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, CASSANDRA JORDAN, JULIA LAUZON, AMMY LEWIS, ASHLEY MACDONALD, COREY MONAHAN, MISTY MARSHALL, SHERRI OGDEN, JAHMAL PIERRE, and LINSLEY GREAVES

Applicants

-and-

CITY OF HAMILTON

Respondent

APPLICANTS' APPLICATION RECORD

VOLUME 12 – TABS 107-110

HĀKI CHAMBERS

319 Sunnyside Avenue
Toronto, ON M6R 2R3
Sujit Choudhry (LSO# 45011E)
Tel: 416-436-3679
sujit.choudhry@hakichambers.com

COMMUNITY LEGAL CLINIC OF YORK REGION

21 Dunlop Street
Richmond Hill, ON L4C 2M6

Sharon Crowe (LSO# 47108R)
Tel: 905-508-5018 ext. 57
sharon.crowe@yr.clcj.ca

Michelle Sutherland (LSO# 70159T)
michelle.sutherland@yr.clcj.ca

Curtis Sell (LSO # 84128A)
curtis.sell@yr.clcj.ca

ROSS & MCBRIDE LLP

1 King Street West, 10th Floor
Hamilton, ON L8P 1A4
Wade Poziomka (LSO# 59696T)
Tel: 905-572-5824
wpoziomka@rossmcbride.com

Counsel to the Applicants

TO:

GOWLING WLG (CANADA) LLP
Barristers & Solicitors

1 King Street W, Suite 1500
Hamilton ON L8P 1A4

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

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

Counsel to the Respondent

VOLUME 12 INDEX – *HEEGSMA ET AL.* v. *CITY OF HAMILTON*

TAB (EXHIBIT LETTER)	Document
APPLICATION RECORD VOLUME 12	
107.	Transcript of the Cross Examination of Kaitlin Schwan dated Aug 27, 2024
a.	Exhibit 1 - Form 53 Acknowledgement of Expert's Duty of Kaitlin Schwan dated June 13, 2022
b.	Exhibit 2 - WNHHN - About the Women's National _br __Housing and Homelessness Network
c.	Exhibit 3 - About _ The Canadian Observatory on Homelessness
d.	Exhibit 4 - Homeless Encampments – The Shift
e.	Exhibit 5 - 20230110 How alumna Kaitlin Schwan became a leading advocate for the right to housing _ University of Toronto Alumni
f.	Exhibit 6 - 20230201 CBC Encampment evictions cause 'tremendous harm,' defy human rights, say experts _ CBC News
g.	Exhibit 7 - 20230131 Toronto 'extremely vulnerable' to legal challenge after homeless encampment ruling, experts say _ CBC News
h.	Exhibit 8 - Reconsidering Gender
i.	Exhibit 9 - Stats Can The Daily — Canadian residential facilities for victims of abuse, 2017_2018
j.	Exhibit 10 - Highlights o f National Shelter Study Em12-17-1-2019-eng
k.	Exhibit 11 - 20210606 Toronto's shelters see triple the number of violent incidents, rise in overdoses during COVID-19 pandemic, data show - The Globe and Mail
l.	Exhibit 12 - OShea et Al Pilot Study of COVID-19 Testing ciaa743
m.	Exhibit 13 - 20201207 Star 'We're the vulnerable ones'_ Why women living in Toronto's public parks during COVID-19 choose outdoor tents over indoor shelters
DR. ANDREA SEREDA	
108.	Affidavit of Andrea Sereda dated May 12, 2023 (Misspelled in Affidavit)
a.	Exhibit A - Curriculum Vitae of Andrea Sereda (P 31/40)
b.	Exhibit B – Maslow's Hierarchy of Needs (P 39/40)
109.	Form 53 Acknowledgement of Expert's Duty of Andrea Sereda dated May 12, 2023
110.	Transcript of Cross Examination of Andrea Sereda dated Aug 23, 2024

Court File No. CV-21-77187

ONTARIO

SUPERIOR COURT OF JUSTICE

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Applicants

- and -

CITY OF HAMILTON

Respondent

--- This is the Cross-Examination of KAITLIN SCHWAN on her Affidavit sworn June 13, 2022, herein, taken via videoconference hosted by Nimigan Mihailovich Reporting Inc. on the 27th day of August 2024.

APPEARANCES:

Sujit Choudhry — For the Applicants

Bevin Shores — For the Respondent
Vivian Caldas

IN ATTENDANCE:
Curtis Sell - CLCYR
Michelle Sutherland - CLCYR
Nonye Okenwa - CLCYR
Sharon Crowe - HCLC
Liz Marr

TABLE OF CONTENTS

A7639

INDEX OF EXAMINATIONS: PAGE NO.

The following list of undertakings, advisements and refusals is meant as a guide only for the assistance of counsel and for no other purpose.

INDEX OF UNDERTAKINGS

The questions/requests undertaken are noted by U/T and appear on the following page/line numbers:
None noted

INDEX OF ADVISEMENTS

The questions/requests taken under advisement are noted by U/A and appear on the following page/line numbers: None noted

INDEX OF REFUSALS

The questions/requests refused are noted by R/F and appear on the following page/line numbers: 83:22, 87:15

TABLE OF CONTENTS (Continued)

INDEX OF EXHIBITS.

A3355

NO. 12 (for identification): 65
O'Shea et al study: "Pandemic Planning in Homeless Shelters: A pilot study of a COVID-19 testing and support program to mitigate the risk of COVID-19 outbreaks in congregate settings."
NO. 13: Toronto Star article: 73
'We're the vulnerable ones': Why women living in Toronto's public parks during COVID-19 choose outdoor tents over indoor shelters

---Upon Commencing at 10:00 a.m.

KAITLIN SCHWAN; Affirmed.

CROSS-EXAMINATION BY MS. SHORES:

1 **Q.** Good morning, Dr. Schwan. We're here for your cross-examination on an affidavit affirmed June 13th, 2022. Can we start by getting you to state your full name for the record, please.

A. Yes, my name is Kaitlin Schwan.

2 **Q.** And how would you like to be addressed, is there any name you would prefer to go by?

A. Kaitlin is great, or Dr. Schwan, either one is great.

3 **Q.** Any pronouns that you wish to share?

A. She and her.

4 **Q.** Where are you participating from today?

A. I'm participating from Owen Sound, Ontario today.

5 **Q.** And you're alone in the room that you're participating from?

A. Yes, I am.

6 **Q.** You're aware that you're to

have no assistance in giving your answers today?

A. I am aware.

7 **Q.** And you've previously confirmed to us that if you're referring to any materials in giving your answers, other than your affidavit and the exhibits thereto, you're aware that you need to state what you're referring to so that we can make it an exhibit and explain how it informs your evidence today, correct?

A. Correct.

8 **Q.** And you've been affirmed to tell the truth?

A. Correct.

9 **Q.** Just a couple of other minor things before we get on to the questioning. Please be sure to speak up and give verbal answers so that Sheila, our Court Reporter, can transcribe your evidence clearly and accurately. If you don't understand a question that I'm asking you, please let me know and I'll rephrase it. If at any time you need a break, please also let us know and we can accommodate that for you as well; is that understood?

A. Understood, thank you.

10 **Q.** What do you understand your

role is in this litigation?

A. I understand that I've been engaged as an expert witness in the areas of women's homelessness, women's unique experiences with respect to encampments and the causes and conditions of homelessness for women and gender diverse people.

11 **Q.** And I understand that you're evidence has been used in two court proceedings in Ontario that I can find so far?

A. Correct.

12 **Q.** One is the Region of Waterloo decision in 2023?

A. Correct.

13 **Q.** And one of them was the City of Kingston decision in earlier 2024?

A. Correct.

14 **Q.** Both of those were about homeless encampments?

A. Correct.

15 **Q.** And both of those you gave evidence on behalf of the parties who were opposing?

A. Correct.

16 **Q.** Your affidavit of June '22

June 13, in the form that was provided to my office it didn't contain a Form 53. I'm going to share my screen. Your -- I'm sorry, the lawyers for the applicants have pointed out that a Form 53 was later provided in a motion relating to evidence. I'm going to put that up on the screen right now. Are you able to see that?

A. I am.

17 **Q.** So this your Acknowledgement of Expert's Duty form?

A. Correct.

18 **Q.** It's dated June 13, 2022, when was it signed?

A. On that date.

19 **Q.** So we're going to make this Form 53 dated June 13, 2022 Exhibit 1 to the examination?

EXHIBIT NO. 1: Form 53 dated June 13, 2022

BY MS. SHORES:

20 **Q.** I'm going to go back to your affidavit. At the time you wrote your affidavit, what instructions were provided to you?

A. The instructions that were provided, as I recall, were to provide expertise

on the research I've conducted with respect to women and gender diverse people's experiences of homelessness specifically relative to a study I conducted call the Pan-Canadian Survey on -- or, Pan-Canadian Survey on Women's Homelessness.

21 **Q.** And what you're referring to is the document that's attached as Exhibit "B" to your affidavit?

A. Correct.

22 **Q.** So the factual assumptions that your opinions are based on, those are set out in your affidavit?

A. They're set out in my affidavit alongside Exhibit "B" and "C".

23 **Q.** And the documents that you relied on in forming your opinions, those are also set out in your affidavit?

A. Correct.

24 **Q.** And you didn't conduct any specific research on your own for the purposes of informing the opinion in this affidavit?

A. Correct.

25 **Q.** In the preamble to your June 13, 2022 affidavit you state you're in the City of Guelph, is that where you're based?

A. I have since relocated to Los Angeles. I've taken up a position as an associate professor in the department of family medicine at the University of Southern California.

26 **Q.** And when did you --

A. My apologies. I relocated in April 2024. The affidavit describing my role and location is correct at the time of me producing it and signing it, but I've since relocated to Los Angeles.

27 **Q.** So if we look at paragraph 1 of your affidavit. So as of June 13, 2022 when you gave this affidavit you had described yourself as the National Director of the Women's National Housing and Homelessness Network, so that was accurate at the time?

A. Yes.

28 **Q.** Are you still the National Director of the Women's National Housing and Homelessness Network?

A. No, I'm a research advisor.

29 **Q.** When did that change happen?

A. That change happened in January 2024.

30 **Q.** And is that related to you

accepting the position in Los Angeles?

A. Correct.

31 **Q.** And so just by way of further update, so in June 13, 2022 you also identified that you were a Senior Researcher at the Canadian Observatory on Homelessness. Do you still hold that position?

A. I do.

32 **Q.** And you had indicated you were appointed Assistant Professor, Status Only, at the University of Toronto's Faculty of Social Work. Are you still an Assistant Professor, Status Only, at the University of Toronto's Faculty of Social Work?

A. Yes.

33 **Q.** Can you describe what "Status Only" means?

A. Status Only means you're not appointed as like a research faculty or a teaching faculty, you're identified as either a community based scholar that's linked to the faculty in some way, either through a collaborative research project or identified as an external expert in a topical area that is of benefit to the faculty of social work. They appoint you as such in order to

enrich the opportunities and offers provided to students and the faculty.

34 **Q.** And so you're not, for example, teaching a course for every semester at the University of Toronto's Faculty of Social Work?

A. Correct, no, I'm not.

35 **Q.** All right. You've also described yourself in the paragraph as a former Senior Researcher for the UN Special Rapporteur on the Right to Adequate Housing. I think I saw in your CV that was from 2019 to 2020.

A. Correct.

36 **Q.** Okay. And at the time the UN Special Rapporteur was Leilani Farha?

A. Correct.

37 **Q.** And she's also a witness in this proceeding, are you aware of that?

A. I saw her name listed when I was provided with the scheduling for the cross-examination.

38 **Q.** And you also indicate at paragraph 1 that you were formerly a Research Director for The Shift. I understand the director of that organization is also Leilani Farha?

A. Correct.

39 **Q.** What was the time period in which you were Director of Research for The Shift?

A. I believe 2019 to 2021.

40 **Q.** I don't mean to make you guess. Let's see where it is on your CV. So your CV shows 2019 to 2022.

A. Correct, yes.

41 **Q.** I want to go back to the Women's National Housing and Homelessness Network. I took a look at the organization and specifically the About Us page on their website. So what I've placed on the screen here is a printed version of the About Us page from the Women's National Housing and Homelessness Network; do you recognize that?

A. Yes, that looks correct.

42 **Q.** Okay. And so under the heading Our Purpose this narrative states:

"Women's homelessness is an urgent crisis in Canada, requiring immediate action. Housing insecurity and homelessness for women is largely invisible and women remain profoundly underserved across many systems and services. Women, especially those who are multiply marginalized, face systemic barriers to accessing

safe, affordable, and adequate housing.

The Women's National Housing and Homelessness Network is trying to change that."

[All quotes are as read]

Do you agree that that's an accurate encapsulation of the Women's National Housing and Homelessness Network process?

A. Correct, I do.

43 **Q.** Okay. And some activities are listed under bullet points, or, I'm sorry, in bullet point form under the heading Activities of the Network include but are not limited to: The first one says:

"Conducting research on the causes of, and solutions to, homelessness and housing insecurity for women, girls, and gender diverse people."

That's accurate?

A. Yes.

44 **Q.** And also the second bullet:

"Advocating for policy change in support of preventing and ending homelessness for women, girls, and gender diverse peoples."

You agree that that's accurate?

A. Yes.

45 **Q.** And further down it looks like there's a heading that's cut off, but there's a numbered list and number one on the list says:

"We are vocal, determined advocates and allies for the voices of lived experience."

Do you agree that that's accurate?

A. Yes.

46 **Q.** So this page I'm going to mark as Exhibit 2 to the cross-examination of Dr. Schwan.

EXHIBIT NO. 2: Page from Women's National Housing and Homelessness Network - Our Purpose.

BY MS. SHORES:

47 **Q.** Turning to the Canadian Observatory on Homelessness where you've indicated that you're still a Senior Researcher, I've, again, visited that website and printed off a copy of the About Us page from that website. I'm just going to give my pdf viewer a moment to catch up and stop freezing. Bear with me a moment here.

A. No problem.

48 **Q.** Okay, sorry about that. So what I've placed on the screen was pulled from the link to the title Our Story. What I'd like to do

is scroll down to the heading that says Our Story. So do you recognize this part of the Canadian Observatory on Homelessness web page?

A. Yes.

49 **Q.** And under the Our Store heading, the first paragraph says:

"The Canadian Observatory on Homelessness is a non-partisan research and policy partnership between academics, policy and decision makers and people with lived experience of homelessness."

You'd agree that's accurate?

A. Yes.

50 **Q.** Okay.

"Led by Stephen Gaetz, President & CEO, the Canadian Observatory on Homelessness works in collaboration with partners to conduct and mobilize research designed to have an impact on solutions to homelessness."

You agree that's also accurate?

A. Yes.

51 **Q.** Steve Gaetz is also a witness in this case; are you aware?

A. Yes, I saw his name listed as well.

52 **Q.** And you'd agree that the Canadian Observatory on Homelessness research is designed to have an impact on solutions to homelessness?

A. Yes, I would.

53 **Q.** You had also indicated that you were involved with an organization called The Shift, and there's a hyperlink in paragraph 1 of your affidavit to the website, make-the-shift.org, that's the website for The Shift?

A. I believe so, unless it has been updated.

54 **Q.** Okay. And before we change to those topics, I'm going to make the Canadian Observatory on Homelessness About page Exhibit 3 to Dr. Schwan's examination?

EXHIBIT NO. 3: Canadian Observatory on Homelessness About page

BY MS. SHORES:

55 **Q.** So, once again, I visited that website and printed off what's placed on the screen, a page on The Shift website titled Homeless Encampments; do you recognize this web page?

A. Yes.

56 **Q.** And in the first paragraph on this page, second sentence, it says:

"The Shift has developed several resources to help ensure the rights of encampment residents are upheld. Download them and use them in your community!"

So you'd agree that The Shift is providing resources for people in the community to use to effect policy change?

A. I would rather articulate that The Shift has produced research and resources at various times to support governments in upholding the right to housing with respect to people residing in encampments. As part of those resources we developed tools and materials for people residing in encampments to understand their human rights and the obligations of governments to uphold them.

57 **Q.** So when it says, "Download them and use the in your community!", who is the intended audience for that?

A. The audience could range between people who are residing in encampments. But also municipalities themselves, other stakeholders who are involved in developing responses to encampments.

58 **Q.** So scrolling down the resources on this page include homeless encampments, municipal engagement guidance?

A. Yes.

59 **Q.** And scrolling down even further there's a document titled A National Protocol for Homeless Encampments in Canada, and the names on it are Leilani Farha and Kaitlin Schwan as one of the resources on this page.

A. Correct.

60 **Q.** And Kaitlin Schwan is you?

A. Yes.

61 **Q.** So you authored this document along with Leilani Farha?

A. I did.

62 **Q.** I'm going to make the homeless encampment web page from The Shift website Exhibit 4 to Dr. Schwan's examination.

EXHIBIT NO. 4: Homeless encampment web page from The Shift website

BY MS. SHORES:

63 **Q.** Now I'm going to return to your CV. Your CV was attached as Exhibit "A" to your June 13, 2022 affidavit. So would your CV have

been current to the date that your affidavit was affirmed, June 2022?

A. Yes.

64 **Q.** I'm going to go down to page 3 of your CV under the heading Research Grants. I noticed there's years listed and then the nature of the grant and then the amounts.

A. Correct.

65 **Q.** Okay. When I looked, just going from the grants from 2021, so the first seven down to the one with Yakubovuch, so from 2021 up until when your affidavit was affirmed in June 2022, if I added up all of the amounts of those research grants I got $1,255,991.00; does that sound about right?

A. That sounds plausible. I would need to do the calculation myself, but I am sure your calculations are correct.

66 **Q.** So for about, you know, the year and a half between 2021 to mid 2022 when your CV was current to, that's about one and a quarter million dollars in grants that you've obtained through your homelessness research?

A. That a very large number of scholars, including myself, have obtained for this

research.

67 **Q.** And those scholars are the people listed alongside your name on the Research Grants section of your CV?

A. Correct.

68 **Q.** Similarly, if we go on to page 5 under Research Contracts. So research contracts are different from the research grants, right?

A. Correct.

69 **Q.** So, again, if I look at the seven of them, just going back to about 2021, so 2021 up until when your CV was current to, I added those up and I got $499,358.00; does that sound about right?

A. That does sound about right.

70 **Q.** So, again, from 2021 to when this CV was current to in May '22, that's an additional almost half a million dollars in contract money you've received for your homelessness research?

A. I would have to calculate the numbers precisely, but I imagine your calculations are correct.

71 **Q.** I'm going to take you next to a news article published by the University of

Toronto about alumni, and the heading is "How alumna Kaitlin Schwan became a leading advocate for the right to housing", this article is dated January 10, 2023. Do you recognize this article?

A. I do.

72 **Q.** This article is about you?

A. It is.

73 **Q.** And you would agree with the description of yourself as an advocate for the right to housing?

A. I would -- so I didn't write the article. I would say I'm a publicly-engaged scholar rather than advocate. But I understand that that perhaps doesn't lend itself to media as well and the author chose to use the term advocate.

74 **Q.** Okay. So in the article there's a picture, that's you?

A. Correct.

75 **Q.** So in the article, unfortunately it's not paginated, but on page 4 of the pdf the first full paragraph states:

"Since taking the helm at the Women's National Housing and Homelessness Network earlier this year, Schwan has continued this

rights-based approach. She says urgent action on homelessness amongst women and gender-diverse people is essential, given the current context."

You gave that statement?

A. Correct.

76 **Q.** And you agree?

A. Yes.

77 **Q.** So I'm going to make this article Exhibit 5 to the cross-examination of Dr. Schwan.

EXHIBIT NO. 5: University of Toronto article "How alumna Kaitlin Schwan became a leading advocate for the right to housing" dated January 10, 2023

BY MS. SHORES:

78 **Q.** There's another article I would like to take you to. This one is a CBC News article with the title, "Encampment evictions 'tremendous harm', defy human rights, say experts". It was written by a journalist named Clare MacKenzie and it's dated February 1, 2023; do you recognize this article?

A. Yes.

79 **Q.** And, in particular, if we go down to the third paragraph of the article it

refers to you by name. Do you recall being interviewed or quoted in this article?

A. I don't recall it specifically, but I don't doubt that I was.

80 **Q.** And the second paragraph of this article refers to -- well, I'll just read it. It says:

"A few days later, the Ontario Superior Court blocked the Region of Waterloo from demolishing an encampment in Kitchener, Ontario, saying it would infringe on the constitutional rights of people living there because there are not enough shelter beds in the city."

That's the Waterloo decision in which you were an expert witness?

A. Correct.

81 **Q.** And your evidence in that proceeding took the form of an affidavit?

A. Correct.

82 **Q.** So continuing on with the article, we're going down to the fourth paragraph. The authority states that you:

"...told Island Morning's Mitch Cormier the Waterloo ruling sets a precedent which may empower encampment residents and their

advocates to challenge municipal policies."

You gave that statement?

A. Yes.

83 **Q.** And you agree with that?

A. Yes.

84 **Q.** So your role in that litigation was part of that empowering encampment residents and their advocates to challenge municipal policies?

A. My role in that case was to provide expert evidence with respect to the research I'd conducted on gendered homelessness.

85 **Q.** But then when you gave comment on your role in that litigation, you informed CBC News that the ruling set a precedent which may empower encampment residents and their advocates to challenging municipal policies. So your evidence is that this statement is completely divorced from your role as an expert witness in that litigation?

A. In this statement I'm articulating that the precedent may have particular affects with respect to how advocates and their allies engage legally around encampments. I wasn't commenting there on my role

in the case.

86 **Q.** And going down to the sixth paragraph of the article it states:

"Schwan said municipal safety concerns such as fire hazards are not adequate reasons for evictions."

It goes on to quote:

"'You can't use that as a basis to evict an encampment under human rights law,' she said."

That's a quote that you gave?

A. Yes.

87 **Q.** That's your belief?

A. That is my statement with respect to what international human rights law articulates.

88 **Q.** Based on your understanding?

A. Based on my understanding.

89 **Q.** And, of course, that understanding would be informing your views?

A. Yes.

90 **Q.** And your evidence?

A. The evidence I provided in that case didn't comment on international human rights law. It was specific to the study I'd conducted

on gendered homelessness in Canada.

91 **Q.** And your evidence in this case?

A. My evidence in this case is similarly just focused on research with respect to women and gender diverse people's experiences in homelessness.

92 **Q.** I'm going to make the February 1, 2023 CBC article Exhibit 6 to Dr. Schwan's examination.

EXHIBIT NO. 6: February 1, 2023 CBC article

BY MS. SHORES:

93 **Q.** I'm going to take you to another CBC article, this one entitled, "Toronto 'extremely vulnerable' to legal challenge after homeless encampment ruling, experts say". This is an article by a journalist named Jordan Omstead dated January 31, 2023. Do you recognize this article?

A. Yes.

94 **Q.** And do you recall being interviewed for this article?

A. Yes.

95 **Q.** Now, I'm going to go down in the article under the heading that says "Future

legal challenges to rely on ruling, expert says".
Then immediately under that heading it states:
"Kaitlin Schwan, executive director of the Women's National Housing and Homelessness Network, said that while encampment residents in Toronto unsuccessfully challenged an eviction in a 2020 case, the circumstances since that decision combined with this precedent-ruling have created a different set of circumstances."
You gave that statement?

A. I don't know if I said it precisely in that language. I think the author is summarizing me there.

96 **Q.** What did the author get wrong?

A. Perhaps it's just the phrasing, "the circumstances since that decision"...

97 **Q.** It does seem like they're missing a word.

A. I think they mean precedent-setting ruling.

98 **Q.** Now, if I go down a little bit further under the heading "Ruling called 'critical first steps'", under the first paragraph under that heading the author of this article writes?
"The case is a 'critical first

step', but falls well short of placing any positive obligations on municipalities to provide any shelter or housing, said Kaitlin Schwan, executive director of the Women's National Housing and Homelessness Network."
You gave that statement?

A. Correct.

99 **Q.** And then moving down, the author of this article has quoted you as saying:
'"It says we're very, very far away from actually realizing the right to housing in Canada. We have so far to go,' said Schwan, who acted as an expert witness in the Kitchener case."
You gave that statement?

A. Yes.

100 **Q.** And is it fair to say that you see this case as a step along the path of realizing the right to housing in Canada?

A. This current case or this case for which I'm being interviewed?

101 **Q.** My question was about the case you were speaking about, so the Waterloo decision.

A. Yes, I would say that.

102 **Q.** And I'll ask you the same question about this case, the Heegsma decision and

the City of Hamilton?

A. I think that cases such as these help us understand and articulate how we currently are responding to homelessness and how we understand it with respect to the right to housing and the federal legislation, the housing Act legislation that articulates Canada's obligation to uphold the right to housing. Cases such as these illuminate where we are at and, depending on their conclusion, may contribute to or harm the realization to the right to housing.

103 **Q.** I'm going to make this January 31, 2023 CBC article Exhibit 7 to Dr. Schwan's cross-examination.

EXHIBIT NO. 7: January 31, 2023 CBC article

BY MS. SHORES:

104 **Q.** Now I'm going to take you, Dr. Schwan, back to your affidavit once my pdf view unfreezes, there we go. So at paragraph 4 of your affidavit you refer to the Pan-Canadian Women's Housing & Homelessness Survey, which is appended as Exhibit "B" to your affidavit, correct?

A. Correct.

105 **Q.** So let's go to this survey.

Now, survey, I understand that this may mean different things to different people, but in the general sense methodologically this survey means that participants were asked questions and their answers were recorded, correct?

A. Correct.

106 **Q.** So if we go to the 19th page of this Exhibit "B" under the heading Data Analysis, the paragraph here states:
"Following data cleaning, data analysis was conducted by the authors of this report using SPSS software. Data analysis techniques included frequencies, cross tabulations, chi square tests, and T tests. Analysis was iterative, with emerging themes in the data identified and further explored through additional analyses."
So this paragraph here is encapsulating what was done with the data, correct?

A. Correct.

107 **Q.** And that data being the responses from the survey participants?

A. Correct.

108 **Q.** Okay. So, based on this, the

data analysis in the survey did not include verifying the accuracy of the answers given in response to the survey, correct?

A. In the sense that we didn't ask respondents whether they accurately reported on their life experiences, that would be correct.

109 **Q.** Okay. And not doing any sort of collateral interviews or research to verify the accuracy of the answers. I realize that some things may be subjective, but some may be objective and capable of corroboration, but that wasn't done, correct?

A. Correct.

110 **Q.** I want to take you back to the body of your affidavit, paragraph 6. At paragraph 6 you state:

"Homelessness amongst women, girls, and gender-diverse people in Canada remains both understudied and underestimated, despite indications that these groups disproportionately experience both poverty and core housing need. This is linked to the ways in which commonly used definitions, typologies, and ways of measuring homelessness have failed to account for the hidden ways that women, girls and gender diverse people

often experience housing instability and homelessness."

So, for the second sentence here, footnote 2, you've cited, I'll take you down to your footnotes, an article by Savage titled "Gendering Women's Homelessness", which is an article in the Irish Journal of Applied Social Studies, according to footnote number 1; is that correct?

A. That is correct.

111 **Q.** Okay. And so that is an article focused on the Irish experience of gendering women's homelessness, correct?

A. That is an article that provides a literature review on gendered homelessness across the global north. So the author reviews literature from the United States, Canada, Europe, a range of sources, including Ireland, but it was published in an Irish journal.

112 **Q.** Similarly, the second citation in footnote 2 is an article by Nicholas Pleace, "Exclusion by Definition: The Under-Representation of Women in European Homelessness Statistics". You'd agree that article is about women's homelessness in Europe?

A. It's specific to Europe, but Nicholas Pleace also articulates the ways in which this is consistent with definitional exclusion in the global north more broadly, including the United States and Canada.

113 **Q.** At paragraph 7 of your affidavit you state, you're referring to women, girls and gender diverse people, are more likely to negotiate a number of high-risk survival strategies. You cite for that footnote number 3, an article by Joanne Bretherton, "Reconsidering Gender in Homelessness", from the European Journal of Homelessness. Now, I do believe we have a copy of that. I'll placed this up on the screen; do you see that?

A. I do see that.

114 **Q.** This is the article cited in footnote 3 of your affidavit?

A. Correct.

115 **Q.** And so just taking you to the abstract of the article, and if you look at the last sentence of the abstract:

"Drawing on recent UK studies and the wider European literature, this paper argues that there is a need to cease a longstanding focus

on the streets, homelessness services and (predominantly) male experience and to look instead at the more nuanced interrelationships between gender and agency to fully understand the nature of homelessness in Europe."

So you'd agree that this paper is focused on homelessness in Europe, correct?

A. That paper is focused on homelessness in Europe.

116 **Q.** And not Canada?

A. It's not focus on Canada. I would argue that Exhibit "C", which I included, found very similar experiences within Canada and the global north more broadly. And Joanne Bretherton kind of stands as a preeminent scholar in the area gendered homelessness, and this piece in particular is highly respected, which is why I cited it despite its focus on Europe.

117 **Q.** So we're going to make the article reconsidering gender and homelessness Exhibit 8 to Dr. Schwan's examination.

EXHIBIT NO. 8: Joanne Bretherton, article "Reconsidering Gender in Homelessness"

BY MS. SHORES:

118 **Q.** Again, my pdf jumped a couple

steps ahead of me, just bear with me a moment.

I'm going to take you again to your affidavit, and this time paragraph 9. There's a quote:

"'It may be that the major trigger for homelessness is poverty and exclusion, but it is also clear that women do not experience homelessness in the same way as men. The triggers for women's homelessness are often different and their trajectories while homeless are often different, women's experience of homelessness is different. Gender plays a role'."

So that's a quote. Again, you footnoted footnote 5, Bretherton: "Reconsidering Gender in Homelessness" article. So that's the one we just discussed focusing on Europe, correct?

A. Correct.

119 **Q.** And at paragraph 10, again you've -- for the first sentence at paragraph 10, footnote 6, again, refers to the Reconsidering Gender in Homelessness article focusing on Europe, correct?

A. Correct.

120 **Q.** If we go to paragraph 11 of your affidavit under the heading, "Inequitable

Access to Emergency Shelters, Supports & Housing for Women, Girls and Gender Diverse People", the first sentence at paragraph 11 reads:

"Data from Statistics Canada, Employment and Social Development Canada, parliamentary reports, and municipal data and research consistently indicate that emergency shelters across the country are operating at (or over) capacity and there remains a severe lack of gender-specific supportive, transitional, and permanent affordable housing that meets the needs of women, girls, and gender diverse people."

I just want to take you through some of the citations for that statement. So there's citations, or footnotes, rather, I'll say, for each Statistics Canada, Employment and Social Development Canada, parliamentary reports, and municipal data and research. So let's start with Statistics Canada. Footnote 10 goes Statistics Canada, "Canadian Residential Facilities for Victims of Abuse", April 17, 2019 and there's a hyperlink there. So I'll pull that up on the screen.

So this is a pdf of that hyperlink. So the title on this Statistics Canada page is

"Canadian residential facilities for victims of abuse, 2017/2018"; is that correct?

A7648

A. Yes.

121 **Q.** And it says released 2019-04-17, so that's the April 17, 2019 date?

A. Yes.

122 **Q.** Okay. According to the title and also the summary of the document, these statistics are focusing on specifically for victims of abuse, correct?

A. Correct.

123 **Q.** Okay. So this isn't about women's -- shelters serving women in a homelessness sector, this is focusing on women who are victims of abuse or intimate partner violent, correct?

A. That's right.

124 **Q.** So I'm going to make the Statistics Canada document Exhibit 9 to Dr. Schwan's cross-examination.

EXHIBIT NO. 9: Statistics Canada document - "Canadian residential facilities for victims of abuse, 2017/2018."

BY MS. SHORES:

125 **Q.** Now, going back to the footnote

to paragraph 11, footnote 11, so Employment and Social Development Canada, this citation is different, as document titled, "Highlights of the National Shelter Study 2005-2016: Emergency Shelter Use in Canada", there's a hyperlink there. Go up to the top, is this the document cited at footnoted 11 to your affidavit?

A. Yes.

126 **Q.** And I want to take you down to the Conclusion section, and particularly the second paragraph under the heading Conclusion. So the authors of this document state:

"Despite a decrease in shelter users, occupancy rates have increased since 2005 and have consistently remained above 90% since 2012."

So is that what you're relying on in terms of speaking to shelter occupancy, or I'm sorry, that shelters across the country are operating at or over capacity in paragraph 11 of your affidavit?

A. That's one part of numerous materials that I'm relying on. I believe with the study they also found that the occupancy rate for family shelter has increased, the lengths of stay

A3364

for families had increased, and family homelessness, a vast majority of families that are homeless are led by women.

127 **Q.** Okay. And part of what you indicate, if you go down to the sixth paragraph under Conclusion, the author states:

"Shelter use by families has remained relatively consistent since 2011 with occupancy rates hovering between 84% and 90%. However, there has been a marked increase in stay lengths for families, which continued into 2016. Families typically stay in a shelter almost twice as long as individual."

A. Correct.

128 **Q.** Now, just going back to the second paragraph under the heading Conclusion, the author here states that shelter occupancy consistently remained above 90 per cent, but they're not specifically saying that they're at or over capacity, are they?

A. Not in this report, no.

129 **Q.** So I'm going to make the Employment and Social Development Canada Report Exhibit 10 to Dr. Schwan's cross-examination.

A. What I'd like to add, if I

could.

EXHIBIT NO. 10: Employment and Social Development Canada Report

THE DEPONENT: What I'd like to add, if I could, is that some shelters in some cities have particular standards with respect to occupancy in shelters, and that would be ranging from 80 to 90 per cent, would be considered at occupancy, at the occupancy standard they're shooting for. So above 80 or 90 would be seen as over capacity.

BY MS. SHORES:

130 **Q.** Okay. To put a finer point on it, they may define that as over capacity even though if they're at 80 or 90 per cent, or whatever that target is, they may still be able to accept intakes.

A. In some cases, yes.

131 **Q.** Returning to paragraph 11 of your affidavit, footnote 12 refers to parliamentary reports, specifically report by Vecchio called "Surviving Abuse and Building Resilience – A Study of Canada's Systems of Shelters and Transition Houses Serving Women and Children Affected by Violence". Again, this

document, I can put it up on the screen for you, but this is, again, focusing on shelters for women who are experiencing violence, not the homelessness sector in general, correct?

A7649

A. The report considers data and testimony from like violence against women's shelters specifically, but it also includes testimony from people providing services in the homelessness sector and broader on this issue with respect to abuse experienced by women and children.

132 **Q.** Okay. But I put it to you, Dr. Schwan, that this report doesn't say that homelessness sector shelters more broadly are consistently at or over capacity?

A. The report articulates that the shelters available to women experiencing abuse, whether they're in the violence against women sector or the homelessness sector are consistently at or above capacity.

133 **Q.** And footnote 13 to paragraph 11, I'll take you to that in your affidavit before we put the document to you. Give me one moment. So footnote 13 refers to municipal data and research. The citation for that is Street Needs

Assessment 2018, City of Toronto. Again, there's a hyperlink. So following the hyperlink, that leads to a document called "Street Needs Assessment 2018". That's the -- this is the document that you're citing in footnote 13 to your affidavit?

A. Correct.

134 **Q.** Now, this document is put out by the City of Toronto?

A. Correct.

135 **Q.** Okay. And it's about the City of Toronto?

A. Yes.

136 **Q.** Okay. It's not about the City of Hamilton?

A. Correct.

137 **Q.** So I'm going to take you back to your affidavit, paragraph 15. Now, you're referring again to, in this paragraph, to the Pan-Canadian Women's Housing & Homelessness Survey.

"Our survey findings contained in Exhibit "B" suggest that some women and gender diverse people are harmed by how the homelessness and VAW sectors structure and deliver services.

A3365

In addition to the severe capacity issues that are well-documented, personal accounts indicate that shelters can exacerbate the very needs they are meant to address, including through discriminatory policies, duty to report policies, and rigid eligibility and acuity criteria."

So I wanted to take you to Exhibit "B". Specifically we'll start with discriminatory policies. Now, when I reviewed this document at Exhibit "B", what I think you were referring to is page 41, or the discussion starting on page 41 of this survey, so number 7 under the heading "Women and gender diverse people reported significant barriers to accessing emergency services, with almost a third being unable to access a bed when they needed one". The first subheading there is Discrimination. Is that what you were relying on?

A. These are two examples of narratives that people articulated with respect to discrimination. But the data ranged considerably with respect to the kind of discrimination that was identified by people.

138 **Q.** The survey participants in the Pan-Canadian Women's Housing & Homelessness Survey it, perhaps, is obvious from the title, but this

is data collected from people all across Canada, correct?

A. That is correct. I was able to look at the primary data in preparation for the cross-examination and identified a minimum of 21 participants from Hamilton. There may be additional participants who didn't disclose their city. But the data as a whole is Pan-Canadian.

139 **Q.** And that data that you say you consulted in preparation for your cross-examination, that's not appended to your affidavit?

A. No.

140 **Q.** And that data is included in your report that's appended as Exhibit "B" to your evidence?

A. No, it wouldn't be accessible under university research ethics boards to disclose that primary data.

141 **Q.** So that's primary data that you reviewed but you're not able to disclose because of research ethics standards?

A. Without going through a research ethics protocol.

142 **Q.** That would likely involve

retaining consent from the individual participants?

A7650

A. Yes.

143 **Q.** Returning to your affidavit at paragraph 15. Again, you're referring to discriminatory policies, but I don't see, Dr. Schwan, anywhere in your affidavit that you discuss whether there are policies prohibiting gender diverse people from accessing shelters in the City of Hamilton; is that correct?

A. Would you mind restating that or just repeating that?

144 **Q.** I don't see anywhere in your affidavit that you indicate that there are policies that prohibit gender diverse people from accessing shelters in the City of Hamilton?

A. No, there's nothing in my affidavit or exhibits that speak to gender diverse people's experience in Hamilton specifically.

145 **Q.** And when you refer to rigid eligibility and acuity criteria, again, I don't see anything in your affidavit that suggests that shelters in the City of Hamilton have a rigid eligibility and acuity criteria for people to access shelters.

A. Yeah, neither my affidavits or exhibits speak to that specifically for the City of Hamilton.

146 **Q.** Now, continuing on to paragraph -- sorry, the last sentence at paragraph 15 of your affidavit, my apologies. The last sentence of paragraph 15 states:

"In some cases, seemingly benign or very minor operational policies within shelters, drop-ins, transitional housing, and other emergency services produce horrific results for those seeking or receiving support."

There are footnotes also in your affidavit, Dr. Schwan, but I don't see any citations for that particular paragraph, correct?

A. Yes. I, in this case, should have cited Exhibit "C". There are numerous cases throughout Exhibit "C" that exemplify these types of experiences. Exhibit "B" as well.

147 **Q.** And, again, so Exhibit "B" we've already established doesn't pertain specifically to the City of Hamilton. Exhibit "C", which is called "The State of Women's Housing Need & Homelessness in Canada: Literature Review", this is also with respect to the country

A3366

of Canada as a whole, correct?

A. Yes.

148 **Q.** Not with respect to the City of Hamilton?

A. Correct.

149 **Q.** With respect to the "horrific results", again you're not pointing to anything specific that's happened in the City of Hamilton as a result of these policies that you refer to?

A. Correct.

150 **Q.** And, in fact, you're not commenting on any particular policies that exist in shelters in the City of Hamilton, correct?

A. Correct.

151 **Q.** At paragraph 16 of your affidavit you describe violence against women's shelters and specifically state, first sentence:

"Violence Against Women shelters, which in many jurisdictions serve only women fleeing intimate-partner violence, create gaps in service for women who are experiencing violence due to being homeless or street-involved, or experiencing violence from other family members."

Again, you haven't reviewed or commented on it, but on policies, violence against

women shelters in the City of Hamilton, correct?

A. Correct.

152 **Q.** Or whether they have restrictions on the type of violence a person must be experiencing in order to access them?

A. Correct.

153 **Q.** And you'd agree that this gap, this gaps in service that you refer to at sentence 1 in paragraph 16, that gap could be reduced or eliminated if there are shelters who serve women that don't require them to claim violence or a specific type of violence, correct?

A. Sorry, would you mind restating that.

154 **Q.** So you've referenced a gap in service due to violence against women shelters. Put it this way, violence against women shelters, you're saying here, only serve a subset of the population, correct?

A. Yes.

155 **Q.** Okay. And as you've said, you frame it here, they are only open to women who are experiencing violence or a certain type of violence as you conceptualize it here, correct?

A. Yes. In a vast majority of

cases there are parameters around who -- around the type of violence someone is experiencing, the duration over which they've experienced that, and who perpetrated the violence. So requiring that women experience violence from an intimate partner within a particular period of time in order to access the service.

156 **Q.** In fairness to you, you indicated that you're not commenting specifically on policies for violence against women's shelters in the City of Hamilton?

A. Correct.

157 **Q.** So there is a gap for women who may need somewhere to go but don't fit that definition, correct?

A. That's right.

158 **Q.** And so you would agree that if there are shelters that are open to women who aren't claiming violence, or who aren't claiming a specific type of violence, that gap would be reduced or eliminated, correct?

A. It could be reduced. It depends on the type of -- whether there are additional access barriers for people, for example, experiencing sexual violence on the

street. There may be additional barriers to them being able to access a shelter, even if they aren't excluded from that shelter with respect to the type of violence they're experiencing.

159 **Q.** Okay. But you're not saying that the only shelters available to women and gender diverse people are violence against women shelters, correct?

A. Correct.

160 **Q.** So there are shelters, then, in the homelessness serving system more broadly that are available to women and don't require them to be experiencing violence as a condition?

A. Yes. Yes.

161 **Q.** And so the presence of those shelters could exist to reduce or close that gap?

A. Yes. Again, depending on the nature of the services in operation. But, yes, you remove that barrier, then potentially there's greater access for people experiencing other kinds of violence.

162 **Q.** And you haven't quantified in your affidavit the extent, or I'm sorry, whether or to what extent such a gap exists in Hamilton?

A. Correct.

163 **Q.** At paragraph 17 of your affidavit you described:

"Experiences of gender-based discrimination and race-based discrimination at shelters further disenfranchise women and gender diverse people from spaces that are meant to be..."

I think maybe "be" is a typo:

"...meant to protect them and their families."

Again, I notice that you didn't cite any support for this statement; is that correct?

A. Correct. I think I'm continuing on in citing my Exhibit "B" and "C" here.

164 **Q.** Okay. But I'll put it to you that this paragraph or Exhibit "B" and "C" don't quantify to what extent gender-based discrimination or race-based discrimination occurs at shelters?

A. Correct.

165 **Q.** And, specifically, you haven't cited any sources that quantify to what extent gender-based discrimination or race-based discrimination might occur at shelters in the City

of Hamilton?

A. Correct.

166 **Q.** At paragraph 19 of your affidavit, again, so you're referring to the participants of the survey referenced in paragraph 4, so that's the Pan-Canadian Women's Housing & Homelessness Survey, Exhibit "B" to your affidavit, you state:

"79% of women and gender diverse people experiencing housing need or homelessness report having a disability."

So I wanted to take you to that, I believe, you can correct me if I'm wrong, the discussion of disability begins on page 50 of the report with a heading number 10, and then there's that statistic again:

"79% of women and gender diverse people experiencing housing need or homelessness report having a disability."

A. Correct.

167 **Q.** Okay. In reviewing Exhibit "B" I didn't see how the term disability was defined. Is that not set out in Exhibit "B"?

A. Correct, it's not.

168 **Q.** Okay. And we don't have the

survey questions here, so it's not indicated how the term disability was defined for survey participants, correct?

A. Correct.

169 **Q.** And so there's a graph here quantifying, in terms of percentages, participant disabilities, and the caption for the figures, Figure 15, states "Disabilities reported by participants". So would I be correct in understanding that the types of disabilities listed here in this graph are the types of disabilities that were disclosed by the participants in the survey?

A. That's correct. In this survey we asked people whether any of the -- we asked people to identify, amongst a long list of items, if any of these create disabling conditions in their day-to-day life, create barriers for their well-being and survival, ability to conduct necessary tasks in their day-to-day life.

170 **Q.** So that's how disability was more or less defined in terms of collecting the survey responses?

A. Correct.

171 **Q.** And that's not, that definition

is not, in Pan-Canadian Women's Housing & Homelessness Survey?

A. Correct.

172 **Q.** So the examples of disabilities are psychiatric or mental health, substance use, chronic medical issues, pain related disabilities, memory issues, vision issues, mobility issues, cognitive or intellectual, environmental sensitivity, brain injuries, or deaf or hard of hearing. Were those all of the options for the survey participants to select from?

A. I believe so. I can confirm if you'd like me to bring up the survey.

173 **Q.** Well, we can only go with what's in your report that's appended to your affidavit.

A. It may have been that we had an additional item that no one endorsed. But these are all of the items that were endorsed by participants.

174 **Q.** I see, okay. And, again, in collecting these responses, the respondents to the survey are self disclosing, there's no corroboration whether or not people, for example, actually had diagnoses of the condition that

they're reporting?

A. Correct.

175 **Q.** If I can go back to the body of your affidavit, paragraph 20. Under the heading Problems Accessing Shelters you indicate:

"My data collection and analysis in the survey referenced at paragraph 4 concluded that people with disabilities reported being unable to access shelter beds when they needed them at roughly twice the rate of those without disabilities (65.1% for people with physical disabilities vs. 34.9% for those without; 43.1% for those with mental health disabilities vs. 18% for those without)."

So, again, these statistics, the percentages in the first sentence here, those aren't with respect to Hamilton, that's the result of the Pan-Canadian survey and the Pan-Canadian survey respondents?

A. Correct.

176 **Q.** Again, this is a survey, so there's no verification of whether access to shelter was, in fact, denied to these survey respondents?

A. Correct.

177 **Q.** At paragraph 21 you state:

"Research indicates that women, transwomen, and gender-diverse persons commonly experience harassment or violence within large mainstream homeless shelters, particularly co-ed and congregate shelters."

So you cite your Exhibit "C", The State of Women's Housing Need & Homelessness in Canada, so I wanted to go to that. I believe the citation to this is a full quote at page -- it's not paginated. What's described as, so under item 5 the discussion continuing on to the subheading Duty to Report Policies, there's a quote with a blue box around it; do you see that?

A. Yes.

178 **Q.** And so I'll just read it for the record:

"In the United States, a survey of 6,450 transgender and gender non-conforming people found that one-fifth had experienced homelessness, and that 'the majority of those trying to access a homeless shelter were harassed by shelter staff or residents (55%), 29% were turned away altogether, and 22% were sexually assaulted by residents or staff'."

So that's the citation that you're referencing?

A7653

A. No. There's a range of other research in this report upon which I based that statement. If it's helpful I can bring you to it.

179 **Q.** Yes, please.

A. Is it acceptable for me to bring up the document on my laptop?

180 **Q.** Yes.

A. Okay. At the bottom of page 19.

181 **Q.** It's not paginated?

A. Oh, apologies. It's under section 4, sorry, not Chapter 4 but -- yeah. So you see the big numbers at the top. There's 3 and then 4 is coming up, yeah, keep going a little bit, there. So just scroll to the next page and the paragraph there, "Importantly, this violence", that paragraph.

182 **Q.** So let's just state what we're looking at. So under the heading "Occurrence of Sexual Assault amongst Youth Experiencing Homeless", is that --

A. That title refers to the statistics in this table here. The paragraph that

I'm referring to speaks to broader literature beyond youth.

183 **Q.** So you're stating here, or sorry, this report states here:

"Importantly, this violence can occur within homelessness services and supports themselves, with multiple studies documenting sexual violence in co-ed shelters across the country."

