are marginalized and often largely disconnected from medical and social supports. HAMSMaRT and Shelter Health Network are two of the primary and most accessible forms of healthcare for this population. Both organizations use a group practice model, meaning that several practitioners are involved in patient care.

47. In short, it would place an unreasonable and unattainable burden of proof on the Applicants if they were required to adduce evidence from each and every medical practitioner involved in their care in order to speak to a specific diagnoses or medical finding.

48. Lastly, the Respondent ultimately has interest in removing opinion evidence that is beyond the scope of the Applicant fact witness doctors. There is an unusual, shared interest amongst the parties in this regard.

It is in the interests of justice to permit the evidence

49. For the reasons set out above – particularly in relation to the lack of prejudice to the Respondent in amending the affidavits – it would be in the interests of justice to permit the amendments as requested by the Applicants.

PART IV – ORDER SOUGHT

50. The Applicants seek the amendment of the four fact medical affidavits as set out in the attached Schedule.

51. The Applicants ask that costs in respect of this motion be considered along with the costs of the underlying Application.



Sujit Choudhry

Michelle Sutherland

Curtis Sell

Sharon Crowe

Wade Poziomka

SCHEDULE "A"

LIST OF AUTHORITIES

Jurisprudence

Davies v. The Corporation of the Municipality of Clarington, 2016 ONSC 1079

Westerhof v. Gee Estate, 2015 ONCA 206

Paul v. Miller, 2022 NSSC 255

HEEGSMA et al. Respondents (Applicants)	and	**CITY OF HAMILTON** Respondent (Respondent)	Court File No: CV-21-00077187-0000

Ontario

Superior Court of Justice

Factum of Moving Party/Applicants

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TAB 156

Court File No. CV-21-00077187-0000

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, GLENN 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

Moving Parties / Applicants

-and-

CITY OF HAMILTON

Responding Party / Respondent

MOTION RECORD FOR MOVING PARTY/APPLICANTS

HEEGSMA ET AL.

November 5, 2024

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Lawyers for the Responding Party / Respondent

Court File No. CV-21-00077187-0000

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, GLENN 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

Moving Parties / Applicants

-and-

CITY OF HAMILTON

Responding Party / Respondent

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TAB 1

Court File No. CV-21-00077187-0000

ONTARIO
SUPERIOR COURT OF JUSTICE

THE HONOURABLE	)	……..…, THE ……
	)	
MR. JUSTICE RAMSAY	)	DAY OF……., 2024

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

APPLICATION UNDER 14.05 OF THE *RULES OF CIVIL PROCEDURE*

NOTICE OF MOTION

The Applicants will make a motion to the court to the Honourable Justice James A. Ramsay as soon as the motion can be heard by Justice Ramsay.

PROPOSED METHOD OF HEARING: The motion is to be heard:

[ ] In writing under subrule 37.12.1 (1) because it is (insert one of on consent, unopposed or made without notice);

[X] In writing as an opposed motion under subrule 37.12.1 (4);

[ ] In person;

[ ]By telephone conference;

[ ] By video conference.

THE MOTION IS FOR:

1. Leave to amend the Affidavits of Dr. Jill Wiwcharuk, dated June 7, 2024, Dr. Timothy O'Shea, dated June 7, 2024, Dr. Claire Bodkin dated May 5, 2023, and Dr. Rachel Lamont, dated July 4, 2023 and June 7, 2024 by striking portions of the affidavits pursuant to Rules 1.04(1), 1.05, 2.01(1), 25.11, 37.10. 37.13;
2. The Applicants ask that costs in respect of this motion be considered along with the costs of the underlying Application; and
3. Such further and other relief as this Honorable Court deems appropriate.

THE GROUNDS FOR THE MOTION ARE:

4. The Applicants bring this motion to seek leave from this Honourable Court pursuant to Rules 1.04(1), 1.05, 2.01(1), 25.11, 37.10 and 37.13 to amend the affidavits of Dr. Jill Wiwcharuk, Dr. Timothy O'Shea, Dr. Claire Bodkin, and Dr. Rachel Lamont, for the purposes of removing opinion evidence.
5. The affidavits speak to the Applicants' medical conditions and experiences in encampments, and are of central relevance to the Applicants' *Charter* challenge. The Applicants wish to put these statements into evidence to assist the Court.
6. The affiants are put forward as fact witnesses only, with no intention to adduce improper opinion evidence.
7. The Respondent would not suffer prejudice from the removal of portions of the affidavits. The parties' dispute concerns the extent of appropriate amendments.
8. Such further and other grounds as counsel may advise and this Honourable Court may accept.

THE FOLLOWING DOCUMENTARY EVIDENCE will be used at the hearing of the motion:

1. Affidavit of Jill Wiwcharuk (dated June 7, 2024);
2. Affidavit of Timothy O'Shea (dated June 7, 2024);

3. Affidavit of Claire Bodkin (dated May 5, 2023);
4. Affidavit of Rachel Lamont (dated June 7, 2024);
5. Cross Examination Transcript of Jill Wiwcharuk (dated August 16, 2024);
6. Redirect Examination Transcript of Jill Wiwcharuk (dated September 6, 2024);
7. Cross Examination Transcript of Timothy O'Shea (dated September 6, 2024);
8. Cross Examination Transcript of Claire Bodkin (dated September 6, 2024);
9. Cross Examination Transcript of Rachel Lamont (dated October 7, 2024);
10. Such further and other evidence as counsel may advise and this Honourable Court may permit.

November 5, 2024

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Counsel to the Respondent

TAB 2

Court File No. CV-21-00077187-0000

ONTARIO SUPERIOR COURT OF JUSTICE

BETWEEN:

KRISTEN HEEGSMA, DARRIN MARCHAND, GORD SMYTH, MARIO MUSCATO, SHAWN ARNOLD, BRADLEY CALDWELL, CHRISTINE DELOREY, GLENN 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

AFFIDAVIT OF JILL WIWCHARUK

SWORN JUNE 7, 2024

I, Doctor Jill Wiwcharuk, of the City of Victoria in the Province of British Columbia, AFFIRM AND STATE:

1. I have personal knowledge with respect to the facts and reports 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 physician formally with the Shelter Health Network (SHN) and the Hamilton Social Medicine Response Team (HAMSMaRT). These organizations provide medical care to individuals affected by homelessness or housing precarity.

3. I provided a report to the Hamilton Community Legal Clinic dated May 31, 2022 with respect to Cory Monahan. Attached hereto and marked as **Exhibit "A"** is a copy of this medical letter.

4. I provided a report to the Hamilton Community Legal Clinic dated June 1, 2022 with respect to Cassandra Jordan. Attached hereto and marked as **Exhibit "B"** is a copy of this medical letter.

5. I provided a report to the Hamilton Community Legal Clinic dated June 2, 2022 with respect to Sherri Ogden. Attached hereto and marked as **Exhibit "C"** is a copy of this medical letter.

6. I provided a report to the Hamilton Community Legal Clinic dated June 3, 2022 with respect to Patrick Ward. Attached hereto and marked as **Exhibit "D"** is a copy of this medical letter.

7. I provided a report to the Hamilton Community Legal Clinic dated June 8, 2022 with respect to Jahmal (Jammy) Pierre. Attached hereto and marked as **Exhibit "E"** is a copy of this medical letter.

8. I provided a report to the Hamilton Community Legal Clinic dated June 9, 2022 with respect to Mario Muscato. Attached hereto and marked as **Exhibit "F"** is a copy of this medical letter.

9. I provided a report to the Hamilton Community Legal Clinic dated June 9, 2022 with respect to Misty Marshall. Attached hereto and marked as **Exhibit "G"** is a copy of this medical letter.

10. I provided a report to the Hamilton Community Legal Clinic dated June 10, 2022 with respect to Shawn Arnold. Attached hereto and marked as **Exhibit "H"** is a copy of this medical letter.

Affirmed remotely by Dr. Jill Wiwarchuk stated as being located in the City of Victoria in the Province of British Columbia, before me at the City of Richmond Hill, Province of Ontario, in accordance with O. Reg 431/20, Administering Oath or Declaration Remotely.

Dr. Jill Wiwcharuk

Commissioner for Taking Affidavits
Sharon Crowe LSO 47108R

Shelter Health Network

82 Stinson St
Hamilton, Ontario
L8N 1S2
Phone: 905-526-7137
Fax: 905-526-7969
Shelterhealthnetwork.ca

May 31, 2022

Hamilton Community Legal Clinic

100 Main St. E. Suite 203

Hamilton ON L8N 3W4

ATTN: Sharon Crowe and Stephanie Cox

This is Exhibit "A" referred to in the affidavit of J.U. Wiwchank sworn before me, this 7 day of June 2024.
Sharon Crowe
A COMMISSIONER, ETC.

RE: Cory Monahan, dob: April 26, 1976

I am a physician with the Shelter Health Network in Hamilton, Ontario. The Shelter Health Network provides healthcare to people who are homeless or precariously housed. Mr Monahan has accessed medical care through the Shelter Health Network since April, 2020. Throughout this time, notes indicate that this gentleman has been homeless and has commonly been sleeping rough (ie: not accessing shelters and instead sleeping outdoors). One note dated March 9, 2022 outlines his distress at sleeping outside in the cold and wishing for help accessing a shelter bed. He had been trying to access a men's shelter bed and had been unable to do so. He notes he "is frustrated he can't get into a shelter" and that he "just wants to feel warm again." At that time, the health care practitioner who saw him advocated for agency staff to use the HIFIS system to check on whether there were service restrictions in place. She was able to help secure a bed for him at Mission Services Men's Centre on that occasion.

~~As is common in the homeless population who often only access healthcare episodically~~, We do not have in depth medical records available for this gentleman. I do know that this gentleman suffers from opioid use disorder, stimulant use disorder and I am convinced that he has undiagnosed mental health issues. He has had near fatal opioid overdoses which required multiple doses of naloxone (opioid antidote) and emergency care. Mr Monahan has mostly made contact with the SHN looking for help with acute skin infections. On July 28, 2020 he saw us with infected bites on his body. Note was made that he was sleeping outside and had no access to a tent. ~~It is likely that if Mr Monahan had had access to a tent, he would have had fewer bug bites resulting in infection~~.

I have spoken to Mr Monahan about his homeless status and he has shared the mental distress this causes him. He has broken down in tears on occasion when he speaks to me about his desperate desire to be housed. ~~I believe that his homeless state causes him deep, ongoing stress that negatively impacts his mental health. This increased state of anxiety is often cited as a reason why people use illicit substances; to cope with stressors that feel insurmountable.~~

I hope this is helpful. Please let me know how I can be of further assistance.



Dr Jill Wiwcharuk, MD, CCFP (EM)

Shelter Health Network

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Fax: 905-526-7969
Shelterhealthnetwork.ca

This is Exhibit "B" referred to in the affidavit of JM Wiwcharuk sworn before me, this 1 day of June 20 24
Sharon Crowe
A COMMISSIONER, ETC.

Hamilton Community Legal Clinic

100 Main St. E. Suite 203

Hamilton ON L8N 3W4

June 1, 2022

ATTN: Sharon Crowe and Stephanie Cox

RE: Cassandra Jordan, dob: April 29, 1983

I am a physician with the Shelter Health Network in Hamilton, Ontario. The Shelter Health Network provides healthcare to people who are homeless or precariously housed. Ms Jordan has accessed medical care sporadically through the Shelter Health Network since October, 2020.

~~As is common in the homeless population who often only access healthcare episodically,~~ We do not have in depth medical records available for this woman. I do know that she suffers from opioid use disorder, stimulant use disorder, chronic pain and a recent acetabular fracture and hip dislocation requiring surgery. I am also certain she has significant undiagnosed mental health issues.

On November 24, 2021, I provided medical care to Ms Jordan in her tent at JC Beemer Park. She had sustained a significant burn to the back of her leg two days prior. This was a partial thickness burn that encompassed ¼ of her back upper thigh and was causing her significant pain. If she had presented to hospital, she would likely have been admitted to a specialized burn unit.

While I was assessing her and providing care, there was a large police presence who were engaged in clearing this encampment. Ms Jordan was very distressed in that she had no appropriate options available to her with regards to where she could go. She had a large tent

with significant possessions and was totally overwhelmed as to how to keep her possessions safe.

Follow-up for high quality wound care was paramount to treating this burn. I tried my best to organize follow up for her but it was essentially impossible because she had no idea where she was going to be the following day. She did end up accessing the Barrett Centre (a crisis shelter that is only for short stays up to 5 days usually) and was seen the following day by a nurse practitioner from the SHN. Unfortunately, she left the Barrett Centre after a few days and did not receive any other care for her burn that I am aware of. I saw her two months later in January and her burn had healed by that time.

Given the severity of her injury, if Ms Jordan had not been evicted from her encampment, I would have made it a priority to see her daily for wound care. As it played out, being evicted from the encampment while in the midst of a significant medical issue like that made it impossible for me to follow up with her on an ongoing basis. Her priorities in this case were far more focused on keeping her tent and her possessions and finding a new place to stay than on her medical care. ~~This is a common hierarchy of priorities among people who are homeless.~~

More recently, I saw Ms Jordan during her stay at the Hamilton General Hospital after she sustained an acetabular fracture and hip dislocation secondary to an altercation with police on May 6, 2022. She required surgery at that time. I was involved in providing addiction related care for her during her inpatient stay. She had significant pain from this injury and is likely to develop chronic pain in this hip in the future.

I hope this is helpful. Please be in touch if I can be of further assistance.



Dr Jill Wiwcharuk, MD, CCFP (EM)

Shelter Health Network

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This is Exhibit "C" referred to in the affidavit of J.M. Winschanik *sworn before me, this* 7 *day of* June *20*22

Sharon Crowe
COMMISSIONER, ETC.

June 2, 2022

ATTN: Sharon Crowe and Stephanie Cox

RE: Sherri Ogden, dob: July 31, 1993

I am a physician with the Shelter Health Network in Hamilton, Ontario. The Shelter Health Network provides healthcare to people who are homeless or precariously housed. Ms Ogden has accessed medical care through the Shelter Health Network since 2010 when she was 17 years old. Initially she was seen infrequently but she has been seen regularly since September 2020. I am certain she has been homeless since 2020 ~~and I suspect she has been in and out of homelessness her entire adult life~~.

Ms Ogden has a family physician outside of SHN whom she sees sporadically. She has only ever seen SHN practitioners for issues related to contraception, poor sleep or aches/pains and various rashes. I am certain that she has very significant undiagnosed mental health illness. ~~Many people who are homeless are unable to access specialized medical care as they have so many competing priorities in their lives. Medical records do not always capture all the conditions that a homeless individual struggles with because they access care so sporadically and often do not have the time or inclination to address some of the underlying issues.~~

For the majority of the last two years, Ms Ogden has been sleeping rough. At one point she was sleeping in a tent in her mother's back yard. Other times she sleeps outside of the Wesley Day Centre. On November 11, 2021 she came to see me and stated that she wanted to get inside from the cold and asked for help getting into a shelter. I asked Wesley staff to help her with this process. To my knowledge she did not end up securing a shelter bed at that time.

Ms Ogden would often see me with complaints of poor sleep and being tired. Although she would sometimes have a tent, many other times she was sleeping entirely unsheltered. This can result in a lot of anxiety and stress and a feeling of constantly having to be on the look-out. ~~Women in particular~~

~~describe feeling unsafe sleeping unsheltered outside~~. I would often see her sleeping in the Wesley Day Centre during the day, simply exhausted from having slept so poorly outside the night before.

Hospital records indicate that Ms Ogden has accessed the emergency department on 10 occasions since the fall of 2020. I notice that all of these visits were for functional pain. Functional pain diagnoses are things like headaches and abdominal pain that can often be related to stress and anxiety but have no underlying pathology and is not associated with any abnormal labwork or imaging. This would be in keeping with the extraordinarily stressful situation that Ms Ogden has been in as she continues to remain homeless, often unsheltered and at times unable to access a shelter bed when she feels she needs one.

I hope this is helpful. Please let me know if I can be of further assistance.



Dr Jill Wiwcharuk, MD, CCFP (EM)

Shelter Health Network

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100 Main St. E. Suite 203

Hamilton ON L8N 3W4

This is Exhibit "D" referred to in the affidavit of Patrick Ward *sworn before me, this* 7 *day of* June *20*24

Sharon Crowe
COMMISSIONER, ETC.

June 3, 2022

ATTN: Sharon Crowe and Stephanie Cox

RE: Patrick Ward, dob: Dec 17, 1963

I am a physician with the Shelter Health Network in Hamilton, Ontario. The Shelter Health Network provides healthcare to people who are homeless or precariously housed. Mr Ward has accessed medical care sporadically through the Shelter Health Network since February, 2014. I have provided care for him quite regularly since late 2014.

Mr Ward has a past medical history that includes alcohol use disorder, stimulant use disorder, peptic ulcer disease, pancreatitis, hepatitis C, major depressive disorder, osteoarthritis causing chronic pain, previous fractures in spine, pelvis, wrist causing chronic pain and substance-induced psychosis.

According to my notes, Mr Ward has been homeless continually since 2019. Earlier on in this stretch of homelessness, he was couch surfing but for at least the past two years Mr Ward has been sleeping rough.

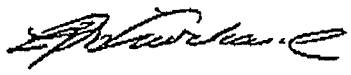
I have spoken to Mr Ward on numerous occasions about his lack of housing. He was unable to tolerate the close quarters of homeless shelters and all of the stress that these can incur on individuals. He found all the mental health acuity very distressing.

He has done much better from a personal mental health perspective when he was sleeping outside. He has had elaborate set-ups with a tent and a camp which he took great pride in. Even during the coldest winter months, I would see him dressed in layers at a drop-in centre and he would assure me that he had a heating system that was keeping him warm. He would also spend most of the day inside at the drop-in to stay warm during the daytime hours.

I asked where his tent was and he would tell me how he had chosen a location that was deep in the woods on the escarpment or by the railway where people couldn't find him. He was trying hard to avoid detection so that he wouldn't be told he had to pack up his camp and leave. Eventually he would be found and would have to move his tent. Sometimes he would just be moving it a couple hundred meters away. When he had his full camp set-up, he would be able to tell me in detail all the ways he had to stay warm, that he was safe even in the bitter cold and that I should not worry. When he was having to set everything back up in a new location, he would inevitably lose some of the safeguards he had in place to stay warm and he would be extremely cold at night. This constant fear of being detected and having to move his tent was very distressing to Mr Ward and caused him a significant amount of stress.

I hope this is helpful. Please be in touch if I can be of further assistance.

Sincerely,



Dr Jill Wiwcharuk, MD, CCFP (EM)

Shelter Health Network

82 Stinson St
Hamilton, Ontario
L8N 1S2
Phone: 905-526-7137
Fax: 905-526-7969
Shelterhealthnetwork.ca

This is Exhibit "F" referred to in the affidavit of JM Wiwcharuk sworn before me, this 7 day of June 20 24

Sharon Crowe A COMMISSIONER, ETC.

June 8, 2022

ATTN: Sharon Crowe and Stephanie Cox

RE: Jahmal (Jammy) Pierre, dob: Dec 20, 1989

I am a physician with the Shelter Health Network in Hamilton, Ontario. The Shelter Health Network provides healthcare to people who are homeless or precariously housed.

Ms Pierre is a trans woman who suffers from stimulant use disorder and opiate use disorder. She has rarely sought help through the Shelter Health Network so the medical history I can provide is very limited. She has only been seen on three occasions and these were all related to opiate overdoses in 2020. On one occasion in August she had an unintentional opiate overdose and was hospitalized in the Intensive Care Unit for a period of time. She was encouraged to follow up with doctors at the YWCA after that incident and that is when she saw my SHN colleagues. Ms Pierre described this overdose as entirely unintentional. She had used a contaminated supply of methamphetamine and did not know that there was street fentanyl in the supply that she had received. Ms Pierre was lucky to have survived as I have had had many opiate-naive patients in the exact same situation who have died in this scenario.

In November of 2020, I was doing outreach work and saw Ms Pierre slumped over on the sidewalk. I approached her and quickly recognized that she had suffered an opiate overdose. It required many doses of the opiate anecdote naloxone to get her to start breathing spontaneously on her own. Once again, she was very lucky to survive. I saw her later that day in the emergency department where she had been brought by EMS. Unfortunately, she was not at a point where she was ready to engage with treatment for her substance use disorders. Given this, she continues to be at an extremely high risk of overdose in the future.

I hope this is helpful. If there is any way I can be of further assistance, please let me know.

Sincerely,

Dr Jill Wiwcharuk, MD, CCFP (EM)

Shelter Health Network

82 Stinson St
Hamilton, Ontario
L8N 1S2
Phone: 905-526-7137
Fax: 905-526-7969
Shelterhealthnetwork.ca

Hamilton Community Legal Clinic

100 Main St. E. Suite 203

Hamilton ON L8N 3W4

This is Exhibit "F" referred to in the affidavit of Jill Winchurch sworn before me, this 1 day of June 20 24

Sharon Crowe
A COMMISSIONER, ETC.

June 9, 2022

ATTN: Sharon Crowe and Stephanie Cox

RE: Mario Muscato, dob: Oct 31,1973

I am a physician with the Shelter Health Network in Hamilton, Ontario. I also practice addiction medicine at The Hamilton Clinic. I regularly provide healthcare to people who are homeless or precariously housed. Mr Muscato has been a patient of mine since early 2019 and I see him both at SHN clinics and at The Hamilton Clinic. I often see him several times a week for medical care. Mr Muscato has been homeless the entire time I have cared for him. He is often unable to access shelter beds due to service restrictions and shelters being at capacity. For this reason, he often ends up sleeping rough. ~~Despite Mr Muscato's very significant disabilities, he has never been prioritized for housing in an effective way~~.

Mr Muscato has very significant disabilities. He suffers from opioid use disorder, stimulant use disorder, HIV, post-traumatic stress disorder, major depressive disorder, acquired brain injury, left partial forearm amputation, extensive burn injuries to neck and face resulting in chronic pain, severe neuropathy to both upper extremities, right forearm amputation, tendon and nerve grafts to left forearm resulting in severely compromised use of this arm.

Mr Muscato suffered a near fatal electrocution in 2018 which resulted in the partial amputation of his left forearm. He also had severe burn injuries to his right forearm and there was extensive grafting that needed to be done to try to salvage any use of this hand/arm. Unfortunately, the grafting was only partially successful. So Mr Muscato now has extremely limited use of his right forearm. He is unable to fully extend the arm, and his fingers are

permanently fixed in a claw-like grip. He has no sensation to any of these fingers which puts him at a constant risk of further injury. For example, he has seen me for burns to these fingers from the top of an electic stove that he was cleaning and he didn't even know that the stove was hot. In the winter, he has suffered frostbite injuries to this hand due to an inability to feel the cold.

When he suffered this near fatal electrocution, he also ended up with a bleed in his brain. This eventually improved with time, but I believe he has been left with a significant acquired brain injury. People with acquired brain injuries struggle with things like memory, mood lability (ie: are often quick to anger and have difficulties with their emotions), chronic headaches, etc. They will have a harder time managing psychiatric diagnoses such as anxiety and depression and have a high propensity for addictions.

Mr Muscato would be eligible for a right arm prosthesis but the process to obtain one requires multiple appointments and fittings. His precarious housing situation, rarely having reliable access to a phone, his acquired brain injury and the chaotic lifestyle that ensues due to his unstable addictions have made it impossible for him to follow up as is necessary to obtain a prosthesis.

Mr Muscato's mental health has suffered. As I mentioned, he has posttraumatic stress disorder both from adverse events in childhood (physical and sexual abuse) as well as from the electrocution injury in 2018. In order to use drugs intravenously, he relies on other people to inject him due to his disability. He has spoken to me on numerous occasions of feeling so depressed that he would like to die by overdose and to do that he feels he would need to trick someone into injecting too much fentanyl.

Another significant health issue of Mr Muscato's is that he has untreated HIV. In order to benefit from medications for HIV, an individual has to be able to take medications consistently. If this is not possible, it is highly likely that the virus will become treatment-resistant and therefore harder to treat. ~~Because Mr Muscato's lifestyle is so chaotic~~, He has never been able to access medications consistently. ~~He is a target on the street due to his disability and often has his belongings stolen. So~~ When he does have medications on him, more often than not, they are lost or stolen within a few days. From a practical standpoint, it would be near impossible for him to even open a standard pharmacy bottle of pills on his own. Given his untreated HIV, he is at risk of developing AIDS down the road if he does not find enough stability to start accessing medications regularly.

Mr Muscato sees me regularly in most part for addictions related care. He wants to access opioid replacement therapy and stop using street drugs. To get to a therapeutic dose of opioid replacement therapy (ie: methadone), he needs to access a pharmacy every day to receive his dose. This consistency has been his biggest struggle. His housing instability is the main factor behind this inability to access a pharmacy daily. Because he bounces between shelters, encampments and couch surfing, he can rarely count on being able to access medications from

one geographic location every day. For example, someone that is housed knows that they will wake up in the same place every day and can simply build a routine of waking up and walking to a nearby pharmacy for their daily dose of medication. Mr Muscato does not have this luxury.

On April 11, 2019, note is made in Mr Muscato's chart that "this patient needs housing above all else" and this is reiterated in his medical chart over the subsequent years. This is specifically because his most critical medical issues are simply not being effectively treated while housing is so unstable. There were times when he would receive two weeks of opioid agonist therapy consistently but then he would be service restricted from a shelter or moved from an encampment and he would lose that stability and have to restart again down the road.

Mr Muscato has spoken to me on numerous occasions about difficulties that he encounters in the shelter system. He has cited racism as one of the issues that he faces. He feels that he is commonly discriminated against due to his Indigenous status. He also has difficulty in congregate settings because his physical needs are so different than others'. For example, he needs much more time to eat a meal due to his compromised ability to manipulate utensils. He also often needs much longer in bathrooms or other hygiene facilities due to his disability. He has people getting angry at him when he cannot complete tasks in the same time that it takes an able-bodied individual to do so.

I hope this has been helpful. Please be in touch if there is any further way I can be of assistance.

Sincerely,

Dr Jill Wiwcharuk, MD, CCFP (EM)

Shelter Health Network

82 Stinson St
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L8N 1S2
Phone: 905-526-7137
Fax: 905-526-7969
Shelterhealthnetwork.ca

This is Exhibit "G" referred to in the affidavit of L.M. Winchank sworn before me, this 7 day of June 20 24

Sharon Crowe
COMMISSIONER, ETC.

Hamilton Community Legal Clinic

100 Main St. E. Suite 203

Hamilton ON L8N 3W4

June 9, 2022

ATTN: Sharon Crowe and Stephanie Cox

RE: Mysty Marshall, dob: Dec 18, 1991

I am a physician with the Shelter Health Network in Hamilton, Ontario. The Shelter Health Network provides healthcare to people who are homeless or precariously housed. I first met Ms Marshall when she was living in a tent on Ferguson Avenue in the summer of 2020. Since that time she has remained homeless. Prior to that, she was couch surfing or staying in budget motels (which is also a form of homelessness). I am unsure how long she was in that position.

To my knowledge, Ms Marshall has a past medical history of opiate use disorder, stimulant use disorder, major depressive disorder with suicidal ideation and asthma. She has a history of abuse in childhood and has been in abusive relationships throughout her adult years.

I saw Ms Marshall initially for asthma exacerbations when she was homeless and living in a tent on Ferguson Avenue. The heat and humidity were very oppressive and this often exacerbates asthma in people who are unable to access cooler indoor air. I saw her on October 1st and was able to reassess her the following week. I noted that her asthma had worsened and she needed some emergency treatment at that time. I was glad that she was in the same area because knowing that she was at risk of deteriorating medically, I was able to reassess her and provide the emergency treatment when it was needed.

In September, 2021, I again saw Ms Marshall at a drop-in centre for individuals experiencing homelessness. She was extremely disheveled, had dirty clothes and extensive matting of her

hair with a severe case of head lice that was causing underlying cellulitis (skin infection) to her scalp and ears. She also had an extensive body rash that was likely caused by scabies. ~~It was clear she had had no access to shower or laundry facilities for a long period of time~~. I suspected that she was profoundly depressed as well.

Despite having an addiction to opioids, she has not been ready to engage with treatment. Nor does she readily engage with anyone regarding her mental health. It is noted that she does not accept help from people readily. ~~This is not at all uncommon in the Indigenous population who face systemic racism in many colonial institutions, often preferring to avoid these institutions altogether.~~

~~In instances like this, what is needed above all else is regular contact with someone to slowly build trust over time.~~ Once Ms Marshall was evicted from the encampment on Ferguson Avenue, I did not see her for a year and when I did finally see her again, she had drastically decompensated physically and mentally. When I knew where she was living, I was able to follow up with her from a medical perspective and treat the issues that were surfacing. ~~It is my opinion that if she had remained in one place, she would not have decompensated to the extent that she did. I would also have had a chance to build more of a relationship with her and help build the trust that many people require to start engaging in addictions and mental health treatment.~~

I hope this is helpful. Please be in touch if I can be of further assistance.

Sincerely,



Dr Jill Wiwcharuk, MD, CCFP (EM)

Shelter Health Network

82 Stinson St
Hamilton, Ontario
L8N 1S2
Phone: 905-526-7137
Fax: 905-526-7969
Shelterhealthnetwork.ca

This is Exhibit ....H..... referred to in the affidavit of ....JM Wowchanik..... sworn before me, this ....7..... day of ....June..... 2022.....

Sharon Crowe
Sharon Crowe COMMISSIONER, ETC.

Hamilton Community Legal Clinic

100 Main St. E. Suite 203

Hamilton ON L8N 3W4

June 10, 2022

ATTN: Sharon Crowe and Stephanie Cox

RE: Shawn Arnold, dob: July 23, 1969

I am a physician with the Shelter Health Network in Hamilton, Ontario. The Shelter Health Network provides healthcare to people who are homeless or precariously housed. I am also a physician with The Hamilton Clinic which is an addiction medicine clinic. Mr Arnold has been a regular patient of mine both through the SHN and The Hamilton Clinic since 2020 although I sporadically provided care to him since 2018.. His past medical history is significant for opiate use disorder, stimulant use disorder, attention deficit hyperactive disorder, hepatitis C (recently treated) and chronic left shoulder pain.

I saw Mr Arnold regularly during 2021. He was living in a tent at JC Beemer Park in the winter of 2020/21. Prior to that time, he only came to see me sporadically but would always talk about his desire to treat his opioid use disorder and get on opioid agonist therapy (ie: methadone). However, he was unable to follow up regularly enough to do so. Getting to a therapeutic dose of methadone requires attending a pharmacy daily for doses and not missing appointments. From at least the summer of 2020 (and possibly earlier), Mr Arnold was homeless and regularly sleeping outside. He found the crowded conditions in shelters too hard to manage and he would end up sleeping outside or couch surf somewhere.

Once he was settled at JC Beemer Park, Mr Arnold was able to see me regularly and attend a pharmacy daily. He was able to stay on a methadone maintenance program for well over a year and used much less illicit street drugs than he had ever used previously. Because of his

consistency, I was also able to treat his hepatitis C. He followed through on the entire two month program of anti-virals and is now cured from hepatitis C. This is something that can only be achieved when people are able to take their medications daily. Otherwise, treatment resistant strains of hepatitis can develop.

~~If Mr Arnold had been forced to move from place to place the entire winter, it is clear to me that he would not have reached the level of stability he did with regards to treatment of his addiction and his hepatitis C. He was able to engage with housing workers who ultimately knew where to find him and were able to follow up with him because he was in one place. This led to him becoming housed later in 2021.~~

I hope this is helpful. Please let me know if I can be of further assistance.

Sincerely,



Dr Jill Wiwcharuk, MD, CCFP (EM)

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

Affidavit of Dr. Jill Wiwcharuk

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Ashley Wilson (LSO# 82988A)
awilson@kastnerko.com
Counsel to the Applicants

TAB 3

Court File No. CV-21-00077187-0000

ONTARIO SUPERIOR COURT OF JUSTICE

BETWEEN:

KRISTEN HEEGSMA, DARRIN MARCHAND, GORD SMYTH, MARIO MUSCATO, SHAWN ARNOLD, BRADLEY CALDWELL, CHRISTINE DELOREY, GLENN 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

AFFIDAVIT OF TIMOTHY O'SHEA

Sworn June 7, 2024

I, Doctor Timothy O'Shea, of the City of Hamilton in the Province of Ontario, AFFIRM AND STATE:

1. I have personal knowledge with respect to the facts and reports 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 physician with the Shelter Health Network (SHN) and the Hamilton Social Medicine Response Team (HAMSMaRT). These organizations provide medical care to individuals affected by homelessness or housing precarity. I have worked with SHN since its inception in 2007. I also joined HAMSMaRT at its formation in 2016.

3. I provided a report to the Hamilton Community Legal Clinic dated June 13, 2022 with respect to Kristen Heegsma. Attached hereto and marked as Exhibit "A" is a copy of this medical letter and I endorse the contents therein.

4. I provided a report to the Hamilton Community Legal Clinic (undated) with respect to Ammy Lewis. Attached hereto and marked as Exhibit "B" is a copy of this medical letter and I endorse the contents therein.

5. I make this Affidavit for no improper purpose.

Sworn remotely by Timothy O'Shea in the Province of Ontario, before me on June 7, 2024 in accordance with O. Reg. 431/20, Administering Oath or Declaration Remotely.

Commissioner for Taking Affidavits
Sharon Crowe LSO 47108R

Timothy O'Shea

This is Exhibit 'A' referred to in the affidavit of Dr. Timothy O'Shea affirmed before me this 7th day of June, 2024.

EXHIBIT 'A'

McMaster University

TIMOTHY O'SHEA, BSc, MD, MPH, FRCPC
Internal Medicine, Infectious Diseases, Medical Microbiology
Associate Professor, Department of Medicine
Faculty of Health Sciences
McMaster University

Hamilton Health Sciences

Phone 905-521-2100
Ext. 42471
Fax 905-575-7320
osheat@mcmaster.ca

June 13, 2022

To Whom It May Concern:

Hamilton Community Legal Clinic
100 Main St. E. Suite 203
Hamilton ON L8N 3W4

Attention: Sharon Crowe and Stephanie Cox

Re: (Kristen Heegsma, DOB 1990/10/20)

I am a physician with the Shelter Health Network (SHN) and the Hamilton Social Medicine Response Team (HAMSMaRT), two organizations that provide medical care to individuals affected by homelessness or housing precarity. I have worked with the SHN since its inception in 2007, and similarly joined HAMSMaRT at its formation in 2016. I first met Ms. Heegsma in July of 2021 and have been seeing her on average once every two weeks since then. To the best of my knowledge, Kristen has been homeless for at least the past 4 years.

Kristen has the following medical conditions:

1) Crohn's disease
2) Opioid Use Disorder
3) Stimulant Use Disorder
4) Attention Deficit Hyperactivity Disorder
5) Post-traumatic stress disorder

~~It is my opinion that each of Ms. Heegsma's medical conditions have been negatively impacted by her lack of access to stable housing. Due to her lack of housing~~ Kristen has enormous barriers to accessing consistent medical care, leading to a pattern of starting and stopping treatments which has been in some cases counterproductive to her goal of improving her overall wellbeing. ~~Furthermore the trauma that she has experienced (outlined below) as a direct result of her lack of housing has further exacerbated her underlying mental health conditions to a severe ex tent~~. Despite her being able to see me on a fairly regular basis over the past six months Kristen's overall condition continues to fluctuate, ~~and our progress has been far below what I would expect if she were stably housed.~~

It is important to note that Ms. Heegsma's health status has fluctuated in concert with the degree to which her shelter status has been stabilized or destabilized. There have, for example, been short periods of time when Ms. Heegsma has been able to access shelter within the city's hotel shelter program, and briefly through a transitional housing program run by the YWCA. ~~Although in no ways ideal~~, These brief sojourns allowed Kristen some space to focus more on her health needs, and allowed,

for instance, time to more effectively titrate medications for the treatment of opioid use disorder and for some of her mental health concerns. However, for the majority of the last year Kristen has lived outside. She has stayed both within small formal encampments and when forced to has sought shelter elsewhere, including sleeping in stairwells ~~and seeking shelter in situations which put her physical safety in jeopardy. Again, although it is clear that sleeping in a tent in a park is not a desired outcome, Kristen's health was dramatically better in this situation then when she was in less safe, less stable settings.~~ Kristen described feeling safe in the most recent park where she sought shelter due to the presence of others that looked out for her, and as well secondary to the fact that those involved in caring for her, including my clinic, knew where to find her if we needed to. Shortly after this small encampment was cleared Kristen began alternating her time sleeping outside on park benches, stairwells and abandoned buildings with staying inside with a male acquaintance who assaulted her multiple times physically and emotionally. As a result her mental health has significantly deteriorated, and her stability with respect to her opioid use disorder has dramatically worsened.

~~Due to the profound impact of Kristen's housing status on her physical and mental health~~ much of our appointments end up focusing on securing a more stable housing arrangement. Kristen is often reluctant to access shelter beds, with the primary reason being that she is fearful of her physical safety in a congregate shelter setting, after suffering physical assaults within shelter previously. Kristen has also previously been restricted from accessing shelter space due to behaviours related to her underlying mental health and substance use disorders, leading to a lack of trust with the shelter system. Nevertheless we have attempted on multiple occasions to secure shelter space for Kristen particularly through the cold winter months between December 2021 and March 2022. On at least three occasions we called multiple shelters for women from my clinic office and on each occasion were told that there was no shelter space available for Kristen; on each occasion we were asked to check back the following day.

Kristen's health has clearly suffered to a significant extent due to her homelessness and housing precarity. She has several medical conditions which in ideal circumstances could be managed effectively, however given her circumstances we have struggled to make consistent progress in terms of improving her health. ~~Furthermore her health status has been negatively impacted by policies which have led to her displacement from settings in which she has managed to achieve some degree of stability.~~

I would be happy to answer further questions as required.

Sincerely



Timothy O'Shea, BSc, MD, MPH, FRCPC
Internal Medicine, Infectious Diseases, Medical Microbiology
Associate Professor, Department of Medicine
Consultant Physician – Inpatient Addiction Service
Faculty of Health Sciences
McMaster University

This is Exhibit 'B' referred to in the affidavit of Dr. Timothy O'Shea affirmed before me this 7th day of June, 2024.

EXHIBIT 'B'

McMaster University

TIMOTHY O'SHEA, BSc, MD, MPH, FRCPC
Internal Medicine, Infectious Diseases, Medical Microbiology
Associate Professor, Department of Medicine
Faculty of Health Sciences
McMaster University

Hamilton Health Sciences

Phone 905-521-2100
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osheat@mcmaster.ca

Hamilton Community Legal Clinic
100 Main St. E. Suite 203
Hamilton ON L8N 3W4

Attention: Sharon Crowe and Stephanie Cox

Re: (Ammy Lewis, DOB 1978/07/04)

I am a physician with the Shelter Health Network (SHN) and the Hamilton Social Medicine Response Team (HAMSMaRT), two organizations that provide medical care to individuals affected by homelessness or housing precarity. I have worked with the SHN since its inception in 2007, and similarly joined HAMSMaRT at its formation in 2016. I first met Ms. Lewis in March of 2021 and have been seeing her on average once every two weeks since then. To the best of my knowledge, Kristen has been homeless for at least the past 3 years.

Kristen has the following medical conditions:

- HIV infection
- Opioid Use Disorder
- Stimulant Use Disorder
- Post-traumatic stress disorder

~~It is my opinion that each of Ms Lewis' medical conditions have been negatively impacted by her lack of access to stable housing.~~ ~~Due to her lack of housing~~ Ammy has faced enormous barriers to accessing consistent medical care. As well Ammy's search for housing has been all consuming for her, making it very difficult to act upon recommendaitons from her healht care team with respect to her chronic medical conditions. ~~Furthermore the trauma that she has experienced (outlined below) as a direct result of her lack of housing has further exacerbated her underlying mental health conditions to a severe extent~~. Despite her being able to see me on a fairly regular basis over the past six months Ammy's overall condition has overall deteriorated, and our progress has been far below what I would expect ~~if she were stably housed~~.

I first met Ammy when she was briefly housed in a rooming house in Hamilton. Ammy had been released from detention centre and was initially homeless, seeking shelter in a local park with her dog in the spring of 2020. She was able to access housing from this location, however she was unfortunately assaulted by the landlord at that location and evicted shorlty thereafter. Since that time Ammy has been homeless and sleeping rough. Ammy was able to find some relateive stability while staying at a park which she choose due to its proximity to her pharmacy. Overall she stayed in this location for about two months, during which time she was able to get her medications daily and attend clinic visits with me. Furthermore she was able to engage with city housing workers during this time, in large part thanks to her being in a reliable place where she could be tracked down. Ammy was evicted from this park in late summer of 2021, and has been moving from place to place since. This most recent period of Ammy's life has been characterized by extreme instability. She has lost all of her belongings on multiple occasions, been subjected to verbal harrassment and has on at least two occasions been physically assaulted at her camping site. Ammy has become increasingly desperate to find shelter due to the trauma that she is suffering on a day to day basis. Unfortunately, despite engagement with my clinic and city housing workers, suitable inside accomodation has not been found. Barriers to this include shelters being full when we have attempted to call, and Ammy's devotion to her dog, who she does not want to leave despite the fact that shelters have refused to admit her with her dog. ~~With all of the above contributing, Ammy's mental and physical health have suffered severely.~~

~~Ammy's health has clearly suffered to a significant extent due to her homelessness and housing precarity.~~ She has several medical conditions which in ideal circumstances could be managed effectively, however given her circumstances we have struggled to make consistent progress in terms of improving her health. ~~Furthermore her health status has been negatively impacted by policies which have led to her displacement from settings in which she has managed to achieve some degree of stability.~~

I would be happy to answer further questions as required.

Sincerely,

Timothy O'Shea, BSc, MD, MPH, FRCPC
Internal Medicine, Infectious Diseases, Medical Microbiology
Associate Professor, Department of Medicine
Faculty of Health Sciences
McMaster University

TO/lb

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

Affidavit of Dr. O'Shea dated June 7, 2024

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Ashley Wilson (LSO# 82988A)
awilson@kastnerko.com
Counsel to the Applicants

TAB 4

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 CLAIRE BODKIN

SWORN MAY 5, 2023

I, Doctor Claire Bodkin, of the City of Hamilton in the Province of Ontario, do hereby AFFIRM:

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 Physician and the Co-Medical Director of Hamilton Social Medicine Response Team (HAMSMaRT). HAMSMaRT is an organization of health providers and community organizers providing community-centred care to people experiencing homelessness, including encampment residents. I have worked with HAMSMaRT for three years.

3. I have known Mr. Greaves for approximately ten months, and have provided medical care to him on two occasions.

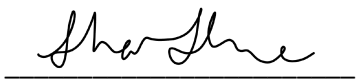
4. I authored the April 24, 2023 report attached hereto as Exhibit "A" and endorse the contents therein.

Sworn remotely by Claire Bodkin at the City of Hamilton in the Province of Ontario, before me on May 5, 2022 by "zoom" videoconference in accordance with O. Reg. 431/20, Administering Oath or Declaration Remotely.

Sharon Crowe
Commissioner for Taking Affidavits

Claire Bodkin

THIS IS EXHIBIT “A” TO THE
AFFIDAVIT OF CLAIRE BODKIN
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 5TH DAY OF MAY, 2023



SHARON CROWE

Commissioner for Taking Affidavits, etc.

903

Dr. Claire Bodkin

HAMSMaRT

140 King St East, Suite 101
Hamilton, Ontario, L8N 1A5

Phone: 833-426-7678
Fax: 833-563-2210

Date:	2023/04/27
To:	
Address:	
Phone:	
Fax:	

Patient:	GREAVES, LINSLEY
Address:	
	NFA, Hamilton, ON
Phone:	
Birthdate:	1969/10/23
Health Card No:	

904

To Whom It May Concern

I assessed Linsley Greaves on December 15 2022 in my outpatient clinic. He was brought in my paramedics, and presented with 2 weeks of worsening left foot infection and worsening right soft tissue injury. He had been repeatedly evicted from his encampment locations by the City of Hamilton in the few weeks prior, and his belongings kept getting wet, while the weather was fluctuating above and below freezing. This had led to tissue injury and infection of both feet.

On examination of the left foot, there was extensive skin sloughing/desquamation of ankle and hindfoot on dorsal side with capillary bleeding across ulcerated area; skin more intact midfoot then more sloughing forefoot. The first toe was autoamputated, with ulceration in this area, then other toes insensate and gangrenous without signs of circulation. There was an intensely foul odour.

On examination of the right foot, there was edema and erythema over midfoot and forefoot, and gangrenous blackened toes with loss of sensation and no evidence of circulation.

I was concerned for osteomyelitis (bone infection), dry gangrene (dead or necrotic tissue), wet gangrene (dead or necrotic tissue with superimposed bacterial infection of the dead tissue), and cellulitis (skin infection). I sent him immediately to the emergency department, where he was admitted, and ultimately underwent amputation of his left leg below the knee.

~~It is my medical opinion that the repeated eviction of Mr. Greaves from his encampment during wet weather with temperatures around 0 degrees celsius resulted in repeated freezing and thawing of tissue, and this directly caused frostbite and subsequent wet gangrene requiring amputation of his left leg below the knee, leaving him permanently disabled.~~



Claire Bodkin MD CCFP

TAB 5

Court File No. CV-21-00077187-0000

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, GLENN 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

AFFIDAVIT OF RACHEL LAMONT

SWORN JUNE 7, 2024

I, Doctor Rachel Lamont, of the City of Hamilton in the Province of Ontario, AFFIRM AND STATE:

1. I have personal knowledge with respect to the facts and reports 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 physician with the Shelter Health Network (SHN) and the Hamilton Social Medicine Response Team (HAMSMaRT). These organizations provide medical care to individuals affected by homelessness or housing precarity. I have worked with SHN since May 2022. I also joined HAMSMaRT in September 2021.

3. I met with Kristen Heegsma prior to the time that the report was prepared, attached as Exhibit ‘A’ and I endorse the contents therein.
4. I met with Darrin Marchand prior to the time that the report was prepared, attached as Exhibit ‘B’ and I endorse the contents therein.
5. I met with Shawn Arnold prior to the time that the report was prepared, attached as Exhibit ‘C’ and I endorse the contents therein.
6. I met with Cory Monahan prior to the time that the report was prepared, attached as Exhibit ‘D’ and I endorse the contents therein.
7. I met with Ammy Lewis prior to the time that the report was prepared, attached as Exhibit ‘E’ and I endorse the contents therein.
8. I met with Sherri Ogden prior to the time that the report was prepared, attached as Exhibit ‘F’ and I endorse the contents therein.
9. I met with Jahmal (Jammy) Pierre prior to the time that the report was prepared, attached as Exhibit ‘G’ and I endorse the contents therein.
10. I met with Linsley Greaves prior to the time that the report was prepared, attached as Exhibit ‘H’ and I endorse the contents therein.