"Across the country", that means Canada?

A. Correct.

184 **Q.** And:

"This violence is particularly pronounced for gender diverse peoples."

And you cite Abramovich and Lyons.

A. Yes, correct.

185 **Q.** Those studies are referring to Canada as a whole?

A. That's correct.

186 **Q.** Not Hamilton in particular?

A. Correct.

187 **Q.** And in your affidavit or the exhibits appended to it, you don't have any sources that quantify whether or to what extent

A3369

gender-based violence is occurring in shelters in the City of Hamilton?

A. Correct.

188 **Q.** One other thing that I wanted to take you to on the topic of violence against women, girls and gender diverse people, so at Chapter 4 of Exhibit "C", the third page into that chapter under the subheading "Gender-Based Violence, Intimate Partner Violence, and Abuse", it's stated here:

"Once on the streets, exposure to violence and harassment is a part of everyday life for women, girls, and gender diverse peoples."

And you cite *Gaetz et al.*, 2016 for that proposition. You'd agree that statement is accurate?

A. Yes.

189 **Q.** And so it's also fair to say that exposure to violence and harassment for women, girls and gender diverse people is not limited to just occurring in shelters?

A. Correct.

190 **Q.** Taking you back to the body of your affidavit at paragraph 22, you state:

"In a recent study, one transwoman

testified: 'They asked me why don't I go to men's [shelter] before and I was getting sexually harassed all the time. I remember one time waking up [at a men's shelter] and there was like five guys standing around my bed in the dark and they were all naked from the waist down. After I left the building. I never went back'."

And then the citation for this, citation number 17, Tara Lyons et al, "Experiences of Trans Women and Two-Spirit Persons Accessing Women-Specific Health and Housing Services in a Downtown Neighborhood of Vancouver, Canada". So this quote would have come from somebody's experience in Vancouver?

A. Correct.

191 **Q.** Not the City of Hamilton?

A. Correct.

192 **Q.** You describe it as a recent study, but it's 2016, that's about eight years ago, so it's not really recent anymore, is it?

A. There would be more recent examples to draw from, correct.

193 **Q.** Paragraph 23 of your affidavit you state:

"Violence in homeless shelters

appears to be increasing in some Ontario cities. In Toronto, for example, violent incidents have increased by 200% in the last five years, and deaths have increased by 125%."

A7654

For that you cite Liam Casey, "Toronto's Shelter's See Triple the Number of Violent Incidents, Rise in Overdose During COVID-19 Pandemic, Data Show". This is a Globe and Mail article?

A. Yes.

194 **Q.** So let's go to that. So up on the screen, this is a printout of the Globe and Mail article, so Liam Casey, with the headline there published June 6th, 2021. That's the article you were citing?

A. Correct.

195 **Q.** And so I'm going to make this Exhibit 10 to Dr. Schwan's cross-examination.

THE REPORTER: Can I just interrupt, there were two Exhibit 9s.

MS. SHORES: My apologies, let's go off.

-- OFF RECORD --

BY MS. SHORES:

196 **Q.** So just with a clarification

off record, it appears that I misspoke when numbering the exhibits. So Exhibit 9 is going to the Stats Canada article; Exhibit 10 is going to be Employment and Social Development Canada; and, this article that I've placed on the screen now, Liam Casey, a reporter for the Globe and Mail will be Exhibit 11.

EXHIBIT NO. 11: Liam Casey Globe and Mail article.

BY MS. SHORES:

197 **Q.** So, again, to reorient us, Dr. Schwan, the case, the article is cited as support for the example that in Toronto violence incidents have increased. So this article is about the COVID-19 pandemic in Toronto, correct?

A. Correct.

198 **Q.** Okay. Again, this isn't discussing Hamilton, correct?

A. Correct.

199 **Q.** Okay. And in your affidavit and in the exhibits to your affidavit you're not citing any research or scholarly works about the incidents of violence in shelters in Hamilton, correct?

A. Correct.

A3370

200 **Q.** Paragraph 24 of your affidavit you state:

"Safety in homeless shelters was significantly undermined during the COVID-19 pandemic."

I wanted to bring to your attention a document that I don't believe you've seen before, but maybe you have. Just bear with me. What I'm going to be placing up on the screen is a study by O'Shea et al called "Pandemic Planning in Homeless Shelters: A pilot study of a COVID-19 testing and support program to mitigate the risk of COVID-19 outbreaks in congregate settings".

Are you aware of this study?

A. I am not.

201 **Q.** So we'll mark this for identification and we'll make it Exhibit 12.

EXHIBIT NO. 12 (for identification):

O'Shea et al study: "Pandemic Planning in Homeless Shelters: A pilot study of a COVID-19 testing and support program to mitigate the risk of COVID-19 outbreaks in congregate settings."

BY MS. SHORES:

202 **Q.** Once my viewer unfreezes I'll

take you to the portion of the document I would like you to review.

-- Recessed at 11:18 a.m.

-- Reconvened at 11:30 a.m.

BY MS. SHORES:

203 **Q.** Before we took our break, Dr. Schwan, I was directing your attention to a document that I've marked for identification as Exhibit 12. This is a study called "Pandemic Planning in Homeless Shelters: A pilot study of a COVID-19 testing and support program to mitigate the risk of COVID-19 outbreaks in congregate settings". The corresponding author for this study is a Dr. Timothy O'Shea, who is also a witness in this proceeding. Are you aware of that, Dr. Schwan?

A. No.

204 **Q.** Okay. And in the abstract to this study, which in fairness to you you indicated that you weren't familiar with, the author states:

"We tested 104 residents and 141 staff for coronavirus disease 2019 who failed daily symptom screening in homeless shelters in Hamilton, Canada. We detected 1 resident (1%), 7 staff (5%), and 1 case of secondary spread.

Shelter restructuring to allow physical distancing, testing, and isolation can decrease outbreaks in shelters."

Do you have any knowledge of that study?

A. I don't, no.

205 **Q.** In the Discussion section of this study the author states:

"We have thus far been successful in preventing large outbreaks in the shelter setting despite identifying positive cases in both staff and residents. Our results emphasize the importance of taking a proactive, aggressive approach to outbreak mitigation in high risk settings."

I'll put it to you, Dr. Schwan, that the authors of this study, at least, supports that measures were effective in preventing large COVID outbreaks in the shelters studied in Hamilton.

A. I would need to review the report. What I'm seeing here looks like there was some interventions within that space, that particular shelter space, that prevented the spread of COVID or reduced it, which makes sense to me.

206 **Q.** I'm returning to paragraph 24 of your affidavit. I'll put it to you, Dr. Schwan, if you're not able to say with respect to Hamilton shelters in particular, that safety in homeless shelters were significantly undermined during the COVID-19 pandemic?

A. Correct.

207 **Q.** At paragraph 25 of your affidavit, you state:

"Some women and gender-diverse persons will be unable to access a shelter in their communities due to their disabilities, necessitating that they reside outdoors and/or within an encampment. For example, a DAWN Canada study reports that only 75% of homeless shelters have a wheelchair accessible entrance, 66% provide wheelchair accessible rooms and bathrooms, 17% provide sign language, and 5% offer braille reading materials."

Again, this study was across Canada not specific to the City of Hamilton, correct?

A. Correct.

208 **Q.** And you don't identify in your affidavit, or any of the sources cited in your affidavit, statistics with respect to

accessibility, wheelchair accessibility, sign language and braille reading materials in the City of Hamilton shelters, correct?

A. Correct.

209 **Q.** At paragraph 26 of your affidavit you state, the second sentence at paragraph 26:

"Across Canada, there are fewer women-specific emergency shelter beds – 68% of shelter beds are co-ed or dedicated to men, compared to 13% dedicated to women. Men's shelters also have more than double the number of beds that women's emergency shelters have (4,280 beds compared to 2,092 beds)."

Again, the citation here is "Employment and Social Development Canada, 'Homelessness Partnering Strategy'". So, again, these are statistics for across Canada not specific to the City of Hamilton, correct?

A. Correct.

210 **Q.** Now, at the last sentence of paragraph 26 you state:

"Further, while 38% of beds are reported to be within 'general' emergency shelters across Canada – meaning shelter beds that are

co-ed or open to all genders – research consistently demonstrates that many women will avoid co-ed shelters for fear of violence or because they have experienced violence within those spaces."

Now, footnote 23 you cite Bretherton, "Reconsidering Gender in Homelessness". So that's the article that was based in Europe, correct?

A. Correct.

211 **Q.** And then the second source that you cite is the National Inquiry into Missing and Murdered Indigenous Women and Girls, The Final Report". There's the hyperlink to the final report. The final report is in two volumes collectively of about a thousand pages, correct?

A. Correct.

212 **Q.** And you haven't cited any particular portion of the report that says that women will avoid co-ed shelters for fear of violence or because they have experienced violence within those spaces, correct?

A. I haven't cited, no, I didn't cite a specific section.

213 **Q.** Okay. Are you able to point us

to where in the Missing and Murdered Indigenous Women and Girls report it says that? A7656

A. I would need to consult the document.

214 **Q.** Bear with me, I'm going to pull up the document. So the closest thing I could find, and again this is me, not you, but the closest thing I could find is in Volume 1, 1a, under the term of Findings, so the eighth and ninth bullet point down. The authors state:

"For example, 2SLGBTQQIA individuals face barriers and discrimination in accessing a broad range of services and in accessing services that are appropriate to their needs, including housing (emergency shelter and safe long-term housing); health, mental health, and addictions treatment; child welfare; Elder care; policing; corrections; criminal justice; and victim and other support services."

And then the next bullet point says:

"In particular, there is a lack of appropriate emergency housing and shelters and safe housing to meet the needs of 2SLGBTQQIA individuals in all communities. Therefore, 2SLGBTQQIA people are forced to live in unsafe

conditions."

That's what I could find. Is that the source that you were referring to?

A. I would need to go through the document once more to pull out instances where individuals are reporting experiences of violence within the shelter system.

215 **Q.** Okay. And, in any event, the Missing and Murdered Indigenous Women and Girls report was not about the City of Hamilton specifically, correct?

A. Correct.

216 **Q.** It didn't focus on housing and homelessness as its central issue, correct?

A. Correct.

217 **Q.** At paragraph 27 of your affidavit, the last sentence, you state:

"For many marginalized women and gender-diverse persons, the confluence of these factors makes residing in an encampment a rational or necessary choice amongst a number of minimal (or non-existent) options."

And then the citation, footnote 24, you state, "For first-person accounts of these constrained choices, see", and then there's a A3372

hyperlink to a Toronto Star article, so I'm going to take you to that.

I've placed up on the screen a Toronto Star article, December 7, 2020, the hyperlink is at the top. The title is: "'We're the vulnerable ones': Why women living in Toronto's public parks during COVID-19 choose outdoor tents over indoor shelters." That's the article you cited?

A. Correct.

218 **Q.** So we're going to make this, if I'm correct with the numbers, Exhibit 13 to Dr. Schwan's cross-examination.

EXHIBIT NO. 13: Toronto Star article: 'We're the vulnerable ones': Why women living in Toronto's public parks during COVID-19 choose outdoor tents over indoor shelters?

BY MS. SHORES:

219 **Q.** So you didn't write this article, correct?

A. Correct.

220 **Q.** And you didn't speak to the people in the article, correct?

A. Correct.

221 **Q.** And the people interviewed in

the article are giving their annecdotes, correct?

A. Correct.

222 **Q.** This is in Toronto, not Hamilton?

A. Correct.

223 **Q.** And returning to paragraph 27 of your affidavit, within your affidavit you don't cite any research or scholarly works that specifically conclude that residing in an encampment is a rational or a necessary choice for women or gender diverse people, correct?

A. No. I conclude that based on my review of the literature and the research I've conducted that's involved a very broad engagement with women and gender diverse people experiencing homelessness, including engagement with women and gender diverse people experiencing homelessness, including engagement with probably between 40 and 50 woman and gender diverse people living in encampments in Ontario.

224 **Q.** Living in encampments across Ontario?

A. Yes.

225 **Q.** At paragraph 28 of your affidavit you state in the second sentence:

"While the women I've met with have reported safety concerns related to residing outdoors and in encampments (e.g., vulnerability to physical violence), overwhelmingly women state that residing in an encampment is a *safer* [and safer is italicized] option than the other options available to them (e.g., accessing a shelter, returning to an abusive relationship, etc.)."

So, again, you're referring to your research on homelessness in visiting encampments across Ontario. So, again, this is not specific to encampments in the City of Hamilton, correct?

A. Correct.

226 **Q.** And you don't cite any research or scholarly work to support that residing in encampments it's actually a safer option, correct?

A. I'm relying on engagements with women residing in encampments and their articulation that it is safer for them.

227 **Q.** At paragraph 31 of your affidavit you state:

"Nonetheless, feeling *safer* is not the same as feeling *safe* within an encampment..."

Now, Dr. Schwan, I put to you that feeling safer is not the same as objectively being

safe; would you agree?

A. I would struggle to believe that there is a one coherent objective definition of safety. I think in the case of encampments we're talking about people who are assessing what is or is not safer within the available options to them.

228 **Q.** So I'll put it to you a different way, Dr. Schwan. Just because someone feels safe doesn't mean that they are actually safe; would you agree?

A. Correct, yeah, in some instances I would agree.

229 **Q.** At paragraph 29 of your affidavit you state that your:

"...conversations with women residing in encampments indicated that the violence they face is often not from others within the encampment, but from housed persons (mostly men) outside of the encampment."

Again, these are conversations with women not specifically in Hamilton?

A. Correct.

230 **Q.** And the violence that they reported to you is often not from others within

the encampment, but I take it that it can be from others within the encampment, correct?

A. Correct.

231 **Q.** And the violence from housed persons (mostly men) outside of the encampment, you'd agree that in a women's shelter would be more protected from violence from housed persons, correct?

A. They would be more protected from violence from housed persons, yeah, if they're -- at the time that they're physically in the shelter. If they're required to leave during the day or leave early in the morning and then roam the streets, they may experience violence from housed members of their community.

232 **Q.** At paragraph 30 of your affidavit you state in the second sentence:

"For example, I have met numerous women encampment residents in Toronto who described how their relationships with other people living in encampments was a protective factor because they could 'look out for each other,' warn each other of dangerous or exploitive men, watch over each other's tents and possessions, and remain with partners or pets

(e.g., dogs) who provided physical safety."

Again, we're talking about Toronto not Hamilton specifically?

A. Yes.

233 **Q.** Just specifically on remaining with partners, Dr. Schwan, given the prevalence of women who have experienced intimate partner violence, you'd agree it's not always the case that remaining with a partner is beneficial for the women's safety, is it?

A. I would leave it to the women themselves to determine what is safer and safest for them.

234 **Q.** So if a woman is with a partner in your conception she's not likely experiencing intimate partner violence with that partner?

A. It's possibly she's experiencing intimate partner violence. It may be that remaining in -- what I have understood in my conversations with women and through the research is that some women will choose to remain in situations with intimate partner violence in order to be protected from that partner. If they're on their own they're exposed to violence from multiple men and others, perhaps, and they, in

some cases, will make the calculation to remain in a situation of intimate partner violence because it is, quote/unquote, safer.

235 **Q.** So put another way, intimate partner violence can still occur in encampments?

A. Yes.

236 **Q.** And with respect to pets, you'd also agree that people's pets within an encampment can also pose a safety concern if those pets are, for example, aggressive or fully socialized?

A. Yes.

237 **Q.** At paragraph 32 of your affidavit you state:

"My engagements with women residing in encampments indicated that encampment evictions often eroded the security systems, safety measures, and mutual aid systems women had adopted for themselves within encampments. These were not easily reestablished."

Again, you don't cite any sources for this or research or scholarly work --

A. Correct.

238 **Q.** You anticipated where I was going with the rest of that question.

And, specifically, this is not

talking about the City of Hamilton in particular, correct?

A. Correct. There I'm relying on conversations I've had with women across a number of cities in Ontario, but not Hamilton.

239 **Q.** And particularly you don't cite any research or scholarly work that supports that the security system, safety measures and mutual aid systems women have adopted were unable to be reestablished?

A. This data I'm referring to here is, as of yet, unpublished. So it's in process for being written up and seeking publication. But I'm not citing any research there. These are firsthand accounts that I collected between 2019 and 2023.

240 **Q.** And in terms of the support systems not being reestablished, you haven't indicated whether those systems weren't replaced or the need to be eliminated by other factors, such as becoming housed, correct?

A. Correct.

241 **Q.** Those are my questions for you, Dr. Schwan. Before we conclude, you've understood all of my questions today?

A. I have.

242 **Q.** Are there any of your answers that you want to change?

A. No.

243 **Q.** Okay, thank you, those are my questions. I appreciate you taking the time and your patience this morning.

A. Thank you very much.

MR. CHOUDHRY: Thank you. I just have a few questions on redirect.

RE-EXAMINATION BY MR. CHOUDHRY:

244 **Q.** Dr. Schwan, I want to ask you about Exhibit "B" generally, not about it specifically. So Ms. Shores asked you a number of questions about surveys and survey research and what it means and what it doesn't mean. I just want to ask you few questions. You're a professor at the University of Southern California, correct?

A. Yes.

245 **Q.** I want to ask you a few quick kind of quite precise questions, if I could.

A. Of course.

246 **Q.** So the first question is, why are survey methods used to study homelessness?

A. Survey methods are used because

they enable us to collect a range of data, both qualitative and quantitative, in order to create a portrait of any number of phenomenons that are happening for people who are unhoused, whether it's the conditions of their living, their causes of their current situation as being unhoused, surveys range, as you would know, considerably between short surveys and longer surveys. Surveys are often used in engagements with folks who are unhoused to be brief, in order to not infringe on their time and efforts to kind of survive day-to-day. And they can be very helpful for understanding any number of phenomenon and for creating policy solutions.

247 **Q.** So how does survey methods compare to other research methods to study homelessness?

A. Survey methods, again, depending on the type of survey we're talking about, but in general survey methods are considered a stronger form of research data comparted to smaller qualitative studies which, for example, might dive into the depth of a particular phenomenon, who people understand what home means, for example. Those kind of questions

lend themselves more to qualitative research studies that include interviews and focus groups. Surveys enable us to create a larger portrait of a phenomenon and compare and contrast across different subpopulations.

248 **Q.** Why did you choose a survey method for the study in Exhibit "B"?

A. To my knowledge this remains the largest survey conducted on women and homelessness among gender diverse people in the country. There had yet to be a broad portrait of the unique challenges and circumstances that women and gender diverse people experience. And because of a lack of data in that area, it created barriers to understanding what was happening at a systems or structural level to create the kind of housing need and homelessness we are seeing for women and gender diverse people across the country.

249 **Q.** I guess in your expert opinion, how reliable is the data from the survey study?

R/F MS. SHORES: Counsel, that's an objection. She's not entitled to expand on her expert opinion as re-direct. That is not a question that arises from the questions put to her

on cross. It is improper.

MR. CHOUDHRY: Well, counsel, I note your objection, counsel, but I think you've asked her, you've put at issue the reliability of survey data. I'm asking her to provide an answer on how reliable survey data is. I will note your objection for the record. Sorry, go.

MS. SHORES: You're asking for this witness's expert opinion. Again, it is expanding on the answers -- I'm sorry, expanding on the evidence that are in her affidavit and is not addressing matters that were put to her in cross-examination.

MR. CHOUDHRY: So I disagree, counsel, with respect. I note your objection and I will note the objection for the record. The witness will answer the question, you can move to have the question struck or disregarded by the Court and the answer.

BY MR. CHOUDHRY:

250 **Q.** Dr. Schwan, will you please go ahead.

MS. SHORES: Counsel, that's not proper. That is not how this is done.

MR. CHOUDHRY: With respect,

counsel, I've noted your objection for the record and it is entirely open for you to ask the Court to disregard her answer to that question when considering the admissibility of her evidence. I note that you're protesting the question, but I would like her to answer the question. It's a core issue and you've put it at issue in your questions, with respect, how reliable are the results from survey methods, it seems to be central to your case.

MS. SHORES: Once again, I'm stating my objection on the record. This is an improper attempt to expand the evidence. I'm also stating that the improper conduct of this re-examination will also be an issue going forward.

MR. CHOUDHRY: Thank you.

BY MR. CHOUDHRY:

251 **Q.** Dr. Schwan.

A. Would you mind restating the question, the reliability of?

252 **Q.** How reliable is the data yielded by survey methods?

A. It ranges considerably depending on whether the survey instrument has gone through research ethics approval, the

development of the survey instrument.

In the case of our survey it went through the York University research ethics board. It had very significant pilot testing with people living in situations of homelessness across a range of subpopulations. The survey instrument was drawn from questions that were asked in validated survey tools produced by governments, for example, as well as other leading researchers. And we worked with women and gender diverse people living in experiences of homelessness to understand are the ways we're phrasing questions understandable to them, do they feel like they're leading or not.

We spent many months pilot testing the survey to ensure that as an instrument it was strong, would be understandable to participants, would be accessible to participants and that the data generated from it would be highly reliable.

253 **Q.** And I would like to ask you a question about the data Ms. Shores referred to at paragraphs 28 and 32 of your affidavit. Do you have your affidavit in front of you?

A. Yes, let me just quickly pull it up. Paragraph 28?

254 **Q.** Yes. I'm going to get there as well myself, if you give me a second. So this is under the heading Physical Safety Encampments. Do you have your affidavit there?

A. Yes.

255 **Q.** You didn't -- Ms. Shores asked you or indicated that this, that there wasn't a citation or a footnote to a published study here. Could you describe, could you just help to identify the status of this data, where it came from and what it is?

A. Absolutely. So between 2019 and 2023 I visited a range of encampments across Ontario.

R/F MS. SHORES: Again, sorry, I'm going to interject again because this is another attempt to expand on the affidavit. This is not something that was in the affidavit. This witness previously confirmed that the factual assumptions were set out in the affidavit, which is a requirement of Rule 53.03. So I'm stating on the record my objection to this witness expanding on and adding to the expert opinion. This was not a matter that was raised on cross-examination.

MR. CHOUDHRY: And, Ms. Shores, I

note your objection for the record. And I note in your question you asked specifically how the witness came to know about this information, where it came from. I'm simply on redirect asking her to provide and building on your question.

MS. SHORES: You are expanding on it improperly. That's not the purpose of re-examination.

MR. CHOUDHRY: Ms. Shores, I disagree. I note your protest and we'll take it up with the judge.

BY MR. CHOUDHRY:

256 **Q.** Dr. Schwan, please continue.

MS. SHORES: As well as, again, the improper conduct of this re-examination.

BY MR. CHOUDHRY:

257 **Q.** Dr. Schwan.

A. Between 2019 and 2023 I visited encampments in Toronto, Kitchener, Guelph, Ontario and Kingston. I met with approximately 40 to 50 women residing in encampments in order to understand their experiences. That data has been collected by myself and research teams I was part of and it's in process for analysis and publication at a future date.

258 **Q.** Okay, those conclude my questions. Thank you, Dr. Schwan.

A. Thank you.

---Whereupon examination adjourned at 11:58 p.m.

REPORTER'S CERTIFICATE

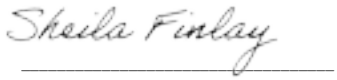
I, SHEILA M. FINLAY, CSR, Certified Shorthand Reporter and Commissioner of Oaths within and for the Province of Ontario, certify;

That the foregoing proceedings were taken before me at the time and place therein set forth, at which time the witness was put under oath by me;

That the testimony of the witness and all objections made at the time of the examination were recorded stenographically by me and were thereafter transcribed;

That the foregoing is a true and correct transcript of my shorthand notes so taken.

Dated this 30th day of August 2024



[Signed Electronically]
SHEILA M. FINLAY, CSR/ACT
CERTIFIED SHORTHAND REPORTER/
AUTHORIZED COURT TRANSCRIPTIONIST
Commission Expires September 1, 2024

Court File No. CV-21-00077817-0000

ONTARIO
SUPERIOR COURT OF JUSTICE

BETWEEN:

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

Applicants

-and-

CITY OF HAMILTON

Respondent

ACKNOWLEDGMENT OF EXPERT'S DUTY

1. My name is Kaitlin Schwan. I live at the City of Guelph, in the Province of Ontario.

2. I have been engaged by or on behalf of the Hamilton Community Legal Clinic to provide evidence in relation to the above-noted court proceeding.

3. I acknowledge that it is my duty to provide evidence in relation to this proceeding as follows:

   (a) to provide opinion evidence that is fair, objective and non-partisan;

   (b) to provide opinion evidence that is related only to matters that are within my area of expertise; and

   (c) to provide such additional assistance as the court may reasonably require, to determine a matter in issue.

4. I acknowledge that the duty referred to above prevails over any obligation which I may owe to any party by whom or on whose behalf I am engaged.

Date June 13, 2022

Signature

About the Women's National Housing and Homelessness Network

Our Purpose

Women's homelessness is an urgent crisis in Canada, requiring immediate action. Housing insecurity and homelessness for women is largely invisible and women remain profoundly underserved across many systems and services. Women, especially those who are multiply marginalized, face systemic barriers to accessing safe, affordable, and adequate housing.

The Women's National Housing and Homelessness Network is trying to change that.

Activities of the Network include, but are not limited to:

- Conducting research on the causes of, and solutions to, homelessness and housing insecurity for women, girls, and gender diverse peoples;
- Advocating for policy change in support of preventing and ending homelessness for women, girls, and gender diverse peoples;
- Valuing, listening to, and actualizing the voices and ideas of women-identifying people with lived experience of homelessness and housing insecurity in policy discussions and public debate;
- Developing toolkits and training to support transformation of programs and systems to support ending homelessness for women and girls (for example, developing toolkits and training on Housing First for Women)
- Hosting webinars featuring best and promising practices on preventing and ending women's homelessness

1. **We are vocal, determined advocates and allies for the voices of lived experience.**
2. **We believe that ending homelessness is possible.**
3. **We serve women and girls who are at risk of or are experiencing homelessness.**
4. **We believe in the Right to Housing.**
5. **We employ an intersectional approach.**
6. **We are committed to equity and inclusivity.**
7. **We honour trans and gender diverse identities.**
8. **We are committed to children's rights.**
9. **We commit to advancing the Truth and Reconciliation Commission's Calls to Action and the Calls for Justice from the National Inquiry into Missing and Murdered Indigenous Women and Girls.**

National Indigenous Women's Housing Network

The **National Indigenous Women's Housing Network** is a movement of First Nations, Inuit, and Métis Peoples who are dedicated to improving the living situations of Indigenous women and girls, Two-Spirit, and gender-diverse persons across Turtle Island and ending incidents of becoming unsheltered. All members have the lived experience of needing adequate shelter and a place to call home. Read their Human Rights Claim, *Homeless on Homelands* by **clicking here**.

Network Team

Khulud Baig

Director of Policy and Community Engagement

View bio

Stefania Seccia

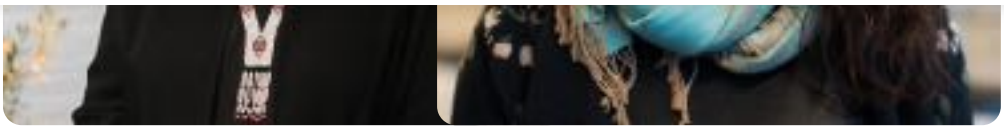
Director of Advocacy and Strategic Communications

View bio

Marie McGregor Pitawanakwat

Chair, National Indigenous Women's Housing Network & Co-Chair, WNHHN

View bio



Arlene Hache

Co-Chair, WNHHN

View bio

Dr. Kaitlin Schwan

Research Advisor

View bio

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Become a member

The COH is a collaborative partner of the WNHHN. The WNHHN website was designed in part by the COH's in-house design team and funded by revenue generated from Hub Solutions, a COH social enterprise.

canadian observatory on homelessness

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We're a Global Thought Leader on Homelessness Prevention

We know how to prevent homelessness. For over a decade, the Canadian Observatory on Homelessness has been building an evidence base and paving the way for governments and communities to move from addressing homelessness through an emergency crisis response to preventing it altogether.

From an emergency response...

Each year nearly 235,000 Canadians will experience homelessness. It doesn't have to be this way. By shifting how we respond, from a reliance on emergency services to a coordinated system of

A3384

Our Strategic Objectives

Work in collaboration with key partners to **co-create and operationalize a comprehensive, multidisciplinary research agenda** that will produce knowledge on effective approaches to the prevention of homelessness.

Nurture reciprocal partnerships with Indigenous stakeholders to support an Indigenous-led research agenda focusing on the prevention of Indigenous homelessness in Canada.

Leverage high impact partnerships to **enhance uptake and integration** of key research evidence into policy and practice and ultimately lead to systems transformation.

Contribute to the **broader adoption of upstream responses to homelessness** that reduce the number of individuals and families at risk of or experiencing homelessness.

Support the **development of a new generation of scholars with expertise** in homelessness research, Indigenous methodologies and ways of knowing to co-create and mobilize research

Achieve a more equitable, diverse, and inclusive Canadian research enterprise through meaningful engagement of people with lived experience.

Our Projects

homeless hub

Homeless Hub

The Homeless Hub is the largest library of homelessness research in the world.

Visit website →

homelessness learning hub

Homelessness Learning Hub

The Homelessness Learning Hub is professional development and community capacity-building that provides free training and resources to the homeless-serving sector.

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hub solutions

Hub Solutions

Hub Solutions is our social enterprise that supports agencies, communities, and policymakers to improve their capacity to prevent and end homelessness.

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MAKING THE SHIFT

Making the Shift

Making the Shift contributes to the transformation of how we respond to youth homelessness through research and knowledge mobilization specific to youth homelessness prevention and housing stabilization

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Youth Homelessness Prevention

Our Geneva UN Charter Centre housed at York University aims to mobilize and adapt Canadian and international innovations, leadership, and knowledge on youth homelessness prevention and sustainable exits from homelessness.

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Systems Planning Collective

A partnership between COH, A Way Home Canada and HelpSeeker, the Systems Planning Collective is dedicated to helping communities and governments prevent and end homelessness by supporting evidence-based systems planning, capacity building and technical assistance.

Visit website →

Our Story

The Canadian Observatory on Homelessness is a non-partisan research and policy partnership between academics, policy and decision makers, service providers and people with lived experience of homelessness.

Led by Stephen Gaetz, President & CEO, the Canadian Observatory on Homelessness works in collaboration with partners to conduct and mobilize research designed to have an impact on solutions to homelessness. The Canadian Observatory on Homelessness evolved out of a

A3387

the Canadian Observatory on Homelessness has established itself as a global thought leader on solutions to homelessness and an innovator in knowledge mobilization practices.

To bridge the gap between research, policy, and practice, the COH goes beyond the mandate of a traditional research institute. As one of the largest homelessness-dedicated research institutes in the world, we support service providers, policy makers and governments to improve their capacity to end homelessness.

OUR PHILOSOPHY IS SIMPLE

Through collaborative approaches across research, evaluation and design, we can develop and mobilize evidence-based solutions and, together, prevent and end homelessness.

Learn About our Impact →

canadian observatory on homelessness

program delivery for homelessness prevention.

Read our publications →

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canadian observatory on homelessness

The Canadian Observatory on Homelessness is a non-partisan research and policy partnership based out of York University.

YORK UNIVERSITÉ UNIVERSITY

Canada

(https://maketheshift.org/)

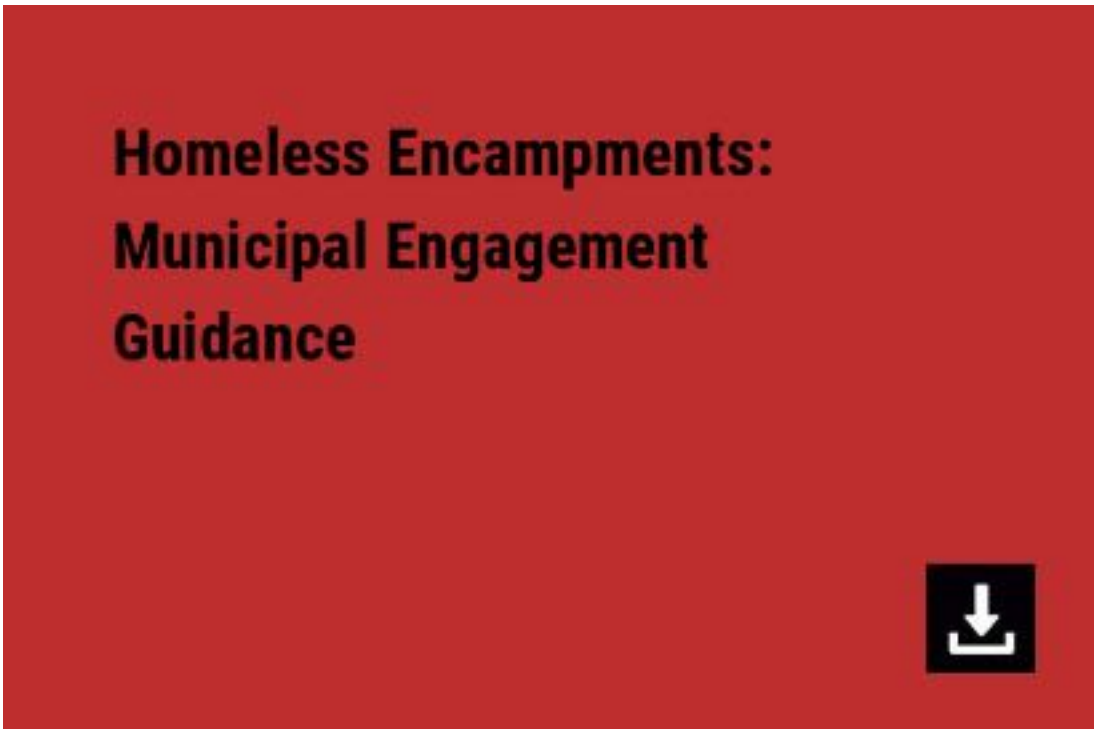
HOMELESS ENCAMPMENTS

As access to affordable housing becomes more difficult, the number of homeless encampments across Canada has increased. While encampments to do not satisfy the right to housing, the rights of encampment residents must be protected. The Shift has developed several resources to help ensure the rights of encampment residents are upheld. Download them and use them in your community!

Campements de sans-abri: des orientations pour l'implication des municipalités

The National Working Group on Homeless Encampments (NWG-HE) – convened by The Shift since January 2023 – presents a Municipal Engagement Guidance. This Guidance is intended to support municipalities in engaging homeless encampments in a constructive and peaceful manner. The Guidance is not a road map to solving homelessness. It is an effort to establish national standards, based in human rights, for municipal government engagement with encampments across the country of Canada. It is intended to help ensure the best outcomes for those living in encampments and their communities in the short term, while establishing a foundation for longer-term solutions.

(HTTPS://MAKE-THE-SHIFT.ORG/WP-CONTENT/UPLOADS/2023/11/NWG-HE-GUIDANCE-FRENCH-W-LIST-1.PDF) **DOWNLOAD**



Homeless Encampments: Municipal Engagement Guidance

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(HTTPS://MAKE-THE-SHIFT.ORG/WP-CONTENT/UPLOADS/2023/11/NWG-HE-GUIDANCE-W-LIST.PDF) **DOWNLOAD**

A National Protocol on Homeless Encampments: A Human Rights Approach

In April 2020, former UN Special Rapporteur on the Right to Adequate Housing Leilani Farha and Dr. Kaitlin Schwan released *A National Protocol on Homeless Encampments: A Human Rights Approach* (https://www.make-the-shift.org/wp-content/uploads/2020/04/A-National-Protocol-for-Homeless-Encampments-in-Canada.pdf). The Protocol, based in international and domestic human rights law, outlines eight Principles to guide governments in their responses to homeless encampments.

(HTTPS://MAKE-THE-SHIFT.ORG/WP-CONTENT/UPLOADS/2020/08/A-NATIONAL-PROTOCOL-FOR-HOMELESS-ENCAMPMENTS-IN-CANADA.PDF) **DOWNLOAD**

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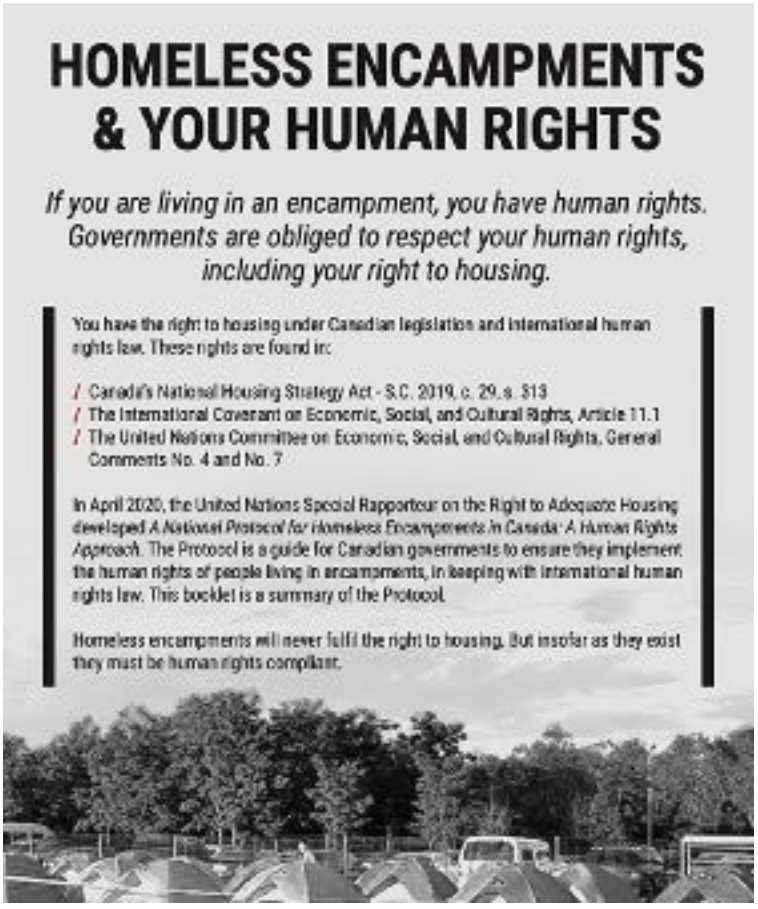

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This Handout, *Homeless Encampments & Your Human Rights* (https://www.make-the-shift.org/wp-content/uploads/2020/12/THESHIFT-Tent-Encampment-Protocol-Handout.pdf), is for people living in encampments in Canada. It outlines residents' human rights and how governments are obliged to respect them. Download and freely distribute!

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January 10, 2023 | Alumni

How alumna Kaitlin Schwan became a leading advocate for the right to housing

By Megan Easton

Kaitlin is the Executive Director of the Women's National Housing and Homelessness Network and a Senior Researcher at the Canadian Observatory on Homelessness.

When Kaitlin Schwan (PhD, 2016) was about six years old, she secretly gave her mother's credit cards to people she encountered living on the streets in Toronto. "After I saw the realities of homelessness for the first time, I'd lie in bed and think about how painful it must be to have cold, wet feet all day and night," says Schwan, who grew up in Owen Sound but sometimes visited the city. "I didn't understand credit cards, but I had a sense that they would help somehow." Decades after that act of innocent generosity, she's become a leading researcher on homelessness in Canada.

"Most children are confused and distressed when they witness homelessness, because kids are deeply empathetic," says Schwan, who earned her PhD from U of T's Factor-Inwentash Faculty of Social Work (FIFSW). "As they get older, they go through a process of socialization where they are taught to understand it as a normal feature of Canadian society. But that normalization didn't happen for me. It never came to feel normal for me that, in a wealthy nation, people had nowhere safe and warm to live."

Today, Schwan is the Executive Director of the Women's National Housing and Homelessness Network and a Senior Researcher at the Canadian Observatory on

Homelessness. (She was also recently appointed Assistant Professor, Status-Only, at FIFSW). Her path to those roles began during her undergraduate degree in women's studies, when she ran arts-based programs in homeless shelters for youth. "I'd discovered through volunteering that some form of art practice is often central to these young people's emotional and psychological survival," says Schwan, who is also a jewellery artist.

After a master's degree, where she explored the importance of the arts for unhoused youth, she decided to investigate the broader problem of homelessness from a social work and policy perspective. Her doctoral thesis, supervised by Professor David Hulchanski, traced the history of homelessness in Canada. She credits Hulchanski, the Dr. Chow Yei Ching Chair in Housing, for giving her crucial insight into the political landscape around the subject. "He showed me how policy failures have created and perpetuated homelessness in ways that are deeply unjust and entirely unnecessary," she says.

Schwan also points to her personal mentor, Professor Faye Mishna, for shaping the way she conducts research. "Because of her, I centre the voices and experiences of people with lived experience," she says. "The depth of her integrity and ethics were foundational to how I developed as a researcher."

During her PhD, Schwan became interested in the largely untold stories of women and gender-diverse individuals without adequate housing. "Their experiences are unique in that they often live in situations that we call 'hidden homelessness,' such as couch surfing, trading sex for shelter and remaining in abusive relationships because they can't access housing," she says.

While Schwan was examining these issues as a scholar, her personal life highlighted their critical necessity. "My sister was dealing with significant violence in her life, and the buffer to that was safe housing. Yet so many women have no door to lock against their abusers," she says. "This firsthand knowledge collided with my research to reinforce my sense that national change was needed in this area."

Yet the doctoral program soon inspired Schwan to look beyond Canada to the impact she could make in the international arena. "The faculty is gifted at fostering global connections and global analysis," she says. "I felt like the sky was the limit in terms of what would be possible for my work and the kind of connections I would build."

Armed with that confidence, a few years after graduation she contacted United Nations Special Rapporteur on the Right to Housing Leilani Farha after seeing a documentary on her work. Schwan offered to build a research team for her, and Farha agreed. When

Farha's UN term ended, the whole team formed The Shift, an international movement to secure the right to housing, where Schwan was Director of Research until 2022.

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WNHHN submitted two human rights claims in partnership with the National Indigenous Feminist Housing Working Group to the Federal Housing Advocate. In November 2022, the group presented at the national conference of the Canadian Alliance to End Homelessness in Toronto and led a symposium.

Since taking the helm at the Women's National Housing and Homelessness Network (WNHHN) earlier this year, Schwan has continued this rights-based approach. She says urgent action on homelessness amongst women and gender-diverse people is essential, given the current context. "The combination of a public health crisis, a decrease in service provision, an increase in violence against women and the pandemic's disproportionate negative economic impact on women has produced a very difficult housing situation." This summer, the WNHHN submitted two human rights claims in partnership with the National Indigenous Feminist Housing Working Group to the Federal Housing Advocate, who is charged with promoting and protecting the right to housing as a human right (as outlined in the 2019 National Housing Strategy Act).

"We developed the claims in collaboration with a group of about 25 women who have lived, or are living, in situations of homelessness," says Schwan, noting that people with direct personal experience guide all of the Network's initiatives. In November, the group

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presented at the national conference of the Canadian Alliance to End Homelessness in Toronto and led a symposium where the Federal Housing Advocate heard deputations from 40 women with lived or living experiences of homelessness. Schwan said that the participants reported feeling empowered to translate their experiences into policy action. “Being in a room with so many incredible people, giving so much of themselves was one of the most powerful things I have ever been witness too,” said one of the participants about the experience. “I will take that energy, rage, passion, and resolve as a responsibility for action.”

In the next year, Schwan expects that the human rights claims will prompt policy recommendations for the Minister of Housing. Though she’s acutely aware of the complexity of the political process, she remains optimistic. “The depth of my commitment flows from the depth of my care for the women I struggle alongside,” she says. “We know that the solution to homelessness — access to safe, affordable housing — is imminently financially possible in a country with the ninth largest GDP in the world. This gives me the hope to keep going.”

Originally published by the Factor-Inwentash Faculty of Social Work

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Encampment evictions cause 'tremendous harm,' defy human rights, say experts

'For the vast majority, staying where they are is probably the safest space for them'

Clare MacKenzie · CBC News · Posted: Feb 01, 2023 12:33 PM EST | Last Updated: February 1, 2023

Charlottetown police supervised the dismantling of the city's encampment last week. (Wayne Thibodeau/CBC)

Last week, Charlottetown city crews used bulldozers and other equipment to tear down tents at Charlottetown's encampment site and the last two remaining people who had been staying there were forced off the property.

But a few days later, the Ontario Superior Court blocked the Region of Waterloo from demolishing an encampment in Kitchener, Ont., saying it would infringe on the constitutional rights of people living there because there are not enough shelter beds in the city.

Kaitlin Schwan, a senior researcher at the Canadian Observatory on Homelessness, was an expert witness in the case.

She told *Island Morning*'s Mitch Cormier the Waterloo ruling sets a precedent which may empower encampment residents and their advocates to challenge municipal policies.

The residents of this encampment in Kitchener, Ont., cannot be evicted, an Ontario Superior Court judge ruled last week. Experts say the decision could have far-reaching implications. (James Chaarani/CBC)

"In Ontario, this is really a critical first step for emphasizing that the human rights of people who are unhoused supersedes the enforcement of bylaws when it comes to encampments," she said.

Schwan said municipal safety concerns such as fire hazards are not adequate reasons for evictions.

"You can't use that as a basis to evict an encampment under human rights law," she said.

"In international human rights law and domestic human rights law, it's the obligation of governments to ensure that people have safe, livable conditions and encampments, that they can heat spaces, that they can access water."

- **Court ruling blocking Kitchener, Ont., encampment eviction could affect cases across Canada, say legal experts**
- **Court rules Region of Waterloo can't evict people from encampment due to lack of shelter space**

The Charlottetown emergency shelter offers overnight beds for people experiencing homelessness, but Schwan said it's not just the availability of beds that's important.

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"Are these beds accessible?... It doesn't help you if you have a disability or the shelter requires that you abstain from substance use, for example... it's not just the number of beds, but it's also the accessibility and the appropriateness of shelter beds."

'It's the obligation of governments to ensure that people have safe, livable conditions and encampments, that they can heat spaces, that they can access water,' says Kaitlin Schwan, a senior researcher with the Canadian Observatory on Homelessness. (Supplied by Kaitlin Schwan)

Safety concerns

Jeff Karabanow, a professor at Dalhousie University's School of Social Work, is a homelessness researcher who has done extensive work with people living in encampments in Halifax.

"What's come to light is that for the vast majority, staying where they are is probably the safest space for them," he said.

- **Last remaining occupants pack up as Charlottetown tent encampment dismantled**
- **Mounting debris at homeless encampment a 'daily' concern for fire department, chief says**

Karabanow said many encampment residents have nowhere else to go.

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"So the fact of kind of moving in and just dismantling the only stuff that people have and then having no alternative to offer it, I think, is deeply problematic," he said.

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'Moving in and just dismantling kind of the only stuff that people have and then having no alternative to offer it, I think, is deeply problematic,' says Dalhousie University social work professor Jeff Karabanow. (CBC)

People living outdoors in extreme weather is alarming, however, and one of the reasons he said advocates in Halifax are "pushing for better, more dignified accommodation than simply allowing people to sleep outside or putting them in very overcrowded and dangerous spaces like shelters."

Karabanow also said it's important that people experiencing homelessness and living in encampments are included in discussions about solutions.

'Exposed to violence'

Schwan too stressed the dangers people face when they are forced to leave encampments, adding that evictions don't solve the problem — they just move the problem.

"Encampment evictions result in tremendous harm for people. Like people lose property, lose resources or are exposed to violence.... In most cases it reduces people's ability to survive because it destroys their property — they lose ID, experience other kinds of traumas," she said.

Officials in Charlottetown are encouraging people experiencing homelessness to stay at the province's mobile housing units on Park Street.

Housing Minister Matthew MacKay has said the government hopes to have a 24/7 shelter in place by next winter.

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With files from Island Morning

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Toronto

Toronto 'extremely vulnerable' to legal challenge after homeless encampment ruling, experts say

Judge in Kitchener, Ont. blocked an encampment eviction due to Charter rights

Jordan Omstead · The Canadian Press · Posted: Jan 31, 2023 4:30 PM EST | Last Updated: January 31, 2023

A woman pushes a stroller past the shelter of an unhoused person in Toronto on Tuesday as the coldest weather in years arrives. A precedent-setting legal ruling in Kitchener, Ont. on the eviction of unhoused encampments could lead to a wave of legal challenges starting in other cities, experts say. (Frank Gunn/Canadian Press)

A precedent-setting ruling in Ontario could place pressure on cities to address the crisis of homelessness with better shelters and housing, experts say, while giving encampment residents more defined protections against evictions.

In the first decision of its kind in the province, a judge in Kitchener, Ont., ruled last week that there is a constitutional right to shelter outside when there are no accessible and available indoor spaces.

The decision makes Toronto "extremely vulnerable" to a legal challenge, said Estair Van Wagner, an associate professor at York University's Osgoode Hall Law School.

There are more people in the city who are homeless than at any time in the past five years and record numbers of people are entering the shelter system compared to those leaving, according to city data dating back to 2018.

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Violent evictions have been carried out by police, shelter hotels have closed, and the shelter system routinely runs at capacity most nights.

Future legal challenges to rely on ruling, expert says

Kaitlin Schwan, executive director of the Women's National Housing and Homelessness Network, said that while encampment residents in Toronto unsuccessfully challenged an eviction in a 2020 case, the circumstances since that decision combined with this precedent-ruling have created a different set of circumstances.

"There will be, I suspect significant pressure ... to ensure that precedent informs how the city moves forward in its engagement with encampments. And future challenges in court will rely on this ruling and it's quite pervasive," said Schwan, who is also a senior researcher at the Canadian Observatory on Homelessness.

- **Court ruling blocking Kitchener, Ont., encampment eviction could affect cases across Canada, say legal experts**

The city has long maintained that encampments are unsafe and that it works to help those living at the sites into shelters or other housing.

An insulated shelter in Toronto's Alexandra Park is pictured on Feb. 12, 2021. (Evan Mitsui/CBC)

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Until now, Ontario courts have been slow to follow the lead of courts in British Columbia, where judges have recognized a constitutional right to shelter themselves when a jurisdiction fails to provide sufficient spaces.

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More than previous Ontario decisions, the Kitchener decision affirmed it's not just about how many spaces are available in the city, but also about whether those spaces truly accommodate the needs of people experiencing homelessness, Van Wagner said.

"We see the judge turn their mind to things like whether there are proper supports around addiction, mental health, whether there are spaces for couples," Van Wagner said.

Justice Michael Valente denied the Region of Waterloo's request to evict roughly 50 people from a homeless encampment on a half-acre empty gravel lot finding the region's trespassing bylaw violated the Charter rights of the residents in the absence of sufficient shelter spaces.

The Kitchener case also represents a "really significant" departure from Ontario case law around what it means to "choose" to live outside, Van Wagner said.

Ruling called 'critical first step'

Cities have often argued encampment residents are choosing to live outside when there's available shelter options. But in the Kitchener decision, the judge said that choice, in this context, must account for circumstances such as poverty, disability, addiction, and insufficient shelter alternatives.

"The courts have tended to adopt the idea of choice as a kind of black and white thing," Van Wagner said. "We see the decision here give us a much more nuanced understanding of the fact that this 'choice' is happening in a really constrained context."

Couples in the Kitchener case testified about being separated from one another when they stayed at shelters, people who use drugs noted the harm of abstinence-based policies, and others talked about the "weight of uncertainty" around available shelter space on any given night.

The case is a "critical first step," but falls well short of placing any positive obligations on municipalities to provide any shelter or housing, said Kaitlin Schwan, executive director of the Women's National Housing and Homelessness Network.

As a result, she called it a "complicated victory" for encampment residents and their allies.

"It says we're very, very far away from actually realizing the right to housing in Canada. We have so far to go," said Schwan, who acted as an expert witness in the Kitchener

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case.

- **Court rules Region of Waterloo can't evict people from encampment due to lack of shelter space**

The court has moved in the direction, evidenced by the Kitchener case, because encampment residents continue to organize and speak about the realities of what it looks like to live outside, said Sima Atri, a lawyer with the Community Justice Collective who has represented encampment residents.

Atri said the ruling could place pressure on cities to address the crisis of homelessness and encampments by building housing and accessible, permanent shelter spots. At the same time, she said she hopes it will mean residents will not face threats of violent eviction.

But she said the solutions to the housing crisis will not come from the court.

"It's going to come from people standing up together to organize around that issue and actually take on a much broader housing crisis problem in our cities," she said.

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Reconsidering Gender in Homelessness

Joanne Bretherton

Centre for Housing Policy, University of York, UK

Abstract_ *Although research has been sporadic, the available evidence indicates that gender is consistently associated with differentiated trajectories through homelessness in Europe. Women's pathways through homelessness have been linked to domestic violence, women being 'protected' by welfare systems when dependent children are living with them and an apparently greater tendency for women to use and exhaust informal support, rather than homelessness or welfare services. This evidence is frequently disregarded in current European homelessness research, which often uses conceptualisations, definitions and methodologies developed when homelessness was seen predominantly as a social problem among lone adult men. The sites at which homelessness is studied and the ways in which data are collected, limit accuracy of measurement and inhibit understanding, but, this paper contends, the real issues centre on how mainstream definitions of homelessness exclude women. Women, who lack any security of tenure, physical safety, privacy and whose living conditions are otherwise unacceptable – who are homeless – are too often outside the scope of contemporary European homelessness research. Drawing on recent UK studies and the wider European literature, this paper argues that there is a need to cease a longstanding focus on the streets, homelessness services and (predominantly) male experience and to look instead at the more nuanced interrelationships between gender and agency to fully understand the nature of homelessness in Europe.*

Keywords_ *Gender, homeless women, hidden homelessness, agency*

ISSN 2030-2762 / ISSN 2030-3106 online first A3414

Women's Homelessness: Invisibly Different

Women's disadvantage in European housing markets, reflecting women's greater experience of relative and absolute economic marginalisation, was first highlighted by social researchers decades ago (Watson with Austerberry, 1986). Women continue to experience some forms of housing exclusion at a higher rate than men across much of Europe (Domergue *et al.*, 2015).

Research has reported European welfare systems conditionally ending or preventing women's homelessness when they have dependent children with them, but often being less supportive in other circumstances (Doherty, 2001; Löfstrand and Thörn, 2004; Baptista, 2010). Culturally driven and often inherently sexist responses to women experiencing homelessness are also reported, particularly when a woman is not living in the 'expected' role of mother, wife or carer, within homelessness services as well as health and welfare systems (Bretherton *et al.*, 2016; Hansen Löfstrand and Quilgars, 2016).

Visibility is also linked to how welfare systems respond to women's homelessness. The UK has statutory systems specifically focused on family homelessness, disproportionately supporting lone women parents and recording the support that is provided. In other European contexts, family homelessness may be less visible because mainstream welfare systems respond more effectively to it or do not record such families as 'homeless'. Family homelessness may also be less visible because there are few supports, beyond the informal help a woman can find for herself and her children (Bretherton *et al.*, 2016).

The distinct nature of family homelessness, as a highly gendered experience, disproportionately experienced by younger women who are lone parents, has been recorded both in Europe (Pleace *et al.*, 2008) and the USA (Shinn *et al.*, 2013). This research highlighted major differences between family and single homelessness. Family homelessness often involves lone women with dependent children and is closely linked to domestic violence and economic marginalisation. It is not often associated with the high rates of severe mental illness, drug use, contact with the criminal justice system and poor health, seen among single long-term and recurrently homeless men (Busch-Geertsema *et al.,* 2010).

Women have also been found sleeping rough and within lone adult homeless populations across Europe, seemingly less numerous than men, but nevertheless clearly present. Inaccuracies in enumeration, particularly street counts which include only visible rough sleepers, when there are obvious reasons for women to hide themselves, may partially explain this pattern (Busch-Geertsema *et al.*, 2014, Johnson

et al., 2017). The point, however, is that there are, quite evidently, women among the people experiencing what is still seen, and often still recorded, as the largely male experience of single adult homelessness.

Finally, there is the evidence that women appear to often *choose* to take specific trajectories through homelessness, particularly in relying on informal supports to keep themselves accommodated (Jones, 1999; Mayock and Sheridan, 2012). Women appear more likely to rely on relatives, friends and acquaintances to keep themselves accommodated when they become homeless, only approaching homelessness and other services when or if these supports are exhausted (Shinn, 1997; Reeve *et al.*, 2007; Pleace *et al.*, 2008; Mayock and Sheridan, 2012). Women's homelessness appears to be different to that experienced by men because there is evidence that women often do not react to homelessness in the same way as men.

Reviewing the evidence on women's homelessness in Europe, it becomes apparent that data showing, or at least suggesting, the *inherently* gendered nature of homelessness, are routinely ignored in European research (Mayock and Bretherton, 2016). Homelessness is still often defined by European researchers in terms of people living rough and in emergency accommodation. While researchers tend to report that women are present in these homeless populations, it will often be in relatively low numbers and when a female presence is detected it often is merely noted, rather than thoroughly investigated (Pleace, 2016).

Typologising Women's Homelessness

Women's homelessness falls outside the focus of much European homelessness research because of how homelessness is defined. Women who lose their homes due to male violence and who have to use refuges and other services are often defined – and researched – as women who are 'victims of domestic violence' not as *homeless* women (Baptista, 2010; Jones *et al.*, 2010; Quilgars and Pleace, 2010). European research has shown that in Denmark, Germany, Hungary, Ireland, Italy, the Netherlands, Poland, Portugal, Slovenia, Spain and Sweden, women made homeless by domestic violence who are being accommodated in refuges or similar services, are *not* counted as homeless. If a woman, made homeless by domestic violence, were in an emergency shelter, living on the street or in temporary supported housing for homeless people, in any of these countries, she *would* be recorded as homeless (Busch-Geertsema *et al.*, 2014). In the UK, women made homeless by domestic violence are recorded as homeless if they receive the main or full duty (re-housing) under the four different sets of homelessness legislation.

However, women are not necessarily recorded as homeless if they head straight to a refuge because they have been made homeless by domestic violence and do not seek assistance under the statutory systems (Quilgars and Pleace, 2010).

Feminist analyses are characterised by discussions on the social construction of homelessness and the role of patriarchy and misogyny within the definition of homelessness. Such analysis is framed in terms of how a society and welfare systems within a society responds to women, particularly the social and cultural construction of women's roles. Women's homelessness is therefore viewed as a function of how women, in general, are responded to by the societies in which they live. Women's homelessness can then be seen and defined as being a social problem generated via these wider, structural and cultural, patriarchal forces (Watson, 2000).

For Neale (1997), feminist discussions of homelessness have added something to the discussion on the nature of homelessness, because patriarchy has shaped the contexts in which women's homelessness has occurred. Yet, as she argues, these feminist interpretations can reduce women to 'passive victims constrained to the private sphere of the home' (Neale, 1997, p.51). There is evidence that, even in what are regarded as some of the most advanced welfare and homelessness systems in Europe, sexist and culturally influenced responses to women's homelessness exist (Löfstrand and Thörn, 2004; Bretherton *et al.*, 2016; Hansen Löfstrand and Quilgars, 2016). However, for Neale (1997), experiencing homelessness within biased systems, while disadvantageous, does not mean that women lack agency, the capacity to influence their trajectory through homelessness.

Two variables are working in combination to influence how women's experience of homelessness in Europe is viewed. The first is the tendency to focus on largely male experience in research that is focused on male domains of homelessness, the street and emergency shelters. The forms of homelessness that women, on some evidence at least, appear more likely to experience, the hidden homelessness of living as a concealed household with friends, relatives or acquaintances, receive less attention from researchers, partially because only some European countries recognise hidden homelessness and partially because hidden homeless populations are harder to find and to research (Pleace and Bretherton, 2013). The second is both conceptual and administrative. Homeless women in refuges are often not regarded as homeless, but as 'victims' of domestic violence. Similarly, lone women parents with dependent children are visible when specific support systems exist and record their activities, but are not necessarily visible in other contexts.

The Differences in Women's Homelessness

Criticisms of the idea that women's experience of homelessness is distinct from that of men rest on the argument that the analysis of gender in homelessness is incomplete. When gender is used to explain differential experience of homelessness, critics usually argue that other variables, that would 'explain away' any apparent associations between patterns in homelessness and gender, are missing from the analysis.

For example, one criticism is that apparent 'gender' associations fail to take sufficient account of lifetime experience of poverty, poor educational attainment and other variables. This leads to an over-emphasis of the fact that someone is female, while de-emphasising the poverty, marginalisation and stigmatisation, shared with men, that are 'better' explanatory variables (Drake, 1987). Here, the argument is that class, rather than gender, 'explains' homelessness. It may be that the major trigger for homelessness is poverty and exclusion, but it is also clear that women do not experience homelessness in the same way as men. The triggers for women's homelessness are often different and their trajectories while homeless are often different, women's experience of homelessness is *different*. Gender plays a role.

Evidence of support and treatment needs can also be used to criticise the use of gender as an explanatory variable, arguing for example that single homeless women have characteristics, such as poor mental and physical health, that are more 'important' than their gender in explaining their experiences of homelessness. When socially scientific robust research shows single homeless women in homelessness services, sharing characteristics with homeless men (see for example, Benjaminsen, 2016), the idea that gender is a less important explanatory variable than support needs, can seem like it is being reinforced.

However, there is a real need for caution here, as it is clearly the case that women living rough and in emergency accommodation are only one *aspect* of female homelessness. There are women experiencing sustained and recurrent hidden homelessness, some of whom have high support needs, who do not appear to have contact with services or live rough. Female experience of family homelessness is also much more strongly correlated with poverty than with the presence of any support needs. The presence of women who share characteristics with men among rough sleepers merely means that male and female rough sleepers share characteristics. This does not mean all homeless women experience homelessness in the same way, or for the same reasons as homeless men, as, again, it is clearly the case that women's experiences are often different.

Consequently, recent debates around gender and homelessness have been informed by discussions on intersectionality and the interaction of multiple identities and experiences of exclusion (Davis, 2008). As Mostowska and Sheridan (2016) argue, the use of intersectionality to attempt to understand women's homelessness, with its capacity to encompass the interaction between the differing categorizations that women find themselves in alongside the macro (structural) and micro (lived experience) analysis is a more appropriate methodological approach.

Women's response to homelessness

If homeless women are assumed to be, broadly, the same as homeless men, two questions arise. The first centres around the logic of that assumption, in the face of what appears to be a very considerable difference in the nature of homelessness causation among women, i.e. the scale of the role of domestic violence, both in the experience of single women and women with families (Jones, 1999; Reeve *et al.*, 2007; Baptista, 2010; Mayock and Sheridan, 2012). If women are experiencing homelessness due to domestic or gender based violence at much higher rates than men, the idea that their needs and their pathways through homelessness can really be *consistent* with those of men, does seem rather a large assumption to make.

The second question centres on where all the homeless women are, because if anything, women experience socioeconomic marginalisation, poverty and poor life chances at higher rates than men (Domergue *et al.*, 2015). The standard answer, that women are not present because welfare systems and domestic violence services prevent and reduce a substantial proportion of women's homelessness, is not satisfactory in the light of the, now considerable, evidence that women *avoid* services and use informal support to maintain themselves in situations of hidden homelessness (Baptista, 2010).

Patriarchy, welfare system operation and responses to domestic violence are explanations of the differentiated nature of women's homelessness that effectively remove agency from homeless women (Neale, 1997; Casey *et al.*, 2008; McNaughton-Nicolls, 2009). Following these arguments, women's experience of homelessness is lower, or at least takes a different form, largely because potentially homeless and homeless women are processed by welfare and homelessness systems in a different way from men. The evidence on women's homelessness is less extensive than the evidence on male homelessness in Europe, but it is nevertheless the case that multiple studies clearly show women influencing and also determining their own trajectories through homelessness (Mayock and Bretherton, 2016).

Homeless women are often not in homelessness services, not living rough, not using domestic violence services, nor, when they have dependent children with them, necessarily being supported by welfare systems; they are instead using

friends, family and acquaintances to keep a roof over their heads (Shinn, 1997; Jones, 1999; Reeve *et al.*, 2007; Baptista, 2010; Mayock and Sheridan, 2012). Structural responses seem likely to have a significant role in the causation and sustainment of women's homelessness, but it is important not to become overly focused on the observable differences between welfare and homelessness systems when there is clear evidence that agency can determine whether and how women experience homelessness.

The enumeration quandary

The question then arises as to what the true extent of the differences between female and male homelessness are. Women are, the available European and North American evidence shows, living in situations of hidden homelessness in which they lack any legal right to occupancy and may lack privacy or any separate living space. The problem, across much of Europe, is that hidden homelessness is difficult to count. There are several issues here, including the fluid, temporary and often precarious nature of arrangements made by women experiencing hidden homelessness, and the inherent difficulty in counting multiple households living in a single dwelling (Pleace and Bretherton, 2013).

In the relatively data-rich context of the UK, specifically the administrative area of Northern Ireland where the State is a major provider of social housing, the author explored the possibility of enumerating homelessness using ETHOS and ETHOS Light as a broad framework for data collection. The inherent challenge in enumeration centred on the need for administrative contact, i.e. the statutory and other homelessness systems, which are extensive, could only record women and women with dependent children, when or if, they made contact. The challenges in counting hidden homelessness were summarised by one service provider (Pleace and Bretherton, 2013, p.42):

> *They could be homeless for a long period of time and be bouncing from family to friend and only eventually come to the attention of the* [homelessness services] *when that breaks down, or they've exhausted all those options.* Service Provider.

Attempting to populate ETHOS and ETHOS Light for this research was challenging in respect of people living in insecure accommodation (8.1, 8.2 and 8.3 in ETHOS[1]). However, data on broader housing conditions were relatively rich, and it was possible to draw on survey data and statistical estimates to determine that, in 2013, approximately 11 057 households were living temporarily with family and friends,

1 http://www.feantsa.org/en/toolkit/2005/04/01/ethos-typology-on-homelessness-and-housing-exclusion?bcParent=27

out of a total estimated homeless population of 25 445 experiencing homelessness. In other words, the best estimate was that 43% of the homeless population was experiencing *hidden* homelessness (Pleace and Bretherton, 2013).

Finland, which has been enumerating homelessness for decades through a combination of data collection and estimation, reported that the bulk of the homeless population was people experiencing hidden homelessness in 2014 (76%). This figure was recorded in the context of a sustained, strategic effort to reduce long-term homelessness among people with complex needs and extensive homelessness services and generous welfare and social housing systems. The Finnish homeless population, including hidden homelessness, was relatively small in 2014, at only 7 107 households, but Finland estimated that 23% of homeless people were lone women (ARA, 2015).

Where hidden homeless populations are counted, or estimated, within Europe, they tend to be recorded as a significant proportion of overall homelessness. Denmark has reported that 28% of all homelessness is people sharing temporarily with friends or family, and one region of Germany with relatively extensive homelessness statistics, North Rhine-Westphalia, has reported 37% of homeless people are in the same situation (Busch-Geertsema *et al.*, 2014).

The presence of hidden homelessness – in those areas of Europe where staying temporarily with family and friends in the absence of any alternative is seen as homelessness – is not direct evidence of women's homelessness. The Finnish data do indicate significant numbers of women, but that is one country among many and the patterns shown there may not be replicated elsewhere, especially as Finland has systemically pursued the reduction of homelessness. Nevertheless, the scale of hidden homelessness, when combined with the research about the nature of women's homelessness, raises at least the possibility that women's homelessness may involve considerable numbers. There are caveats, for example the evidence that young people of both genders often experience hidden homelessness (Quilgars *et al.*, 2011) and of course men are not exempt from trying to temporarily put a roof over their head by relying on friends or relatives.

Some research suggests that hidden homelessness may be a more 'practical' option for women than men, although this is difficult to quantify, and risks entering into the kinds of generalisations that Neale (1997) criticises in some feminist interpretations of homelessness. The idea here is that women are seen as non-threatening and are more likely to be perceived as victims in need of support due to cultural constructions of women as more 'vulnerable' than men. Also within this of course, is the possibility that sexual exploitation can be used to barter for somewhere to sleep. The risks of these ideas and images are raised by Löfstrand and Thörn (2004) who highlight

assumptions made by service providers in Sweden that women had exchanged sex for somewhere to stay and that their homelessness equated to moral debasement, regardless of the reality of a woman's situation or her experiences.

Differing pathways – the evidence

Research based on the still widely used definition of homelessness, lone adults sleeping rough and/or using homelessness services, provides another means by which to explore the extent to which homelessness pathways are differentiated by gender. European evaluations of homelessness services targeted on lone adults tend, as in some of the author's own work, to report a minority of women among largely male service users. In an analysis of an innovative London-based service, using a 'Time-Banking' model, wherein homeless people enter into a barter economy based on exchanging time, one hour of activity helping someone else produces a time credit that can be spent accessing a service, support or other activity for an hour, the author found 26% of a user group of 412 were female (Bretherton and Pleace, 2014). Women using this service, alongside being less numerous, were significantly less likely to report contact with the criminal justice system, but were otherwise not found to be consistently distinct from the men. They were not characterised by engaging with the service any differently than the men. As noted, other European analysis of single homeless adults using homelessness services can report similar patterns (Benjaminsen, 2016).

In the evaluation of a large programme of education, training and support services, designed to promote socioeconomic integration for single homeless people, the author was again able to look at gender. The Crisis Skylight programme engaged with 14 148 single homeless people, who shared information on their gender, in the UK, over the course of 2013-2015. Fieldwork took place in six sites, Birmingham, Edinburgh, Merseyside (Liverpool), Newcastle-upon-Tyne, London and Oxford (Bretherton and Pleace, 2016).

Both parallels and differences were found between women and men. While outnumbered by men, 32% of those using the Crisis Skylight programme were women. Women were, at first contact with services, significantly less likely to be sleeping rough (4% compared to 13% of men), but reported being in a state of hidden homelessness (16%) at only a slightly greater rate than men (14%). The programme was open to single people at imminent risk of homelessness, i.e. housed but at risk of losing that housing, which women were significantly more likely to report than men (42% of women, 29% of men) (Pleace and Bretherton, 2017).

The 4 500 women using the programme reported experiencing domestic violence at much higher rates than men (26% compared to 7%) and were, as found in earlier research, less likely to have had contact with the criminal justice system

(9%, compared to 26% of men). Women also reported a history of drug and alcohol use less often than men (20% compared to 30%), though were closer to men when it came to a history of mental health problems (36% compared to 32% of men). Women were, following contact with the programme, marginally less likely than men to secure a job (8% compared to 10%), entered further education at essentially the same rate (9%) and did the same with respect to volunteering (8%) (Pleace and Bretherton, 2017).

An in-depth longitudinal analysis of use of the programme, tracking 158 single homeless people who had actively engaged with services, involving up to four interviews with each person over three years, identified different trajectories through the programme. Some service users regained progress, homelessness having disrupted what had hitherto been a position of socioeconomic integration, others made progress for the first time, moving away from sustained marginalisation that had characterised their life until that point, some experienced a mix of progress and problems, while for others, little progress, in terms of socioeconomic integration, appeared to be possible (Bretherton and Pleace, 2016). Women represented 30% of the group whose progress through the programme was tracked over time. In this group the women were quite distinct from the men, 53% of the women had regained progress, i.e. had returned to a situation of relative socioeconomic integration that had existed prior to homelessness, compared to 37% of the men. The men were, by contrast, more likely to be moving towards socioeconomic integration for the first time (38%) compared to women (17%). A similar proportion of both genders had made less progress (Bretherton and Pleace, 2016; Pleace and Bretherton, 2017). Again, women had experienced domestic violence at a far higher rate than men, though not every respondent chose to answer questions on this subject.

This research was an examination of a homelessness service programme, it was not a representative survey of the single homeless population, not least because it was research on the use of an entirely voluntary education and training focused programme. Several trends, also suggested by some other European research, did however appear to be evident among the people using the programme. Women were significantly less likely to be literally homeless, and more likely to report being at risk of homelessness or in a situation of hidden homelessness. Compared to the men, women were less likely to be using drugs or alcohol, less likely to have had contact with the criminal justice system and much more likely to have experienced domestic violence. Among the subgroup whose experience of using the programme was tracked over a period of up to three years, there was a sense of women being more likely to be people whose relatively integrated socioeconomic position had been disrupted by homelessness, but who, given support, had been able to move back towards their former position. The men were, by contrast, more likely to have experienced sustained socioeconomic exclusion.

A French national survey reported that lifetime prevalence of homelessness was clearly associated with gender, with men markedly more likely to experience rough sleeping and emergency accommodation than women. This research was based around a working definition of homelessness that focused on people living rough and in emergency shelters. Analysis indicated isolation, beginning with a disrupted childhood, was predictive of these forms of homelessness, i.e. men who had become socially marginalised as children and stayed that way, were those who entered homelessness. This kind of isolation, or at least this type of homelessness, was something women seemed less likely to experience. Living without a family or partner was interpreted as introducing personal emotional vulnerability and financial insecurity. The greater tendency of men to be single for prolonged periods was, in itself, seen as a risk factor (Brousse, 2009). By contrast, research into women's homelessness has tended to highlight relationship breakdown, particularly violent relationship breakdown, as a causal factor and the creation and deployment of relationships as a key resource that women draw upon to counteract homelessness, using friends, acquaintances and family to keep a roof over their heads (Reeve *et al.*, 2007; Baptista, 2010; Mayock and Sheridan, 2012).

Belgian research focused on populations characterised by precarious housing, i.e. not actually homeless but at heightened risk of homelessness, found more single people than couples or families compared to the general population, but not the same overwhelmingly male group as reported in many studies of single homelessness. This research suggested that once the focus is moved away from the extremes of single adult homelessness, into an examination of those at risk of homelessness, hidden homelessness and the experience of housing exclusion, women start to become much more visible (Meert and Bourgeois, 2005).

It could be concluded therefore that there is evidence that suggests patterns of visible female homelessness, i.e. women captured by surveys and in service evaluations, may still be distinct from male experience (see also Mayock *et al.*, 2015). While some single homeless women do look similar to homeless men, in terms of their experiences and needs, others do not.

Domestic violence

Domestic violence is a leading cause of women's homelessness and is a widespread experience among homeless women (Pleace *et al.*, 2008; Mayock *et al.*, 2016). The interrelationships between domestic violence and women's homelessness exist at two broad levels. First, there is the differential causation, which can be linked to specific trajectories through homelessness, which will not be experienced in the same way and certainly not to the same extent by homeless men. Second, there is the interface between homeless women and domestic violence services; where present, domestic violence services may prevent and reduce

homelessness, but this option may not always be open to women. Equally, women going through some domestic violence services may not receive the same kinds of support as that offered by homelessness services, in terms of preventing homelessness and sustaining an exit from homelessness. Some domestic violence services, such as Sanctuary Schemes (see Jones *et al.,* 2010) are in many senses a preventative intervention designed both to remove a woman from risk and to prevent homelessness, but some refuges may be more focused on immediate safety and emotional support, rather than housing sustainment.

In a survey and analysis of 321 domestic violence services in England, 57% reported that they "frequently" turned away women and women with children seeking support, with a 93% occupancy rate being reported for 3 707 bed spaces in refuge services. The survey also reported that 27% of domestic violence services were operating a waiting list, this included the emergency services designed to provide a woman at risk of violence with a safe and secure environment. Women made homeless by domestic violence or the threat of violence, were, in the UK at least, approaching domestic violence services at a rate higher than those services could manage (Quilgars and Pleace, 2010). This research was conducted prior to the sustained cuts to domestic violence services that has followed the 'austerity' measures being introduced in the UK from 2010 onwards. British research conducted in 2005 reported 13% of family homelessness in England was directly caused by domestic violence, with 44% of women experiencing such violence and 14% having experienced sexual assault (Pleace *et al.*, 2008). Similar associations appear to be universally present in Europe, Australia and in North America (Baptista, 2010; Mayock *et al.*, 2016).

Many homeless women appear to experience something that most men do not, homelessness that is triggered by violent relationship breakdown, homelessness that begins with having to escape what is supposed to be the secure and safe environment of their own home. The damage that this violence can do, and the disruption to women's lives that can result from it, brings a dimension to women's homelessness that is unique. Counter arguments are sometimes made, i.e. that men also experience violence of this sort, which is of course true, but one cannot assert there is some sort of parity or comparability in experience between genders. Men do experience domestic violence and abuse, as a cause and contributing factor to homelessness, but at a fraction of the rates experienced by women (Mayock *et al.*, 2016).

The Similarities in Women's Homelessness

One danger in emphasising differences in pathways through homelessness associated with gender is the risk that women having very similar experiences to homeless men, particularly single homeless men, might receive less attention than they should. Looking at long-term homelessness, Bowpitt *et al.* (2011), drawing on qualitative research results, highlight what they view as evidence that certain assumptions about women's homelessness are flawed. In particular, they argue that the assumption that long-term homeless women are less likely to sleep rough than men is flawed. It is important to note that this research was with a specific population, specifically selected on the basis that they were long-term homeless, which as North American research (Piat *et al.*, 2014) and some European data (Jones and Pleace, 2010) indicate may only be a relatively small element of overall homelessness. Yet for Bowpitt *et al.* (2011), women in this specific situation of long-term homelessness shared many characteristics with long-term homeless men, to the extent that the similarities were viewed by these researchers as more important than the differences.

The author evaluated nine of the first Housing First services to be piloted in England in 2014/15, 27% of service users were women, their support needs paralleling those of male service users in every respect. Again, while women had distinct needs, the similarities with the men, in this specific population of homeless people with high and complex needs were notable (Bretherton and Pleace, 2015).

This reiterates the point that gender differences relate to definitions. Women's homelessness, in Finland, Germany or Northern Ireland, is more visible because the categorisations of homelessness, like ETHOS, include hidden homelessness. Use a narrower definition of homelessness as in France, Spain or Italy and women become less visible. Women become less prominent and less distinctive because, as in the French case, the homelessness taxonomy basically incorporates people living rough, in emergency shelters and in temporary accommodation. In these countries, women are apparently less numerous, but this is because hidden homelessness is not recognised, meaning that the distinctive nature of many women's homelessness pathways are not recorded, or indeed, researched (Busch-Geertsema *et al.*, 2014).

Here, the evidence that homelessness can, in contexts like Finland and Denmark, be reduced to what is effectively a functional zero, may be important. In these contexts, women can and do, experience hidden homelessness, but the rate at which they do so may be comparatively very low. In those European contexts where poverty and therefore homelessness itself is less common, women's homelessness may be both narrower and, in some respects – probably excepting associations with domestic violence – less distinctive from that of men. The prevalence of severe mental illness, drug and alcohol use, disrupted childhoods, criminality and other

shared characteristics *may* sometimes be more important than gender (Benjaminsen, 2016). In European countries without integrated homelessness strategies, or sufficient welfare, health and social housing services and where poverty is more widespread, experience of homelessness among women appears to extend well beyond being a part of populations living rough or in emergency accommodation, and to include hidden homelessness on what may be some scale (Reeve *et al.*, 2007; Baptista, 2010; Mayock and Sheridan, 2012).

One further point can be raised here, which is the possibility that the effect of the more commonly researched forms of homelessness, rough sleeping and living in homelessness services may not be even. The differences within genders may be greater than the differences between genders, but some research has raised the possibility that women may sometimes be even more harmed by these forms of homelessness than some men. Following an evaluation of the first pilot of a Housing First service in London in 2012/13, it became apparent to the author that the needs of women, in what was a small service, tended to exceed those of men. Their experiences had been more negative, more damaging and their requirements for treatment were higher and more complex than those of the men among the small group of service users (Pleace and Bretherton, 2013).

Conclusions

The evidence base on women's homelessness in Europe is less well developed than is the case for single homeless men. The deficiencies in European evidence are fourfold. First, what may be a key aspect of women's homelessness, the experience of hidden homelessness, has received only limited attention. Second, family homelessness is less extensively researched than single homelessness among men. Third, when women are found among single homeless people, their presence is more likely to be noted than examined in depth (Bretherton and Mayock, 2016). Fourth, the experience of domestic violence causing homelessness is not sufficiently recorded, recognised or analysed as being homelessness, instead being treated as a 'separate' social problem of domestic violence (Mayock *et al.,* 2016).

The limitations in evidence have to be seen in the context of the wider evidence base on European homelessness. Research is heavily skewed to the North West, particularly the UK, and tends to focus on people living rough and in homelessness services. Data on homelessness is improving; Spain, Italy, Portugal and Poland now collect quite extensive data, for example. However, the issue of using definitions or frames of reference that exclude various dimensions of female homelessness remains widespread (Busch-Geertsema *et al.*, 2010; Busch-Geertsema *et al.*, 2014).

A key gap in the evidence base centres on understanding the roles of women's agency and decisions, both in terms of their homelessness and in terms of the nature of European homelessness itself (Neale, 1997; McNaughton-Nicolls, 2009). Women's homelessness is influenced by welfare systems, culture, sexism, patriarchy, the nature of homelessness services and the economy and housing markets. All of these influence the contexts in which women experience homelessness, but how women react to homelessness remains a key determinant of their experience. There is too much evidence showing women not using services and employing their own resources, often in the form of existing and new relationships, as their initial, or sometimes their sole, response to homelessness (Bretherton and Mayock, 2016). A woman experiencing domestic violence who becomes homeless as a consequence may use homelessness services, may go to domestic violence services (and often not be recorded as homeless) or may rely largely, or solely on friends, relatives or acquaintances. Choices may sometimes be constrained, there may not be a service to go to, but that does not mean that it is still not possible to decide which of a limited choice of trajectories through homelessness to pursue.

The hypothesis advanced by this paper is that while European homelessness is gendered by a range of interacting factors, understanding the *decisions* of homeless women is central to understanding how gender differentiates the experience of homelessness. While economics, culture, sexism, and patterns of welfare, health and social housing system provision may all play a role, women are not, this paper contends, deprived of agency once they are at risk of homelessness (McNaughton-Nicolls, 2009). Understanding how women navigate through homelessness may be the key to comprehending the differences in women's homelessness and the true nature and extent of women's homelessness in Europe.

Decisions and actions are not the sole means to understand women's homelessness, but understanding and focusing on this subject is the first step in understanding the multiple trajectories that women can take through homelessness. Homelessness systems and homelessness research have missed women's homelessness, in large part because of definitions which created a narrow focus on only some aspects of homelessness. Whole dimensions of the social problem of homelessness, which are often those involving or disproportionately experienced by women, from family homelessness to the role of domestic violence in homelessness causation and the nature and extent of hidden homelessness are underresearched. The pathways that women take through homelessness need to be better understood (Clapham, 2003).

Clearly, better understanding must involve much more systematic attempts to understand hidden homelessness. Of particular interest are two questions. The first is the extent to which Shinn's (1997) hypothesis in relation to North America, that

homeless women and female headed lone parent families have a tendency to exhaust every source of informal help from friends and relatives before seeking services, holds true in European contexts. The second is the extent to which hidden homelessness is a perpetual or near perpetual state for some women (Mayock and Sheridan, 2012), because if there is a population experiencing hidden homelessness for years, even perhaps decades, without accessing formal support, it is clearly a cause for concern. Alongside this, understanding both the relative and absolute scale of hidden homelessness, while presenting challenges (Pleace and Bretherton, 2013), is important, not least to try to understand quite what the real dimensions of women's experience of homelessness may be.

Another dimension of women's homelessness highlighted by this paper is the true level of understanding of women's experience of the most widely recognised forms of single homelessness. Women's presence in these populations has been noted by researchers, but it has been argued here and elsewhere that there is a tendency to note that a minority of women are present, but not to pursue further analysis (Casey *et al.*, 2008; Bowpitt *et al.*, 2011). Some research indicates that at the extremes of homelessness, women and men may have many experiences and needs in common, but while there is this possibility, the evidence is not yet at a point where it can be safely assumed, for example, that the effects and experience of rough sleeping is not differentiated by gender.

Equally, there are specific dimensions of women's homelessness that it is important to better understand. Some research suggests migrant women may be at heightened risk of homelessness, facing specific issues alongside the challenges of trying to integrate, work and seek publicly funded support in European countries (Mayock *et al.*, 2012). There are also indications that trajectories through youth homelessness may be differentiated by gender, particularly when young people reach their late teens and early twenties and males start to outnumber females. These patterns have been interpreted as young women forming relationships more quickly than young men and also, perhaps rather crudely and possibly incorrectly, interpreted as young homeless women becoming pregnant and accessing welfare systems and exiting homelessness through that route (Quilgars *et al.*, 2008).

Some of the intersecting concerns and issues with European homelessness research, for example the need to redress the 'Northern' bias in evidence, apply specifically to women. A key question here is whether and to what extent women's homelessness, including their tendency to resort to, or choice to use, informal support from friends, family and acquaintances may relate to welfare systems, social housing and the nature of strategic responses to homelessness (Bretherton *et al.*, 2016).

The key concern, as the author and others have raised elsewhere (Mayock and Bretherton, 2016), is the relative neglect and, by extension, the untested nature of the assumptions about gender and homelessness in Europe. This gap in understanding about women's homelessness is a major gap in evidence about European homelessness, indeed homelessness in general. The failure to fully research gender and homelessness is a failure to fully research and seek to understand the nature of homelessness itself.

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Canadian residential facilities for victims of abuse, 2017/2018

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Released: 2019-04-17

In 2017/2018, there were 552 facilities operating across Canada which had a primary mandate to serve victims of abuse, and these facilities admitted over 68,000 people. Residential facilities for victims of spousal and interpersonal violence have been providing an essential service since the 1970s.

Almost all (99.9%) of the admissions to residential facilities in 2017/2018 were women (60.3%) and their accompanying children (39.6%). A small number of these facilities, a total of 15 or 3%, also served men. In all, facilities admitted 86 men in 2017/2018.

On the snapshot day of April 18, 2018, there were 3,565 women, 3,137 children, and 8 men residing in residential facilities for reasons of abuse.

A7721

According to the latest self-reported data on victimization, equal proportions of men and women reported having been a victim of spousal violence during the preceding five years (4%, respectively). Women were nearly twice as likely to have experienced the most severe types of spousal violence as men.

A *Juristat* article focused on the characteristics of Canadian residential facilities for victims of abuse and their residents is now available. The article, "Canadian residential facilities for victims of abuse, 2017/2018," uses data from the first iteration of the Survey of Residential Facilities for Victims of Abuse, as does the accompanying infographic "Residential facilities for victims of abuse in Canada, 2017/2018." This survey is a redesign of the Transition Home Survey, which was last conducted in 2014.

Abuse by a current or former intimate partner was the most common reason for admittance to the facilities

Of the 3,565 women who resided in facilities and reported abuse as their primary reason for seeking shelter on snapshot day, 66% identified a current intimate partner as their abuser, while 18% identified a former intimate partner. Intimate partners include individuals who are or were legally married, common-law, dating or who are or were in other types of intimate relationships.

About one in five women leaving a residential facility return to live with their abuser

Chart 1
Relationship of abuser to women residing in facilities primarily for reasons of abuse, Canada, April 18, 2018

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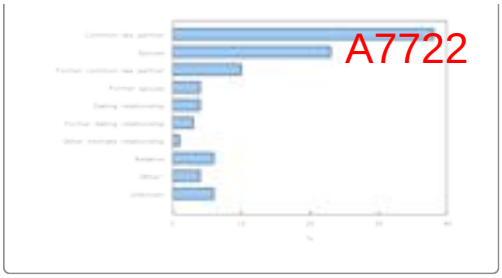


Among the women who left a residential facility on snapshot day, 21% said they were returning to a residence where their abuser continued to live. For an additional 36% of women who left on that day, either they or the facility did not know where they were going upon departure. Other women reported they would be living with friends or relatives (18%), or entering another residential facility for victims of abuse (11%). The remaining 14% of women had other plans, such as returning home or moving to a new residence without their abuser.

More than one-third of short-term residential facilities for victims of abuse were full on snapshot day

In Canada in 2018, 428 facilities offered short-term accommodation for victims of abuse. Short-term facilities are those with an expected length of stay of less than three months. Nationally, 36% of these short-term residential facilities were considered full on snapshot day, meaning 90% or more of their beds were occupied. Among the provinces, Saskatchewan reported the highest percentage of short-term facilities that were full (47%), followed by Quebec (43%), British Columbia (43%) and Ontario (42%).

In general, short-term facilities in urban areas were more likely to be reported full (41%) than similar facilities in rural areas (29%).

Across Canada, there were 6,500 funded beds in short-term residential facilities in 2018. Funded beds are those that officially exist due to funding typically from government sources and exclude temporary sleeping arrangements such as cots, sofas or sleeping bags. Over three-quarters (78%) of these funded beds were reported occupied on snapshot day. Among the provinces, Quebec (90%), Ontario (84%) and Saskatchewan (78%) reported the highest proportion of occupied beds. In the territories, 98% of 120 funded beds in short-term facilities were occupied.

A3438

While the occupancy rate was consistently higher in urban (83%) than rural (67%) short-term facilities, there were three exceptions. These exceptions were Manitoba, where the occupancy rate was 23% in urban facilities versus 58% in rural facilities, as well as Saskatchewan at 75% occupancy in urban facilities compared with 86% in rural facilities. In addition, Newfoundland and Labrador reported an occupancy rate of 48% in urban facilities versus 53% in rural facilities.

A full residential facility is the most common reason for turning away victims seeking shelter

On snapshot day, 669 women, 236 accompanying children, and 6 men were turned away from residential facilities for victims of abuse. The most common reason reported for a woman being turned away was that the facility was full (82%). Other reasons for turning away a woman included the individual's profile being outside of the facility's mandate (8%), a safety issue for the facility (for example, the individual was on a non-admit or caution list) (2%), and the type of abuse experienced is outside the facility's mandate (2%).

Short-term residential facilities for victims of abuse in Ontario and Manitoba report longer average lengths of stay

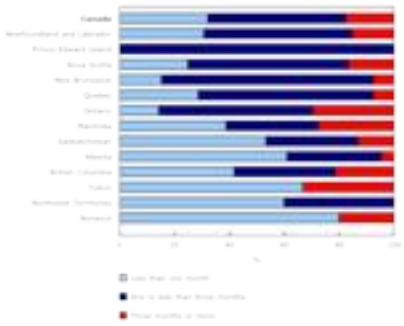
Typically, short-term facilities are mandated to provide shelter for a stay less than three months. For 18% of short-term facilities in Canada, the average length of stay exceeded the mandated maximum of three months. Among the provinces, 30% of short-term facilities in Ontario reported average lengths of stay of three months or longer, as did 28% of facilities in Manitoba.

Two of the top challenges facing facilities and their residents, which may help explain extended stays, were a lack of permanent housing (reported by 38% of facilities), and a lack of affordable and appropriate long-term housing options

upon departure from residential facilities (reported by 77% of facilities on behalf of their residents).

Indigenous and non-permanent resident women and children overrepresented in residential facilities for victims of abuse

Chart 2
Percentage of short-term residential facilities for victims of abuse by average length of stay, by province or territory, 2017/2018



Indigenous women (First Nations, Métis and Inuit) were overrepresented in residential facilities for victims of abuse by approximately five times their representation in the Canadian population. Similarly, Indigenous children were overrepresented by approximately three times their representation in the Canadian population. More than one in five (22%) women and one-quarter of children (25%) residing in facilities for victims of abuse were Indigenous. At the same time, Indigenous women accounted for 4% of Canadian women aged 18 and older, while Indigenous children comprised 8% of Canadian children 17 and under.

According to data from the most recent General Social Survey (GSS) on Canadians' Safety (Victimization), Indigenous females had an overall rate of self-reported violent victimization that was nearly triple that of non-Indigenous females. As well, Indigenous women were more likely than non-Indigenous women to be a victim of spousal violence in the five years that preceded the GSS on Victimization.

Non-permanent residents in Canada are also overrepresented in residential facilities for victims of abuse. Of the women in residential facilities whose residency status was known, 9% were non-permanent residents, a rate six times higher than their representation in the Canadian population (1.5%). Nationally, 8% of accompanying children were non-permanent residents, compared with 0.9% of the general population. Non-permanent residency often carries additional barriers

to accessing affordable and safe housing, including lower income, less stable housing and employment, financial interdependence, and a lack of awareness of available services.

A7725

Note to readers

This *Juristat* article uses data from the Survey of Residential Facilities for Victims of Abuse (SRFVA). The SRFVA collected annual (2017/2018 fiscal year) and snapshot day (April 18, 2018) information on residential facilities in Canada that are primarily mandated to serve victims of abuse.

Facilities were asked to report the type of facility they operated based on the expected length of stay provided for in their service mandate, regardless of practice. They were grouped into two categories:

Short-term residential facilities include those with a general policy of providing accommodation for less than three months and typically provide individual beds to residents.

Long-term residential facilities include those with a general policy of providing accommodation for three months or more and typically provide residential units (for example, apartments or houses) to residents.

The SRFVA is a redesign of the Transition Home Survey (THS), which was conducted every two years from 1993 through 2014. Due to differences in survey scope and content, data collected for the SRFVA are not comparable with historical THS data.

Other intimate partners include people who had a sexual relationship or a mutual sexual attraction but to which none of the other relationship options apply. This can include "one-night stands" or brief sexual relationships.

An urban area is defined as a census metropolitan area (CMA) or a census agglomeration (CA). Rural areas are all areas outside of CMAs and CAs.

A3441

Population data for Indigenous and non-permanent resident populations in Canada are based on 2016 Census of Population estimates from the long-form census questionnaire. Readers should be aware that the universe for the long-form census questionnaire is the population in private households only, which excludes persons in collective dwellings. Additionally, while every attempt has been made by the Census to enumerate non-permanent residents, there are factors (for example, not being aware of the need to participate) which may have affected the estimate of this population. Previous coverage studies have indicated that the non-permanent resident population was missed at a higher proportion than the general population.

Products

The article "Canadian residential facilities for victims of abuse, 2017/2018" is now available as part of the publication *Juristat* (85-002-X). The infographic "Residential facilities for victims of abuse in Canada, 2017/2018" (11-627-M) is also released today.

Additional data are available upon request.