Affirmed remotely by Dr. Rachel Lamont stated as being located in the City of Hamilton in the Regional Municipality of Hamilton-Wentworth, before me at the Town of New Tecumseth in the Region of Simcoe on June 7, 2024, in accordance with O. Reg 431/20, Administering Oath or Declaration Remotely.

.

Commissioner for Taking Affidavits
Michelle Sutherland LSO#:70159T

……

Dr. Rachel Lamont

This is Exhibit ‘A’ referred to in the affidavit of Dr. Rachel Lamont affirmed before me this 7th day of June, 2024.



EXHIBIT ‘A’

McMaster University | DEPARTMENT OF PSYCHIATRY AND BEHAVIOURAL NEUROSCIENCES

June 20, 2023

ATTN: Sharon Crowe

RE: Heegsma, Kristen DOB: 1990-10-20

I am a psychiatrist with both the Hamilton Social Medicine Response Team and the Shelter Health Network in Hamilton, Ontario. Both services provide health care to people who are unhoused or precariously housed.

I have been Ms. Heegsma's treating psychiatrist since November 2021 and can confirm that she has diagnoses of Post-Traumatic Stress Disorder (PTSD), Borderline Personality Disorder, Generalized Anxiety Disorder, Depression, and Opioid and Stimulant use disorders (severe).

When I first met with Ms. Heegsma, another physician providing care to her had expressed significant concern for mental health and referred her to me. Ms. Heegsma had just been evicted from a tent in Corktown neighbourhood by the City of Hamilton. She had been repeatedly evicted from encampments previously. Following this particular eviction, she experienced an exacerbation of PTSD symptoms as well as severe suicidal ideation and described feeling the most desperate she had in her entire life. Additionally, because her tent had been destroyed, she was sleeping on a park bench in the days following the encampment eviction. Despite daily attempts to get into shelter, there were no spaces available. A few days after the eviction from her tent in Corktown neighbourhood and while she was sleeping on the park bench, she was the victim of a violent sexual assault. This caused additional severe worsening of her mental health conditions and substance use. She also had her belongings stolen repeatedly.

Ms. Heegsma has since spent brief amounts of time in shelter and in YWCA transitional housing, though has also been asked to leave those spaces due to her complex health needs and those services being unable to offer the required level of support. She has thus continued to spend most of her time living outside. When she is living in a tent and surrounded by community, there is notable improvement in her sense of personal safety, and we are able to initiate treatment for her conditions, and members of our team are able to reliably locate Ms. Heegsma for follow-up. Unfortunately, she is unable to remain in one place for very long due to ongoing pressure from By-Law officers and Police to move repeatedly. While Ms. Heegsma has identified goals of working toward stabilization of her mental health and substance use, her ongoing experiences of being unhoused and focus on day-to-day survival have made it very difficult for the focus of any appointments to move beyond trying to help her find ways to have her most basic survival needs met. As a result, her mental health conditions and substance use disorders have remained under-treated and continue to cause her immense suffering.

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~~It is my opinion that repeated encampment evictions, and in particular the encampment eviction in November 2021 and subsequent sexual assault, have been a major contributor to the ongoing instability in Ms. Heegmsa's mental health and worsening of her substance use disorders over the past three years. This has been exacerbated by the ongoing lack of available, suitable shelter spaces or permanent housing options.~~

Please feel free to contact me should any further information be required.

Sincerely,

R. Lamont

Dr. Rachel Lamont, MD, FRCPC
Psychiatrist, Hamilton Social Medicine Response Team and Shelter Health Network
Assistant Professor
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McMaster University
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Fax: 1-833-563-2210

This is Exhibit ‘B’ referred to in the affidavit of Dr. Rachel Lamont affirmed before me this 7th day of June, 2024.



EXHIBIT ‘B’

McMaster University
DEPARTMENT OF PSYCHIATRY AND BEHAVIOURAL NEUROSCIENCES
HAM SMaRT

Dec 14, 2023

ATTN: Sharon Crowe

RE: Darrin Marchand (DOB Oct 15 1966)

I am a psychiatrist with both the Hamilton Social Medicine Response Team and the Shelter Health Network in Hamilton, Ontario. Both services provide health care to people who are unhoused or precariously housed.

I have known Mr. Marchand since May 2023 and can confirm that he has diagnoses of Psychosis (substance-induced vs. schizophrenia), and opioid and stimulant use disorders (severe).

Mr. Marchand has shared his story with me, dating back prior to my involvement with him. He has endured numerous traumas in his life which impact the way he views himself, regulates his emotions, and relates to other people. In the summer of 2021, he was evicted from an encampment along Strachan St in Hamilton and again from an encampment on Rebecca St during that summer. Following this, he gave up on trying to stay in a tent and slept outside in the open. He describes feeling a sense of hopelessness and despair following these encampment evictions, and that his substance use escalated. For Mr. Marchand, there is a direct link between his substance use (particularly that of stimulants) and symptoms of psychosis. As his substance use escalated and mental health declined further, he continued on a downward trajectory in terms of his wellbeing. Additionally, while sleeping out in the open in Dec 2021, he was shot by a gun in the shoulder, which has contributed to additional ongoing trauma symptoms. Mr. Marchand said that he felt much more secure in a tent with community who looked out for each other, something that is not possible when sleeping alone outside, as he had resorted to doing because of repeated evictions.

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DEPARTMENT OF PSYCHIATRY AND BEHAVIOURAL NEUROSCIENCES
HAM SMaRT

RE: Darrin Marchand (DOB Oct 15 1966)

Mr. Marchand shared that he has avoided living in encampment because of the toll eviction has taken on his well being. He said he feels like he is losing his mind because he cannot function living outside; he has been repeatedly kicked out of and service-restricted from shelters in the city. At present, he contemplates suicide regularly because he cannot stay in shelter, he cannot stay in a tent, and staying outside is becoming unbearable. He cannot sleep for long for fear of being assaulted or having his possessions stolen, leading to profound sleep deprivation. This sleep deprivation has further destabilized his mental health condition as well as contributed to escalation in substance use. The last time Mr. Marchand was housed was in 2017.

~~It is my opinion that repeated encampment evictions have been a major contributor to the deterioration in Mr. Marchand's mental health and worsening of his substance use disorders over the past 3 years.~~

Please feel free to contact me should any further information be required.

Sincerely,

R. Lamont

Dr. Rachel Lamont, MD, FRCPC
Psychiatrist, Hamilton Social Medicine Response Team and Shelter Health Network
Assistant Professor
Department of Psychiatry and Behavioural Neurosciences
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This is Exhibit ‘C’ referred to in the affidavit of Dr. Rachel Lamont affirmed before me this 7th day of June, 2024.



EXHIBIT ‘C’

McMaster University
DEPARTMENT OF PSYCHIATRY AND BEHAVIOURAL NEUROSCIENCES
HAM SMaRT

Dec 21, 2023

ATTN: Sharon Crowe

RE: Shawn Arnold (DOB July 23, 1969)

I am a psychiatrist with both the Hamilton Social Medicine Response Team and the Shelter Health Network in Hamilton, Ontario. Both services provide health care to people who are unhoused or precariously housed.

Mr. Arnold has a diagnosis of Opioid Use Disorder (severe). Mr. Arnold has been living outside since January 2023. Priot to this, he was housed for two years, but the building in which he lived burned down and he has since has been living outside. He is on ODSP. He has not been accessing the shelter system as he does not feel safe there.

Mr. Arnold shared with me that he first achieved some stability while allowed to remain in an encampment at JC Beemer which allowed him to access nearby supports and ultimately find housing approximately 2.5 years ago.

He is staying outside in a tent now, though did not wish to have his location shared for fear it could lead to eviction. He is connected with another person there who is also living outside, that he trusts to watch over this things from time to time. Workers from the city have come and spoken to him to tell him he cannot stay on the property he is currently on. He has a housing worker at Wesley but finds it difficult to connect with her. He is concerned about eviction and about leaving his possessions to access services and thus misses many commitments and appointments, which has been having a deleterious impact on his ability to stay connected with supports.

Mr. Arnold has shared that being allowed to stay in an encampment in the past without threat of eviction (JC Beemer 2.5 years ago) was a major stabilizing force in helping him connect with needed resources, ultimately leading to a period of sustained housing for two years. Now, he is again outside and facing the threat of eviction from his encampment, which has been hindering his ability to connect with needed supports, and has thus been having a deleterious impact on his health including escalating opioid use and numerous unintentional overdoses.

McMaster University
DEPARTMENT OF PSYCHIATRY AND BEHAVIOURAL NEUROSCIENCES
HAM SMaRT

RE: Shawn Arnold (DOB July 23, 1969)

~~It is my opinion that the threat of encampment eviction at present is a major contributor to Mr. Arnold's difficulty in connecting with needed supports including a housing worker and medical and substance use care, thereby increasing his risk of serious health harms including unintentional overdose. Allowing him to remain in place was a major contributor to his finding and being housed 2.5 years ago.~~

Please feel free to contact me should any further information be required.

Sincerely,



Dr. Rachel Lamont, MD, FRCPC
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This is Exhibit ‘D’ referred to in the affidavit of Dr. Rachel Lamont affirmed before me this 7th day of June, 2024.



EXHIBIT ‘D’

McMaster University
DEPARTMENT OF PSYCHIATRY AND BEHAVIOURAL NEUROSCIENCES

April 9, 2024

ATTN: Sharon Crowe

RE: Cory Monahan (DOB 1976-04-26)

I am a psychiatrist with both the Hamilton Social Medicine Response Team and the Shelter Health Network in Hamilton, Ontario. Both services provide health care to people who are unhoused or precariously housed.

I confirm that Mr. Monahan has diagnoses of ADHD, Fetal Alcohol Syndrome, and Opioid and Stimulant use disorders (severe). He also has an extensive history of trauma in his life dating back to his early childhood years which have impacted his development.

Mr. Monahan shared his story with me, prior to my involvement in his care. He has always struggled with impulse control and mood swings secondary to his conditions of ADHD, FASD, and the impact of developmental trauma. He was evicted approximately 4 years ago from an apartment. He briefly stayed at a Budget Inn and then moved to Gage Park to an encampment in late 2020. He has since experienced numerous encampment evictions, firstly when his camp in Gage Park was "bulldozed", as per his description, in winter 2020. He was traumatized by this experience because he lost all of his possessions and then felt extremely desperate because he had nowhere to go. He then went to stay at Salvation Army Booth Centre and was subsequently service restricted from that shelter after an altercation with another resident and sent to the street in the middle of winter in early 2021. He then set up a camp across the street from The Hub. He recalls during this time that his drug use escalated significantly, his mood plummeted, and he describes "losing control of everything", because he felt like he no longer had anything to lose and was in constant fear that he would lose his tent and belongings again. He said this did in fact happen, and his tent and belongings set up across from the Hub were torn down and disposed of. He then stayed at Salvation Army again briefly and went on to set up camp outside Wesley Day Centre in 2021 and then behind Hutches in a forested area as well as near the tugboat at Pier 4 in the ensuing years. He describes being forced to move by the city from each location and with each move, having many of his belongings lost or thrown out. Most recently, he was moved by city workers from the opening of the Cootes Paradise trail opening to another path off Bayfront. He described the new location as being "where the wind is most strong" which made for a difficult camp set-up and very cold nights. After he had not been to his site for 2 days, he returned and everything was once again torn down and thrown out.

~~Given ongoing mental health symptoms, high levels of substance use, and lack of appropriate housing options for Mr. Monahan, as well as the constant threat of being forced to move, he continues to live outside in a very precarious state.~~ This has led to profound sleep deprivation, which further exacerbates his underlying mental health conditions and substance use. He has

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had at least 4 unintentional overdoses since 2020 and reports having none prior to this time, which coincides with an escalation in substance use following encampment evictions.

~~It is my opinion that repeated encampment evictions have been a major contributor to the profound deterioration in Mr. Monahan's mood, as well as worsening impulse control difficulties, substance use disorders, and resultant overdoses. This is due to the profound stress caused by the constant threat of encampment eviction, the impact of eviction itself including loss of beloved possessions, and the state of absolute desperation that encampment evictions have plummeted Mr. Monahan into.~~

Please feel free to contact me should any further information be required.

Sincerely,

R. Lt

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This is Exhibit ‘E’ referred to in the affidavit of Dr. Rachel Lamont affirmed before me this 7th day of June, 2024.



EXHIBIT ‘E’

McMaster University
DEPARTMENT OF PSYCHIATRY AND BEHAVIOURAL NEUROSCIENCES
HAM SMaRT

October 5, 2023

ATTN: Sharon Crowe

RE: Lewis, Ammy (1978-07-04)

I am a psychiatrist with both the Hamilton Social Medicine Response Team and the Shelter Health Network in Hamilton, Ontario. Both services provide health care to people who are unhoused or precariously housed.

I have been Ms. Lewis' treating psychiatrist since October 2021 and can confirm that she has diagnoses of Post-Traumatic Stress Disorder (PTSD), Borderline Personality Disorder, Generalized Anxiety Disorder, Depression, and Opioid and Stimulant use disorders (severe).

Ms. Lewis was referred to me in October 2021 by another physician providing care to her, who noted significant concern for her mental health. Ms. Lewis had recently been released from a federal penitentiary and had returned to Hamilton in late 2020. She was briefly housed after her release, though reports having suffered sexual assault from her landlord and she left that residence. Ms. Lewis lived outside for the latter part of 2021 and most of 2022 in a tent with her dog. She was evicted by the city from a tent in November 2021 which led her to have to return to an abusive living situation, causing considerable decline in her mental health. She then returned to living outside because of the harm of that situation. Ms. Lewis suffered chronic severe suicidal ideation, an exacerbation of symptoms of Post-Traumatic Stress Disorder and Depression, and worsening of her substance use disorders while living outside. She would regularly report to me her intense fear of having her tent taken down and belongings stolen. She was unable to go to shelter because of her dog, as her dog was her main source of support and companionship.

~~It is my opinion that encampment evictions and the threat thereof repeated threat have been major contributors to the ongoing instability in Ms. Lewis' mental health and worsening of her substance use disorders from 2021-2022.~~ Due to considerable support from our team and outside agencies, Ms. Lewis was able to secure housing in 2023.

McMaster University | DEPARTMENT OF PSYCHIATRY AND BEHAVIOURAL NEUROSCIENCES

HAM SMaRT

Please feel free to contact me should any further information be required.

Sincerely,

Dr. Rachel Lamont, MD, FRCPC
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This is Exhibit ‘F’ referred to in the affidavit of Dr. Rachel Lamont affirmed before me this 7th day of June, 2024.



EXHIBIT ‘F’

McMaster University
DEPARTMENT OF PSYCHIATRY AND BEHAVIOURAL NEUROSCIENCES

Feb 22, 2024

ATTN: Sharon Crowe

RE: Sherri Ogden, DOB July 31, 1993

I am a psychiatrist with both the Hamilton Social Medicine Response Team and the Shelter Health Network in Hamilton, Ontario. Both services provide health care to people who are unhoused or precariously housed.

Ms. Ogden is a 30 year old Indigenous woman who is presently unhoused and living outside. She is supported by ODSP. I can confirm that Ms. Ogden has diagnoses of Complex Post-Traumatic Stress Disorder (c-PTSD), Major Depressive Disorder, Attention Deficit Hyperactivity Disorder (ADHD), Opioid Use Disorder, and Stimulant Use Disorder. She has been on medication for depression for many years, prescribed by her family physician.

Ms. Ogden has been experiencing homelessness in the Hamilton area for over 5 years. It was after she became unhoused that she began using street drugs. Due to a lack of shelter space and lack of supportive environments for Ms. Ogden to stay, she has been forced to live outside for prolonged periods. Because of the chaotic nature of her daily life, she has difficulty recalling specific dates and locations of where she has stayed outside. She has however repeatedly experienced forced displacement from encampments on numerous occasions including being forced to move from behind City Hall in 2023. Most of her belongings were thrown out under the city's direction after that particular eviction, including her tent, and also on many other occasions in her past. Each time she loses her possessions and is forced to move, Ms. Ogden reports increasing feelings of hopelessness with worsening depressive and trauma symptoms, which in turn cause her to use increasing amounts of substances. While Ms. Ogden used to find safety and comfort living in a tent amongst others in community, she has given up attempting to do so and now sleeps outside without shelter. She has had numerous community agencies offer her support; each time she begins to build connections, she is forced to move and has difficulty re-engaging with supports because they have difficulty locating her.

Because she ~~is forced to~~ sleeps outside, Ms. Ogden gets very little sleep and uses large amounts of stimulants to try to stay awake to protect both herself and her belongings. Sleep deprivation and stimulant use further exacerbate her underlying mental health conditions of depression, ADHD, and complex PTSD.

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DEPARTMENT OF PSYCHIATRY AND BEHAVIOURAL NEUROSCIENCES

~~It is my opinion that encampment evictions and the repeated threat thereof have been major contributors to the ongoing instability in Ms. Ogden's mental health and worsening of her substance use disorders.~~

Please feel free to contact me should any further information be required.

Sincerely,

R. Lt

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This is Exhibit ‘G’ referred to in the affidavit of Dr. Rachel Lamont affirmed before me this 7th day of June, 2024.



EXHIBIT ‘G’

McMaster University
DEPARTMENT OF PSYCHIATRY AND BEHAVIOURAL NEUROSCIENCES
HAM SMaRT

May 11, 2023

ATTN: Sharon Crowe

RE: Jahmal (Jammy) Pierre, DOB Dec 20, 1989

I am a psychiatrist with both the Hamilton Social Medicine Response Team and the Shelter Health Network in Hamilton, Ontario. Both services provide health care to people who are unhoused or precariously housed.

I have known Ms. Pierre since fall 2021 and can confirm that she has diagnoses of PostTraumatic Stress Disorder (PTSD), generalized anxiety disorder, depression, and opioid and stimulant use disorders (severe).

Ms. Pierre has shared her story with me, prior to my involvement with her. In March 2019, she was evicted from her apartment at 881 King St and had nowhere to go, as she had a dog, and shelters do not accept pets. Her income is through OW and thus did not have enough to cover rent for a new apartment. Thus, she went and bought a tent for herself and her dog. Due to repeated evictions from the city over the course of several months in 2019, she had to move her tent once every few days. At one point, several months into living outside, her tent was taken down and thrown out as part of a city-led encampment eviction, while she was away at a store. She had left her dog in the tent and her dog was gone when she returned.

~~Individuals suffering from complex mental health conditions and substance use disorders, in particular individuals who have suffered repeated traumatic events, commonly experience a marked decline in their mental health and substance use following repeated traumatic events.~~ Ms. Pierre describes the repeated forced movement of her belongings and particularly the loss of her dog as highly traumatic. Following this, she suffered worsening PTSD symptoms, depressive symptoms, and anxiety disorder symptoms. As is common with individuals who have comorbid substance use disorders, the worsening of her mental health conditions drove increased substance use. She has subsequently suffered multiple overdoses from the toxic street drug supply, which include an ICU admission in August 2020 as well as ER visit in November 2020.

Given ongoing severe mental health symptoms, high levels of substance use, and lack of appropriate housing options for Ms. Pierre, ~~as well as the constant threat of being forced to move~~, she continues to spend most of her time living outside, and has largely given up on trying to set up a tent because of the trauma that repeated evictions cause. She is thus living rough, and ~~forced to~~ stay awake for prolonged periods to protect her personal safety. This has led to

McMaster University
DEPARTMENT OF PSYCHIATRY AND BEHAVIOURAL NEUROSCIENCES
HAM SMaRT

profound sleep deprivation, which further exacerbates her underlying mental health conditions and substance use. She has had brief times in shelter and in the YWCA but has also been asked to leave those spaces due to her complex health needs and those services being unable to offer the required level of support.

~~It is my opinion that repeated encampment evictions have been a major contributor to the profound deterioration in Ms. Pierre's mental health and worsening of her substance use disorders over the past four years. This is due to the profound stress caused by the constant threat of encampment eviction, the impact of eviction itself, encampment eviction causing the loss of a beloved pet, and the resultant need to live outside without the protection a tent can afford, causing extreme sleep deprivation, which further exacerbates symptoms of her mental health conditions.~~

Please feel free to contact me should any further information be required.

Sincerely,

Dr. Rachel Lamont, MD, FRCPC
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This is Exhibit ‘H’ referred to in the affidavit of Dr. Rachel Lamont affirmed before me this 7th day of June, 2024.



EXHIBIT ‘H’

McMaster University
DEPARTMENT OF PSYCHIATRY AND BEHAVIOURAL NEUROSCIENCES
HAM SMaRT

Jan 30, 2024

ATTN: Sharon Crowe

RE: Greaves, Linsley DOB: 1969-10-23

I am a psychiatrist with both the Hamilton Social Medicine Response Team and the Shelter Health Network in Hamilton, Ontario. Both services provide health care to people who are unhoused or precariously housed.

Linsley Greaves ("Jay") has sought care from HamSmart since December 2022. He has diagnoses of Stimulant Use Disorder as well as Stimulant-Induced psychosis.

Mr. Greaves as been experiencing homelessness since 2021 after being evicted from his apartment. Due to negative experiences in shelter as well as shelter capacity limits, he was often forced to live outside for prolonged periods. While living outside, Mr. Greaves developed a strong community, particularly while living in the Woodlands encampment in late 2021/early 2022 for many months. In early 2022, he has shared with me that was evicted from the encampment by the city after being told by city workers that "the city wants their parks back". As part of this process, all of Mr. Greaves' belongings and tent were taken by city workers. He was given a phone number to call and told he had 3 days to claim his belongings. Mr. Greaves did not have his own phone. He called the number offered using other individuals' phones but always received a voicemail and had no call-back number to give. As such, he was never able to collect his belongings and all were thrown out, as far as he is aware. He was subsequently forced to sleep outside without any protection from the elements in early 2022, and suffered frostbite of his lower limbs ~~as a result~~. This went unattended for many months and he ultimately became very ill and required a below-knee amputation of his left leg and amputation of several toes on his right foot in December 2022.

As mentioned, Mr. Greaves also has a diagnosis of Stimulant Use Disorder, severe. He identifies that his stimulant use also escalated after the encampment eviction at Woodlands in early 2022 because he needed to force himself to stay awake for prolonged periods when living outside, unprotected from the elements and without the community he had developed at Woodlands. The increased stimulant use resulted in profound sleep deprivation and an increase in paranoid delusions and auditory hallucinations; this has subsequently impacted his mood and impulse control, creating a vicious cycle of increased use as a means of survival causing exacerbation of mental health symptoms.

McMaster University
DEPARTMENT OF PSYCHIATRY AND BEHAVIOURAL NEUROSCIENCES
HAM SMaRT

RE: Greaves, Linsley DOB: 1969-10-23

Mr. Greaves now suffers immensely as a result of the loss of his lower left leg. He feels deeply ashamed of this and has not been to visit his mother or daughter in Toronto since his amputation, because he is embarrassed that this has happened and does not want to upset them. As a result, Mr. Greaves feels increasingly isolated and grieves the nature of the relationship he once had with his family that is no longer. He describes feeling a sense of despair about where his life has come to.

Further, Mr. Greaves described a number of other encampment evictions he had faced both near Wesley Centre as well as on Ferguson St. near the train station, though he was less sure of the timelines of these evictions. He identified that now he feels there is nowhere to go because he constantly faces the threat of being told to move and losing his belongings if he does set up a new tent, and shelters are often full.

~~It is my opinion that repeated encampment evictions, and in particular the encampment eviction in early 2022 from Woodlands Park and subsequent experience of frostbite leading to tissue death and amputation have been a major contributor to the ongoing instability in Mr. Greave's substance use disorder and symptoms of psychosis, as well as ongoing immense psychological and emotional suffering secondary to limb loss and resultant isolation from family. This has been exacerbated by the ongoing lack of available, suitable shelter spaces or permanent housing options.~~

Please feel free to contact me should any further information be required.

Sincerely,

Dr. Rachel Lamont, MD, FRCPC
Psychiatrist, Hamilton Social Medicine Response Team and Shelter Health Network
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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

Affidavit of Dr. Lamont dated June 7, 2024

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TAB 6

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. JILL WIWCHARUK,
on behalf of the Applicants,
on her affidavit dated June 7, 2024,
held via Zoom Videoconference hosted by
the offices of Nimigan Mihailovich Reporting Inc.,
Hamilton, Ontario, on Friday, August 16, 2024,
at 11:17 a.m. EDT

APPEARANCES:

Sujit Choudhry	for the Applicants
Sharon Crowe	
Curtis Sell	
Michelle Sutherland	
Nnonyechi Okenwa	
Bevin Shores	for the Respondent
Jordan Diacur	
Vivian Caldas	

ALSO PRESENT:

Jojo Johnson	Articling Student

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LIST OF UNDERTAKINGS, REFUSALS, & UNDER ADVISEMENTS

Undertakings (U/T) found at pages:
NONE

Refusals (REF) found at pages:
NONE

Under Advisements (U/A) found at pages:
21

Zoom Videoconference

--- Upon commencing on Friday, August 16, 2024, at 11:17 a.m. EDT

AFFIRMED: DR. JILL WIWCHARUK

CROSS-EXAMINATION BY MR. DIACUR:

1 Q. Good morning, Dr. Wiwcharuk. My name is Jordan Diacur. I'm a lawyer acting for the City of Hamilton. So my questions are going to be posed to you from that perspective.

I understand that there is an affidavit in your name with a date of June 7th -- I can pull it up -- June 7, 2024. Do you have a hard copy of that document?

A. I do in front of me, yes.

2 Q. Okay. And I can see that you're in a room that looks like it's got some other documents in it. Is that the only document that you have in front of you?

A. Correct.

3 Q. Okay. Are you at home?

A. I am, in my office at home.

4 Q. And are you alone in the room?

A. I am indeed.

5 Q. So just to be clear, if there are any interruptions or if anyone enters the

room, I'd like you to tell me. We can always take a break if something happens, or if you need one, let me know. But for purposes of this examination, you are to be alone and have just a copy of your affidavit with you, not to refer to any other documents.

A. That sounds fine. No problem.

Q. Thank you.

So I'm also going to share my screen so that there's a copy of the affidavit that I'm referencing up on the screen. You can reference either that or the hard copy that you have in front of you, just as long as you have a copy that you are able to reference.

So my first question for you has to do with the form of the affidavit. I note that at the beginning it does say "Sworn June 7, 2024." However, if I scroll through it to the end, it indicates that it was, in fact, affirmed remotely by you and that you stated that you were located in the city of Victoria.

Is that accurate that this affidavit was affirmed and it was done remotely with you in the city of Victoria in British Columbia?

A. Yes.

7 Q. Okay. And I note that this part of the affidavit, called the jurat, doesn't indicate a date that it was commissioned. Do you recall the date that you signed this affidavit?

A. I would have to look at my notes. So no, I don't recall that date off the top of my head. I assume it's the date that was noted, June 7, 2024, but that would just be an assumption. I'd have to look at my calendar.

MS. CROWE: Sorry, if I could interject for one second and just direct your attention to the first page where it indicates sworn June 7, 2024 --

MR. DIACUR: Yes, I understand that it references that it's sworn June 7, 2024, on the first page. I posed that question to the witness, but she's also indicated that she didn't swear it -- in fact, she affirmed it -- and there's no date in the jurat. So I'm trying to establish the date that it was actually signed. If the witness doesn't recall, I'll accept that answer.

MR. CHOUDHRY: We'll provide an undertaking to give it.

MS. CROWE: We will provide you

with an undertaking to provide that information.

MR. DIACUR: To provide what information?

MS. CROWE: The date that it was affirmed.

MR. DIACUR: The witness doesn't recall. That was the question. I don't know how you can answer on behalf of the witness.

MR. CHOUDHRY: Counsel, we can provide you with an undertaking to get you the information as counsel. I think we've settled it. So why don't you move on.

MR. DIACUR: I don't believe that we've settled anything. The witness stated that she doesn't recall when she swore the affidavit, or I should say affirmed the affidavit. I'm accepting that answer.

8 Q. Now, if I scroll through this affidavit, you indicate that you have personal knowledge with respect to the facts and reports set out below, except where stated otherwise. You state:

"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." (As read.)

You then state:

"I am a physician formally with the Shelter Health Network, SHN, and the Hamilton Social Medicine Response Team, HAMSMaRT." (As read.)

The word "formally," does that mean that you are still with the Shelter Health Network, SHN, and the Hamilton Social Medicine Response Team, HAMSMaRT, as of the date of this affidavit?

A. As of the date that I -- that I wrote the letters is when I was -- I was part of Shelter Health Network and Hamilton Social -- the HAMSMaRT.

Q. Okay. It's perhaps the word "formally" that's causing the issue. Do you mean formerly, F-O-R-M-E-R-L-Y?

A. No. No, no. No. I believe it is meant to be formally. I am a physician with the -- yeah, I don't believe it's formerly. It's meant to be formally. Yeah.

Q. As of today's date, are you still a physician with the Shelter Health Network,

SHN, and the Hamilton Social Medicine Response Team, HAMSMaRT?

A. No.

Q. So as of today's date, you are formerly a physician --

A. Yeah, as of today's date, indeed. Yeah.

Q. And as of the date that you swore this affidavit, whatever date that was, you were formally with them?

A. So I -- yes, absolutely, because I swore that when I swore it.

Q. And I understand --

A. I think I -- I think I'm mixed up between swearing and affirming. I'm not -- I'm not clear on what those terms are and what -- what the dates --

Q. When this affidavit was signed by you, was it explained to you that you had the opportunity to take an oath in order to, as you've done today, tell the truth?

A. Well, that's exactly what I did when I swore it. That's what I do -- yeah.

Q. Was it explained to you that there's a difference between swearing to tell the

truth on a holy book that binds your conscience or to take an oath affirming that you will tell the truth without doing so on a holy book that binds your conscience?

A. I do not recall.

Q. Do I understand that you are no longer practising medicine in Hamilton?

A. Correct.

Q. When did you cease practising medicine in Hamilton?

A. June 30, 2022.

Q. Did you resign from the College of Physicians and Surgeons of Ontario as of that date?

A. Yes.

Q. And have you considered -- or continued, I should say, practising medicine in the province of British Columbia?

A. Yes.

Q. And you currently reside in the city of Victoria, British Columbia?

A. Yes.

Q. And scrolling down beyond paragraph 2 of your affidavit, you then begin to reference a series of what you call reports to the

Hamilton Community Legal Clinic. They're on various dates and they're attached as exhibits to your affidavit; is that accurate?

A. Yes.

22 Q. And beyond stating that you provided reports to the Hamilton Community Legal Clinic on certain dates with respect to certain individuals, which are also referred to as medical letters, there are no other statements in your affidavit?

A. Yes, correct.

23 Q. There's no statement in your affidavit that you adopt any of the statements in the exhibits to your affidavit as true. Your affidavit is limited to providing copies of these reports, or what you call medical letters; is that accurate?

A. Can you say that one more time? I'm -- this seems -- like, you're getting --

24 Q. There is no statement in your affidavit, as we've just seen, that you adopt any of the statements in any of the exhibits to your affidavit as true. Your affidavit is limited to providing copies of what you refer to as reports

or medical letters; that's accurate?

A. No, that's not accurate because Number 1 says that the information --

"I have personal knowledge with respect to these facts... Where the information is not based upon my personal knowledge, it's based upon information provided by others which I believe to be credible and true." (As read.)

I'm not in the habit of writing letters that I do not believe are true.

25 Q. I understand that.

But you do not state in your affidavit that you adopt any of the statements in the exhibits to your affidavit as true. Your affidavit is limited to providing copies of the reports, or what you call medical letters; is that accurate?

A. Yes.

26 Q. In this matter, you've not provided any current or up-to-date curriculum vitae, or CV; is that accurate?

A. Yes. I believe that can be found in a -- my CV is in evidence in the

injunction motion, that I believe you have a copy of.

27 Q. The injunction motion occurred in 2021. You've not provided any current or up-to-date curriculum vitae, or CV, in this matter; is that accurate?

A. Yes.

28 Q. You've not signed any form entitled "Form 53, Acknowledgement of Expert's Duty" in this matter; is that accurate?

A. Yes.

29 Q. And in this affidavit, you do not describe any factual assumptions on which any of your opinions are based; is that accurate?

A. Do not describe any factual assumptions -- I don't think I understand what that means.

30 Q. Well, as we've just scrolled through, there are no statements in this affidavit which state "I am assuming to be true for purposes of my opinion X, Y or Z facts." Is that accurate?

A. Yes.

31 Q. And in this affidavit, you do not describe any research conducted by you that led you to form any opinions; is that accurate?

A. Yes.

32 Q. And in this affidavit, you do not describe or list any documents, if any, relied upon in forming any opinions; is that accurate?

A. No. I -- I refer to medical records for every one of these patients, legal medical record documents.

33 Q. So the documents that are referenced in the reports, or what you call medical letters, attached as exhibits to this affidavit are the extent of the documents that you relied upon in forming any opinions that are expressed?

A. No. That's not accurate. I wrote these letters based on medical records that -- for each of these patients.

34 Q. Yes. So the medical letters referenced in the reports, or what you call medical letters, attached as exhibits to this affidavit are the extent of the documents on which you relied in forming any opinions that are expressed?

A. No. These medical reports are not medical records. The medical reports are based on medical records that are not part of the

affidavit. They're -- they're in an electronic medical record that is part of the patient's health record.

35 Q. Yes, Doctor. I'd ask that you listen to my question.

The medical records or notes referenced in the reports, or medical letters, that are attached as exhibits to your affidavit are the extent of the documents that you reviewed or relied upon in forming any opinions that are expressed; is that accurate?

A. No, because in Number 1, I said when information is not based on my personal knowledge, it's based upon other information. So, for example, if I said that I -- at times, I would ask a -- well, there's -- there's examples of that in the letters.

36 Q. Examples of what in the letters?

A. Where something was based -- like, I -- for example, I would ask a shelter worker to find a bed for one of my patients. I would ask someone at a drop-in centre to find a bed for one of my patients, and then I would -- I would note to my knowledge, that was not available

or, if it was available, that it became available. But it's not solely medical-record information that I was giving there.

37 Q. No, I understand.

We're solely talking about documents; you understand? I'm saying the --

A. Okay. Documents. Okay.

38 Q. The medical records or notes that are referenced in the reports, or what you call medical letters, that are exhibits to your affidavit form the extent of the documents on which you relied in forming any opinions that are communicated; is that accurate?

REF MS. CROWE: Asked and answered.

THE WITNESS: Yes.

MR. DIACUR: That has not been answered. She --

MR. CHOUDHRY: Counsel, she just said, "Yes."

THE WITNESS: Yep. Let's move on.

MR. CHOUDHRY: She just said, "Yes."

MR. DIACUR: So after an objection was raised to the question being asked and answered, the answer was given? I want to --

THE WITNESS: No. Actually, it --
MR. DIACUR: -- be clear for the record.
THE WITNESS: Actually, it happened at the same time. I said "Yes" at the same time.
MR. DIACUR: No. That's not going to be clear on the record. I'm not going to accept an answer that's given after an objection by counsel. I want to --
MS. CROWE: No, no, no --
MR. DIACUR: -- ask this question and get an answer to it. Are you --
MR. CHOUDHRY: Mr. Diacur --
MR. DIACUR: -- objecting to the question?
MR. CHOUDHRY: Mr. Diacur, please watch your tone. Why don't you restate your question calmly and then --
MR. DIACUR: I am perfectly calm.
I am responding to an objection from counsel. Is the question objected to or not?
MS. CROWE: It is because our position is that, prior to the objection, the question had been asked and answered. She's explained what she has done, what kind of

consultations she undertook --

MR. DIACUR: Yes. That's not a response to the answer to the question. Talking about oral conversations she had with others is not an answer to a question about documentation, and I want, on the record, an answer to the question.

39 Q. Dr. Wiwcharuk, other than any medical records or notes that are referenced in the reports, or what you call medical letters, that are attached as exhibits to your affidavit, were there any documents that you relied upon in forming any opinions expressed?

A. Was there any documents that I relied upon. That's a different question than you first asked -- no, there wasn't any other documents I relied upon.

40 Q. Thank you.

A. Yes, no.

41 Q. Dr. Wiwcharuk, do you consider yourself to be independent in this case?

A. Yes. I'm a treating physician of these patients.

42 Q. You consider yourself to be independent in this case?

A. Yes.

43 Q. And by that, I mean you do not favour one side or the other?

A. I am the treating physician of these patients in front of me, and I'm here to provide objective evidence of that. That is what I'm here for.

44 Q. You prepared the medical letters or reports referenced in your affidavit at the request of the lawyers for the applicants; is that correct?

A. Yes.

45 Q. In fact, you addressed the letters to the lawyers for the applicants?

A. Indeed.

46 Q. The letters were prepared at or after the time that this litigation began?

A. Yes.

47 Q. You've not included any of the applicant lawyers' requests or instructions to you in your affidavit or in the attached medical letters; is that accurate?

A. Yes.

48 Q. Is there -- I'm sorry, you're saying that you have not done that?

A. Sorry, can you repeat that question one more time?

49 Q. Yes. You have not included the applicants' lawyers' requests or instructions to you in the affidavit or in the attached medical letters; is that accurate?

A. I don't have any instructions from the lawyers regarding these applicants. I was simply asked to provide a letter for them.

50 Q. Is there any additional correspondence -- emails, letters, notes of calls -- between you and the applicants' lawyers with reference to this matter?

A. With reference to each individual patient?

51 Q. With reference to this litigation, this matter.

A. I can't recall of any off the top of my head right now, no. But there -- I mean, probably if I go back in my emails.

52 Q. Did you prepare the medical letters on your own, or did the applicants' lawyers assist you with that?

A. I 100 percent prepared these letters on my own. There was -- there was no one

helping me with that, at all.

53 Q. Well, tell me about how you were contacted and asked to provide the letters.

A. Okay. I'm trying to bring this back. This is 2021 that I wrote these letters. So there's a bit of a time gap here. I --

54 Q. Well, just to be clear, they're dated in 2022; correct?

A. Sorry, 2022. That's right. Sorry, my bad. My mistake.

So I guess I can't recall exactly. I know that I would receive an email stating that this -- that someone has been -- well, actually, no, I -- I can't recall exactly. I would have to check my emails. I was requested to provide a letter, a medical letter, and I did so. And there -- that's all I can speak to.

MR. DIACUR: Counsel, I'd request an undertaking that copies of any emails that Dr. Wiwcharuk is able to locate with respect to the instructions or requests that she provide these medical letters attached to her affidavit be disclosed.

MR. CHOUDHRY: We're happy to do

so, subject to litigation privilege.

MR. DIACUR: Is there an assertion that litigation privilege attaches --

MR. CHOUDHRY: We'll look at the -- sorry, go ahead. Just to be clear, I just want to make sure --

MR. DIACUR: Is there an assertion of litigation privilege with respect to instructions or requests being made to a participant expert? Is that --

MR. CHOUDHRY: No.

MR. DIACUR: -- the case?

MR. CHOUDHRY: No, I said subject to it. So we'll review the correspondence and determine whether to make any assertions of privilege in relation to them.

MR. DIACUR: And so you're taking that under advisement?

U/A MR. CHOUDHRY: We're taking it under advisement. We'll get back to you.

MR. DIACUR: Thank you.

55 Q. Dr. Wiwcharuk, did you review the notice of application in this litigation before preparing the reports or medical letters?

A. No.

56 Q. Did you speak with any of the applicants before preparing medical letters or reports with respect to them?

A. Well, they're my patients. I spoke to them regularly. I would see them.

57 Q. So at the time you were preparing the reports or medical letters attached to the affidavits, did you speak again with the applicants?

A. Well, I would ask for their consent because I would never -- I would never provide something to someone, a third party, without consent from a patient.

58 Q. So I don't believe that's referenced in the reports or medical letters. So you obtained the consent of each of the applicants that are referenced in these reports or medical letters before preparing them?

A. That is a standard procedure for any -- for any physician who is providing medical -- medical information to a third party. That is -- it would be entirely unethical to do otherwise.

59 Q. Did you provide drafts to the applicants before finalizing the letters?

A. Absolutely not. That is not -- no.

60 Q. What information did you provide to the applicants when seeking their consent?

A. I would ask them if they were okay with me providing their medical history to the legal clinic as requested by the lawyers. That is what I would ask them.

61 Q. Was consent obtained in writing?

A. No. Verbal consent would have been obtained and documented in their medical record, as is common practice amongst physicians.

62 Q. Did you review the applicants' own affidavits in this matter before preparing your reports or your medical letters?

A. No.

63 Q. You're aware that some of the affidavits were prepared before the dates of your medical letters?

A. I'm not aware of that.

64 Q. Are you aware of the other portions of the record in this case, other experts on behalf of the applicants or on behalf of the

City of Hamilton, and did you review that material before preparing your affidavit?

A. Not before -- no. So there's two questions you just asked there. I'm not sure which one you want me to answer, but --

65 Q. Are you aware of any other parts of the record in this case?

A. I am aware of other people's names that are mentioned as witnesses, yes.

66 Q. Did you review any affidavits by any other person before preparing your own affidavit?

A. No.

67 Q. Did you review the evidence of Dr. Koivu given by affidavit on behalf of the City of Hamilton?

A. Just a week or two ago.

68 Q. You did not prepare any reply affidavit responding to the evidence of Dr. Koivu; is that accurate?

A. Correct.

69 Q. You did not prepare any reply affidavit responding to the evidence of any other witness on behalf of the City of Hamilton; is that accurate?

A. Yes.

70 Q. I'd like to know, while you were employed or working on behalf of the Shelter Health Network or HAMSMaRT, how you provided services to patients. Can you explain that?

A. Yeah. I was a -- I worked in a clinic in the basement of the Salvation Army, and so every Monday, I would be there providing care throughout the entire day for people that would come and see me for health care, not just residents of the Salvation Army.

I also worked a full day a week at a drop-in centre for people experiencing homelessness, at the Wesley Day Centre, and I would also do outreach work. So I worked -- I would go directly to encampments, directly to people living outside, providing health care and so would often be -- you know, would come in my car with medical supplies. In my car, I'm able to provide direct care there.

I am also -- being an addiction medicine specialist trained with a diploma from the International Society of Addiction Medicine, I also provided addiction care in my role as outreach and -- outreach -- as an outreach doctor.

71 Q. And was that the sole -- the sole -- I'll ask it this way. In terms of your medical practice, was that the only services that you were providing to patients, or did you have a broader medical practice than this?

A. Yes. I'm also an emergency doctor.

72 Q. So you have hospital privileges and served in emergency departments in hospitals?

A. Yes. And at that time, I was also working as an inpatient addiction medicine specialist.

73 Q. And at what hospitals did you provide emergency services?

A. Brantford General Hospital.

74 Q. Any others?

A. Not at that time, no.

You did -- oh, no. Go ahead.

75 Q. I did what?

A. I -- no, that's fine. I was just -- I was curious if you had asked about the affidavit from Dr. Koivu as I was -- as I was describing my medical practice, which is, in particular, working with people who are homeless

in encampments, in shelters.

It -- I was thinking of the fact that with that experience of 13 years -- at this time, I guess 11 years in 2022 -- working directly with people in their own environments, whether that be shelter or encampments, I certainly have -- you know, I was able to see very clearly what was happening with these patients as opposed to just working in a hospital setting.

76 Q. Were there any other parts to your practice at these times?

A. No, that was them. Oh, sorry, I had a -- I had a -- no, that's wrong. I had an addiction practice as well, a very specific addiction practice at The Hamilton Clinic, and so --

77 Q. At which Hamilton clinic?

A. It was called "The Hamilton Clinic."

78 Q. Okay, at The Hamilton Clinic?

A. You got it. Capital "T."

79 Q. Understood.

Anything else you can recall about your practice?

A. I enjoyed it.

80 Q. You'd agree that in treating a patient, just as a general statement, it's important to obtain an accurate medical history; is that right?

A. Yes.

81 Q. And it's important that a medical history be comprehensive?

A. So that, I do not always agree with, no. And the reason for that -- or, well, no.

82 Q. Comprehensive in the sense that it doesn't leave out anything significant?

A. So when -- when you are dealing with people who have a lot of competing priorities and who are homeless and are often in a state of crisis, it is not an appropriate time to -- there are some times when you cannot get an extremely comprehensive health history.

83 Q. You'd agree that an accurate medical history is important in giving a medical opinion?

A. Oh, yes.

84 Q. And you'd agree that having an inaccurate or an incomplete medical history may affect the reliability of a medical opinion or a

medical assessment?

A. No, I would not agree with that.

85 Q. On what basis?

A. Because when you provide patient-centred care, you -- you do what is best for the patients given -- given the circumstances that are there and given the difficulties that they're facing. So you -- over time, you may get an entire medical -- you slowly develop the medical history over time.

Classically, you might have the idea of a patient coming in and you have a 40-minute intake and you discuss all your past medical history with all previous reports, and that is a very privileged way of being able to access health care, and it's not the reality for the majority of people that are -- have significant mental health and addictions histories.

So in my extensive practice working with people in these scenarios, I have found that I can absolutely get an accurate medical history over the time that I spend with them, and it might not all be in one specific time and it might be

put together over time, but a medical opinion that is -- that is given from that is absolutely just as -- just as accurate as it would be if I had spent more time -- you know, if they were able to give me more time at the beginning of a session.

86 Q. I understand that you can develop a more accurate picture of a patient over time. But you would agree that an inaccurate or incomplete medical history would affect the reliability of a medical opinion or assessment?

A. No, I would not agree with that.

87 Q. On what basis?

A. Because there are all sorts of medical opinions that can be given. If I were to give a medical opinion of a certain part of something on someone, then yes, I might need an entire medical history. But if I were to give a very specific medical opinion on something, I would not do so unless I had an accurate history on which to do that.

88 Q. So I --

A. So I actually --

89 Q. So, again, I appreciate that an accurate history can be obtained. But if you

had an inaccurate history, it would affect the reliability of a medical opinion or assessment; isn't that accurate?

A. That is not accurate because there are different medical opinions. There are -- there are different medical opinions that someone can give for different things. So if you were to ask me a medical opinion on a certain specific -- a specific area for I do not have an accurate medical history, then yes, I would not be able to -- I would not be able to provide that.