Contact information

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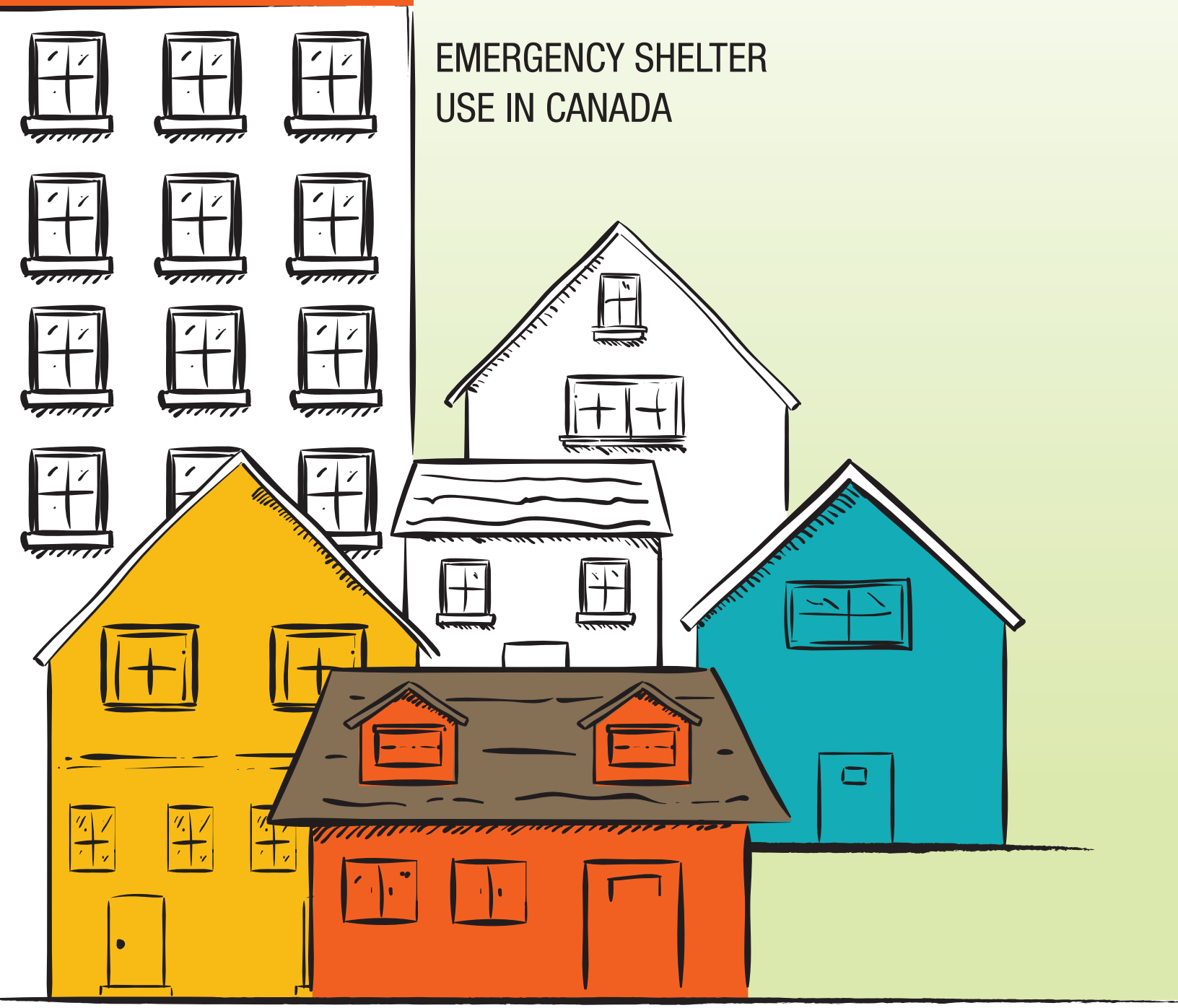
2005 to 2016

HIGHLIGHTS OF THE NATIONAL SHELTER STUDY

EMERGENCY SHELTER USE IN CANADA



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Canada

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Highlights of the National Shelter Study 2005-2016 – Emergency Shelter Use in Canada

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PDF
Cat. No.: Em12-17/1-2019E-PDF
ISBN: 978-0-660-31971-1

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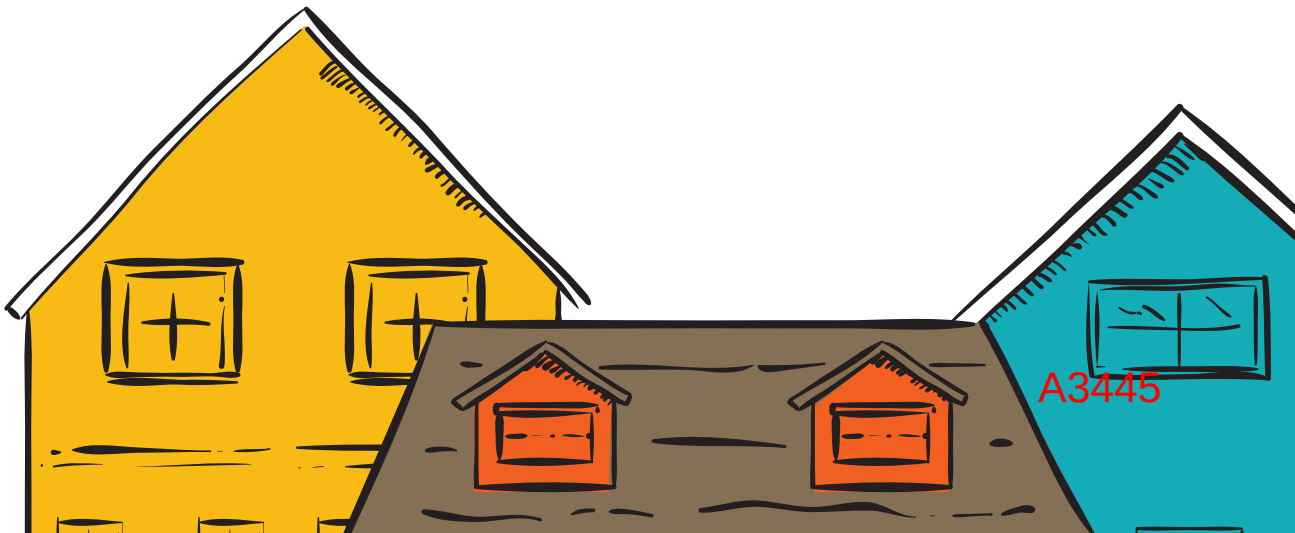
TABLE OF CONTENTS



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Acknowledgements

This study has been compiled by the Homelessness Policy Directorate, Income Security and Social Development Branch, Employment and Social Development Canada.

We would like to acknowledge the collaboration and efforts of the Province of Alberta, BC Housing, the City of Toronto, the region of Peel and each of the 216 service providers that contributed data used in this report. Through this collaborative effort, we are able to advance our collective understanding of homelessness in Canada and support decision making, and the development of policies and programs to prevent and reduce homelessness.

We also would like to thank shelter staff for collecting the data, as well as shelter users for agreeing to share their information.

Author and Principal Investigators

Annie Duchesne, Analyst

Dr. Jacqueline Rivier, Analyst

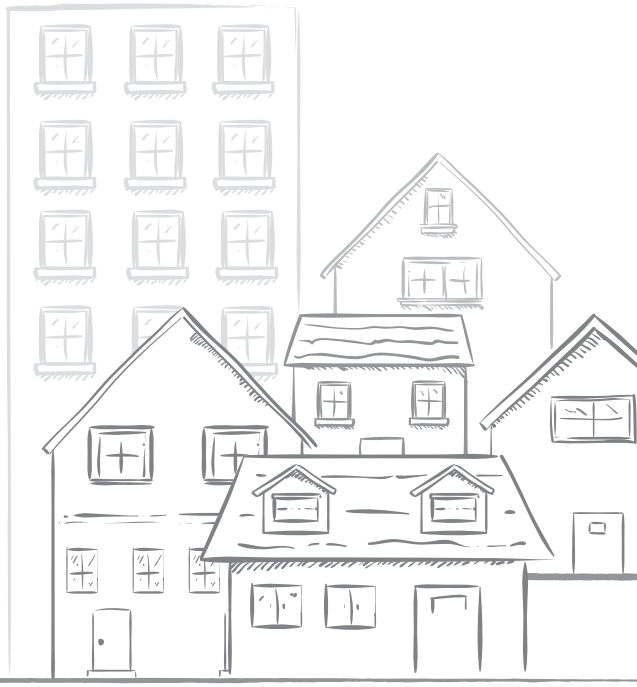
Dr. Patrick Hunter, Senior Analyst

Dr. Ian Cooper, Manager

Abstract

The National Shelter Study is an ongoing analysis of homelessness shelter use trends in Canada. It provides the most reliable national-level estimate of homelessness and is vital for understanding changing trends over time. There are just over 15,400 emergency shelter beds distributed in 400 emergency shelters across Canada. The information used in this study was collected from over 200 shelters across Canada, most of which use the **Homeless Individuals and Families Information System** (HIFIS). This report updates the **National Shelter Study 2005-2014** with new data from 2015 and 2016. While the data show an ongoing decrease in the number of individuals and families using shelters per year, the national occupancy rate remains above 90%. The findings also show ongoing overrepresentation in shelters of people who identify as Indigenous.

LIST OF FIGURES



Introduction

The National Shelter Study is an ongoing analysis of homelessness shelter use trends in Canada. This report is the third analysis of national emergency shelter data collected over time. The first study was published in 2013 and covered the period from 2005 to 2009. This information was updated in 2016 and extended the timeframe of the analysis from 2005 to 2014. The current report updates and extends findings to include data from 2015 and 2016.

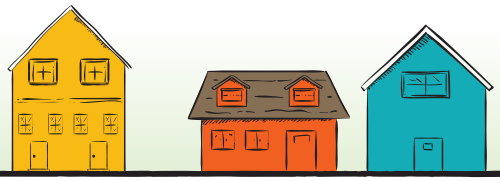
The National Shelter Study is the most comprehensive national-level study of homelessness in Canada and is vital for understanding changing trends over time. It provides a descriptive account of the demographic characteristics of the homeless population using shelters in Canada (for example: families, youth, Indigenous Persons, etc.), and trends in the average shelter occupancy rate, the overall number of Canadians using shelters, shelter bed use and the length of stay by individuals using Canada's emergency shelter system.

This report is based on data collected through the Homeless Individuals and Families Information System (HIFIS) and data sharing agreements with communities and service providers. It includes anonymous information from nearly 3.1 million shelter stays that occurred at over 200 of the approximately 400 emergency shelters across Canada between 2005 and 2016.

The National Shelter Study is conducted as part of the Reaching Home program, a community-based program aimed at preventing and reducing homelessness by providing direct support and funding to Designated Communities (urban centers), Indigenous communities, territorial communities and rural and remote communities across Canada.

For more information about Reaching Home visit: **www.canada.ca/en/employment-social-development/programs/homelessness.html**

For questions related to the information included in this report, contact: **ESDC.ISSD.RHInfo-infoVCS.DGRSDS.EDSC@hrsdc-rhdcc.gc.ca**



Systems and Methods

The National Shelter Study is based on anonymous information from nearly 3.1 million shelter stays that occurred at over 200 of the approximately 400 emergency shelters across Canada between 2005 and 2016. Only emergency shelters are included in the study as data received from these facilities is the most comprehensive, reliable and represent the best available indicator of large-scale homelessness trends. While the report represents the extent of shelter use, homelessness among populations that are less likely to access shelter, such as Indigenous Peoples and youth, is likely underrepresented.

The study uses a stratified cluster sample of emergency shelters to ensure accurate estimates of the number and characteristics of shelter users. For the 2014 to 2016 portion of the study, the sample included most of the largest shelters in Canada, covering approximately 70% of the total emergency shelter beds in the country. The sample is based on emergency homeless shelters for individuals and families only and does not include Violence Against Women shelters, transitional housing, or refugee shelters. The study's methodology also considers people who use more than one shelter by adjusting the sampling weights based on the average rate of client duplication within strata.

The study contains administrative shelter data obtained from emergency shelters using HIFIS and similar data provided by partners including the City of Toronto, Peel Region, the Province of Alberta and BC Housing. Only fields that are filled with sufficient consistency are used in the analysis. For shelters, only those with complete annual data are included in the sample.

While this study covers the 2005 to 2016 period, three demographic variables were collected for the first time in 2014 to improve the understanding of homelessness in Canada: citizenship status, Indigenous identity, and veteran status.

The Homeless Individuals and Families Information System (HIFIS)

HIFIS was developed by ESDC in consultation with communities and is provided to communities free of charge, in exchange for the provision of anonymous shelter data. HIFIS is a comprehensive data collection and case management system that supports the day-to-day operations of homelessness service providers, the coordination of services and helps clients to access the right programs at the right time. HIFIS is designed to support the implementation of Coordinated Access by allowing multiple service providers from the same community to access real-time homelessness data and refer clients to the appropriate services at the right time. HIFIS allows these service providers to collaborate through a community-wide system that can be accessed from a variety of web-enabled devices, such as laptops, smartphones and tablets.

HIFIS is a leading tool for building homelessness sector intelligence. By adopting HIFIS, communities acquire the capacity to collect and analyze homelessness sector information that can be used to monitor existing trends, identify arising ones and, more generally, support decision-making. ESDC receives non-identifiable data for 38 fields through a Data Provision Agreement with shelters and communities that use HIFIS. By providing their data to ESDC, HIFIS users also contribute to building knowledge and advancing the understanding of homelessness in Canada.

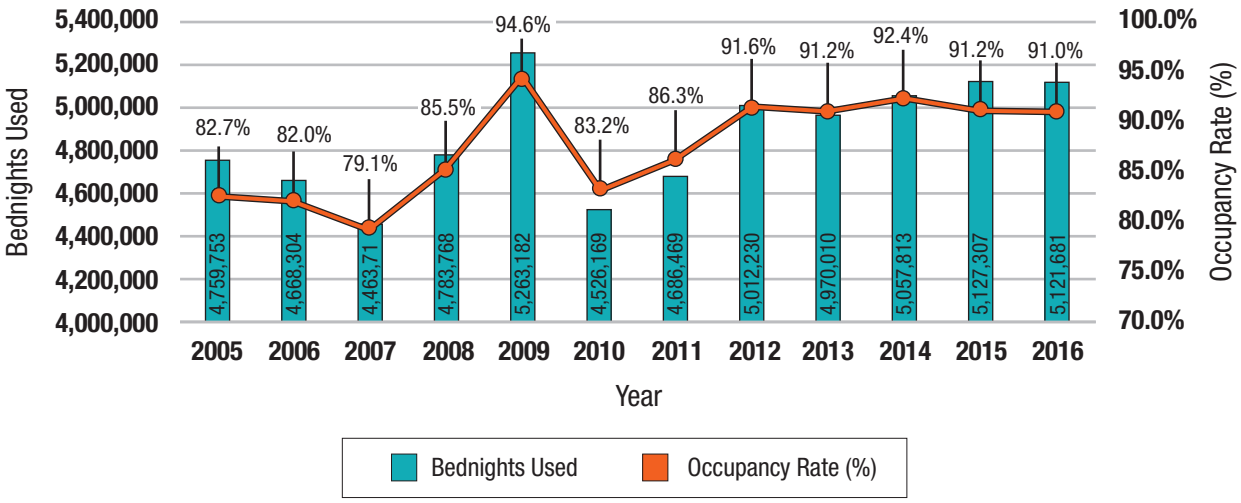
1. Shelter system use

Over 14,000 Canadians slept in an emergency shelter on an average night.

Shelter use in Canada remains high with an occupancy rate of 91% in 2016. On an average night in 2016, over 14,000 Canadians slept in an emergency shelter. Between 2005 and 2011, occupancy was more variable, with a notable spike in 2008 and 2009 following the 2008 financial crisis before dropping back down in 2010 to pre-recession numbers. Between 2012 and 2016, shelter occupancy stabilized, hovering between 91% and 92%.

There are just over 15,400 emergency shelter beds distributed in 400 emergency shelters across Canada[1]. While the overall number of emergency shelter beds in Canada was similar in 2005 and 2016 (15,774 beds in 2005, 15,413 beds in 2016), demand for shelter beds has increased during the same period. Bednights measure the number of times a shelter bed is used in a year. Compared to 2005 when shelter beds were used 4.76 million times, emergency shelters served more people per night in 2016 (5.1 million).

Figure 1: Bednights Used and National Shelter Occupancy Rate (2005 to 2016)



Source: Data collected through HIFIS and data sharing agreements

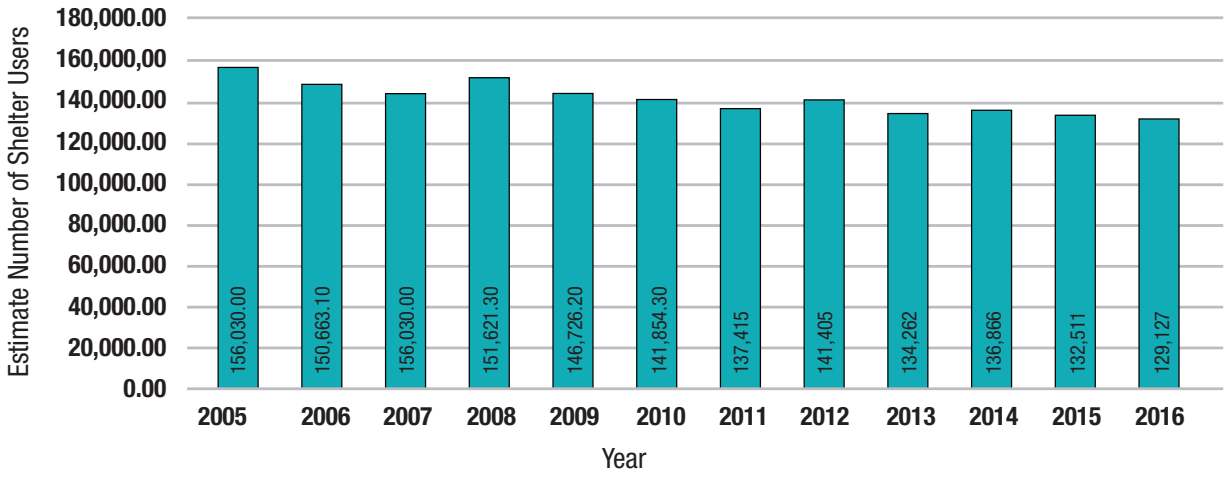
[1] *Shelter Capacity Report 2016,* Employment and Social Development Canada. www.canada.ca/en/employment-social-development/programs/homelessness/publications-bulletins/shelter-capacity-2016.html

2. Shelter users and bednights

The number of unique people using emergency shelters has declined.

Despite the increasing demand on shelter beds, the annual number of unique shelter users has decreased gradually by nearly 20% from approximately 156,000 in 2005 to 129,000 in 2016.

Figure 2: Estimated Number of Annual Shelter Users (2005 to 2016)



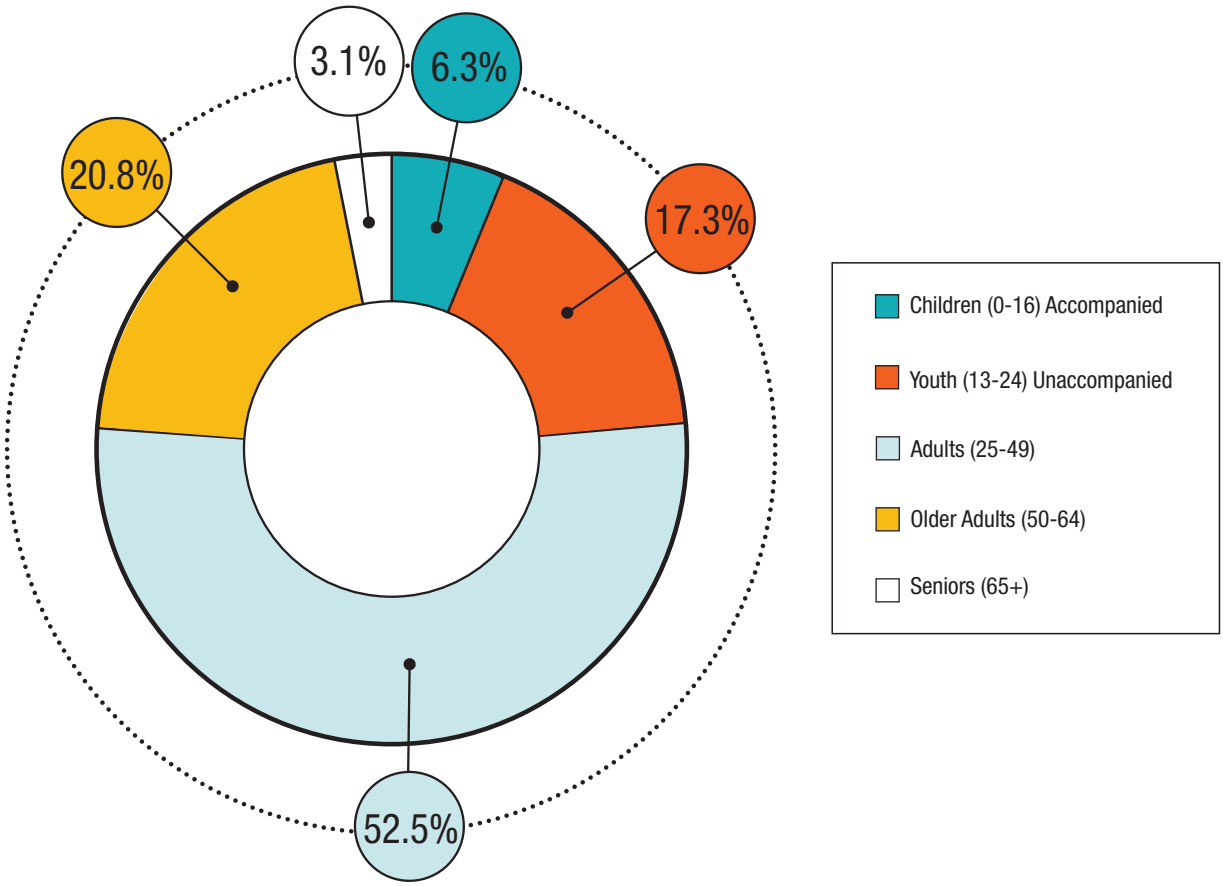
Source: Data collected through HIFIS and data sharing agreements

3. Shelter use by age group

The majority of emergency shelter users are adults (aged 25-49).

Adults aged 25-49 make up the largest group of emergency shelter users (52.5%), followed by older adults aged 50-64 (20.8%). Unaccompanied youth[2] (aged 13-24) also make up a significant proportion of the shelter population (17.3%). Children[3] (aged 0-16) comprise 6.3% of the population. Relatively few seniors aged 65+ use shelters, comprising just 3.1% of all shelter users.

Figure 3: Distribution of Shelter Users by Age Group (2016)



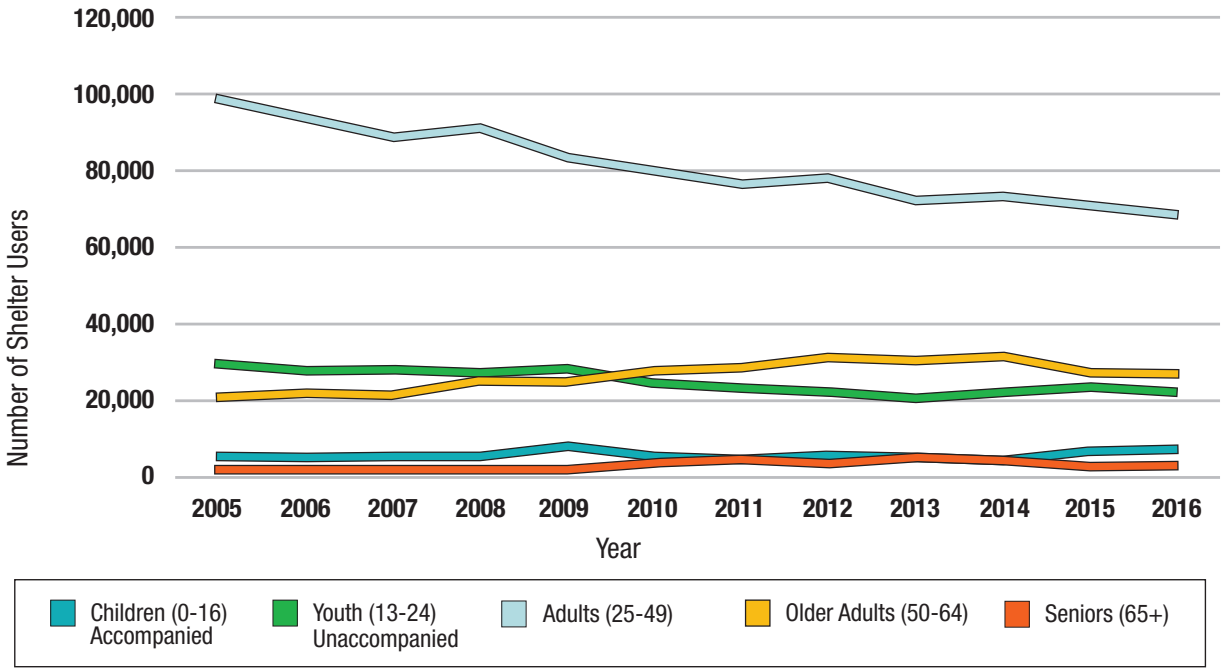
Source: Data collected through HIFIS and data sharing agreements

[2] Persons between the ages of 13 and 16 who are unaccompanied by a parent or guardian during their episode of homelessness. People between the ages of 17 and 24 are considered to be youth regardless of accompaniment status.

[3] Persons between the ages of 13 and 16 who are accompanied by a parent or guardian during their episode of homelessness. People under the age of 13 are considered to be children regardless of accompaniment status.

The number of adult shelter users dropped 30% between 2005 and 2016 (from 97,177 to 67,764), which accounts for much of the overall decrease in shelter users over the study period displayed in Figure 2. For unaccompanied youth aged 13-24, the number of shelter users decreased almost 25%, from 29,591 in 2005 to 22,398 in 2016. The number of children using shelters increased 35% from 5,998 in 2005 to 8,124 in 2016. By contrast, the number of shelter users aged 50-64 has increased by more than 26%, from 21,209 in 2005 to 26,839 in 2016. The number of seniors using emergency shelter services has increased by 50% from 2,680 in 2005 to 4,003 in 2016.

Figure 4: Estimated Number of Shelter Users by Age Group (2005 to 2016)



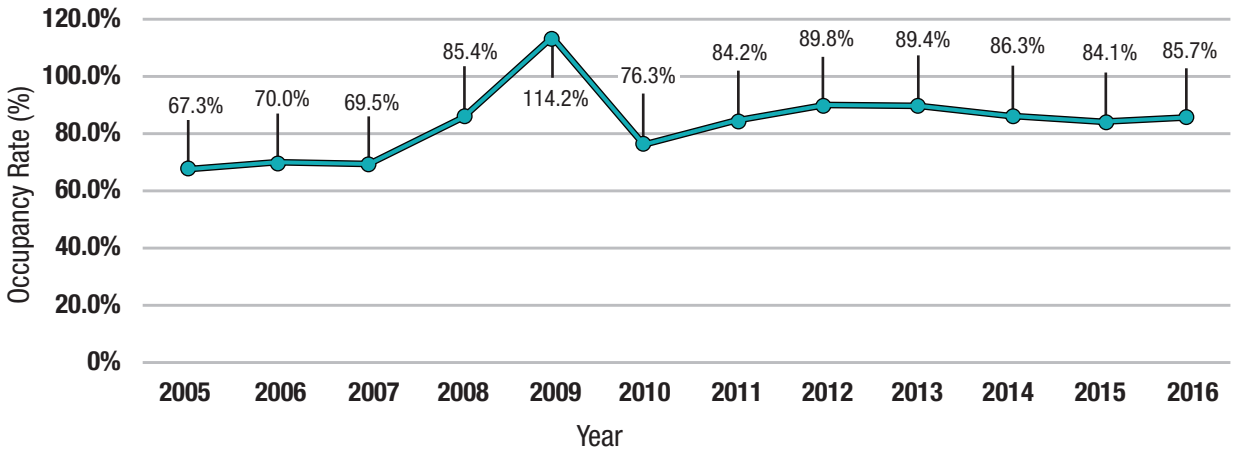
Source: Data collected through HIFIS and data sharing agreements

4. Family shelter use

The occupancy rate at family shelters was 85.7% in 2016, a 27% increase since 2005.

In 2016, family shelters had an occupancy rate of 85.7%, a 27% increase since 2005. There was a spike in family shelter occupancy (114.2%) in 2009 following the 2008 financial crisis. Family shelter occupancy rates have remained relatively stable since 2011, between 84% and 90%.

Figure 5: Occupancy Rate at Family Shelters (2005 to 2016)



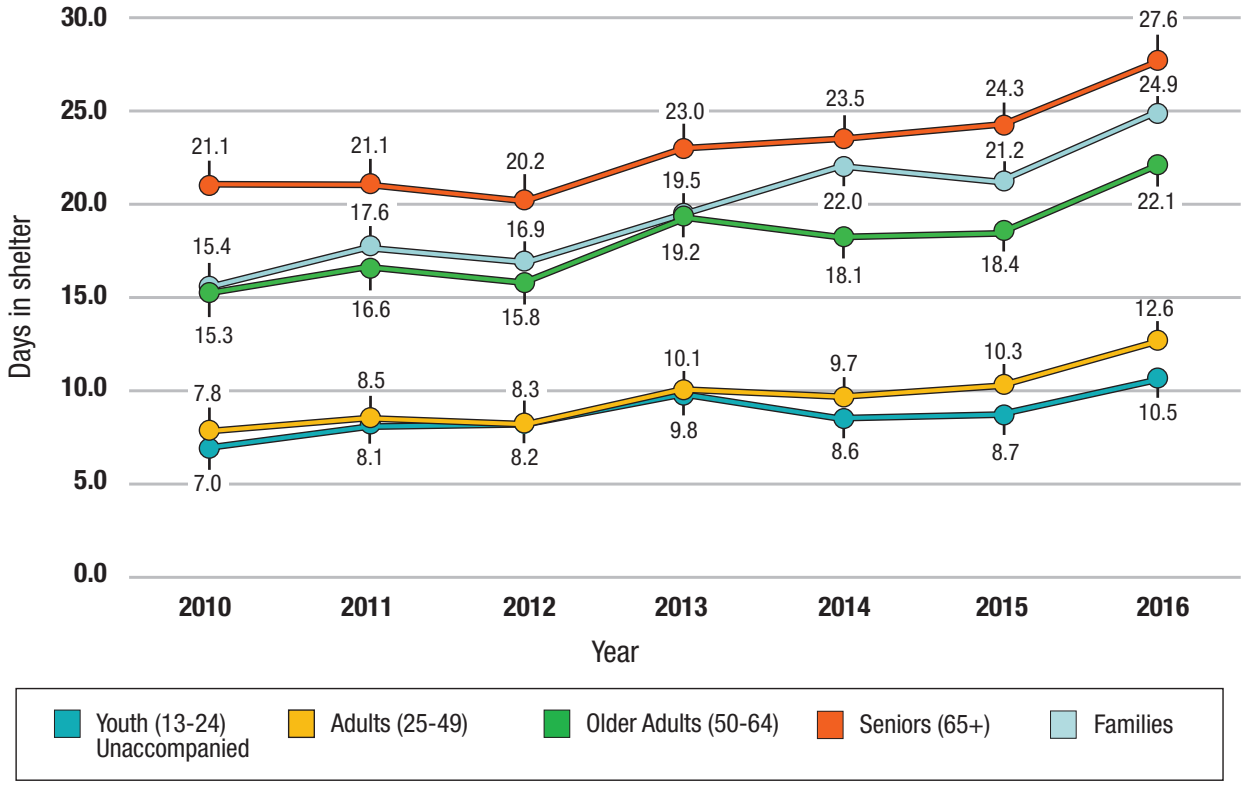
Source: Data collected through HIFIS and data sharing agreements

5. Shelter stay duration by age group and by families

The number of days spent in shelter has increased over time.

Since 2010, the duration of time spent in a shelter has increased for all age groups and for families. In a negative truncated binomial regression controlling for gender, age, family status, and multiple stays, the marginal estimate for a typical shelter stay by a family with a single stay was 24.9 days. This is nearly twice as long as the estimated length of stay by an individual (13.2 days). Older adults and seniors were also estimated to have significantly longer shelter stays compared to other age groups. Older adults with a single shelter stay had an estimated length of stay of 22.1 days while seniors had an estimated length of stay of 27.6 days in 2016.

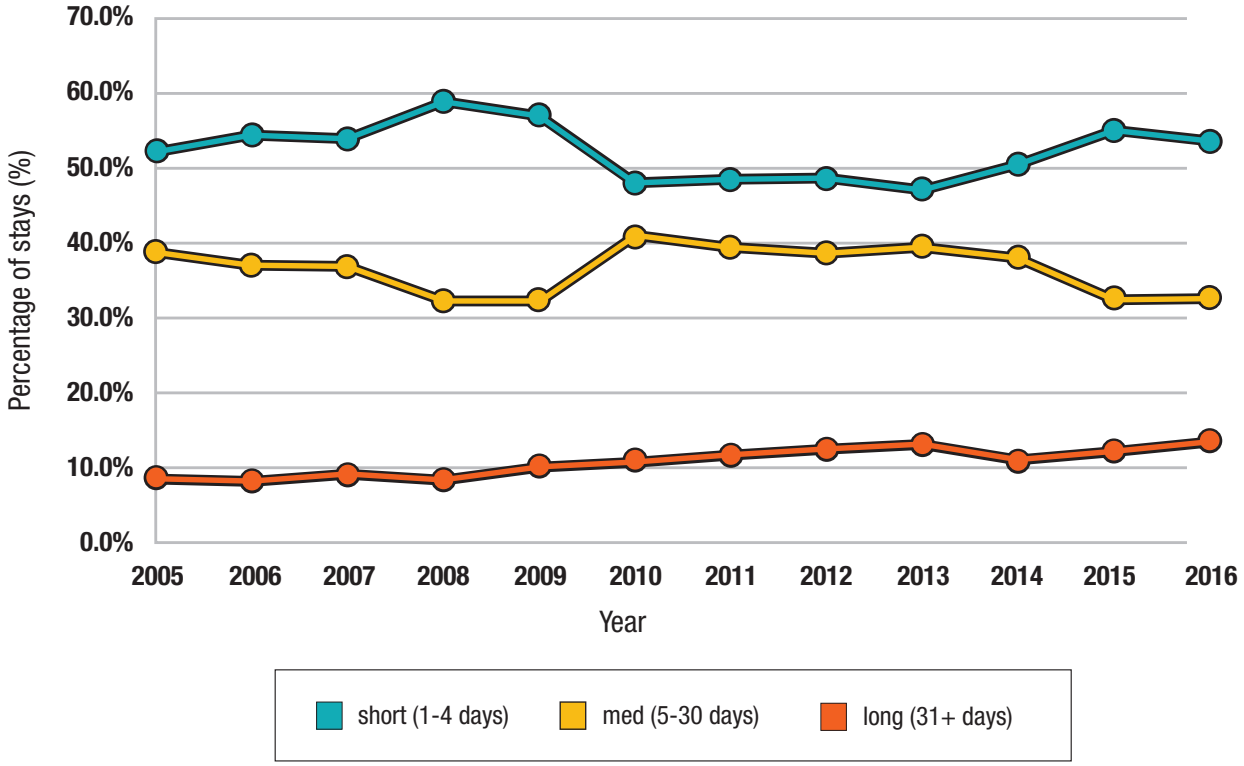
Figure 6: Typical Number of Days in Shelter (2010 to 2016)



Source: Data collected through HIFIS and data sharing agreements

The majority (about 50%-60%) of shelter stays in a given year are short (1-4 days), while another 30%-40% of shelter stays are of medium duration (5-30 days). In 2016, 53.6% of all shelter stays were between 1-4 days. Short and medium stays have an inverse relationship. Long stays (30+ days) have increased slowly and steadily over time, from about 9% in 2005 to about 14% of all stays in 2016. This increase in longer stays contributes to the increase in demand for bednights, displayed in Figure 1.

Figure 7: Percentage of Short, Medium and Long Stays by Year (2005 to 2016)



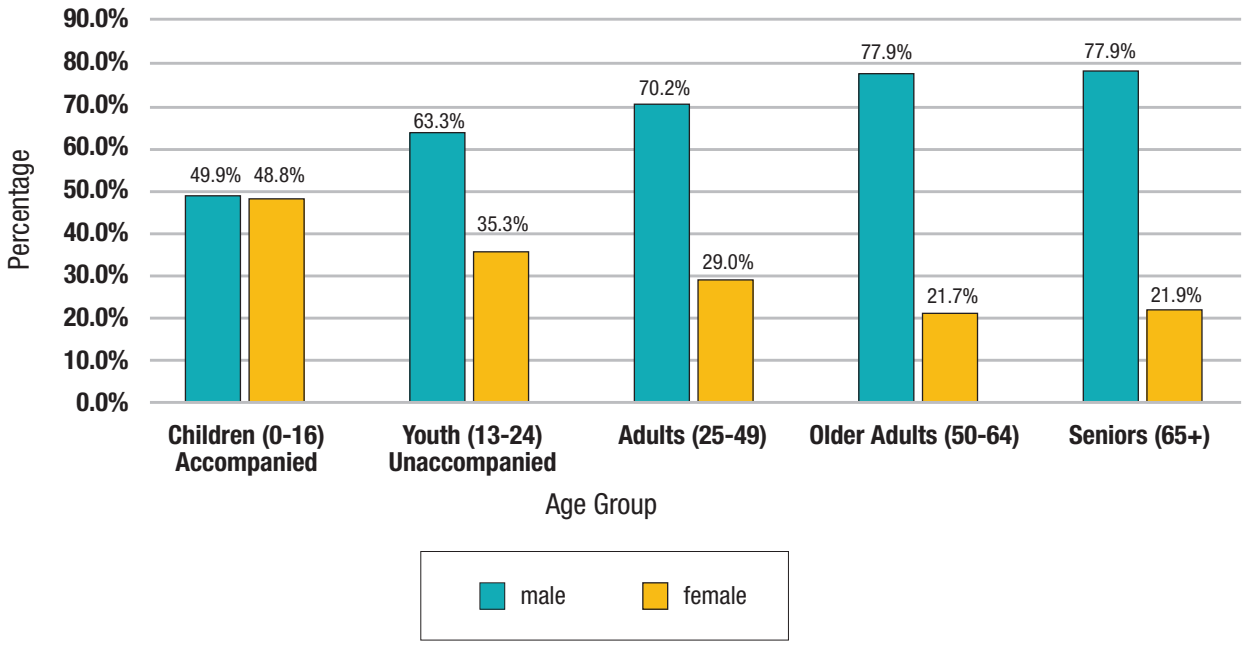
Source: Data collected through HIFIS and data sharing agreements

6. Shelter use by gender

The majority of emergency shelter users are male. This gender gap increases with age.

There has been little change in the proportion of male and female shelter users over the study period (2005 to 2016). In 2016, 69.5% of shelter users were male and 29.7% were female, while 0.8% of people in shelter reported a gender other than male or female. Female shelter users are, on average, younger than male shelter users. The average age for males is 40, compared to 37 for females. Although the proportion of male (49.9%) and female (48.8%) children using shelters is similar, male shelter use increases with age while the reverse is true for female shelter use. For seniors aged 65 and over, 77.8% of all shelter users are male. Note that Violence Against Women shelters are not included in this study, therefore it is likely that the full extent of women's shelter use is underrepresented in this report.

Figure 8: Shelter Use by Gender by Age Group (2016)



Source: Data collected through HIFIS and data sharing agreements

7. Shelter use by Indigenous Peoples

Indigenous Peoples remain overrepresented in Canada's emergency shelters.

While this study covers the 2005 to 2016 period, information on Indigenous identity was collected for the first time in 2014 to improve the understanding of homelessness in Canada. Indigenous Peoples remain overrepresented in Canada's emergency shelters. The number of Indigenous shelter users remained relatively stable between 2014 and 2016. It is estimated that between 34,400 and 45,300 {Estimate: 39,700}[4] Indigenous Peoples used an emergency shelter in 2016, compared to between 38,080 and 45,820 {Estimate 40,519} in 2014. The percentage of shelter users in Canada reporting Indigenous ancestry is approximately 31%, while they represented 5% of the Canadian population in 2016[5]. However, this varies widely by region, from less than 5% in some suburban communities to over 90% in many northern communities. In each of the communities where data are available, Indigenous Peoples are over-represented in homeless shelters compared to the overall population.

8. Shelter use by other priority groups

Veterans

The proportion of shelter users reporting military service decreased between 2014 and 2016.

In 2016, 1.8% of shelter users—an estimated 2,400 people—reported having served in the military. This is down from nearly 3,000 (2.2%) in 2014, the first year this information was collected. Shelter users reporting military service were more likely to be male (84.4%). Male shelter users reporting military service tended to be older (48 years old on average) than female veterans (38 years old on average). Nearly half (42.7%) of females reporting military service were under age 30 compared to 13.8% of males.

Immigrants, refugees and temporary residents

The number of refugees using emergency shelters increased between 2014 and 2016.

In 2016 over 7,600, or 5.9%, of shelter users reported that they were not Canadian citizens compared to 4.9% in 2014. This includes 5,067 permanent residents or immigrants, 1,991 refugees and 558 temporary residents (student, work or visitor visa). Compared to 2014, the first year that this data was collected, the number of permanent residents or immigrants using shelters remained stable (5,067 in 2016 vs. 5,036 in 2014) while the number of refugees increased by almost 900 (1,991 in 2016 vs. 1,096 in 2014). Non-citizens were more likely to access the shelter system as part of a family (35%) compared to non-citizens (12%). Data from refugee shelters are not included in this analysis.

[4] Estimate of proportion using survey weights: 39,700. Lower confidence interval: 34,400. Upper confidence interval: 45,300.

[5] Statistics Canada 2016 Census. Estimates that there are 1,673,785 Aboriginal people in Canada accounting for 4.9% of the total population

Conclusion

In 2016 the estimated number of shelter users was at its lowest in the past 12 years. The annual number of individuals using shelters has fallen from 156,000 in 2005 to 129,000 in 2016.

Despite a decrease in shelter users, occupancy rates have increased since 2005 and have consistently remained above 90% since 2012.

The trend of longer stay lengths continued for all types of shelter users, especially for those over 50 years old. As a result, although the number of shelter users has decreased in 2016, there are still more than 14,000 Canadians using an emergency shelter on an average night.

In 2016, 69.5% of shelter users were male and 29.7% were female. The gender distribution among shelter users has not changed significantly since 2005.

The average age of emergency shelter users was 39.5 years in 2016. Females tended to be slightly younger (37.0 years old) compared to male shelter users (40.5 years old).

Shelter use by families has remained relatively consistent since 2011 with occupancy rates hovering between 84% and 90%. However, there has been a marked increase in stay lengths for families, which continued into 2016. Families typically stay in a shelter almost twice as long as individuals.

Although data from refugee shelters are not included in this study, there was an observable increase in the number of refugees using shelters, from about 1,100 in 2014 to nearly 2,000 in 2016. By contrast, the number of permanent residents or immigrants using shelters remained consistent over this period. Among non-citizens, 35% accessed shelters as part of a family compared to just 12% of Canadian citizens.

Indigenous Peoples remain overrepresented among shelter users, with approximately 31% of shelter users reporting Indigenous ancestry.

A full National Shelter Study 2005 to 2016 is expected to be completed in fall 2019. Further analysis will include more in-depth profiles for population and age groups.

A7744

HIGHLIGHTS

OF THE NATIONAL SHELTER STUDY

2005-2016

The National Shelter Study 2005-2016 is an ongoing analysis of homelessness trends in Canada. In 2016, the estimated number of emergency shelter users was at its lowest in the past 12 years.

2016

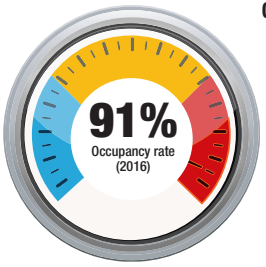
129,000

ANNUAL SHELTER USERS

2016

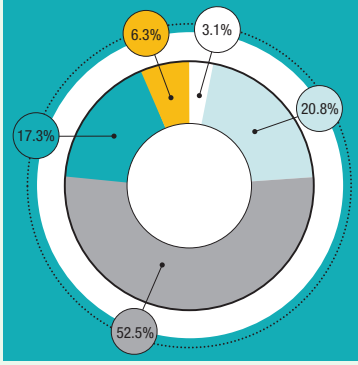
14,000

NUMBER OF CANADIANS USING SHELTERS ON A GIVEN NIGHT



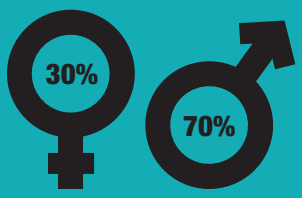
ONGOING DECREASE IN THE NUMBER OF INDIVIDUALS AND FAMILIES USING SHELTERS PER YEAR

Demographic Characteristics of Shelter Users



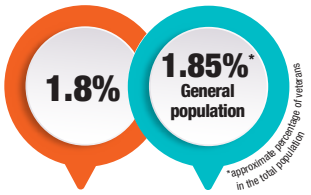
- Children (0-16 accompanied by an adult)
- Youth (13-24 unaccompanied)
- Adults (25–49)
- Older Adult (50-64)
- Seniors (65+)

2016



Average Age **39.5**

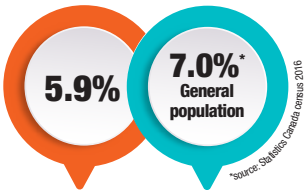
VETERANS



2016

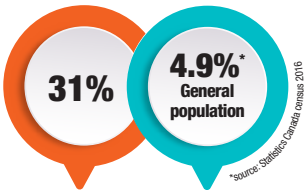
NON-CANADIAN CITIZENS*

*includes immigrants, refugees, visa holders who do not hold Canadian Citizenship



2016

INDIGENOUS



2016

% Shelter users % General Population in Canada

The National Shelter Study Highlights Report is available at:
https://www.canada.ca/en/employment-social-development/programs/homelessness/publications-bulletins.html

A3460

Employment and Social Development Canada
Emploi et Développement social Canada
Canada

Glossary of Terms

Adult: Person between the ages of 25 and 49.

Bednights: The number of times a shelter bed is used in a year.

Child: Any person under the age of 13 OR a person between the ages of 13 and 16 that is accompanied by a parent or guardian during their episode of homelessness.

Emergency Shelter: Facility that provides temporary, short-term accommodation for homeless individuals and families. This may or may not include other services such as food, clothing or counselling.

Homelessness: The living situation of an individual or family who does not have stable, permanent, appropriate housing, or the immediate prospect, means and ability of acquiring a home.

Family: People who report being in the company of one or more family members during their episode of homelessness.

Family Shelter: Facility that provides temporary, short-term accommodation specifically for families.

Immigrant: A landed immigrant/permanent resident is a person who has been granted the right to live in Canada permanently by immigration authorities. This is self-reported at time of shelter-entry.

Indigenous Homelessness: refers to Indigenous Peoples who are in the state of having no home due to colonization, trauma and/or whose social, cultural, economic, and political conditions place them in poverty. Having no home includes: those who alternate between shelter and unsheltered, living on the street, couch surfing, using emergency shelters, living in unaffordable, inadequate, substandard and unsafe accommodations or living without the security of tenure; anyone regardless of age, released from facilities (such as hospitals, mental health and addiction treatment centers, prisons, transition houses), fleeing unsafe homes as a result of abuse in all its definitions, and any youth transitioning from all forms of care.

Indigenous Peoples: A person who self-reports as being First Nations, Métis, Inuit, status or non-status person, regardless of residency or membership status.

Individual: Person who is not part of a family with children during an episode of homelessness. Individuals may be homeless as single adults, unaccompanied youth, or in multiple-adult or multiple-child households.

Older adult: Person between the ages of 50 and 64.

Seasonal/Temporary/Emergency Weather Response shelters: Facilities that open temporarily to provide additional seasonal, emergency shelter spaces during period of extreme weather (winter, storm, heat, etc.).

Senior: People aged 65 and older.

Shelter Users: Individuals and families who use the emergency shelter system in Canada.

Transitional Housing: Facilities that provide temporary shelter, but can be differentiated from emergency shelters by the longer length of stay and greater intensity of support services offered to clients. Transitional housing is an intermediate step between emergency shelter and permanent housing. Stays are typically between three months and three years.

Youth: Person between the ages of 13 and 16 who is unaccompanied by a parent or guardian during their episode of homelessness.[6] People between the ages of 17 and 24 are considered to be youth regardless of accompaniment status.

Veteran: A former member of the Canadian Armed Forces. This is self-reported at time of shelter-entry.

Canadian Citizen: Person who was born in Canada or became a citizen through Canada's naturalization process. This is self-reported at time of shelter-entry.

Refugee: Person who has been offered refugee protection in Canada who fear persecution and who are unwilling or unable to return to their home country. This is self-reported at time of shelter-entry.

Refugee Claimant: A person who has claimed refugee protection in Canada. This is self-reported at time of shelter-entry.

Refugee Shelter: Facility that provides temporary accommodations specifically to refugees, refugee claimants or immigrants.

Permanent Resident: Person who has been given permanent resident status by immigrating to Canada, but is not a Canadian citizen. This is self-reported at time of shelter-entry.

Visa Holder: Person who has been granted admission to Canada as a temporary resident (a visitor, student or worker).

Violence Against Women Shelter: Facility that provides temporary shelter to single women or women with children fleeing domestic abuse. They may function in either a crisis capacity or as transitional or second-stage housing.

Additional resources

Information on Reaching Home:
www.canada.ca/en/employment-social-development/programs/homelessness.html

The National Shelter Study 2005-2009:
publications.gc.ca/collections/collection_2014/rhdcc-hrsdc/HS64-20-2012-eng.pdf

The National Shelter Study 2005-2014:
publications.gc.ca/collections/collection_2017/edsc-esdc/Em12-17-2017-eng.pdf

National Coordinated Point-in-Time Counts:
www.canada.ca/en/employment-social-development/programs/homelessness/reports/highlights-2016-point-in-time-count.html

Shelter Capacity Report 2018:
www.canada.ca/en/employment-social-development/programs/homelessness/publications-bulletins/shelter-capacity-2018.html

National Service Provider List:
open.canada.ca/data/en/dataset/7e0189e3-8595-4e62-a4e9-4fed6f265e10

[6] People between 13 and 16 who are accompanied by a parent or guardian are considered to be children.

Toronto's shelters see triple the number of violent incidents, rise in overdoses during COVID-19 pandemic, data show

LIAM CASEY
TORONTO
THE CANADIAN PRESS
PUBLISHED JUNE 6, 2021

Michael Eschbach, who is currently unhoused, is temporarily staying at the Comfort Inn in Mississauga, Ont., as part of the city's response to the homelessness crisis during COVID-19.

CHRIS YOUNG/THE CANADIAN PRESS

New data show the number of violent incidents in Toronto shelters has more than tripled during the COVID-19 pandemic, a phenomenon those who use the system say is partly driving an increase of outdoor encampments.

City data reveal there were, on average, 120 violent incidents a month in the shelter system in 2016. That increased to an average of 270 incidents a month in 2020, and peaked at 368 incidents in January, 2021.

In total, there have been 11,677 violent incidents between March, 2016, and mid-February, 2021.

The data, which were obtained through freedom of information laws and provided to The Canadian Press, show the number of overdoses also increased.

The city maintains its shelter system is safe and wants the hundreds living in makeshift tents and encampments to move inside.

Michael Eschbach disagrees.

“The shelter system needs to be torn down from the bottom all the way to the top and needs to be reassessed,” he says.

“Everybody should be able to have their own little private space.”

The 60-year-old has lived in the shelter system for eight years. He has too many stories of violence to remember them all, but says he learned quickly to lay low and expect the unexpected.

“The slightest accidental jostle and fists are flying and tables are all over the place,” Mr. Eschbach says. “It’s just insane, but what’s really insane is the randomness – nothing leads you to see it go off and then all of a sudden there’s this explosion of fury and violence and blood.”

While in the shower one day, he says a naked man attacked him and tried to rape him. Mr. Eschbach delivered a quick punch and was able to slip away.

He says he’s seen friends knocked out and countless others robbed. He’s lived in fear during much of his time in shelters.

Brian Cleary’s shelter odyssey began in the “absolutely miserable” basement of an old church. He’s bounced around the systems since then and witnessed violence first-hand.

One night a few years back, the man in the cot next to his spilled juice all over Mr. Cleary’s shoes and sleep apnea machine. As Mr. Cleary was cleaning up the mess, the man jumped and choked him, prompting staff to kick them both out.

Gru, whose legal name is Jesse Allan, says he has not suffered physical violence at the various shelters he's lived in, but has witnessed "a ton of violence" there. It is why he prefers to live outside.

"I don't feel safe in the shelters," he says.

When he first arrived in Toronto six years ago after breaking up with his girlfriend, Gru said he couldn't afford first and last month's rent. He had a full-time job as a bike courier, bought a nice tent and lived in a ravine for a time.

But Toronto's brisk downtown bicycle courier business evaporated almost overnight when the pandemic hit last March.

Gru, terrified of contracting COVID-19 and keen to steer clear of people, opted to get out of town for the summer and spent months touring around Southwestern Ontario on his bike.

When he returned, he lived for several weeks in the Don Valley. That's when he heard about the encampments and the supports being offered by volunteers and outreach workers.

He ultimately moved into one at Trinity Bellwoods Park, where he stayed through the winter.

"It's a real community," he says of the encampment. "We care for each other."

Gord Tanner, the city's director of homelessness initiatives and prevention services, admits there's been a rise in violence in the shelters.

"In many ways I think that runs parallel to the fact that we're working with some people that have more complex needs now related to whether it's untreated health or mental-health issues or substance use," he says.

Mr. Tanner says the demographics of shelter users began shifting in 2020, with more singles and fewer families tapping into the system. He says he believes the shift may be related to the spike in violent incidents.

Mr. Tanner said the city has increased training for front-line staff, including de-escalation techniques.

Mr. Eschbach, Mr. Cleary and Gru all hope the shelter system can be changed.

All three men ended up in the city's hotel program for the homeless and say they feel safer in their own rooms that lock.

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But issues remain, according to Gru, who says security guards performed "wellness checks" three times a day at a downtown hotel the city leased for those who were previously living outside.

Gru says the checks involved guards using their keys to enter rooms at will, including late at night when occupants may be in bed.

"It's traumatizing when they just walk in, especially if I'm sleeping," he says.

"It's the same surveillance and harassment systems that we have out in the parks where police officers come through on a regular basis to keep an eye on us."

He says he persuaded management to stop the wellness checks after weeks of negotiations.

Mr. Eschbach is on a waiting list for housing and hopes to move into a new downtown building the city is refurbishing to provide supportive housing for 250 people.

He's been staying at the Comfort Hotel near the Pearson International Airport while he waits.

He doesn't see as much violence there, but it does still happen. During his first week, for instance, he says one resident "went nuts" and trashed the lobby, launching computers everywhere and terrifying the receptionist.

Mr. Eschbach feels the big downside to the hotel is the isolation.

"I'm in the middle of nowhere," he says, referring to the hotel's location in a sprawling suburb well west of central Toronto. "If I want to go pick up something from the pharmacy, I have to walk a mile and I'm disabled. It's the land of the car, and homeless people have all their supports downtown."

Mr. Eschbach has access to other amenities, including a television in his room, WiFi and a doctor and nurse on-site.

Mr. Cleary moved to the same hotel as Mr. Eschbach in June, 2020, and shared similar concerns. In March, Mr. Cleary won the lottery of sorts when the city helped him find a rare, rent-geared-to-income apartment.

A3466

“I finally have some peace,” he says. “I just wish my friends outside and in the shelters can get their own spot too.”

Our Morning Update and Evening Update newsletters are written by Globe editors, giving you a concise summary of the day’s most important headlines. Sign up today.

Pandemic Planning in Homeless Shelters: A pilot study of a COVID-19 testing and support program to mitigate the risk of COVID-19 outbreaks in congregate settings

Timothy O'Shea MD, MPH (Corresponding Author)

Department of Medicine, McMaster University

Hamilton Shelter Health Network

Juravinski Hospital & Cancer Centre

A3-66, 711 Concession Street

Hamilton, ON, Canada L8V 1C3

Phone: (905) 389-4411 Ext. 42471

osheat@mcmaster.ca

Claire Bodkin BA, MD

Department of Family Medicine, McMaster University

Hamilton, Canada

Vaibhav Mokashi BSc, MD

Department of Medicine, McMaster University

Hamilton, Canada

Kerry Beal RT, ART, BSc, MD;

Adjunct Clinical Professor, Faculty of Health Sciences, McMaster University

Hamilton, Canada

Jill Wiwcharuk MD

Department of Family Medicine, McMaster University

Hamilton Shelter Health Network

Hamilton, Canada

Robin Lennox MD

Department of Family Medicine, McMaster University

Hamilton Shelter Health Network

Hamilton, Canada

Dale Guenter MD, MPH

Department of Family Medicine, McMaster University

Hamilton Shelter Health Network

Hamilton, Canada

Marek Smieja MD, PhD

Department of Medicine, Pathology and Molecular Medicine, McMaster University

Hamilton, Canada

Abstract:We tested 104 residents and 141 staff for COVID-19 who failed daily symptom screening in homeless shelters in Hamilton, Canada. We detected one resident (1%), seven staff (5%) and one case of secondary spread. Shelter restructuring to allow physical distancing, testing and isolation can decrease outbreaks in shelters.

Keywords: coronavirus, homeless, shelter, surveillance, outbreak

Introduction:

SARS-CoV-2, the novel coronavirus responsible for causing COVID-19, has particularly affected those in congregate settings such as nursing homes, prisons and homeless shelters (1,2). In Canada, there have been several outbreaks documented in homeless shelters (3,4).

Preventing and minimizing outbreaks in shelter settings using limited resources protects residents and staff within shelters as well as those they may interact with in the broader community. Furthermore, the higher prevalence of comorbidities amongst shelter residents places them at higher risk of severe COVID-19 disease (5). Preventing transmission in this population may have a greater impact on reducing hospital admissions and burden on critical care resources.

The objective of this report is to describe our experience with shelter facility restructuring, daily symptom screening and rapid testing to mitigate the risk of COVID-19 in the homeless shelter setting in Hamilton, Ontario, Canada.

Methods:

The homeless shelter system in the city of Hamilton is operated as a partnership between the municipality and social service agencies. Healthcare within the shelters is provided by the Hamilton Shelter Health Network, a group of physicians (Family Medicine, Internal Medicine and Psychiatry), nurse practitioners, nurses and midwives who are funded through an alternate funding plan by the Provincial Government of Ontario.

At the start of the pandemic, there were approximately 341 shelter beds across eight shelters in Hamilton. Collaboration between the local public health unit, municipal government, shelter operators and the Shelter Health Network began in March of 2020. The collaboration allowed an increase from 341 to 395 shelter beds spread across the pre-existing shelters, three additional hotel sites and one additional temporary men's shelter. This enabled increased physical spacing between shelter beds and lower density within each shelter. Furthermore, a temporary isolation center (from a repurposed recreation center) was created for COVID-19 positive homeless individuals.

Through a partnership with the Hamilton Regional Laboratory Medicine Program (HRLMP) we were able to access COVID-19 testing with rapid turnaround time. This allowed us to use existing spaces within shelters for short-term isolation while awaiting COVID-19 testing results and to immediately arrange two-week isolation for those who tested positive.

Between March 17 and April 30, 2020, COVID-19 testing was performed on all shelter residents and staff who failed daily screening for potential COVID-19 related symptoms as well as staff and residents identified as close contacts of positive cases. Symptom screening was conducted according to direction given by the local public health unit, and was updated as new information regarding potential symptoms of COVID-19 were uncovered (e.g. anosmia). Nasopharyngeal swabs (NPS) were performed by trained nurses, paramedics and physicians. Between March 19 and April 16, testing was done using a laboratory-developed BD Max Multiplex Real-Time Polymerase Chain Reaction (RT-PCR) for COVID-19 (using 5'-Untranslated region, or 5'-UTR), Influenza A, Influenza B, Respiratory Syncytial Virus (RSV), Metapneumovirus, Parainfluenza 1, Adenovirus and Rhinovirus/Enterovirus. After April 17,

testing exclusively for COVID-19 was undertaken in order to streamline result times and tests were considered positive if RT-PCR was positive for COVID-19 5'-UTR or Envelope genes.

Residents awaiting results were isolated within their shelter in single room areas. Residents who tested positive for COVID-19 and did not require hospitalization were transferred to our prepared isolation center for further monitoring. Transportation was organized by the City of Hamilton and involved the use of a dedicated transportation vehicle with enhanced infection control measures including a barrier between patient and driver and surgical mask, face shield, gloves and gown for the driver. Isolation continued for a total duration of fourteen days, with the ultimate decision to end isolation made in conjunction with our local public health unit. Nurses performing tests and shelter staff caring for isolated residents wore a disposable gown, surgical mask, face shield and disposable gloves. Staff who tested positive were excluded from work and provided with information related to self-isolation and symptom monitoring. All positive results were reported to the local public health unit for appropriate case management and contact tracing.

For context, the provincial government declared a state of emergency on March 17, limiting public gatherings to 50 people or less, and subsequently closed non-essential businesses on March 23. Gatherings were further limited to five people on March 28. No specific limitations were imposed upon shelter residents during the study period although movement between shelters was discouraged. Universal masking within common areas in the shelter system was initiated on April 18.

Results:

Between March 19 and April 30, a total of 245 NPS were obtained from 141 staff and 104 residents (Figures 1a and 1b). Of the 88 total tests (59 residents and 29 staff) completed on the multiplex PCR platform prior to April 17, 12 (13.6%) were positive for a viral pathogen. Ten of 59 residents (16.9%) were diagnosed with rhinovirus/enterovirus infection and two of 29 staff (6.8%) were diagnosed with COVID-19 infection. A total of 157 (44 residents and 113 staff) tests performed after April 17 were tested exclusively for COVID-19; of these 1 resident (2.3%) and 5 staff (4.4%) tested positive. Overall during our study period, 1 of 104 residents (1.0%) and 7 of 141 staff (5.0%) were diagnosed with COVID-19 infection, and a total of 17 tests (6.9%) identified a viral pathogen. All positive cases were detected only through the daily symptomatic screening protocol or contact tracing.

Follow up contact tracing and testing revealed no secondary spread linked to the one positive shelter resident. Of the seven staff diagnosed with COVID-19, four were part of a cluster that was cohabiting at the same location distant from the shelter and were presumed to be community acquired. The remaining three staff worked at two separate shelter sites. During the time period of our study, one additional shelter resident was diagnosed with COVID-19 after presentation to a local emergency room (outside of our surveillance protocol).

For comparison, during the study time period, the City of Hamilton reported 422 patients with COVID-19 and a positivity rate of approximately 5-7%. Approximately 10% of the cases

were in congregate settings (mainly long term care homes). In the province of Ontario, there were 15973 reported COVID-19 infections and 1080 deaths during our study period.

Test turnaround time throughout our study period averaged 14 hours from time of specimen arrival in the lab to time of reported results and 89 per cent of results were reported within 24 hours.

Discussion:

We have thus far been successful in preventing large outbreaks in the shelter setting despite identifying positive cases in both staff and residents. Our results emphasize the importance of taking a proactive, aggressive approach to outbreak mitigation in high risk settings. While there has certainly been some random chance, we postulate that four factors have been particularly important in increasing our chances of success:

1. Increased capacity of shelter space by opening surge shelters and hotel rooms, allowing for more effective physical distancing in congregate shelters;
2. Access to rapid assessment and testing on site when symptomatic residents or staff are identified through active screening;
3. Restructuring of physical spaces to accommodate isolation of residents with confirmed COVID-19 and those awaiting test results; and
4. Rapid turnaround of test results through collaboration with our regional laboratory program allowing triage of individuals into isolation spaces without exceeding available capacity.

There are several limitations which should be taken into account in interpreting our data. Our testing program provided evaluation of those staff and residents who were identified as symptomatic through active screening within the shelters. We are aware of instances where shelter residents and staff have presented to other settings where testing has been performed, and is not captured in our data. Secondly the test characteristics of a NPS can be influenced by testing technique, and as such the sensitivity of our test in the real world setting of a mobile testing unit has not been clearly established. However, the lack of large scale outbreaks in area shelters suggests that we have not had a large number of false negative tests thus far.

Efforts to mitigate the risk of outbreaks of COVID-19 in high risk congregate settings such as long term care facilities, homeless shelters, and prisons are essential in moving towards the broader goal of managing COVID-19 risk in the general community. Our group has recently initiated a cluster randomized control trial to examine the effectiveness and acceptability of various surveillance testing strategies of asymptomatic individuals within our shelter system in an ongoing effort to enhance our ability to rapidly detect and isolate COVID-19 infected individuals. However, such efforts should be conceptualized as secondary prevention. There is also a pressing need to consider primary prevention - that is, upstream actions to end homelessness.

Our study demonstrates that accessible shelter housing that allows for rapid testing, isolation and physical distance is imperative to outbreak prevention in the shelter setting. The strategy presented here should be considered as part of the COVID-19 pandemic response alongside other homelessness prevention and reduction interventions.

Acknowledgements:

We thank the Hamilton Regional Laborary Medicine Program (HRLMP), Hamilton Public Health, City of Hamilton and staff working within the Hamilton Shelter Health Network.

None of the authors has any potential conflicts of interest to disclose.

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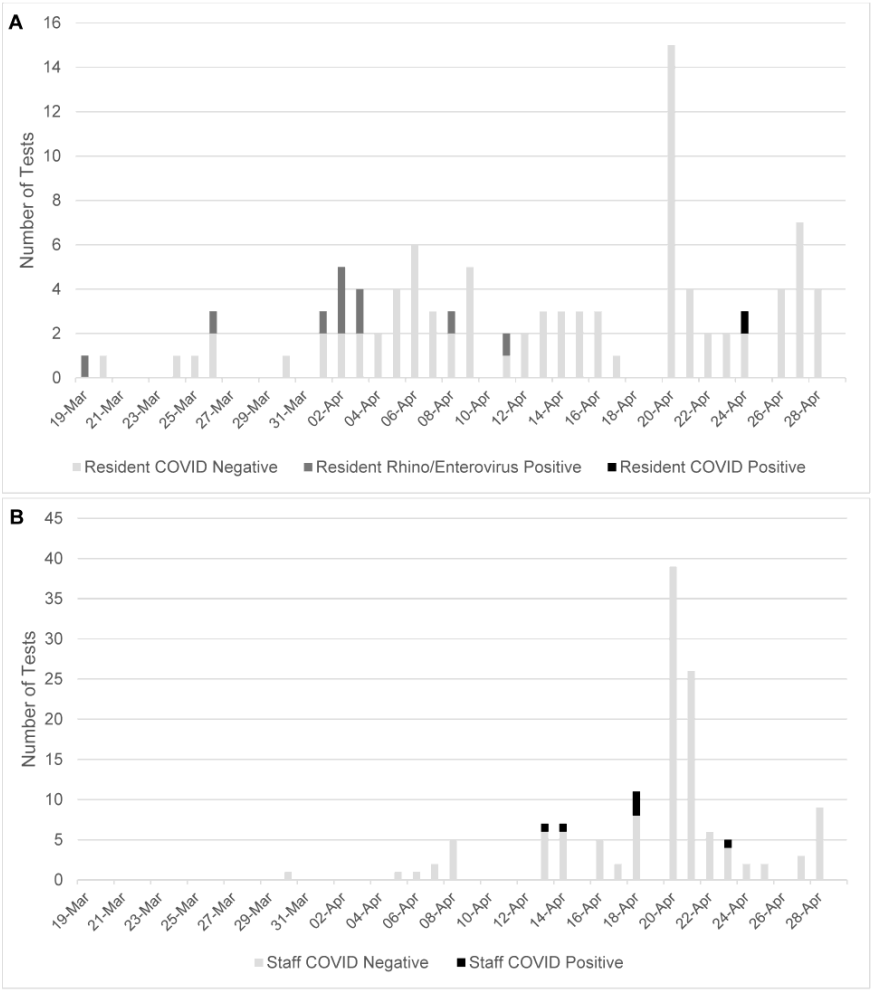
Figure 1 legend

Number of daily tests and test results in residents (A) and staff (B).

Figure 1



Number of daily tests and test results in residents (A) and staff (B).

https://www.thestar.com/news/gta/we-re-the-vulnerable-ones-why-women-living-in-toronto-s-public-parks-during-covid/article_afd83d15-db21-546b-9ae0-74d7484c0ec4.html

GTA

‘We’re the vulnerable ones’: Why women living in Toronto’s public parks during COVID-19 choose outdoor tents over indoor shelters

Several women in encampments say they intend to stay outside – preparing to hunker down as the winter takes hold.

Dec. 7, 2020

Kassandra Grainger, 36, vows to stay put in the Moss Park encampment until she’s offered a permanent home.

Jeff Bierk photo

By **Victoria Gibson Local Journalism Initiative Reporter**

For a fleeting moment this summer, Kassandra Grainger lived indoors.

She packed her things from Toronto's Moss Park, and followed a path encouraged by city officials — accepting a space in a nearby hotel it was using as a shelter.

Grainger said she'd been homeless since leaving an unhealthy relationship. Before coming to the park, she'd worried about sleeping places with enough visibility to be safe, noting that being in public places is an important consideration for homeless women living outside.

"Anywhere where there's a gathering, somewhere where other people can see me. That way, if something's being done wrong to me, then hopefully somebody would've been able to help," she said. "We have to, because we're the vulnerable ones. We're taken advantage of more than a man."

Throughout the COVID-19 pandemic, encampments like the one in Moss Park have sprung up increasingly across Toronto, with the city most recently counting 395 tents in 66 parks.

And roughly 31 per cent of encampment residents who have interacted with the city's Streets to Homes team have been women, who face particular fears and difficulties when living outside. But several also challenge the city's assertion that indoor shelters are safer, their stories showing it isn't just fear of catching COVID-19 that's keeping people in in public parks.

Angelique Beaupre said a key hurdle to her going inside is finding somewhere she and her boyfriend can go together.

Supplied by Greg Cook

Multiple women told the Star they intend to stay outside until they're offered adequate housing — preparing to hunker down as the weather cools, and Toronto's parks are blanketed in snow.

While the city says 1,100 people have been moved during the pandemic from encampments — which are illegal — to indoor spaces, Grainger's time in the hotel was short-lived.

Within days of leaving Moss Park, she was back, and now vows to stay put until she's offered a permanent home.

The 36-year-old, who said she struggles with mental disabilities and obsessive-compulsive disorder, found it impossible to adjust to the sudden rules of the formal shelter setup — most of all, the visitor restrictions in the hotel.

She also feared having to cage her brown mastiff, Tasha, in order to enter the city's regular shelter system. She keeps the dog by her side for extra security. "She is my safety," Grainger said.

Being a woman outside meant being particularly vulnerable, she told the Star, and carefully considering where she slept in order to avoid being "taken advantage of."

When she first moved to Moss Park, she'd been living in a tent — though she said it was prone to collapsing. Grainger and others also noted their tents were regularly stolen.

More recently, she and Tasha have stayed in a tiny wooden shelter made by a Toronto carpenter, designed to keep as much warmth in as possible. The city has warned the shelter-maker to stop distributing them, saying they break the municipal code.

On a recent afternoon, the structure was slung with a large blue tarp, coated with a fresh layer of snow. Beyond the warmth, Grainger said being able to lock the door while she's sleeping has made a difference: "It makes me feel a heck of a lot safer."

To Julie Watson, a 55-year-old who found herself homeless after struggling with a gambling problem, life in an encampment feels like a safer option than the shelter system.

She described an incident that took place near the last shelter where she stayed, alleging that a man had tried to sexually assault her.

"If it happened to other women, they might turn around and say, 'I'll just go to another shelter,'" she said. "But I refuse to go."

Now in Alexandra Park, Watson stays with a man named Domenico, who she described as her protector and brother figure.

"He will never let anything harm me," she said. She was frightened of being alone; Domenico, she said, never let that situation arise.

Angelique Beaupre hasn't been as lucky. The 28-year-old said she was sexually assaulted while staying in a downtown encampment this summer, by someone who wasn't living there. Staff at nearby Sanctuary Ministries confirmed the incident,

and that police were involved.
“It kind of messes with a person’s brain,” Beaupre said.

“(But) the first mistake he made was doing what he did to me … I don’t like bullies.”

She doesn’t shy away from discussing her other struggles — challenges with her mental health, and drug use that started after she used painkillers for scoliosis long ago.

Living outside, she’s gotten used to feeling ill constantly: she had a cold when she first spoke to the Star.

But Beaupre said a major hurdle to going inside is finding a place where she and her boyfriend can go together.

The city declined to provide information on Beaupre’s case — or any others in this story — but said couples are generally eligible for hotel spots, respites and some shelters.

Several women who spoke to the Star discussed their concerns around safety, but Priyanka Sheth — executive director of Sistering, a Toronto agency that works with homeless and precariously housed women — pointed out their definitions may be drastically different.

When the city was trying to encourage women to come inside, Sheth urged staff to consider what a safety concern meant for each person. Were they scared for their physical security, or was it their emotional safety that kept them outside?

She questioned whether the city’s stance that indoor shelter is always the safer option is the most effective approach.

“In the same way we look at war — anything else — women are at greater risk,” she said, about the dangers of sexual violence for women in the encampments.

But for some, she said, the encampment gives them something intangible that they couldn’t find elsewhere.

“The encampments at least allow for a sense of belonging. When nobody wants you, any sense of belonging is significant … it’s about how you form community,” she said. “When the streets become your home, and you’re shunned from so many places, then you survive with each other.”

In Sheth’s ideal world, the city would allow people to camp in a specific area, and provide supports there to create a sort of stepping-stone for them to accept more help.

Women with bad experiences in shelters may not trust someone simply telling them it was safe, she said, and the transition isn’t always easy.

Dr. Andrew Boozary, executive director of population health and social medicine at Toronto's University Health Network, urged officials to avoid taking a "paternalistic" view of the camps.

A7770

"We can't keep prescribing things for people that we think are best for them. When people are saying what they feel is unsafe, we have to listen," Boozary said.

Kassandra Grainger keeps her dog Tasha by her side for security. "She is my safety," said Grainger.

Jeff Bierk

"I really do support what the encampment movement has been. It's been people who are marginalized, who felt shut out of the system, who've not felt safe. They've made the active decision to take care of each other, and support each other, through the pandemic."

While some members of the public may not like the look of "tent cities," tearing them down didn't address the root issue. "We have to build up housing, and trust," Boozary said.

Sylvia Braithwaite, director of 24-hour services at Toronto's Fred Victor, said she believes the city is coming from a "caring perspective" in trying to move people from encampments.

There is a "huge risk" to being outside through the winter, but she's seen women scared of the shelter system, feeling it to be unsafe. Temporary shelters in hotels are a good solution for those needing private space, she said.

A3486

But if some chose to stay outside, particularly during COVID-19, Braithwaite suggested the city make sure they're out of harm's way.

"Hopefully, there is flexibility in the system to provide a coordinated approach, to support them while this pandemic is happening," said Braithwaite.

Beyond the Streets to Homes team, she suggested the city could create a sort of community outreach team — potentially including nurses, mental health and addiction supports, and housing workers — to ensure people living outside had what they needed.

The city has said it made a decision based on scarce resources to make "safer" indoor spaces available, instead of building infrastructure to support people who live in the parks.

Shelter system director Gord Tanner said Braithwaite and Sheth raise valid questions, but he still believes the city needs to "do better than settling for people living in parks" — though he acknowledged it may need to be "an interim strategy of sorts."

Tanner said the city hadn't recently been enforcing the bylaw prohibiting tents in parks because it could lead to residents scattering to other parks or even ravines.

"If people aren't going to accept the offers that we have to come indoors and we move forward with enforcement, or we don't have the adequate space to come indoors, then where are they going to go?" Tanner said.

The city's focus for now is to provide people with options, he added.

Some women in encampments have taken up the city's offer. Sarah White, 31, lived in a tent in Toronto with her partner from March until they moved into a shelter hotel mid-summer.

The hotel offered her personal space, and eliminated the worries of sleeping in an open room, like having her possessions stolen. She's also grateful to be out of the cold.

Still, White said, "in a lot of ways, I miss my tent," noting that she had more privacy without staff regularly knocking at her door.

She's hoping that staying puts her on a "fast track" to permanent housing.

Since Grainger left her hotel spot, that's been her hope, too. "I'm not leaving until I have somewhere I can call home, my own home," she said.

But her resolve has been weakening. Without volunteers supporting the camp, she suspects she'd have already relented.

"We would not make it," she said. "The government would have won a long time ago."

Victoria Gibson *is a Toronto-based reporter for the Star covering affordable housing. Reach her via email:* ***victoriagibson@thestar.ca****.*

Court File No. CV-21-00077817-0000

ONTARIO

SUPERIOR COURT OF JUSTICE

BETWEEN:

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

Applicants

-and-

CITY OF HAMILTON

Respondent

AFFIDAVIT OF ANDREA SEREA

SWORN MAY 12, 2023

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1. I, Doctor Andrea Sereda, of the City of Aylmer, Ontario in the Province of Ontario, MAKE OATH (AFFIRM) AND STATE:
2. I have personal knowledge with respect to the facts set out below, except where stated otherwise. Where the information is not based on my personal knowledge, it is based upon information provided by others which I believe to be credible and true.

Credentials and Nature of Work

3. A copy of my *Curriculum Vitae* is attached hereto as **Exhibit 'A'.**

4. I am a physician practicing at London Intercommunity Health Centre (the "Health Centre") in London, ON. The Health Centre serves patients with barriers to healthcare in the traditional healthcare system, providing a broad spectrum of interdisciplinary supports. My practice within the Health Centre focuses on people deprived of housing (homelessness), people who inject drugs (PWID) and women working in the survival sex trade. Most of my patients are unhoused or precariously housed, living in encampments, solo rough sleeping, staying in shelters, couch surfing or any combination thereof. Living unhoused means that patients are in a state of forced transience throughout the city, and focus their days on survival living (obtaining food, hygiene, income, a place to sleep that day, prescribed or unregulated medication, staying safe). Because of the enormous daily time investment required to just survive living on the street, acute and chronic health conditions often are not prioritized by patients due to more pressing needs on Maslow's Hierarchy. A copy of the Hierarchy is attached hereto as **Exhibit 'B'**.

5. My team at LIHC focuses on dismantling structural barriers to care for people who are unhoused by "meeting people where they are at". This phrase refers to a harm reduction practice that prioritizes creatively meeting a person's needs in their individual context, instead of expectations they fit into traditional models of care. "Meeting people where they are at" can mean providing culturally appropriate care, understanding a person's social and emotional context, consideration of personal history and tailoring assessment and treatment plans to their individual framework. Or, with people living rough and in encampments, "meeting people where they are at" can be interpreted literally by medical teams, into

actions such as bringing medical services directly to people living in encampments and other unstable housing sites. This approach is essential to providing successful medical care to people who are living in encampments.

6. I personally provide primary care for my patients through a blended model of traditional office-based medicine, as well as mobile outreach and street-level care (street medicine).

Expertise in providing health care to unhoused people

7. I have been a physician for 15 years, graduating from the Schulich School of Medicine in 2007. I completed a residency in Family Medicine in 2009, and a fellowship in Emergency Medicine in 2010. Both residency training programs were completed at the Schulich School of Medicine.
8. I have been providing health care to unhoused and precariously housed people for 12 years.
9. I have been working with LIHC since 2012.
10. I am the lead physician in Health Outreach, and I provide direct care, medical consultation or care coordination to all patients care for by my team.
11. The Health Outreach team cares for 1800 rostered patients, all of whom have been unhoused at some point in their life. Precise numbers are hard to determine because people's housing status can shift abruptly and frequently. People often do not declare all changes in their housing status, and thus this cannot be accurately tracked in charts. However, based on my experience I estimate that 800 rostered Health Outreach patients are unstably housed and 200 rostered patients sleep rough at any given time. This estimate is based on personal knowledge and consultation with the Health Outreach team.
12. The HOME bus and street outreach teams care for an additional 1100 unrostered people. All people seen via HOME and street outreach are unhoused. These 1100 people shift

between shelters, sleeping solo rough or in encampments. While precise numbers are unknown for the same reasons as above, our team estimates that 700 of these 1100 people regularly sleep rough, with a known 300-350 sleeping rough in the City of London on any given day.

Service delivery model to unhoused persons

13. The Health Centre provides support for people experiencing homelessness or who are heavily street-involved in London, Ontario. The Health Centre provides several creative approaches to patient care, tailored to where patients are located and their structural barriers. All patients are offered a broad array of wrap-around health and social care by an interdisciplinary team consisting of primary care physicians, nurse practitioners, nurses, systems navigators, social workers, outreach workers and care facilitators, addressing clients' health and social needs through a social determinants of health and harm reduction approach. The model also includes:

    i) <u>Office based care</u>

    This is a mixture of booked and drop-in appointments, providing MD/NP led primary medical care, specialty care (HIV, HCV treatment), walk-in acute services such as wound care, nursing care, basic needs support such as ID and food security. The "bricks and mortar" care serves people who live in close proximity to the clinic, either housed or sleeping rough in the Dundas corridor. Office based care at the Health Centre differs from a traditional health clinic in several ways. A robust team of clinicians and allied health professionals such as Social Workers, Care Facilitators, Systems Navigators, and Outreach Workers provide intensive support and wrap-around services. These services can all be initiated same-day, and they

can be provided concurrent to each other. Same day and concurrent support mean that the Health Centre team meets people where they are at in time and space and significantly improves linkages and retention in care.

ii) HOME (Health Outreach Mobile Engagement) "The Bus"

All of the services provided in the Health Outreach bricks and mortar clinic are also provided on a retrofitted city bus that acts as a mobile clinic. HOME visits encampment and shelter sites, and flexibly adapts to the ever-changing locations of encampments and other places unhoused people gather. HOME meets people where they are physically at. This is essential to serving encampment residents who are unwilling to leave their tents or sites due to fear of bylaw clearing their possessions or who are physically unable to leave due to the severity of their medical needs. This can include ambulatory limitations, lack of accessible transportation, and lack of access to assistive devices or mental health. HOME also meets people where they are in time; encampment residents have survival priorities that often preclude having time to come to clinic. HOME serves people who have traumatic experiences to healthcare infrastructure such as hospitals, clinics and jails. For people who have experienced structural trauma, visiting a healthcare site with a door, or a lock, or security can completely emotionally preclude them from care. HOME seeks to remove this barrier by removing structural triggers for trauma.

iii) Community Paramedicine "home visits"

The HOME team includes a team of paramedics who provide home visits to people who are unhoused. This team can bring intensive treatment, like intravenous antibiotics or wound care, directly to people who are living precariously housed or

living rough in encampments. The team often is treating people in encampments who cannot participate in emergency room, or hospital-based care due to trauma and structural barriers. Video conferencing can also be facilitated with one's primary care provider while the medical team is present.

iv) Street Outreach Medicine

Health Outreach clinicians and Allied Health staff also seek out people utilizing a "boots on the ground and backpack" approach with capacity to support intensive wound care, primary care and social care. This is critical for people sleeping rough who are living either in newly established encampment sites that need to be located or are hard to get to, or people who have been evicted from encampments and are living in locations hidden from bylaw or other services that seek to move them along.

Practical difficulties with delivering health care to the unhoused

14. There are many difficulties providing healthcare to the unhoused. I have categorized these difficulties below.

i) Building and Rebuilding Trust

This can be thought of as both a challenge and an opportunity. People who live in encampments are marginalized not just from healthcare but from the rest of community. People are deprived of housing in the context of significant accumulated lifetime trauma; they have often been traumatized and neglected across multiple systems such as child protective services, the school system, healthcare, "addiction care", the "justice" system and the housing sector. Their housing deprivation is a final common pathway of societal failures to a group of

citizens. Thus, people living in encampments have a healthy and legitimately carried distrust of people representing the system, including healthcare professionals. Trust needs to rebuilt; both trust that healthcare professionals will help, but also that they will not actively harm by further victimizing people with health care services.

ii) Locating

Physically locating a patient who is unhoused can become the better part of a day's work. People who are unhoused often have no choice but to move their camping site based on weather, bylaw enforcement, safety concerns or any other number of reasons. Healthcare teams spend an inordinate amount of time and resources looking for patients who do not have a stable living site. This can result in a delay in diagnosis and treatment of acute conditions (pneumonia, wound care), chronic conditions (diabetes, heart disease), chronic conditions with life-altering disease courses (HIV), mental health conditions (schizophrenia) and normal life transitions that require medical support (pregnancy).

iii) Maslow's Hierarchy of Needs dictates patient priorities

People who are unhoused are not only deprived of housing. They are also almost always deprived of the needs at the base of Maslow's triangle. These are physiologic needs, and include not just housing but also food, water, sleep and clothing (which is also a type of shelter). When these needs have not been met, healthcare teams often need to tend to these first, before a person can engage meaningfully in their own healthcare.

iv) Absence of Maslow's Meeds – sleep deprivation, nutrition, hygiene, safety

The *absence* of Maslow's needs on the ability to provide healthcare to unhoused persons are related to, but distinct from, the need for patients to prioritize these needs. For example, people who do not eat for days at a time will have nutritional deficits that complicate disease presentation, diagnosis and treatment. People who have nowhere safe to sleep commonly have profound sleep deprivation, which can impact physical and mental health, but also contribute to greater risk of death through mechanisms like overdose.

v) Linkage to hospital-based care and diagnostics – trauma

Most people who are unhoused have had terrible and traumatizing experiences in the hospital system. They usually face stigma, untreated withdrawal from unregulated drugs, care provided in an invasive and paternalistic manner (searches, security guards.) Traditional hospital settings for those who are unhoused are typically judgemental, stigmatizing and provide negligent and/or inequitable care. These experiences make it very difficult to refer patients to specialty care, hospital-based imaging or diagnostics or to have patients consider a hospital admission when needed.

vi) Linkage to hospital-based care and diagnostics – loss of possessions

People who are unhoused have a tenuous and survival relationship to their possessions. Survival items like tents, cooking and warmth tools, clothing, and tents can take significant effort to obtain. When people living unhoused have to leave their tents, or their encampments are cleared, they are at high risk of losing all of their incredibly hard-won possessions. This affects people practically; they may

have no shelter to return to if they leave for an x-ray or a hospital visit. It is also important to recognize that for people who have so little, belongings can also be part of one's identity. People can lose a bit of their identity and self-worth as they repeatedly have fewer and fewer possessions. The community and city bylaw often see these meagre possessions as entirely disposable and having no meaning. This becomes a proxy for how people view themselves, and how they feel they are viewed by the rest of the community. When people lose their possessions, they also lose the function those possessions had in their life (shelter warmth, cooking). This directly negatively impacts their health, and creates another layer that healthcare teams caring for unhoused people need to attend to. The loss of phones is particularly profound as it also results in loss of contacts – to support workers, peers, family and resources. Similarly, when people lose their identification, they face additional barriers such as being able to access healthcare and apply for housing. People start all over again.

vii) Acute vs. Chronic medical concerns - Having to choose

People who are unhoused face sometimes overwhelming layers of unmet healthcare needs. These needs can be acute (wound care, burns, pneumonia) or chronic (diabetes, schizophrenia). Due to the health consequences of living unhoused, and the persistent onslaught of environmental factors (heat, cold, rain, snow) causing injuries and acute illness, it is difficult for healthcare providers to help unhoused people move beyond the treatment of acute issues to focus on chronic health needs.

viii) Interruptions in continuity of care and longitudinal care by forced transiency

The forced transience faced by unhoused persons, which can include encampment clearing by cities, interrupt the ability of healthcare teams to complete diagnostic and treatment plans. This is exacerbated by the lack of shared data systems between community healthcare teams, hospitals and jail.

ix) No access to Home Care Nursing, PSW, Physio or OT support

Most community support agencies are unable and unwilling to support people without an address. Most people living unhoused cannot travel to bricks and mortar locations for these services, for all of the reasons described above. This creates a large gap in necessary healthcare services for people who are unhoused.

x) Decreased access to "risky"/ intensive treatments such as (PICC lines) or surgeries

Unregulated drug use (for example fentanyl or crystal meth) is common among people living unhoused. This unregulated drug use is a survival support mechanism for most people, used to treat and cope with the extreme deprivation they live within. However, the use of unregulated street drugs, particularly intravenous use, is seen as a contraindication to many lifesaving medical interventions such as surgeries or PICC lines (a special IV used to deliver medications like antibiotics over many weeks or months). This "contraindication" is not based in evidence, but in primarily in stigma. Therefore while IV drug use is used by many unhoused people to survive their circumstances, this drug use is also used by hospitals and specialists to deny lifesaving treatments to people. This creates an abundance of untreated or undertreated infections in the unhoused population, which community healthcare teams need to "MacGyver" in order to try and keep people alive. These untreated

infections often worsen, then resulting in more drastic and expensive hospital-based treatments which could have been avoided if unhoused persons were given equitable access to care in the first place.

xi) Tech inequity

Sleeping rough makes it incredibly difficult to obtain, keep and maintain a cell phone. Services are increasingly relying on these methods of communication to follow-up with clients, a trend exacerbated by the COVID-19 pandemic. This results in missed virtual court appointments, inability to call intake phone numbers to receive health services or social services. If a phone call is made with a service provider, there is often an appointment set for days in the future, a task exacerbated by constant change in location as noted above.

xii) Geographical barriers

Being constantly forced into increasingly remote locations makes it difficult to get to pharmacy, get to probation, make housing viewings, make medical appointments, access food programs in the city's core, and attend court.

The Health Care Model's Attempt to Overcome Barriers in Healthcare

15. The Health Centre model of care seeks to ameliorate the practical difficulties described above, by designing service delivery that places the person in the centre of their care. The model attempts to overcome traditional barriers as follows:

i) Prioritize people needs over system needs

The Health Outreach teams designs services that meet people where they are at. This phrase refers to a harm reduction practice that prioritizes creatively meeting a person's needs in their individual context, instead of expectations they fit into

traditional models of care. “Meeting people where they are at” can mean providing culturally appropriate care, understanding a person’s social and emotional context, consideration of personal history and tailoring assessment and treatment plans to their individual framework. Or, with people living rough and in encampments, “meeting people where they are at” can be interpreted literally by medical teams, into actions such as bringing medical services directly to people living in encampments and other unstable housing sites. This approach is essential to providing successful medical care to people who are living in encampments.

ii) Culturally appropriate care to reduce stigma

Stigma causes people to disengage from healthcare that traumatizes, re-traumatizes, judges or shames them. The Health Outreach team reduces the impact of stigma by recognizing the lived and living expertise of people who are unhoused, as well as people who use drugs. This means centring these voices, and providing care that recognizes the benefits that using drugs can have on people surviving outside. The Health Outreach team prioritizes *supporting changes that improve both physical health* as well as social determents of health, over enforcing a structure based off of pre-conceived notions of how a person should fit into and move through the mold of traditional healthcare systems.

iii) Allied health team to address social factors in care and advocacy (housing, income, criminal justice, etc.)

An allied health team approaches care and reframes health care in the context of the social determinants of health. This is an acknowledgement of the social, societal, cultural, historical, and lifestyle factors which affect an individual and their

wellness. This can include their income, criminal "justice" system involvement, housing, education, culture, gender, employment, food security and the reciprocal relationship between these factors on overall wellness. A team that is literate in interpreting these factors in concert is equipped to address these contextual factors in a way that builds toward holistic wellness and equity. This broader picture of how inequity within a singular system, ripples into broader personal and systemic marginalization provides a powerful vantage point for care planning/ wrap-around care. This is also a valuable perspective in advocacy as building a context around inequity supports developing a community and ecosystem better suited for the wellness of people.

iv) <u>High-threshold accessibility/low or "no" barrier care</u>

The Health Outreach Team acknowledges the complexities that can result in missed appointments and medication adherence difficulties. The team is incredibly flexible, creative and solution focused in creating solutions to these difficulties. For example, medication may be delivered at a meal program that serves breakfast, or appointments with specialists may be conducted via facetime from a park.

Impact of Encampment Evictions on Healthcare Delivery

16. The Health Centre has encountered many of the healthcare problems created by encampment evictions. These include:

i) <u>Obliterates progress – personal stability</u>

Encampments provide more than just stability of physical location. They provide stability of community structures and human connections, the stability to build tomorrow upon the work accomplished today and yesterday. Stable community

structures allow people to stay connected with survival partners and other safe friends. Forced eviction upends this stability.

ii) Obliterates progress - Return immediately to the Bottom of Maslow's Hierarchy

The long-term act of surviving on the streets necessitates the accumulation of possessions to ensure needs and comforts are established, Being consistently moved from an established location results in progress toward building the materials needed for survival long-term being dismantled and reversed. When people are able to establish a space that is conducive to their survival in a way that does not require round-the-clock investment of time, they are able to engage in other areas of their wellness. The dismantling of this foundation in the form of encampment evictions pushes people back into a space where their focus must be on satisfying the most basic of needs, unravelling with it the progress toward other medical goals in that process.

iii) Locating

Programs and services for people who are housing deprived rely on the ability to support these people where they are known to be. When individuals are forced to frequently change their location, they are often unable to follow-up with supports and commitments, such as: missed court dates, applications for service waiting for signatures, health care needs which are unmet, missed appointments with healthcare specialist, and missed viewings for apartments. In sum, once people are disconnected from their support services, their ability to recover and stabilize is immediately compromised.

iv) Evictions create more acute illness

People's possessions are almost always lost during encampment evictions and clearing. The loss of items such as tents, clothing, and medications results in more acute health conditions such as frostbite or exposure. Loss of medications creates challenges in managing chronic and acute health conditions. The act of survival also creates acute and chronic health care needs. For example, losing diabetic medications such as insulin results in acute deterioration of blood sugars and resulting chronic deterioration of glycemic control when this happens recurrently.

v) Mental health impact

Eviction creates emotions of loss, fear, uncertainty, the de-valuing of people, and grief. Being treated as "human garbage to be swept along" (patient quote) exacerbates emotions of loss, and also exacerbates mental health conditions such as depression, anxiety, PTSD and panic disorders.

vi) Discharged from services which cannot locate patient

The precedent taken by survival can make it difficult or impossible for housing deprived people to maintain the required level of engagement for some programs. When some social and medical programs, such as housing supports, cannot reach a client, or the client does not regularly attend appointments, they risk being discharged from the program. Being discharged leaves an already marginalized individual with even fewer supports and community connections.

vii) Loss of trust, loss of therapeutic relationship

The "system" is seen as several interconnected pieces working together to support people in our communities. The clearing of encampments by large systemic figures

such as municipal bylaw officers deepens the mistrust in municipal services/authorities. This permeates the programs such as outreach and emergency shelter, which are directly funded by municipalities, as well as the rapport and relationship with agencies that partner with municipalities and rely on their ability to provide timely and effective service to people in acute need.

Encampment Evictions in London

17. Encampments often emerge in locations that are central to services which support street-based survival (hygiene, food, health care, harm reduction).
18. The City of London bylaw enforcement team regularly clears encampments, and will clear them daily at times.
19. As a result, there are no permanent encampments in London. Instead, encampment locations are continuously being cleared, the people evicted, and encampment locations shifting every few days to weeks. Therefore, it can be assumed that every person in London with a history of living in an encampment, can also be assumed to have been evicted from an encampment.
20. My current best estimate of patients currently cared for by Health Outreach, with an experience of encampment eviction, would be approximately 700 – 900 people.