But other -- you know, you -- I can absolutely give accurate medical opinions based on -- and I would never -- I would never pretend to give a medical opinion that wasn't accurate with -- with -- I wouldn't -- if I didn't have -- if I didn't have information on which to base my medical opinion, I would never presume to give a medical opinion.

90 Q. A medical opinion or assessment would be less reliable if the medical history that you had was inaccurate or incomplete; is that true?

A. That would depend on what the medical opinion -- what medical opinion is being

asked, is being requested.

91 Q. You'd agree that some patients may not be able to give you an accurate or a comprehensive medical history for themselves; is that true?

A. Yes. I have -- I have referenced that in my letters.

92 Q. And patients may not be able to comprehensively report their own experiences; is that true?

A. Yes, that's true. And physicians get medical histories from more places than just the -- than just the patient. We're often accessing -- well, all the time, we're accessing hospital records, former psychiatric records, other doctors' records. So the patient's history is just one place where we get medical history.

93 Q. So in taking a medical history from a patient, obtaining it from these various sources, do you take any steps to account for the possibility that there may be inaccuracies?

A. We do that all the time. That's what we do as doctors.

94 Q. What steps do you take?

A. We cross-reference. We check things out in emergency records. We check things out in addictions records. We call other providers to -- to get collaboration. We -- we -- that's how we -- that's how we build a medical record, and that is what I do with my patients as well, of course.

95 Q. So if I understand, there are times when you would render a medical opinion without gathering a complete medical history?

A. No, absolutely not. And I find that quite offensive.

96 Q. Well, if I understood your answer previously, it's that you may render an opinion on a small part of a person's treatment without having a full understanding of their medical history. Did I misunderstand?

A. Yes, you did.

97 Q. All right. So you would not render a medical opinion without gathering a complete medical history on a patient?

A. Do you want me to say something after that? You're telling -- sorry --

98 Q. Is that correct, the proposition I've just put to you?

A. Sorry, can you say that one more time?

99 Q. You would not render a medical opinion with respect to a patient without gathering a complete medical history on that patient; is that accurate?

A. No, but I'm happy to rephrase that to make it accurate. I would not render a medical opinion on someone unless I had appropriate past medical history and a medical to do so.

100 Q. So you would render a medical opinion with respect to a patient without having a complete medical history on that patient in some circumstances; is that true?

A. No. I told you that a medical opinion on a certain aspect, you -- there are -- for -- I would not -- I would not render a medical opinion on someone without having all the medical history I needed to provide that medical opinion. Absolutely not. I would never do that.

101 Q. And that would involve reviewing all of the necessary medical records?

A. All of the necessary medical records, correct.

102 Q. And it would involve taking time to carefully examine the patient?

A. Of course.

103 Q. And you would agree that your opinion would not be valid if you did not review the appropriate medical records and if you did not carefully examine the patient?

A. No. I believe that my medical opinion would be valid based on my practice for the last 13 years, which is always -- I would never -- again, as -- as a physician with integrity, one does not provide medical opinions unless they would be accurate.

104 Q. I'm not sure that was an answer to my question.

A. Yeah.

105 Q. You would agree that your opinion would not be valid if you did not review the appropriate medical records and did not carefully examine the patient you were --

A. Yeah. No, I -- I suppose, yeah. Yeah, I agree that it would not be valid if I -- yeah. Yeah, no. That's --

106 Q. I'd like to turn now to the --

A. Sorry, can I just ask -- I

have 30 minutes booked for this time and I have medical care that I need to -- I have things going on. Are we at 30 minutes here, or where -- what's going on here? Can I just double-check on the time?

107 Q. I'm going to be posing questions to you. If you have to leave, then we can address it via counsel.

A. I --

MS. CROWE: Sorry. Sorry, Dr. Wiwcharuk. One moment.

Mr. Diacur, do you have an estimate for how much longer you have in your examination?

MR. DIACUR: Well, it would be difficult for me to estimate. I have some questions about each of the reports and medical letters attached to the affidavit. I would estimate about another half an hour, maybe 45 minutes.

THE WITNESS: That is a lot longer.

MS. CROWE: Can we go off record for a moment?

MR. CHOUDHRY: Can we go off record for a moment?

MR. DIACUR: Yes, that's fine.

--- (Off-the-record discussion.)

MR. DIACUR:

108 Q. I'd like to turn briefly to Exhibit A to your affidavit. It's a report or letter relating to Corey Monahan.

A. Yes. I have it here.

109 Q. It's dated May 31, 2022.

A. Mm-hmm.

110 Q. Now, you state that this letter is based on your review of Mr. Monahan's medical records; is that accurate?

A. Yes.

111 Q. And you reference notes; one note dated March 9, 2022, for example?

A. I do reference that.

112 Q. And that's not a note that you prepared?

A. Yeah, that was a note that I made in his medical -- well, actually, I can't be absolutely certain that it was me that wrote that note in his medical record. But it was in his Shelter Health Network EMR, yes.

113 Q. And you also reference a health-care practitioner who saw him at a different time. Do you see that?

A. Yes. I -- where does it say different time, though?

114 Q. It says "At that time" --

A. Yeah, at that time --

115 Q. -- "the health-care practitioner who saw him" --

A. Yeah.

116 Q. That was not you?

A. I -- I cannot confirm or deny that. I have -- I don't know. I'm just speaking to the note in his medical record.

117 Q. And you do not attach the medical note that you referred to dated March 9, 2022?

A. No.

118 Q. Have you ever personally observed Mr. Monahan outside of a clinic circumstance?

A. Oh, yes.

119 Q. Is that part of your visits to encampments? Is that when that would have occurred?

A. Well, not necessarily. Just in everyday -- like, at a soup kitchen. I would see him walking around town. People that are

homeless are very visible. They're around all the time because they have no place to stay inside, often. So I --

120 Q. There were times that you observed him outside of the clinic just walking around?

A. And in a clinic and in an encampment, possibly, and at a soup kitchen, possibly.

121 Q. Did you ever personally assess Corey Monahan?

A. Many times, yes.

122 Q. Was that part of treating Mr. Monahan?

A. Yes.

123 Q. Do you recall how many times you saw Mr. Monahan for treatment?

A. No.

124 Q. Do you recall when you started treating Mr. Monahan yourself?

A. Not off the top of my head, no.

125 Q. Do you keep medical notes when you were treating Mr. Monahan?

A. Of course I do.

126 Q. And you have not produced any medical records evidencing your treatment of Mr. Monahan?

A. They are all sitting in his record. I don't have any in my affidavit here. My notes are based on those, on the EMR. My notes are based on his medical records, as noted.

127 Q. Do you recall when you spoke with Mr. Monahan about his homeless status?

A. It comes up at every single appointment with someone. It's -- so every time I would have seen him, it would have been a discussion.

128 Q. Did you discuss Mr. Monahan's homeless status with him after you were asked to prepare the medical letter at Exhibit A to your affidavit?

A. I have no idea.

129 Q. It's possible?

A. I -- I can't remember. I do not recall.

130 Q. I'd like to turn to Exhibit B to your affidavit, which has to do with Cassandra Jordan. This letter is dated June 1, 2022.

Do you have a copy of that?

A. I do.

131 Q. You state in the second paragraph:

"I do know that she suffers from opioid use disorder, stimulant use disorder, chronic pain and a recent acetabular fracture and hip dislocation requiring surgery. I am convinced she has significant undiagnosed mental health issues." (As read.)

A. Yes. No, "I am also certain she has" is what it reads, but yes.

132 Q. Did you personally assess Ms. Jordan to establish these diagnoses?

A. Well, I have -- as noted here, they're undiagnosed.

133 Q. Did you ever personally assess Ms. Jordan at all?

A. Yes.

134 Q. Was that part of treating Ms. Jordan?

A. Yes.

135 Q. Do you recall how many times you saw Ms. Jordan for treatment?

A. I do not recall.

136 Q. And, again, you have not produced any medical records evidencing your treatment of Ms. Jordan?

A. No. The letter that I've written is based on her medical records.

137 Q. In terms of undiagnosed mental issues, or mental health issues, do you ever make referrals to mental health practitioners so that such diagnoses could be considered?

A. Yes, regularly when -- when that's something that is in the patient's best interest. Yes. Many times --

138 Q. Did you do that with --

A. Many times, family doctors or addictions doctors like myself can also make those diagnoses when there's --

139 Q. Did you do that with respect to Ms. Jordan?

A. Did I do what?

140 Q. Make a referral to a mental health practitioner so that a diagnosis could be pursued.

A. One -- just give me one second. I have to read the thing.

No, and the reason is because she was -- she was receiving care from another doctor regarding -- this particular patient had another doctor that was involved in their care and she was seeing him at his clinic, and I was only involved for the wound care that was -- that I talk about in this -- in this report.

141 Q. So that is the burn that you reference?

A. Yes.

142 Q. You indicate that if she had presented to hospital, she would likely have been admitted to a specialized burn unit. Did she decline such care?

A. Yes. I reference that in my letter, yeah. She was --

143 Q. And that burn --

A. She --

144 Q. Sorry, please continue.

A. She was living in a tent and there was a huge police presence all around her, and she was afraid of having all her possessions taken if she were to leave. So she -- again, her health care -- health care goes way down on a list of priorities when someone is afraid that

everything they own in the world is going to be taken away.

So that's why she felt she was absolutely unable to go to the hospital, and that's why she asked that I come back and that I take care of her wound as best I can, which I did until she was no longer at that park and I could no longer find her.

145 Q. And that burn healed without being admitted to hospital or a specialized burn unit; is that accurate?

A. In this case, yes, it did. She will have had a much larger scar and may be left with chronic pain from that scar. So it may not have been the most optimal healing process, and it likely would have been much better had she received specialized wound care.

146 Q. Did you treat her for chronic pain?

A. No, I did not treat her for chronic pain at that time. No. Again, as noted, she did have another doctor that was involved in her care as well.

147 Q. And when you say that she may have suffered from chronic pain, that's an

assumption you're making?

A. That is an assumption, yeah.

148 Q. Did you treat Ms. Jordan in an encampment or in a clinic setting?

A. In an encampment.

149 Q. Were you present and saw the police presence that you just referenced, or is that something reported to you by Ms. Jordan?

A. I was present.

150 Q. Have you listed in this letter all the instances where you provided medical care to Ms. Jordan?

A. I can't recall. Yeah. Again, a lot of times people come to us for episodic care only because there's an acute infection or there's an acute -- you know, there's something and they're unable to get to their regular provider. So we do often provide -- we can, in some circumstances, be providing acute ad hoc care.

Most people are really only seeing us. But this -- in particular, this patient also had an addictions and -- an addictions doctor that was also providing some family care, some family medicine care, at another clinic.

151 Q. You do also reference on the

second page an altercation with police on May 6, 2022, in the second-last paragraph. Now, is it the case that you did not observe the alleged altercation with police?

A. No, but I was -- I was privy to hospital records that spoke to that.

152 Q. And it was also something reported to you by Ms. Jordan?

A. Yes.

153 Q. You provided Ms. Jordan with addiction-related care; is that true?

A. Yes, because I was an inpatient addiction medicine doctor and she had an inpatient stay in hospital. So I saw her in that capacity as well, while she was in hospital, yeah.

154 Q. What addiction-related care did you provide?

A. Opioid agonist therapy.

155 Q. The expected progression of an opioid-addicted patient who is not getting such treatment is to worsen; is that true?

A. Not always, no.

156 Q. That's not the expected progression?

A. No. No, it's not -- that's --

no, that's not the expected progression.

157 Q. The best practice for treating a patient with opioid addiction is to get a baseline; is that true?

A. I don't even know what getting a baseline would mean.

158 Q. How do you assess if somebody is getting better or not?

A. By looking at their social situation, their work situation, their relationship situation, their housing situation, how much -- like, how much -- how much -- how many substances they're using, how they're interacting with people. You look at it all and, most importantly, you talk and listen to the patient.

159 Q. So in terms of my question about getting a baseline, that would be a baseline for their current usage of opiates. So is it best practice for treating a patient with opioid addiction to get a baseline for their opiate usage?

A. Oh, yeah. Okay. Mm-hmm, yes.

160 Q. Is it an accepted premise in addiction medicine that the goal is for the patient to stop using the opiates that they are

addicted to?

A. Not necessarily, no. That does not have to be -- that does not have to -- that's certainly not everyone's goal. That's where harm reduction and an understanding of harm reduction comes in.

161 Q. The four pillars of addiction medicine are prevention, treatment, harm reduction and enforcement; is that true?

A. I've never heard of enforcement in those pillars. I'm not aware of -- I'm not aware of -- of where that -- that specific -- those specific four pillars -- like, I -- I'm -- certainly, the first three ring true to me. Enforcement, I am not at all sure about.

162 Q. Is it true that changes in the brain of an addicted person affect their executive function?

A. Sorry, can I -- are we -- I'm here to provide evidence for these affidavits, as a treating physician of these affidavits -- of these patients of mine. Is this -- is this relevant to that?

163 Q. Yes.

A. Okay. Can you ask the

question again?

164 Q. Is it true that changes in the brain of an addicted person will affect their executive function?

A. Yes.

165 Q. Is it true that patients rely on health-care providers to provide them with the information they need in order to make an informed decision about something like opioid agonist therapy?

A. That is a part of the picture. Many of the decisions that are -- I mean, we take our direction from patients on what their goals are, and that is how -- that is what patient-centred care is and that is what harm reduction is, which is by far the more -- the more successful way of treating people with opiate use disorder.

166 Q. So opioid agonist therapy is still something that you use in your practice?

A. Every single day, yes.

167 Q. What form of opioid agonist therapy do you recommend or use?

A. Well, those are two questions. But I use methadone. I use Kadian, which is

long-acting, sustained-release oral morphine. I also use buprenorphine, both sublingual tablets and extended-release injection, and I use hydromorphone.

There's -- I mean, there's many different medications that are used for opioid agonist -- again, I am -- I'm not entirely sure where -- how this is relating to the affidavits in front of me.

168 Q. What is --

A. I thought I was here as a treating medical physician of these -- of these patients.

169 Q. What is the reason why one form of opioid agonist therapy might be used as opposed to another?

A. There's all sorts of different reasons. It depends on patients' goals above and -- above and beyond anything else.

170 Q. What form of opioid agonist therapy was Ms. Jordan put on?

A. So she was not treated by me. I was not her -- I was not her addictions doctor, and I make -- I make no reference to being her -- in hospital, when she was in the hospital, she was

on opioid agonist therapy, and I can't recall what that was.

But as an outpatient, prior to being in hospital, she was being treated for her opiate use disorder by another doctor, and I was just providing wound care for her. In the -- however, again, in the hospital, I don't know what her opiate -- I cannot recall what her opiate agonist therapy was.

171 Q. Do you recall what practitioner was providing her with those services?

A. In -- as an outpatient? Yes.

172 Q. Who was that?

A. Dr. Dennis Divalentino.

I remember also, because she was so distressed in that tent with the police all around her, she had no way of getting to the pharmacy to get her medications for her addiction because she was so -- so worked up and distressed.

And I went to the pharmacy around the corner to get her medications for her while she stayed in her tent trying to protect her belongings from this huge presence at the park. So I specifically remember going to the pharmacy,

picking those medications up and bringing them back to her that day.

173 Q. So she was on a form of opioid agonist therapy that required her to go to a pharmacy every day?

A. Yes.

174 Q. There are forms of opioid agonist therapy that do not require that; is that true?

A. Yes.

175 Q. Was there any consideration given to putting her on a form of opioid agonist therapy that would --

A. I was not her addiction medicine doctor.

MR. CHOUDHRY: Mr. Diacur, I understand -- I mean, I think -- just if I could clarify, I think she provided addiction-related treatment on an inpatient basis but not on an outpatient basis, and she's indicated that another doctor did.

A lot of the questions you're asking are about outpatient addiction treatment care that this witness is not -- doesn't have information about. So I'm not sure what the value

is of asking her questions about treatments she didn't provide.

MR. DIACUR: Comments noted, Counsel.

She references opioid agonist therapy in the document that she's attached and I'm examining her on her statements.

MR. CHOUDHRY: Yeah, but I think she also has clarified, Counsel, with respect, that she provided therapy on an inpatient basis, and you're asking lots -- and she's also indicated and given you the name of the physician who provided her addiction therapy on an outpatient basis, and she said she didn't provide that; she only provided wound care.

And on one occasion, I believe, she's provided evidence that she went to a pharmacy to get that medication. So I'm not quite sure what else she can tell you other than to say she doesn't know. And she shouldn't be giving evidence about care she didn't provide and doesn't know about, unless she --

MR. DIACUR: I certainly agree with you on that, Counsel.

MR. CHOUDHRY: Yes, and --

MR. DIACUR: I'll take that answer as -- I'll take that as noted.

MR. CHOUDHRY: Yeah. Thanks, Mr. Diacur.

I just don't know what the value is of asking her about care that she wasn't responsible for providing.

MR. DIACUR: No, I agree.

176 Q. So let's move on to --

A. I just want to -- Counsel, do you know the difference between inpatient and outpatient? Do you know what those terms mean?

177 Q. Yes, I understand --

A. Okay. I just wanted to be sure. I wondered if that was the --

178 Q. No. I appreciate the comment of counsel stating that you shouldn't be giving evidence about something that you didn't do.

A. Yes. I agree as well.

179 Q. So in Exhibit C to your affidavit, this is a letter dated June 2, 2022, regarding a Sherri Ogden.

It appears from this letter that you treated Ms. Ogden at least once; is that true?

A. I treated her many times, yes.

Many times.

180 Q. And is it the case that you did not obtain a complete medical history or examine Ms. Ogden with respect to medical -- or with respect to mental health complaints? Is that accurate?

A. That is untrue. Entirely untrue.

181 Q. Well, if I'm reading this letter correctly, you state:

"She has only ever seen SHN practitioners for issues related to contraception, poor sleep or aches or pain and various rashes." (As read.)

A. Yep.

182 Q. That's true?

A. Yes. And when you -- when you see someone -- when someone walks in to say, "This is my concern," I look at that patient's concern and I also look at the whole person, every time they come to see me.

So they -- they are here because they have a rash. I am there. I see the rash and I look at the whole person, and I see their

past -- I see the mental health issues that they're struggling with, and I see all the social determinants of health that are causing poor health outcomes. I see that stuff as well.

So that is part -- they're coming to us with one thing, because that is their concern, and as a doctor with the years of experience I have, I am looking at the whole person and I am seeing the background stuff. So yes, every time she came to see me, I would also see the fact that she had significant undiagnosed mental health issues.

183 Q. Yes. You refer to undiagnosed mental health illness.

You're qualified to diagnose mental health illnesses?

A. Yes.

184 Q. And you did not diagnose Ms. Ogden with any mental health illness?

A. That I can -- so I can't -- I have not looked in my -- in those medical records recently, and I can't recall if I have -- if -- I can't recall.

185 Q. Did you ever see Ms. Ogden subsequent to writing this letter?

A. I'm -- I don't recall.

186 Q. You refer to any mental health illness she may have as undiagnosed. Can we not infer from that that you did not diagnose her with anything?

A. No, I would say we can't, because it doesn't say that I have -- that I have actually not diagnosed certain mental illnesses as well. So I may very well have diagnosed certain illnesses, but there may have been other ones that were undiagnosed.

187 Q. You've not provided any medical records or reports with any diagnosis with respect to any mental health issue suffered by Sherri Ogden; is that true?

A. In this letter? No, I have not, yes.

188 Q. And, in fact, in your affidavit, you've not provided any medical records or reports of your diagnosis of any mental health issue by any person?

A. Correct. There's no -- there's no -- yeah, no medical records that are attached, just the letters.

189 Q. There is no treatment plan

attached to this medical letter or any treatment plan for Ms. Ogden, period?

A. No. As noted, I'm not her -- I was not her family doctor. She has a family doctor outside of Shelter Health Network, who she also sees sporadically, who would have -- who would presumably have more medical records.

190 Q. Did you provide any medical care to Ms. Ogden with respect to the issues of contraception, poor sleep or aches or pains and various rashes?

A. Yes.

191 Q. Did anyone else at the Shelter Health Network do so?

A. I am -- I don't know. I think likely -- I think it's highly likely, but I can't be certain without looking at the medical record.

192 Q. Do you know where you saw Ms. Ogden, in a clinic or in an encampment?

A. I definitely saw her at the Wesley Drop-in Centre, the Wesley Day Centre, and I can't recall if I've seen her in other places.

193 Q. You refer to some hospital records in this letter. Did you see Ms. Ogden when she accessed an emergency department?

A. No, but the reference to that goes back to how I say we find our medical records on people. You go into hospital records and look to help build a bigger picture and understanding of the issues at hand. It's part of being a comprehensive and good doctor.

194 Q. You reference Ms. Ogden suffering from functional pain. Is that something that you diagnosed Ms. Ogden with?

A. Let me look.

No. I do indicate that these are hospital records. All the hospital records were noted to be visits for functional pain, which is commonly seen in people that have mental health issues.

195 Q. Is that something that you treated Ms. Ogden for?

A. Yes, and I referenced that we would see her for aches and pains -- poor sleep or aches and pains and various rashes, so yes.

196 Q. Is functional pain something that is a symptom of withdrawal from opiates?

A. No. Not necessarily, no.

197 Q. Is --

A. Pain can be. Pain can be, but

not functional pain, necessarily.

198 Q. Not necessarily. So sometimes it is?

A. No. No, it's not. It actually -- it would be a different diagnosis of pain.

199 Q. I'd like to turn to Exhibit D to your affidavit. This is a letter dated June 3, 2022, with reference to a Patrick Ward.

Do you have that?

A. Yes.

200 Q. How did you see Mr. Ward for medical treatment?

A. I don't understand the question.

201 Q. Did you see him in a clinic setting or in an encampment?

A. Mostly in a clinic setting, and sometimes I would see -- I believe I may have -- actually, I can't be absolutely certain if I saw him in an encampment. I'd have to access my medical records.

202 Q. And you've not attached any medical records to this letter; is that accurate?

A. That is accurate.

203 Q. In paragraph 2 there's a list of different portions of a past medical history. Is that something that you treated Mr. Ward for?

A. Every single one of those issues? Is that what you're asking?

204 Q. Yes, the list.

A. I think it's unlikely that I treated him for every single one of these issues. No. A past medical history is not about what one doctor has treated someone for. It's their -- over their health history.

205 Q. So it's possible that many other physicians have provided treatment for Mr. Ward with respect to all of these things?

A. No. That's unlikely because he is someone that doesn't access health care regularly. But he -- he will -- and hepatitis C, for example, sometimes people never receive treatment for that.

206 Q. But this is a past medical history.

A. Right.

207 Q. So, clearly, he has received some form of treatment for all of these things; isn't that accurate?

A. That is absolutely not accurate. You do not -- you have your hand up. Sorry.

No. People can have medical issues that do not get treated and that never get treated because their mental health might be too poor, because their housing -- because all sorts of -- all sorts of reasons why they might never receive care for their -- for their health issues.

Having a diagnosis of something absolutely does not mean that you are -- that you have at some point in your life received care for that. You have received a diagnosis. You have not necessarily received care.

208 Q. I see. So you're drawing a distinction between seeing a doctor and the doctor doing anything to assist?

A. No, that's not what I'm doing. You assist a patient in many ways, not just by handing them a pill and not just by treating their whatever it is. Every time you see a patient, when you have -- when you have a patient-centred encounter with that patient, you have been assisting that patient.

209 Q. So does diagnosis include

treatment?

A. No.

210 Q. So you're drawing a distinction between diagnosis and treatment.

You're saying that Mr. Ward has a past medical history of diagnosis with this list of things -- alcohol use disorder, stimulant use disorder, peptic ulcer disease, pancreatitis, hepatitis C, major depressive disorder, osteoarthritis causing chronic pain, as well as previous fractures in spine, pelvis and wrist causing chronic pain, and substance-induced psychosis -- is that accurate?

A. You just read a big, long list. What did you start with? What was the question?

211 Q. Mr. Ward has been diagnosed with all of these things --

A. Yes, he has. He's been diagnosed with all of -- and I've actually treated him for many of them, but not all of them.

212 Q. You've provided treatment to him for some of these things?

A. For many of them is what I just said.

213 Q. And you are unable to tell me whether any other medical practitioner treated him for any of the others or for some that you --

A. Oh, he had -- for his peptic ulcer disease, he was in the -- he was -- had an inpatient stay in hospital receiving blood transfusions because he was -- he nearly died during a perforated peptic ulcer disease. So he -- he received hospital care for that, yes.

214 Q. For the aspects of this list that you've not provided treatment, you're not able to tell us whether anyone else has provided treatment?

A. I just told you that he received treatment in hospital by other providers as well.

215 Q. You mentioned in the third paragraph that Mr. Ward has been sleeping rough. What does that mean?

A. Sleeping outside unsheltered.

216 Q. Does that include --

A. Or in a tent. It could -- it's sleeping when you're outside.

217 Q. Does that include being housed in a shelter system?

A. No. Sleeping rough is sleeping outside.

218 Q. Potentially in a tent, potentially completely unsheltered?

A. Correct.

219 Q. And you're not aware of the full chronology of when Mr. Ward has been sheltered indoors versus not?

A. I would have to access my notes, and even then I'm not sure it would give an exact chronological picture.

220 Q. In the fourth paragraph, you mention that Mr. Ward was unable to tolerate the close quarters of homeless shelters and all of the stress that these can incur on individuals. That's what he reported to you?

A. Yes.

221 Q. Is that something that you've seen firsthand?

A. Commonly, yes.

222 Q. No, I mean in Mr. Ward.

A. Yes.

223 Q. How did that come to pass?

A. He -- given his -- he just shuts off. He gets -- he has to leave. He has a

hard time with all the close quarters. Like many people who have very significant mental health issues, it makes his stress level go really high. He would feel extremely uncomfortable and he wouldn't be able to tolerate. It was -- it was very clear.

224 Q. Again, this is something he's reporting to you?

A. Well, and I saw it.

225 Q. Where did you see it?

A. I would -- I would also see him in -- I mean, when I saw him even inside a crowded soup kitchen, if he wasn't sleeping, which he often was, but if he would -- you know, if he was up, he would often not being able to tolerate being in large crowds for a long time.

226 Q. When would you have seen him in a soup kitchen?

A. At the Wesley Day Centre, where I provided care for him.

227 Q. Anywhere else?

A. I can't recall. It's possible. I can't recall.

228 Q. I'd like to move to Exhibit E. This is a letter dated June 8, 2022, with respect

to a Jahmal Jammy Pierre.

Do you see that?

A. Yep.

229 Q. Now, from the letter, it appears that you may have treated Ms. Pierre once when doing outreach work. It's not clear. Do you recall how many times you saw Ms. Pierre?

A. Let me see here.

I saw her on three occasions. Well, me or another person saw her on three occasions for --

230 Q. That's the area that I'm unclear on. It says that she's only been seen on three occasions. Do you recall seeing her on more than one occasion?

A. I -- I don't recall, no. I can't be absolutely certain that I saw her other than that very significant overdose in the street that I talk about here.

231 Q. So it's possible that parts of this letter are based on the reports of others?

A. Well, that's what -- an electronic medical record is made up of -- of reports of all the health-care providers -- I mean of all the doctors that are part of that specific

-- you know, in this case, Shelter Health Network. So it's her Shelter Health Network record that I would have accessed.

232 Q. And those records are not identified or included with this letter?

A. Correct.

233 Q. You indicate here that records indicate that the overdose was unintentional, the significant overdose that you just referenced?

A. Let me see.

Well, I see that she told me they were entirely unintentional, that she described it as entirely unintentional, as most overdoses are.

234 Q. Now, did she describe that to you, or was that somebody else that reported that description within a reference for it --

A. Oh, she was --

235 Q. -- on the medical note?

A. She described that directly to me, and I would have then put it in her medical record.

236 Q. I just want to be clear. What the letter states is:

"She was encouraged to follow up with doctors at the YWCA after that

incident, and that is when she saw my SHN colleagues. Ms. Pierre described this overdose as entirely unintentional." (As read.)

A. Yeah. She -- she described that to me. I responded to her overdose with multiple doses of naloxone in the street. We called EMS. She went straight to the hospital. As noted, I am also an inpatient addiction specialist, and I subsequently saw her in the hospital several hours later, hoping to engage --

237 Q. I see. I understand now. I think that there's confusion over the timeline.

A. Okay.

238 Q. So at the second paragraph of this letter, you state:

"On one occasion in August she had an unintentional opiate overdose and was hospitalized in the intensive care unit for a period of time." (As read.)

A. Yep.

239 Q. In the third paragraph, you reference a different time, November of 2020, and you say, "I was doing outreach work and saw

Ms. Pierre slumped over," and you recognized that she'd suffered an opiate overdose.

A. Oh, yes.

240 Q. Then you're talking about the occasion in August, and you say that she saw your SHN colleagues and that Ms. Pierre described the overdose in August as entirely unintentional.

A. She may have told me -- she may have told me that -- well, I know she told me that her opioid overdoses were unintentional. One of the things is that she wasn't an opiate user. She didn't -- she didn't have opioid use disorder.

So she was entirely opiate-naive and she used a contaminated supply of a stimulant, and that is why she had such a severe overdose, because she had no tolerance to opiates. So that is -- so she would tell me each time, "Oh, my God, I can't believe I overdosed," and when I say "unintentional," she unintentionally used opiates. She did not want to use opiates.

She had -- she -- she had a stimulant use disorder and used a contaminated supply. So I referenced that many of my patients have died in this scenario when they have no opiate tolerance and use a contaminated supply of

a stimulant, yeah.

So each time I saw her, she would say, "I --" you know, that it was entirely unintentional. She didn't -- what I mean by that, it was unintentional that she used opiates at all. She thought she was accessing either crack or crystal meth.

241 Q. And then she became diagnosed with opiate use disorder subsequent to that time? It's indicated there --

A. She absolutely very well may have. So those -- those overdoses, oftentimes someone with stimulant use disorder might go on to develop opiate use disorder. That would not be uncommon. But with those, the specific overdoses that I am referencing here, she has -- they were when she was opiate-naive and only using stimulants.

So she -- she did -- subsequently, after these, she developed opiate use disorder because that is something that -- as noted, that is something that you often, you know -- it can lead -- one can lead to another. So she initially was a stimulant -- had stimulant use disorder only, had these unintentional overdoses, and then

started using opiates and did develop an opiate use disorder.

242 Q. You indicate in the second paragraph:

"She was not at a point where she was ready to engage with treatment for her substance use disorders."

(As read.)

Is that based on your assessment of her or based on a review of notes?

A. I'm not sure. Probably both.

243 Q. There's no indication in this letter of any options being presented to her for treatment for her substance use disorders; is that true?

A. The fact that she was in the emergency department and went to the ER and was seen by multiple doctors and was even seen by me in the ER as the inpatient addiction doctor, it is absolutely presumed that she was -- and, in fact, I remember very clearly begging her to get on opiate agonist therapy, would help -- which would help protect her from future overdoses.

244 Q. That's not referenced anywhere in this letter?

A. And I -- I reference that I saw her in the ER, I believe. Yeah. I went specifically to the ER to see her and try to engage with her further to -- to start some treatment, which would help protect her from future overdoses, namely Suboxone, buprenorphine.

245 Q. And it was determined she was not ready for that?

A. She determined that, indeed. She determined that.

246 Q. I'd like to turn to Exhibit F to your affidavit now, a letter dated June 9, 2022, with reference to a Mario Muscato.

Do you have a copy of that?

A. I do, and I'm looking at -- yeah. Yeah. Okay. Let's keep going.

247 Q. You state in the letter that he can't get regular treatment but also that he sees you -- or saw you regularly, several times a week, in fact, on the second page of this letter.

A. Yep.

248 Q. That's accurate?

A. Yes. So by "regular treatment," I mean getting to a pharmacy every day to get a dose of opioid agonist therapy. He was

not able to manage that. His -- he was sleeping in a different place every night and not able to get there.

249 Q. Right. And I think we established earlier that there are other forms of opioid agonist therapy. You referenced buprenorphine; right?

A. Yes, and that is appropriate for some people and it's inappropriate for others.

250 Q. It doesn't need to be administered daily?

A. That is an -- that's an injection that is monthly that -- at the time, it was a very new -- it was newly covered in Ontario at that time, but unfortunately it was not in keeping with Mr. Muscato's goals. It would not have been an appropriate medication for him.

251 Q. Well, you mention in this letter that there were times that Mr. Muscato would receive two weeks of opioid agonist therapy. Is that true?

A. If I wrote it in the letter, it's true. I -- it's a rather lengthy one, if you want to remind me where that is.

252 Q. So we can go to that. It's in

the first full paragraph on page 3. So it's on the screen now:

"There were times when he would receive two weeks of opioid agonist therapy consistently but then he would be service-restricted from a shelter or moved to an encampment and he would lose that stability and have to restart again down the road." (As read.)

That's accurate?

A. Yes. Over and over, yes.

253 Q. Now, if I understand how buprenorphine works, there's a week of Suboxone first, which is administered daily at a pharmacy, and then there is the injection you referenced, which lasts for a month, and that's the buprenorphine; is that accurate?

A. That is only one way that it can be -- and I -- there are intricacies to addiction medicine that specialists -- I mean, I could talk to you about five different ways of starting buprenorphine, and I'm not interested in explaining that to you here because I have patients that are waiting to get it from me at my

clinic right now, but yes.

254 Q. Is what I just put to you accurate?

A. No. It is only one way that buprenorphine is started. Buprenorphine is started many different ways.

255 Q. Mr. Muscato showed the ability to, for a period of two weeks at a time, attend daily and receive opioid agonist therapy. He could have attended for one week to receive Suboxone; isn't that true?

A. If he wanted Suboxone, that would have been true. As I've noted when you asked me about all the different types of opioid agonist therapy, I said different ones are appropriate for different people, and it is -- the number-one thing is patient preference.

And when someone does not have buy-in to a certain type of opioid agonist therapy, it is by far -- what kind of paternalistic approach would I be if I said, "This is what you need, because I know better than you what you need."

Of course I would offer every single type of opioid agonist therapy to every

patient I had in hopes that they would take one to somehow have higher chances of remaining alive down the road. But they do not -- when they are -- they will decline certain types of medications that are not in keeping with their goals, and he declined Suboxone.

256 Q. You're saying that you did offer it to him and he declined it?

A. Many times. And there -- and yes, he was also -- we even tried Suboxone at different times. We tried several different types -- I think we've -- I think we tried all three different types of opioid agonist therapy with him, including methadone, buprenorphine, and Kadian, all three lines.

257 Q. Is there a reason that wasn't referenced in this medical letter?

A. Because I'm -- there's -- this is a lengthy letter and there's no reason for me to -- I mean, I'm not -- I don't know what you -- for some reason, you would think you would need to know that I -- I, you know, try to get my patients to access opioid agonist therapy every single time I see them in an effort to help them stay alive.

That is actually something that one

would assume an addiction doctor is doing every day that they see the patient. That's -- I wouldn't -- I wouldn't presume that would have to be written down in a letter. I provided -- I saw him multiple times a week at times when he was able to get in to see me. I was his addiction medicine doctor and I provided him with all sorts of different avenues for care.

258 Q. You'd agree that it is the case that doctors have more information about what treatments are available or appropriate than patients?

A. I don't. People -- people with opioid agonist therapy are on -- are always taking to each other on the street. They're always discussing different -- what people are doing here, what people are doing there.

Only when a new therapy becomes available would a -- would a doctor necessarily have more information than a patient. I mean, you know, certainly there are certain patients that are more informed than other patients, but patients come to us very well-informed about what's available.

259 Q. Would you consider

Suboxone and buprenorphine more appropriate for a patient who has difficulty attending a pharmacy daily?

A. I would -- not necessarily. Again, I told you it's about patient goals. And I could sit here and describe the pharmacology of buprenorphine. Buprenorphine -- which I -- which I'm not very interested in doing right now.

But buprenorphine blocks opioid receptors. Some people, in a harm reduction approach, they still want to be able to access a high, a euphoria when they use. When you use -- when someone is on buprenorphine, it will be harder for them to have any sense of euphoria.

Again, people access this euphoria because they are -- they are having a lot of -- often self-treating mental health issues and other stresses in their life. So when people are on buprenorphine, it is much harder for them to actually have any sense of euphoria and to get high. So many people don't want buprenorphine at all.

260 Q. Did you ever provide treatment to a Linsley Greaves?

A. I -- I believe I did, yes. I

don't have an affidavit here in front of me.

261 Q. No, I understand that.

We've heard his evidence, and he said that he saw you for a complaint of frostbite. Do you have any recollection of that?

A. Yes. I do remember him having frostbite. Clearly, actually. Yeah.

262 Q. I'm going to show you, briefly, his affidavit because he makes some reference to you. I'm just going to click through to that.

So what I have on the screen is the Affidavit of Linsley Greaves sworn June 2, 2022, and at paragraph 32 he states:

"I only learned of this application today after meeting with Dr. Wiwcharuk at the Wesley Day Centre for treatment of my frostbite." (As read.)

A. Yes. Mm-hmm.

263 Q. Is it true that you were the one who informed him of this litigation?

A. Sorry, do I -- I don't have an affidavit in front of me for -- am I here to provide -- I'm just trying to -- am I missing

something? Am I supposed to have an affidavit about my information for Linsley Greaves?

MR. CHOUDHRY: Dr. Wiwcharuk?

THE WITNESS: Yeah?

MR. CHOUDHRY: There's an affidavit on the screen.

THE WITNESS: Yeah.

MR. CHOUDHRY: That's from Mr. Greaves.

THE WITNESS: Yep.

MR. CHOUDHRY: And there's a statement there --

THE WITNESS: Oh, yeah.

MR. CHOUDHRY: -- at paragraph 32, and I think you should -- I think Mr. Diacur is asking you a question based on Mr. Greaves' evidence, which he's put on the screen for you to review.

THE WITNESS: Okay. Yeah, mm-hmm. So yeah, I believe that's accurate. Yeah.

MR. DIACUR:

264 Q. Can you tell me what you told Mr. Greaves about this litigation?

A. I can't recall. I -- I'm -- I can't recall with certainty. I suspect that --

based on what I'm seeing here, I do absolutely remember him, his frostbite. I remember his toes were essentially autoamputating; they were starting to fall off.

I had -- I had seen that he had -- he had sustained significant harm from being unsheltered, from losing his tent, from losing his source of warmth, and we were in the middle of some -- of, you know, this litigation that was coming up, and I asked him if he wanted to -- if this -- he -- he was distraught at this and very angry at the fact that it had happened.

And I asked him if he would like to -- if he'd like me to connect him with someone who -- with one of the lawyers who was doing some work, and after that I made a connection. And that would have been the extent of my -- my part in letting him know about that.

265 Q. And he references, at paragraph 31 just before that, getting frostbite on his left foot and toes last winter.

A. Yeah.

266 Q. You saw him in June of 2022; is that accurate?

A. Yep, and that's about how long

it takes for toes to autoamputate. It's a long process.

267 Q. So frostbite doesn't always result in amputation?

A. No, not always. Not always, but many times it does. It's very common. I have many patients who are missing the ends of multiple digits, and it can take up to six months or even longer for them to slowly, again, autoamputate, kind of fall off. They become black and they eventually fall off.

268 Q. In particular, it's unlikely that frostbite will result in amputation if it's treated properly?

A. That is inaccurate.

269 Q. In what way?

A. In that frostbite, once you have -- so frostbite is difficult -- is just about impossible to treat. Once you have established frostbite and you have lost those capillaries, it is a waiting game. You can't get back circulation to tissue that was -- that has been lost to frostbite. So the only way to ensure that one does not lose digits from frostbite is to ensure that frostbite does not happen.

270 Q. When Linsley Greaves presented to you with this frostbite that he says was months old, did you refer him for any treatment? What did you do?

A. I -- I don't have an affidavit in front of me and I haven't referenced his medical records. So I don't know. This is a question out of the blue. This is over, you know --

271 Q. You recall meeting with him and you recall his frostbite. Do you recall what treatment you recommended or referred him for?

MR. CHOUDHRY: Mr. Diacur?

MR. DIACUR: Yes?

MR. CHOUDHRY: Out of fairness, could you maybe scroll through the affidavit to the top so she can at least read the rest of this affidavit before she answers questions about it?

MR. DIACUR: Well, I'm not asking her about the affidavit in front of her.

MR. CHOUDHRY: I think --

MR. DIACUR: She remembers meeting with him. I'm asking if she remembers what treatment was recommended.

MR. CHOUDHRY: So, Mr. Diacur,

you're putting to her an affidavit from another witness. I think it's fair when anyone does that in this proceeding to any other witness that they be provided with that affidavit in full and they be able to review it.

MR. DIACUR: I disagree. I think that --

MR. CHOUDHRY: Well, I disagree with --

MR. DIACUR: -- she understands what I'm asking her. I'm asking her about a meeting that she recalls. I'm only asking her if she recalls what treatment she recommended at that time. That's it.

THE WITNESS: I don't recall.

MR. DIACUR:

272 Q. Thank you.

So just a brief indulgence. I believe I may be finished. I just want make sure that I haven't inadvertently skipped a question. Just a moment.

A. So I will have a brief indulgence after that, if you don't mind.

MR. DIACUR: Yes. I confirm those are all of my questions for this witness.

Thank you, Dr. Wiwcharuk, for attending and answering.

THE WITNESS: I am appalled that you took this long when you had me here for half an hour.

MR. CHOUDHRY: Dr. Wiwcharuk, please --

THE WITNESS: Okay.

MR. CHOUDHRY: Okay, please. We're all doing our best here.

So, Dr. Wiwcharuk, now what happens is there's something called redirect, and we realize that you have patients and I can see the impatience in your face and I'm very, very sorry about this.

THE WITNESS: Okay. All right.

MR. CHOUDHRY: We have a couple of different options, and I'm trying to do this collaboratively with our friends from the City. Option one is that we take a short break so that Ms. Crowe and I can collect ourselves and assess what the scope of the redirect would be, and Ms. Crowe would lead those questions. She would try to be as efficient as possible. I expect she would be 10 to 15 minutes.

MS. CROWE: Yes, no more.

MR. CHOUDHRY: No more than 10 to 15 minutes.

Option 2 is to do what we call -- is to not dismiss you but to what's called adjourn this cross-examination and then to schedule, at a time that works for everyone, the redirection by Ms. Crowe, which again would be no more than 10 or 15 minutes. But if we were to do that, I have to put on the record that you are still under oath.

THE WITNESS: Yep.

MR. CHOUDHRY: You cannot speak with me or anyone from this legal team. You cannot be in touch with us.

THE WITNESS: Yep.

MR. CHOUDHRY: You cannot speak with anyone else about this evidence or this testimony. You are still under oath. You have to be -- unfortunately, you have to be in -- you're in that room for the purpose --

THE WITNESS: Yep. That's no problem. That is no problem at all.

MR. CHOUDHRY: I just want to clarify that it's very natural to want to speak with partners or loved ones about these

experiences, and you can't.

THE WITNESS: No.

MR. CHOUDHRY: Okay?

THE WITNESS: Yep.

MR. CHOUDHRY: So given that we're way past time, I think we'd like to present you with these two options: Push it on a bit further, with giving us a bit of a break -- so 10 minutes of a break and then 10 to 15 minutes more, possibly, so 20, 25 -- or we adjourn under those very strict conditions and we work with you simply -- we communicate with you simply for the purposes of scheduling, and the communications will be with all counsel copied on these emails.

THE WITNESS: That is -- yeah.

MR. CHOUDHRY: So what would you prefer of those two options?

THE WITNESS: Thank you very much for giving me the option. I have to take number two. I'm so sorry because I know it's just harder for everyone involved. I'm really sorry, but I do -- I am -- I have a commitment to my patients who are all waiting for me right now.

MR. CHOUDHRY: So just to be clear, and, Mr. Diacur, just -- so what we will do is we

will adjourn this cross-examination but not dismiss.

We will -- you and I or someone from our team and someone from your team, Mr. Diacur, will work -- will communicate jointly to Dr. Wiwcharuk to propose some alternative times. She's on the west coast, I'm gathering. So there's a three-hour time difference that we should be alert to.

And we will be in touch with you as soon as possible, Dr. Wiwcharuk.

Mr. Diacur, is that acceptable?

MR. DIACUR: That's fine.

MR. CHOUDHRY: Okay, good. Thank you.

THE WITNESS: I can be very flexible because in, like, three hours I am on vacation for two weeks. I can -- anytime you tell me, I can be available.

MR. CHOUDHRY: Okay. We will be -- we really are grateful for your time, and we will jointly be in touch with you; okay? And so please -- don't call us; we'll call you. Okay?

THE WITNESS: Okay. Thank you.

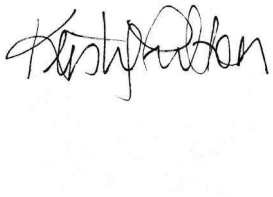
MR. CHOUDHRY: Okay. Thank you.

MS. CROWE: Thank you.

--- Whereupon the proceedings adjourned at 12:53 p.m. sine die

* * * * * * * *

This is to hereby certify that the foregoing is a true and accurate transcript of DR. JILL WIWCHARUK to the best of my skill and ability.



_____

Kristy Fulton

Court Reporter

TAB 7

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 Continued Cross-Examination of **Dr. Jill Wiwcharuk**, on Affidavits dated October 3rd, 2021, and June 7, 2024, taken upon affirmation in the above action this, 6th of September, 2024, **conducted via videoconference hosted by the offices of Nimigan Mihailovich Reporting Inc.**

APPEARANCES:

For the Applicants:

For the Hamilton Community Legal Clinic:

SHARON CROWE

For the Community Legal Clinic of York Region:

MICHELLE SUTHERLAND

NONYE OKENWA

BENJAMIN HOGNESTAD

For the City of Hamilton:

JORDAN DIACUR

JOJO JOHNSON

Gowling WLG (Canada) LLP

I N D E X

PAGE

WITNESS: DR. JILL WIWCHARUK

Re-Examination by MS. CROWE 29

EXHIBITS

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:

(None noted).

--- Commencing at 1:23 p.m.

DR. JILL WIWCHARUK,

THE WITNESS HEREINBEFORE NAMED,

Having been duly sworn by me to testify to the truth, testified on their oath as follows, to wit:

RE-EXAMINATION BY MS. CROWE:

70 **Q.** This is a follow-up to the examination that took place a couple of weeks ago with Mr. Diacur. And so you indicated that you were practising with Shelter Health Network and HAMSMaRT at the time of completing your affidavit.

Are there other doctors with either of those organizations?

A. Yes.

71 **Q.** Do you know how many?

A. I don't know exactly how many there were with Shelter Health Network. It was at least 18. At least 18. And with HAMSMaRT, there were, I believe, three.

72 **Q.** Okay. And were there any other types of medical practitioners with either organization?

A. Oh, yes, many. Certainly with Shelter Health Network, there were numerous nurses, and nurse practitioners, and social workers.

And with HAMSMaRT, there were peer workers

and a midwife. Yeah.

73 **Q.** Okay. What about non-medical practitioners working with either organization?

MR. DIACUR: No. I object to that. That's not a new issue whatsoever. There's nothing asked of her about nonmedical practitioners and there is no ambiguity in her answers about these questions.

That's not proper re-examination, counsel.

BY MS. CROWE:

74 **Q.** Okay. That's fine. We will move on.

Mr. Diacur asked you about what information sources for patient records you consult and you indicated that you often access hospital records, former psychiatric records, other doctors' records.

Was this is an exhaustive list of where you might get information about a patient's history or are there other sources of information?

A. There are other sources. I would also talk to a pharmacist. I would look at pharmacy records, especially regarding opioid agonist therapy because it would help me know what they have been taking and how often they're getting their medication if they are missing doses, et cetera.

And sometimes it would also just be calling another doctor and speaking over the phone without getting

official records, but calling. And as we are all part of the circle of care, and discussing the patient, and working together to provide best care.

75 **Q.** Sorry, what do you mean by "circle of care"?

A. Circle of care is when there are multiple different providers involved in providing care for someone. Yeah. So that would be a circle of care.

And I would also, with patient's consent, I would also speak to, for example, shelter workers about issues, and housing workers, and even ministry workers.

If there's any involvement with the Ministry, often people are obviously on social assistance, and ministry workers can be an area of support. So with patient consent, I would speak to many different people.

76 **Q.** Okay. And Mr. Diacur also asked about steps that you take to account for the possibility that there might be inaccuracies in a patient history; and you responded that you cross-reference:

> "We checked things in emergency records. We checked things in addiction records. We call other providers to get collaboration."

What are the other providers you are referring to?

A. The other. Well, for example, sometimes I will be the addiction doctor for someone and they have a family doctor elsewhere. There was one patient in particular we had discussed about that.

So, yeah, their family doctor would be a very important source of collaboration.

77 **Q.** Okay.

A. Yes. Sometimes -- I'm trying to think of other. You are asking about other healthcare providers in particular?

78 **Q.** You just indicated you call other providers --

A. Yeah.

79 **Q.** -- in collaboration?

A. A pharmacist also would be another source because they see a patient every single day for their OAT, when they are on opioid agonist therapy. So sometimes I would want to know, hey, are they getting their dose every day. And also how are they when they come in. Are they reliable? Do they look like they are in a reliable and mentally health space when they are there because certainly pharmacists are big collaborators with us as well.

80 **Q.** Okay. And then you mentioned "accessing addiction records". Where are those records that you

would have access to?

A. So accessing addiction records. Do you remember the context in which I said that just so that I know exactly what?

81 **Q.** Yes. It was a question about potential inaccuracies and having a fulsome having a sense of a patient's medical history.

A. Yeah.

82 **Q.** And you were explaining what things you might check or cross-reference.

A. Yes. So hospital records are really important because it can even tell us the reasons that people are visiting the emergency department.

It could be very clear that they are being seen for addiction-related issues or addiction-related sequela. So I can see, for example, that they were seen for multiple abscesses, for example, for many years back; and then I could say, Is it possible that you been injecting for this long because I see that you've been seen for a lot of abscesses, and then it might help clarify a timeline.

Do you know what I mean?

So hospital records would be a really good source of that.

And also whenever someone is on social

assistance, you can -- and their meds are getting paid for them, that's just about every single addiction patient that I would see, there is a provincial record of their medications that I can access. So I can see how long they've been receiving methadone, or Suboxone, or whatever it may be.

83 **Q.** Thank you.

Mr. Diacur also asked you about what steps must be taken before you can give a valid medical opinion and put it to you that your opinion would not be valid if you didn't review the appropriate medical records and didn't carefully examine the patient.

There was some back-and-forth where you answered both yes and a no and so I would like to clarify.

In your past practice with Shelter Health Network and HAMSMaRT what steps did you take to ensure that you formed a valid medical opinion for a particular patient?

A. Well, it's communication with a patient. It's having an appropriate interaction with the patient so that they feel non-judged so that they can actually open up to me and tell me what they are feeling and that is something that addiction doctors do, I think, really well.

And so a lot of it is getting information from the patient. And then, again, if there's any

ambiguity -- some people are able to give you a very accurate history it's very clear that they are not at all feeling -- just that they are able to give you a really accurate history that is -- that they understand as well.

Some people have more understanding of health issues than others so some people need more cross-referencing than others. You know, when there is ambiguity, when people aren't sure, that's when I need to do some more checking; and with their permission, reach out to other people, and other people in their circle of care, to be asking and double-checking things.

But these, again, are generally patients that you get to know over weeks and months. Sometimes I would see people three times a week. You get to know folks really, really well. Like, I know about their struggles, you know, oftentimes in the past as well as the present; medical issues that they've let go to the wayside.

Other things are their goals as wanting to get healthcare issues taking care of.

These are not people that I meet on a one-off. These are patients that I know, I know really well, because addictions doctors see patients, again, like I said, sometimes multiple times a week.

So it is an ongoing part of their medical

history is something that you get on an ongoing basis.

84 **Q.** Thank you.

Mr. Diacur asked you about the medical history that you had for Sherri Ogden. And you indicated that every time she came to see, you would also see the fact that she had significant undiagnosed mental health issues.

What did you mean that you could see that she had significant undiagnosed mental health issues?

A. So she -- let's see, you know, there's a large part of -- so sometimes people have, for example, personality disorders, right?

So that is something, again, that takes and is often a process to diagnose. It might take quite a while of getting to know someone and observing how they interact with other people and the world around them.

Personality disorders. So I think you often as a doctor you often get a feel for someone having access to issues or personality disorders that have affected their way of interacting with the world and made things difficult for them.

I had a feeling that, and I'm quite sure that she has a personality disorder, and it's not really important for me to write that on her chart and formally diagnose that. It's just not, again, I wasn't her main

family doctor.

Also, again, I think that there is an intellectual disability. So that was obvious also with me interacting with her, speaking with her. I am suspicious -- and I have many patients who have Fetal Alcohol Syndrome, for example. Again, that is a really hard thing. That's really not diagnosable unless you know birth history and things like that; and neither is it really super relevant for the things that I was helping her with.

So she is coming to me with issues. I am in the background recognizing there's a whole lot of other stuff going on here, but that is undiagnosed that is not on -- it is not her priority right now to deal with. And it's not my place. It's not important for me to be writing down labels on her chart. I know.

I know that this is part of the whole picture of the person that I'm seeing in front of me and I can park that and go ahead with what her issues are on that day.

85 **Q.** What is your memory of Ms. Ogden and how she presented?

A. She was very, very vulnerable and mainly because she was so extraordinarily naïve. And I think that points to her repeated trauma that she would

experience. She -- I remember just feeling sick sometimes knowing that she was being taken advantage of by people on the streets because she just didn't have a strong voice for herself.

And, again, I think it -- she was also very small she's a very small person and she has a bit of a phenotype for Fetal Alcohol Syndrome. And I just was always thinking there's intellectual disability here. There is -- and she's got so many stacks against her.

And her whole thing, you know, she was just struggling with some of the most basic, basic issues like housing. Like staying warm at night. And then, you know, she had a mom and sometimes she would be putting her tent in her mom's backyard and it really spoke to intergenerational trauma and issues.

She is also part of a family that has -- I know that in the community, that there is, again, very much intergenerational trauma, and addictions, and mental health struggles.

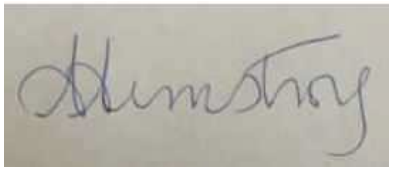
86 **Q.** Thank you, Dr. Wiwcharuk, those are my questions.

A. Okay.

--- The examination concluded at 1:38 p.m.

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 Continued Cross-Examination of DR. JILL WIWCHARUK, given under oath before me on the 6th of September, 2024.

Amy Armstrong, CVR-RVR



Certified Realtime Verbatim Reporter #7305

Certified Commissioner of Oaths

Certified this 8th of September,2024

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TAB 8

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. Timothy O'Shea**, on an Affidavits dated June 7, 2024 and August 12, 2024, taken upon affirmation in the above action this, 6th of September, 2024, conducted via videoconference hosted by the offices of Nimigan Mihailovich Reporting Inc.

APPEARANCES:

For the Applicants:

For the Hamilton Community Legal Clinic:

SHARON CROWE

For the Community Legal Clinic of York Region:

MICHELLE SUTHERLAND

NONYE OKENWA

BENJAMIN HOGNESTAD

For the City of Hamilton:

JORDAN DIACUR

JOJO JOHNSON

Gowling WLG (Canada) LLP

I N D E X

PAGE

WITNESS: DR. TIM O'SHEA

Cross-Examination by MR. DIACUR 5
Re-Examination by MS. CROWE 43

EXHIBITS

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:

[2] 10/4, 10/22.

--- Commencing at 1:45 p.m.

DR. TIM O'SHEA,

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:

1 **Q.** Thank you. So, Doctor, I have questions for you today about your two affidavits provided in this matter. They are dated June 7, 2024, and August 12th, 2024.

Do you have copies of those affidavits available to you?

A. I do have them on my computer, yes.

2 **Q.** Okay. My intention would also be to put copies of them up on the screen when I'm asking about them.

A. Sure.

3 **Q.** So that you can look at either version, but there will be a copy that's on the screen for you.

A. That's perfect, thank you.

4 **Q.** I will put that up and make sure that you can see it to begin with.

So on the screen now is your first affidavit, June 7, 2024.

You can see that, okay?

A. Yes, sir.

Q. Okay. So to begin with, you have not provided a copy of your CV or curriculum vitae in this matter; correct?

A. I don't think so.

Q. And you have not provided any studies or evidence regarding the capacity or the sufficiency of the shelter system in the City of Hamilton?

A. As far as I know, I have not.

Q. And you've not signed a document called an "Acknowledgement of Expert's Duty" or sometimes called a Form 53 in this matter; right?

A. I don't believe so.

Q. So, Dr. O'Shea, do you consider yourself independent in this matter?

A. What I consider is I provided my findings with respect to my patients. I'm independent as a medical practitioner in terms of assessing my patients.

Q. By "independent", I mean that you do not favour one side or the other?

A. My intention isn't to favour one side or the other, but to provide information about my patients.

Q. Understood. And you prepared the medical letters that are attached to your affidavit; is that right?

A. Correct.

Q. And you did so at the request of the lawyers for the Applicants; is that correct?

A. Correct.

Q. And they are addressed, in fact, to the Hamilton Community Legal Clinic; correct?

A. I can have a look and see. I don't --

Q. I'm putting the first of them dated June 13, 2022, on the screen.

A. Yeah.

Q. With reference to Kristen Heegsma. It says:

"To whom it may concern[...]"

And the address is the Hamilton Community Legal Clinic.

A. Yes, I agree.

Q. These letters, they were prepared around the time that this litigation began. Were they prepared, to your knowledge, after this litigation began?

A. I honestly don't know the timeline.

Q. Yes. You have not included in your affidavit the request or instructions you received from the Applicants' lawyers in preparing these medical letters; correct?

A. Correct.

17 **Q.** And is the any additional correspondence; emails, letters, notes of calls between you and the Applicant lawyers regarding the preparation of your medical letters?

A. From what I recall I was requested to provide information about my patients' health status as it relates to their housing status.

18 **Q.** Did you prepare these medical letters that are attached on your own or did you applicants' lawyers assist you?

A. I prepared these on my own.

19 **Q.** Did you review a draft of the Notice of Application in this matter prior to preparing the medical letters?

A. I don't believe I did. It's been a long time, but I don't believe I saw such a thing.

20 **Q.** Have you seen a Notice of Application in this matter at all?

A. To my knowledge, I have not.

21 **Q.** Did you speak with the applicants who are referenced in your medical letters prior to preparing your medical letters?

A. I see the Applicants on a regular basis so I spoke to them -- I speak to them frequently, multiple times a month.

22 **Q.** Okay. Did you speak with any of the applicants about the medical letters prior to preparing them?

A. I don't believe I did beyond getting their consent which was provided to me.

23 **Q.** Did you review the Applicants' own affidavits in any form prior to preparing the medical letters?

A. I did not.

24 **Q.** Have you reviewed those affidavits since?

A. I have not.

25 **Q.** And are you aware that a Dr. Koivu gave evidence in this matter?

A. I was given a list of people being cross-examined and I saw Dr. Koivu on that list so that is the extent of my knowledge of her involvement.

26 **Q.** Okay. But you would confirm that you've not provided any reply evidence responding to the affidavit or evidence of Dr. Koivu; right?

A. Correct.

27 **Q.** Would you agree that homelessness itself causes poor sleep, stress, anxiety, new medical conditions, worsening of existing medical conditions, and generally poor health outcomes in those experiencing homelessness?

MS. CROWE: I'm going to object to that. That is beyond the scope of what he is here to testify about.

---REFUSAL

MR. DIACUR: Well, again, that is not the test in terms of what can be asked of these witnesses. Anything relevant to this matter can be posed to them. It's not limited to what he states in his affidavit.

MS. CROWE: Well, he's here is a fact witness and not here to give opinion evidence about these issues at large.

MR. DIACUR: Well, that's also not something that has been settled. The's opinion in the affidavits that we've received so my question stands. If it's a refusal then, for the record, I would like for you to state that.

MS. CROWE: It's a refusal.

BY MR. DIACUR:

28 **Q.** Would you agree, Doctor, that homelessness as a general proposition is bad for you?

MS. CROWE: It's a refusal.

---REFUSAL

BY MR. DIACUR:

29 **Q.** Would you agree that in treating a patient it's important to obtain an accurate medical history?

A. Yes, of course.

30 **Q.** It is important that the medical history be comprehensive?

A. Yes.

31 **Q.** In the sense that it doesn't leave out anything significant?

A. I don't understand the question, I'm sorry.

32 **Q.** Well, I'm trying to get at what comprehensive means in terms of a medical history. A medical history would not be comprehensive --

A. I can give you a bit of an idea.

33 **Q.** A medical history wouldn't be comprehensive if it leaves out something significant; is that fair?

A. Yes. And I think the test of significance is dependent on the presentation of a patient. So I wear a number of different hats as an infectious disease physician. If I'm assessing somebody for HIV, for instance, then a different set of questions and a set of things that might be considered significant then if I'm assessing for an ingrown toenail or something else.

So certainly, a careful medical history should be taken on every assessment, and depending on what the purpose of the visit is, that will guide what types of questions I'm asking and what type of information I'm gathering.

34 **Q.** Understood. So the nature of the medical history that's required is something that the expertise of a physician allows them to determine?

A. Correct.

35 **Q.** Would you agree that getting a baseline for patient is important in terms of being able to tell whether they are getting better or worse?

A. Yes.

36 **Q.** Would you agree that to say that a condition has worsened requires a significant level of investigation?

A. Again, dependent on the condition, sometimes it's quite obvious. Sometimes very detailed investigations are required to determine if something is worsening or improving.

37 **Q.** And, again, that something that's within the expertise of a physician to determine?

A. Correct.

38 **Q.** Would you agree that patient self-reporting about their condition can be challenging because it's not clear what parameters the patient is using?

A. I don't know if I agree with that entirely. I mean, a lot of times I rely on patient self-report around a lot of their conditions in terms of what's getting better and what's getting worse.

Really, for me in a lot of cases what is most important is how the patient perceives their condition as improving or not improving. My goal is to make my patients feel better overall and so the self-report ends up being quite important in that instance.

39 **Q.** Would you agree that in inaccurate medical history could affect the reliability of an assessment or diagnosis?

A. Certainly. Yes.

40 **Q.** Would you agree that some patients, and some of your patients in particular, may not be able to give an accurate or comprehensive medical history for themselves?

A. I wouldn't qualify it as you did, as "my patients", in particular. I think, yes, I mean, patients have differing degrees of ability to recall, to report, et cetera.

I don't think it's better, worse, or other in the patients that I see. And, again, I see a lot of patients in different contexts so it's hard to generalize.

41 **Q.** Understood.

In taking a medical history from a patient, do you, as a physician, take any steps to account for the possibility that they may not be able to give you an

accurate or comprehensive report of their medical history?

A. Certainly. I mean, the medical histories are a very important part of the assessment of my patients. And, again, the importance of that changes over time.

Most of my patients I see extremely frequently, and regularly, and have long-term relationships with; and so as I get to know somebody, I can kind of get a sense of how much trust I can put in the self-report, if you will, and how much I need to rely on other sources of information.

I think the question was whether I look for other sources of information and certainly we do. We have a network of other physicians that we consult with. We have access to extensive medical charts, including the hospital charts, that we can review and do review on a regular basis.

We get reports from community pharmacists who are interacting with the patients on a daily basis. That's a very important point of contact for our patients and source of information for us in terms of how things are going overall.

We are in contact with social service agencies including workers in the shelters, workers with the Social Navigator Program, and we work very closely

with patient advocacy groups as well who have fairly intimate knowledge of how people are doing, again, on a day-to-day basis because they see them on a day-to-day basis and can report that back to us.

42 **Q.** Okay. Well, thank you.

You wouldn't render a medical opinion without gathering a comprehensive medical history, reviewing necessary medical records, and carefully examining the patient in question; correct?

A. Correct.

43 **Q.** You would agree that a medical opinion rendered without taking those steps would not be valid?

A. I mean, again, I think it depends on the degree to how much investigation is required depends on the condition that is being looked at.

So if I see someone who comes in with an abscess on their arm, I'm not necessarily going to review their entire medical history on their hospital records to make a diagnosis of an abscess and treat that abscess.

If I'm seeing someone with more long-term condition that requires like I had mentioned a more detailed investigation and more detailed information, then I'm going to seek that information.

44 **Q.** No. I understood. I'm talking specifically about a medical opinion, not determining

whether treatment is appropriate. Determining, for example, the cause of an illness, it would require those steps to be taken in order to be valid?

A. The cause of an illness can be determined by -- yes. I mean, it depends again on the illness in question. Sometimes it take a lot of time and effort to figure out what caused a condition and sometimes it takes much less.

45 **Q.** Sure. And that something like reviewing the necessary medical records, what's necessary is within your expertise as a physician?

A. Correct.

46 **Q.** Diagnosis of things like PTSD and Substance Use Disorder would require a full assessment of the patient; correct?

A. Correct, yes.

47 **Q.** The expected progression of a patient who is addicted to opiates and who is not getting treatment is to worsen. Would you agree with that?

A. I don't know if there's an expected outcome in that situation. I would say most people would not improve if they weren't getting treatment. I don't know if --

48 **Q.** I'm not saying not improve. I'm saying worsen. So not that they would stay static, but that

their condition would worsen.

Is that not the expected progression?

A. In my opinion, again, it would be hard to tell you what an individual patient's expected progression would be without treatment. It's, again, individual.

If you're asking me about a population level of what would generally happen, I think that what the evidence would show is that people would not generally improve without treatment I think. They would remain stable or worsen. I think those are both possibilities.

49 **Q.** Is it an accepted premise of addiction medicine that the goal is for the patient to stop using the drug?

A. I think in my practice of addiction medicine, the goal is to minimize the harms that are occurring to patients, and then to work with them to set their goals, and to help them achieve those goals.

50 **Q.** Now, opiate addiction can cause changes in the brain and affect executive function and decision-making; correct?

A. Opioid use can affect executive functioning and decision-making. If people are intoxicated with opioids, their executive function and decision-making would be impaired.

51 **Q.** And even when they are not using, the use

over a period of time can affect the brain in a negative way, affecting executive functioning and decision-making; correct?

A. I think depending on the situation, if people are experiencing withdrawal from not using that would affect their executive function decision-making.

I think if somebody is not using and has stopped using, I don't know that there is good evidence to support that their executive function decision-making wouldn't return to normal.

52 **Q.** Okay. An opiate-addicted patient may not be able to make decisions in their own medical best interests.

Would you agree with that?

A. I would object a little bit to the phrasing. I think that many different patients may not be able to make decisions about their own medical care regardless of whether our they are making substances or not. I think that is an individual assessment at the time of an interaction with a patient.

53 **Q.** All right. So I'd like to turn to your affidavit dated June 7, 2024, which I put back on the screen.

You do say at paragraph 2 that you are a physician with the Shelter Health Network, SHN, and the

Hamilton Social Medicine Response Team, HAMSMaRT. You indicate that you have worked with the SHN since its inception in 2007 and you also joined HAMSMaRT at its formation in 2016.

Is it fair to say that you are a founding member of both the Shelter Health Network and HAMSMaRT?

A. It would be fair to say that I'm a founding member of HAMSMaRT. I joined Shelter Health Network about two or three weeks after the founding members who are three family physicians started the organization.

54 **Q.** Okay. So essentially you joined a couple of weeks --

-- SIMULTANEOUS SPEAKERS --

BY MR. DIACUR:

55 **Q.** -- after its inception?

A. Correct.

56 **Q.** Okay. You are aware that HAMSMaRT previously sued the City of Hamilton alongside two of the current applicants, Mr. Caldwell and Ms. MacDonald, correct, in 2020?

A. Correct.

57 **Q.** Would you consider that HAMSMaRT is, among other things, an advocacy organization?

A. I think it is self-evident from our

website, et cetera, that one of the things that we do participate in is advocacy for patients according to what their needs and desires are in terms of where they want advocacy to be directed.

58 **Q.** But also by participating in litigation.

A. If needed, yes.

59 **Q.** All right. So I'm going to scroll down to Exhibit B to your affidavit. You mentioned it in paragraph 4 is a report that relates to Ammy Lewis. You also indicate that this report is undated and that you endorse the contents of it.

Do you recall when this report at Exhibit B was prepared by you?

And I will scroll down to it. It's on the screen now and I will try to make a bigger so that you can see it there.

A. Yes, thank you very much. I don't recall the exact date. It would have been around the same time that I provided the letter for Ms. Heegsma.

60 **Q.** Thank you.

And you do state in this letter in the last sentence of the first paragraph:

> "To the best of my knowledge, Kristen has been homeless for at least the past three years."

Given that you referred to Ammy Lewis as Kristen here, is it possible that you prepared the letters at exactly the same time; so the Kristen Heegsma letter and this Ammy Lewis letter?

A. It's likely that I -- and apologies for the typo -- it's likely that I, yes, prepared them around the same time. I don't know if it was like the same day, but it would have been a similar timeframe.

61 **Q.** Okay. Thank you. So you do mention that Kristen has -- and, again, you say "Kristen" but meaning Ammy; is that right?

A. Yes, correct.

62 **Q.** And you do say that:

> "She has the following medical conditions, the first being HIV infection[...]"

Do you know long Ms. Lewis has been HIV-positive?

A. I do. And I can get that information, the exact date if you like, because I was the person who made the diagnosis. It would have been I believe, it would have been late -- well, when did I first meet her? March of 2021. So it would have been late 2021.

63 **Q.** That's I think close enough for our purposes.

Have you provided any treatment to Ms. Lewis as a result of her HIV infection?

A. I have.

64 **Q.** Okay. And what treatment have you provided to her for that?

A. Would you like the name of the medication?

65 **Q.** Yes. The name of the medication or any other treatments that you provided.

A. Yes. So she's been on antiretroviral therapy since the time of her diagnosis. She's been taking medication called Biktarvy.

66 **Q.** The next item in the list is Opioid Use Disorder. Also Stimulant Use Disorder.

Did you diagnose those conditions?

A. She came with me -- sorry, to me with those conditions diagnosed, but I can confirm the --

67 **Q.** Okay.

A. -- diagnosis of both of them.

68 **Q.** Have you provided treatment for those two conditions?

A. I provided treatment for Opioid Use Disorder and continue to do so.

69 **Q.** And what treatment have you provided?

A. She's been on opioid substitution therapy with Methadone and Kadian and she's been on safer supply

prescribing with Dilaudid tablets.

70 **Q.** Understood. Thank you.

The last on the list is Post-traumatic Stress Disorder. How long has Ms. Lewis had PTSD to your understanding?

A. To my understanding, it's been longstanding. And, again, this would be a diagnosis that I didn't make myself but one she came to me with and which has been confirmed through our in-house psychiatry services.

71 **Q.** And have you provided treatment to her for her PTSD?

A. Only insofar as referring her to our psychiatrist.

72 **Q.** And she has received treatment via that psychiatrist?

A. Presumably.

73 **Q.** You do reference trauma that Ms. Lewis experienced as a direct result of her lack of housing. And at the top of page 2 you reference a criminal assault.

Now, I understand from Ms. Lewis that that criminal assault was perpetrated by a landlord. Is that your understanding?

A. That is my understanding, yeah.

74 **Q.** Okay.

A. She's reported to me more than one assault. The initial assault when I first met her was perpetrated by a landlord.

75 **Q.** Okay. And that's the one that is referenced in this letter?

A. Can I just read through?

76 **Q.** Yes. Of course. It's at the top of page 2. You mentioned the rooming house in Hamilton.

A. Correct.

[Reading].

Yes, agreed.

77 **Q.** And Ms. Lewis has provided evidence in this matter. She was also cross-examined. She had indicated that she was homeless for about five months as of June 2022. And prior to that she had been renting an apartment which she left because she felt unsafe.

You don't have any reason to contradict Ms. Lewis' own evidence; right?

A. No. I don't.

78 **Q.** Under cross-examination, Ms. Lewis indicated that she first became homeless when released from a penitentiary in Kitchener. She can't remember that when that occurred. You indicate here in Exhibit B that it may have been within the spring of 2020, however you also say that you first met Ms. Lewis in March of 2021.

That's correct; that you first met her then?

A. Correct.

79 **Q.** So you would agree that you can't be sure what her housing status was before you met her?

A. Again, that was from her self-report to me.

80 **Q.** No. Understood.

A. Which I don't have any reason not to --

81 **Q.** So that's the only reason. You can tell us what she told you, but you can't confirm what her housing status was before you met her?

A. Agreed, correct.

82 **Q.** She also indicated under oath that she became homeless at that time because her mother kicked her out of the house on the first day she was released from the penitentiary.

She stated that she tried to access a shelter but no one would take her on as she had a dog. She stated that she stayed with her daughter who is also experiencing homelessness. She was first at a place called her -- that she referred to any way as "The Underground", but was told it was not safe there.

She then indicated she moved to a park or building at Barnesdale and Barton in Hamilton. She then went on to a place behind No Frills or a Fortinos near

train tracks for a few months.

You don't have any evidence to contradict any of Ms. Lewis' evidence on any of those points?

A. I do not.

83 **Q.** Ms. Lewis also testified that the apartment she's living at now, 95 Hess in Hamilton, was obtained for her while she was staying at Mary's Place and that she went there after her dog was placed with a foster. She also indicated that she has now been living in that same apartment with her dog for over two years and that she pays market rent at that apartment.

You don't have any evidence to contradict that either?

A. I'm just trying to think of the timeline because I'm fairly clear on the timeline of when she got into that apartment and that was according to my medical records.

84 **Q.** I'm sorry? Does that timeline fit with what you know or not?

A. I don't have the dates in front of me. If you'd like, I can check. I've got my medical record here.

85 **Q.** I'm sorry, I can't have you referring to documents that haven't been produced to us.

A. Yes, no problem.

86 **Q.** So the question is about your recollection.

So do you have any evidence to contradict Ms. Lewis' evidence?

A. Can you repeat when she said she was housed?

87 **Q.** Yes, of course. So and then, in fact, I'm coming to that because Ms. Lewis was cross-examined on August 14, 2024. And at that time --

A. Yes.

88 **Q.** -- she testified that the apartment she is living at now, 95 Hess in Hamilton, had been her residence for over two years. So --

A. I don't believe --

89 **Q.** By my calculation --

A. -- that's accurate from my record.

90 **Q.** -- that would be at least August 2022.

A. Yeah.

91 **Q.** Do you have any reason to dispute or contradict that timeline?

A. That is different than my records. So yes, I would dispute that.

92 **Q.** I'm sorry, are you referencing your medical record?

A. No. I have nothing else on my screen. But I know for certain that in the summer -- I know for certain in the summer -- that she was outside into the

winter, because I recall the time when we did finally get her into Mary's Place, the main reason why she finally agreed to let her dog get fostered was because of the extreme cold.

93 **Q.** Okay. Well, would you agree that Ms. Lewis could have sought to place her dog with a foster sooner than she did?

A. We tried multiple, multiple times to be honest with you and weren't successful. So it was only through the efforts of Dr. Lamont that we were able to get a foster for her dog.

94 **Q.** So it was Dr. Lamont who was successful in doing that?

A. Correct.

95 **Q.** And in terms of your recollection when did Ms. Lewis obtain housing?

A. My sense, if I had to guess without consulting my records, would be that it would have been early in 2023 or late in 2022. I believe I provided an affidavit to that effect at some point.

96 **Q.** Well, we do have your further affidavit dated August 12th, 2024. I understand that you did prepare a second affidavit after reviewing evidence that was provided by Rob Mastroianni of the City.

That's accurate?

A. Correct.

97 **Q.** So Mr. Mastroianni's evidence indicated that city records indicate that Ms. Lewis has been housed since October of 2021?

A. Yes.

98 **Q.** Is that your recollection?

A. Is that my recollection of the affidavit?

99 **Q.** Well, yes. Of the affidavit that you reviewed and then responded to.

A. That sounds correct. I don't have the dates off the top of my head, but if you're telling me that's what's in the affidavit, I believe you.

100 **Q.** Well, understood. You would agree that October of 2021 would align with Ms. Lewis' own evidence that she had been in her present apartment for over two years? October 2021 is over two years ago, in other words.

A. It is over two years ago. I would agree with your math.

101 **Q.** During the period that Ms. Lewis has been stably housed, what improvement has her condition seen?

A. So a couple of things I would point to. The main thing, again, the two main things that I'm treating her for would be her HIV infection and her Opioid Use Disorder.

With regard to her HIV infection, she's been more consistent in taking her medications; and from that perspective, we have seen a stabilization of her infection through her viral load being consistently suppressed.

The second thing for her Opioid Use Disorder is us being able to see her on a more consistent basis has been helpful in adjusting and titrating her doses; and so we've been able to get to a more stable dose that has led to her decrease use of opioids.

And then finally, again, from my perspective, Ammy suffers from a lot of mental health issues and so being able to engage consistently with Dr. Lamont has been a major benefit to her.

And I would say all of those have improved as her housing status has been more stable, with the caveat that she's gone through a lot of other social upheaval even while she's been housed, including the death of her mother and so there's been periods of time, again, where she's continued to struggle.

102 **Q.** Would you agree that between obtaining shelter and having a pet, medical priority must be given to obtaining shelter due to the dangers of remaining outside without shelter?

A. I don't think that I am in a position to say what was best for Ammy in terms of those two choices.

103 **Q.** Well, I'm not asking specifically about Ammy. I just want to be clear I'm asking about what should be given medical priority.

So as a general proposition would you agree that between obtaining shelter and having a dog, medical priority for any individual must be given to obtaining shelter due to the dangers of remaining without shelter?

A. I would say in my practice, I rely on my patients to make decisions about what's best for them. We talked to Ammy consistently about the benefits of her being housed and our concerns about her being unhoused.

She was not willing to part with her dog because the dog provided her with a lot of emotional support; and given her mental health issues, she identified her dog as being extremely important to her mental health. I have no reason to doubt that, or disbelieve it, as it was her -- in my opinion, her prerogative to make decisions about what's most important to her.

104 **Q.** I understand that. But as soon as the dog was put into a foster, she obtained shelter and then subsequently permanent stable housing; you would agree with that?

A. In fact, the only thing that allowed her to take that step of fostering her dog was the fact that she would be able to obtain shelter and housing, correct.

105 **Q.** All right. So I would like to turn now to Exhibit A to your first affidavit. This is the letter with reference to Kristen Heegsma, dated June 13, 2022.

I've got it on the screen now. Can you see it?

A. Not yet.

106 **Q.** Actually I can make it a bit bigger than that even.

A. Okay.

107 **Q.** So this letter has a number of similarities to the letter regarding Ms. Lewis that we just reviewed. The first paragraph is very similar in both, save for the length of time that you have seen the patient and the patient's name, as well as your understanding of how long they have experiencing homelessness.

Would you agree with that?

A. I would agree.

108 **Q.** The second paragraph is the list of medical conditions which is tailored to the patient.

You would agree with that?

A. I agree.

109 **Q.** The third paragraph, other than the name of

the individual, is identical for both. It states:

"It is my opinion that [...]"

-- each of the patients --

[...]Medical conditions have been negatively impacted by her lack of access to stable housing."

Is that correct?

A. Agreed, yes.

110 **Q.** There are then some sentences tailored to the patient. But then, both state, quote:

"Furthermore, the trauma that she experienced outlined below as a direct result of her lack of housing has further exacerbated her underlying mental health conditions to a severe extent."

That was stated about both patients; is that right?

A. Agreed.

111 **Q.** And then in the third paragraph, the last sentence in both letters is very similar. And I will put that just in the centre of the screen here. So the last sentence here starting, "despite". They state:

"Despite her being able to see me on a fairly regular basis over the past six months[...]"

Then you identify the patient. And you state that:

"Ammy's overall condition has overall deteriorated but our progress has been far below what I would expect if she were stably housed."

With respect to Ms. Heegsma, on this screen now, you state:

"Kristen's overall condition continues to fluctuate, and our progress has been far below what I would expect if she were stably housed."

Is that correct?

A. I can see the one on the screen and I can confirm that that's what it says in this letter. I don't have the other one in front of me.

112 **Q.** Okay. Well, I can go to the other one. There might be a little bit of switching back-and-forth required. But here. I will put on the screen now the letter to do with Ammy Lewis. And it says:

"Despite her being able to see me on a fairly regular basis over the past six months, Ammy's overall condition has overall deteriorated, and our progress has been far below

what I would expect if she were stably housed."

So that is what was written about Ammy and Kristen; correct?

A. I'm sorry, it might be my Internet. I just got Ms. Lewis' up now; and yes, I agree that that is what that says.

113 **Q.** And then in both letters there's a section that's tailored to each patient. So looking at Exhibit B, being the Ammy Lewis letter, there is a paragraph about her background and information to do with her.

Scrolling up to Exhibit A, there are two paragraphs about Ms. Heegsma's status.

Then the last two paragraphs in each letter are essentially identical, save for the patient's name at the very beginning. The one that's on the screen now is to do with Kristen Heegsma. And so, for example, it says here:

"Kristen's health has clearly suffered to a significant extent due to her homelessness and housing precarity."

If we scroll down to Exhibit B, the Ammy Lewis letter, the second-last paragraph is:

"Ammy's health has clearly suffered to a significant extent due to her homelessness and housing precarity."

The rest of the paragraph is identical in both letters. I will let you look at those.

But this is Exhibit B that is on the screen now. Can you let me know when you are done reading that paragraph?

A. [Reading].

Yep, all good.

114 **Q.** And I'm going to scroll up to the Exhibit A letter to do with Kristen Heegsma. The second-last paragraph. The rest of it is identical.

Could you just confirm that?

A. Correct.

115 **Q.** And then the last paragraph in both letters says:

"I would be happy to answer further questions as required."

Can you confirm that too?

A. Yes, sir.

116 **Q.** Okay. Well, this appears to me to be a form letter with some areas that allow for personal details for each patient to be added.

Would you agree with that?

A. It's not a form letter. I would disagree with that.

117 **Q.** Well, the letters ultimately reach the exact same conclusions about the patients.

Would you agree with that?

A. There's a similar conclusion in terms of how homelessness has affected their health. I would agree with that. But there's differences in terms of their individual circumstances.

118 **Q.** Yes. And as we've seen, the individual circumstances are listed.

But you would agree that the same conclusions are reached about both of the patients?

A. I think there are conclusions that go beyond the last paragraph, sir. So the last paragraph is similar in terms of the conclusions that are in that. But I think that there's differences in terms of the individual patient circumstances.

119 **Q.** Well, I think we've established that the last paragraph is identical --

A. Agreed.

120 **Q.** -- except for the name.

Would you agree with that.

A. Agreed, yes.

121 **Q.** And you first?

A. I don't think --

122 **Q.** Sorry, I didn't mean to cut you off.

A. Go ahead, please.

123 **Q.** Please, go ahead.

A. No, no. Pardon me.

124 **Q.** I didn't mean to cut you off.

A. No. Go ahead.

125 **Q.** Okay.

A. I'm just establishing that there's nothing in that last paragraph that says "in conclusion" or says "this is the end" or that this is the entire opinion.

I think there's reports throughout the entire letter that talk about facts.

126 **Q.** I would certainly agree that there's opinion throughout the letter.

You first met Ms. Heegsma in July of 2021; is that right?

A. I believe that's what it says -- states in the --

127 **Q.** Yes.

A. -- in the, yeah.

128 **Q.** I'll scroll up to the top. It says there in the first paragraph that you first met her in July of 2021.

That's accurate?

A. Correct.

129 **Q.** Do you still provide Kristen Heegsma with medical treatment today?

A. I do.

130 **Q.** And you indicate in your medical letter that to the best of your knowledge Kristen has been homeless for at least the past four years.

And that would be as of the date of this letter in June of 2022?

A. Correct.

131 **Q.** Okay. And Kristen Heegsma gave an affidavit and was cross-examined in this matter.

She testified that she was living with her grandparents in 2019, and that after that she stayed in a City of Hamilton hotel space on-and-off, for roughly one year total, as well as two other shelters. One was identified as Mary's Place in Hamilton, and one she mentioned was Burlington.

She also indicated she was employed by a temp agency during this period and that she stayed at the Ferguson encampment in Hamilton until October of 2020 as well as encamping at several locations in Hamilton; including Jackie Washington Park, Beasley Park, and Woolverton Park.

You don't have any evidence to dispute that; correct?

A. Sorry, can I pause for just a quick second I'm borrowing an office because I don't have an office at this hospital. I am just going to grab something for somebody so that they are not in the room at the same time.

132 **Q.** Absolutely take care of that it. We will go off the record for a moment.

---OFF THE RECORD

BY MR. DIACUR:

133 **Q.** So Kristen Heegsma gave an affidavit and was cross-examined in this matter. She testified to several things. She indicated she was living with her grandparents in 2019. She indicated that after that, she stayed in a City of Hamilton-funded hotel space on-and-off for roughly one year total, as well as staying in two other shelters; one was Mary's Place in Hamilton, and one other that she mentioned was in Burlington.

She indicated that she was employed for a period of time by a temp agency during the period after 2019. She also testified that she stayed at the Ferguson encampment in Hamilton until October of 2020, and then encamped at several locations in Hamilton, including Jackie Washington Park, Beasley Park, and Woolverton Park.

You don't have any evidence to dispute any of that that was testified to by Kristen Heegsma?

A. I do not.

134 **Q.** Ms. Heegsma also testified that she was provided with a mental health crisis bed for a period of time at the Hamilton Barrett Centre; that she was enrolled in the Hamilton YWCA's transitional living program for about four months until September of 2021, but was terminated from that program when she made what she called "a dumbass decision" involving breaking into the YWCA staff office.

You don't have any evidence to dispute any of that testimony of Ms. Heegsma?

A. I do not.

135 **Q.** Ms. Heegsma also testified that after being terminated from the YWCA's transitional housing program, she obtained housing at 123 Bold Street in Hamilton in January of 2022.

You don't have any evidence to dispute that?

A. I do not.

136 **Q.** She also indicated that later in 2022, roughly June, she moved to Oakville for a time and then spent some time in jail in Milton for breaking into cars.

You don't have any evidence to dispute that

testimony of Ms. Heegsma?

A. I don't.

137 **Q.** Ms. Heegsma also indicated that she spent some time in Toronto. And then in December of 2023, she moved to a residence at 9 Faircourt Drive in Stoney Creek to live with her father.

I realize that that postdates your medical letter. But given that you have continued to treat her, can you confirm that you have no evidence to dispute that testimony of Ms. Heegsma?

A. I can confirm that.

138 **Q.** Oh, you can confirm that that is actually the case?

A. No, no.

139 **Q.** That she moved in to an apartment with her dad?

A. No. No, I'm sorry. I said, "Can I confirm that?" I don't have any evidence to dispute that.

140 **Q.** Thank you.

I understand that. Yes, the question has to be asked in that way.

Ms. Heegsma also testified that she occasionally travels to and from London, Ontario by bus or train to stay with her mother and daughter. You don't have any evidence to dispute that testimony of

Ms. Heegsma?

A. Correct.

141 **Q.** To the extent that Ms. Heegsma was truthful, you would agree that she has spent a significant amount of time over the past six years with various forms of indoor shelter; some with family, some in various programs; and some in housing that she, herself, obtained?

A. I agree that she has spent time indoors, significant time indoors.

142 **Q.** No. But would you agree that some of it was with family; some of it was in housing programs; and some of it was in housing that she, herself, obtained?

A. Based off of her testimony, I would agree with that.

143 **Q.** Okay. All right. Well, thank you very much, Doctor. I appreciate you attending and answering those are all my questions.

MS. CROWE: Thank you, Dr. O'Shea. I think I just have one redirect question actually if you will give me a moment to screenshare.

RE-EXAMINATION BY MS. CROWE:

144 **Q.** Dr. O'Shea, you should be seeing the August 12, 2024, affidavit. Can you see that on your screen?

A. Yes, I can.

145 **Q.** Okay. I want to scroll down to paragraph 5. Mr. Diacur had asked you about your knowledge of the timing for Ms. Lewis' housing. And in this paragraph you indicate that based on your records she was housed as of February 2023.

Can you just clarify what records and how did you come to that conclusion?

A. Yes. Sorry, that was based off of my medical records. So, again, in our medical records, and at each visit, we document the patient's housing status; and so I reviewed those records back to the time that I wrote the letter, and before, and obtained those dates from that.

Beyond that, as well, both Dr. Lamont and I were fairly closely involved in her placement at Mary's Place initially and onwards from there. And so I would say the notes were more detailed than the typical in Ammy's case because of our direct involvement in her obtaining the space at Mary's Place initially.

146 **Q.** Okay. So to the best of your knowledge is February 2023 the date that Ms. Lewis was, in fact, housed?

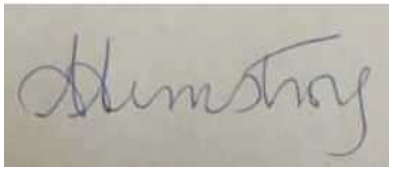
A. Correct.

147 **Q.** Thank you. Those are my questions.

--- The examination concluded at 2:30 p.m.

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. TIM O'SHEA, given under oath before me on the 6th of September, 2024.

Amy Armstrong, CVR-RVR



Certified Realtime Verbatim Reporter #7305

Certified Commissioner of Oaths

Certified this 7th of September, 2024

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TAB 9

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. Claire Bodkin**, on an Affidavit dated May 5, 2023 taken upon affirmation in the above action this, 6th of September, 2024, conducted via videoconference hosted by the offices of Nimigan Mihailovich Reporting Inc.

APPEARANCES:

For the Applicants:

For the Hamilton Community Legal Clinic:

SHARON CROWE

For the Community Legal Clinic of York Region:

MICHELLE SUTHERLAND

NONYE OKENWA

BENJAMIN HOGNESTAD

For the City of Hamilton:

JORDAN DIACUR

JOJO JOHNSON

Gowling WLG (Canada) LLP

I N D E X

PAGE

WITNESS: DR. CLAIRE BODKIN

Cross-Examination by MR. DIACUR 5

EXHIBITS

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] 37/25.

--- Commencing at 12:21 p.m.

DR. CLAIRE BODKIN,

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:

1 **Q.** So, ma'am, I have questions for you today principally about your affidavit that was sworn May 5th, 2023. I want to make sure that you have a copy of that available to you.

Do you have a copy, either a hard copy or an electronic copy?

A. I can open it up, yeah. Just give me a second.

2 **Q.** My plan would also be to put it on the screen so that everybody can see it so if we reference it, we'd all be looking at the same thing. But please feel free to either refer to that or a copy that you have.

But other than that, other than your affidavit or the documents that are put to you, you are not to refer to any other notes or documents.

Understood?

A. Understood.

3 **Q.** Okay. And actually, I'll do that now. I will share my screen and make sure that everybody can see

it. So can you see what's on the screen now, your affidavit sworn May 5th, 2023?

A. Yeah.

4 **Q.** Okay. And so you just so I understand correctly, you have not provided a copy of your CV or curriculum vitae in this matter; correct?

A. I have not.

5 **Q.** And you have not provided any studies or evidence regarding the capacity or the sufficiency of the shelter system in the City of Hamilton?

A. I have not.

6 **Q.** And you have not provided a signed document called either an Acknowledgement of Expert's Duty or a Form 53 in this matter; correct?

A. I have not.

7 **Q.** And so, Dr. Bodkin, what do you consider your role to be in this litigation?

A. I was Linsley's treating physician when he presented with the injury -- with the infection and injury that immediately preceded his amputation.

8 **Q.** Okay. And so you would be giving evidence specifically about that subject?

A. Yes.

9 **Q.** And do you consider yourself to be independent in this matter?

A. Yes.

Q. And by that I mean you do not favour one side or the other?

A. I mean, I think I have a duty to my medical responsibility, like my medical license, to provide truthful and honest, yeah, like assessment of the situation. So yeah, I think that in the matter specifically of just discussing Linsley's assessment, treatment and injury, I am required by my license to give my independent medical advice, which doesn't mean that I don't have an opinion about things, but it doesn't impact or affect my assessment and management of his medical condition, which is the only thing that I'm speaking to in this case.

Q. Understood. Thank you.

So you did reference Mr. Greaves. You are authored what is referred to in your affidavit at paragraph 4, I should say, as the April 24, 2023, report attached as Exhibit A to your affidavit, and you endorse the contents of that document; correct?

A. Yes.

Q. Okay. I'm going to go to that document. I will jump down to Exhibit A, and I will put it up on the screen. I can see on the first page of it that it is dated April 27, 2023, or at least the entry in the records

of what you referred to as HAMSMaRT is dated April 27 2023.

The document itself doesn't have a date on it. So one thing I wanted to clarify with you is it is referred to the April 24, 2023, report in your affidavit, but it's dated April 27 on the face of the document.

Do you recall which of the two dates the document was prepared on?