Advantages and Disadvantages of Living in a Tent/Encampment: Aggregate Themes Amongst this demographic

21. Based on my 12 years' experience caring for unhoused people and people who live in encampments, the **most common** themes of harm associated with encampment evictions are as follows:

i) Environmental/weather related ailments – frost bite, heat stroke, burns

ii) Loss of survival possessions – tents

iii) Food insecurity and starvation

iv) Increased substance use

v) Fatal overdose

vi) Medical destabilization

vii) Lack of prenatal and perinatal care

viii) Increased sexual and physical violence

ix) Further marginalization

x) Loss of community safety and structure

Case studies of the themes

22. The following are case studies of patients supported by the Health Centre who experienced some of the harms set out above:

i) Example of environmental complication

- Person dug hole in park to hide from bylaw, laid there for several days in winter, and developed frost bite so severe that it resulted in multiple limb amputations

ii) Example of loss of survival possessions

- Loss of all clothes, boots, coats in winter due to bylaw clearance of encampment site, resulting in severe frost bite to both feet
- Person lost tent, flashlights, blankets, food, power sources/generators due to time limit attached to dismantle campsite (not afforded the time/ability to gather live-saving items). The person was then arrested after shoplifting to try and replace those survival items.

iii) Example of food insecurity and starvation

- Forced to move so far into margins to avoid encampment eviction/clearing, person could not access food banks
- No ability to own cooking pot or heat (for fear of discovery), existed on granola bars
- Died of starvation related illness

iv) Example of fatal overdose

- Person evicted from encampment. Had lived communally in encampment for many years
- Used drugs communally, following best practices which is to not use opioids alone
- Evicted from encampment, forced into solo living space
- Died of overdose within days

v) Example of medical destabilization

- Personal who required daily medication was unable to keep medication safe/storage, cyclically incarcerated due to crimes of poverty (stealing to eat, breaking/damaging store fronts) resulting in poor adherence to medical treatment, increased infection, increased substance use that directly impacted physical and mental health
- Person developed resistance to HIV medication due to poor adherence, resulting in an AIDS diagnosis with high risk of death

vi) Example of pregnancy/prenatal complication

- Lack of stable living site resulted in no prenatal care and cardiac arrest of baby during labour due to preventable pregnancy complication

vii) Example of increased sexual and physical violence

- Woman separated from survival partner during bylaw eviction
- Neither partner had phone, could not locate each other after being separated
- Slept solo for many days
- Without protection of partner, woman was gang raped while sleeping behind a dumpster, and then subsequently raped multiple more times, with each encampment eviction and separation from partner

viii) Example of further marginalization

- City bylaw cleared central encampment
- People moved to city margin to escape detection – resulted in complete disconnect from healthcare services, missed anti-psychotic injections resulting in acute psychosis and person became victim of violence

ix) Example of loss of community structure and safety

- People have lost feeling of community belonging due to inability to create peer-regulated spaces
- People are forced into isolated, inaccessible areas that created heightened risk of violence
- People are forced from rural areas to city limits resulting in new community members with no relationship with existing street-entrenched community often

resulting in increased violence, “othering” and lack of understanding of shelter services/basic needs services

Examples of Medical Care Provided to Evicted Encampment Residents

23. The following case studies based on patients supported by the Health Centre:

i) Woman recently evicted from downtown tent encampment

- Severe soft tissue infection to her lower leg
- Requested hospital admission three times over the previous months, was discharged twice and told to follow up with cellulitis clinic
- Left hospital against medical advice after stigmatized treatment in hospital
- Sepsis being kept at bay with antibiotics and care from mobile medical team but still requires surgical amputation
- Ongoing eviction every few days from encampment, mental that medical team spends more time locating this woman than treating her infection
- Woman is currently sleeping in an alleyway

ii) Man with multiple encampment evictions by city staff

- Untreated schizophrenia, untreated HIV
- Presented to team with multiple AIDS-defining illness
- Zero primary care, zero supports
- City deems him ineligible for hotel or city-funded shelters due to schizophrenic-related behaviours
- Has visited ER 42 times in last year. No referrals, no outpatient appointments, because he cannot be found

iii) Woman, multiple tent encampment evictions

- Severe seizure disorder
- No diagnostics, no treatment, no medications due to inability to locate and distrust of the system
- Seizures are so debilitating that she is unable to attend soup kitchens or church drop-ins for fear of injury or assault while post-letal
- Blood work shows severe malnutrition

iv) Woman evicted from tent encampment while actively miscarrying foetus

- By the time she was found in new tent location by medical team, was diagnosed with sepsis due to uterine infection

v) Woman with long-standing diagnosis of schizophrenia

- Numerous encampment evictions
- No supports, no medications, no form of treatment
- As per police, has been forcibly sexually trafficked for 18 months
- Ongoing psychosis makes her incredibly vulnerable to sex traffickers
- Active syphilis

24. I have reviewed many of the Applicant affidavits and find that their experiences and reports of being homeless and evicted from an encampment or not permitted to stay in an encampment, are consistent with the harm related themes reported by my patient pool.

Advantages of living in an encampment versus living in public space without a tent

25. Having reviewed the files of my patients who have reported living in an encampment, I have identified many benefits of living in an encampment compared to sleeping rough:

i) Health outcomes: Encampments decrease forced transiency which increases the odds that the unhoused can maintain routine connection to outreach services such as health care, system navigators, street outreach of basic needs (food, clothing), housing services, delivery of medications, harm reduction supplies, etc.

ii) Decreased isolation and risk of fatality: When people know they will be evicted by authorities, they will move further into the margins where they are less visible and more alone in order to avoid eviction enforcement by the authorities. By moving further into the margins such as forests, train tracks, abandoned buildings, holes dug into the ground, people place themselves at greater risk of harm because they are alone and disconnected from routine services. This places them at greater risk of violence, overdose and loss of connection to medical services.

iii) Community: Encampments give people a sense of community as opposed to when people are alone and hiding from authorities. The benefits of this include increased mental health stabilization, decreased drug use, increased chances of being helped during an overdose, emotional support, someone to watch possessions if the person is required to leave the site to use a bathroom, attend a food bank, an appointment, etc. Encampments also decrease risk of sexual violence because community members look out for each other.

iv) Privacy: Having a tent facilitates better sleep, the ability to store and use medications, to complete hygiene and other basic self-care. Tents also allow for privacy from the public gaze and abuse, which can be very detrimental to mental health.

v) Place to store possessions: There is often a sense of community that develops among encampment residents, and people come to rely on one another to watch their belongings when they leave the encampment site. Perspectives from individuals living in tent cities in the US have revealed that encampments can provide a sense of safety and autonomy that is not felt in shelters.[1]

vi) Minimizes sleep deprivation: Many unhoused persons with nowhere to sleep, need to stay up at all hours due to fear of violence and theft if they sleep in the open while alone.

vii) Shelter from elements: Tents provide an essential layer of protection from wind, rain, snow and sun. Without this layer of protection, there is an increased risk of weather-related ailments such as frost bite.

viii) Physical and mental rest: It is both physically and mentally taxing to have to constantly move and search for new places to shelter. Being able to remain in one place gives people a chance to rest and focus on recovery.

Advantages of living in an encampment versus shelter

26. Although there are safety risks in encampments, patients routinely make trade-offs between what the safest situation is given their options and personal circumstances.

i) Couples

In encampments, couples or "survival partners" can remain together. Almost always, there is insufficient shelter options for couples. This forces them to choose between separating in shelter or remaining together on the street. Separation causes stress,

[1] Hunter, J., Linden-Retek, P., Shebaya, S., & Halpert, S. (2014). Welcome home: The rise of tent cities in the United States. National Law Center on Homelessness & Poverty, Allard K. Lowenstein International Human Rights Clinic, Yale Law School.

anxiety and panic in partners who can no longer protect each other. When couples or survival partners separate to move into shelter, a female identifying partner may not get into shelter resulting in their being outsides alone and at serious risk of violence. As a result, the male identifying partner will usually elect to remain outside with the female identifying partner to provide them with safety and to avoid the emotional anguish of separating knowing that their loved one may be at serious risk of injury or death, or that reconnecting after they leave the shelter may be difficult if not impossible for days. Many unhoused do not have cell phones that would otherwise assistance with reconnecting.

ii) Connection to pets

Most people with pets are unable to find shelter space that will accommodate their animals. People who are experiencing homelessness are often estranged from family and close friends and their pets can be their biggest source of emotional support. These people often turn down shelter space due to their overwhelming need to remain with their pet. Pets are sources of emotional support for the unsheltered population. Many rely on their pet as their single source of support and consequently the loss of their pets can be traumatizing for them and can lead to dysregulation.

iii) Continuity and ability to plan

Shelter stays are inherently unpredictable and precarious. Many people can find themselves abruptly evicted onto the street at any time of day and with any weather conditions. People who have routinely experienced shelter evictions will opt to remain in an encampment because they know it has the ability to provide more day-to-day stability.

iv) Harm reduction vs abstinence-based shelters

Shelter spaces are often abstinence-based, refusing to adopt a harm reduction approach to provide increased safety and support for people who are housing deprived and using substances. Having to hide one's substance use in a shelter places people at grave risk of overdose as they are required to use alone or in hidden spaces such as showers or locked bathrooms. Such spaces inherently provide privacy and, therein, a space where response to accidental overdose would be greatly delayed or impossible in a timely manner. These structural barriers lead people to prioritize their safety by staying outside where they can access the support of peers and harm reduction services to stay well and stay safe.

v) Relief from physical burden of leaving and entering shelter every day

Given that shelters are routinely full and residents do not often have phones, they must walk with their possessions from shelter to shelter. It is very physically taxing, especially for those with physical disabilities to spend their days like this. It is physically and mentally less taxing to remain in a tent in one location. Additionally, when people must leave the shelter in the early morning, they are left with nowhere to go to rest, decompress or re-group until they return at night simply to attempt to sleep. As a population that experiences exceptionally high rates of physical disability (according to one study conducted in Toronto, 43% of homeless respondents reported arthritis or rheumatism, 23% reported problems walking, a lost limb, or another physical handicap, 20% reported heart disease, and 17% reported high blood

pressure, among others) encampments can provide reprieve from the need to constantly be moving and carrying belongings.[2]

vi) Restrictive rules regarding substances

Many shelters do not allow substances to be used or stored onsite. Some shelters do not even allow for harm reduction materials. Despite these restrictions, drug use can be rampant in shelters. People who are attempting to maintain sobriety are at risk of compromising their sobriety if they are at a shelter where drug use is high and it is trafficked. Sobriety is also threatened when people cannot bring harm reduction materials into shelter. At the other end of the spectrum, people with substance use disorders risk being kicked out of shelter if they are found using or with drug use paraphernalia.

vii) Shelters can be re-traumatizing

People with a history of trauma or abuse may be triggered by a congregate setting of strangers. People have a valid fear of being a victim of an assault or sexual assault in shelter, or may have a history of these incidents during their stay at a shelter that reasonably precludes them from returning to shelter due to this trauma.

Experience attempting to access shelter for my patients

27. Clients with complex medical needs secondary to their experience of living rough are often precluded from accessing shelter supports as their needs are often interpreted as "outside of the scope" of these shelters where the norm is to provide a bed and space for the night with discharges often early in the morning. Traditional home care nursing, PSW and OT

[2] The Street Health Report 2007. The Health of Toronto's Homeless Population. https://homelesshub.ca/sites/default/files/2.2%20Street%20Health%20Report.pdf at p. 16.

supports are often not open to providing service in these programs, resulting in gaps to therapeutic intervention even if a space is secured. In this way, housing deprivation leads to severe health complications which leads directly to further deprivation.

28. The institutional structure of traditional shelter programs can elicit a trauma response in client accessing these services with limitations on the activities they can do, the self-care they can perform, the safety they can find and the privacy they can be afforded. Clients packed into these spaces can respond in defensive manners interpreted as aggressive, leading to eviction and, at times, long term bans.
29. There are people in the city of London who are banned from every shelter program that exists within the city for these concerns. The high turnover of staffing and capacity of these spaces means care planning has limited efficacy when looking to mitigate these concerns for an individual.
30. The need for shelter has burgeoned for decades, exacerbated further by the COVID-19 pandemic. The number of people in need of space exceeds the amount of available emergency shelter space by hundreds. This means there are people who “fit” within the eligibility criteria for these spaces that are unable to access them due to over-whelming capacity issues.
31. The nature of survival places some people at risk for victimization in the community. There is a large subset of people who refuse shelter referrals due to fear of physical safety.
32. It can be anything but straightforward to try to access a shelter bed. As an initial barrier, many people experiencing homelessness do not have a phone to call for a bed.

33. The Health Centre often tries to secure shelter beds for patients. Most often, we are not successful. The following is an example of an attempt to navigate the shelter admission process:

    i) Client presented in crisis and sleeping rough with 16 year old daughter. Systems Navigator (SN) placed call to Coordinated Access (CA) to secure a shelter bed, however CA intake was not timely and booked 6 days post call with client having no access to phone. SN placed call to London Cares day-time resting space, however no space was available at that time. SN placed call to CMHA Stabilization Space, however no space was available at that time. SN placed call to Anova (VAW shelter), however no space was available at that time. SN placed call to St. Thomas shelter with answer of "maybe" should client be able to secure independent transport to city. SN placed call to Youth shelter, however daughter could access, but mother could not due to age limitations. SN placed call to London Cares again with answer of "maybe" but not the daughter due to lack of shelter capacity. Client leaves frustrated and back to street, to find encampment for the night. Client has never re-engaged after this experience.

34. I make this Affidavit in support of the Notice of Application, and for no improper purpose.

Sworn remotely by Andrea Sereda in the Province of Ontario, before me on May 12, 2023 in accordance with O. Reg. 431/20, Administering Oath or Declaration Remotely.

Commissioner for Taking Affidavits

Sharon Crowe

Andrea Sereda

May 12/2023

Bibliography

Hunter, J., Linden-Retek, P., Shebaya, S., & Halpert, S. (2014). Welcome home: The rise of tent cities in the United States. National Law Center on Homelessness & Poverty, Allard K. Lowenstein International Human Rights Clinic, Yale Law School.

The Street Health Report 2007. The Health of Toronto's Homeless Population. https://homelesshub.ca/sites/default/files/2.2%20Street%20Health%20Report.pdf at p. 16.

THIS IS EXHIBIT “A” TO THE
AFFIDAVIT OF ANDREA SEREDA
AFFIRMED REMOTELY BEFORE ME AT
THE CITY OF HAMILTON DURING A “ZOOM” VIDEOCONFERENCE
IN ACCORDANCE WITH O.REG. 431/20,
ADMINISTERING OATH OR DECLARATION REMOTELY
THIS 12th DAY of MAY, 2023

Sharon Crowe

Sharon Crowe
Commissioner for Taking Affidavits, etc

Dr. Andrea Michelle Sereda - CV

September 2022

A7804

London Intercommunity Health Centre
659 Dundas St, London, ON N5W 2Z1
Phone: 519-660-0874
Email: asereda@lihc.on.ca

1. Education

BSc (*honours*)	Honours Microbiology and Immunology, University of Western Ontario 2003
MD	Schulich School of Medicine & Dentistry, University of Western Ontario 2007

2. Qualifications

College of Physicians and Surgeons of Ontario (CPSO)
2007

Licentiate of the Medical Council of Canada (LMCC)
2009

Certification in the College of Family Physicians of Canada (CCFP)
Schulich School of Medicine & Dentistry, Rural Family Medicine stream
2009

Certification in the College of Family Physicians of Canada - Emergency Medicine (CCFP-EM)
Schulich School of Medicine & Dentistry
2010

3. Clinical Practice Experience

Current

Family Physician - London Intercommunity Health Centre, London, ON
Practice focus: Care for people experiencing homelessness (particularly women experiencing homelessness); care of people who use drugs
2013 – present

Lead Physician: Safer Opioid Supply Program, London Intercommunity Health Centre
2016 – present

Lead Physician: Street Level Women at Risk (SLWAR), London Intercommunity Health Centre
2016 – present

Past

Lead Physician: Transgender Health Program, London Intercommunity Health Centre
2016 – 2021

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Emergency Medicine Physician - St. Thomas Elgin General Hospital
2010 – 2016

Family Physician - Centre of Hope Family Health Team
Practice Focus: Homeless healthcare, primary care
2010-2013

Hospitalist Physician - St. Thomas Elgin General Hospital
2009

4. Teaching Experience

London Intercommunity Health Centre
Medical Student and Resident placements focusing on homeless healthcare
2013 – present

Red Cross Emergency Medical Responder Instructor
Each fall, teach 80 hour course to Western Students who then go on to provide 911 response to the UWO campus
2008 - present

5. Administrative Positions

Governance Group Member, Executive Leadership Role, Street Level Women at Risk (SLWAR) program
2017 to present

Community Advisory Group, Street Level Women at Risk (SLWAR) program
2015 to present

Community Advisory Group, Youth Shelter Development, Youth Opportunities Unlimited
2017 to 2018

Community Advisory Group, Salvation Army Centre of Hope Homeless Shelter
2014 to present

Medical Director, Student Emergency Response Team, University of Western Ontario
2010 to present

6. Awards

Alumni of Distinction Award – Community Service Award
Schulich School of Medicine & Dentistry, Western University
2021

Health Equity Champion Award
Alliance for Healthier Communities
2020

A3521

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Community Inspiration Award
Addiction Services of Thames Valley
2020

Canada's Top 40 under 40
Awarded for work with Street Level Women At Risk (SLWAR) program
2018

London's Top 20 Under 40
Awarded for work with Street Level Women at Risk (SLWAR) program
2018

CCFP Resident Research Award: "Healthcare for the Homeless"
Schulich School of Medicine & Dentistry, Western University
2009

7. Grants

Health Canada - Substance Use and Addiction Program (SUAP) grant
$6.7 million to expand access to Safer Supply program, London Intercommunity Health Centre, London, ON,
February 2020

Health Canada - Substance Use and Addiction Program (SUAP) grant
$2 million to develop Safer Opioid Supply Community of Practice,
June 2020

8. Peer Reviewed Publications

Gomes, T, Kolla, G, McCormack, D, Sereda, A, Kitchen, S, Antoniou, T. (2022) Clinical outcomes and healthcare costs among people entering a safer opioid supply program in Ontario: a comparative time series analysis. In-press (publication date - 19 September 2022. *CMAJ: Canadian Medical Association Journal*. www.cmaj.ca/lookup/doi/10.1503/cmaj.220892

Glegg, S, McCrae, K, Kolla, G**,** Touesnard, N, Turnbull, J, Brothers, T, Brar, R, Sutherland, C, Le Foll, B, Sereda, A, Goyer, ME, Rai, N, Berstein, S, Fairbairn, N. (2022). "COVID just kind of opened a can of whoop-ass": The rapid growth of safer supply prescribing during the pandemic documented through an environmental scan of addiction and harm reduction services in Canada. *International Journal of Drug Policy,106*, 103742. https://doi.org/10.1016/j.drugpo.2022.103742

Ryan, A., Sereda, A., & Fairbairn, N. (2020). Measures to support a safer drug supply. *CMAJ : Canadian Medical Association Journal*, *192*(49), E1731–E1731. http://doi.org/10.1503/cmaj.77303

Formosa, E., Grainger, L., Roseborough, A. D., Sereda, A., & Cipriano, L. (2020). A Survey of Canadian, Student-Run Campus Emergency Medical Response Teams. *Journal of Collegiate Emergency Medical Services*, *3*(2), 11-19. https://www.collegeems.com/a-survey-of-canadian-student-run-campus-emergency-medical-response-teams/

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9. Clinical Guidelines

Hales, J., Kolla, G., Man, T., O'Reilly, E., Rai, N., Sereda, A. (2019) *Safer Opioid Supply Programs (SOS): A Harm Reduction Informed Guiding Document for Primary Care Teams*. Available online: https://bit.ly/3dR3b8m

10. Published Commentaries

Rai, N., Sereda, A., Hales, J. & Kolla, G (2019, June 19). Urgent call on clinicians: Prescribe alternatives to poisoned drug supply. *Healthy Debate.* https://healthydebate.ca/opinions/safer-supply-opioids

Wiltshire, K & Sereda, A (February 2019). Suffering in Silence: Intimate Partner Violence Amongst Physicians. *Vital Signs.* https://static1.squarespace.com/static/568eb5bbd82d5eecf06026c4/t/5c5dc7799b747a6e18de095f/1549649796829/VS0219.pdf

11. Academic Conference Presentations

Kolla G, Gomes T, McCormack D, Sereda A, Kitchen S, Campbell T, Singh S, Antoniou T. 2022. *Health system utilization outcomes and healthcare costs among safer opioid supply program clients in London, Ontario: a population-based cohort study.* Canadian Society for Addiction Medicine 2022 Scientific Conference. Saskatoon, Canada. November 3-5, 2022.

Kolla, G, Gomes, T, McCormack, D, Sereda, A, Kitchen, S, Campbell, T, Singh, S, Antoniou, T. 2022. *Clinical outcomes and healthcare costs among safer opioid supply program clients in Ontario: a population-based cohort study.* Canadian Association of HIV Research Conference 2022 (virtual). April 28-29, 2022.

Sereda, A. 2022. *Safer Supply & HIV*. Building Enhanced Treatment Responses (BETR) Provincial Conference. February 2022

Sereda, A. 2021. *Stimulant Safer Supply*. Harm Reduction International Conference (virtual). November 2021

Sereda, A. 2021. *Fentanyl, the Opioid Crisis & the Injection Drug User: Re-Imagining Solutions.* Opioid Use Disorder in Primary Care Conference, Centre for Addiction and Mental Health (virtual). March 2021.

Sereda, A. 2020. COVID-19, Substance Use and Safer Supply. British Columbia Centre for Substance Use (BCCSU) (virtual). May 2020 https://www.youtube.com/watch?v=an3yogOl5g0&t=85s

Kolla, G., Sereda, A., Rai, N., Hales, J. 2020. *Building resources for Safer Opioid Supply prescribing to address the opioid overdose crisis in Ontario.* Canadian Public Health Association Conference, Winnipeg, Canada. April 28-30, 2020. (Conference cancelled due to COVID-19)

Sereda, A. 2019. *Harm Reduction 101.* Family Medicine Forum (FMF), Vancouver, Canada. November 2019

A3523

Sereda, A., Brothers, T., Kolla, G. 2019. *Initial impacts of a "Safe Supply" oral hydromorphone substitution prescribing initiative for people who inject drugs in London, Ontario*. Canadian Society of Addiction Medicine. Halifax, Canada. October 24-27, 2019.

Sereda, A. 2019. *Building Trust: Using Safer Supply to change the Opioid overdose epidemic*. Canadian Society of Addiction Medicine. Halifax, Canada. October 24-27, 2019.

Sereda, A. 2018. *Street Involved Sex Workers; A United Model from Streets to Homes*. Canadian Association to End Homelessness (CAEH). November 2018

Sereda, A. 2017. Outreach Medicine and Street Level Women. London Health Sciences Centre Vulnerable Populations Symposium. December 2017

12. Invited Presentations

Briefings for policy makers

Invited Speaker, "Safer Supply - a common sense approach to the overdose crisis" Briefing for the federal Minister of Mental Health and Addictions Health Carolyn Bennett. London, Canada. April 2022

Invited Speaker, "Introduction to Safer Opioid Supply". Timmins Mayor's Office
Timmins, Canada. May 2021

Invited Speaker, "Fentanyl, the Opioid Crisis & the Injection Drug User: Re-Imagining Solutions". Briefing for the Federal Opioid Response Team, Ottawa, Canada. October 2020

Invited Speaker, "Safer Opioid Supply in the Context of the Overdose Crisis". Briefing for the federal Minister of Health Patty Hajdu. 13 July 2020

Invited presentations at conferences, grand rounds or community organizations

Keynote, Safer Supply Community of Practice Regional Meeting, Toronto, Canada, 10 June 2022

Panelist, "The Future of Safer Supply". Alliance for Healthier Communities Conference. Toronto, Canada. 9 June 2022.

Invited Speaker, "Introduction to SOS". Thames Valley Family Health Team. London, Canada. April 2022

Invited Speaker, "Care of Marginalized Persons". Critical Care Rounds, London Health Sciences Centre, London, Canada. November 2021

Invited Speaker, "Safer Supply 101". Schulich School of Medicine & Dentistry, London, Canada. December 2021

Keynote, "Safer Supply 101". Neighbourhood Legal Annual General Meeting, Toronto, Canada. November 2021

Panelist, "Women & Safer Supply", Women and HIV/AIDS Initiative, Toronto, Canada. September 2021

Invited Speaker, “Introduction to Safer Opioid Supply”. Hamilton Urban Core Community Health Centre, Hamilton, Canada. August 2021

Invited Speaker, “Introduction to Safer Opioid Supply”. Sudbury Harm Reduction Network. Sudbury, Canada. July 2021

Invited Speaker, “Harm reduction, Marginalized Persons and SOS”. Oncology Grand Rounds, London Health Sciences Centre, London, Canada. May 2021

Invited Speaker, “Introduction to Safer Opioid Supply”. Timmins Public Health Unit, Timmins, Canada. April 2021

Invited Speaker, “Introduction to Safer Opioid Supply”. London Children’s Aid Society, London, Canada. April 2021

Invited Speaker, “Introduction to Safer Opioid Supply”. Sudbury Drug Strategy, Sudbury, Canada. April 2021

Keynote, “Fentanyl, the Opioid Crisis & the Injection Drug User: Re-Imagining Solutions.” University of Western Ontario Alumni Association. London, Canada. February 2021

Invited Speaker, “Fentanyl, the Opioid Crisis & the Injection Drug User: Re-Imagining Solutions”. Chatham Kent Hospital Association. February 2021

Invited Speaker, “Fentanyl, the Opioid Crisis & the Injection Drug User: Re-Imagining Solutions”. Thunder Bay Community Health Centre. February 2021

Invited Speaker, “Harm Reduction 101”. University of Western Purple Hands. January 2021

Invited Speaker, “Fentanyl, the Opioid Crisis & the Injection Drug User: Re-Imagining Solutions”. John Gordon Home HIV/AIDS Hospice, London, Canada. January 2021

Invited Speaker, “Fentanyl, the Opioid Crisis & the Injection Drug User: Re-Imagining Solutions”. Internal Medicine Grand Rounds , London Health Sciences Centre, London, Canada. November 2020

Invited Speaker, “Fentanyl, the Opioid Crisis & the Injection Drug User: Re-Imagining Solutions”. Family Medicine Grand Rounds, Schulich School of Medicine & Dentistry, London, ON. September 2020

Invited Speaker, “Safer Opioid Supply in the Context of the Overdose Crisis”.
Alliance for Healthier Communities Conference, June 2020

Invited Speaker, **“**Building Trust: Using Safer Supply to change the opioid overdose narrative”. Psychiatry Grand Rounds, London Health Sciences Centre, London, Canada. February 2020

Invited Speaker, “Harm Reduction 101”. Abuse Shatters Lives Conference, Timmins, Canada. February 2020,

Invited Speaker, “Safer Opioid Supply Programs in the Context of the Opioid Overdose Crisis.” Grand Rounds, Sherbourne Health. Toronto, Canada. 20 January 2020.

Panelist, “Safer Supply”. Addictions and Mental Health Ontario (AMHO) Leadership Panel. Toronto, Canada. November 2019

Panelist, “Safe Supply Community Summit”. Community Forum for people who use drugs in the Downtown Eastside, Vancouver, Canada. November 2019

Invited Speaker, “Safer Supply”. Pan-Canadian Opioid Prescribing Initiative, College Family Physicians of Canada, Toronto, Canada. October 2019

Keynote, “Harm Reduction and Palliative care for marginalized and vulnerable Londoners”. University of Western Ontario Palliative Care, London, Canada. October 2019.

Panelist, “Safer Supply, Hepatitis C and drug-user health”. Ontario Hepatitis C Teams Workshop. Toronto, Canada. 29 October 2019.

Keynote, “Safer supply in the context of the overdose crisis”. Parkdale Queen West Community Health Centre Safer Supply Presentation. Toronto, Canada. 3 July 2020.

Keynote, “Safer Supply”. Regional HIV/AIDS Connection, London, Canada. June 2019.

Invited Speaker, “Safer Supply & SLWAR”. Emergency Medicine Grand Rounds, London Health Sciences Centre, London, Canada. March 2019

Invited Speaker, “Street Level Drugs of Abuse”. My Sister’s Place (Drop-in centre for homeless women), London, Canada. May 2016.

THIS IS EXHIBIT “B” TO THE
AFFIDAVIT OF ANDREA SEREDA
AFFIRMED REMOTELY BEFORE ME AT
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IN ACCORDANCE WITH O.REG. 431/20,
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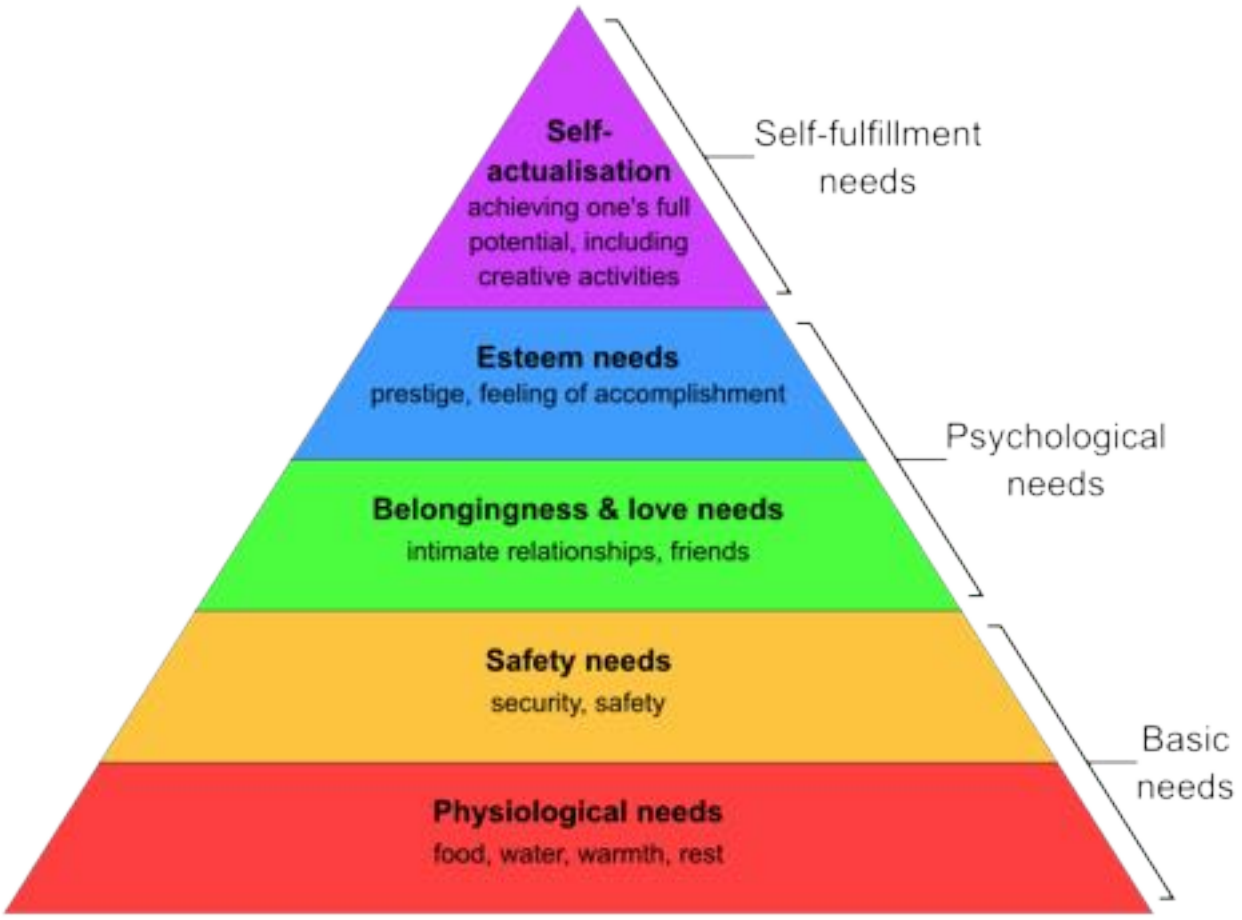
Sharon Crowe

Sharon Crowe
Commissioner for Taking Affidavits, etc

A7812


Self-actualisation
achieving one's full potential, including creative activities
Esteem needs
prestige, feeling of accomplishment
Belongingness & love needs
intimate relationships, friends
Safety needs
security, safety
Physiological needs
food, water, warmth, rest
Self-fulfillment needs
Psychological needs
Basic needs

A3528

Court File No. CV-21-00077817-0000

ONTARIO

SUPERIOR COURT OF JUSTICE

BETWEEN:

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

Applicants

-and-

CITY OF HAMILTON

Respondent

AFFIDAVIT OF ANDREA SEREA

SWORN MAY 12, 2023

---

1. I, Doctor Andrea Sereda, of the City of Aylmer, Ontario in the Province of Ontario, MAKE OATH (AFFIRM) AND STATE:
2. I have personal knowledge with respect to the facts set out below, except where stated otherwise. Where the information is not based on my personal knowledge, it is based upon information provided by others which I believe to be credible and true.

Credentials and Nature of Work

3. A copy of my *Curriculum Vitae* is attached hereto as **Exhibit 'A'.**

4. I am a physician practicing at London Intercommunity Health Centre (the "Health Centre") in London, ON. The Health Centre serves patients with barriers to healthcare in the traditional healthcare system, providing a broad spectrum of interdisciplinary supports. My practice within the Health Centre focuses on people deprived of housing (homelessness), people who inject drugs (PWID) and women working in the survival sex trade. Most of my patients are unhoused or precariously housed, living in encampments, solo rough sleeping, staying in shelters, couch surfing or any combination thereof. Living unhoused means that patients are in a state of forced transience throughout the city, and focus their days on survival living (obtaining food, hygiene, income, a place to sleep that day, prescribed or unregulated medication, staying safe). Because of the enormous daily time investment required to just survive living on the street, acute and chronic health conditions often are not prioritized by patients due to more pressing needs on Maslow's Hierarchy. A copy of the Hierarchy is attached hereto as **Exhibit 'B'**.

5. My team at LIHC focuses on dismantling structural barriers to care for people who are unhoused by "meeting people where they are at". This phrase refers to a harm reduction practice that prioritizes creatively meeting a person's needs in their individual context, instead of expectations they fit into traditional models of care. "Meeting people where they are at" can mean providing culturally appropriate care, understanding a person's social and emotional context, consideration of personal history and tailoring assessment and treatment plans to their individual framework. Or, with people living rough and in encampments, "meeting people where they are at" can be interpreted literally by medical teams, into

actions such as bringing medical services directly to people living in encampments and other unstable housing sites. This approach is essential to providing successful medical care to people who are living in encampments.

6. I personally provide primary care for my patients through a blended model of traditional office-based medicine, as well as mobile outreach and street-level care (street medicine).

Expertise in providing health care to unhoused people

7. I have been a physician for 15 years, graduating from the Schulich School of Medicine in 2007. I completed a residency in Family Medicine in 2009, and a fellowship in Emergency Medicine in 2010. Both residency training programs were completed at the Schulich School of Medicine.
8. I have been providing health care to unhoused and precariously housed people for 12 years.
9. I have been working with LIHC since 2012.
10. I am the lead physician in Health Outreach, and I provide direct care, medical consultation or care coordination to all patients care for by my team.
11. The Health Outreach team cares for 1800 rostered patients, all of whom have been unhoused at some point in their life. Precise numbers are hard to determine because people's housing status can shift abruptly and frequently. People often do not declare all changes in their housing status, and thus this cannot be accurately tracked in charts. However, based on my experience I estimate that 800 rostered Health Outreach patients are unstably housed and 200 rostered patients sleep rough at any given time. This estimate is based on personal knowledge and consultation with the Health Outreach team.
12. The HOME bus and street outreach teams care for an additional 1100 unrostered people. All people seen via HOME and street outreach are unhoused. These 1100 people shift

between shelters, sleeping solo rough or in encampments. While precise numbers are unknown for the same reasons as above, our team estimates that 700 of these 1100 people regularly sleep rough, with a known 300-350 sleeping rough in the City of London on any given day.

Service delivery model to unhoused persons

13. The Health Centre provides support for people experiencing homelessness or who are heavily street-involved in London, Ontario. The Health Centre provides several creative approaches to patient care, tailored to where patients are located and their structural barriers. All patients are offered a broad array of wrap-around health and social care by an interdisciplinary team consisting of primary care physicians, nurse practitioners, nurses, systems navigators, social workers, outreach workers and care facilitators, addressing clients' health and social needs through a social determinants of health and harm reduction approach. The model also includes:

    i) <u>Office based care</u>

    This is a mixture of booked and drop-in appointments, providing MD/NP led primary medical care, specialty care (HIV, HCV treatment), walk-in acute services such as wound care, nursing care, basic needs support such as ID and food security. The "bricks and mortar" care serves people who live in close proximity to the clinic, either housed or sleeping rough in the Dundas corridor. Office based care at the Health Centre differs from a traditional health clinic in several ways. A robust team of clinicians and allied health professionals such as Social Workers, Care Facilitators, Systems Navigators, and Outreach Workers provide intensive support and wrap-around services. These services can all be initiated same-day, and they

can be provided concurrent to each other. Same day and concurrent support mean that the Health Centre team meets people where they are at in time and space and significantly improves linkages and retention in care.

ii) HOME (Health Outreach Mobile Engagement) "The Bus"

All of the services provided in the Health Outreach bricks and mortar clinic are also provided on a retrofitted city bus that acts as a mobile clinic. HOME visits encampment and shelter sites, and flexibly adapts to the ever-changing locations of encampments and other places unhoused people gather. HOME meets people where they are physically at. This is essential to serving encampment residents who are unwilling to leave their tents or sites due to fear of bylaw clearing their possessions or who are physically unable to leave due to the severity of their medical needs. This can include ambulatory limitations, lack of accessible transportation, and lack of access to assistive devices or mental health. HOME also meets people where they are in time; encampment residents have survival priorities that often preclude having time to come to clinic. HOME serves people who have traumatic experiences to healthcare infrastructure such as hospitals, clinics and jails. For people who have experienced structural trauma, visiting a healthcare site with a door, or a lock, or security can completely emotionally preclude them from care. HOME seeks to remove this barrier by removing structural triggers for trauma.

iii) Community Paramedicine "home visits"

The HOME team includes a team of paramedics who provide home visits to people who are unhoused. This team can bring intensive treatment, like intravenous antibiotics or wound care, directly to people who are living precariously housed or

living rough in encampments. The team often is treating people in encampments who cannot participate in emergency room, or hospital-based care due to trauma and structural barriers. Video conferencing can also be facilitated with one's primary care provider while the medical team is present.

iv) Street Outreach Medicine

Health Outreach clinicians and Allied Health staff also seek out people utilizing a "boots on the ground and backpack" approach with capacity to support intensive wound care, primary care and social care. This is critical for people sleeping rough who are living either in newly established encampment sites that need to be located or are hard to get to, or people who have been evicted from encampments and are living in locations hidden from bylaw or other services that seek to move them along.

Practical difficulties with delivering health care to the unhoused

14. There are many difficulties providing healthcare to the unhoused. I have categorized these difficulties below.

i) Building and Rebuilding Trust

This can be thought of as both a challenge and an opportunity. People who live in encampments are marginalized not just from healthcare but from the rest of community. People are deprived of housing in the context of significant accumulated lifetime trauma; they have often been traumatized and neglected across multiple systems such as child protective services, the school system, healthcare, "addiction care", the "justice" system and the housing sector. Their housing deprivation is a final common pathway of societal failures to a group of

citizens. Thus, people living in encampments have a healthy and legitimately carried distrust of people representing the system, including healthcare professionals. Trust needs to rebuilt; both trust that healthcare professionals will help, but also that they will not actively harm by further victimizing people with health care services.

ii) Locating

Physically locating a patient who is unhoused can become the better part of a day's work. People who are unhoused often have no choice but to move their camping site based on weather, bylaw enforcement, safety concerns or any other number of reasons. Healthcare teams spend an inordinate amount of time and resources looking for patients who do not have a stable living site. This can result in a delay in diagnosis and treatment of acute conditions (pneumonia, wound care), chronic conditions (diabetes, heart disease), chronic conditions with life-altering disease courses (HIV), mental health conditions (schizophrenia) and normal life transitions that require medical support (pregnancy).

iii) Maslow's Hierarchy of Needs dictates patient priorities

People who are unhoused are not only deprived of housing. They are also almost always deprived of the needs at the base of Maslow's triangle. These are physiologic needs, and include not just housing but also food, water, sleep and clothing (which is also a type of shelter). When these needs have not been met, healthcare teams often need to tend to these first, before a person can engage meaningfully in their own healthcare.

iv) Absence of Maslow's Meeds – sleep deprivation, nutrition, hygiene, safety

The *absence* of Maslow's needs on the ability to provide healthcare to unhoused persons are related to, but distinct from, the need for patients to prioritize these needs. For example, people who do not eat for days at a time will have nutritional deficits that complicate disease presentation, diagnosis and treatment. People who have nowhere safe to sleep commonly have profound sleep deprivation, which can impact physical and mental health, but also contribute to greater risk of death through mechanisms like overdose.

v) Linkage to hospital-based care and diagnostics – trauma

Most people who are unhoused have had terrible and traumatizing experiences in the hospital system. They usually face stigma, untreated withdrawal from unregulated drugs, care provided in an invasive and paternalistic manner (searches, security guards.) Traditional hospital settings for those who are unhoused are typically judgemental, stigmatizing and provide negligent and/or inequitable care. These experiences make it very difficult to refer patients to specialty care, hospital-based imaging or diagnostics or to have patients consider a hospital admission when needed.

vi) Linkage to hospital-based care and diagnostics – loss of possessions

People who are unhoused have a tenuous and survival relationship to their possessions. Survival items like tents, cooking and warmth tools, clothing, and tents can take significant effort to obtain. When people living unhoused have to leave their tents, or their encampments are cleared, they are at high risk of losing all of their incredibly hard-won possessions. This affects people practically; they may

have no shelter to return to if they leave for an x-ray or a hospital visit. It is also important to recognize that for people who have so little, belongings can also be part of one's identity. People can lose a bit of their identity and self-worth as they repeatedly have fewer and fewer possessions. The community and city bylaw often see these meagre possessions as entirely disposable and having no meaning. This becomes a proxy for how people view themselves, and how they feel they are viewed by the rest of the community. When people lose their possessions, they also lose the function those possessions had in their life (shelter warmth, cooking). This directly negatively impacts their health, and creates another layer that healthcare teams caring for unhoused people need to attend to. The loss of phones is particularly profound as it also results in loss of contacts – to support workers, peers, family and resources. Similarly, when people lose their identification, they face additional barriers such as being able to access healthcare and apply for housing. People start all over again.

vii) Acute vs. Chronic medical concerns - Having to choose

People who are unhoused face sometimes overwhelming layers of unmet healthcare needs. These needs can be acute (wound care, burns, pneumonia) or chronic (diabetes, schizophrenia). Due to the health consequences of living unhoused, and the persistent onslaught of environmental factors (heat, cold, rain, snow) causing injuries and acute illness, it is difficult for healthcare providers to help unhoused people move beyond the treatment of acute issues to focus on chronic health needs.

viii) Interruptions in continuity of care and longitudinal care by forced transiency

The forced transience faced by unhoused persons, which can include encampment clearing by cities, interrupt the ability of healthcare teams to complete diagnostic and treatment plans. This is exacerbated by the lack of shared data systems between community healthcare teams, hospitals and jail.

ix) No access to Home Care Nursing, PSW, Physio or OT support

Most community support agencies are unable and unwilling to support people without an address. Most people living unhoused cannot travel to bricks and mortar locations for these services, for all of the reasons described above. This creates a large gap in necessary healthcare services for people who are unhoused.

x) Decreased access to "risky"/ intensive treatments such as (PICC lines) or surgeries

Unregulated drug use (for example fentanyl or crystal meth) is common among people living unhoused. This unregulated drug use is a survival support mechanism for most people, used to treat and cope with the extreme deprivation they live within. However, the use of unregulated street drugs, particularly intravenous use, is seen as a contraindication to many lifesaving medical interventions such as surgeries or PICC lines (a special IV used to deliver medications like antibiotics over many weeks or months). This "contraindication" is not based in evidence, but in primarily in stigma. Therefore while IV drug use is used by many unhoused people to survive their circumstances, this drug use is also used by hospitals and specialists to deny lifesaving treatments to people. This creates an abundance of untreated or undertreated infections in the unhoused population, which community healthcare teams need to "MacGyver" in order to try and keep people alive. These untreated

infections often worsen, then resulting in more drastic and expensive hospital-based treatments which could have been avoided if unhoused persons were given equitable access to care in the first place.

xi) Tech inequity

Sleeping rough makes it incredibly difficult to obtain, keep and maintain a cell phone. Services are increasingly relying on these methods of communication to follow-up with clients, a trend exacerbated by the COVID-19 pandemic. This results in missed virtual court appointments, inability to call intake phone numbers to receive health services or social services. If a phone call is made with a service provider, there is often an appointment set for days in the future, a task exacerbated by constant change in location as noted above.

xii) Geographical barriers

Being constantly forced into increasingly remote locations makes it difficult to get to pharmacy, get to probation, make housing viewings, make medical appointments, access food programs in the city's core, and attend court.

The Health Care Model's Attempt to Overcome Barriers in Healthcare

15. The Health Centre model of care seeks to ameliorate the practical difficulties described above, by designing service delivery that places the person in the centre of their care. The model attempts to overcome traditional barriers as follows:

i) Prioritize people needs over system needs

The Health Outreach teams designs services that meet people where they are at. This phrase refers to a harm reduction practice that prioritizes creatively meeting a person's needs in their individual context, instead of expectations they fit into

traditional models of care. “Meeting people where they are at” can mean providing culturally appropriate care, understanding a person’s social and emotional context, consideration of personal history and tailoring assessment and treatment plans to their individual framework. Or, with people living rough and in encampments, “meeting people where they are at” can be interpreted literally by medical teams, into actions such as bringing medical services directly to people living in encampments and other unstable housing sites. This approach is essential to providing successful medical care to people who are living in encampments.

ii) Culturally appropriate care to reduce stigma

Stigma causes people to disengage from healthcare that traumatizes, re-traumatizes, judges or shames them. The Health Outreach team reduces the impact of stigma by recognizing the lived and living expertise of people who are unhoused, as well as people who use drugs. This means centring these voices, and providing care that recognizes the benefits that using drugs can have on people surviving outside. The Health Outreach team prioritizes *supporting changes that improve both physical health* as well as social determents of health, over enforcing a structure based off of pre-conceived notions of how a person should fit into and move through the mold of traditional healthcare systems.

iii) Allied health team to address social factors in care and advocacy (housing, income, criminal justice, etc.)

An allied health team approaches care and reframes health care in the context of the social determinants of health. This is an acknowledgement of the social, societal, cultural, historical, and lifestyle factors which affect an individual and their

wellness. This can include their income, criminal "justice" system involvement, housing, education, culture, gender, employment, food security and the reciprocal relationship between these factors on overall wellness. A team that is literate in interpreting these factors in concert is equipped to address these contextual factors in a way that builds toward holistic wellness and equity. This broader picture of how inequity within a singular system, ripples into broader personal and systemic marginalization provides a powerful vantage point for care planning/ wrap-around care. This is also a valuable perspective in advocacy as building a context around inequity supports developing a community and ecosystem better suited for the wellness of people.

iv) <u>High-threshold accessibility/low or "no" barrier care</u>

The Health Outreach Team acknowledges the complexities that can result in missed appointments and medication adherence difficulties. The team is incredibly flexible, creative and solution focused in creating solutions to these difficulties. For example, medication may be delivered at a meal program that serves breakfast, or appointments with specialists may be conducted via facetime from a park.