A. I don't. I would assume that I had probably drafted a first copy and then maybe I needed to print it again and that's why the new date is on it, but I actually don't remember.

13 **Q.** Okay. Understood. I just wanted to see if there was a clarification on that. But it was sometime around the end of April of 2023 that it was prepared; is that fair?

A. Yes, absolutely. And I provided care to him the previous December 2022.

14 **Q.** Understood. Okay. And the document itself, I put it on the screen here, it opens, "To whom it may concern."

Who was the intended recipient of this report?

A. So this was a request from the legal team to provide a report for this litigation on the medical

care that I had provided to Linsley Greaves. And I know the formatting is odd, but it is all one document. It's just that our electronic medical record apparently cannot format things properly.

15 **Q.** Understood. Okay. You got provided the request or instructions that you received from the Applicants' lawyers in your affidavit or in this report; correct?

A. My instructions were just to write a report on the care that I provided.

16 **Q.** Is there any additional correspondence, emails, letters, or notes of any phone calls between you and the Applicants' lawyers regarding this matter?

A. There's no notes of any phone calls. There was communication just in the last day around a part that was in my original affidavit that you or your team wanted struck from the affidavit, but that's it.

And there was some communication before the affidavit around just trying to find Linsley to get him to sign a release of information so that I could write this with his consent. And it took us some time to actually find him and get him to sign that because of -- because he's living outside and moving around, but that was it.

17 **Q.** Okay. And I guess that was obtained?

A. Yeah.

18 **Q.** And was there any correspondence specifically about your instructions to provide this document?

A. I think it was truly just -- yeah, it was truly just can you comment on this medical care. I don't think there was anything besides that.

19 **Q.** Okay. And did you prepare this document on your own or did the Applicants' lawyers assist you?

A. No. I prepared it on my own.

20 **Q.** Did you review the Notice of Application in this matter prior to preparing this document at Exhibit A to your affidavit?

A. No.

21 **Q.** Did you speak with Linsley Greaves prior to preparing it?

A. Yes, because I needed to get the consent signed.

22 **Q.** Okay. So I had understood that the consent came after the fact. So the consent was actually obtained prior to the preparation of this document?

A. Yes.

23 **Q.** Okay. And did you review Mr. Greaves' affidavit dated June 2nd, 2022, prior to preparing this document at Exhibit A to your affidavit?

A. No, no. The timeline on that doesn't make

sense, does it?

24 **Q.** Well, this document --

A. I came on in April. Oh, 2023.

25 **Q.** Yeah. So his --

A. Okay.

26 **Q.** So his affidavit was prepared the previously year in June 2022.

A. No. No.

27 **Q.** Have you reviewed that affidavit prior to today?

A. No.

28 **Q.** Have you reviewed any of the evidence in this matter, any of the other affidavits from the Applicants?

A. I reviewed Dr. Rachel Lamont's affidavit, yes.

29 **Q.** Okay. And I understand that you did not provide any reply evidence to the affidavit of Dr. Koivu?

A. I don't know that that is so. I don't think so.

30 **Q.** Okay. Understood. That makes sense. If you are not even aware of it, then I can understand that response.

Okay. So my understanding is that you practice family medicine and have been in that practice

area since September of 2021; do I have that right?

A. Sort of, yeah. So I practice family medicine. I work both in an inner-city setting where I provide care that's focused to people who use drugs, and then I actually also work as a rural locum physician, so I'm a family doctor that provides emergency medicine, in-patient care, long-term care. I'm like an old-school general practitioner with a particular focus on the care of people who use drugs.

31 **Q.** Understood. Thank you for that. That's helpful. So I'm going to scroll back up quickly to your affidavit, paragraph 2.

You state here that -- it says that as well as being a physician, you are the Co-Medical Director of Hamilton Social Medicine Response Team or HAMSMaRT.

A. Yeah, I was at the time that I wrote this affidavit. I'm on parental leave right now.

32 **Q.** Okay. So you are away from HAMSMaRT, but will be returning once your parental leave is owner?

A. That's a good question. As of right now, yes.

33 **Q.** Okay. Well, I understand that can be somewhat up in the air for sure.

You understand that HAMSMaRT previously

sued the City of Hamilton, along with two of the current applicants in this matter, Mr. Caldwell and Ms. MacDonald; correct?

A. Yes.

34 **Q.** And that was in 2020?

A. Yes. I mean, it was a loosely affiliated group of people at that point in time. It was not like an incorporated organization, but, yes, I do understand that.

35 **Q.** And would you agree that HAMSMaRT is, among other things, an advocacy organization?

A. I would.

36 **Q.** All right. There is also one other document I would like to show you. It's an email in your name that is attached to an affidavit of a Lisa Nussey, N-U-S-S-E-Y.

I'm going to put it on the screen now. So this is -- and I should scroll up so that you can see it. This is Exhibit B to the affidavit.

MS. CROWE: Sorry, counsel. Before you continue, we have withdrawn this affidavit.

BY MR. DIACUR:

37 **Q.** I understand, but it is a document that was disclosed to us, and it's in the name of this witness, so I'd like to put it to her, and I have a couple of questions for her about it.

So this is listed as Exhibit B to the affidavit of Lisa Nussey. And it was sworn on July 13, 2023. And if I scroll down, there is on this page here, page 3 of 12 -- it's identified in the bottom left-hand corner -- an email from info@HAMSMaRT.ca, but the email itself is signed, it appears anyway, by you, Claire Bodkin, on behalf of HAMSMaRT; is that fair?

A. Yes.

38 **Q.** And the email is dated April 29 2020. We can see that in the top right-hand corner?

A. I actually can't see it. Let me see if I can --

39 **Q.** I can try to zoom in on it. I realize it is a bit small. Let's see if that's better. How is that?

A. Yeah.

40 **Q.** Top right-hand corner, April 29 2020, can you see that?

A. Yeah.

41 **Q.** And this email was sent by you in your name?

A. Yeah.

42 **Q.** And given that it was sent in April of, 2020, it was sent a couple of months before that previous lawsuit we were just discussing that included HAMSMaRT in 2020?

A. Yes.

43 **Q.** And this is copied to a number of people, including Jason Farr@Hamilton.ca; correct?

A. Yes.

44 **Q.** And Jason Farr was a city councillor at that time?

A. Yes.

45 **Q.** And the greeting in this email is to Councillor Farr only, "Hi, Councillor Farr," correct?

A. Yes.

46 **Q.** and you state in this email that -- in the third sentence:

"Dismantling encampments further destabilizes people."

This is you lobbying a city politician and advocating against dismantling encampments; correct?

A. Like -- so I'm -- can I just ask Sharon, like should we keep going here? Am I okay to answer things? Like what's the --

47 **Q.** It's a relevant question, so you are required to answer it.

MS. CROWE: I will object as needed, Dr. Bodkin. Thank you.

THE WITNESS: Okay. Yes.

BY MR. DIACUR:

48 **Q.** You would agree that you are at least in part an advocate who has engaged with the City of Hamilton specifically on the subject of encampments?

A. Yeah. Yes, I would.

49 **Q.** Okay. So I'm going to jump back to your affidavit now. It's just going to take me a second to do. I'll do that via the index to this document, pull it back up.

So we are back on the cover page of your affidavit sworn May 5th, 2023. In paragraph 3 of your affidavit you indicate that you have known, Mr. Greaves, so Linsley Greaves, for approximately 10 months and have provided medical care to him on two occasions.

A. Yeah.

50 **Q.** Now, in terms of the medical care provided, was that diagnostic care, was it medical treatment, or was it both?

A. So in both cases he needed a higher level of care than what I could provide as a community-based physician. So it was taking a history, doing a physical examination.

In one of those instances, it was actually my colleague that took over his care at that time, so I didn't even finish the assessment and plan part of it.

In the December 2022 instance, I assessed him. I did provide treatment in the form of pain management and then calling the hospital to advocate for him to be seen by the emergency room doctor in a timely fashion and to give them handover on why I was sending him to the emergency room.

And then his treatment continued in the emergency room and then as an admitted inpatient at the Hamilton General Hospital.

51 **Q.** Okay. And you mentioned the time in December of 2022 that you saw Mr. Greaves. When was the other time that you provided medical care to him?

A. So -- and again -- like, I don't -- in terms of medical care -- so it was July 2022. I did see him. I did, like, take a look at his foot at that point in time. But then I immediately called over a colleague who took over his care.

So it was a very, like, brief, brief interaction. And yeah, you know, I was acting in my capacity as a physician in that I, like, saw him, assessed him, and then asked another colleague to come over and take over.

But it was a very brief interaction in July of 2022.

52 **Q.** Okay. Who was the colleague?

A. Dr. Lauren Cook-Chaimowitz.

53 **Q.** I will take you now back to that report, the April 24 or 27th, 2023 report, Exhibit A to your affidavit, and I will scroll down to it.

So you do say here that Mr. Greaves was brought to your outpatient clinic by paramedics.

A. Yeah.

54 **Q.** Is that common? I would think that they would take him to the hospital; right?

A. Yeah, that's a good question. So we have a program in Hamilton called Social Navigator.

55 **Q.** Mm-hmm.

A. And they are paramedics that specifically do a lot of work and outreach with people who face all sorts of social barriers, but a lot of them are people deprived of housing.

And so they often will bring people to our HAMSMaRT clinic because we offer drop-in care to people in a timely way where they don't need to wait hours and hours, say, at the emergency room. So if they can treat somebody in an out-patient setting, it's often better for the patient, and it's better for the healthcare system for that to happen.

In this case, they brought him to me and I assessed him and determined that, unfortunately, it was

not amenable to outpatient treatment, so than I referred him on to the emergency room. But actually that's quite common that Social Navigator would bring patients to us.

56 **Q.** Understood. That's helpful.

You indicate here that Mr. Greaves presented with two weeks of worsening left foot infection and worsening right soft tissue injury.

Based on what you've told me, you didn't see him in the two weeks previous; correct?

A. No. But as a physician, like, the very basis of my practice is taking a history, a detailed history. So I ask people about, you know, what's been happening, what's led up to this, what were things like. And I document that in contemporaneous notes as part of my -- then I move on to the physical examination and then the assessment is based on the combination of history and physical examination.

57 **Q.** Understood. But you would agree that the timeline, two weeks of worsening of foot infection, for example, that's based on Mr. Greaves' self-report?

A. That and also Social Navigator paramedics had been seeing him as well. So they also were able to corroborate that.

58 **Q.** Okay. That's helpful as well.

Would you agree that getting a baseline for

a patient is important in terms of being able to tell whether they are getting better or worse?

A. I mean, I work as an emergency room physician, so actually a lot of my job is assessing people in the moment who I haven't met before where I'm making an assessment on the basis of history and physical exam within, you know, a few minutes kind of thing.

So it's not that it doesn't have value, but actually no, I don't see it as a core part of the assessment in this particular instance.

I didn't need to see him before in order to make the assessment and diagnosis and plan that I made that day.

59 **Q.** Okay. And you indicate here that he was repeatedly evicted -- and when I say "he," I mean Mr. Greaves -- was repeatedly evicted from his encampment location in the two weeks previous by the City of Hamilton.

That's something that was reported to you. You didn't witness repeated evictions of Mr. Greaves from encampments; correct?

A. No. It was reported to me by Mr. Greaves and by the Social Navigator paramedics.

60 **Q.** Understood. Was the specific number of evictions reported to you?

A. No. What was relevant to his medical care was just that he had lots of risk factors for non-freezing cold injury or trench foot and lots of risk factors for frostbite related to the -- like his belongings getting wet and then his tissue in his feet getting frozen and thawed.

So the number of evictions was not particularly important, only that it happened, you know, more than once and that the result of that was this particular exposure that led to this particular injury.

61 **Q.** Okay. Was it reported to you how long Mr. Greaves was able to stay at an encampment between any of the evictions?

A. No. I didn't ask him. No, I didn't.

62 **Q.** Was it reported to you whether Mr. Greaves was offered indoor shelter at the time of any encampment dismantlement?

A. It was not, no. It wasn't reported. I don't know if it was offered.

63 **Q.** Was it reported to you whether Mr. Greaves was offered any assistance in finding somewhere else to go?

A. It was not reported, no.

64 **Q.** Was it reported to you what kind of tent Mr. Greaves had in his encampments?

A. No, it was not reported.

65 **Q.** Was it reported to you whether Mr. Greaves had sufficient shelter in an encampment to protect him from the elements?

A. I mean, in the context of the repeated evictions, it was not sufficient. In terms of what it was like two weeks prior to this, like, getting moved around a lot and the temperatures changing -- yeah, you know what, I actually can't recall, and I didn't document it in my notes, so...

66 **Q.** Okay. And you do state in this document your medical opinion that it was what you call, quote:

> "The repeated eviction of Mr. Greaves from his encampment that directly caused frostbite and subsequent wet gangrene, requiring amputation of his left leg below the knee."

A. Yes.

67 **Q.** That is accurate?

A. It is.

Sorry, Sharon. Can I just ask you? I thought that the affidavit was changing, although that is my medical opinion.

MS. CROWE: Yes. Can we go off record for

a moment?

MR. DIACUR: Sure, but it is unusual for the witness to be asking counsel questions.

--OFF-THE-RECORD DISCUSSION

---RECESS TAKEN AT 12:45 p.m.

---UPON RESUMING AT 12:52 p.m.

BY MR. DIACUR:

68 **Q.** So, ma'am, I would like to take you through to an affidavit that was sworn by Linsley Greaves in this matter. It's dated June 2nd, 2022, as I said, previously.

And I'd like to take you particularly to paragraph 31 of his affidavit, the second-last paragraph. As you can see here from the jurat, it was sworn June 2nd, 2022, signed by Linsley Greaves.

He says in paragraph 31 of his affidavit that he ended up getting frostbite on his left foot and toes, quote, last winter. So that would be December of 2021 to March 2022, given when his June 2nd, 2022, affidavit was sworn; correct?

A. Yeah. Sometime in that winter, yeah.

69 **Q.** And that's about one year prior to when you saw him in December of 2022; right?

A. Yes.

70 **Q.** And he says in paragraph 32 of his affidavit that he saw Dr. Wiwcharuk on June 2nd, 2020, the

same day that he swore this affidavit, for treatment of the frostbite.

That's roughly three to six months after he says the frostbite occurred in the first place; right?

A. Yes. Roughly, yes.

71 **Q.** And he says in paragraph 31 that his foot had been getting steadily worse and that Dr. Wiwcharuk told Mr. Greaves that day, June 2nd, 2022, he was going to lose his left big toe, that he was going to be an amputee. That's when Mr. Greaves' foot injury was diagnosed; correct?

A. So different foot injury. I agree that this is like a -- because he spent so much time outside he's had repeated injuries in terms of frostbite and then trench foot or non-freezing cold injury. So he's had recurrent injuries.

And once you get frostbite once and have damage to the vasculature in your foot once, you're going to be at further risk with further exposures. But they are not the same injury, no. Or it's like a much further escalation and evolution with a new injury, like new frostbite, new non-freezing cold injury.

Does that makes sense?

72 **Q.** I think so. And you are saying that --

A. He's had frostbite more than once.

73 **Q.** Frostbite can re-occur; is that what you are saying?

A. Yeah. And that when I saw him, it was a new injury. Like at that point in time, that left big toe had already auto amputated, which I think is in my affidavit, that the toe was gone. But he then had a new injury again, another episode of frostbite and non-freezing cold injury.

74 **Q.** Well, that's where I'm going with my questions. It does say here that Dr. Wiwcharuk indicated he was going to lose his left big toe and that amputation was indicated. You would agree with that?

A. Sorry. So amputation just means lost of a digit or a limb; right? And so he was an amputee from his left big toe, which is very different than losing your leg below the knee, which is the amputation he had like immediately after I saw him.

So yes, he would be an amputee of his left big toe. But that is not the same in terms of function or degree of injury or like, you know -- that we call it auto amputation, so it falls off on its own, you don't need a major surgery, versus a below knee amputation, which is a major orthopedic surgery.

75 **Q.** Certainly amputation of a toe is far better than amputation of a leg below the knee.

You would agree with that?

A. Yes.

76 **Q.** And he was told at this time, in June of 2022, that an amputation was indicated?

A. No, no, no. Of his left big toe, not of his leg.

77 **Q.** I understand. But he was told that an amputation was the indicated treatment for his injury in June of 2022.

A. It wasn't -- I disagree. It was not the indicated treatment. It was the inevitable outcome. He auto amputated that toe. He did not have surgery.

78 **Q.** I understand that it auto amputated, but Dr. Wiwcharuk is saying that his toe needed to be cut off and amputated.

A. No. She's not saying that. She's saying that is the inevitable outcome.

79 **Q.** What other treatment is there for this issue?

A. So in an immediate frostbite situation, there is hyperbaric treatment if it is caught early enough.

80 **Q.** Sorry. I want to be clear. I'm not talking about immediate treatment. I'm talking after three to six months, when a doctor is saying that this toe

needs to be amputated, it is going to be lost, what treatments other than amputation are available?

A. So she is not saying that it needs to. She is saying that that is the inevitable outcome, like that is just what will happen. That is the course of things, and there is nothing that can be done to reverse that.

81 **Q.** Sure. I heard your answer on that subject. But other than amputation, after three to six months of a progressive injury due to frostbite, what other treatments are there than amputating?

MS. CROWE: This has been asked and answered.

MR. DIACUR: No, it hasn't.

THE WITNESS: I did not see him and treat him at that time. I don't know why we're --

BY MR. DIACUR:

82 **Q.** But I'm asking you as a physician, other than amputation, after three to six months of a frostbite injury, what other treatments are there?

A. So I think that that question would actually be better directed at a vascular surgeon or somebody who specializes in thermal injuries. Like, that's not my area of expertise.

83 **Q.** So you are not able to answer the question?

A. If there's other things besides auto

amputation at that point in time? I mean, I didn't see him.

And in terms of speaking generally to the management of frostbite injuries after three to six months, no, that's not my area of expertise. No, I can't answer it.

84 **Q.** You would agree that on the basis of Mr. Greaves' own evidence, he presented to you in December of 2022 with a months' old frostbite injury?

A. No. That's not what I'm saying. He had a new frostbite injury and a new non-freezing cold injury that occurred during the two weeks prior to when I saw him in a further part of his foot.

85 **Q.** So he had the original injury, and you are saying that there was a further injury?

A. Yes.

86 **Q.** How did you determine that there was a further injury?

A. Sorry. So I did a history. I asked him what's been going on, what's changed about your foot, what's changed about your skin, what's changed about -- like, what is going on there.

I also got collateral from the Social Navigator paramedics that had been seeing him. Then I did a physical examination.

And then I came to my assessment which is that, yes, in the two weeks prior -- I mean, you are right that he was, like, already vulnerable to this kind of injury because he had had frostbite before. He had had an auto amputation of the toe before. It had some impairment to his circulation before for sure. And those are also things when you are doing a history that you take into account.

But that is not the same as he had a new injury, indeed, in the two weeks prior to when I saw him.

87 **Q.** And how did you determine that? Was it solely from his self-reporting to the paramedics, Social Navigator?

A. And from seeing him. You cannot have a massive -- like, so I was concerned for osteomyelitis, bone infection. I was concerned for wet gangrene, which is infected gangrenous tissue. You can't have that untreated for months and months and months and months and not go into sepsis.

Like, it just -- that timeline does not -- it would be extraordinarily unusual to have the level of tissue damage that he had and for that to be possible for months at a time without having a full body infection.

88 **Q.** Right. And that's ultimately my point. I mean, untreated frostbite can lead to an infection,

gangrene, skin sloughing, desquamation, bleeding, ulceration, and eventually auto amputation, all of the things that you list in your report; right?

A. So auto amputation typically is just in digits. It's not typically what would happen with a limb.

89 **Q.** No, understood. But untreated frostbite can lead to infection, worsening infection, gangrene, skin sloughing, desquamation, bleeding, ulceration, and eventually auto amputation; you would agree with that?

A. Yes, it can.

90 **Q.** And that's actually what happened here in the case of Mr. Greaves; correct?

A. I think where we disagree is on the timeline, though. Like, I don't agree with you -- this was not brewing for a year. This was -- he had a prior injury. He kept having recurrent injuries, and then he had this one that was particularly bad.

91 **Q.** No. So I think I see what you are saying. So he did have untreated frostbite for months; you would agree with that?

A. No. No, no, I would not agree with that.

92 **Q.** Okay.

A. I do not agree with that.

93 **Q.** So he sees Dr. Wiwcharuk here?

A. Yeah.

94 **Q.** In his own words, June 2nd, 2022?

A. Yeah.

95 **Q.** And he's talking about frostbite that he got last winter?

A. Yes.

96 **Q.** So that's three to six months previously?

A. Sure, yes.

97 **Q.** He had untreated frostbite for months?

A. Okay. But frostbite is not a full body experience; right? Like a local area of tissue freezes and thaws.

98 **Q.** His left foot and toe, as he says. That was the area that was affected.

A. I don't know if it was his whole foot or, because I didn't see him then. I didn't assess him then. I didn't treat him then.

99 **Q.** I understand. I'm asking you about his evidence. He says his left foot and toes.

A. He doesn't say, "my whole foot." He doesn't say the entire foot. He says on his left foot. I don't know what part of the left foot that means.

100 **Q.** So you are saying that you can't say whether or not he had untreated frostbite for months, based on his own evidence?

A. I don't think -- so, frostbite itself is

just the process of freezing and thawing tissue; right? So that happens in a discrete amount of time.

And then there may be residual damage from the frostbite injury; right? So damage to the blood vessels, damage to the tissue. And then you have this dead or devitalized tissue with poor circulation that then becomes more -- more at risk of either future episodes of frostbite and non-freezing cold injury and becomes more vulnerable to things like infections, because we don't have as good blood supply there to help you fight infections.

But then he had another injury, right, like another episode of tissue either freezing and thawing, which is frostbite, or of non-freezing cold injury, which is where the tissue gets wet around cold. There's a lot of vasoconstriction that happens. There's, again, damage to the tissue which is not frozen all the way through.

And so what I am saying, and I feel like I said ten times now, is that he did have frostbite, yes. And then after that frostbite, he had tissue damage. That was the sequela or the outcome of the frostbite. And then he had the toe auto amputation. I agree. That is what's here.

Then he had months where I didn't see him as a doctor. And then I saw him and I did what I do as a

physician who does primary care and does emergency medicine all the time, which is that I took a history, I did physical examination, and then I made an assessment and a diagnosis, and then I arranged for appropriate care, because it wasn't what I could provide in my outpatient clinic.

But I want to be really clear that this is not just one static injury that happened over the course of a year, that the frostbite episodes are the freezing and thawing of tissue, that the non-freezing cold injury or trench foot is the immersion in cold, like usually cold, wet environments and causing vasoconstriction and damage to the tissue.

And once that is damage damaged, like, the immediate treatment for frostbite is rewarming, but there is still this sequela of the damage itself in terms of tissue damage and in terms of susceptibility to infection.

And there was a new episode of that that happened in the two weeks prior to when I saw him.

101 **Q.** That's what I'm asking you to clarify. So we've established that untreated frostbite can lead to infection.

You would agree with that?

A. So what I would agree with is that untreated damage tissue after frostbite can lead to

infection.

102 **Q.** Okay. And an untreated infection can spread. You would agree with that?

A. Yes.

103 **Q.** So how did you determine that it was a new injury that was caused in the two weeks prior -- so you saw him in December of 2022 -- and not a worsening or spreading of the infection that went untreated that began in or around, based on his own evidence, in the winter of 2021-2022?

A. So respectfully, I'm here on my own time. I am unpaid. And I have already answered that question, which is that you cannot have the level of tissue damage that he had on his foot and for that -- sorry, cannot -- it is extremely unlikely. I won't say cannot, because in medicine nothing is 100 per cent.

It is extremely, extremely unlikely that you would have the level of tissue damage that he had when I saw him and for that to have been going on for longer than maybe two and a half weeks or three weeks. But, like, it would not have gone on for that long at that level without spreading.

That is extremely unlikely. And I've already answered that question.

104 **Q.** Well, in terms of spreading, I mean, we are

talking about an individual whose toe had auto amputated.

MS. CROWE: Mr. Diacur, I have to interject. The question has been asked and answered over and over. She's repeatedly explained that she feels that this is a distinct injury and was not connected to the original frostbite in the winter of 2021.

So I think it is time to move on.

BY MR. DIACUR:

105 **Q.** Well, I disagree, but I am prepared to move on.

Are you aware that Mr. Greaves has indicated that he is or was a user of crystal meth?

A. It actually wasn't the focus of my treatment for him, but I was aware of that, yeah.

106 **Q.** And you would agree that crystal meth, there are impurities In it that can cause neuropathy, particularly in the extremities?

A. So, I mean, it does act a vasoconstrictor, which can then in turn, in some people, lead to neuropathy.

107 **Q.** And neuropathy is nerve damage, in layman's terms?

A. Yeah.

108 **Q.** Neuropathy can lead to loss of sensation in the extremities?

A. It usually is painful first, but sometimes it can lead to loss of sensation.

109 **Q.** And when there is a loss of sensation, the patient's injuries to the extremities may not be treated properly as a result; would you agree with that?

A. This is really conjecture outside of -- maybe conjecture is a legal word I'm using wrong, but we are moving beyond what I actually know about Linsley and his specific condition and situation.

110 **Q.** I'm asking you in general about a user of crystal meth and somebody who suffered from neuropathy. They can lose sensation. It's possible that an injury might occur and not be treated properly as a result.

As a general proposition, would you agree with that?

MS. CROWE: Mr. Diacur, she's indicated that she can't speak to that in the context of Mr. Greaves, and she's here to give evidence with respect to his experience.

BY MR. DIACUR:

111 **Q.** No. That's not true at all. She's here to give relevant evidence that's applicable to this matter. It is not limited to Mr. Greaves whatsoever.

So the question is --

MS. CROWE: It should be limited to what is

in her affidavit and what her knowledge --

MR. DIACUR: Absolutely not. No. Not even close, counsel. No.

MS. CROWE: Okay, Mr. Diacur, I'm going to ask you --

MR. DIACUR: Any relevant question -- any relevant question --

MS. CROWE: I'm going to ask you again to, first of all, let me finish my questions and my comments and to use a respectful tone when we're speaking to each other.

MR. DIACUR: No, no. That is a ridiculous objection, counsel. It is not limited to the four corners of her affidavit.

MS. CROWE: I think your response is ridiculous.

MR. DIACUR: No. It is not limited in any way to the four corners of this witness's affidavit.

MS. CROWE: And her knowledge.

MR. DIACUR: She can answer relevant questions that.

MS. CROWE: Well, I guess that's where we disagree, then. I disagree that what you are asking is relevant, and so that's a refusal.

---REFUSAL

BY MR. DIACUR:

112 **Q.** Okay. Well, that is a completely different matter. But that refusal is -- again, it is ridiculous. It's a relevant question.

Was drug use neuropathy and untreated injury considered as a potential causative factor in terms of Mr. Greaves' foot issues?

A. I mean, I was mostly focused, honestly, on getting him to the right level of care. Like at that point in time, the focus was on the fact that he had this massive infection that needed timely treatment.

And so whether or not crystal methamphetamine contributed to it wasn't a primary driver in me referring him to the hospital.

Yeah. Yeah. And then in terms of whether it contributed to his injury --

113 **Q.** No. That's not the question.

A. No?

114 **Q.** Did you consider as a differential diagnosis the possibility that his injury was either caused or contributed to by his drug use, neuropathy, loss of sensation?

A. And, sorry. How does that apply to my assessment and treatment of him?

115 **Q.** I'm asking you if you did any sort of

differential diagnosis. Did you?

A. So, a different -- I mean, yes. I laid it out in my affidavit, which is the differential diagnosis is osteomyelitis, wet gangrene, dry gangrene.

Can we go back to my --

116 **Q.** I can put it back up on the screen for you. That's what I'm asking you --

A. I guess the thing --

117 **Q.** I'm not asking you about the possible knock on effects, let's call them, in layman's terms of the injury.

I'm asking you about the diagnosis of the cause. Did you consider any other potential causes, including Mr. Greaves' drug use, including neuropathy which may flow from it, and including --

A. So I think I see what you are saying. So rarely, almost never, would somebody's diagnosis be due to one thing. Right? If you have a heart attack, it's probably age, it's genetics, it's smoking, it's environmental. All of those sorts of things.

So in terms of considering what could have contributed, yes, I did consider that crystal methamphetamine could have contributed to things in a more distal way.

In terms of proximal issues, so then the

most immediate cause leading to his injury and presentation, no, I did not consider it as part of the most proximal causes, because I do not think, and still don't think that, you know, smoking crystal methamphetamine that day or that week or two weeks prior contributed.

However, I did think -- and it's not in my affidavit. I can appreciate that. I did think that, you know, months prior using crystal methamphetamine could have been, one, not the direct, just to be clear, very clear, not the direct reason, but could have been a contributing factor, along with other factors, to his overall presentation, yes.

118 **Q.** What other factors did you consider?

A. So the fact that he had a prior injury in terms of the frostbite before and tissue damage before.

119 **Q.** So having existing tissue damage is also a potential causative factor for new injury?

A. So causative is not the word I would use. It doesn't meet the causative criteria. It is a risk factor, for sure. That's a risk factor. Smoking anything is a risk factor, whether that's cigarettes or methamphetamine or whatever. That is a risk factor.

Age is a risk factor in terms of -- not getting frostbite, like, that doesn't have to do with it,

but the ability of the body to, like, modulate its response to cold and exposure and the ability of -- like, also just in terms of atherosclerosis and other forms of peripheral vascular disease. So those would be the main things that would be potential risk factors.

However -- and like the main reason, just to be clear, of me thinking of what are the main contributing factors to him having this infection have nothing to do with litigation. They have to do with what can we actually do to prevent worsening of this and prevent this from happening again. They're for his health.

And the main factor in that was getting cold and getting wet. Those were the main factors. Those were the main preventable things that we could -- I reviewed my clinic notes immediately prior to this, and it says, like, there's no way that he's going to be able to recover from an infection if he's constantly on the move and can't get his antibiotics and he's constantly getting wet. He really needs to be admitted to hospital so that he can be in one place and be dry so that he can get treatment for this, because at that point in time I worried that he would need an amputation, but I didn't know that that was what was going to happen.

And sometimes the treatment for these

infections is intravenous antibiotics, and they are able to salvage the tissue. So at that point in time, that was my thinking.

120 **Q.** Okay. Well, I think that was actually in answer to my earlier question.

You mentioned medical notes or records that have not been produced in this matter. Why didn't you include these other contributing factors that you just mentioned in your report prepared for purposes of this litigation?

A. Because I was focusing on the most proximal factors that led to the situation.

121 **Q.** Your report doesn't say the most proximal factors. It says it's the direct cause.

A. I guess we interpret proximal differently. I would interpret direct as this is the thing that happened right before the thing -- the other thing that happened. That's direct, rather than indirect causes.

122 **Q.** And you don't mention any other contributing factors, including the ones that you now say that you did consider?

A. Yeah, fair enough. Again, I was looking at direct causes. Yeah. And -- yeah, anyway. We won't go there.

MR. DIACUR: Okay. Well, thank you very

much, Doctor. I appreciate you attending and answering. Those are all my questions.

MS. CROWE: Thank you, Dr. Bodkin. If you can just give me a moment to look at my notes and see if there's any thing further that I'd like to ask you about.

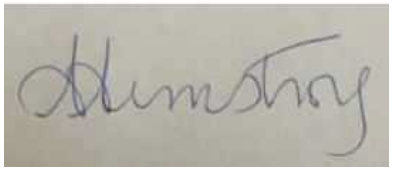
---OFF THE RECORD AT 1:15 p.m.

MS. CROWE: Thank you very much for your time, Dr. Bodkin. I don't have any other questions for you.

--- The examination concluded at 1:16 p.m.

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. CLAIRE BODKIN, given under oath before me on the 6th of September, 2024.

Amy Armstrong, CVR-RVR



Certified Realtime Verbatim Reporter #7305

Certified Commissioner of Oaths

Certified this 7th of September,2024

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TAB 10

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

Respondents

--- This is the Cross-Examination of DR. RACHEL LAMONT, upon her two affidavits sworn July 4, 2023 and her affidavit sworn June 7, 2024, taken via video conference hosted by the offices of Nimigan Mihailovich Reporting Inc., 1 James Street South, Suite 701, Hamilton, Ontario, L8P 4R5, on the 7th day of October 2024.

A P P E A R A N C E S :

Sharon Crowe, Esq., for the Applicants
& Michelle Sutherland, Esq.,
& Curtis Sell, Esq.

Bevin Shores, Esq., for the Respondents

REPORTED BY: Lorraine Fedosoff, (CSR) Ontario

I N D E X

WITNESS: DR. RACHEL LAMONT

PAGE

CROSS-EXAMINATION BY MS. SHORES..... 5

RE-EXAMINATION BY MS. CROWE..... 135

The following list of undertakings, advisements and refusals is meant as a guide only for the assistance of counsel and no other purpose

INDEX OF UNDERTAKINGS

The questions/requests undertaken are noted by U/T and appear on the following pages: None

INDEX OF ADVISEMENTS

The questions/requests taken under advisement are noted by U/A and appear on the following pages: None

INDEX OF REFUSALS

The questions/requests refused are noted by R/F and appear on the following pages: 26:21, 27:2, 27:7, 27:13, 27:19, 28:23

INDEX OF EXHIBITS

NUMBER/DESCRIPTION	PAGE NO.
1: Capture of September 2, 2021 Twitter comment of Dr. Rachel Lamont in response to a comment by Joey Coleman.	12
2: Thread of Twitter posts.	17

--- upon commencing at 1:33 p.m.

DR. RACHEL LAMONT: Affirmed

CROSS-EXAMINATION BY MS. SHORES:

1. Q. Good afternoon, Dr. Lamont. As I indicated off record, my name is Bevin Shores. My pronouns are she and her. I'm one of the lawyers for the City of Hamilton in this matter.

Can we start by just having you please state for the record your full name, how you would like to be addressed and if you have any pronouns you wish to share?

A. Thank you. My full name is Rachel Lamont. I'm happy to be called Rachel or Dr. Lamont, whatever is more comfortable for you, counsel, and pronouns are she and her.

2. Q. And where are you participating in your examination from today?

A. I am in an apartment in Hamilton.

3. Q. And can you confirm that you're alone in the room?

A. I can confirm I'm completely alone, yes.

4. Q. And as we discussed off record, you're aware that you're to have no assistance in giving your answers today?

A. Yes.

5. Q. And if you're referring to any materials in giving your answers other than your affidavits and the exhibits to your affidavits, we need to state what you're referring to, make an exhibit and explain how it forms your evidence. Is that understood?

A. Yes, it is.

6. Q. You've been affirmed to tell the truth just now?

A. Yes.

MS. SHORES: I'd like to just state for the record before we get underway there is currently a dispute among counsel about whether Dr. Lamont's evidence is fact witness or expert witness evidence, and so this examination is being conducted without prejudice who are observing all positions regarding that dispute.

BY MS. SHORES:

7. Q. Dr. Lamont, what do you understand your role is in this litigation?

A. I understand my role was to provide my medical knowledge in relation to some of the individuals who are applicants in the matter and to state whether in my medical -- based on my

medical knowledge if I believe there to be any sort of impact on encampment evictions -- sorry, from encampment evictions on the health and well-being of the applicants.

8. Q. And I understand that you haven't previously been qualified to give evidence as an expert witness in a court in Ontario; correct?

A. That is correct.

9. Q. Okay. And perhaps stating the obvious, but there's no Rules of Civil Procedure Form 53 appended to your affidavits; correct?

A. That is correct.

10. Q. And no curriculum vitae appended to your affidavits; correct?

A. That is correct.

11. Q. You're a psychiatrist?

A. Yes, I am.

12. Q. And you're currently working with the Shelter Health Network in Hamilton?

A. Yes.

13. Q. And I believe if I understand on the CP -- or College of Physicians and Surgeons' website, that you gained your independent practice certificate in June 2019?

A. Yes, that is correct.

14. Q. Okay. And the independent practice certificate is what permits you to provide independent and unsupervised medical practice in Ontario; correct?

A. Yes, it is.

15. Q. So basically to put it in more lay terms, you've been practicing independently as a psychiatrist for about five years to the present day?

A. Yes, that is correct.

16. Q. Now, the College of Physicians and Surgeons has your main office located in Welland; is that accurate?

A. Yes, it is. I have a number of practice locations in addition to the Shelter Health Network and Hamilton's Social Medicine and Response Team.

17. Q. So you're still practicing in Hamilton, but also practicing in Welland and potentially other locations as well?

A. Yes, that is correct.

18. Q. Now, your affidavits append several letters collectively between them, the subject matter of which are eight of the applicants in this proceeding, one per letter. Were each of

the letters written by you?

A. Yes, they were.

19. Q. All of the letters are addressed to Sharon Crowe who is here with us today, one of the lawyers for the applicants; is that correct?

A. Yes, they are.

20. Q. Were there instructions provided to you in writing those letters?

A. No, there were no instructions. There was a question asked of me, which was if I, in my knowledge -- or sorry, if I could complete assessments of individuals to see if -- based upon those assessments if I thought there were any impact of encampment evictions on the health and well-being of those individuals, but I was asked that as a question. I was not given instructions.

21. Q. And you haven't conducted any research independently in the preparation of the letters appended to your affidavits; correct?

A. I'm not sure what you mean by "research". Could you clarify?

22. Q. I've not been asked that question before. Research meaning did you conduct any experiments, do any reviews of literature, anything like that, research?

A. I see. I see what you're saying. No, I did not, not specifically related to this. I wonder if you meant research into the clinical records and that type of thing before --

23. Q. You perhaps anticipated my next question, which is that I noticed that there were no documents identified in your letters as points of reference. So can we take it that there were no documents reviewed in preparing your letters?

A. No, you cannot. I did review many clinical records for each applicant.

24. Q. Okay. So how do you know looking at your letters which records were reviewed?

A. I did not specify in the letters; however, before every assessment that I completed of those individuals, I can confirm that I did review Clinical Connect, which is a centralized repository of hospital records for Southwestern Ontario, and reviewed any and all records available for each applicant contained within Clinical Connect.

I also reviewed every applicant's Shelter Health Network electronic medical record and reviewed their Hamilton Social Medicine Response Team electronic medical record.

25. Q. And none of that is indicated in any of the letters?

A. It's not indicated in the letters, no.

26. Q. Have you ever used a social media platform known as X formally Twitter?

A. I used to have Twitter, yes.

27. Q. All right. Your handle was @lamontrachel11?

A. Yes, it was.

28. Q. I'm going to take you to a document which I'll place on the screen. Now, this is a capture, Dr. Lamont, and it is a capture of a tweet.

If you see at the bottom, it's dated 2 September 2021, and at the top it says Rachel Lamont, @lamontrachel11. Is that your Twitter handle?

A. Yes, it is.

29. Q. And it appears to be a tweet responding to a tweet by Joey Coleman, Twitter handle @joeycoleman stating:

"The @cityofhamilton encampment support team operates out of this building. The closure of public

washrooms to block their use by homeless individuals is one of the many reasons medical and social professionals who help homeless people say City Hall is making things worse."

He goes on with his hashtags, and then you respond stating:

"I used to feel proud to call Hamilton home. Actions by City officials, especially over the past year, make me ashamed. I cannot comprehend the complete lack of understanding, compassion or even common sense in these situations @cityofhamilton."

You made that tweet?

A. I did.

30. Q. And you agree with that statement?

A. I do.

31. Q. Now, I'll take you --

MS. SHORES: Let's, I'm sorry, mark this as Exhibit 1 to the examination of Dr. Lamont.

EXHIBIT NO. 1: Capture of September 2, 2021 Twitter comment of Dr. Rachel

Lamont in response to a comment by Joey Coleman.

BY MS. SHORES:

32. Q. I'll take you to another printout, Dr. Lamont. This one is again a capture and it appears to be dated September 5, 2022, again, from the Twitter handle @lamontrachel11, and the first one says:

"A few days ago, my attention was drawn to a deeply disturbing sign posted at 124 Walnut Street South. I could not stop thinking about it. Thanks @marcie58632320 for writing this response poem with me."

Did you write that tweet?

A. Yes, I did.

33. Q. And @marcie58632320, that's Marcie McIlveen?

A. Yes, it is.

34. Q. She's a friend of yours?

A. She's a colleague of mine.

35. Q. And you are aware that she's also -- she was a witness in the injunction motion in this proceeding?

A. I was not aware of that, no.

36. Q. Okay. So let's scroll down in the capture of this tweet and I'll zoom in. So there appears to be a tweet by Marcie, @marcie58632320:

"What is this? Who put this up? Presently writing a response poem with a friend."

And then there's a photograph of a sign for 124 Walnut Street South and there's a poem in yellow type on a black background there. Do you see that?

A. Yes, I do.

37. Q. And you'd agree that that is the deeply disturbing sign posted at 124 Walnut Street South referenced in your tweet?

A. Yes, it is.

38. Q. Now, in terms of your response powem referenced in your tweet, Ms. McIlveen tweets in another tweet dated September 3 "Our response", and there appears to be a photograph of a word processor with a poem typed on it. Do you see that?

A. Yes, I do.

39. Q. Okay. And did you work with Ms. McIlveen in creating that poem?

A. Yes, I did.

40. Q. Now, if we scroll down, there's another tweet by Marcie, @marcie58632320:

"@lamontrachel11, we shall post it, right?"

And then beneath it, it says:

"Replying to @marcie58632320 and @jennbrasch [spelled J-E-N-N, B-R-A-S-C-H] I have the supplies."

And a smiley face emoji. You wrote that tweet?

A. Yes, I did.

41. Q. And then subsequently, there is a photograph showing the -- what appears to be the same sign at 124 Walnut Street South. You'd agree that was the same sign?

A. It appears to be, yes.

42. Q. Okay. And there's some black paint over the wording of the yellow type on the black background; correct?

A. There is, yes.

43. Q. And there is what appears to be a handwritten poem pasted -- or I'm sorry, taped beneath; correct?

A. Yes, there is.

44. Q. What appears to be white paper with some sort of black handwriting?
A. Yes.
45. Q. And you'd agree that's the poem that you and Ms. McIlveen wrote?
A. Yes, it is.
46. Q. The black paint over the yellow and -- the yellow type on the black background appears to be in the shape of an upside down "A" with a circle. Do you agree?
A. It's very hard to see, but I can appreciate what you're suggesting what the outline is.
47. Q. That's commonly known as a symbol for anarchy?
A. Yes.
48. Q. Did you have any involvement in the spray painting or the pasting of the poem on this board?
A. Absolutely not, and I've actually not seen a picture with -- I didn't see the sign after the -- I knew the sign was being put up, the poem sign. I did not see any sort of picture that showed that symbol above.
49. Q. So you have no knowledge of this?

A. I have no knowledge of that.

50. Q. But you did partake in writing the poem?

A. Yes, I did.

51. Q. And you were aware that the poem was intended to be posted on that sign?

A. Yes, I was.

MS. SHORES: I'm going to mark this thread of Twitter posts as Exhibit 2 to Dr. Lamont's examination.

EXHIBIT NO. 2: Thread of Twitter posts.

BY MS. SHORES:

52. Q. You'll agree, Dr. Lamont, that you're an advocate for people experiencing homelessness?

A. I would agree that on many occasions, that in my professional role as a physician, it is my obligation to advocate for my patients, many of whom are unhoused.

53. Q. And your involvement in this case is part of that work, advocating for people who experience homelessness?

A. Yes, it is.

54. Q. You've attended at least one of

the meetings of Hamilton City Council; correct?

A. Yes, I have.

55. Q. And at least one of those meetings was in January 2023?

A. I can't remember the date. I know I did attend one. I don't recall the date it was specifically.

56. Q. And your attendance on that occasion was with the intention of urging the City Council to allow people to remain in encampments?

A. I don't know which meeting you're specifying. So I can't say with certainty what my role was there.

57. Q. Have you ever attended at Hamilton City Council for any other reason other than on the subject matter of encampments?

A. I have watched many council meetings.

58. Q. Okay. But specifically with respect to a delegation at the City of Hamilton City Council meeting, have you ever attended on any subject matter other than encampments?

A. No, I have not.

59. Q. I'm going to turn you to your affidavits now, and I'll start with your June 7,

2024 affidavit which will be the bulk of my examination today.

I'm going to ask you first about the first paragraph of this affidavit, which I'll put to you and you can take a minute to look at them, but it appears to be the same wording as in your July 4th affidavits. So I'll read for the record and then I'll let you read for yourself:

> "I have personal knowledge with respect to the facts and reports 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 creditable and true."

So first question is just confirming that that's the same in each of your affidavits. So this is your July 4, 2023 affidavit appending the report of -- the report concerning Kristen Heegsma, your July 4, 2023 affidavit which appends the report of Dr. Pierre -- or I'm sorry, of Ms. Pierre, and then, again, the first paragraph of your June 7, 2024 affidavit. So we agree those are all the same text?

A. Yes, they are.

60. Q. Okay. And you'll agree that that paragraph is accurate?

A. Yes, it is.

61. Q. Now, just with respect to the two July 4 affidavits, those each append letters dated May 11, 2023. So I'll take you to Exhibit A to your first July 4, 2023 affidavit. This is the letter dated May 11, 2023 with respect to Ms. Pierre.

As best I can tell, Dr. Lamont, that seems to be the same letter that appears as Exhibit G to your July 7 -- I'm sorry, June 7, 2024 affidavit which I'll take you to now. Would I be correct in that understanding, it's the same letter?

A. Yes.

62. Q. Okay. And so I'll ask you the same question with respect to your letter concerning Kristen Heegsma.

So taking you first to your July 4, 2023 affidavit, Exhibit A to that affidavit is a June 20, 2023 letter regarding Kristen Heegsma, and then if we go to your June 7, 2024 affidavit, Exhibit A to that affidavit is also a June 20, 2023

letter regarding Kristen Heegsma, which again, as far as I can tell, is the same letter. Is that also correct?

A. Yes, that's correct.

63. Q. Okay. All right. So then for purposes of this cross-examination, I'm going to focus on your June 7, 2024 affidavit.

So turning back to the body of your affidavit, you describe at paragraph 2 of your June 7, 2024 affidavit that you're a physician with Shelter Health Network and the Hamilton Social Medicine Response Team, which goes by HAMSMaRT, and then you go on to describe in the last sentence that you've worked with SHN, Shelter Health Network, since May of 2022 and that you joined HAMSMaRT in September 2021.

Can you just describe what your role is first with Shelter Health Network?

A. Yes, so my role with Shelter Health Network is primarily as a consulting psychiatrist, so providing comprehensive diagnostic assessments and treatment recommendations for individuals experiencing homelessness or who are precariously housed.

I often as well act as a point person

for some of the family doctors working for Shelter Health who may call me for advice about a specific patient in relation to mental health diagnosis or treatment.

64. Q. And around the time that you gave these affidavits, so 2023 and 2024, how frequently were you working at Shelter Health Network?

A. About once per week.

65. Q. Okay. And on those once per week occasions, would you be seeing patients the entire time?

A. It depended on the week and the number of people that would attend. But yes, most weeks I would be seeing patients for Shelter Health Network.

66. Q. And how long were the days that you worked at Shelter Health Network?

A. A half day, one-half day.

67. Q. Okay. And half days means different things in different professions. What would a half day be in term of hours, roughly?

A. Three to four hours.

68. Q. And is that still your -- an accurate description of your role at Shelter Health Network these days?

A. With Shelter Health Network these days, primarily I'm actually only with them about one half day per month.

69. Q. Okay. And when did that change?

A. It's about a year, in the last year, yeah.

70. Q. So we're in October of 2024. So about fall of 2023 you would have gone down to about once a month at Shelter Health Network?

A. Yes, that is correct.

71. Q. And with respect to HAMSMaRT, are you still working with HAMSMaRT?

A. Yes, I am.

72. Q. And so at the time that you gave these affidavits, so 2023 and the first half of 2024, what was your role at HAMSMaRT?

A. So my role at HAMSMaRT is also consulting psychiatrist, though at HAMSMaRT I do follow people longitudinally as well. So I work every Tuesday afternoon with HAMSMaRT every week, and I often work Tuesday mornings, perhaps one to two Tuesday mornings per month.

And again, I'm available for advice for my colleagues, internal medicine colleagues at HAMSMaRT if they have questions or require advice

about specific patients.

73. Q. And the afternoons that you're there, again, would that be about three to four hours?

A. Yes, it is.

74. Q. And the work that you do for HAMSMaRT is separate than the work that you do with Shelter Health Network? So in other words, you would have one day at Shelter Health Network and a separate day at HAMSMaRT seeing separate patients?

A. Yes, that is correct.

75. Q. Are you aware that HAMSMaRT previously sued the City of Hamilton regarding encampments in 2020?

A. I am aware, yes.

76. Q. And you'd agree with me that HAMSMaRT is, among other things, an advocacy organization?

A. Yes, it is.

77. Q. With respect to your -- sorry, you indicate at paragraph 2 of your affidavit that the Shelter Health Network and HAMSMaRT are organizations that provide medical care to individuals affected by homelessness or housing precarity.

I want to ask you some questions about homelessness. You'd agree that people who become homeless often have physical and mental health problems which worsen over the period that they're homeless; correct?

MS. CROWE: Ms. Shores, I want to just interject for a moment because she's here to speak about the individual applicants that she saw and assessed.

MS. SHORES: Well, but her -- but Dr. Lamont's evidence is expressing among other places opinions, in our submission, on the effects of homelessness on individuals including the individuals that she speaks to, and it's perfectly in bounds to get a baseline of her understanding about what the causes -- or I'm sorry, about what the effects of homelessness cause of these individuals.

MS. CROWE: In these individuals. Yes, so -- okay. So if we're confining it to the -- her patients that she's seeing and assessing, then I take no issue with that.

MS. SHORES: Well, but I want to be absolutely clear. My question is just about homelessness in general.

MS. CROWE: So the difficulty that we have, Ms. Shores, is, as you know, we disagree on -- so our intention is very clear to have Dr. Lamont here and participate as a fact witness, and so to give her factual knowledge of the individuals that she assessed in completing her affidavits. So I think those are the proper boundaries of her examination.

MS. SHORES: Well, I maintain my position that this is a proper question. So I will ask my questions and you can provide your position. With respect to that one, is that a refusal, or will Dr. Lamont be answering the question?

MS. CROWE: Can you ask it again, please?

BY MS. SHORES:

78. Q. Would you agree, Dr. Lamont, that people who become homeless often have physical and mental health problems which worsen over the period that they're homeless?

R/F MS. CROWE: That's a refusal.

BY MS. SHORES:

79. Q. And Dr. Lamont, would you agree that deaths due to unintentional overdose of drugs or alcohol or both are also common in a population

of people who experience homelessness?
R/F MS. CROWE: That's a refusal as well.
BY MS. SHORES:
80. Q. Dr. Lamont, would you agree that the prevalence of serious mental illness is high among people who experience homelessness?
R/F MS. CROWE: It's a refusal.
BY MS. SHORES:
81. Q. And Dr. Lamont, would you agree that infectious diseases are a common cause of health problems in people who experience homelessness?
R/F MS. CROWE: It's a refusal on the same grounds.
BY MS. SHORES:
82. Q. Would you agree, Dr. Lamont, that homeless people with mental illnesses often receive inadequate care for their medical comorbidities?
R/F MS. CROWE: Ms. Shores, that's a refusal, and I think -- obviously you can continue to ask the questions, but I think you understand the nature of my objections.
MS. SHORES: And I am asking my questions, put them on the record, and you --
MS. CROWE: Okay.

MS. SHORES: -- your objection on the record.

BY MS. SHORES:

83. Q. Dr. Lamont, you'd agree that people can be assaulted in encampments; that's correct?

THE WITNESS: I'm okay to answer this one?

MS. CROWE: Yes.

THE WITNESS: Okay. It is possible for a person to be assaulted anywhere. So yes.

BY MS. SHORES:

84. Q. And similarly, you'd agree that people can have things stolen from them in encampments; correct?

A. Things can be stolen from someone anywhere. So yes.

85. Q. You'd agree that people can suffer hypothermia in encampments; correct?

A. It is theoretically possible, yes.

86. Q. You'd agree that people can suffer frostbite in encampments; correct?

R/F MS. CROWE: So I think I'm going to interject again because, again, we're just talking about generalized statements. We're really moving

away from the individual applicants.

And the other point, the other basis for my refusal on that question is that, as you know, Dr. Lamont is here as a psychiatrist.

MS. SHORES: Well, we'll get to that.

BY MS. SHORES:

87. Q. Now, Dr. Lamont, you'd agree that in treating a patient it's important to obtain an understanding of their medical history?

A. Yes.

88. Q. And that it's important to obtain an accurate medical history to the extent you can?

A. Yes.

89. Q. And that to the extent you can, it's also important to obtain a comprehenstive medical history in the sense that it doesn't leave out anything significant?

A. Yes.

90. Q. And you'd agree that an accurate and comprehensive medical history is also important in giving a medical opinion about a patient?

A. Yes.

91. Q. You'd agree that an inaccurate or incomplete medical history would affect the reliability of a medical opinion that's based on

that history; correct?

A. It's possible that it could, yes.

92. Q. In a sense that it could be less reliable if the medical history is inaccurate or incomplete, yes?

A. It's possible, yes.

93. Q. And you'd agree that some patients may not be able to give you an accurate or comprehensive medical history; correct?

A. That is correct in all areas of medicine, yes.

94. Q. And that some patients may not be able to accurately or comprehensively report their experiences to you; correct?

A. That does happen, though I would say, for the most part, individuals are able to relay their own experiences quite well.

95. Q. If a patient is unable to accurately or comprehensively report their medical history or experiences to you, you'd agree that could compromise the reliability of a medical opinion based on that report; correct?

A. Well, I would place a caveat on that, that within psychiatry in particular, a special part of our training is ascertaining

whether the information an individual is providing is reliable or not based on internal consistencies within their report as well as consistencies in relation to collateral information, and a very important piece of any psychiatric and medical history is obtaining collateral information.

96. Q. And so did you obtain collateral information with respect to the patients that you're speaking to in your June 7, 2024 and July 4, 2023 affidavits?

A. Yes, I did wherever possible, and I can speak to each applicant as we raise their letters, if that's helpful.

97. Q. Okay. We will do that. You'd agree that opioid and stimulant use disorder are conditions that could affect a patient's ability to give you an accurate and complete history; correct?

A. Having the diagnosis itself doesn't necessarily make someone unable to provide accurate information. I think at times if someone is particularly intoxicated or if they've had long cycles of intoxication and withdrawal, it may give them some difficulty with memory and recall of information, yes.

98. Q. And a psychosis could be a

condition that would affect a patient's ability to give you an accurate and complete history; correct?

A. It can, although typically it only impacts a person's ability to provide information in relation to whatever the nature of their psychosis is.

For example, if they have delusions about a particular person, the information they provide about that particular person may not be reliable, but they might be quite reliable in providing information about other topics that are not central to their psychotic symptoms.

99. Q. Schizophrenia would be a condition that could affect a patient's ability to give you an accurate and complete history?

A. I don't -- I mean, certainly it's possible, especially if someone's very acutely unwell and thought disordered, but most people with schizophrenia would actually be able to provide a reliable history.

100. Q. And fetal alcohol syndrome, the symptoms of that condition, you'd agree, could affect a patient's ability to give you an accurate history?

A. Some of the symptoms, particularly

the cognitive symptoms of that condition, could affect an individual's ability to provide information, yes.

101. Q. Turning to your letters that are appended to the affidavits as exhibits, just looking at the letterhead, there's two logos that appear at the top for each of these letters. One of them is the McMaster Department of Psychiatry and Behavioural Sciences and the other appears to be HAMSMaRT.

Are these letters provided under the auspices of the McMaster Department of Psychiatry and Behavioural Services?

A. Behavioural Neurosciences? No, they're not. That's simply one of my credentials as an assistant professor with the university, and so it's typically on the letterhead that I use.

102. Q. Are you still an assistant professor with McMaster University?

A. Yes, I am.

103. Q. And you were at the time that you wrote these letters?

A. Yes, I was.

104. Q. Is the McMaster Department of Psychiatry and Behavioural Neurosciences affiliated

with HAMSMaRT?

A. Not in any way, no.

105. Q. And were you providing these letters under the auspices of HAMSMaRT?

A. Not directly, no. It was my own -- I was seeing the patients through HAMSMaRT's electronic medical record, but there was no direction from the organization of HAMSMaRT for me to provide these letters.

106. Q. Referring first to Exhibit A to your June 7, 2024 affidavit, which again for the record also appears as Exhibit A to your July 4, 2023 affidavit regarding Kristen Heegsma, at paragraph 2 you state that you've been Ms. Heegsma's treating psychiatrist since November 2021. I take it, then, you saw her either through Shelter Health Network or HAMSMaRT?

A. Yes, she was my patient through HAMSMaRT since November 2021.

107. Q. Approximately how many times would you have seen her for treatment before writing this letter in June of 2023?

A. [Indiscernible] 15.

108. Q. You state at paragraph 2 that you can confirm that she has diagnoses of

post-traumatic stress disorder, borderline personality disorder, generalized anxiety disorder, depression and opioid and stimulant use disorders, but you don't say that you diagnosed her with these. Can I take it that someone else diagnosed these conditions previously?

A. Those diagnoses were all pre-existing prior to my involvement and already a part of her medical record; however, I did confirm those diagnoses while I treated her.

109. Q. And when you say "medical record", you're referring to that electronic medical record that you described previously?

A. Yes.

110. Q. And in the third paragraph of your letter, the third sentence you state with respect to Ms. Heegsma:

> "She had been repeatedly evicted from encampments previously."

And in the sentence immediately preceding that, you say that:

> "She had just been evicted from a tent in Corktown neighbourhood by the City of Hamilton."

I take it that's information that Ms. Heegsma reported to you?

A. Yes, it was.

111. Q. Okay. Was that information that she reported to you, or was that documented in a medical record? Do you know?

A. I believe it was both. I do distinctly remember the first time I met Ms. Heegsma because she was highly distressed, and Dr. O'Shea was her treating physician at that time. I believe he documented the eviction from Corktown and then she also reported it to me.

112. Q. And so Dr. O'Shea would have been recording in the records what Dr. -- or I'm sorry, what Ms. Heegsma reported to him?

A. That's correct.

113. Q. So you don't have any first knowledge of how these so-called evictions transpired? You didn't witness them?

A. I did not witness them, no.

114. Q. And so in terms of corroborating information that's relayed to you, that's not something that you took independent steps to verify?

A. No, I did not.

115. Q. And similarly, if we go to the middle of the second paragraph, you state:

"Additionally, because her tent had been destroyed, she was sleeping on a park bench in the days following the encampment eviction."

Again, that was reported to you?

A. By Ms. Heegsma, yes.

116. Q. And again, was that reported to you, or written down in a medical record?

A. It was reported to me by Ms. Heegsma.

117. Q. And again, you weren't aware of -- firsthand of her tent having been destroyed; correct?

A. Not firsthand, but I did see her shortly after it did happen.

118. Q. And similarly, the sleeping on a park bench, that's not something that you independently viewed yourself? That's what she reported?

A. That is what she reported, yes.

119. Q. In the second -- or I'm sorry, third to last sentence of the second paragraph of this letter you state:

"A few days after the eviction from her tent in Corktown neighbourhood and while she was sleeping on a park bench, she was the victim of a violent sexual assault."

Did you treat her for that?

A. In terms of her mental health in the immediate aftermath, yes.

120. Q. And what is the source of your information that she was a victim of a violent sexual assault?

A. Ms. Heegsma.

121. Q. And in writing this report, the source of your information is those records that you have referred to previously?

A. In terms of other alternate sources of information? Is that what you are asking?

122. Q. Yes.

A. Yes. And I would also note that Ms. Heegsma regularly attended the Keeping Six Drop-In Centre, and other individuals that attend the drop-in expressed a lot of concern about her well-being at that time.

123. Q. When you say in the second to last sentence of the second paragraph "This caused additional, severe worsening of her mental health conditions and substance use", what's your source for that?

A. That was my direct observation of worsening in symptoms, both in frequency and severity of both her mental health conditions and escalations in her substance use.

124. Q. I have to put it to you, though, Dr. Lamont, you indicate that at that time, that was when you had just met her. So wouldn't you agree that you didn't have a baseline for her substance use prior to that incident?

A. I did have records from Dr. O'Shea, who is my colleague who works in the same clinic and who had been following her for a period of time before that, who was -- very clearly indicated a worsening in the substance use and a very clear deterioration in her mental health, which was also corroborated by other individuals using the space who knew Ms. Heegsma.

125. Q. The last sentence of the second paragraph you state:

"She also had her belongings

stolen repeatedly."

Again, what was the source of that information?

A. That was reported by Ms. Heegsma, and I would often see her coming into clinic asking for very basic necessities and refills of her prescriptions because everything had been stolen.

126. Q. So again, she indicated that things had been stolen and she was asking for refills of her prescriptions?

A. And other basic necessities like clothing and hygiene products.

127. Q. Now, with respect to prescriptions, in particular, Dr. Lamont, I have to ask you'd agree that that can sometimes be an indicia of drug seeking behaviour; correct?

A. Not typically, and especially not the medications I was prescribing Ms. Heegsma. I was prescribing her anti-depressant medications which have absolutely no street value and do not provide a high for anyone. So they're not -- asking for a refill of that medication is not a sign of drug seeking behaviour.

128. Q. In the fourth paragraph of the letter concerning Ms. Heegsma, you state in the

first sentence that:

"Ms. Heegsma has since spent brief amounts of time in shelter and in YWCA transitional housing, though has also been asked to leave those spaces due to her complex health needs and those services being unable to offer the required level of support."

Speaking specifically to the reasons that she was reportedly asked to leave, what is the source for that information?

A. So I did not call the shelters specifically. I only know that she was asked to leave and service restricted and I was not given a reason from the shelters.

I did speak to the YWCA personally because I was trying to advocate for her to get a spot, and they said that her -- they simply said, "Her needs are higher than that which we can support." They have some sort of scoring system that they use and they felt that her needs were too high.

129. Q. When did that occur?

A. Oh, I don't have a specific

recollection of the date, I'm sorry.

130. Q. And with respect to incidents other than your consultation with the YWCA, do you have any knowledge speaking about your firsthand knowledge about whether she was, in fact, asked to leave those spaces or the reasons for that?

A. Just as they were reported to me by Ms. Heegsma.

131. Q. You say that Ms. Heegsma in the next sentence "Thus continued to spend most of her time living outside." Again, what is the source for that information?

A. It is both her report as well as when I reviewed her medical record because she saw Dr. O'Shea more frequently than myself, and he would take note during their visits of where she was staying and the vast majority of the time she was outside.

132. Q. When you say "living outside", in the next sentence you refer to living in a tent. And so are those synonymous, she's living outside in a tent?

A. There were times when she was in a tent and there were times when she's been unsheltered outside.

133. Q. And again, based on her report to you?

A. That's correct. I just would like to add, because it keeps coming up, that people don't generally lie about whether they're sleeping in a tent or sleeping rough. They have no reason to do so.

134. Q. And your source for this letter in here again would be your recollection of what Ms. Heegsma reported to you and those records that you consulted that -- aren't referenced in this letter; correct?

A. Yes, that's correct.

135. Q. The second to last paragraph of your letter, so the first paragraph on the second page, you state:

> "It is my opinion that that repeated encampment evictions and, in particular, the encampment eviction in November 2021 and subsequent sexual assault, have been a major contributor to the ongoing instability in Ms. Heegsma's mental health and worsening of her substance use disorders over the

past three years."

I take it, Dr. Lamont, that you're giving that opinion based primarily on information that was relayed to you?

A. No, I would say I'm basing that largely on my clinical assessment of Ms. Heegsma in the time that I knew her and the deterioration I witnessed throughout that process and the impact that each encampment eviction, particularly the November 2021 eviction, had on her well-being.

136. Q. But again, those encampment evictions are what she has reported to you; correct?

A. Yes, she reported them to me, and would show up in absolute crisis after losing all of her belongings and having her tent torn down.

137. Q. And speaking of the corroboration that you described previously when I was asking you about patients reporting their histories and experience to you, you haven't done any sort of independent corroboration of those experiences; correct?

A. I would say that it would be uncommon in medicine to seek third party information for which something someone -- there's

no reason that Ms. Heegsma would lie about having her tent torn down. The way that she was presenting was very much in keeping with someone who would have had that experience.

There was no need for me to independently verify that. Just as much as if someone came in with, you know, chest pain, I wouldn't call their family and verify that they, too, had been told this person had chest pain. It doesn't -- it's not necessary.

138. Q. With respect to your opinion about the ongoing instability in Ms. Heegsma's mental health and her substance use disorders, you don't indicate any other potential causes such as other sequela of homelessness or any other conditions or factors; correct?

A. I did not indicate in this particular letter, no.

139. Q. And you'd agree that if the information provided to you was incorrect, that may change your opinion?

A. It would depend on the information that was provided.

140. Q. So let's go to Exhibit B of your June 7, 2024 affidavit. This is a letter dated

December 14, 2023 concerning Darrin Marchand.

Now, at the second -- or I'm sorry, second paragraph of this letter, you state that you've known Mr. Marchand since May 2023. So first off, if I'm doing the math correctly, that would be about seven months before writing this letter?

A. Yes, that is correct.

141. Q. Okay. And you say you've known Mr. Marchand, but was that in a doctor-patient relationship, or were you acquainted with him some other way?

A. So he was in a doctor-patient relationship with me since May of 2023, though I had seen him around and knew that he was someone named Darrin. Before that, I had no personal knowledge of him until he became my patient.

142. Q. And in that second sentence you state that you confirm:

"He has diagnoses of psychosis (substance-induced versus schizophrenia), and opioid and stimulant use disorder (severe)."

Again, you don't say that you diagnosed him with these. So may I take it that these were previous diagnoses?

A. They were previous diagnoses that I then confirmed with my own assessment, yes.

143. Q. Do you know when he was diagnosed with these conditions?

A. So again, I don't have specific dates, but I know that he was on a long-acting injectable anti-psychotic medication for at least ten years which is used to treat psychosis. So he would have been diagnosed with that condition many, many years before my involvement with him.

And the opioid and stimulant use disorders were also longstanding diagnoses, but I cannot comment specifically on the number of years.

144. Q. In the third paragraph you start with the sentence:

> "Mr. Marchand has shared his story with me dating back prior to my involvement with him."

And then in this third paragraph you go on to describe incidents that appear to have occurred in 2021. You're welcome to review that paragraph if you want. My question is that is everything in that paragraph based on what he reported to you?

A. It is based on what he reported to

me. However, when he was shot in the shoulder, that was then -- I independently verified that with his medical record, electronic medical record via the hospital system, as well as other peer workers at HAMSMaRT and Keeping Six who had known him during that time.

145. Q. When you say he was shot in the shoulder, you mean his treatment for the gunshot wound; correct?

A. Yes, that's correct.

146. Q. You didn't witness the gunshot?

A. No, I did not.

147. Q. And none of the other providers that you interacted with witnessed the gunshot?

A. No.

148. Q. Okay. And so just to put a finer point on it, you weren't his medical treatment provider at the time in 2021; correct?

A. That's correct.

149. Q. So you describe in the third sentence of the third paragraph:

"In the summer of 2021, he was evicted from an encampment along Strachan Street in Hamilton and again from an encampment on Rebecca

Street during that summer."

Again, you weren't treating him at the time that that -- those alleged encampment evictions occurred, right?

A. That is correct.

150. Q. And so when you say two sentences ahead that "He describes feeling a sense of hopelessness and despair following these encampment evictions and that his substance use escalated again", that's based on his reporting?

A. It is based on his reporting. Mr. Marchand also has a number of outreach workers that work with him and, in particular, an outreach worker out of the AIDS Network named Tess, and she also had observed a significant change in his substance use, a worsening in his substance use since that time.

151. Q. And to put a finer point on it, an outreach worker is someone who's going out in the community and interacting with Mr. Marchand when she can find him?

A. That's correct, and when he comes to the drop-in space at the AIDS Network.

152. Q. Okay. So you'd agree with me, though, that that doesn't provide a very regular

set of interactions in order to gauge the extent of his substance use?

A. I actually don't agree with that. I think an outreach worker that knows an individual and sees them, you know, whether it be every week or every two weeks or even every three weeks, you can notice a pattern over time and an escalation in someone's substance use.

153. Q. But in any event, this outreach worker's observations are not appended to or even referred to in your letter; correct?

A. That's correct.

154. Q. Now, with respect to your comment again in the third paragraph of your letter concerning Mr. Marchand, the second last sentence referencing the gunshot in December of 2021, you state that it contributed to additional ongoing trauma symptoms.

Again, you weren't treating him at the time. So that's not your medical opinion; correct?

A. It is what he reported to me, and it's very much consistent with what I would expect in someone with his history of mental health conditions and repeated traumatic experiences.

155. Q. In the last sentence of

paragraph 3 you state that:

"Mr. Marchand said that he felt much more secure in a tent with community who looked out for each other, something that's not possible when sleeping outside alone as he has resorted to doing because of repeated evictions."

So again, just with respect to the first part of that sentence, Mr. Marchand's reported feeling for security in a tent, you'd agree that there still can be violence against people who are staying in encampments; correct?

A. You did mention that earlier and, as I said, there can be violence toward anyone in any place. So of course there could be violence toward people in encampments.

I would say that for individuals with substance use disorders, with histories of trauma, a feeling of safety is extremely important and foundational for someone to find any sort of stability and recovery. And so when people feel unsafe, it is nearly impossible to find recovery.

And so for Mr. Marchand, when he said he did not feel safe when alone outside, that to me

is kind of a -- it would be a very common time when someone's substance use would escalate because they're feeling unsafe, and that is a driver of the substance use.

156. Q. But wouldn't you also agree, Dr. Lamont, that if someone feels safe in a circumstance actually not very safe, that could also not be a good thing for them because they'll remain in that circumstance and, thus, exposed to risks for longer?

A. I think most individuals have common sense and will seek the safest -- like I don't want to speak too generally here, but in the individuals that I've worked with and what has been reported to me, people don't want to be outside period.

They want inside -- to be inside in dignified, adequate housing, but, in the absence of that, people want the next safest option, and for individuals like Mr. Marchand and what he described to me at that time, he felt safer in a tent than exposed to the elements and he did not feel there were other options available to him.

157. Q. And so when you say at the very end of the third paragraph that Mr. Marchand had

resorted to sleeping alone outside because of repeated evictions, again, you don't have any firsthand knowledge of these so-called evictions; correct?

A. I don't have firsthand knowledge beyond which was reported to me by him and by -- and corroborated by the outreach worker.

158. Q. And so you don't know how long he would have been able to stay in a tent in between these so-called evictions; correct?

A. I don't know how long he was in between, that's correct.

159. Q. And you don't know whether he would have been offered shelter at any point in the process; correct?

A. I don't know.

160. Q. And whether he was offered help finding somewhere else to go; correct?

A. I'm assuming I know that Tess, the outreach worker, had often offered to try and find him help, but they were not able to secure him any anywhere.

161. Q. And at what point in time are you talking about? Is that on the one occasion where the -- I'm sorry, was that referring to the

evictions in 2021, or some other point in time?

A. I'm speaking when I knew Mr. Marchand. So beginning in the spring of 2023, I know that there were efforts and attempts to look for shelter and housing for him.

162. Q. And what is that knowledge based on?

A. Based on what Mr. Marchand and the outreach worker, Tess, reported to me.

163. Q. How frequently did the outreach worker, Tess, provide these reports to you?

A. There was no formal reporting. I don't know that I could offer you a specific timeline. I just know that when I worked with Mr. Marchand -- I have not seen him in sometime now, but, when I worked with Mr. Marchand, Tess would occasionally pop in and provide me with an update perhaps, you know, once every couple of weeks.

164. Q. Going to the top of the second page, in the third sentence you state:

> "At present, he contemplates suicide regularly because he cannot stay in shelter, he cannot stay in a tent, and staying outside is

becoming unbearable."

I want to ask you a few questions about that sentence. The first one is with respect to the report that he contemplates suicide regularly, there's no indication here that he was referred to inpatient treatment.

So would you agree with me -- or I take it that he wasn't actually expressing suicidal ideation, but something different, being contemplation?

A. No, I would disagree with you very strongly, actually. He did have suicidal ideation. It's very common for individuals in the community to have suicidal ideation, sometimes even with a plan to harm themselves.

Part of my role as a psychiatrist -- as a physician in general, but, as a psychiatrist, is to have an ability to perform a risk assessment and determine whether or not someone requires hospitalization or involuntary admission.

And so if I'm able to speak with someone and come up with a plan, whereby even though they're having suicidal ideation with a plan to harm themselves, they also have other protective factors and they're willing to come up with a

safety plan, then I do not -- they do not require hospitalization or even an ER visit.

165. Q. So can we take it, then, in these circumstances with respect to Mr. Marchand, those mechanisms, the safety plan and other resources, were sufficient and he didn't require hospitalization?

A. That is true, though I don't want to minimize the degree of suffering to which someone is experiencing when they are having suicidal ideation. It is a very clear sign of deterioration in their health and a strong signal that meant suffering.

166. Q. In that same sentence where you say he cannot stay in shelters, is that again based on what Mr. Marchand is telling you?

A. Mr. Marchand and the outreach worker, Tess. Mr. Marchand was service restricted from a number of shelters.

167. Q. And at what point in time, to your knowledge, was he service restricted from a number of shelters?

A. Again, I would be guessing, so I don't want to provide a specific date and time. I just recall in my involvement with him the shelters

were not an option because of service restrictions is what I was told.

168. Q. So to put a finer point on it, your understanding was that he was service restricted from every shelter and, therefore, could not stay in shelter?

A. That was my understanding, yes.

169. Q. For the entire time that you were treating him?

A. For those several months, yes.

170. Q. You say he cannot stay in a tent. Again, is this based on what he told you?

A. Yes.

171. Q. What was the reason for him not being able to stay in a tent?

A. He told me he was just too frustrated. It wasn't worth the effort to set up a tent just for it to be torn down again, and it was very upsetting to have that done repeatedly.

172. Q. So it would be more accurate to say, then, that he found it frustrating to stay in a tent, but not that he was unable to stay in a tent?

A. I think he felt unable to. Whether you want to say unable to because of the

intense frustration he felt, he just -- he felt it was not an option any more, not a viable option.

173. Q. And in the second to last sentences of the first paragraph on page 2, you describe sleep depravation and state that it further destabilized his mental health condition as well as contributed to an escalation in substance use. Again, this is based on Mr. Marchand's reports to you?

A. Yes.

174. Q. In the last -- or I'm sorry, second last paragraph of your letter, you state that it is your opinion that:

> "Repeated encampment evictions have been a major contributor to the deterioration of Mr. Marchand's mental health and worsening of his substance use disorders over the past three years."

So you're speaking about three years, but, again, I think we've just established that you had treated him for about seven months; correct?

A. That is correct, though I did receive information from an outreach worker that knew him well who also observed that decline.

175. Q. So your opinion, at least in part, is based on what Mr. Marchand told you and what this outreach worker told you?

A. Yes, that's correct.

176. Q. And so you can't say from your own personal assessment of Mr. Marchand whether, for example, substance use disorders have actually worsened over the previous three years to your letter?

A. I find that question particularly difficult to answer because, in general, in medicine we're not accompanying people through their entire life and observing every moment and everything that happens to them.

We take a history and we -- and when I take a history first of someone, I ask about their substance use and I ask specific questions about their use over time, and, from that, that is often how we can determine whether someone's substance use disorder has gotten worse or gotten better.

And so I do think that there is credibility to an assessment done at a point in time when a history is obtained from a patient and from other people that know the person.

177. Q. But in this context, in a legal

proceeding where you're speaking to your observations, I mean you could have just spoken to what you observed over the seven months that you treated him, right?

A. I could have -- that is not -- so the practice of psychiatry is not -- it's not only what I observe when I see a person. It's based on their entire life, really, but, in particular, around specific disorders and symptoms of those disorders, and we obtain a longitudinal history as part of our diagnostic process, and also in terms of our -- when we follow folks, we revisit those symptoms and their severity to evaluate whether things have gotten better or worse over time.

So I think it important to include the fullness of the history as it -- to obtain even in a legal proceeding because it does inform my opinion of a person at a point in time.

178. Q. But that history, the longitudinal history, to use your term, it's not included in this letter. You've provided your summary of it and your opinion that it deteriorated over three years, but we don't actually have that history that you base it on; correct?

A. Do you mean in terms of, like,

detailing specific symptoms and the amount of substance use at one point versus another point versus another point? Is that what you mean?

179. Q. Well, I don't actually know what I'm referring to because I don't have it. You reference a longitudinal history --

A. Right.

180. Q. -- an explanation for why you felt confident to give your opinion with respect to three years when you've been treating this patient for seven months. So -- but we don't have it; correct?

A. You don't have a copy of his clinical records, no, you don't. But I did include information there that I obtained from Mr. Marchand and Tess, the outreach worker, in the years preceding my involvement with him, and that is detailed in the letter.

181. Q. With respect to your opinion about the causative effect of encampment evictions, again, you haven't mentioned any other potential causes, conditions or factors that may have contributed to Mr. Marchand's condition; correct?

A. I call it a major contributor. I didn't call it a cause. So I didn't feel a need to

-- I didn't say the encampment evictions were the sole cause of his deterioration. I described them as a major contributor. So in that way, I wasn't identifying all major contributors. I was identifying a specific contributor for the purposes of the letter.

182. Q. So there could have been other major contributors, to use your terminology, to Mr. Marchand's condition?

A. There are always different elements contributing to someone's mental health and substance use disorder. They're never one sole contributor.

Part of my job is to ascertain what the predisposing, precipitating and perpetuating factors are to someone's mental health and substance use disorder and always there are several things happening, though I think that in this case, as I have mentioned, encampment evictions were a major component for Mr. Marchand.

183. Q. But with respect to Mr. Marchand in particular, were there other major contributors not identified in this report?

A. I mean, not that I have personal knowledge of. I would say in general -- actually,

I'm just going to leave it there. I'm just going to leave it there, yeah.

184. Q. So you haven't indicated in this letter whether you considered other potential major contributors; correct?

A. I did not include them in the letter, no.

185. Q. And again, here you'd agree that if the information that was relayed to you either by Mr. Marchand, the caseworker or other sources, if that information's correct [sic], that could change your opinion; correct?

A. It's possible, yes.

186. Q. So let's go to Exhibit C, which is a letter dated December 21, 2023 concerning Shawn Arnold. I note here in the second paragraph of this letter you just go right into describing Mr. Arnold's diagnosis and don't describe your history with him. Do I take it you haven't actually treated Mr. Arnold?

A. I met Mr. Arnold for a consultation on one occasion, and he did not follow up after that with me.

187. Q. And was the consultation for the purpose of generating this letter?

A. No, it was actually because there was concern for Mr. Arnold's well-being from other outreach workers.

188. Q. And when was the consultation relative to your writing of this letter?

A. I don't -- when I did write the letter shortly after consultation and I was informed they were someone that was part of this application, then I generated a letter quite quickly.

So I don't have the date on the top of my head that I assessed him, but it would have been within a few weeks of providing the letter.

189. Q. Would it have been before, or after writing this letter?

A. Absolutely before. I didn't write a letter unless I assessed a patient.

190. Q. And in paragraph 2 where you describe Mr. Arnold has a diagnosis of opioid disorder severe, again, you don't say who diagnosed him. I take it someone else did?

A. I mean, that was very much noted throughout Mr. Arnold's medical record, and, again, in my assessment of him, his presentation was consistent with that of a severe opioid use

disorder.

191. Q. So let me just back up. So when you saw Mr. Arnold, recognizing that you don't quite remember the date sometime before this letter was written, you saw him because someone had expressed a concern about his condition needing treatment --

A. Yes.

192. Q. And so you didn't see him again before writing this letter; correct?

A. That's correct.

193. Q. Okay. And your assessment of him, was that for -- to diagnose him of opioid use disorder or something related to his opioid use disorder?

A. I mean, with many people with substance use disorder, there's a question about whether or not there's a comorbid mental health condition in addition to the substance use disorder which was the purpose of my initial assessment.

194. Q. And what was the thing that was comorbid with his substance use disorder that you assessed him for?

A. Well, there was a question that there was something, and I was not able to

ascertain an additional disorder for Mr. Arnold. So I did not include an additional diagnosis.

195. Q. So when you say in the second sentence of the second paragraph that Mr. Arnold has been living outside since January 2023, what's your source for that information?

A. That is Mr. Arnold, as well as he sees the Shelter Health Network fairly frequently and their notes indicate where he is when they see him. So it was a combination of a report from Mr. Arnold and corroboration with his Shelter Health Network records.

196. Q. And you don't know if any of that time was in a tent; correct?

A. The timing since January 2023?

197. Q. Well, when you say Mr. Arnold has been living outside since January 2023, yeah, whether he had been in a tent for any of that time?

A. Well, he reported to me when I saw him that he was in a tent. I don't know how often that he was in and out of a tent, but he was in a tent when I saw him, I believe.

198. Q. And I take it, then, you also don't have any knowledge of whether he stayed in shelter for any periods of time, correct, indoor

shelter?

A. That's correct.

199. Q. In the third paragraph of your letter you state that Mr. Arnold shared with you that:

"He first achieved some stability while allowed to remain in an encampment at JC Beemer which allowed him to access nearby supports and, ultimately, find housing approximately two and a half years ago."

Again, this was reported to you -- sorry, was it reported directly by Mr. Arnold, or was this contained in the records?

A. It was reported to me by Mr. Arnold, and it was consistent with what was in his Shelter Health Network chart.

200. Q. And I take it you don't have firsthand knowledge of the circumstances of his obtaining housing; correct?

A. I don't, no.

201. Q. And to your knowledge, was he housed, or unhoused when he saw you?

A. He was unhoused when he saw me, to

my knowledge. He was in a tent.

202. Q. As is indicated in the following paragraph where you say he's staying outside in a tent now. So again, what was the source for that?

A. That was Mr. Arnold's report, and he also presented as someone who was staying in a tent, meaning that he appeared to have -- like to smell of campfire and to be a bit disheveled.

203. Q. And not to belabour the point too much, but in that sentence, you know, you're referring in the third person. This is what Mr. Arnold is either telling you or the people who are writing the records that you've reviewed?

A. Yes, that's correct.

204. Q. And just with respect to his connection to supports, in the second sentence you state that Mr. Arnold is connected with another person there who is also living outside, that he trusts to watch over his things from time to time. But then in the last sentence you state:

> "He's concerned about eviction and about leaving his possessions to access services and, thus, misses many commitments and appointments which has been having a deleterious

impact on his ability to stay connected with supports."

So like those two things seem not to line up. He has someone who watches his things, but he's nevertheless concerned about leaving his possessions to access services and thus doesn't.

Is it fair to say that you're not able to speak to what extent his concern about leaving his possessions affects his ability to stay connected with supports?

A. When I met with Mr. Arnold, he found it very difficult to leave and was quite anxious to get back even though this other person was looking after his possessions, and it -- I mean, I don't know that this person was always available whenever Mr. Arnold had a particular appointment to then watch over his things. I can't speak to that specifically, but I would be surprised if there were someone else available whenever he needed to watch his things.

205. Q. And if we go to the second last paragraph of your letter, again, you state it's your opinion that:

"The threat of encampment eviction at present is a major

contributor to Mr. Arnold's difficulty in connecting with needed supports, including a housing worker and medical substance use care, thereby increasing his risk of serious health harms including unintentional overdose."

So with respect to -- let's break that down because there's a few things in that sentence. So talking first about unintentional overdose, you know, in fairness to you, Dr. Lamont, you're not actually treating him. So you can't actually say that he's at risk of overdose; correct?

A. No, I did a comprehensive assessment of Mr. Arnold. In review of his records, he has a severe opioid use disorder. He had numerous overdoses. He had two that required paramedics and emergency department care. So -- and he has ongoing opioid use disorder. So he's very much at high risk of unintentional overdose.

206. Q. Are you aware that in Mr. Arnold's cross-examination, he gave evidence that he has not had escalating opioid use and that he disagreed that he had had numerous unintentional overdoses?

A. I mean, I can't speak to what

Mr. Arnold said during his cross-examination. I can only speak to what he reported to me and what I found in his medical record.

I found that he had, in fact, had unintentional overdoses and was brought to hospital for those.

207. Q. Again, the details of those are not reproduced anywhere in your letter; correct?

A. I summarized it by -- but I did not include the specific details of his overdoses, no.

208. Q. Well, when you say "summarize", I mean you say -- at the very bottom of the first page, you refer to numerous unintentional overdoses, but we don't have indication about when those happened, the circumstances of how they happened, what treatment he was provided, none of that; correct?

A. It's not in the letter, that's correct.

209. Q. And then when you say in the last sentence of that paragraph "Allowing him to remain in place was a major contributor to his finding in being housed two and a half years ago", that's not something that you can say from your firsthand

knowledge; correct?

A. It's not from my firsthand knowledge in terms of knowing him at the time, but it is what he reported and what I have observed to be a consistent pattern in my practice and which was outlined in his Shelter Health Network chart as well.

210. Q. In that chart that we don't have?

A. Correct.

211. Q. Now, with respect to, again, your comment about the threat of encampment eviction being a major contributor to Mr. Arnold's difficulty in connecting with needed supports thereby increasing his risk of serious self harms, just to put a finer point on it, you don't know if those actual harms have come to pass; correct?

A. I don't know if they've come to pass, but the increased risk was absolutely there.

212. Q. Now, you're talking about the threat of encampment eviction. This letter is dated December 21st, 2023. At the time you're writing this, the encampment protocol in the City of Hamilton had been in place for about four months, you'd agree?

A. I don't recall when the encampment

protocol was put into place, but Mr. Arnold reported to me the day that I saw him that City workers had been repeatedly coming and telling him that he had to move. So he was quite afraid that his tent was going to be torn down.

213. Q. And did he say anything about any steps that he would have taken to prevent his tent being torn down such as packing it up and moving it and engaging with people on a more suitable place to place his tent?

A. He didn't speak to that, but he did have someone, a friend watching his things to protect them if someone did try and come and tear it down.

214. Q. But again, Dr. Lamont, because you're giving the opinion here that the threat of encampment eviction was a contributor to Mr. Arnold's difficulty and thus his risks, I want to narrow down this supposed threat of encampment evictions where there was a protocol that I put to you allowed encampments in parks in the City of Hamilton provided that they met the specified criteria; correct?

A. Again, I don't recall when the protocol was put in place. I'll have to trust that

you're offering the correct date and that that could have been in place, yes.

215. Q. So if that was the case, then, you know, that threat is something that could be mitigated, I'll put to you; correct?

A. Again, I don't know exactly where his tent was. I don't know what it was and wasn't in violation of. I don't feel comfortable or confident to comment on that.

216. Q. And again, with respect to your opinion about the major contributor that the threat of encampment evictions presented, again, you don't indicate any other causes that you would have considered as being a major contributor to Mr. Arnold's risks or conditions; correct?

A. Correct.

217. Q. And if the information that was relayed to you was incorrect or your understanding was incorrect, that could change your opinion; correct?

A. It's possible.

218. Q. So let's go to Exhibit D to your affidavit, which is a letter dated April 9, 2024 concerning Corey Monahan. And again in this letter, you don't describe your history with Mr.

Monahan. So may we conclude that you have not been in a treating relationship with Mr. Monahan prior to writing this letter?

A. I did meet Mr. Monahan on one occasion to conduct a diagnostic assessment.

219. Q. And when was that occasion that you conducted the diagnostic assessment?

A. Again, I don't have the date in front of me, but it would have been in close proximity to this letter and before this letter was provided.

220. Q. Was it for purposes of creating this letter?

A. The -- for Mr. Monahan, I was connected with him to provide an assessment and to see if I could ascertain whether there were any impact on encampment evictions on his health.

MS. SHORES: Off record.

-- OFF THE RECORD DISCUSSION --

BY MS. SHORES:

221. Q. So Dr. Lamont, at the second paragraph you describe again Mr. Monahan's diagnoses, and given what you've just told us about assessing him shortly before generating this letter, may I take it that these diagnoses were

made by someone else?

A. The majority of -- sorry, yes, the diagnoses already existed in his medical record. But in my assessment on Mr. Monahan, his presentation was consistent with those diagnoses.

222. Q. And those diagnoses would have been made sometime before you wrote your letter in April of 2024?

A. Yes.

223. Q. And you don't know when?

A. It would have been, again, within a short number of weeks prior to writing the letter, but I don't have a specific date off the top of my head, no.

224. Q. The third paragraph starts with:

"Mr. Monahan shared his story with me prior to my involvement in his care."

And then you go on to describe events taking place in 2020 going into 2021. I just want to put a finer point on it. Is this something that Mr. Monahan reported to you, or is this something that would have been based on the medical records?

A. The majority is that which was reported to me by Mr. Monahan, and then I went and

cross-referenced any clinical records that could offer more specific dates or timelines if they were available.

225. Q. And so it's not indicated in that paragraph what is reported to you by Mr. Monahan versus what you were able to locate in the medical records; correct?

A. That's correct.

226. Q. And in any event, you were not treating him at the time, and so you would have not have any firsthand knowledge of the events that are described in that third paragraph; correct?

A. That's correct, yep.

227. Q. So in the fifth sentence of paragraph 3 you state that:

> "Mr. Monahan has since experienced numerous encampment evictions, firstly when his camp in Gage Park was 'bulldozed' as per his description in winter 2020."

And then you go on to describe other events. But again, you don't have firsthand knowledge of those encampment evictions; correct?

A. That's correct.

228. Q. And you don't have knowledge of

how those so-called evictions transpired; correct?

A. That's correct.

229. Q. And with respect to his camp in Gage Park being "bulldozed", as you've described, you don't know what was involved in that so-called bulldozing; correct?

A. That's correct.

230. Q. Are you aware Mr. Monahan gave evidence in his cross-examination that he wasn't even present for that so-called bulldozing?

A. I'm not aware of what he gave in his evidence. So no.

231. Q. So again, you don't know if the details that are reported in this third paragraph are accurate; correct?

A. I mean, I'm just re-reading that because I don't know that it even says that he suggested he was present when the camp was bulldozed. He doesn't suggest that he was present.

232. Q. But you do go on to state that he was traumatized by that experience because he lost all of his possessions and then felt extremely desperate because he had nowhere to go?

A. Right. So he might not have witnessed the bulldozing, but he might have gone

back to see that all of his stuff was gone, which is quite traumatic for many individuals.

233. Q. You said he might have. So again, you're engaging in conjecture based on what you were told; correct?

A. Well, he told me that he had lost all his stuff and had nowhere to go, and I don't have any reason to doubt that that is true.

234. Q. But bulldozed is used in quotes. So why is that in quotes?

A. Because those were his words and I -- as I indicated there by his description.

235. Q. So again, if we go back to what you told us earlier in your cross-examination about corroboration, those are not details that you had corroborated; correct?

A. No, but I'm quite clear there, I think, that the -- I put the word bulldozed in quotes and indicated that it was by his description. So I think it's clear there that that was my source of information.

236. Q. And in the last sentence -- or I'm sorry, the last paragraph of page 2 continuing on to -- I'm sorry, I misspoke. The last sentence of the last paragraph on page 1 continuing on to

page 2, you describe that:

"Mr. Monahan has had at least four intentional -- unintentional overdoses since 2020 and reported to having none prior to this time, which coincides with an escalation in substance use following encampment evictions."

Again, if that's starting in 2020, you wouldn't have been treating him at the time of those overdoses; correct?

A. That's correct.

237. Q. What was the source for indicating that he had at least four unintentional overdoses since 2020?

A. That was contained in his medical record.

238. Q. And with respect to the escalation in substance use following encampment evictions, again, that's based on your understanding from his report of when and how those evictions -- so-called evictions happened; correct?

A. Yes, that's correct.

239. Q. And in terms of gauging his substance use, again, you weren't treating him at

the time. So you can't say based on your assessment of Mr. Monahan that his substance use in fact escalated during that timeframe; correct?

A. It's simply based on the history provided by Mr. Monahan in terms of the worsening of substance use and -- which I mention coincided with an increase in unintentional overdoses which is consistent with worsening substance use.

240. Q. Are you aware that when Mr. Monahan was cross-examined he gave evidence that his most recent overdose was four years ago?

A. I'm not aware that he gave that evidence. When I reviewed his medical record, there were overdoses more recent than that.

241. Q. But I thought you said that this was based on what Mr. Monahan reported to you?

A. And his medical record.

242. Q. Which again we don't have?

A. You're right, you don't have his medical record, that's correct.

243. Q. Are you aware that Mr. Monahan also gave evidence on his cross-examination that his drug use has actually decreased?

A. I'm not aware of what evidence he gave in his cross-examination. So no, I was not

aware of that.