Impact of Encampment Evictions on Healthcare Delivery

16. The Health Centre has encountered many of the healthcare problems created by encampment evictions. These include:

i) <u>Obliterates progress – personal stability</u>

Encampments provide more than just stability of physical location. They provide stability of community structures and human connections, the stability to build tomorrow upon the work accomplished today and yesterday. Stable community

structures allow people to stay connected with survival partners and other safe friends. Forced eviction upends this stability.

ii) Obliterates progress - Return immediately to the Bottom of Maslow's Hierarchy

The long-term act of surviving on the streets necessitates the accumulation of possessions to ensure needs and comforts are established, Being consistently moved from an established location results in progress toward building the materials needed for survival long-term being dismantled and reversed. When people are able to establish a space that is conducive to their survival in a way that does not require round-the-clock investment of time, they are able to engage in other areas of their wellness. The dismantling of this foundation in the form of encampment evictions pushes people back into a space where their focus must be on satisfying the most basic of needs, unravelling with it the progress toward other medical goals in that process.

iii) Locating

Programs and services for people who are housing deprived rely on the ability to support these people where they are known to be. When individuals are forced to frequently change their location, they are often unable to follow-up with supports and commitments, such as: missed court dates, applications for service waiting for signatures, health care needs which are unmet, missed appointments with healthcare specialist, and missed viewings for apartments. In sum, once people are disconnected from their support services, their ability to recover and stabilize is immediately compromised.

iv) Evictions create more acute illness

People's possessions are almost always lost during encampment evictions and clearing. The loss of items such as tents, clothing, and medications results in more acute health conditions such as frostbite or exposure. Loss of medications creates challenges in managing chronic and acute health conditions. The act of survival also creates acute and chronic health care needs. For example, losing diabetic medications such as insulin results in acute deterioration of blood sugars and resulting chronic deterioration of glycemic control when this happens recurrently.

v) Mental health impact

Eviction creates emotions of loss, fear, uncertainty, the de-valuing of people, and grief. Being treated as "human garbage to be swept along" (patient quote) exacerbates emotions of loss, and also exacerbates mental health conditions such as depression, anxiety, PTSD and panic disorders.

vi) Discharged from services which cannot locate patient

The precedent taken by survival can make it difficult or impossible for housing deprived people to maintain the required level of engagement for some programs. When some social and medical programs, such as housing supports, cannot reach a client, or the client does not regularly attend appointments, they risk being discharged from the program. Being discharged leaves an already marginalized individual with even fewer supports and community connections.

vii) Loss of trust, loss of therapeutic relationship

The "system" is seen as several interconnected pieces working together to support people in our communities. The clearing of encampments by large systemic figures

such as municipal bylaw officers deepens the mistrust in municipal services/authorities. This permeates the programs such as outreach and emergency shelter, which are directly funded by municipalities, as well as the rapport and relationship with agencies that partner with municipalities and rely on their ability to provide timely and effective service to people in acute need.

Encampment Evictions in London

17. Encampments often emerge in locations that are central to services which support street-based survival (hygiene, food, health care, harm reduction).
18. The City of London bylaw enforcement team regularly clears encampments, and will clear them daily at times.
19. As a result, there are no permanent encampments in London. Instead, encampment locations are continuously being cleared, the people evicted, and encampment locations shifting every few days to weeks. Therefore, it can be assumed that every person in London with a history of living in an encampment, can also be assumed to have been evicted from an encampment.
20. My current best estimate of patients currently cared for by Health Outreach, with an experience of encampment eviction, would be approximately 700 – 900 people.

Advantages and Disadvantages of Living in a Tent/Encampment: Aggregate Themes Amongst this demographic

21. Based on my 12 years' experience caring for unhoused people and people who live in encampments, the **most common** themes of harm associated with encampment evictions are as follows:

i) Environmental/weather related ailments – frost bite, heat stroke, burns

ii) Loss of survival possessions – tents

iii) Food insecurity and starvation

iv) Increased substance use

v) Fatal overdose

vi) Medical destabilization

vii) Lack of prenatal and perinatal care

viii) Increased sexual and physical violence

ix) Further marginalization

x) Loss of community safety and structure

Case studies of the themes

22. The following are case studies of patients supported by the Health Centre who experienced some of the harms set out above:

i) Example of environmental complication

- Person dug hole in park to hide from bylaw, laid there for several days in winter, and developed frost bite so severe that it resulted in multiple limb amputations

ii) Example of loss of survival possessions

- Loss of all clothes, boots, coats in winter due to bylaw clearance of encampment site, resulting in severe frost bite to both feet
- Person lost tent, flashlights, blankets, food, power sources/generators due to time limit attached to dismantle campsite (not afforded the time/ability to gather live-saving items). The person was then arrested after shoplifting to try and replace those survival items.

iii) Example of food insecurity and starvation

- Forced to move so far into margins to avoid encampment eviction/clearing, person could not access food banks
- No ability to own cooking pot or heat (for fear of discovery), existed on granola bars
- Died of starvation related illness

iv) Example of fatal overdose

- Person evicted from encampment. Had lived communally in encampment for many years
- Used drugs communally, following best practices which is to not use opioids alone
- Evicted from encampment, forced into solo living space
- Died of overdose within days

v) Example of medical destabilization

- Personal who required daily medication was unable to keep medication safe/storage, cyclically incarcerated due to crimes of poverty (stealing to eat, breaking/damaging store fronts) resulting in poor adherence to medical treatment, increased infection, increased substance use that directly impacted physical and mental health
- Person developed resistance to HIV medication due to poor adherence, resulting in an AIDS diagnosis with high risk of death

vi) Example of pregnancy/prenatal complication

- Lack of stable living site resulted in no prenatal care and cardiac arrest of baby during labour due to preventable pregnancy complication

vii) Example of increased sexual and physical violence

- Woman separated from survival partner during bylaw eviction
- Neither partner had phone, could not locate each other after being separated
- Slept solo for many days
- Without protection of partner, woman was gang raped while sleeping behind a dumpster, and then subsequently raped multiple more times, with each encampment eviction and separation from partner

viii) Example of further marginalization

- City bylaw cleared central encampment
- People moved to city margin to escape detection – resulted in complete disconnect from healthcare services, missed anti-psychotic injections resulting in acute psychosis and person became victim of violence

ix) Example of loss of community structure and safety

- People have lost feeling of community belonging due to inability to create peer-regulated spaces
- People are forced into isolated, inaccessible areas that created heightened risk of violence
- People are forced from rural areas to city limits resulting in new community members with no relationship with existing street-entrenched community often

resulting in increased violence, “othering” and lack of understanding of shelter services/basic needs services

Examples of Medical Care Provided to Evicted Encampment Residents

23. The following case studies based on patients supported by the Health Centre:

i) Woman recently evicted from downtown tent encampment

- Severe soft tissue infection to her lower leg
- Requested hospital admission three times over the previous months, was discharged twice and told to follow up with cellulitis clinic
- Left hospital against medical advice after stigmatized treatment in hospital
- Sepsis being kept at bay with antibiotics and care from mobile medical team but still requires surgical amputation
- Ongoing eviction every few days from encampment, mental that medical team spends more time locating this woman than treating her infection
- Woman is currently sleeping in an alleyway

ii) Man with multiple encampment evictions by city staff

- Untreated schizophrenia, untreated HIV
- Presented to team with multiple AIDS-defining illness
- Zero primary care, zero supports
- City deems him ineligible for hotel or city-funded shelters due to schizophrenic-related behaviours
- Has visited ER 42 times in last year. No referrals, no outpatient appointments, because he cannot be found

iii) Woman, multiple tent encampment evictions

- Severe seizure disorder
- No diagnostics, no treatment, no medications due to inability to locate and distrust of the system
- Seizures are so debilitating that she is unable to attend soup kitchens or church drop-ins for fear of injury or assault while post-letal
- Blood work shows severe malnutrition

iv) Woman evicted from tent encampment while actively miscarrying foetus

- By the time she was found in new tent location by medical team, was diagnosed with sepsis due to uterine infection

v) Woman with long-standing diagnosis of schizophrenia

- Numerous encampment evictions
- No supports, no medications, no form of treatment
- As per police, has been forcibly sexually trafficked for 18 months
- Ongoing psychosis makes her incredibly vulnerable to sex traffickers
- Active syphilis

24. I have reviewed many of the Applicant affidavits and find that their experiences and reports of being homeless and evicted from an encampment or not permitted to stay in an encampment, are consistent with the harm related themes reported by my patient pool.

Advantages of living in an encampment versus living in public space without a tent

25. Having reviewed the files of my patients who have reported living in an encampment, I have identified many benefits of living in an encampment compared to sleeping rough:

i) Health outcomes: Encampments decrease forced transiency which increases the odds that the unhoused can maintain routine connection to outreach services such as health care, system navigators, street outreach of basic needs (food, clothing), housing services, delivery of medications, harm reduction supplies, etc.

ii) Decreased isolation and risk of fatality: When people know they will be evicted by authorities, they will move further into the margins where they are less visible and more alone in order to avoid eviction enforcement by the authorities. By moving further into the margins such as forests, train tracks, abandoned buildings, holes dug into the ground, people place themselves at greater risk of harm because they are alone and disconnected from routine services. This places them at greater risk of violence, overdose and loss of connection to medical services.

iii) Community: Encampments give people a sense of community as opposed to when people are alone and hiding from authorities. The benefits of this include increased mental health stabilization, decreased drug use, increased chances of being helped during an overdose, emotional support, someone to watch possessions if the person is required to leave the site to use a bathroom, attend a food bank, an appointment, etc. Encampments also decrease risk of sexual violence because community members look out for each other.

iv) Privacy: Having a tent facilitates better sleep, the ability to store and use medications, to complete hygiene and other basic self-care. Tents also allow for privacy from the public gaze and abuse, which can be very detrimental to mental health.

v) Place to store possessions: There is often a sense of community that develops among encampment residents, and people come to rely on one another to watch their belongings when they leave the encampment site. Perspectives from individuals living in tent cities in the US have revealed that encampments can provide a sense of safety and autonomy that is not felt in shelters.[1]

vi) Minimizes sleep deprivation: Many unhoused persons with nowhere to sleep, need to stay up at all hours due to fear of violence and theft if they sleep in the open while alone.

vii) Shelter from elements: Tents provide an essential layer of protection from wind, rain, snow and sun. Without this layer of protection, there is an increased risk of weather-related ailments such as frost bite.

viii) Physical and mental rest: It is both physically and mentally taxing to have to constantly move and search for new places to shelter. Being able to remain in one place gives people a chance to rest and focus on recovery.

Advantages of living in an encampment versus shelter

26. Although there are safety risks in encampments, patients routinely make trade-offs between what the safest situation is given their options and personal circumstances.

i) Couples

In encampments, couples or "survival partners" can remain together. Almost always, there is insufficient shelter options for couples. This forces them to choose between separating in shelter or remaining together on the street. Separation causes stress,

[1] Hunter, J., Linden-Retek, P., Shebaya, S., & Halpert, S. (2014). Welcome home: The rise of tent cities in the United States. National Law Center on Homelessness & Poverty, Allard K. Lowenstein International Human Rights Clinic, Yale Law School.

anxiety and panic in partners who can no longer protect each other. When couples or survival partners separate to move into shelter, a female identifying partner may not get into shelter resulting in their being outsides alone and at serious risk of violence. As a result, the male identifying partner will usually elect to remain outside with the female identifying partner to provide them with safety and to avoid the emotional anguish of separating knowing that their loved one may be at serious risk of injury or death, or that reconnecting after they leave the shelter may be difficult if not impossible for days. Many unhoused do not have cell phones that would otherwise assistance with reconnecting.

ii) Connection to pets

Most people with pets are unable to find shelter space that will accommodate their animals. People who are experiencing homelessness are often estranged from family and close friends and their pets can be their biggest source of emotional support. These people often turn down shelter space due to their overwhelming need to remain with their pet. Pets are sources of emotional support for the unsheltered population. Many rely on their pet as their single source of support and consequently the loss of their pets can be traumatizing for them and can lead to dysregulation.

iii) Continuity and ability to plan

Shelter stays are inherently unpredictable and precarious. Many people can find themselves abruptly evicted onto the street at any time of day and with any weather conditions. People who have routinely experienced shelter evictions will opt to remain in an encampment because they know it has the ability to provide more day-to-day stability.

iv) Harm reduction vs abstinence-based shelters

Shelter spaces are often abstinence-based, refusing to adopt a harm reduction approach to provide increased safety and support for people who are housing deprived and using substances. Having to hide one's substance use in a shelter places people at grave risk of overdose as they are required to use alone or in hidden spaces such as showers or locked bathrooms. Such spaces inherently provide privacy and, therein, a space where response to accidental overdose would be greatly delayed or impossible in a timely manner. These structural barriers lead people to prioritize their safety by staying outside where they can access the support of peers and harm reduction services to stay well and stay safe.

v) Relief from physical burden of leaving and entering shelter every day

Given that shelters are routinely full and residents do not often have phones, they must walk with their possessions from shelter to shelter. It is very physically taxing, especially for those with physical disabilities to spend their days like this. It is physically and mentally less taxing to remain in a tent in one location. Additionally, when people must leave the shelter in the early morning, they are left with nowhere to go to rest, decompress or re-group until they return at night simply to attempt to sleep. As a population that experiences exceptionally high rates of physical disability (according to one study conducted in Toronto, 43% of homeless respondents reported arthritis or rheumatism, 23% reported problems walking, a lost limb, or another physical handicap, 20% reported heart disease, and 17% reported high blood

pressure, among others) encampments can provide reprieve from the need to constantly be moving and carrying belongings.[2]

vi) Restrictive rules regarding substances

Many shelters do not allow substances to be used or stored onsite. Some shelters do not even allow for harm reduction materials. Despite these restrictions, drug use can be rampant in shelters. People who are attempting to maintain sobriety are at risk of compromising their sobriety if they are at a shelter where drug use is high and it is trafficked. Sobriety is also threatened when people cannot bring harm reduction materials into shelter. At the other end of the spectrum, people with substance use disorders risk being kicked out of shelter if they are found using or with drug use paraphernalia.

vii) Shelters can be re-traumatizing

People with a history of trauma or abuse may be triggered by a congregate setting of strangers. People have a valid fear of being a victim of an assault or sexual assault in shelter, or may have a history of these incidents during their stay at a shelter that reasonably precludes them from returning to shelter due to this trauma.

Experience attempting to access shelter for my patients

27. Clients with complex medical needs secondary to their experience of living rough are often precluded from accessing shelter supports as their needs are often interpreted as "outside of the scope" of these shelters where the norm is to provide a bed and space for the night with discharges often early in the morning. Traditional home care nursing, PSW and OT

[2] The Street Health Report 2007. The Health of Toronto's Homeless Population. https://homelesshub.ca/sites/default/files/2.2%20Street%20Health%20Report.pdf at p. 16.

supports are often not open to providing service in these programs, resulting in gaps to therapeutic intervention even if a space is secured. In this way, housing deprivation leads to severe health complications which leads directly to further deprivation.

28. The institutional structure of traditional shelter programs can elicit a trauma response in client accessing these services with limitations on the activities they can do, the self-care they can perform, the safety they can find and the privacy they can be afforded. Clients packed into these spaces can respond in defensive manners interpreted as aggressive, leading to eviction and, at times, long term bans.
29. There are people in the city of London who are banned from every shelter program that exists within the city for these concerns. The high turnover of staffing and capacity of these spaces means care planning has limited efficacy when looking to mitigate these concerns for an individual.
30. The need for shelter has burgeoned for decades, exacerbated further by the COVID-19 pandemic. The number of people in need of space exceeds the amount of available emergency shelter space by hundreds. This means there are people who “fit” within the eligibility criteria for these spaces that are unable to access them due to over-whelming capacity issues.
31. The nature of survival places some people at risk for victimization in the community. There is a large subset of people who refuse shelter referrals due to fear of physical safety.
32. It can be anything but straightforward to try to access a shelter bed. As an initial barrier, many people experiencing homelessness do not have a phone to call for a bed.

33. The Health Centre often tries to secure shelter beds for patients. Most often, we are not successful. The following is an example of an attempt to navigate the shelter admission process:

    i) Client presented in crisis and sleeping rough with 16 year old daughter. Systems Navigator (SN) placed call to Coordinated Access (CA) to secure a shelter bed, however CA intake was not timely and booked 6 days post call with client having no access to phone. SN placed call to London Cares day-time resting space, however no space was available at that time. SN placed call to CMHA Stabilization Space, however no space was available at that time. SN placed call to Anova (VAW shelter), however no space was available at that time. SN placed call to St. Thomas shelter with answer of "maybe" should client be able to secure independent transport to city. SN placed call to Youth shelter, however daughter could access, but mother could not due to age limitations. SN placed call to London Cares again with answer of "maybe" but not the daughter due to lack of shelter capacity. Client leaves frustrated and back to street, to find encampment for the night. Client has never re-engaged after this experience.

34. I make this Affidavit in support of the Notice of Application, and for no improper purpose.

Sworn remotely by Andrea Sereda in the Province of Ontario, before me on May 12, 2023 in accordance with O. Reg. 431/20, Administering Oath or Declaration Remotely.

Commissioner for Taking Affidavits

Sharon Crowe

Andrea Sereda

May 12/2023

Bibliography

Hunter, J., Linden-Retek, P., Shebaya, S., & Halpert, S. (2014). Welcome home: The rise of tent cities in the United States. National Law Center on Homelessness & Poverty, Allard K. Lowenstein International Human Rights Clinic, Yale Law School.

The Street Health Report 2007. The Health of Toronto's Homeless Population. https://homelesshub.ca/sites/default/files/2.2%20Street%20Health%20Report.pdf at p. 16.

THIS IS EXHIBIT “A” TO THE
AFFIDAVIT OF ANDREA SEREDA
AFFIRMED REMOTELY BEFORE ME AT
THE CITY OF HAMILTON DURING A “ZOOM” VIDEOCONFERENCE
IN ACCORDANCE WITH O.REG. 431/20,
ADMINISTERING OATH OR DECLARATION REMOTELY
THIS 12th DAY of MAY, 2023

Sharon Crowe

Sharon Crowe
Commissioner for Taking Affidavits, etc

Dr. Andrea Michelle Sereda - CV

September 2022

A7844

London Intercommunity Health Centre
659 Dundas St, London, ON N5W 2Z1
Phone: 519-660-0874
Email: asereda@lihc.on.ca

1. Education

BSc (*honours*)	Honours Microbiology and Immunology, University of Western Ontario 2003
MD	Schulich School of Medicine & Dentistry, University of Western Ontario 2007

2. Qualifications

College of Physicians and Surgeons of Ontario (CPSO)
2007

Licentiate of the Medical Council of Canada (LMCC)
2009

Certification in the College of Family Physicians of Canada (CCFP)
Schulich School of Medicine & Dentistry, Rural Family Medicine stream
2009

Certification in the College of Family Physicians of Canada - Emergency Medicine (CCFP-EM)
Schulich School of Medicine & Dentistry
2010

3. Clinical Practice Experience

Current

Family Physician - London Intercommunity Health Centre, London, ON
Practice focus: Care for people experiencing homelessness (particularly women experiencing homelessness); care of people who use drugs
2013 – present

Lead Physician: Safer Opioid Supply Program, London Intercommunity Health Centre
2016 – present

Lead Physician: Street Level Women at Risk (SLWAR), London Intercommunity Health Centre
2016 – present

Past

Lead Physician: Transgender Health Program, London Intercommunity Health Centre
2016 – 2021

A3560

A7845

Emergency Medicine Physician - St. Thomas Elgin General Hospital
2010 – 2016

Family Physician - Centre of Hope Family Health Team
Practice Focus: Homeless healthcare, primary care
2010-2013

Hospitalist Physician - St. Thomas Elgin General Hospital
2009

4. Teaching Experience

London Intercommunity Health Centre
Medical Student and Resident placements focusing on homeless healthcare
2013 – present

Red Cross Emergency Medical Responder Instructor
Each fall, teach 80 hour course to Western Students who then go on to provide 911 response to the UWO campus
2008 - present

5. Administrative Positions

Governance Group Member, Executive Leadership Role, Street Level Women at Risk (SLWAR) program
2017 to present

Community Advisory Group, Street Level Women at Risk (SLWAR) program
2015 to present

Community Advisory Group, Youth Shelter Development, Youth Opportunities Unlimited
2017 to 2018

Community Advisory Group, Salvation Army Centre of Hope Homeless Shelter
2014 to present

Medical Director, Student Emergency Response Team, University of Western Ontario
2010 to present

6. Awards

Alumni of Distinction Award – Community Service Award
Schulich School of Medicine & Dentistry, Western University
2021

Health Equity Champion Award
Alliance for Healthier Communities
2020

A3561

A7846

Community Inspiration Award
Addiction Services of Thames Valley
2020

Canada's Top 40 under 40
Awarded for work with Street Level Women At Risk (SLWAR) program
2018

London's Top 20 Under 40
Awarded for work with Street Level Women at Risk (SLWAR) program
2018

CCFP Resident Research Award: "Healthcare for the Homeless"
Schulich School of Medicine & Dentistry, Western University
2009

7. Grants

Health Canada - Substance Use and Addiction Program (SUAP) grant
$6.7 million to expand access to Safer Supply program, London Intercommunity Health Centre, London, ON,
February 2020

Health Canada - Substance Use and Addiction Program (SUAP) grant
$2 million to develop Safer Opioid Supply Community of Practice,
June 2020

8. Peer Reviewed Publications

Gomes, T, Kolla, G, McCormack, D, Sereda, A, Kitchen, S, Antoniou, T. (2022) Clinical outcomes and healthcare costs among people entering a safer opioid supply program in Ontario: a comparative time series analysis. In-press (publication date - 19 September 2022. *CMAJ: Canadian Medical Association Journal*. www.cmaj.ca/lookup/doi/10.1503/cmaj.220892

Glegg, S, McCrae, K, Kolla, G**,** Touesnard, N, Turnbull, J, Brothers, T, Brar, R, Sutherland, C, Le Foll, B, Sereda, A, Goyer, ME, Rai, N, Berstein, S, Fairbairn, N. (2022). "COVID just kind of opened a can of whoop-ass": The rapid growth of safer supply prescribing during the pandemic documented through an environmental scan of addiction and harm reduction services in Canada. *International Journal of Drug Policy,106*, 103742. https://doi.org/10.1016/j.drugpo.2022.103742

Ryan, A., Sereda, A., & Fairbairn, N. (2020). Measures to support a safer drug supply. *CMAJ : Canadian Medical Association Journal*, *192*(49), E1731–E1731. http://doi.org/10.1503/cmaj.77303

Formosa, E., Grainger, L., Roseborough, A. D., Sereda, A., & Cipriano, L. (2020). A Survey of Canadian, Student-Run Campus Emergency Medical Response Teams. *Journal of Collegiate Emergency Medical Services*, *3*(2), 11-19. https://www.collegeems.com/a-survey-of-canadian-student-run-campus-emergency-medical-response-teams/

A3562

A7847

9. Clinical Guidelines

Hales, J., Kolla, G., Man, T., O'Reilly, E., Rai, N., Sereda, A. (2019) *Safer Opioid Supply Programs (SOS): A Harm Reduction Informed Guiding Document for Primary Care Teams*. Available online: https://bit.ly/3dR3b8m

10. Published Commentaries

Rai, N., Sereda, A., Hales, J. & Kolla, G (2019, June 19). Urgent call on clinicians: Prescribe alternatives to poisoned drug supply. *Healthy Debate.* https://healthydebate.ca/opinions/safer-supply-opioids

Wiltshire, K & Sereda, A (February 2019). Suffering in Silence: Intimate Partner Violence Amongst Physicians. *Vital Signs.* https://static1.squarespace.com/static/568eb5bbd82d5eecf06026c4/t/5c5dc7799b747a6e18de095f/1549649796829/VS0219.pdf

11. Academic Conference Presentations

Kolla G, Gomes T, McCormack D, Sereda A, Kitchen S, Campbell T, Singh S, Antoniou T. 2022. *Health system utilization outcomes and healthcare costs among safer opioid supply program clients in London, Ontario: a population-based cohort study.* Canadian Society for Addiction Medicine 2022 Scientific Conference. Saskatoon, Canada. November 3-5, 2022.

Kolla, G, Gomes, T, McCormack, D, Sereda, A, Kitchen, S, Campbell, T, Singh, S, Antoniou, T. 2022. *Clinical outcomes and healthcare costs among safer opioid supply program clients in Ontario: a population-based cohort study.* Canadian Association of HIV Research Conference 2022 (virtual). April 28-29, 2022.

Sereda, A. 2022. *Safer Supply & HIV*. Building Enhanced Treatment Responses (BETR) Provincial Conference. February 2022

Sereda, A. 2021. *Stimulant Safer Supply*. Harm Reduction International Conference (virtual). November 2021

Sereda, A. 2021. *Fentanyl, the Opioid Crisis & the Injection Drug User: Re-Imagining Solutions.* Opioid Use Disorder in Primary Care Conference, Centre for Addiction and Mental Health (virtual). March 2021.

Sereda, A. 2020. COVID-19, Substance Use and Safer Supply. British Columbia Centre for Substance Use (BCCSU) (virtual). May 2020 https://www.youtube.com/watch?v=an3yogOl5g0&t=85s

Kolla, G., Sereda, A., Rai, N., Hales, J. 2020. *Building resources for Safer Opioid Supply prescribing to address the opioid overdose crisis in Ontario.* Canadian Public Health Association Conference, Winnipeg, Canada. April 28-30, 2020. (Conference cancelled due to COVID-19)

Sereda, A. 2019. *Harm Reduction 101.* Family Medicine Forum (FMF), Vancouver, Canada. November 2019

A3563

Sereda, A., Brothers, T., Kolla, G. 2019. *Initial impacts of a "Safe Supply" oral hydromorphone substitution prescribing initiative for people who inject drugs in London, Ontario*. Canadian Society of Addiction Medicine. Halifax, Canada. October 24-27, 2019.

Sereda, A. 2019. *Building Trust: Using Safer Supply to change the Opioid overdose epidemic*. Canadian Society of Addiction Medicine. Halifax, Canada. October 24-27, 2019.

Sereda, A. 2018. *Street Involved Sex Workers; A United Model from Streets to Homes*. Canadian Association to End Homelessness (CAEH). November 2018

Sereda, A. 2017. Outreach Medicine and Street Level Women. London Health Sciences Centre Vulnerable Populations Symposium. December 2017

12. Invited Presentations

Briefings for policy makers

Invited Speaker, "Safer Supply - a common sense approach to the overdose crisis" Briefing for the federal Minister of Mental Health and Addictions Health Carolyn Bennett. London, Canada. April 2022

Invited Speaker, "Introduction to Safer Opioid Supply". Timmins Mayor's Office
Timmins, Canada. May 2021

Invited Speaker, "Fentanyl, the Opioid Crisis & the Injection Drug User: Re-Imagining Solutions". Briefing for the Federal Opioid Response Team, Ottawa, Canada. October 2020

Invited Speaker, "Safer Opioid Supply in the Context of the Overdose Crisis". Briefing for the federal Minister of Health Patty Hajdu. 13 July 2020

Invited presentations at conferences, grand rounds or community organizations

Keynote, Safer Supply Community of Practice Regional Meeting, Toronto, Canada, 10 June 2022

Panelist, "The Future of Safer Supply". Alliance for Healthier Communities Conference. Toronto, Canada. 9 June 2022.

Invited Speaker, "Introduction to SOS". Thames Valley Family Health Team. London, Canada. April 2022

Invited Speaker, "Care of Marginalized Persons". Critical Care Rounds, London Health Sciences Centre, London, Canada. November 2021

Invited Speaker, "Safer Supply 101". Schulich School of Medicine & Dentistry, London, Canada. December 2021

Keynote, "Safer Supply 101". Neighbourhood Legal Annual General Meeting, Toronto, Canada. November 2021

Panelist, "Women & Safer Supply", Women and HIV/AIDS Initiative, Toronto, Canada. September 2021

Invited Speaker, “Introduction to Safer Opioid Supply”. Hamilton Urban Core Community Health Centre, Hamilton, Canada. August 2021

Invited Speaker, “Introduction to Safer Opioid Supply”. Sudbury Harm Reduction Network. Sudbury, Canada. July 2021

Invited Speaker, “Harm reduction, Marginalized Persons and SOS”. Oncology Grand Rounds, London Health Sciences Centre, London, Canada. May 2021

Invited Speaker, “Introduction to Safer Opioid Supply”. Timmins Public Health Unit, Timmins, Canada. April 2021

Invited Speaker, “Introduction to Safer Opioid Supply”. London Children’s Aid Society, London, Canada. April 2021

Invited Speaker, “Introduction to Safer Opioid Supply”. Sudbury Drug Strategy, Sudbury, Canada. April 2021

Keynote, “Fentanyl, the Opioid Crisis & the Injection Drug User: Re-Imagining Solutions.” University of Western Ontario Alumni Association. London, Canada. February 2021

Invited Speaker, “Fentanyl, the Opioid Crisis & the Injection Drug User: Re-Imagining Solutions”. Chatham Kent Hospital Association. February 2021

Invited Speaker, “Fentanyl, the Opioid Crisis & the Injection Drug User: Re-Imagining Solutions”. Thunder Bay Community Health Centre. February 2021

Invited Speaker, “Harm Reduction 101”. University of Western Purple Hands. January 2021

Invited Speaker, “Fentanyl, the Opioid Crisis & the Injection Drug User: Re-Imagining Solutions”. John Gordon Home HIV/AIDS Hospice, London, Canada. January 2021

Invited Speaker, “Fentanyl, the Opioid Crisis & the Injection Drug User: Re-Imagining Solutions”. Internal Medicine Grand Rounds , London Health Sciences Centre, London, Canada. November 2020

Invited Speaker, “Fentanyl, the Opioid Crisis & the Injection Drug User: Re-Imagining Solutions”. Family Medicine Grand Rounds, Schulich School of Medicine & Dentistry, London, ON. September 2020

Invited Speaker, “Safer Opioid Supply in the Context of the Overdose Crisis”.
Alliance for Healthier Communities Conference, June 2020

Invited Speaker, **“**Building Trust: Using Safer Supply to change the opioid overdose narrative”. Psychiatry Grand Rounds, London Health Sciences Centre, London, Canada. February 2020

Invited Speaker, “Harm Reduction 101”. Abuse Shatters Lives Conference, Timmins, Canada. February 2020,

Invited Speaker, “Safer Opioid Supply Programs in the Context of the Opioid Overdose Crisis.” Grand Rounds, Sherbourne Health. Toronto, Canada. 20 January 2020.

Panelist, “Safer Supply”. Addictions and Mental Health Ontario (AMHO) Leadership Panel. Toronto, Canada. November 2019

Panelist, “Safe Supply Community Summit”. Community Forum for people who use drugs in the Downtown Eastside, Vancouver, Canada. November 2019

Invited Speaker, “Safer Supply”. Pan-Canadian Opioid Prescribing Initiative, College Family Physicians of Canada, Toronto, Canada. October 2019

Keynote, “Harm Reduction and Palliative care for marginalized and vulnerable Londoners”. University of Western Ontario Palliative Care, London, Canada. October 2019.

Panelist, “Safer Supply, Hepatitis C and drug-user health”. Ontario Hepatitis C Teams Workshop. Toronto, Canada. 29 October 2019.

Keynote, “Safer supply in the context of the overdose crisis”. Parkdale Queen West Community Health Centre Safer Supply Presentation. Toronto, Canada. 3 July 2020.

Keynote, “Safer Supply”. Regional HIV/AIDS Connection, London, Canada. June 2019.

Invited Speaker, “Safer Supply & SLWAR”. Emergency Medicine Grand Rounds, London Health Sciences Centre, London, Canada. March 2019

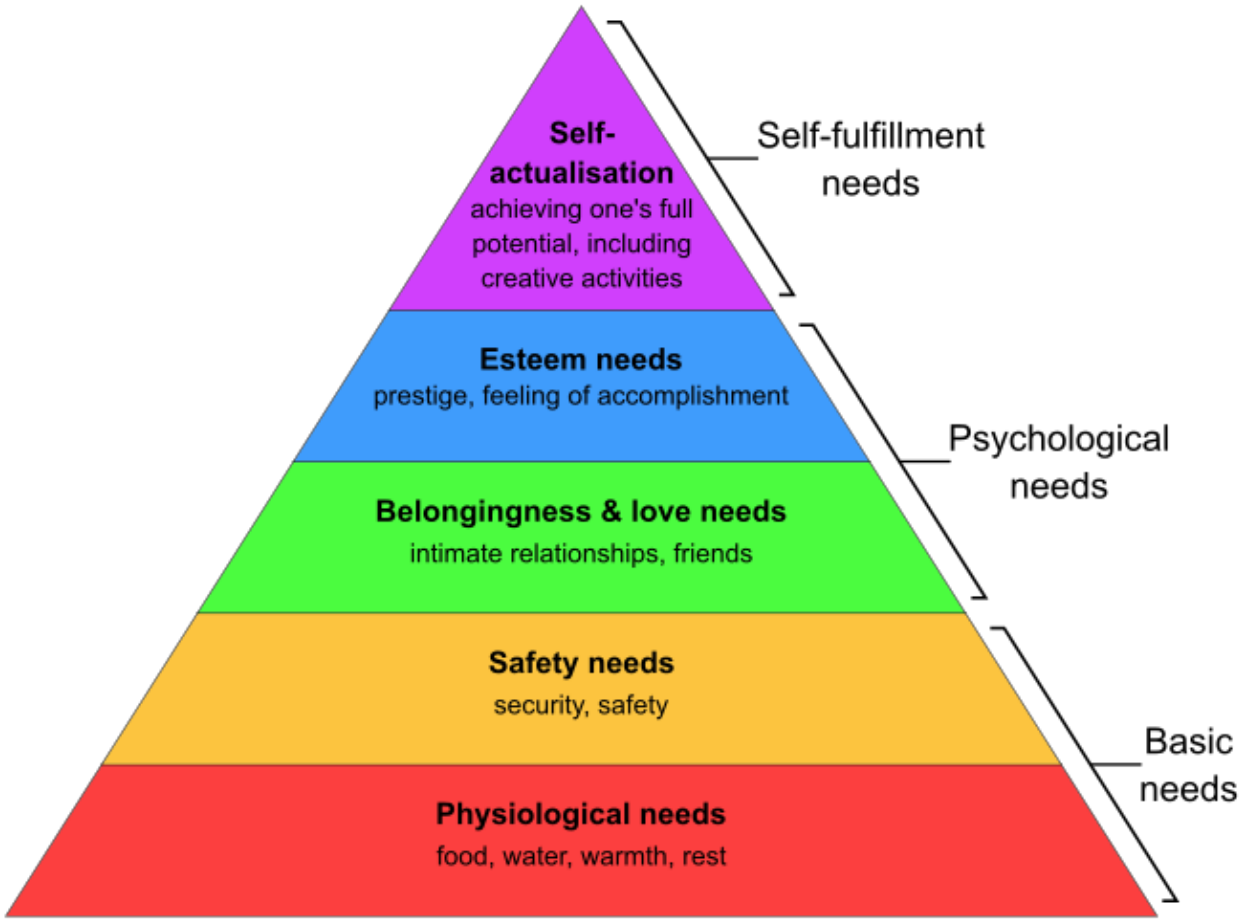
Invited Speaker, “Street Level Drugs of Abuse”. My Sister’s Place (Drop-in centre for homeless women), London, Canada. May 2016.

THIS IS EXHIBIT “B” TO THE
AFFIDAVIT OF ANDREA SEREDA
AFFIRMED REMOTELY BEFORE ME AT
THE CITY OF HAMILTON DURING A “ZOOM” VIDEOCONFERENCE
IN ACCORDANCE WITH O.REG. 431/20,
ADMINISTERING OATH OR DECLARATION REMOTELY
THIS 12th DAY of MAY, 2023

Sharon Crowe

Sharon Crowe
Commissioner for Taking Affidavits, etc

A7852


Self-actualisation
achieving one's full potential, including creative activities
Esteem needs
prestige, feeling of accomplishment
Belongingness & love needs
intimate relationships, friends
Safety needs
security, safety
Physiological needs
food, water, warmth, rest
Self-fulfillment needs
Psychological needs
Basic needs

A3568

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

ACKNOWLEDGMENT OF EXPERT'S DUTY

1. My name is Andrea Sereda. I live in the City of Aylmer, in the Province of Ontario.

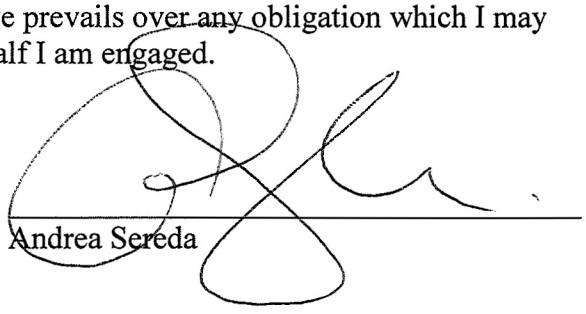
2. I have been engaged by or behalf of the Hamilton Community Legal Clinic to provide evidence in relation to the above-noted proceeding.

3. I acknowledge that it is my duty to provide evidence in relation to the above-noted court proceeding as follows:

    a. to provide opinion evidence that is fair, objective and non-partisan;
    b. to provide opinion evidence that is related only to matters that are within my area of expertise; and
    c. to provide such additional assistance as the court may reasonably require, to determine a matter in issue.

4. I acknowledge that the duty referred to above prevails over any obligation which I may owe to any party by whom or on whose behalf I am engaged.

May 12, 2023



Andrea Sereda

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

Cross-Examination on affidavit sworn May 12, 2023 of DR. ANDREA SEREDA, taken upon affirmation this 23rd day of AUGUST, 2024, via videoconference hosted by the offices of Nimigan Mihailovich Reporting Inc., One James St. S., Suite 701, Hamilton, Ontario, Canada L8P 4R5

APPEARANCES:

For the Applicants: SHARON CROWE
Community Legal Clinic of York Region
SUJIT CHOUDHRY
Haki Chambers Global

For Respondent: JORDAN DIACUR
Gowling WLG (Canada) LLP
VIVIAN CALDAS
LIZ MARR

INDEX

-- Upon commencing at 1:01 p.m.

DR. ANDREA SEREDA, affirmed

CROSS-EXAMINATION BY MR. DIACUR:

BY MR. DIACUR:

1 Q. Doctor, can you tell us where you're participating from today?

A. Where I am participating from?

2 Q. Yes.

A. I am participating from my home office in London, Ontario.

3 Q. Okay. And could you confirm for us that you're alone in the room?

A. I am alone in the room.

4 Q. And do you have a copy of your affidavit?

A. I have a PDF copy on the screen to my left.

5 Q. Well, just to be clear, while you can refer to your affidavit, you're not to refer to any other documents --

A. Yes.

6 Q. -- unless they're put to you, or unless you raise them in answers. So, in referring to any materials in giving answers, you'll, you'd need to state what you're referring too.

A. Uh-huh.

7 Q. And you'd need to explain how it informs your evidence; it would also have to be made an exhibit so that we have a record of it.

A. I understand.

8 Q. Okay. Great.

And finally, you're not to receive any assistance in giving your answers; is that clear?

A. It is clear.

9 Q. Okay. And you've been affirmed to tell the truth today?

A. Yes, I have.

10 Q. And can you tell me what you understand your role to be in this litigation?

A. My understanding is that I'm here as an expert witness as a physician caring for people who are unhoused for the past 14 years; giving evidence on the health consequences of living unhoused, and giving expert testimony on the consequences of living/sleeping rough versus sleeping in an encampment versus sleeping in a shelter; I'm around the situations where people may choose to make decisions among those.

11 Q. And you are to provide opinion evidence that is fair, objective and non-partisan?

A. Yes.
Q. You're to provide opinion evidence that is related only to matters that are within your area of expertise, correct?
A. Yes.
Q. You haven't been qualified to give evidence as an expert in a court in Ontario before now, is that right?
A. That is incorrect. I have been qualified two times previous to this.
Q. Okay. Do you recall what cases those were?
A. They were for the Kingston encampment case, as well as the Kitchener-Waterloo case.
MR. CHOUDHRY: Mr. Diacur, sorry, if you'd like, we can -- unless you need, if you'd like, we can provide you with those citations but you probably should be able to find them yourself.
MR. DIACUR: No, no, I've got the citations. I appreciate it, counsel.
Q. In this matter you've not provided a document called an Acknowledgment of Expert's Duty or a Form 53 it's sometimes referred to, is that correct?

MR. CHOUDHRY: Mr. Diacur, I believe we have that. Excuse me, Ms. Crowe?
MS. CROWE: Sorry. Yes, we do.
MR. CHOUDHRY: Could you provide that to Mr. Diacur, please.
MS. CROWE: Could I provide it right now?
MR. CHOUDHRY: Or an undertaking to provide it to Mr. Diacur?
MS. CROWE: Yes, my understanding was that it was already served, but we can provide that undertaking, yes.
U/T
MR. DIACUR: Thank you.
Q. Doctor, did you prepare your affidavit yourself?
A. I did.
Q. At the time you prepared your affidavit, what instructions were provided to you?
A. Now this was two years ago, so I am coming from memory, but instructions were provided to use my experience and expertise as a physician caring for unhoused people to give my testimony on the health consequences of living rough, sleeping in encampment and sleeping in shelters.

Q. Did you receive those instructions in writing?
A. I would have to go back for my email to answer that question, I do not know.
MR. DIACUR: Counsel, I'd ask for an undertaking that any letter of instructions to Dr. Sereda be produced.
MR. CHOUDHRY: Yeah, we will take than under advisement, and we will refer to it as soon as we can.
U/A
BY MR. DIACUR:
Q. So Doctor, is it the case that you are or were a member of an organization called The Forgotten 519?
A. Yes, that is true. I was a member of The forgotten 519 in the summer of 2022 and the fall of 2022.
Q. Thank you. And you were on the organizing committee of that organization; is that right?
A. That is correct.
Q. And the purpose of The Forgotten 519 was to serve as an advocacy group and lobby the city council of the City of London, Ontario; is that

right?
A. There were different roles among those of us on the committee. My role was to communicate, again, expert, expertise in the health consequences of encampment clearances that were occurring at that time in London, Ontario, other members of the committee engaged with the City of London under various meetings, and this did lead to very positive change.
Q. Yes, I understand that that's your role, but the purpose of The Forgotten 519 organization, its purpose was to serve as an advocacy group and to lobby the City Council of the City of London, Ontario, is that right?
A. I disagree with that description. The purpose of The forgotten 519 was to call attention to an increase in deaths on the streets of London, Ontario, to express information about why these deaths were occurring, and to bring focus onto other ways in which we could serve the unhoused population in London, Ontario.
Q. Okay. I'd like to show you a document, and it's dated July 25th, 2022. I'm going to put it up on the screen now.
A. Uh-huh.

Q. Let me know if you can see that?
A. I can. If you're able to make it slightly bigger, I would appreciate that.
Q. Yeah, I believe I can. Let's see if I can.
A. That's great. That's great there.
Q. Okay. Great.
All right, so this has a symbol at the top left-hand corner that says "The Forgotten 519," and it states "For immediate release Monday, July 25th, 2022," at the top; is that right?
A. It does.
Q. Now, is this a press release?
A. I don't recall. Are you able to scroll down to the bottom?
Q. Yes, I can do that. It's two pages.
A. Uh-huh.
Q. So this is the bottom of the second page.
A. Okay. And if you can scroll back up?
So certainly my recollection is that this was sent to the City of London. From my memory,

I do not recall whether it was released to the media or not; it may have been, I do not recall.
Q. Have you seen this document before?
A. Yes, I have seen this.
Q. And who prepared it?
A. Members of the committee. So primarily it would have been written by Dan Oudshoorn and Jenna Rose Sands who are the third and fourth names at the top of this document, but certainly I had a role in editing and offering advice on the document.
Q. So that, as we see at the top, there is a list under the words "Organization Committee"
A. Uh-huh.
Q. You are the first on that list; is that right?
A. I am.
Q. And you approved the text of this document before it went out?
A. I did.
MR. DIACUR: So I'm going to propose that we mark this document as Exhibit 1 to this examination.

(EXHIBIT 1: Press release dated Monday, July 15, 2022.)
Marc, in order to mark this as an exhibit, I would need to be able to send it to you ; would you be able to put your email address in the chat so that I can do that at the conclusion of this examination?
COURT REPORTER: Yes, but remind me.
MR. DIACUR: I'll do my best.
Q. Now, doctor, if I look at the beginning of the document, so below the list of the organizing committee members, there's a statement in bold and all caps; can you see that?
A. Uh-huh, I do.
Q. And it states, among other things in bold and all caps, "The war on the impoverished." Do you see that?
A. I do.
Q. Is it your opinion that such a war is occurring?
A. It is to my opinion that there are a lot of political ideologies, currently and in 2022, that marginalize folks for living in poverty and do not adequately address their systemic and health care needs.

Q. And that can be accurately described as a war, in your opinion?
A. Yes.
Q. Who are the combatants in that war?
A. I would say this is being used as an analogy to the direness of the situation. As part of the discussions with the Forgotten 519, there were no "combatants," as you describe, that were discussed.
Q. It is a war without combatants? Is that what you were saying?
A. Yes. And I hope that you were referring to these as an analogy and metaphor and not taking it literally, as it was meant.
Q. I see. So it's not meant to be taken literally. Is it meant to be taken seriously?
A. Very much so.
Q. So you believe that the impoverished are suffering like combatants in a war?
A. I do.
Q. Who is the cause of that suffering?
A. Society at large, we all have our roles to play in creating this situation, as well

as ameliorating the situation. Decades and decades of decisions, whether that's at the level of policy or government or health care or individual, you know, interventions that at a health care level have all accumulated to the point where we're at where people are suffering, they are losing housing and their health, and their social determinants of health are suffering.

44 Q. And so below that section that's in bold and all caps, there's another section that's just in bold.

A. Uh-huh.

45 Q. The second sentence says: "We see inadequate city resources being dedicated to this emergency." That is by the City of London?

A. Yes.

46 Q. That was your opinion at the time?

A. Yes.

47 Q. Does that remain your opinion today?

A. It does not.

48 Q. And you believe that adequate city resources are being dedicated by the city of

London today?

A. I think the City of London is dedicating all of the resources at their disposal. We continue to work collaboratively with the city to engage further resources from the federal, provincial and municipal sources of money that can support these folks.

49 Q. One goal of yours and The Forgotten 519 organization was to pressure the City of London to allocate more resources to addressing homelessness; is that true?

A. That is correct.

50 Q. Is it your belief that all municipalities are responsible to address any homelessness within their borders?

A. I believe we are all responsible, again at federal, provincial and municipal levels, and at the level of citizenry. I believe that all citizens have a human right to housing and thus it is everyone's responsibility.

51 Q. And if we scroll down to page 2 of this document, there's an enumerated list, one, two, three in bold; do you see that?

A. I do.

52 Q. Number 1 on this list demands

"Immediate cessation of any removal of encampments, tents, campsites or squats," and, among other things that are listed, city parks; do you see that?

A. I do.

53 Q. And that was a goal and a demand of yours and The Forgotten 519?

A. Yes, it was. At the time that this action, this advocacy was happening, we had seen a surge in people who were dying on our streets due to being in a state of being unhoused, and we saw the implications of encampment clearing and relocation, that was, we believe, and I believe, contributing to morbidity and mortality in this group of humans.

54 Q. Was there an immediate cessation of any removal of encampments, tents, camp sites or squats in city parks in the City of London?

A. There was an immediate discussion, a collaborative discussion to move to larger meetings involving all people working within this sector and outside the sector, including business development, police, so really, you know, agencies from across London; there was a commitment to come together and determine how we could safely support people who live in encampments in London, and yes, we did ask for a moratorium. In hindsight, I

cannot recall if that was done immediately or if it was done during those consultations and collaborative work.