244. Q. If Mr. Monahan's report that his drug use has decreased is accurate, would that alter your opinion?

A. I would need to understand some of the contextual variables, and I would also want to have a conversation with Mr. Monahan that was not in front of legal counsel and other individuals where he felt more comfortable.

245. Q. Well, do you have any information that Mr. Monahan was unable to tell the truth when he gave his evidence on cross-examination?

A. No, I do not. Just in general, I know people can feel quite intimidated and ashamed about their substance use especially in formal settings.

246. Q. In the second to last paragraph of your letter, you state that it's your opinion that:

> "Repeated encampment evictions have been a major contributor to the profound deterioration in Mr. Monahan's mood, as well as worsening impulse control difficulties, substance use disorders, and resultant overdoses."

So again, these repeated encampment evictions, we're talking about a timeframe during which you haven't treated Mr. Monahan; correct?

A. That's correct, yep.

247. Q. And you don't say here that you considered any other causes for the deterioration in his mood, worsening impulse control, worsening substance use disorders or resultant overdoses; correct?

A. I don't include that there, that's correct.

248. Q. And you go on in the second sentence of this paragraph to state:

> "This is due to the profound stress caused by the constant threat of encampment eviction, the impact of eviction itself, including loss of beloved possessions, and the state of absolute desperation that encampment evictions have plummeted Mr. Monahan into."

Again, Dr. Lamont, what is that based on?

A. It's based on the information provided to me by Mr. Monahan and his clinical

records.

249. Q. And if the information that this is based on is incorrect, that would change your opinion; correct?

A. It's possible, yes.

250. Q. Now, again, just to orient us to a point in time, this letter is written April 9, 2024. You're referring to repeated encampment evictions and, again, I'll put it to you, Dr. Lamont, that at that point in time, the encampment protocol in the City of Hamilton had been in place since August of 2023. So for several months at that point in time; correct?

A. Again, trusting that those dates are accurate, yes.

251. Q. So you wouldn't be able to say the extent to which at this point in time, in April of 2024, he was facing a threat of encampment evictions; correct?

A. I cannot speak to that in that specific moment, though I would say most people remain afraid that their tents are going to be torn down even with the protocol in place because of what has happened over the years and the lack of trust in the City.

252. Q. Do you have any knowledge that anyone's tent was actually torn down by the City of Hamilton, firsthand knowledge?

A. Like did I watch the tent be torn down, do you mean?

253. Q. Yes. Do you have firsthand knowledge of anyone's tent actually being torn down in the manner that you describe?

A. I have not witnessed that personally, no.

254. Q. We can go to Exhibit E of your June 7, 2024 affidavit. This is an October 5, 2023 letter regarding Ammy Lewis, and at paragraph 2 you describe that you've been Ms. Lewis' treating psychiatrist since October of 2021.

Would you have seen -- or I'm sorry. Did you see her through Shelter Health Network or HAMSMaRT, or some other form?

A. I saw her through HAMSMaRT.

255. Q. And approximately how many times would you have seen Ms. Lewis for treatment before writing this letter?

A. I saw Ms. Lewis very frequently. The letter is from 2023. I'd known her for almost two years. So I would say, like, more than 40

times, at least.

256. Q. And when you say that you confirm that she has diagnoses of post-traumatic stress disorder, borderline personality disorder, generalized anxiety disorder, depression and opioid and stimulant use disorder severe, did you give those diagnoses, or were those previous diagnoses?

A. I did give her the diagnosis of post-traumatic stress disorder and generalized anxiety disorder. She has previously been diagnosed with the substance use disorder, as well as depression and borderline personality disorder.

257. Q. And when did you diagnose her with post-traumatic stress disorder and generalized anxiety disorder?

A. After my initial assessment of Ms. Lewis in October of 2021.

258. Q. And what was the basis for those diagnoses?

A. How I diagnose those in individuals? It's based on the history provided by the person. A psychiatric diagnostic assessment includes very specific screening questions related to specific disorders, and then very targeted questions about symptom clusters within those

disorders to then ascertain a diagnosis.

So I completed a diagnostic assessment of Ms. Lewis and diagnosed her with those conditions, and that has remained consistent in terms of the way she continues to present as having those diagnoses.

259. Q. What were the factors that led you to give those diagnoses?

A. Review of her medical records, report by Ms. Lewis in terms of her symptoms over years. I also spoke to Ms. Lewis' mother for corroborating information, and Dr. O'Shea had been her treating physician as well who provided some corroborating information.

260. Q. And with respect to the post-traumatic stress disorder specifically, was that related to a singular event?

A. She has numerous traumatic events in her life which I don't think -- I think it's beyond the scope of this to disclose her personal trauma, but it predated -- much of it was in her childhood and adolescence, and she's had yeah, many unthinkable traumas in her life that have contributed to that diagnosis.

261. Q. Dr. Lamont, your hesitance to

disclose Ms. Lewis' trauma is perhaps understandable, but I do need to put it to you that she is seeking damages in this litigation and you're providing a medical report about her medical condition. So her pre-existing conditions, you would agree with me, would be informative to her present conditions; correct?

A. I don't disagree that her pre-existing conditions are informative, but I don't know that it's relevant to the case to know which specific traumas she endured in her childhood.

In fact, I think that's unnecessarily intrusive. Knowing the diagnosis and that she had predisposing trauma, I think, would be enough information.

262. Q. Well, Dr. Lamont, I put it to you that it's for the judge hearing this case to decide what is relevant. But in any event, we don't have the information here so we can only take your word for it.

You state in the third paragraph of your letter Ms. Lewis had been recently -- sorry, second sentence of the third paragraph that:

"Ms. Lewis had been recently

released from a Federal penitentiary and had returned to Hamilton in late 2020."

So at that point in time, you hadn't treated her; correct?

A. That's correct. She had sought care from Dr. O'Shea.

263. Q. And you go on to describe that:

"She was briefly housed after her release, though reports having suffered sexual assault from her landlord and she left that residence."

You didn't treat her for that sexual assault; correct?

A. No, I don't provide -- I mean, I provide maybe some mental health support around sexual assaults, but I also don't treat people for sexual assault.

264. Q. So again, that is based on a secondhand report that you're describing her having sustained that sexual assault?

A. She reported it to me directly and had very much symptoms in keeping with someone who experienced a sexual assault.

265. Q. After it happened, right, because she wasn't a patient of yours at the time it happened?

A. She was a patient of mine very shortly afterward. Dr. O'Shea referred her to me very shortly after that.

266. Q. You go on to describe again in the third paragraph that Ms. Lewis was evicted by the City from a tent in November 2021. Just pausing there, again, you don't have any firsthand knowledge of that so-called eviction; correct?

A. I did not witness her being evicted from the tent, but I did see her very shortly thereafter in crisis because her tent had been torn down and her belongings thrown out.

267. Q. And again, she's telling you that her tent was torn down and her belongings were thrown out? That's what she reported to you?

A. Yes.

268. Q. You don't actually know if that's what happened or if something else occurred?

A. Again, I was not witness to it, but that was a very common experience for many people living in tents at that time. So I had no reason to and still have no reason to doubt that

that is what happened.

269. Q. Well, Dr. Lamont, you say it's a very common experience, but we've talked about several of your patients now, and to every single one you've indicated that you haven't actually witnessed any of these evictions or anyone's tents being torn down in the manner that you describe.

So I'll put it to you that it's actually a very common thing that's reported to you, but you don't know if that's a common experience?

A. It was a very common thing reported to me and I have no reason to doubt it. Just in the same way that I have no reason to doubt if a woman tells me she was sexually assaulted, I didn't have to witness the assault to be quite convinced that it happened as she described.

270. Q. Continuing on with that sentence, you state that the so-called eviction led Ms. Lewis to have to return to an abusive living situation. You don't say whether other options for living arrangements were discussed with her, do you?

A. So Ms. Lewis, as noted, she was with her dog, which significantly limited her option. We certainly explored other options with

her, and I have personally called shelters for Ms. Lewis on numerous occasions and other -- and explored other options and, at that time, there was no option.

There were no foster options for her dog. She was not willing to separate from her dog at that time. She wasn't able to because her dog was such an important part of her well-being.

And so in my working with her and I knew her at -- in that moment in time, she definitely felt her only option other than sleeping outside without a tent was to return to that situation.

271. Q. You also refer in this third paragraph about two thirds of the way down that Ms. Lewis suffered chronic, severe suicidal ideation and go on to describe other symptoms, but the suicidal ideation, again, is something I want to hone in on.

Again, you don't describe referring her to inpatient treatment. So again, we've asked a similar question with respect to one of your other patients. Can we conclude that there were other supports short of emergency inpatient treatment that you felt were sufficient to address the

suicidal ideation?

A. Yes, that's correct.

272. Q. For someone who's experiencing homelessness, though, wouldn't inpatient treatment be helpful for them in terms of providing them, at least temporarily, with a roof over their heads and potentially connecting them to greater supports?

A. Having worked in the psychiatric emergency department at St. Joe's, if there's any whisper that this person is seeking respite from being unhoused for the purpose of admission, that person will not be admitted.

The hospital does not admit individuals primarily for the purposes of providing shelter. They will not admit people, and if I in the community conducted a risk assessment and did not feel she met criteria for hospitalization, I can guarantee you in the hospital they would not have.

273. Q. And so the criteria for hospitalization would be -- can we deduce that other supports are insufficient to address the suicidal ideation that's being presented?

A. That's correct.

274. Q. Similarly with Ms. Lewis to the other patients that you've written about, you state

in the second last paragraph that it's your opinion that:

> "Encampment evictions and the threat thereof repeated threat have been major contributors to the ongoing instability in Ms. Lewis' mental health and worsening of her substance use disorders from 2021 to 2022." [As read]

Again, you don't mention any other possible major contributors to Ms. Lewis' mental health or her condition in 2021 and 2022; correct?

A. That's correct. I don't mention them.

275. Q. Are you aware that Ms. Lewis described being the subject of repeated assaults and threats by her associates of her former landlord when she was cross-examined in this proceeding?

A. I'm not aware of that, no.

276. Q. And so you don't mention that as a potential cause of her mental health challenges; correct?

A. I don't mention that as part of it, no.

277. Q. Are you aware that Ms. Lewis is currently housed or at least at the time of her cross-examination she reported being housed?

A. Yes, she is. She has been since February 2023.

278. Q. You'd agree that she's been doing better since she became housed?

A. Yes.

279. Q. Now, returning again to your opinion, you'd agree again that if the information relayed to you is incorrect, then that would change your opinion?

A. It would, but I know Ms. Lewis extremely well and have been following her very closely for a long time. So I'd be very surprised if there were other information.

280. Q. Just taking a look at the clock, Dr. Lamont, I've got three more letters to ask you questions about.

MS. SHORES: It's just after 3:00. Let's go off record for a moment.

--- Recess commenced at 3:11 p.m.

--- Upon resuming at 3:16 p.m.

BY MS. SHORES:

281. Q. Okay. So Dr. Lamont, I'll next

ask you about Exhibit F to your June 7, 2024 affidavit, which is your February 22, 2024 letter regarding Sherri Ogden.

Again in this letter, you don't describe your treating history with Ms. Ogden. And so may I take it that you hadn't treated her prior in a treating relationship prior to generating this letter?

A. That is correct. I did do an assessment of Ms. Ogden prior to generating the letter, however.

282. Q. And in the second paragraph you state -- or sorry, third sentence you state that:

> "She has diagnoses of complex post-traumatic stress disorder, major depressive disorder, attention deficit hyperactivity disorder, opioid use disorder and stimulant use disorder."

And then you go on to describe that:

> "She's been on medication for depression for many years prescribed by her family physician."

So you don't indicate who diagnosed her with the conditions that you list. I take it was

somebody other than yourself?

A. The diagnoses pre-dated my assessment, and my assessment was consistent with those diagnoses.

283. Q. And you don't say when she was diagnosed with any of these conditions. Do I take it you don't know?

A. I wouldn't be able to give a specific date, no. They are contained throughout her medical record, however.

284. Q. And when we talk about her medical record, you had described for us previously the -- in general the sort of medical records, but I think this is the first of your patients who you've described as also having a family physician. Were you provided with her family physician's records to review?

A. I unfortunately was not, but I did have her Shelter Health Network chart which was also quite fulsome.

285. Q. And do you know the timeframe that the Shelter Health Network chart spanned back to?

A. I can't give you a specific date, but I do recall it being over the course of years.

286. Q. And so just with respect to the

conditions listed in the second paragraph, given that you saw Ms. Ogden for an assessment, it's fair to say you weren't treating her for any of those disorders; correct?

A. That is correct. I certainly offered her follow-up to be treated for those conditions, but she did not follow up.

287. Q. In the third paragraph of your letter you state:

"Ms. Ogden has been experiencing homelessness in the Hamilton area for over five years."

What is your source for that?

A. Ms. Ogden reported that to me. I also spoke with some Good Shepherd outreach workers, which were in the vicinity of where Ms. Ogden often stayed.

Not all of them had known her for that timeframe, but they did note that she had been chronically homeless, and there was -- again, it was like a community member that had taken compassion toward Ms. Ogden and had been working closely with her for at least a couple of years.

Her name was Anne, this woman, and she also indicated to me that Ms. Ogden had been

homeless for quite some time, and that was also consistent with the Shelter Health Network's charts.

288. Q. So with respect to this third paragraph here, would that have been based on what either Ms. Ogden told you, what the shelter worker told you or what was contained in those Shelter Health Network reports?

A. Yeah, just to be clear, it wasn't a shelter worker. It was an outreach worker for Good Shepherd, and then also just a community member named Anne. She wasn't affiliated with any particular organization, but was someone that had just taken an interest in helping Sherri.

289. Q. Now, you do indicate in this report -- again, we're in the third paragraph -- that:

> "Because of the chaotic nature of her daily life [referring again to Ms. Ogden], she has difficulty recalling specific dates and locations of where she has stayed outside."

So would it be correct to take from this that her difficulty with recall is greater

than what you would ordinarily see in patients?

A. It depends which type of patient you're referring to.

290. Q. Well, I guess I'll say the ordinary limits of human memory.

A. She certainly has more significant memory difficulties, yes.

291. Q. And so did that inform your history taking with Ms. Ogden?

A. It did. She had such difficulty, I did not include many of the specific details that she seemed much less sure of or that I could not corroborate.

292. Q. Okay. And so when you say you didn't include things that you couldn't corroborate, what, if anything, in paragraph 3 of your letter was corroborated?

A. The impact of the forced displacement in 2023, and then -- I'm just re-reading now. And then what was observed by this community member named Anne in terms of the worsening of Ms. Ogden's mood and trauma symptoms as well as substance use over time.

293. Q. So let's talk about the forced displacement. In the third paragraph, again you

state:

"She has, however, repeatedly experienced forced displacement from encampment on numerous occasions including being forced to move from behind City Hall in 2023."

How did you corroborate that?

A. This woman named Anne knew Sherri at the time and saw her after that forced displacement. I know -- I do recall there being a significant displacement of individuals from behind City Hall. So that also corroborated my recall of events around that time.

294. Q. When you say "forced displacement", what do you mean?

A. People were forced to move from behind City Hall.

295. Q. But what do you mean by "forced"?

A. Well, again, I wasn't there, but from what I recall, notices were put on tents for a period of time, and then there was a level of enforcement by individuals who came and required people to move. I cannot recall if it was by-law officers or if there was police presence or both. I'm not sure.

296. Q. When you say "a level of enforcement", again, what are you describing?

A. Individuals with authority who are employed by the City. I don't know. Again, I wasn't there. So I can't be more specific than that, but I do know that people were told that they had to move, that they had no other option. If they didn't move by a certain point, their things would be thrown out.

297. Q. So that's what you're describing when you say "forced displacement"?

A. Yes.

298. Q. When you say "Most of her belongings were thrown out under the City's direction", again, that's not something that you have firsthand knowledge of; correct?

A. That's what she reported to me, and, again, it was consistent with what many other people had reported to me around that time that they had experienced.

299. Q. In the second to last sentence of that paragraph you state that:

> "Ms. Ogden used to find safety and comfort living in a tent amongst others in the community."

Again, I take it this is based on what she reported to you?

A. It is, yes.

300. Q. But again, you'd agree that there are still risks to a person such as -- and particularly a woman such as Ms. Ogden -- staying outside in a tent; correct?

A. I would say that there are risks to any human being who is unhoused. However, I think that for Ms. Ogden, and for many individuals who are staying in a tent, there is at least protection from the elements and there can be other individuals they trust in the tent with them.

There's some barrier towards the outside world, and so people do feel a sense of safety in a tent that they don't feel otherwise.

301. Q. In the last sentence -- or the last part of the sentence of this paragraph you state:

> "Each time she begins to build connections, she is forced to move and has difficulty re-engaging with supports because they have difficulty locating her."

Again, what is the source for that

statement?

A. That was, again, Ms. Ogden's report, as well as the community member named Anne supporting Ms. Ogden.

302. Q. But Ms. Ogden in particular, at least, seems to be able to engage with her family physician; correct?

A. It does not seem that that's reliable, a reliable connection. When I interviewed Ms. Ogden, I think that it's largely in the form or prescription renewals.

303. Q. But again, you haven't reviewed the family physician's records. So you can't say for certain?

A. I don't have their records, no.

304. Q. In the last paragraph on the first page of your letter about Ms. Ogden you state:

> "Because she is forced to sleep outside, Ms. Ogden gets very little sleep and uses large amounts of stimulants to try to stay awake to protect both herself and her belongings."

Again, this is based on what she reported to you?

A. It is based on what she reported to me, as well as the observations of the outreach workers from Good Shepherd and the community member named Anne who knows her.

305. Q. But with respect to her stimulant use in particular, you haven't assessed her for stimulant use when she's been outside versus not being outside; correct?

A. I have not observed her during those times, but I would say that it is extremely common for individuals living outside completely unsheltered to use stimulants to stay awake so that they don't lose their belongings.

It's not even necessarily -- even if they have a stimulant use disorder, their use tends to increase because they simply want to stay awake. So they have to use essentially continuously in order to do so; not even to get high, but simply to stay alert so they can protect themselves and their belongings.

306. Q. There's no indication here that you suggested or coordinated any treatment for the stimulant use?

A. I did certainly offer. And in fact when I was there, applications were being put

together for residential treatment for Ms. Ogden by this community member, but I don't -- when I did follow up shortly afterwards, it sounds like she unfortunately wasn't able to attend residential treatment, but there's been a lot of effort to try and offer Ms. Ogden support including from myself.

307. Q. In the second to last paragraph you state that it is your opinion that:

> "Encampment evictions and the repeated threat thereof have been major contributors to the ongoing instability in Ms. Ogden's mental health and worsening of her substance use disorders."

Again, this opinion is based on the information that was relayed to you; correct?

A. That is correct, information relayed to me and the review of her medical record.

308. Q. And again, you haven't identified any other potential major contributors to her condition; correct?

A. That's correct.

309. Q. And more particularly, you haven't indicated here whether any of those have been -- whether any possible other major contributors have

been considered as linked to her current condition?

A. They're not mentioned in the letter, that's correct.

310. Q. And you'd agree that if the information relayed to you is incorrect, that could change your opinion?

A. It's possible, yes.

311. Q. Again, just with respect to the threat of encampment evictions, this is a letter dated February 22, 2024. So you're not able to state to which -- you know, at this point in time the threat of encampment evictions was a feature for Ms. Ogden given the encampment protocol in August of 2023?

A. Right. I can't in relation to the protocol. Though again, as I said before, there's a general fear amongst individuals that has been shared with me that they don't necessarily trust that they will be able to stay where it says they're able to stay even if that's what the City said.

So there's still a feeling of threat. Like if someone is traumatized by something, there can be an ongoing feeling of threat. That's one of the core symptoms of PTSD, is an ongoing feeling of

threat even if the threat is no longer there.

312. Q. But you don't mention that as specifically being a contributing factor to Ms. Ogden's PTSD and, in fact, you were not the physician who diagnosed her with the PTSD; correct?

A. That was a pre-existing diagnosis. But again, when I assess individuals, I did a diagnostic assessment, and her assessment was consistent with that of PTSD.

313. Q. I'll take you next to Exhibit G to your June 7, 2024 affidavit. This is a letter dated May 11, 2023 with respect to Jammy Pierre.

You state at the second paragraph of this letter that you've known Ms. Pierre since fall of 2021. Just pausing there, did you know her in a doctor-patient setting, or some other way?

A. So my initial interactions with Ms. Pierre were actually as -- she was a peer worker with Keeping Six. And so I interacted with her in clinic in that way, though she also sought medical care from HAMSMaRT physicians, and both Ms. Pierre and other physicians suggested that she meet with me for mental health support. She had not done so until a month or two preceding my generation of this letter.

314. Q. So to be clear, she would have seen in you in a doctor-patient setting approximately a month before this letter was written. So sometime around roughly April of 2023?

A. That is correct.

315. Q. Approximately how many times would you have seen her in a doctor-patient setting before writing this letter?

A. I only saw her one time in the doctor-patient setting before writing this letter.

316. Q. And was that for an assessment for purposes of generating this letter?

A. It was not. For Ms. Pierre, it was a diagnostic assessment for the purposes of any other diagnostic assessment for initiating treatment for Ms. Pierre.

317. Q. In the second sentence when you state "And can confirm that she has diagnoses of post-traumatic stress disorder, generalized anxiety disorder, depression and opioid and stimulant use disorders (severe)", those would have been diagnoses made by someone else?

A. She did have a number of pre-existing diagnoses, but, again, I did my own diagnostic assessment and confirmed those

diagnoses.

318. Q. And you can't say when she was first diagnosed with any of those conditions?

A. I cannot, no.

319. Q. In the third paragraph of your letter you state:

"Ms. Pierre has shared her story with me prior to my involvement with her."

So again, may I take it that everything in that third paragraph references her report to you of events that transpired before you started treating her?

A. That is correct.

320. Q. And so you don't have any firsthand knowledge of any of these events described in that paragraph; correct?

A. That is correct.

321. Q. In the second last sentence of the third paragraph you describe Ms. Pierre experiencing:

"...her tent being taken down and thrown out as part of a City-led encampment eviction while she was away at a store. She had left her

dog in the tent and her dog was gone when she returned."

Again, that event in particular you don't have firsthand knowledge of; correct?

A. No, I do not.

322. Q. Okay. Are you aware that Ms. Pierre when she was cross-examined confirmed that she was actually, in fact, out walking her dog at the time that her tent was taken down and that her dog had not been left in the tent?

A. Counsel did inform me that she had reported something that was not consistent with what she had reported to me when I generated this letter.

323. Q. Okay. And so is it possible that what has -- what's written in your letter is incorrect, or are you saying that Ms. Pierre told you something different?

A. She told me something different. I cannot verify which version -- in terms of what -- the location of the dog during the eviction, I cannot comment one way or the other because I don't know.

324. Q. You don't know what happened?

A. That's right.

325. Q. In the fourth paragraph of your letter concerning Ms. Pierre you describe that:

"Individuals suffering from complex mental health conditions and substance use disorders, in particular individuals who have suffered repeated traumatic events, commonly experience a marked decline in their mental health and substance use following repeated traumatic events."

So that sentence you're describing your medical opinion with respect to what happens generally in that population?

A. I would say I'm describing a pattern that I commonly observe.

326. Q. And you state that -- you go on to state in that fourth paragraph that:

"Ms. Pierre describes the repeated forced movement of her belongings, and particularly the loss of her dog, is highly traumatic. Following this, she suffered worsening PTSD symptoms, depressive symptoms and anxiety

disorder symptoms."

Again, what is your source for your statement that she suffered these worsening symptoms?

A. Ms. Pierre's report of symptoms as well as corroborating information from other people working for HAMSMaRT and other physicians involved in her care.

327. Q. And again, with respect to this so-called repeated forced movement of her belongings, Ms. Pierre's belongings, you don't have any firsthand knowledge of what happened in those circumstances?

A. I was not present, no.

328. Q. Okay. And those aren't things that you've been able to corroborate?

A. No.

329. Q. In the last sentence of the fourth paragraph you describe that Ms. Pierre:

"...subsequently suffered multiple overdoses from the toxic street drug supply, which include an ICU admission in August 2020 as well as ER visit in November 2020."

Again, you wouldn't have treated her

for those; correct?

A. No, that's correct. That was based upon review of her medical record.

330. Q. And are you aware that Ms. Pierre when she was cross-examined gave evidence that those were unintentional overdoses?

A. I'm not aware, but that is -- that was my understanding, that they were unintentional.

331. Q. And specifically -- and again, this was Ms. Pierre's evidence -- that not only did she not intend to overdose, but she didn't intend to consume the substance that eventually caused her to overdose; is that correct?

A. Again, I wasn't there when she was cross-examined. So I don't know what information she provided to you, but I was able to ascertain from her medical record that she had had opioid overdoses on those dates as outlined in the letter.

332. Q. Okay. So you can't say based on your firsthand knowledge what the causes of those overdoses were?

A. Well, it was opioid toxicity. That was in the -- that was determined by the physicians that were treating her at the hospital, and that was the -- in her medical record from the

report.

333. Q. But with respect to what caused Ms. Pierre to overdose, you're not able to state to those causes?

A. Are you referring to intentionality of substance use or intent to harm herself? Is that what you're referring to?

334. Q. Well, you state here the worsening of her mental health conditions drove increased substance use, and then you state in the next sentence she subsequently suffered multiple overdoses.

So there's an implication here, although in fairness to you it's not explicitly stated in your letter, that she had a worsening mental health condition and that drove increased substance use and that's implied that it led to the overdoses, but you can't specifically say that; correct?

A. I can simply say what I said there, which is that there was an increase in substance use and, following that, there were a series of overdoses.

335. Q. In the last full sentence of the first page you describe that Ms. Pierre:

"...is thus living rough and forced to stay awake for prolonged periods to protect her personal safety."

Are you aware that Ms. Pierre is housed?

A. I am, yes. She's now in Dorothy Day.

336. Q. And according to Ms. Pierre, she became housed on June 1st, 2023?

A. That sounds accurate, yes.

337. Q. So that would have been within a few weeks after writing this letter which is dated May 11, 2023?

A. Yes.

338. Q. So you'd agree that as soon as a few weeks after you wrote this letter, it was no longer accurate to the extent that Ms. Pierre was reported to be living rough; correct?

A. That's correct.

339. Q. In the second to last paragraph of this letter you state that it's your opinion that:

"...repeated encampment evictions have been a major contributor to the profound

deterioration in Ms. Pierre's mental health and worsening of her substance use disorders over the past four years."

But again, Dr. Lamont, you haven't actually treated Ms. Pierre over the past four years; correct?

A. I have not treated her, no, but other physicians had in the organizations that I worked for, and she also was present in the physical space that I worked in and I was able -- I witnessed as someone who worked in the same space that deterioration.

340. Q. And again, here you don't mention in giving your opinion any other potential contributors to her condition that may have been considered or may have been contributory, do you?

A. No, I do not.

341. Q. And in any event, your opinion is informed, at least in part, on the secondhand information relayed to you about Ms. Pierre's experiences and these so-called evictions; correct?

A. Yes, I mean in terms of psychiatric diagnoses and assessment, it is always based on the patient's report and any other

collateral sources of information. There is no blood test or other way of, you know, confirmatory testing that's done. So I wanted to highlight that, I guess.

342. Q. But even if we're talking about the evictions, again, you've described in your letter one eviction in 2019 where you were of the understanding that Ms. Pierre had left her dog in her tent and her dog was gone when she returned. Ms. Pierre's now told us that that's not actually what happened.

So you'd agree that if the evictions didn't transpire in the way that you understood, that may change your opinion; correct?

A. I think the piece about the dog, I think, is secondary to the eviction itself. We know that many people were evicted from encampments. This happened repeatedly.

I watched a very clear pattern emerge amongst individuals I was seeing that people experienced enormous distress and some crisis when their belongings were thrown out and their tents were thrown out.

So I don't have any reason to doubt. Just as anyone who's been through a trauma, I don't

have reason to doubt that the trauma occurred in the way that they described.

343. Q. Well, Dr. Lamont, you just said "we know" with respect to encampment evictions, but you told us earlier, I think quite clearly, that you haven't actually witnessed any of these encampment evictions, and so you can't say whether they've gone down in the way it was reported to you; correct?

A. I can't say with certainty, but I have no reason to doubt what people are describing to me.

344. Q. But again, that's different than knowing? That's being told; correct?

A. Well, I'm trying to recall what I had just said. I don't know that I said we know that encampment evictions occurred exactly in the way that people described. I didn't say that specifically. I said we know that people were evicted from encampments. We know that that happened.

345. Q. All right. Well, so what are you describing when you say evictions? You're talking about people's tents being torn down and their things being thrown out. Is it your evidence that

every time an eviction happens someone's tent is torn down and their things are thrown out?

A. Not every time because, again, I don't know. Like I'm not there to describe exactly what happens, but I know that that is -- that has been described repeatedly and I've -- I don't want to say anything that isn't -- I'm not confident of.

So I can't say I've -- I know I've seen videos of evictions happening, but I'm not confident that they were based out of Hamilton. So I can't say -- I can't speak to that specifically.

346. Q. I mean, is it possible that what is -- that an event that you would describe as an eviction is simply a by-law officer telling people that they're not allowed to be where they are and they have to move along?

A. It's possible. I think that happens sometimes, but I also -- anyway, I'll stop.

347. Q. And again, with respect to your opinion about Ms. Pierre, if the information that was relayed to you or the assumptions that your opinion is based on turned out to be incorrect, that would change your opinion, could it not?

A. It's possible that it could, yes.

348. Q. And Ms. Pierre in particular,

would you agree that she has been doing better since she became housed?

A. Yes.

349. Q. I'll take you last to Exhibit H of your June 7, 2024 affidavit, which is a letter dated January 30, 2024 with respect to Linsley Greaves.

Again, in your letter about Mr. Greaves, you don't state your history with him. So can I take it that you haven't been in a treating doctor-patient relationship with him prior to writing this letter?

A. That's correct. I did complete an assessment of Mr. Greaves while he was hospitalized at the Hamilton General prior to generating this letter.

350. Q. In the second sentence of your -- sorry, second sentence of the second paragraph of your letter you state that:

> "Mr. Greaves has diagnoses of stimulant use disorder as well as stimulant induced psychosis."

These are pre-existing diagnoses?

A. They are. And again, diagnoses that were confirmed during my assessment.

351. Q. And you don't know who diagnosed him with these -- who first diagnosed Mr. Greaves with these conditions?

A. I don't know who first made the diagnoses, no, but they were both longstanding.

352. Q. And so I take it from your previous answer that you don't know when those diagnoses were first made?

A. No.

353. Q. At the second paragraph, you go on to describe events in Mr. Greaves' life from 2021 to about 2022, and although you don't say how they were reported to you, I take it just given what you've told us about your assessment of Mr. Greaves and the timing thereof, that the third paragraph is all based on what was reported to you secondhand?

A. It was all based on what was reported to me by Mr. Greaves, yes.

354. Q. And with respect to Mr. Greaves' below-knee amputation, in the last sentence in the third paragraph you state -- well, actually, this won't make sense unless we read the sentence before that. So you state:

"Mr. Greaves was subsequently forced to sleep outside without any

protection from the elements in early 2022 and suffered frostbite of his lower limbs as a result. This went unattended for many months, and he ultimately became very ill and required a below-knee amputation of his left leg and amputation of several toes on his right foot in December of 2022."

So again, just with respect to the amputation, what is your source for that information?

A. That was upon review of his medical record and the information contained therein, both in HAMSMaRT medical record as well as his hospital records.

355. Q. And when you describe that Mr. Greaves was forced to sleep outside without any protection from the elements in early 2022, what was your source for that information?

A. Mr. Greaves mentioned that to me, and that was also consistent with what was in his medical record.

356. Q. And when you say that was consistent with what was in his medical record,

what do you specifically mean there?

A. I believe -- and again, I just reviewed a bunch of records in preparation for this, but I want to make sure that I'm providing you with accurate -- an accurate recall.

I know that in his HAMSMaRT record, certainly in the medical record there was indication that he had been outside, and that as a result of being exposed to the elements he suffered frostbite.

357. Q. All right. But specifically saying "forced to sleep outside", you don't have any indication of whether shelter was offered to or available to him? You just are aware that the records say he was outside; correct?

A. Sorry, I didn't realize what you were referring to there. In terms of the forced to sleep outside piece, that would have been based upon Mr. Greaves' report to me, that he felt that was his only option at the time.

358. Q. With respect to his frostbite going unattended for many months, are you aware that Mr. Greaves reports that he was seen by a Dr. Wiwcharuk -- for the record, W-I-W-C-H-A-R-U-K -- in June of 2022 for his frostbite?

A. I don't recall that.

359. Q. Are you aware of any -- receiving any treatment at that point in time?

A. I'm not aware of that, no.

360. Q. You haven't examined him. So you can't say if his leg or toes could have been saved if he had prompt treatment; correct?

A. That would be far beyond the scope of my knowledge to even offer any sort of comment on.

361. Q. You're a psychiatrist. So you wouldn't be treating frostbite?

A. That's correct.

362. Q. In the fourth paragraph of your letter concerning Mr. Greaves you state that:

> "Mr. Greaves identifies that his stimulant use also escalated after the encampment eviction at Woodlands in early 2022 because he needed to force himself to stay awake for prolonged periods while living outside unprotected from the elements and without the community that he had developed at Woodlands."

Again, this is based on what he

reported to you?

A. That's correct.

363. Q. And not to belabour the point, but just with respect to that specific encampment eviction at Woodlands in early 2022, you don't have any firsthand knowledge of what transpired with that so-called eviction; correct?

A. That's correct.

364. Q. And with respect to his reported stimulant use escalating, again, that's not something that you observed in a doctor-patient treating relationship because you hadn't been treating him at the time; correct?

A. Correct.

365. Q. In the third last paragraph of your letter you describe that:

> "Mr. Greaves described a number of other encampment evictions he had faced both near Wesley Centre as well as on Ferguson Street near the train station, though he was less sure of the timelines of these evictions."

Again, this sentence would be based on Mr. Greaves reporting to you; correct?

A. That's correct.

366. Q. Okay. And so you don't have any knowledge of these so-called evictions or what would have happened when they took place; correct?

A. That's correct.

367. Q. Now, you describe in the second last sentence -- or I'm sorry, second last paragraph of your letter that it's your opinion that:

> "...repeated encampment evictions and, in particular, the encampment eviction in early 2022 from Woodlands Park and subsequent experience of frostbite leading to tissue death and amputation have been a major contributor to the ongoing instability in Mr. Greaves' substance use disorder and symptoms of psychosis, as well as ongoing immense psychological and emotional suffering secondary to limb loss and resultant isolation from family."

There's a lot there so I just want to break that down a bit. So again, you're giving your opinion about the repeated -- so-called

repeated encampment evictions and the encampment eviction in 2022, but, again, you're not aware of the -- firsthand of the particular circumstances of those evictions; correct?

A. That's correct.

368. Q. And when we talk about the frostbite, as you had said previously, that's not something within your area of expertise because you're a psychiatrist and not a physician who would treat something like frostbite; correct?

A. That's correct, which is why I just included what was in his medical record and didn't offer my own opinion on the matter.

369. Q. Okay. So you're not speaking to the cause of the frostbite or the tissue death or amputation? That's not your diagnosis? That's just you repeating what was in the medical record that you consulted?

A. That is correct.

370. Q. Okay. And the medical record isn't appended to your report?

A. No.

371. Q. And when you describe the instability in Mr. Greaves' substance use disorder, symptoms of psychosis and his suffering -- although

let me break that down a little bit because otherwise it will be a tricky question for you to answer. So strike that.

With respect to Mr. Greaves' instability with his substance use disorder and symptoms of psychosis, again, you're describing the encampment evictions being a major contributor to those. Again, you're not -- you haven't indicated in this letter here whether you've considered any other major contributors to those conditions; correct?

A. I haven't indicated that in the letter, no, you're correct.

372. Q. And with respect to the psychological and emotional suffering secondary to his limb loss and resultant isolation, again, are you saying that the limb loss is related to the encampment evictions?

A. Well, limb loss is related to frostbite from being exposed to the elements, which seemed to be proximally related to him being evicted from the encampments.

373. Q. Okay. But when I asked you at the beginning of this examination about whether people could get frostbite in encampments, you know, you

said -- and I'm paraphrasing here. This isn't verbatim, but that wasn't something that you were able to speak to. So is that something that you're now giving an opinion on?

A. Based upon I'm pulling together what was in his medical record and putting it in a timeline and that he is suffering immensely because of limb loss which happened when he was sleeping outside.

374. Q. But again, speaking to whether or not if he had been in a tent, you can't say whether or not he would have still suffered the frostbite if he had been in a tent?

A. I think -- yeah, I'm offering opinion here, and I don't know that that's what's being asked of me. So I don't know that I should answer.

375. Q. Well, I'm not asking for opinion. I'm just asking for the scope of what you're saying here. You can't say whether or not Mr. Greaves would have still suffered frostbite if he had been in a tent on that occasion; correct?

A. I think from my understanding of what happened from Mr. Greaves, he was outside completely exposed to the elements, and when he was

in a tent, he had the shelter of the tent as well as blankets and sleeping bags. So it will be much less likely to have suffered frostbite when he had some protection.

376. Q. And you also can't say whether or not -- or sorry, you can't speak to the circumstances that led Mr. Greaves to, as he reports, not being covered by blankets or other protections from the elements?

A. That's correct.

377. Q. When you say in the last sentence of the second last paragraph "This has been exacerbated by the ongoing lack of available, suitable shelter spaces or permanent housing options", again, you haven't yourself investigated shelter space availability for Mr. Greaves; correct?

A. I had not, but it was clear that others had, and, in fact, he was in hospital in part still because they hadn't been able to secure a shelter bed for him.

378. Q. Are you aware that Mr. Greaves has given evidence that he didn't even try to obtain shelter at certain points?

A. I'm not aware of evidence he

provided, no.

379. Q. And again, if the information that was relayed to you that forms the basis of your opinion turns out to be inaccurate, you'd agree that may alter your opinion; correct?

A. It's possible, yes.

380. Q. And with respect to this specific point, if there were shelter spaces available for Mr. Greaves, you'd agree that that would not be an exacerbating factor; correct?

A. Well, my answer to that would be it depends because there are some individuals who for very valid reasons are not comfortable staying in shelter either. So even if there's a shelter bed available, it does not mean that it's -- that that person will access it.

381. Q. But you'd agree, Dr. Lamont, if someone is facing a survival threat by being outside and they just might not feel comfortable in shelter, surely you'd agree that it's preferable for them to be inside in shelter in that circumstance, no?

A. I mean, on the outside looking at the situation, I would say that that seems the common sense approach. However, I would say there

are individuals who have such complicated histories and such significant trauma, many people have experienced traumatic events in shelters, and a common response to a traumatic event is to avoid anything, a profound avoidance to avoid anything that could cause that trauma experience to be triggered.

So many people will avoid shelter for that reason, but I don't know if that's the case for Mr. Greaves. I didn't speak to that specifically with him, but I would say that is a common experience.

MS. SHORES: Just go off record for a brief moment.

-- OFF THE RECORD DISCUSSION --

BY MS. SHORES:

382. Q. So Dr. Lamont, you've with each of these patients given an opinion with respect to the contributory effective encampment evictions on their condition, and we've also discussed that you don't actually have firsthand knowledge of what happens with these so-called encampment evictions. So again, I'd like to put a finer point on that.

If these encampment evictions are not happening in the way that is reporting to you,

you'd agree that that may change your opinion with respect to these patients; correct?

A. Well, I guess my answer to that would be it depends. I liken it to if someone lives in an apartment and they receive an eviction notice, for some people they can deal with it. Other people find it extremely upsetting and traumatic likely related to predisposing conditions for them.

So regardless of how violent an eviction was from an encampment, whether or not it was simply a by-law officer saying you have to move or whether someone's items were throw out, I think in either case that experience can be quite traumatic for someone, and if someone's told to move by an official, that is experienced by many as an enforced eviction, the same as receiving an eviction notice in an apartment would.

383. Q. Dr. Lamont, you've understood my questions today?

A. Yes.

384. Q. Do you wish to change any of your answers?

A. No, I don't think so. Thank you.

385. Q. Okay. Those are my questions, and

thank you again for giving us your time today.

A. Thank you.

RE-EXAMINATION BY MS. CROWE:

386. Q. Thank you, Dr. Lamont. I only have a few questions. We're almost done.

So with respect to Ms. Heegsma, you indicated that you received some information about her accessing drop-in services through Keeping Six. What is Keeping Six?

A. Keeping Six is a harm reduction group based out of Hamilton made up of individuals with [indiscernible] living experience of substance use and people that care about them.

387. Q. And how did you have knowledge of her attendance at these drop-in spaces?

A. The drop-in spaces are co-located with the HAMSMaRT clinic.

388. Q. Okay. Thank you. With respect to Ms. Heegsma's report, so you mentioned that you had talked to -- so your report is based on Ms. Heegsma's report and some records, but then you also mention that you had spoken to Dr O'Shea and you mentioned a couple other sources.

So I just wanted to clarify. Do you remember exactly what information sources you

consulted in preparing your report for Ms. Heegsma?

A. I know that for Ms. Heegsma I consulted her medical record with Shelter Health Network, with HAMSMaRT, Dr. O'Shea spoke with me directly, and, again, I don't recall which peers at Keeping Six, but there were peers at Keeping Six as well.

389. Q. Thank you. And when you were talking about Mr. Marchand, you mentioned an outreach worker with the AIDS Network named Tess. What is the relationship between the AIDS Network and HAMSMaRT or the AIDS Network and the Shelter Health Network?

A. I'm not aware of any direct relationship, but, at the time, the AIDS Network lent space to HAMSMaRT to have their clinics. And so Tess, who was an outreach worker with the AIDS Network, had an office directly across the hall from the clinic room I was using.

390. Q. Okay. Thank you. With respect to Mr. Arnold, you indicated that his presentation was consistent with severe opioid use disorder. What did you mean?

A. His history of reported amounts of the use of opioids, the significant consequences he

faced as a result of use of opioids, ongoing use despite cravings -- sorry, despite consequences, intense cravings, experiences of withdrawal when he doesn't use and escalating tolerance.

391. Q. Thank you. And then you said something similar with respect to Mr. Monahan. You said that his presentation was consistent with a diagnosis, and those diagnosis were ADHD, fetal alcohol syndrome, opioid and stimulant use disorders severe.

So what did you mean by his presentation being consistent with those diagnosis?

A. So in my assessment of Mr. Monahan, again, reviewed -- I reviewed both -- I reviewed those substances in detail with him and he met criteria for both of those disorders with severe severity because of the number of symptoms similar to what I just described in the previous individual.

So ongoing use despite many consequences, development of tolerance, experience of withdrawal, all of which come together to make the diagnosis of severe stimulant use disorders. Did you want me to go through as well his ADHD and fetal alcohol?

392. Q. Yes, please.

A. So Mr. Monahan actually was able to recall being diagnosed with both of those conditions in childhood. He reported being put on stimulant medications in childhood, what are consistent with the diagnosis of ADHD.

He continued to display significant symptoms of inattention, executive dysfunction, very poor impulse control and significant concentration and comprehension deficits.

A lot of those symptoms co-occur with the fetal alcohol syndrome diagnosis. So again, the high impulse control, learning deficits, cognitive deficits, which he displayed during the assessment, and provided the history -- developmental history that was consistent with those diagnoses.

393. Q. Thank you. And then I just want to bring your attention to a portion of your report for Mr. Monahan. So I'm going to screen share.

So this is the third last paragraph -- sorry, third paragraph down on the first page, and it is the third last sentence. So Mr. Shores had asked you about some evictions that you reference in 2020 and 2021, and then there's a sentence that

begins with:

"Most recently, he was moved by City workers from the opening of Cootes Paradise."

So first to clarify, is this after 2021?

A. Yes.

394. Q. Do you have any knowledge of the timeframe surrounding that more recent eviction you were referencing?

A. I don't, unfortunately, no.

395. Q. Okay. And then with respect to Ms. Lewis, you indicated that you had personally called shelters on her behalf. Why were you calling shelters?

A. Yes, to see if they had any suggestions, essentially, for anyone with a small dog, if there were ever any exceptions if it was an emotional support animal, and they said no.

396. Q. Do you remember the timeframe?

A. I mean, from the time -- most of the time that Ms. Lewis was outside, which I have to look at the affidavit because I'm not great with dates, but that was much of 2022 I was calling shelters.

She was -- I called the YWCA. They would not accept her because her needs were too high, and so I -- and Ms. Lewis was unwilling to separate from her dog even temporarily, though over time built enough trust with me to allow me to try and find a foster for the dog as long as I could promise her that she would get her dog back.

And then myself and Dr. O'Shea started looking for a foster for her in -- I think it was May of 2023. It took seven months to find a foster for her dog, and that was with significant advocacy on our part to find that -- the foster. There's so little available.

397. Q. Thank you. Do you remember approximately how many times you were calling shelters trying to access space?

A. I can't give a specific number, but dozens and dozens. Like it was, you know, very hard.

398. Q. So you mentioned that you called the YWCA on behalf of Ms. Lewis and were told that her needs were too high, and you use that same expression when you were describing Ms. Heegsma. What is your understanding of that response that her needs were too high?

A. I believe it's based on -- there's an acronym that I always mess up that is VI-SPDAT or something like that. People are given a score basically about how homeless they are, essentially, is what the score is, and, the higher the score, the more difficult it is for someone to find housing and their scores were above whatever the threshold that the YWCA will accept.

399. Q. Thank you. With respect to Ms. Pierre, did you have any knowledge of her medical diagnosis being PTSD, generalized anxiety disorder, depression, opioid and stimulant use disorder severe prior to seeing her for a medical assessment?

A. Yes, I did.

400. Q. What was your knowledge?

A. I knew that she had severe opioid -- that she had some substance use disorders primarily. I don't believe, actually, though, I had verification of her mental health diagnoses, but, when I assessed her, she reported having been given those diagnoses in the past, and then I completed my own assessment.

401. Q. Thank you. Okay. And you mentioned that you knew that encampment evictions

were occurring and had a discussion with Ms. Shores where you mentioned in addition to patient reports that you may have seen a video.

Did you have any other sources of information with respect to encampment evictions in Hamilton?

A. I mean, there's lots of reporting in the news about encampment evictions. I know that there were often, like, advocacy efforts made, people standing in front of encampments asking that they not be torn down on behalf of those in the encampments and those encampments were torn down anyway, but those were all news stories that I either read or heard about.

402. Q. You mentioned that when you saw Mr. Greaves, that you understood that others had investigated shelter spaces for him. Do you know what those others were?

A. I know that when he was involved with Shelter Health -- there's mention of it in the chart, but I don't know who called or what the circumstances were.

403. Q. Okay. So Ms. Shores asked you repeatedly about the reliability of patient reports as the basis for an assessment and diagnosis. So I

want to ask you what is hopefully a simple question. How do you assess if a patient report is reliable?

A. Yeah, I mean there's multiple ways to think about that. To assess if a patient report is a reliable one, it is does the information hang together that they're describing in a way that is coherent and makes sense.

It also depends on whether that information is consistent with collateral or corroborating information, either from other individuals that know the person or their medical record, and, further, it is whether or not what the person is saying is in keeping with what I would expect to see based on my clinical experience in terms of similar presentation, similar patterns of symptoms or triggers for symptom exacerbation.

404. Q. Thank you, Dr. Lamont. Those are my questions.

-- Whereupon the proceedings adjourned at 4:12 p.m.

REPORTER'S CERTIFICATE

I, LORRAINE FEDOSOFF, Chartered Shorthand Court Reporter, 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. Commissioner of Oath effective to May 1, 2025.

Dated this 16th day of October 2024

Lorraine Fedosoff

_____

PER: LORRAINE FEDOSOFF, CSR (Ontario)

Court File No. CV-21-00077187-0000

KRISTEN HEEGSMA et al. - and - **CITY OF HAMILTON**
Applicants Respondent

ONTARIO
SUPERIOR COURT OF JUSTICE

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Counsel to the Applicants

TAB 157

Court of Appeal File No.:
Superior Court File No.: CV-21-00077187-0000

COURT OF APPEAL FOR ONTARIO

B E T W E E N:

KRISTEN HEEGSMA, DARRIN MARCHAND, GORD SMYTH, MARIO MUSCATO, SHAWN ARNOLD, CASSANDRA JORDAN, JULIA LAUZON, AMMY LEWIS, ASHLEY MACDONALD, COREY MONAHAN, MISTY MARSHALL, SHERRI OGDEN, JAHMAL PIERRE, and LINSLEY GREAVES

Appellants
(Applicants)

-and-

CITY OF HAMILTON

Respondent
(Respondent)

APPELLANTS' CERTIFICATE RESPECTING EVIDENCE

The Appellants certify that the following evidence is required for the appeal, in the appellants' opinion:

All of the materials filed in the Application below before the Honourable Justice Ramsay, in Court File No.: CV-21-00077187-0000.

1. September 9, 2021 Information Report - Encampment Response Update
2. Affidavit of **Shawn Arnold** dated September 29, 2021
3. Affidavit of **Shawn Arnold** dated May 9, 2022
4. Transcript of the Cross Examination of **Shawn Arnold** dated August 14, 2024
5. Affidavit of **Linsley Greaves** dated June 2, 2022
6. Affidavit of **Linsley Greaves** dated June 27, 2023
7. Transcript of the Cross Examination of **Linsley Greaves** dated August 14, 2024

8. Affidavit of **Kristen Heegsma** dated June 7, 2022

9. Affidavit of **Kristen Heegsma** dated April 27, 2023

10. Transcript of the Cross Examination of **Kristen Heegsma** dated August 23, 2024

11. Affidavit of **Cassandra Jordan** dated June 3, 2022

12. Transcript of the Cross Examination of **Cassandra Jordan** dated August 15, 2024

13. Affidavit of **Julia Lauzon** dated June 2022 (unsworn)

14. Affidavit of **Julia Lauzon** dated August 12, 2024

15. Transcript of the Cross Examination of **Julia Lauzon** dated October 15, 2024

16. Affidavit of **Ammy Lewis** (unsworn) dated June 2022

17. Affidavit of **Ammy Lewis** dated August 14, 2024

18. Transcript of the Cross Examination of **Ammy Lewis** dated August 14, 2024

19. Affidavit of **Ashley MacDonald** dated June 13, 2022

20. Transcript of the Cross Examination of **Ashley Macdonald** dated October 10, 2024

21. Affidavit of **Darrin Marchand** dated September 27, 2021

22. Transcript of the Cross Examination of **Darrin Marchand** dated October 13, 2021

23. Affidavit of **Darrin Marchand** dated June 2, 2022

24. Affidavit of **Darrin Marchand** dated April 25, 2023

25. Transcript of the Cross Examination of **Darrin Marchand** dated August 29, 2024

26. Affidavit of **Misty Marshall** dated May 12, 2022

27. Affidavit of **Misty Marshall** dated May 8, 2023

28. Transcript of the Cross Examination of **Misty Marshall** dated August 15, 2024

29. Affidavit of **Cory Monahan** dated May 12, 2022 (Misspelled in Affidavit)

30. Affidavit of **Cory Monahan** dated April 25, 2023 (Misspelled in Affidavit)

31. Transcript of the Cross Examination of **Cory Monahan** dated August 15, 2024

32. Transcript of the continued Cross Examination of **Cory Monahan** dated August 30, 2024

33. Affidavit of **Mario Muscato** dated September 29, 2021

34. Transcript of the Cross Examination of **Mario Muscato** dated October 13, 2021

35. Affidavit of **Mario Muscato** dated May 11, 2022

36. Transcript of the Cross Examination of **Mario Muscato** dated August 14, 2024

37. Affidavit of **Sherri Ogden** dated June 2, 2022

38. Affidavit of **Sherri Ogden** dated March 27, 2023

39. Transcript of the Cross Examination of **Sherri Ogden** dated August 14, 2024

40. Affidavit of **Jahmal Pierre** dated June 7, 2022 (Mispelled in Affidavit)

41. Affidavit of **Jahmal Pierre** dated April 27, 2023

42. Transcript of the Cross Examination of **Jahmal (Jammy) Pierre** dated August 16, 2024

43. Affidavit of **Gord Smyth** dated September 29, 2021

44. Transcript of the Cross Examination of **Gord Smyth** dated October 13, 2021

45. Affidavit of **Gord Smyth** dated March 9, 2023

46. Transcript of the Cross Examination of **Gord Smyth** dated August 28, 2024

47. Affidavit of **Dr. Claire Bodkin** dated May 5, 2023

48. Transcript of the Cross Examination of **Dr. Claire Bodkin** dated September 6, 2024

49. Affidavit of **Audrey Davis** dated July 19, 2023

50. Transcript of Cross Examination of **Audrey Davis** dated August 29, 2024

51. Affidavit of **Benjamin Hognestad** dated June 7, 2024

52. Affidavit of **Dr. Rachel Lamont** dated June 7, 2024

53. Transcript of Cross Examination of **Dr. Lamont** dated Oct 7, 2024

    Exhibit 1 to Cross-Examination: September 2, 2021 Twitter thread

    Exhibit 2 to Cross-Examination: September 5, 2022 Twitter thread

54. Affidavit of **Olivia Mancini** dated October 4, 2021

55. Affidavit of **Olivia Mancini** dated July 18, 2023

56. Transcript of Cross Examination of **Olivia Mancini** dated Aug 20, 2024

    Exhibit A to Cross-Examination: Integrating Best Practices of Harm Reduction Aug 2, 2022

57. Affidavit of **Timothy O'Shea** dated June 7, 2024

58. Affidavit of **Tim O'Shea** dated August 12, 2024

59. . Transcript of Cross Examination of **Tim O'Shea** dated Sept 6, 2024

60. Affidavit of **Medora Uppal** dated July 17, 2023

61. Supplementary Affidavit of **Medora Uppal** dated June 4, 2024

62. Transcript of the Cross Examination of **Medora Uppal** dated Aug 20, 2024

63. Affidavit of **Jill Wiwcharuk** dated June 7, 2024

64. Transcript of Cross Examination of **Dr. Wiwcharuk** dated Aug 16, 2024

65. Transcript of Continued Cross Examination of **Dr. Wiwcharuk** dated Sept 6, 2024

66. Affidavit of **Leilani Farha** dated June 15, 2022

67. Form 53 Acknowledgement of Expert's Duty dated June 15, 2022

68. Transcript of the Cross Examination of **Leilani Farha** dated Aug 27, 2024

    Exhibit 1 to Cross-Examination: The case for a human rights response to homeless encampments - NOW Toronto

    Exhibit 2 to Cross-Examination: The Shift Website – Main Page

Exhibit 3 to Cross-Examination: The Shift Website - Homeless Encampments Subpage

69. Undertaking – Updated Curriculum Vitae of **Leilani Farha**

70. Affidavit of **Stephen Gaetz** dated June 14, 2022

71. Form 53 – Acknowledgement of Expert's Duty of **Dr. Stephen Gaetz** dated June 14, 2022

72. Transcript of the Cross Examination of **Stephen Gaetz** dated Aug 30, 2024

Exhibit 1 to Cross-Examination: Gaetz CV

Exhibit 2 to Cross-Examination: Gaetz Form 53

Exhibit 3 to Cross-Examination: Everyone Counts 2018

Exhibit 4 to Cross-Examination: Hamilton Emergency Shelter Standards

Exhibit 5 to Cross-Examination: Service Restriction Policy

Exhibit 6 to Cross-Examination: O'Shea et Al Pilot Study of COVID-19 Testing ciaa743

Exhibit 7 to Cross-Examination: Wen Hudak Hwang Perceptions of Welcomeness

Exhibit 8 to Cross-Examination: Cohen et al Understanding Encampments

Exhibit 9 to Cross-Examination: Olson Connecting Public Health and Human Rights

Exhibit 10 to Cross-Examination: Rankin Punishing homelessness

Exhibit 11 to Cross-Examination: Olson MacDonald Washington's War

Exhibit 12 to Cross-Examination: Myths and Facts

Exhibit 13 to Cross-Examination: Fischer et al Homelessness Mental Illness and Criminal Activity

Exhibit 14 to Cross-Examination: O'Shea Pandemic Planning in Homeless Shelters

73. Affidavit of **Kate Hayman** dated Feb 28, 2023

74. Form 53 Acknowledgement of Expert's Duty dated June 13, 2022

75. Transcript of the Cross Examination of **Kate Hayman** dated Aug 16, 2024

Exhibit A to Cross-Examination: What Knowledge is needed? Teaching Undergraduate medical students to "go upstream" and advocate on social determinants of health 2020

Exhibit B to Cross-Examination: Aug 21, 2020 Twitter feed

Exhibit C to Cross-Examination: Antecedents of Physical and Sexual Victimization Among 'homeless Women: A comparison to homeless me

Exhibit D to Cross-Examination: Understanding Encampments of People Experiencing Homelessness and Community Responses - USDHUD

76. Affidavit of **Stephen Hwang** dated February 27, 2023

77. Form 53 Acknowledgement of Expert's duty dated June 13, 2022

78. Transcript of the Cross Examination of **Stephen Hwang** dated Aug 28, 2024

Exhibit 1 to Cross-Examination: The Relationship Between Homelessness and Health: An Overview of The Research in Canada"

79. Affidavit of **Ameil Joseph** dated June 14, 2022

80. Form 53 Acknowledgement of Expert's Duty – **Ameil Joseph** dated June 14, 2022

81. Form 53 Acknowledgement of Expert's Duty – **Dr. Ameil Joseph** dated June 5, 2024

82. Supplementary Affidavit of **Ameil Joseph** dated June 7, 2024

83. Transcript of the Cross Examination of **Ameil Joseph** dated Aug 27, 2024

Exhibit 1 to Cross-Examination: Why Hamilton's Encampment consultations can – and should – be different, say advocates – CB

Exhibit 2 to Cross-Examination: SSM Qualitative Research in Health

84. Undertaking – Updated Curriculum Vitae of Dr. Ameil Joseph

85. Affidavit of **Aaron Orkin** dated Sept 14, 2022

86. Form 53 Acknowledgement of Expert's Duty – **Dr Aaron Orkin** – dated Sept 14, 2022

87. Transcript of the Cross Examination of **Aaron Orkin** dated Aug 26, 2024

Exhibit 1 to Cross-Examination: Acknowledgement of Expert's Duty Sept 14, 2022 Aaron Orkin

Exhibit 2 to Cross-Examination: How Should we Define Health

Exhibit 3 to Cross-Examination: A 25 Year Old Woman with Diabetes in Custody – CMAJ Dec 6, 2016

Exhibit 4 to Cross-Examination: Homelessness and Health in Canada 2014

Exhibit 5 to Cross-Examination: Reid et al. Rethinking involuntary admission for individuals presenting to Canadian Emergency Departments with life-threatening substance use disorders

Exhibit 6 to Cross-Examination: Pressure and coercion in the care for the addicted: ethical perspectives 2004

88. Affidavit of **Kaitlin Schwan** dated June 13, 2022

89. Form 53 Acknowledgement of Expert's Duty **Kaitlin Schwan** dated June 13, 2022

90. Transcript of the Cross Examination of **Kaitlin Schwan** dated Aug 27, 2024

91. **Exhibit 1 to Cross-Examination:** Form 53 Acknowledgement of Expert's Duty of Kaitlin Schwan dated June 13, 2022

Exhibit 2 to Cross-Examination: WNHHN - About the Women's National _br __Housing and Homelessness Network

Exhibit 3 to Cross-Examination: About _ The Canadian Observatory on Homelessness

Exhibit 4 to Cross-Examination: Homeless Encampments – The Shift

Exhibit 5 to Cross-Examination: 20230110 How alumna Kaitlin Schwan became a leading advocate for the right to housing _ University of Toronto Alumni

Exhibit 6 to Cross-Examination: 20230201 CBC Encampment evictions cause 'tremendous harm,' defy human rights, say experts _ CBC News

Exhibit 7 to Cross-Examination: 20230131 Toronto 'extremely vulnerable' to legal challenge after homeless encampment ruling, experts say _ CBC News

Exhibit 8 to Cross-Examination: Reconsidering Gender

Exhibit 9 to Cross-Examination: Stats Can The Daily — Canadian residential facilities for victims of abuse, 2017_2018

Exhibit 10 to Cross-Examination: Highlights of National Shelter Study Em12-17-1-2019-eng

Exhibit 11 to Cross-Examination: 20210606 Toronto's shelters see triple the number of violent incidents, rise in overdoses during COVID-19 pandemic, data show - The Globe and Mail

Exhibit 12 to Cross-Examination: OShea et Al Pilot Study of COVID-19 Testing ciaa743

Exhibit 13 to Cross-Examination: 20201207 Star 'We're the vulnerable ones'_ Why women living in Toronto's public parks during COVID-19 choose outdoor tents over indoor shelters

92. Affidavit of **Andrea Sereda** dated May 12, 2023 (Misspelled in Affidavit)

93. Form 53 Acknowledgement of Expert's Duty of **Andrea Sereda** dated May 12, 2023

94. Transcript of Cross Examination of **Andrea Sereda** dated Aug 23, 2024

95. Affidavit of **Brett Aston**, employee St. Matthew's House dated July 23, 2024

96. Transcript of the Cross Examination of **Brett Aston** dated August 19, 2024

Exhibit A to Cross-Examination: Reducing Homelessness and Managing Encampments

97. Affidavit of **Danielle Blake** dated July 30, 2024

98. Transcript of the Cross Examination of **Danielle Blake** dated August 19, 2024

Exhibit 1 to Cross-Examination: Addressing the Needs of Unsheltered Individuals and Emergency Shelter Capacity

Exhibit 2 to Cross-Examination: Encampment Observation Report

Exhibit 3 to Cross-Examination: Reducing Homelessness and Managing Encampments dated June 19, 2024

Exhibit 4 to Cross-Examination: Encampment Protocol Distance Proposals

Exhibit 5 to Cross-Examination: Point in Time Connection Results 2021

99. Affidavit of **David Buckle** dated July 31, 2024

100. Transcript of the Cross Examination of **David Buckle** dated August 19, 2024

Exhibit 1 to Cross-Examination: Reducing Homelessness and Managing Encampments dated June 19, 2024

Exhibit 2 to Cross-Examination: Encampment Observation Report dated May 15, 2024

101. Supplementary Affidavit of **Kara Bunn** dated July 31, 2024

102. Transcript of the cross examination of **Kara Bunn** dated August 21, 2024

103. Second Supplementary Affidavit of **Monica Ciriello** dated July 29, 2024

104. Transcript of the Cross Examination of **Monica Ciriello** dated August 21, 2024

105. Affidavit of **Trevor Haalstra**, Hamilton Fire Department dated July 30, 2024

106. Transcript of the Cross Examination of **Trevor Haalstra** dated August 21, 2024

107. Second Supplementary Affidavit of **Steve Hasselman** dated July 31, 2024

108. Transcript of the Cross Examination of **Steve Hasselman** dated August 21, 2024

109. Supplemental Affidavit of **Wesley Loy** dated July 25, 2024

110. Transcript of the Cross Examination of **Wesley Loy** dated August 16, 2024

111. Affidavit of **Cory Manning** dated July 30, 2024

112. Transcript of the Cross Examination of **Cory Manning** dated Aug 27, 2024

113. Affidavit of **Rob Mastroianni** dated October 6, 2021

114. Supplementary Affidavit of **Roberto Mastroianni** dated October 12, 2021

115. Transcript of the Cross Examination of **Roberto Mastroianni** dated October 13, 2021

116. Third Supplementary Affidavit of **Roberto Mastroianni** dated July 31, 2024

117. Transcript of the Cross Examination of **Roberto Mastroianni** dated August 28, 2024

118. Supplemental Affidavit of **Frank Miscione**, Hamilton Police Service dated July 24, 2024

119. Transcript of the Cross Examination of **Frank Miscione** dated August 22, 2024

120. Affidavit of **Tessa Mcfadzean**, Women's Services, Good Shepherd Centres, Hamilton dated July 26, 2024

121. Transcript of the Cross Examination of **Tessa McFadzean** dated August 22, 2024

> **Exhibit A to Cross-Examination:** CBC Article: "Mom with 5 kids speaks out after being placed in cockroach infested unit at Hamilton shelter" dated June 22, 2021

122. Affidavit of **Shawn Mackeigan**, Mission Services dated July 29, 2024

123. Transcript of the Cross Examination of **Shawn Mackeigan** dated August 21, 2024

> **Exhibit 1 to Cross-Examination:** Hamilton Spectator Article entitled "Homeless, struggling with mental illness, barred from Hamilton shelters" dated January 20, 2021
>
> **Exhibit 2 to Cross-Examination:** Hamilton needs an estimated $60M to address homelessness CBC News
>
> **Exhibit 3 to Cross-Examination:** City of Hamilton, Emergency & Community Services Committee Agenda, March 23, 2023, video (escribemeetings.com)

124. Affidavit of **James Moulton**, The Salvation Army, Hamilton dated July 31, 2024

125. Transcript of the Cross Examination of **James Moulton** dated August 26, 2024

> **Exhibit A to Cross-Examination:** The Salvation Army: Behind the Front Lines

126. Affidavit of **Dr. Sharon Koivu** dated July 26, 2024

127. Transcript of the Cross Examination of **Dr. Sharon Koivu** dated Sept 6, 2024

> **Exhibit 1 to Cross-Examination:** Minutes of the Meeting of the Standing Committee of Health dated May 6, 2024
>
> **Exhibit 2 to Cross-Examination:** National Post Article, Dr. Sharon Koivu, special to the National Post, dated June 10, 2024
>
> **Exhibit 3 to Cross-Examination:** Canadian Affairs Article dated July 8, 2024
>
> **Exhibit 4 to Cross-Examination:** Toronto Sun Article, August 18, 2023
>
> **Exhibit 5 to Cross-Examination:** London Free Press Article, Harms of safe drug supply programs outweigh benefits: Addiction Specialist
>
> **Exhibit 6 to Cross-Examination:** Boston Study

Exhibit 7 to Cross-Examination: NO EXHIBIT EXISTS, REPORTER MISTAKEN

Exhibit 8 to Cross-Examination: Press Release dated June 25, 2024

128. Request to Admit dated August 2, 2023

Tab 1a: Homelessness Dashboard: Data on Homeless Population, Including Shelter Use, Availability and Capacity – Scale of Homelessness

Tab 1b: Homelessness Dashboard: Data on Homeless Population, Including Shelter Use, Availability and Capacity – Shelter Beds Available

Tab 2: City of Hamilton, 2022 Homelessness Point in Time Count

Tab 3: City of Hamilton, 2021 Point in Time Connection Results

Tab 4: City of Hamilton, 2021 Point in Time Count Indigenous Responses

Tab 5: City of Hamilton, 2021 Point in Time Infographic – Indigenous Respondents

129. Response to Request to Admit dated August 23, 2023

130. Request to Admit dated June 7, 2024

Tab 1: City of Hamilton, Information Report: Encampment Response Update (PED21188/HSC20038(c)) (City Wide), September 9, 2021 7/31

Tab 2: City of Hamilton, Healthy and Safe Communities Department (Housing Services Division), Planning and Economic Development Department (Licensing and By-Law Services Division), and Public Works Department (Environmental Services Division): May 15, 2024 Encampment Observation Report (HSC24020/PED24080/ PW24030) (City Wide)

131. Response to Request to Admit dated June 7, 2024

132. Request to Admit dated June 25, 2024

Tab 1: City of Hamilton, Healthy and Safe Communities Department (Housing Services Division), Planning and Economic Development Department (Licensing and By-Law Services Division), and Public Works Department (Environmental Services Division): May 15, 2024 Encampment Observation Report (HSC24020/PED24080/PW24030) (City Wide)

133. Response to Request to Admit dated June 26, 2024

134. Response to Request to Admit dated July 15, 2024

Tab 1: Reducing Homelessness and Managing Encampments (HSC24027)

Tab 2: Appendix "A" to Report HSC24027

135. Request to Admit dated August 26, 2024

Doc 1: "Housing and Homeless Data Dashboard" (May 16, 2022)

Doc 2: "Homelessness – Data Notes" (August 25, 2024)

Doc 3: "Scale of Homelessness" (August 25, 2024)

Doc 4: "Shelter Beds Available" (August 25, 2024)

Doc 5: "Shelter Occupancy" (August 25, 2024)

Doc 6: "Average Market Rent" (August 25, 2024)

Doc 7: "Addressing Needs of Unsheltered Individuals and those Relying on Hamilton's Emergency Shelter System" (HSC23041) (August 14, 2023)

Doc 8: "Encampment Observation Report" (HSC24020/PED24080/ PW24030) (May 15, 2024)

Doc 9: "Further Amended Appendix "A" to Report HSC20036(g)" (July 4, 2024)

Doc 10: City Council Minutes 24-014" (July 12, 2024)

Doc 11: "Encampment Protocol Distance Proposals" (HSC24027(a)) (August 12, 2024)

Doc 12: "Appendix "A" to Report HSC24027(a)" (August 12, 2024)

Doc 13: "Appendix "B" to Report HSC24027(a)" (August 12, 2024)

Doc 14: "Hamilton's Emergency Shelter Standards" (September 2023)

Doc 15: "Service Restriction Policy for Emergency Shelters" (July 15, 2024)

Doc 16: "Emergency Shelters and Drop-ins" (August 25, 2024)

136. Response to Request to Admit dated September 10, 2024

137. Request to Admit dated October 18, 2024

Doc 1: "Addressing Needs of Unsheltered Individuals and those Relying on Hamilton's Emergency Shelter System" with Appendix A and Appendix B (HSC23041) (August 14, 2023)

Doc 2: "Encampment Observation Report" (HSC24020/PED24080/PW24030) with Appendix A (May 15, 2024)

Doc 3: "Encampment Observation Report" (HSC24020/PED24080/PW24030) PowerPoint Presentation (May 15, 2024)

Doc 4: "Hamilton Census Data Maps" webpage

Doc 5: "2001 to 2021 Population and occupied private dwellings by community for Hamilton"

Doc 6: "Census Ethnicity, Indigenous and Visible Minority – About"

Doc 7: "Census Ethnicity, Indigenous and Visible Minority - Data"

138. Response to Request to Admit dated November 7, 2024

139. Request to Admit dated November 8, 2024 (No Response from the City of Hamilton as of November 22, 2024)

Doc 1: "Census Ethnicity, Indigenous and Visible Minority - Data"

140. Request to Admit dated November 19, 2024 (No Response from City of Hamilton as of November 22, 2024)

Doc 1: Council Minutes 24017 dated Sept 25, 2024

Doc 2: General Issues Committee Report dated Oct 16, 2024

Doc 3: Motion: General Issues Committee Report dated Nov 6, 2024

141. Transcript of Hearing (December 16 to 18, 2024)

January 22, 2025

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-and-

CITY of HAMILTON
Respondent (Respondent)

Court File No.

Ontario
Court of Appeal

APPELLANTS' CERTIFICATE RESPECTING EVIDENCE

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Counsel to the Appellants

TAB 158

COURT OF APPEAL FOR ONTARIO

BEFORE: FAVREAU J.A.

DATE: MAY 5, 2025

DISPOSITION OF COURT HEARING:

COURT FILE NO.:
M55946 (COA-25-CV-0166)

TITLE OF PROCEEDING: HEEGSMA, KRISTEN ET AL. V. CITY OF HAMILTON

DATE RELEASED: MAY 7, 2025

Sujit Choudhry and Sharon Crowe, for the moving parties

Bevin Shores and Jennifer King, for the responding party

Heard: May 5, 2025

The appellants are a group of individuals who allege that the respondent, the City of Hamilton, violated their *Charter* rights when they were evicted from City parks between August 2021 and August 2023. The application judge dismissed their application: *Heegsma v. Hamilton (City)*, 2024 ONSC 7154. I have been assigned to case manage the appeal.

The City has brought a motion to quash portions of the appellants' appeal for lack of jurisdiction. The motion is scheduled to be heard this Friday, May 9, 2025.

In support of its position on the jurisdiction motion, the City served a reply factum and supplementary motion record. The appellants brought a motion to be heard by me to strike the reply factum and supplementary record, and for other relief. In advance of the motion to strike, I was advised that the parties had settled the motion to strike, and that the only issue left to determine was the costs.

This endorsement addresses the terms of the settlement and the costs of the motion to strike.

Terms of the settlement

At the motion before me, I clarified one of the terms of the settlement. Based on that clarification, the parties have settled the motion to strike on the following basis:

- The City of Hamilton will withdraw its reply factum and supplementary motion record forthwith;

WARNING: This court's endorsements are usually provided to the parties only. The endorsements may be subject to a publication ban or other restriction(s) on public access. Those receiving these endorsements are responsible for ensuring any subsequent dissemination by them complies with any applicable bans or restrictions.

- The following statement of fact may be put to the panel hearing the motion to quash on May 9, 2025: “in providing its responses to the Requests to Admit, the City expressly stated it did not concede admissibility of any of the documents in the Requests to Admit”;

- The City will be permitted to file its oral compendium as is; and

- The appellants’ motion to strike is settled except on the issue of costs.

The settlement term concerning the oral compendium was the one that was originally unclear, and I discussed it with the parties in an attempt to clarify.

As part of the relief sought on the motion, the appellants requested that the City’s oral compendium not include any portions of the reply factum or supplementary motion record. When the appellants served their motion to strike, the City had not yet served its oral compendium, but the appellants sought this relief in anticipation of its contents. The City has now served its oral compendium, and the appellants do not object to its contents.

As originally drafted, this term of the settlement included language that was meant to confirm the scope of the arguments the City would be permitted to make on the jurisdiction motion: “the Respondent will make its submissions in reply to the Appellants’ Responding Factum and Record in its Oral Hearing Compendium, Outline of Anticipated Oral Argument and Oral Argument, including reference to any reply authorities”.

I was concerned that this term was unclear and that it would ultimately be up to the panel on the motion on Friday to determine the permissible scope of submissions. I have therefore clarified this term, based on discussions with counsel, to confirm that the appellants do not object to the contents of the City’s oral compendium and that it is to be accepted for filing and provided to the panel. It will be for the panel hearing the jurisdiction motion to decide the proper scope of oral submissions.

Costs of the motion

The appellants seek costs of $6,610.50 on a substantial indemnity basis. The City submits that success on the motion was divided and that there should be no costs.

I award costs of $3,000 to the appellants. This is not an appropriate case for substantial indemnity costs. While the City should have sought permission to file a reply factum and additional materials, an issue that could have been determined at a case conference, the City’s attempt to file a reply factum and supplementary record falls far short of the type of reprehensible conduct that warrants an award of costs on a substantial indemnity basis. I also agree with the City that the settlement reflects some compromise on the appellants’ part, which justifies a reduction in its partial indemnity costs from $4,407 to $3,000.

Conclusion

The motion is granted on consent on the terms agreed to between the parties as modified above. The appellants are entitled to costs in the amount of $3,000 all inclusive.

A copy of this endorsement is to be provided to the panel hearing the jurisdiction motion.

C. Fairburn J.A.

TAB 159

COURT OF APPEAL FOR ONTARIO

CITATION: Heegsma v. Hamilton (City), 2025 ONCA 554
DATE: 20250722
DOCKET: M55895 (COA-25-CV-0166)

2025 ONCA 554 (CanLII)

Trotter, Thorburn and Wilson JJ.A.

BETWEEN

Kristen Heegsma, Darrin Marchand, Gord Smyth, Mario Muscato, Shawn Arnold, Cassandra Jordan, Julia Lauzon, Ammy Lewis, Ashley Macdonald, Corey Monahan, Misty Marshall, Sherri Ogden, Jahmal Pierre, and Linsley Greaves

Applicants (Appellants/Responding Parties)

and

City of Hamilton

Respondent (Respondent/Moving Party)

Bevin Shores and Jennifer L. King, for the moving party/respondent, City of Hamilton

Sujit Choudhry, Sharon Crowe and Wade Poziomka, for the responding parties/appellants, Kristen Heegsma et al.

Heard: May 9, 2025

Thorburn J.A.:

A. OVERVIEW

[1] The central question on this motion is whether this court can hear and determine the responding parties' appeal of two interlocutory orders along with their appeal of the application judge's final order.

[2] The two interlocutory orders were made before the application was heard and the responding parties did not seek leave to appeal either order from the Divisional Court.

[3] The responding parties now appeal the final order dismissing their claim for damages for breaches of their ss. 7 and 15 rights under the *Canadian Charter of Rights and Freedoms* to this court.

[4] Ground 3 of the Notice of Appeal pertains to the interlocutory order made on November 12, 2024, excluding some of the evidence of physicians that addresses the responding parties' vulnerabilities, and the harms of sheltering restrictions and evictions on them.

[5] Ground 1 of the Notice of Appeal relates to the interlocutory order made on December 4, 2024. This order struck documents which contain data regarding the number of homeless persons, shelter bed capacity (broken down by sex), and the demographic breakdown of Hamilton's homeless (by sex and Indigenous identity).

[6] The City of Hamilton (the "moving party") claims that Grounds 1 and 3 should be struck from the Notice of Appeal on the basis that the issues decided by the

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interlocutory orders are *res judicata* and the responding parties' attempt to relitigate them now, by way of an appeal of the final order, constitutes an abuse of process and a collateral attack on the interlocutory orders, as such orders must be appealed to the Divisional Court.

[7] The moving party claims the documents in the Certificate Respecting Evidence that were excluded from the record pursuant to the interlocutory orders should be struck from this Appeal Record as "none of the documents had been adduced in any affidavit or exhibit to any cross-examination, and many of them had not been admitted to be authentic."

[8] The responding parties claim the evidence excluded by virtue of the two interlocutory orders are inextricably linked and "integrally related to the substance of the broader appeal" such that leave would inevitably have been granted to appeal the interlocutory orders.

[9] The grounds for the appeal of the final order include, among other grounds, that the application judge (i) committed errors of law leading him to find the moving party's sheltering restrictions and evictions did not violate ss. 7 or 15 of the *Charter*, and that *Charter* damages were not appropriate; and (ii) failed to comply with Rule 51 of the *Rules of Civil Procedure*, R.R.O. 1990, Reg. 194, and applied the wrong test in striking evidence of harm experienced by those subject to living restrictions.

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[10] The responding parties therefore take the position that this court should hear the appeal of these two interlocutory orders excluding evidence, because the application judge made errors of law in these orders and excluded evidence that directly supports their claim on the appeal of the final order, that the shelter restrictions and evictions breached their *Charter* rights resulting in damages.

[11] For the reasons that follow, I would dismiss the moving party's motion.

B. BACKGROUND FACTS

[12] The responding parties are 14 unhoused persons from Hamilton, Ontario. Between August 2021 and August 2023, they erected tents in public parks, in contravention of a municipal by-law. The moving party enforced the by-law and evicted them. The responding parties claim the sheltering restrictions and evictions constitute discrimination on the basis of sex, race, and the intersection of sex and race contrary to ss. 7 and 15 that were not justified under s. 1 of the *Charter*.

[13] On November 12, 2024, the application judge issued an interlocutory order excluding some of the evidence in physician affidavits attesting to the harm experienced by the responding parties due to restrictions and evictions. This evidence is the subject of Ground 3 of the Notice of Appeal which provides that,

> The Application Judge erred in law by applying the wrong legal test in excluding some of the evidence from the Appellants' doctors in his Endorsement of November 12, 2024, which included relevant evidence of the Appellants' experience of sheltering restrictions and evictions and the resulting harms. [Emphasis added.]

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[14] On December 4, 2024, the application judge issued a second interlocutory order excluding documents that contained monthly data on the numbers of actively homeless persons, their sex, shelter bed capacity, and the demographic breakdown of Hamilton's homeless by sex and Indigenous identity. He held that,

> It is the eve of the hearing. I cannot very well let the parties exchange materials on this simple motion about whether three volumes of City documents of various sorts should be admitted into evidence. They are not necessary to understand the issues. The motion was heard at the case conference. The parties knew ahead of time that they had 10 minutes for oral argument on this simple discrete point. Leave is given the respondents to bring the motion without further formality. It is allowed for these reasons.
>
> Volumes XVIII, XIX and XX of the application record might have been admissible if they had been introduced before cross-examinations but admitting them now would be prejudicial to the respondents. The expert witnesses could have relied on the documents in their affidavits or in cross-examination. The requests to admit authenticity do not constitute notice that the documents would be admitted into evidence. These three volumes of the application record are struck.

[15] These documents are the subject of Ground 1 of the Notice of Appeal which provides that,

> The Application Judge erred in law by striking Volumes 18 (as amended), 19, and 20 of the Application Record in his Endorsement of December 4, 2024, containing the Appellants' Requests to Admit attaching the Respondent's public documents, and the Respondent's Responses to Requests to Admit admitting the authenticity of these documents, because he failed to comply with Rule 51 of the *Rules of Civil Procedure*,

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> whereby authenticated documents become part of the record without the need to be adduced by a witness, by superimposing the additional requirement that any party seeking to rely on authenticated documents must make them exhibits to an affidavit or cross-examination. [Emphasis added.]

[16] On December 5, 2024, the responding parties indicated that they would seek leave to appeal from the December 4, 2024 order. On December 6, 2024, the moving party indicated that they would contest any request to adjourn the application.

[17] On December 9, 2024, the responding parties indicated that they would no longer be seeking leave to appeal.

[18] The application was heard on December 16 to 18, 2024, without the evidence that was excluded pursuant to the two interlocutory orders. On December 23, 2024, the application judge issued a final order dismissing the responding parties' application for violation of their ss. 7 and 15 *Charter* rights.

[19] On January 22, 2025, the responding parties appealed the final order dismissing their *Charter* challenge to this court but did not seek leave to appeal the two interlocutory orders to the Divisional Court.

[20] The responding parties now seek to include the appeal of the two interlocutory orders in their appeal of the final order to this court, to be heard with the appeal of the final order. Their Certificate Respecting Evidence on this appeal includes documents excluded by the two interlocutory orders, namely: (i) the

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physician affidavits without the redactions ordered by the application judge; and (ii) Volumes 18 to 20 of the Amended Application Record that include the responding parties' Requests to Admit and the moving party's Responses to Requests to Admit that were struck by the application judge and were excluded from evidence on the application.

[21] The moving party seeks an order denying the responding parties the right to have these two interlocutory orders heard with the appeal of the final order and an order to remove the documents excluded by the application judge, from the Appeal Record.

C. THE ISSUES

[22] The issues are (i) whether this court has jurisdiction to hear the appeal of the two interlocutory orders; and (ii) whether an order permitting the appeal of the interlocutory orders to be heard with the appeal of the final order would contravene the principles of fairness, efficiency and finality in the doctrines of *res judicata,* and/or abuse of process.

D. THE POSITIONS OF THE PARTIES

[23] The moving party claims:

i. this court has no jurisdiction to hear the appeal of the two interlocutory orders because leave was never sought from the Divisional Court and the 15 day timeframe for seeking leave to appeal has expired;

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ii. the issues are not “so interrelated” that leave should now be granted; and

iii. because the interlocutory orders were not appealed before the application was heard, to include those documents that were excluded pursuant to the interlocutory orders on this appeal, would contravene the principles of *res judicata* and abuse of process.

[24] The responding parties claim that they should be permitted to appeal the two interlocutory orders, which should be heard at the same time as the appeal of the final order. They claim the subject-matter of the two interlocutory orders is inextricably linked to the final order dismissing their *Charter* challenge, which was properly appealed to this court.

[25] On their appeal of the final order, the responding parties claim that the application judge made errors of law by excluding (i) some of the evidence from the physicians in the November 12, 2024 order, and (ii) the monthly data on the numbers of actively homeless persons as categorized, when he dismissed the application for violation of the responding parties’ ss. 7 and 15 *Charter* rights. They further claim that allowing them to appeal these two interlocutory orders will not dispose of any issues on appeal; it will simply amplify the record. As such, it would not constitute an abuse of process.

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E. ANALYSIS

(a) Jurisdiction to appeal interlocutory orders

[26] Sections 6(1)(b) and 19(1)(b) of the *Courts of Justice Act*, R.S.O. 1990, c. C. 43, provide that an appeal of a final order lies to the Court of Appeal, while an appeal of an interlocutory order lies to the Divisional Court, with leave.

[27] Rule 61.03(1)(b) of the *Rules of Civil Procedure* provides that leave to appeal an interlocutory order must be sought from the Divisional Court within 15 days of the order.

[28] However, s. 6(2) of the *Courts of Justice Act* provides that,

> The Court of Appeal has jurisdiction to hear and determine an appeal that lies to the Divisional Court or the Superior Court of Justice if an appeal in the same proceeding lies to and is taken to the Court of Appeal.

[29] In the normal course, leave to appeal must be obtained from the Divisional Court before seeking to combine an appeal that lies to the Divisional Court with an appeal of a final order that lies to this court as of right: *Cole v. Hamilton (City)*, (2002), 60 O.R. (3d) 284 (C.A.), at paras. 15-16; *Mader v. South Easthope Mutual Insurance Co.*, 2014 ONCA 714, 123 O.R. (3d) 120, at para. 55; *Brown v. Hanley*, 2019 ONCA 395, at paras. 19 and 20.

[30] However, if the final and interlocutory orders are “so interrelated that leave would inevitably have been granted on the interlocutory issue”, this court can

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assume jurisdiction over the appeal under s. 6(2) even if leave has not been sought from the Divisional Court: *Carcillo v. Ontario Major Junior Hockey League*, 2024 ONCA 685, at para. 35; *P1 v. XYZ School*, 2021 ONCA 901, 160 O.R. (3d) 445, at para. 37, citing *Lax v. Lax* (2004), 70 O.R. (3d) 520 (C.A.), at para. 9.

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[31] The reason for allowing the appeal of interlocutory orders that are interrelated to a final appeal and permitting them to be heard together in this court, is to promote judicial economy and to secure "the just, most expeditious and least expensive determination of every civil proceeding on its merits", as provided for in r. 1.04 of the *Rules of Civil Procedure*.

(b) When is an appeal of an interlocutory order "so interrelated that leave would inevitably be granted" such that it can be heard along with an appeal of a final order to this court?

[32] In *P1*, at paras. 38 and 39, this court determined that the interlocutory order was so interrelated to the final order that they should be heard together. In so finding, they relied on *Lax*, at para. 9, where this court held that,

> Although the motion for summary judgment was dismissed, allowing the case to proceed to trial, the motion judge finally disposed of the issue whether the limitation period is 20 years or six years, thus removing the limitation period as a defence. The order is therefore a final order on a question of law and the appeal is properly brought to this court. Although the second issue would, if brought as a stand-alone appeal to the Divisional Court, require leave of that court, because the two issues are so interrelated, we were able to proceed

> to hear the two appeals together in accordance with s. 6(2) of the *Courts of Justice Act*, R.S.O. 1990, c. C-43, on the basis that once the first issue was before this court, leave would inevitably have been granted on the second. [Citations removed; emphasis added.]

See also, *2099082 Ontario Limited v. Varcon Construction Corporation*, 2020 ONCA 202, 97 C.L.R. (4th) 26, at para. 17; and *Azzeh v. Legendre*, 2017 ONCA 385, 135 O.R. (3d) 721, at paras. 25-26, leave to appeal refused, [2017] S.C.C.A. No. 289.

[33] Most recently, in *Carcillo*, at paras. 33-38, this court specifically addressed hearing an appeal of an interlocutory order for which the moving party had not sought leave to appeal to the Divisional Court. While recognizing that, "in the normal course", the appellant must first obtain leave from the Divisional Court before seeking to combine an appeal that lies to the Divisional Court with an appeal that lies to this court, this court noted at paras. 35 and 38:

> [I]f the interrelated final and interlocutory order are "so interrelated that leave would inevitably have been granted on the interlocutory issue", this court can assume jurisdiction over the appeal under s. 6(2) even if leave has not been sought from the Divisional Court.
>
> …
>
> [H]earing this appeal with the appeals of the Certification and Dismissal orders would promote, not take away from, the time and cost-effective resolution of disputes.

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(c) Whether these interlocutory orders are so interrelated with the final order that leave would inevitably have been granted such that the Orders are not *res judicata* or an abuse of process

[34] As part of its argument that the responding parties' requested relief would contravene the principles of fairness, efficiency and finality in the doctrines of *res judicata,* and/or abuse of process, the moving party claims leave would not have "inevitably been granted" by the Divisional Court. The moving party refers to this court's decision in *Blair v. Ford*, 2021 ONCA 841, 159 O.R. (3d) 415, at para. 28, leave to appeal refused, [2022] S.C.C.A. No. 15, where the court held that "it is not appropriate to await the outcome of the [matter] to then assert that the issue is intrinsically interrelated", and in such circumstances, the appeal of the interlocutory orders should not be heard together with the appeal of the final order.

[35] However, the point was addressed in *Carcillo* at paras. 33-38, where this court noted the decision in *Blair* but reiterated that leave is not required to include the appeal of an interlocutory order as a ground of appeal of a final order, where the grounds of appeal are "so interrelated" that leave to appeal the interlocutory order would inevitably have been granted.

[36] In my view, the interlocutory orders in question pertain to the same issues as the appeal of the final order and are so interrelated to the constitutional

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questions that are the subject of the appeal of the final order, that leave would inevitably have been granted to appeal the interlocutory orders.

[37] Ground 1 is central to the legal questions at the heart of the appeal of the final order as it is evidence of the demand for shelter beds, the challenges and disproportionate effect of the measures taken on the responding parties which is relevant to the issue of whether the sheltering restrictions and evictions constitute a deprivation of their s. 7 right to life, liberty and security of the person, and their s. 15 right to equality, and whether the evictions were conducted in a manner that could be justified as a reasonable limit prescribed by law within the meaning of s. 1 of the *Charter*.

[38] The responding parties will argue that the application judge erred in law in excluding this evidence and holding that any party seeking to rely on authenticated documents must make them exhibits to an affidavit or cross-examination as they claim this is not required by Rule 51 of the *Rules of Civil Procedure*.

[39] The excluded physicians' evidence that is the subject of Ground 3, includes evidence of the effect of sheltering restrictions on the responding parties' mental and physical health, medical treatment and barriers to accessing shelter. This also is interrelated to the claim for damages for physical and psychological harms the responding parties allege were caused by the evictions and barriers to access to shelter which they claim violated their ss. 7 and 15 *Charter* rights.

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[40] At the merits hearing of the appeal, the responding parties will argue that the application judge's decision to exclude this evidence was based on an error of law – categorizing the physicians' as "participant experts" although the responding parties claim the physicians were only ever offered as fact and/or participant witnesses. They will argue that, had the application judge correctly categorized the physicians, he would not have excluded those parts of their evidence.

[41] Since *Lax* was decided, this court has accepted jurisdiction over grounds of appeal challenging interlocutory orders under s. 6(2) of the *Courts of Justice Act*, alongside grounds of appeal challenging final orders, if they were sufficiently interconnected, without requiring appellants to first obtain leave from the Divisional Court. These orders are inextricably linked to whether the moving party breached the responding parties' *Charter* rights and what, if any, damage resulted therefrom.

[42] As such, Grounds 1 and 3 are not barred by the doctrines of *res judicata*, abuse of process, or collateral attack.

F. CONCLUSION

[43] Given that Grounds 1 and 3 are inextricably linked and interrelated to the appeal of the final order, leave to appeal the interlocutory orders would inevitably have been granted and those appeals may be addressed together within this appeal of the final order. The appeal of those orders is neither *res judicata* nor an

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abuse of process. The documents pertaining to those issues may also remain in the Appeal Record.

[44] The motion to exclude Grounds 1 and 3 from the Notice of Appeal is therefore dismissed, with costs reserved to the panel hearing the appeal.

Released: July 22, 2025 “G.T.T.”

“Thorburn J.A.”
“I agree. Gary Trotter J.A.”
“I agree. D.A. Wilson J.A.”

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TAB 160

Court File No. COA-25-CV-0166

COURT OF APPEAL FOR ONTARIO

B E T W E E N:

KRISTEN HEEGSMA, DARRIN MARCHAND, GORD SMYTH, MARIO MUSCATO, SHAWN ARNOLD, CASSANDRA JORDAN, JULIA LAUZON, AMMY LEWIS, ASHLEY MACDONALD, COREY MONAHAN, MISTY MARSHALL, SHERRI OGDEN, JAHMAL PIERRE, and LINSLEY GREAVES

Appellants

- and -

CITY OF HAMILTON

Respondent

- and -

ATTORNEY GENERAL OF ONTARIO

Intervener

CERTIFICATE OF COMPLETENESS

I, Sujit Choudhry, co-counsel for the Appellants, certify that the Appeal Book and Compendium in this appeal is complete and legible.

Dated this August 29, 2025.



Sujit Choudhry, co-counsel for the Appellants

Heegsma et al *-and-* **CITY of HAMILTON**

Appellants *(*Applicants) Respondent (Respondent)

Court File No.COA-25-CV-0166

Ontario
Court of Appeal

APPEAL BOOK - VOLUME 11

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