55 Q. Okay. And so below that enumerated list that we were just discussing, there's a statement that:

"If the City of London does not agree to the enumerated list of demands, one of the members of The Forgotten 519s will begin a hunger strike."

Is that --

A. Right.

56 Q. -- a reference to Mr. Oudshoorn that you had mentioned earlier?

A. Yes, it is.

57 Q. And Mr. Oudshoorn did begin his hunger strike; is that right?

A. He did, yes.

58 Q. And it ended when concessions were given by the City of London; is that right?

A. It was ended after discussions were entered into where basic needs were agreed to be provided, such as water, protection from the elements, and Mr. Oudshoorn was making his own

individual decisions about whether to start or end his hunger strike. I believe he did so after approximately five days, that is an estimate based on my memory.

59 Q. No, thank you, that anticipates my next question. So thank you for that.

You've provided a copy of your CV, your curriculum vitae --

A. Uh-huh.

60 Q. -- in this matter; correct?

A. Yes.

61 Q. Why is The Forgotten 519 not included in that CV?

A. That's a good question. I think it should be, and I will update my CV to include that work.

62 Q. And actually, I'd like to go to that CV at this point; I'm going to jump down to the page that it's on. It's an exhibit to your affidavit.

A. Uh-huh.

63 Q. If I scroll down through your CV, again your CV is enumerated, it's a list.

A. Uh-huh.

64 Q. If I go to number 7, there's a

list of grants. You reference two Health Canada substance use and addiction program, or SUAP, grants, in February 2022 and June of 2022, totaling $8.7 million in funding; is that right?

A. It is correct, other than your statement of date; those were in 2020 not 2022.

65 Q. I'm sorry yes. No, no, that's an error in my notes, I see that; that's just me making that error in my notes.

So yes, the dates are, for the record, February 2020 and June 2020; is that correct?

A. That is correct.

66 Q. And what were those grant funds used for?

A. They were used to hire more staff within the London Inter-Community Health Centre to provide wraparound services such as inreach, outreach, housing support workers, case managers, care facilitators; we hired more nurses; and we were really able to expand the wraparound supports that can help people with their social determinants of health within our Safer Opioid Supply Program.

67 Q. And has all that work been done in the City of London?

A. Can you please clarify your

question. The work itself that was done in the City of London?

68 Q. Well, yes. So, in terms of what the grant funds were used for, the list --

A. Yes.

69 Q. -- the list of different steps that were taken in order to expend those funds, was of that done in the City of London?

A. The first one, the 6.7 million, all of that work was done in the City of London. For The Community of Practice, that was a national organization based out of London Inter-community Health Centre, that acted as a community that gathered evidence, you know, had webinars and education and links to resources, again housed out of Inter-community Health Centre but as a national program. Although I do work with the Community of Practice, I did not have any role in creating it.

70 Q. Okay. So the data that was coming in came from across the country?

A. The data coming to the Community of Practice? Yes.

71 Q. Yes?

A. So the data there is from peer-reviewed published research from across the

country, program evaluations for across the country, educational webinars and seminars, I could go on. But, yes, the information inputted into that resource is from across the country.

72 Q. If I scroll down to number 8 in the enumerated list in your CV --

A. Uh-huh.

73 Q. -- there's a list of peer-reviewed publications.

A. Yes.

74 Q. The first entry on the list, it is entitled "Clinical Outcomes and Health Care Costs among People Entering a Safer Opioid Supply Program in Ontario."

A. Yes.

75 Q. You were part of a team that conducted an interrupted time series analysis of London, Ontario residents who received --

A. I was.

76 Q. -- a diagnosis of opioid use disorder and entered the Safer Opioid Supply Program between January 2016 and March 2019; is that right?

A. That is correct.

77 Q. And so this article, for example, is limited to a study of individuals in

London, Ontario?

A. That is correct.

78 Q. Okay. And if I scroll down to the next part of the enumerated list, clinical guidelines.

A. Uh-huh.

79 Q. You prepared clinical guidelines with respect to what's called Safer Opioid Supply Programs, SOS; is that right?

A. That is correct. We call them clinical guidance documents because there are different parameters for published guidelines, so that could be an update to my CV title, but it is a clinical guidance document.

80 Q. Okay. And that is the question I have for you: How are clinical guidance documents used by physicians?

A. Used by physicians or -- so how are they used?

So this guidance document is again published, for example, on the Community of Practice website, and we use it for teaching purposes. This was our early guidance document in 2019, and it helped people understand the criteria with which people need to meet to be able to access safer opioid

supply; it gives advice on how to initiate people, how to assess them, what indications and contra-indications; it gives advice around dose titrations and dose weanings. It also gives the right -- sorry, it's around safety mechanisms within the program.

81 Q. Do guidance documents have any form of official status in that they're required to be referenced by physicians in a particular area of expertise?

A. I do not know the answer to that question.

82 Q. Okay. That's fine, it's just, it seems to me that if a clinical guideline is available to be used by a physician, it's different than if it's required to be used by a physician. If that's not something that you can assist with, just -- can you confirm that?

A. I can confirm I don't know the answer to that question.

83 Q. All right. Thank you.

So if I scroll down to number 11 in the enumerated list in your CV, there's also, number 12 in your list, so there's Invited Presentations, number 12?

A. Yes.

84 Q. There is Academic Conference Representations, number 11?

A. Yes.

85 Q. By my count, you've presented at 50 conferences or other gatherings, and that includes federal government committees, since 2016; does that sound right?

A. It will be more now because this is a CV that I submitted back in 2022 when I submitted my original affidavit when this litigation, I think that's the correct term to use here, began, so it, actually that number has grown.

86 Q. Okay. Now, as I see it in this list, so that's the number 11 and number 12 in your CV, those presentations appear to have been with respect to either safer supply of opioids or harm reduction; is that correct?

A. That is correct, the bulk of those will be under those topics.

87 Q. Now, does the role of a physician, as you understand it, include the role of an advocate?

A. Absolutely it does.

88 Q. Now, would you agree that you

advocate specifically for people experiencing homelessness?

A. I would agree that, yes, I do, because I have 14 years experience, and my practice is engaged with people who are unhoused; within that group of people who are unhoused, I advocate for different interventions such as safer opioid supply. I also care for women in the survival sex work trades, so I do do advocacy around that as well, because when we're looking at those who are living unhoused, the life expectancy for my patients is approximately 47 years of age compared to the average Canadian life expectancy of 82 years of age, so within 14 years of caring people -- for people in an unhoused state, I would be negligent if I did not try to address that 35-year gap in life expectancy for my patients through advocacy.

89 Q. And your involvement in this litigation is part of your work advocating for people experiencing homelessness?

A. I'm pausing to consider, because I don't know whether this work is considered advocacy; I'm not actually sure what the proper title for it would be, and so I defer that question.

90 Q. Well, I'm sorry, you have to

answer the questions that are posed to you.

A. Fair enough. And I'm trying to give an accurate answer and not speculate.

So, whether this is advocacy, no, I'm going to say that this is, my work here is professional expertise, my professional experience giving evidence in this encampment case.

To me "advocacy" means working with different levels of government, medical agencies, medical institutions and governing bodies, to help them understand the needs of my patients and do better.

91 Q. Well, you'd agree that in this case you would be putting evidence before the judiciary, a level of government, and that it relates to your care for your patients for whom you advocate?

A. Yes, I think we may be getting a bit sidelined with the question though, because, yes, I am giving expert evidence here based on 14 years of experience working with the unhoused, and yes, it would look to improve the lives of people who are living unhoused, but I'm not sure why you're trying to label that as advocacy and why that's a negative thing.

92 Q. I'm not trying to label it as

anything, I'm asking you for answers to my questions.

A. Okay.

93 Q. You were an undergraduate student and went to medical school in London, Ontario; is the correct?

A. That is Correct.

94 Q. And you practiced medicine in London, Ontario and St-Thomas, Ontario, is that right?

A. That is correct.

95 Q. And you're presently licensed to practice medicine in Ontario, certified in family and emergency medicine; is that right?

A. That is right.

96 Q. You don't practice medicine in Hamilton, Ontario?

A. I do not.

97 Q. You have never practiced medicine in Hamilton, Ontario?

A. I have not.

98 Q. Okay. So I'd like to turn to your affidavit now. I'm going to have to do that by the index, because there's no simple way to simply click back to the affidavit once we're in the exhibits.

So on the screen now should be -- yes, your affidavit, sworn May 12th, 2023; do you see that?

A. I do.

99 Q. I understand that there was a previous version of this affidavit prepared in 2022, but what we have sworn in May of 20223 was identical to that; is that right?

A. Yes. The body of it, I don't recall why we re-swore it; I believe it was related to needing to resign or resign a form, that is my memory of why it's 2023.

100 Q. No, understood, I mean I've seen the previous version, it appears identical.

A. Okay.

101 Q. It may have also had something to do with the fact that it wasn't completely legible in parts.

So we have a completely legible document, sworn May 12tn, 2023, and this is the document that you have in front of you electronically?

A. It is, yes. Yes.

102 Q. All right. So I'd like to start with paragraph 4 of your affidavit.

A. Uh-huh

103 Q. Now --

A. And if I could pause for just a second, Mr. Diacur?

104 Q. Yes.

A. I get quite dizzy, if you can try and scroll through it just a little bit more slowly, I would appreciate that.

105 Q. Yes, of course. Yeah. No, no, the last thing I need is --

A. Yeah. Here I am closing my eyes as you scroll, so --

106 Q. Okay. Yes, I will make every effort to go slowly.

So in paragraph 4 of your affidavit you say this:

"Living unhoused means the patients are in a state of forced transience throughout the city."

Now, are you aware that in Hamilton, since August 2023, there has been a protocol in place that permits encampments within certain parameters in city parks?

A. I'm aware that it exists.

107 Q. Would you agree that there is no

current state of forced transience throughout the city in Hamilton, Ontario?

A. I do not have direct knowledge of that and so I cannot speculate, I cannot answer that question.

108 Q. Would you agree that such a protocol allowing encampments within certain parameters in city parks would involve an ending of a state of forced transience throughout the city?

A. If it was a properly enforced, properly written protocol, you know, engaging the advice of experts, that could. I do not know whether that is the state of the Hamilton encampment protocol.

109 Q. Understood. And so the statement that I've just read out to you, that is with respect to your personal knowledge of the unhoused population that you are familiar with in London, Ontario; is that right?

A. That is correct.

110 Q. And also at paragraph 4, and I'll scroll down to the bottom, you reference Maslow's hierarchy and attach a copy of that as an exhibit; is that right?

A. Yes, that is correct.

111 Q. And so, given that there is such a hierarchy of needs, you'd agree that some needs are higher in priority than others?

A. I would say that some needs are more urgent, needing to be attended to.

112 Q. Okay. So, for example, the need for air to breath is more immediate than and takes precedence over the need for food to eat?

A. Yes.

113 Q. Someone who doesn't have shelter, the need to provide them, themselves with shelter will take precedence over other needs in the hierarchy that aren't as high priority?

A. Yes.

114 Q. Is that right?

A. That is correct.

115 Q. So shelter has a higher priority than, for example, wanting a feeling of community?

A. Yes.

116 Q. Or wanting a feeling of autonomy?

A. I think that they are very interrelated, but if we're going on just strict single words here, then, yes, shelter would take priority.

117 Q. Often shelter has a higher priority than wanting privacy?

A. I'm pausing because this is actually at the level of the individual. So while I would choose personally shelter over those things, it would actually be an informed choice of the individual who was making those decisions about where on the hierarchy they choose their greatest need.

118 Q. Okay. Well, I mean I will go through, then, to the hierarchy at Exhibit B, I'll have to click through to that.

A. Yes, I can --

119 Q. I'll scroll down. I mean there are, I believe, five steps in the pyramid at Exhibit B to your affidavit; is that right?

A. Yes. And I am looking at my own PDF copy, at the same affidavit you're referencing to, just because the hierarchy is bigger on my screen.

120 Q. Understood. And so at the base of the pyramid we have physiological needs; is that right?

A. That's correct.

121 Q. That's food, water, warmth and rest?

A. Uh-huh.

122 Q. So when I say that shelter is on this, this pyramid, it would be at the level of physiological needs; is that right?

A. That is correct.

123 Q. And something like privacy that I was just asking you about, that wouldn't be a physiological need, it would be, at best, a safety need; is that right?

A. I can agree with that.

124 Q. Safety needs are higher in priority or above physiological needs in the pyramid but below physiological needs in terms of priority; is that fair?

A. Yes. Again, they are interrelated because often, having safety and security will relate to people's ability to obtain food, water, shelter, rest. So, yes, this is, this is -- the hierarchy is not necessarily meant to be interpreted literally. I think that's where this is going. And so that's why I keep bringing it back to they're interrelated and one supports the other, and therefore to achieve an important need, you often need to rely either on things that are higher or lower in the pyramid, as my example was, that you

often will need to feel security and safety to achieve the needs in the red zone, which is physiologic needs.

125 Q. Well -- and I see on this that the intimate relationship and friendships is at the level of belongingness and love needs?

A. Yes.

126 Q. That's the third level of the pyramid, two above physiological needs; is that right?

A. That is correct.

127 Q. So that you would agree that shelter has a higher priority in terms of Maslow's hierarchy than wanting to stay with a partner?

A. I would say Maslow's hierarchy indicates that, but again, each human makes an autonomous decision about what is more important to them.

128 Q. Understood. But Maslow's hierarchy is a document that you've referenced in your affidavit, and it does inform your opinion in this matter; is that right?

A. That is correct, it informs my opinion and gives an example of things that I refer to in my affidavit.

129 Q. And shelter has a higher priority in Maslow's terms than wanting to stay with a pet; is that right?

A. In Maslow's terms it does.

130 Q. Would you agree that the need for shelter changes depending on the circumstances, for example, the weather?

A. Yes.

131 Q. If it's nice outside on a particular day, shelter may become less important, and it might become more important to attend to one of the individual other competing needs?

A. It may change. Again, this is at the level of the individual who is making their own decisions for that particular day. Some people may still prioritize shelter for various reasons, some people may prioritize other things when the weather is good.

132 Q. Well, certainly people don't need to have a roof over their heads every single minute of every single day in order to have their survival needs met; is that correct?

A. Than would be correct. We all leave our homes and go outside. And so every -- a shelter -- you know, so as you referenced, a roof

over our heads every single minute of every single day, no, I would say that's not required for most humans; for some it might, based on, you know, any medical or chronic health needs that they may have, that may be required on an individual level.

But again, I think we have, really have to be careful generalizing here, because this is going to be specific to a certain person's needs .

133 Q. Understood. Okay. Well, I'd like to return to your affidavit, but, as I say, I will have to scroll up to the --

A. Yes.

134 Q. -- index.

A. I'm actually going to look away here for a moment.

135 Q. If you don't mind, yes --

A. It's okay.

136 Q. -- just to be safe.

A. Yeah.

137 Q. That's really the only way that I have to quickly jump back.

A. That's fine. I'm looking away.

138 Q. Okay. Thank you.

And we are -- I'll scroll slowly down, but at paragraph 11 of your affidavit --

A. Okay.

139 Q. So that's on the screen now.

A. Uh-huh.

140 Q. Do you have a copy of that as well?

A. I do.

141 Q. Okay. You reference a roster here of 1,800 patients; that is your roster as a physician, is that right, or is that the entirety of the team?

A. That is the entirety of the team.

142 Q. Okay. And all 1,800 of those patient reside in or around London, Ontario; is that right?

A. I would say that is mostly correct. There are a very small number of folks who may have transitioned back to family, for example, in Kitchener -- I'm making an example here -- but that would be far less than 1 percent.

143 Q. Okay. So almost all?

A. Almost all.

144 Q. And potentially all of those --

A. Uh-huh.

145 Q. -- 1,800 patients reside in or

around London, Ontario?

A. Correct.

146 Q. Okay. And I'm going to just slowly scroll down to paragraph 12; there's a reference here to an additional 1,100 unrostered people.

A. Yes.

147 Q. Now, in terms of those unrostered people that are seen, this is a reference to the home bus and street outreach teams that you're involved with?

A. It is, yes, that's correct.

148 Q. All of those individuals reside in or round London, Ontario; is that right?

A. That is correct.

149 Q. And I'd like to just scroll down to paragraph 13 of your affidavit. You mentioned in this paragraph the Health Centre.

A. Uh-huh.

150 Q. And you indicate:

"All patients are offered a broad array or wrap around health and social care by an interdisciplinary team,"

And then you mention the team

members. Now, you also use that term "wrap around health and health care."

A. Umm.

151 Q. Here it's health and social care, I understand that. What does wrap around health and social care involve?

A. To me, and to our particular clinic, it means one-stop shopping, where people can access in a coordinated way, often in a simultaneous way, all of the things that they need to support their health. It recognizes that these things are interconnected, that we can't often do them in a sequential way and that we need to wrap around the patient to ensure that all interventions are supporting each other in the care of the patient.

152 Q. Okay. So the meaning of "wrap around" in that sentence is that the various forms of treatment and care that are provided are interrelated and overlapping?

A. Correct.

153 Q. Okay. And if I scroll down to paragraph 14 of your affidavit, that will just take me a moment, I'll do it slowly.

A. Uh-huh.

154 Q. This comes under the heading or

sub-heading "Practical Difficulties with Delivering Health Care to the Unhoused"; do you have that?

A. Yes, I see it.

155 Q. Okay. And in this paragraph there are a number of sub-paragraphs; so starting with paragraph 14(1), under the heading "Building and Rebuilding Trust" --

A. Um.

156 Q. -- you state, the third sentence:

"People are deprived of housing in the context of significant accumulated lifetime trauma."

I just want to understand the word "deprived" in this context --

A. Uh-huh.

157 Q. -- because it could be read as meaning that housing has been lost or that housing has been taken away from the people you are speaking about, that's my understanding of how "deprived" might be interpreted.

What do you mean when you use the word "deprived" in this sentence?

A. Housing deprivation and people who are deprived of housing is one of the more recent

descriptors of what we used to call homeless people, which evolved to people living with homelessness, which evolved to people who are unhoused. And people deprived of housing is also an evolution of that term, recognizing that it's multifactorial, that it's historical that we lead, you know, have a housing crisis where not every citizen can access housing, and recognizing that there actually are mechanisms to achieve housing for all. So those who are living unhoused are deprived of housing in some way.

158 Q. That's helpful. I mean I have noticed that there is a bit of, let's call it linguistic change over time in terms of how this community has been referenced.

A. That is correct.

159 Q. And so currently, that term "deprived" or "experiencing homelessness" is the current or preferred term, is that what you would say?

A. I think, yeah, being able to say "current" or "preferred" would be very vague. I would say different, you know, homeless-serving organizations will pick from kind of the latter terms that I referenced. Almost nobody says "homeless people" anymore. "People living with homelessness"

used a little bit more often, but I would say the vast majority of those of us working in this sector would say people who are unhoused or people deprived of housing.

160 Q. Understood. Okay. Thank you, that's helpful.

In this same subparagraph, and I'll have to scroll down a little bit because it goes over the page, but you, at the bottom of page 6, reference multiple systems, and you say, again referring to people deprived of housing:

"They have often been traumatized and neglected across multiple systems."

And you give examples: Child Protective Services, the school system, health care; you put in quotation marks "addiction care," and you say the "Justice" system and the housing sector. In putting quotation marks around the word "Justice" in the phrase "The Justice system," you're indicating that, in your opinion, we do not have a true Justice system; correct?

A. I am indicating that I do not believe my patients receive justice in many of their encounters with the Justice system.

161 Q. Are you intending to show disdain for the courts?

A. I am intending to show no disdain, I am intending to show real concern about the reality for my patients.

162 Q. Are you intending to say that you do not respect the judges who hear cases and make decisions including about your patients?

A. Not at all.

163 Q. You are specifically saying that the courts sometimes traumatize and neglect the unhoused people that you care for?

A. I'm not actually referring in this context to the courts, I'm referring to things like jails, cells, places where people are held, and then their interactions therein.

My patients are often not listened to, they're also -- they're often considered not experts in their own experiences; they're often marginalized and stigmatized and therefore the truth of their behaviours is not well described , and it's hard for them to seek justice or obtain justice based on all of those systemic factors.

164 Q. Well, to obtain justice, you mean from the courts, do you not?

A. I'm not specifically referencing the courts. So again, I think I see where you're going with this, and I'm not going to be trapped in semantics, I am referring to my patients' experiences.

165 Q. Well, I'm not trying to trap you in semantics, I'm asking you what your affidavit means?

A. Uh-huh.

166 Q. When you say "The Justice system," you are excluding the courts from that?

A. No, I'm not saying I'm excluding the courts from that. I'm saying that my patients have very significant experiences, negative experiences throughout the Justice system, and that is a reality of their lives.

167 Q. And that includes --

MR. CHOUDHRY: Mr. Diacur --

BY MR. DIACUR:

168 Q. -- experiences in court?

MR. CHOUDHRY: Mr. Diacur, may I, sir? I believe that this question has been asked and answered a number of times by reference to the word --

MR. DIACUR: No, no, no, it's been

asked, it has not been answered, counsel. I'm going to get an answer to the question.

MR. CHOUDHRY: Mr. Diacur, I think what we'll agree to is this is a refusal now, I think you -- and you can put that on the record.

R/F

MR. DIACUR: Okay. Well, that's fine, but for the record, that question was not answered.

169 Q. Paragraph 14(4) of your affidavit, which I'll scroll down to slowly, under the heading "Absence of Maslow's" and I believe that should be "needs, sleep deprivation, nutrition, hygiene and safety," do you see that?

A. I do.

170 Q. Do you agree that that's just a simple typo in that sub --

A. That's a simple typo, yes.

171 Q. Okay. You say here that "Sleep deprivation can contribute to greater risk of death through mechanisms like overdose."

A. Yes.

172 Q. Does sleep deprivation directly increase the susceptiblity of a person to overdose or is there another mechanism you're referencing?

A. No, the sleep deprivation directly is -- sorry, I'm looking for the right word -- implicated in increased overdose.

173 Q. Okay. So it does actually increase your susceptibility as an individual if you are sleep-deprived?

A. Yes. Opioids are sedating, the agents that the street supply are cut with, such as benzodiazepines and others, are also sedating. Somebody who is quite sleep-deprived will be more susceptible to those sedating effects and therefore to overdose.

174 Q. Okay. Thank you.

And so if I go to paragraph 14(5) in your affidavit, this is under the heading "Linkage to hospital-based care and diagnostics-trauma."

A. Uh-huh.

175 Q. You say here:

"Most people who are unhoused have had terrible and traumatizing experiences in the hospital system."

On what are you basing this statement that most people who are unhoused have had terrible experiences in a hospital?

A. Based on my experience caring

for my 1,800 patients within the health centre over 14 years.

176 Q. Okay. And what does "most" mean? Is it possible to give me a percentage?

A. "Most" is a majority. "Most" is a majority. Most of the people I talk to tell me experiences, traumatizing experiences that they have experienced in the hospital system. It's a key driver as to why my patients will often refuse to return to hospital, and we need to work with them to either rebuild trust in that system, work with collaborative options that are available once we get them to hospital, or seek other options in the community.

177 Q. Okay. And you referenced that 1,800 rostered patients as being the source of that.

A. Uh-huh.

178 Q. Is it based on anything else?

A. I would say it's based, in my experience working with my patients, collaborating with other, you know, practitioners in this field, reading literature, although I do not have a specific reference at the tip of my tongue for you, working with researchers and any number of people, all tell similar stories, that most of the people that they

know who are unhoused have terrible and traumatizing experiences in the hospital system.

179 Q. And you cite no research for this proposition you mentioned that, that you don't have any at your fingertips?

A. Not at my fingertips, no.

180 Q. But you would agree there's no research cited for that proposition?

A. Not at my fingertips, no.

181 Q. You also say here in this same subparagraph:

"Traditional hospital settings for those who are unhoused are typically judgmental, stigmatizing, and provide negligent and/or inequitable care."

On what are you basing this statement that hospitals typically provide negligent and/or inequitable care to unhoused individuals?

A. Based on my 14 years of experience caring for 1,800 plus unhoused folks within London, Ontario, this is from my direct observation. It is also related to again communications with other clinicians working within this field, attendance at conferences where

discussions on this topic are had, and presentations in, as I'm going to go back to, almost all from the, you know, verbal histories that my patients give me when I sit with them.

182 Q. Okay. And the word "typically," what does "typically" mean? Again, can you give me a rough percentage?

A. "Typically" to me again means the majority, so greater than 50 percent.

183 Q. Okay. Again, there's no research cited for that proposition in this affidavit, correct?

A. No, I have cited no research for that.

184 Q. if I scroll down to paragraph 14(6) -- I'll do that slowly -- this is the sub-heading "Linkage to hospital-based care and diagnostics-loss of possessions."

A. Uh-huh.

185 Q. In reference to "unhoused individuals' possessions," you say"

"The community and city bylaw often see these meager possessions as entirely disposable and having no meaning."

Are you indicating that your opinion is based on insight into the minds of community members and bylaw officers?

A. Can you scroll lower because I don't see the sentence you're referring to?

186 Q. Oh, yes. No, that's fine, it is a lengthy subparagraph.

A. Yeah.

187 Q. I'm sorry, I thought that I had put it on the screen.

A. I'm much better at reading than verbal, so, yes, thank you.

188 Q. So if that sentence, "The community and city bylaw often see these meager possessions as entirely disposable and having no meaning" --

A. That's based on my experience, directly observing the teardowns of encampments and the disposal of possessions directly into garbage trucks and removed. And so, yes, I would be taking a cognitive leap to look into the minds of other people, but their actions convey to me that these personal possessions of people who are living unhoused have no importance or priority.

189 Q. And if I scroll down to the next

subparagraph, this is paragraph 14(7), under the heading "Acute versus chronic medical concerns-having to choose." And I will find the citation. It starts right at the very beginning:

"People who are unhoused face sometimes overwhelming layers of unmet healthcare needs."

You reference acute and chronic conditions and environmental factors.

A. Uh-huh.

190 Q. So there's heat, cold, rain, snow; you'd agree that health conditions and environmental factors will begin to affect anyone living unhoused, correct?

A. Correct.

191 Q. And those are impacts that result from the state of being unhoused, is that correct?

A. They are from the state of being unhoused, but they are also related to what type of state of unhoused that people are in; so whether they are sleeping rough, whether they are in an encampment that supports their sheltering and health care needs and access to clinicians, whether they are in shelter themselves -- and by "shelter" I mean bricks and

mortar shelter systems -- all of those will have different impacts, all of them have variable interactions with people's health and the environment.

192 Q. Can we say, as a general proposition, that being unhoused itself is bad for your health?

A. Yes. And I can reference back to my original statement saying that the average life expectancy of people who are living unhoused is 47 years of age.

193 Q. Understood. Okay.

So now I'd like to scroll down a bit further to paragraph 14(10) of your affidavit. So I'll do that slowly.

A. Uh-huh

194 Q. It's on the next page. It's under the heading "Decreased Access to Risky/Intensive Treatments such as PICC lines or surgeries."

A. Uh-huh.

195 Q. And you do say in this subparagraph that:

"Unregulated drug use is a survival support mechanism for most people

use to treat and cope with the extreme deprivation they've lived within."

A. Yes.

196 Q. Now, that's correct and is your opinion today?

A. That is correct. Many people, for example, a woman living sleeping rough may use crystal meth so that she can stay awake for two or three days and stay safe from sexual assault.

Many people who are sleeping rough use opioids to, you know, deal with the chronic pain of, you know, sleeping on the sidewalks in all four seasons of, you know, Ontario's weather.

Many people will use opioids to deal with the pain of, the physical pain of having to leave shelter every day with chronic illness and chronic disabilities and carrying their possessions around and being outside.

And many will use crystal meth for the same reason, to make sure that they are awake enough to look over their possessions when they are outside.

197 Q. And the term "most people" in this is statement, is that again the majority or

north of 50 percent in your experience?
A. Majority.
198 Q. And that's among the population that you're familiar with --
A. Correct.
199 Q. -- principally 1,800 rostered patients you have?
A. Yes. And the 1,100 that are cared for through the home outreach bus.
200 Q. Yes, I understood. Thank you for clarifying that.
And on this subject, you cite no research for the proposition you're putting forward, correct?
A. I cite no research.
201 Q. Paragraph 14(10), you also say that "Drug use is also used by hospitals and specialists to deny lifesaving treatments to people."
A. Yes.
202 Q. That's here towards the bottom of the screen currently.
"Denying lifesaving treatments," are you indicating that hospitals and specialists are responsible for resulting deaths of doing so?
A. Some are, yes.

203 Q. How many in your experience?
A. I cannot give you a number, I would have to go through my patient charts. Unfortunately, more than I care to count.
204 Q. Okay. I'd like to jump now to paragraph 15 in your affidavit, so that's going to take me a moment.
A. Hmm, hmm.
205 Q. Again, I might have to scroll down.
A. I have to say I'll look away if you --
206 Q. I'll scroll down, it will take a minute.
A. Mm-hmm
207 Q. So 15(2), again paragraph 15 has a number of subparagraphs.
A. Mm-hmm.
208 Q. So I'm going to go down to 15(2). This is a subparagraph entitled "Culturally Appropriate Care to Reduce Stigma."
A. Uh-huh.
209 Q. You see that?
A. I do.
210 Q. Okay. And it states in the

subparagraph:
"The health outreach team reduces the impact of stigma by recognizing the lived and living experience of people who are unhoused as well as people who use drugs. This means centering these voices and providing care that recognizes the benefits that using drugs can have on people surviving outside."
What benefits are you referring to?
A. Again, I spoke to some benefits in my previous statement. There can be safety benefits to using crystal meth. Again, this is particularly for women who need to stay awake in order avoid assault, theft or sexual assault.
There are the benefits of using opioids related to the chronic pain of being unhoused, which is significant and severe.
There's also quite a bit of emotional pain as well. There's a reason heroin is called a warm hug, if your community is constantly displacing you, stepping over you on the sidewalk, calling you derogatory names, if you're constantly having your rights violated, your possessions stolen,

there is severe and significant emotional pain related to that, and opioids can help people cope with that.
211 Q. Okay. Is there anything else?
A. Those are some examples.
212 Q. Okay. But I want to understand the scope of the benefits that are being referenced; is there any other example or any other information you can provide on that subject?
A. I think I'll leave it there.
213 Q. Okay. In terms of what you're basing that statement on, and I know you referenced the health outreach team, but this is again based on your experience with your patients in London, Ontario, is that right?
A. That is correct.
214 Q. And you cite no research to support that proposition beyond your own experience?
A. That is correct.
215 Q. Okay. All right. So I'd like to scroll down now to paragraph 16 in your affidavit, so I'll start doing that now, starting with paragraph 16(2). I believe this will take a moment because I'll have to get there slowly.
So paragraph 16(2) is on screen now

under the subheading "Obliterates Progress."

A. Yes.

216 Q. And you begin by saying:

"The longterm act of surviving on the streets."

In terms of long-term homelessness, what are the causes of that in your opinion?

A. Lack of housing.

217 Q. Is there anything else?

A. That is the primary driver of chronic homelessness in my community.

218 Q. And in terms of a synonym, "chronic" and "longterm" are the same?

A. Yes.

219 Q. Is there a reason in your opinion why some individuals remain on the streets longer than others?

A. Um, often, often it's not -- often it's luck or unluck. We -- often it's income disparity. Whether you're on a housing list with a certain Housing First organization, whether you have a really great housing outreach worker or one who is less supportive, whether you're on OW or ODSP therefore giving you different access to financial resources and what you can afford based to the market

rate, whether, you know, an affordable housing or rent-geared-to-income unit opens up on a list that you happen to be on, whether you need supportive and transitional housing because of significant physical or mental health aspects, whether you use drugs and kind of what facilities or transitional support or other units may be acceptable of people who use drugs, it goes on and on and on; it's highly variable.

220 Q. That's helpful. Thank you.

If I scroll down to paragraph 16(4), which is on the next page, under the heading "Evictions Create More Acute Illness."

You state that:

"People's possession are almost always lost during encampment evictions and clearing."

Again, that's based on your experiences in London, Ontario, and your patient rouster?

A. Yes, it is.

221 Q. And you state:

"The act of survival also creates acute and chronic care health care needs."

A. Yes.

222 Q. This is what we were discussing earlier, that being unhoused itself is bad for your health?

A. Yes. Certainly within that, though, there's ways that people cam ameliorate the impacts on their health. For example, having shelter that's appropriate for them, which can often be supported encampments or shelter-based shelter.

223 Q. Understood.

So if I scroll down to paragraph 16(7), which is the bottom and split between page 15 and 16 --

A. Uh-huh.

224 Q. -- of your affidavit, there's a paragraph:

"Loss of trust, loss of therapeutic relationships."

So the second part -- or I should say the second sentence --

A. Can you scroll down further? Oh, that's okay.

225 Q. Yes.

A. My apologies, I see it.

226 Q. Yeah.

A. Yeah.

227 Q. It's right there at the top, yeah.

A. Yeah.

228 Q. So the second sentence of this states:

"The clearing of encampments by large systemic figures such as municipal bylaw officers deepens the mistrust in municipal services/authorities."

A. Uh-huh.

229 Q. I want to understand what that means. Are you saying that because municipal bylaw enforcement officers may be involved when encamped individuals are directed to move, that that taints supportive programs, including emergency shelter that may be funded by municipalities?

A. Yes, I think it's hard for people who are living unhoused to differentiate who belongs to what organization, who is performing what role, and that's why "the system" is in quotation marks in the first sentence of that paragraph, because often to my patients, parts of the system are indistinguishable from each other.

230 Q. Understood. Okay.
So if I scroll down now to paragraph 17 in your affidavit, that's the next paragraph under "Encampment Evictions in London," and in fact this goes down to paragraph 20 --
A. Uh-huh.
231 Q. -- all in that same section.
This section is concerned with your experiences in London, Ontario; correct?
A. Correct.
232 Q. Okay. And I just want to scroll down now to paragraph 21 of your affidavit, the same page, under the heading "Advantages and Disadvantages of Living in a Tent/Camp."
Now, there's a list of harms in this sub paragraph, or an enumerated list of subparagraphs in paragraph 21 --
A. Yes.
233 Q. -- that includes a number of things, and you reference them as the most common themes of harm associated with encampment evictions.
A. Yes.
234 Q. And it starts with "Environmental/weather-related ailments," I'll put the whole list on the screen.

A. Uh-huh.
235 Q. But you can see that okay?
A. I can.
236 Q. And you do reference environmental/weather-related ailments like frostbite, heat stroke and burns?
A. Yes.
237 Q. Now, those things can and do occur as a result of the fact of being unhoused, correct?
A. Yes, in this population.
238 Q. Yes, now I'm only referencing the unhoused population, yes.
And again, this is based on your experiences in London, Ontario, and your patient roster?
A. Yes. And yes, unhoused people, this is the nature, these are, you know, things that can happen to them because they are unhoused; but certainly within that spectrum, there's different things that, you know, clinicians and teams and the patients themselves can do to ameliorate, make better or worse, the prevalence and the severity of these conditions.
239 Q. Yeah, no, understood.

And so the third item on this enumerated list, food insecurity and starvation.
A. Uh-huh.
240 Q. That can and does occur as a result of the fact of being unhoused as well; correct?
A. Correct.
241 Q. And substance use is also listed at number four on the list, or increased substance use?
A. Uh-huh.
242 Q. Substance use can increase and fatal overdoses can and do occur as a result of the fact of being unhoused; correct?
A. Yes.
243 Q. And medical destabilization is number six on this list; medical destabilization including due to lack or prenatal and perinatal care, which is list next--
A. Uh-huh.
244 Q. -- can and do occur as a result of the fact of being unhoused, right?
A. Uh-huh.
245 Q. Sorry --
A. Yes.

246 Q. -- you have to say "yes" because that, otherwise it doesn't show up on the transcript.
A. Yes.
247 Q. So thank you.
Then there is also a list of three other items: Increased sexual and physical violence, further marginalization, loss of community safety and structure.
A. Yes.
248 Q. You'd agree that crimes such as sexual and physical violence can and do occur or increase as a result of the fact of being unhoused; correct?
A. Yes.
249 Q. And an individual who is already part of a marginalized community may experience a loss of community and safety and structure as a result of the fact of becoming unhoused; is that right?
A. Yes.
250 Q. Okay. So I'd like to now turn to paragraph 22, the next paragraph; this is under "Case Studies --"
A. Yes.
251 Q. "-- of the Themes," that's the

heading for this. There are a number of case studies; again, there's an enumerated list, number 1 being example of environmental complication, for example; that's right?

A. Yes.

252 Q. Okay. And these case studies, they're all based on individuals that resided in or around London, Ontario and were your patients?

A. Yes.

253 Q. You're passing along information that was communicated to you by your patients?

A. Yes.

254 Q. Right. And if I go down to paragraph 22(2), which is the example of loss of survival possessions?

A. Yes.

255 Q. You reference -- and I'll go to the actual citation, I just want to make sure I have it. Yes, the time limit attached to dismantle campsite.

Now, I understand that in the example you're providing, there was insufficient time or ability to gather lifesaving items provided to the individual; is that right?

A. Correct.

256 Q. Are you aware that in Hamilton, Ontario, even before the current protocol that permits indefinite encamping within certain parameters, there was a process that involved notice of 14 days to gather possessions and move?

A. I'm not aware of Hamilton's processes, I'm aware and an expert in London's processes. I can say even based in London, where we've made significant headway, often we still do see people given insufficient time, so it can exist even within a well-running encampment protocol.

257 Q. Understood. But would you consider 14 days to be sufficient time?

A. I'm pausing because it's a difficult question. Fourteen days is sufficient time to do the practical, you know, packing up of these items, but it's not sufficient time if the person doesn't feel that they have a safe alternative to move these possessions to. It's like packing up a house with nowhere to go.

258 Q. Yeah, understood. I don't mean to cut you off. Thank you for that.

If we're in paragraph 22, number -- subparagraph four is on page 18 of your affidavit, I'll scroll to that now.

So number 4 in this enumerated list is example of fatal overdose.

A. Yes.

259 Q. Now, there is a reference here in the third bullet point: "Forced into solo living space."

A. Yes.

260 Q. In that instance, what force was exerted?

A. Sorry, I just didn't hear you.

261 Q. Oh, I'm sorry. In that instance, what force was exerted?

A. This person was removed from the encampment, not allowed to return to their encampment, and told that their only option was to live -- and I believe from my recollection of this case, it was during a COVID period where they went into a COVID hotel shelter space.

262 Q. So, in terms of the force used, it was a lack of other options, is that right?

A. Yes.

263 Q. I'd like to scroll down now to paragraph 23, this will take me a moment, slowly.

A. Uh-huh.

264 Q. This is under the sub-heading

"Examples of medical care provided to evicted encampment residents."

A. Yes.

265 Q. And again, there's a series of case studies.

A. Umm.

266 Q. And it does reference patients supported by the health centre, but just for clarity, all of these case studies stem from your work in London, Ontario and your roster of patients?

A. Yes.

267 Q. And the individuals --

A. As well as the 1,100 unrostered on the --

268 Q. Yes, I use that as a short form.

A. Yeah.

269 Q. Thank you for correcting that.

A. Yeah.

270 Q. It's the patients that you have treated?

A. Yes.

271 Q. Whether they are rostered or unrostered?

A. Yes.

272 Q. Okay. And again, you're passing

along information that was communicated to you by your patients?

A. Yes, but also is supported with my own observations, as well as records. For example, in this case that we're looking at here, 23, subparagraph one, "Left hospital against medical advice," that is documented in hospital records. So, yes, my patients are conveying into it because -- but because I'm directly involved in the case, it is also my own observations, and there are also records.

273 Q. Okay. Well -- and then that's actually my next question. It's the third bullet point in paragraph 23(1)). You indicate that the patient left hospital against medical advice , and that was noted in a medical record --

A. Uh-huh.

274 Q. -- indicating after stigmatized treatment in hospital. So is that something that was communicated to you by the patient or something that you witnessed firsthand?

A. Something that was communicated -- sorry, communicated to me by the patient. In this case she was called a junkie that did it to herself and did not feel safe with the health care team that referred to her in that way.

275 Q. Okay. Yeah, but that was communicated to you --

A. Yes.

276 Q. -- by the patient?

A. Yes.

277 Q. Okay. And I just want to clarify because I mean there was reference to medical records. You referred to the medical record yourself, saw the medical record for this?

A. Yes.

278 Q. Was that also recorded in the medical record, the fact that --

A. Of course it was.

279 Q. Okay. Well, I just want to clarify the answer. So that's no to the fact --

A. That is, the answer is no to that.

280 Q. But yes to the fact that there was leaving hospital against medical advice?

A. Yes.

281 Q. Okay. So if I scroll down to paragraph 24 of your affidavit -- I'll do that slowly.

So that's on the screen now. You indicate:

"I have reviewed many of the Applicant affidavits."

A. Uh-huh.

282 Q. What applicant affidavits did you review?

A. I have since then actually reviewed all of them. At the time of submitting the original application, I think I had only made it to 17 by the deadline and so I had two more to review. I have subsequently reviewed all of them.

283 Q. Okay. Did you identify anything in any of the applicant affidavits that was inconsistent with the themes reported by your patient pool?

A. No, I did not.

284 Q. In reviewing the applicant affidavits, did you consider that at the time you swore your affidavit there was a process in place in Hamilton that did not exist in London?

A. Sorry, you're facing downwards and I can't totally hear your question, could you repeat?

285 Q. I'm sorry, I'm actually trying to speak directly into the microphone, so -- I'll see if I can move it.

MR. CHOUDHRY: Mr. Diacur --

MR. DIACUR: Yes?

MR. CHOUDHRY: -- I think if you're going to ask The witness about the dates of the applicants' evidence, you should perhaps put to her when the affidavits were sworn.

MR. DIACUR: Well, I don't think that's necessary, counsel, I just want asked --

MR. CHOUDHRY: But you have referenced a date, you sort of talked about, as you know, the policies in Hamilton have evolved, you've explained that and you've asked her to date the observation -- the experiences of the applicants relative to the policy at the time; I think it's only fair to her for her to hear the date of the applicants' evidence.

MR. DIACUR: Well, I don't agree, counsel. She has confirmed that she has reviewed all of the applicants' affidavits --

MR. CHOUDHRY: Yeah, I --

MR. DIACUR: -- so I intend to ask about those.

MR. CHOUDHRY: Sure. And you described a process in place but you've not explained what that process is, you've not put it to her,

you've not put it on the screen, so I think it's only fair to her, given that her evidence isn't about Hamilton and she says she doesn't know it, to put to her the processes you're referencing.

MR. DIACUR: Well, we have discussed the process in Hamilton previously in this exact examination.

MR. CHOUDHRY: Sir, I'm sorry, Mr. Diacur, but I think there have been numerous different processes in place in Hamilton at different times, and I think it's important to be specific about which process at which time you're referencing.

BY MR. DIACUR:

286 Q. Yes, well, I am referencing, at the time of the applicant affidavits that you reviewed, Doctor, did you consider that at the time you swore your affidavit, you know the date of that, that there was a process in place in Hamilton that did not exist in London, Ontario?

A. I don't think that needs to be part of my evidence because what I was asked to do is refer them -- or sorry, review the affidavits and determine whether this was consistent with my own experience, and it was.

287 Q. Yes, and it's a relevant

question; I would say again that you must answer it.

MR. CHOUDHRY: Mr. Diacur, With respect, sir, I think you need to put to the witness precisely what process was in place if you're going to ask her whether she considered it at the time.

I think your question is vague, sir. I think you must be specific about the, to what your getting it to, and if we're to persist in this line, sir, I would, I put that down as a refusal.

R/F

MR. DIACUR: Well, I've very specifically asked about the time that she swore her affidavit, which we are aware of.

MR. CHOUDHRY: Yes, but sir, I would --

MR. DIACUR: I'm asking the witness if she identified anything in the applicant affidavits, which she confirmed she reviewed, whether it was anything I noted that was inconsistent with the themes reported by her patient pool, and now I am asking whether, in reviewing those applicant affidavits, any consideration was given that at the time that this affidavit was sworn -- it's on the screen right now -- there was a process in place for Hamilton that did not exist in London, Ontario?

MR. CHOUDHRY: So, sir, I think that's the ambiguity. I think this affidavit was sworn in May of 2023, but the applicant affidavits were sworn at a different time, and so I think what you need to do is to put to her the date on which the Applicant affidavits were sworn and to describe to her the policy that was in place on the date they were sworn.

MR. DIACUR: Yeah, no, I don't agree.

MR. CHOUDHRY: Well, I'm afraid we're going have to disagree, Mr. Diacur, so That's a refusal.

R/F

MR. DIACUR: Okay. Understood.

288 Q. So, if we go to paragraph 24 in your affidavit, under the subheading "Advantages of Living in an Encampment Versus Living in Public Space Without a Tent," is there is again a long enumerated list, but would you agree that the benefits you identify of living in an encampment, such as maintaining connection to outreach services -- which I'll scroll down to -- decreased isolation, community, privacy, storage, sleep and rest are also available at indoor shelters?

A. They could be, but in my experience they are not necessarily so. And again, this is related to informed, you know, patient/person choice about where they can best achieve these outcomes.

289 Q. And again, that statement is based on your experience with shelters in the City of London?

A. That is correct.

290 Q. All right. If I scroll down to paragraph 26 in your affidavit -- which I'll do slowly -- under the sub-heading "Advantages of Living in an Encampment Versus Shelter," you note that there are safety risks in encampments; now, what are those?

A. The same or similar safety risks that may be in shelter. So there may be risk of assault; there may be risk of theft, you know; there may be exposure to different health risks or infections, and people need to make that autonomous informed choice as to which setting better supports avoiding those frisks.

291 Q. Are there any risks in encampments that do not exist in shelters, indoor shelters?

A. I cannot think of any off the

top of my head.

292 Q. Would exposure to the elements be one?

A. No, it's not often different, because most shelters in London, Ontario -- and I would say this would be a typical practice across Canada -- ask their residents to leave during daytime hours. So, for example, shelter residents are often asked to leave after breakfast, around 7:00 or 8:00 a.m. in the morning; many shelters don't re-open for people to come back in until the dinner hour or into the evening. So there are up to 10 to 14 hours in a day where people who are residing in shelter actually are exposed to the elements.

293 Q. And again, that's based on the shelter system in London, Ontario?

A. That is correct.

294 Q. Paragraph 26(1)) -- again there's an enumerated list in this paragraph -- you reference the term "Survival partners."

A. Yes.

295 Q. You'd agree that if there is abuse between a couple, separating them might aid that person in experiencing abuse to get help?

A. It may. I often find that

unilateral decisions to intervene in domestic violence or in people within a couple's choice can often actually make them more acutely unsafe; so sometimes it may help, sometimes it may not, it is entirely dependent on the people and the situation.

296 Q. Certainly an abusive relationship would not be accurately described as a survival partnership; correct?

A. That is correct, and that's not what I'm describing here.

297 Q. No, no, I just want to draw the distinction for the purposes of my next question.

So, returning the hierarchy of needs for a moment, even if it's not an abusive relationship, if someone is at risk of, for example, freezing to death outside, it would be better to be warm and indoors apart than outside and freezing to death; correct?

A. Well, the patient, the person -- I always refer to them as patients, I apologize -- needs to actually weigh risks and benefits. So while there may be freezing temperatures, and that may be improved by sleeping inside a heated building like a shelter, they may have a heavy dependence on Fentanyl which they need to dose every one to two hours to

avoid going into severe withdrawal, which can -- withdraw from Fentanyl can result in severe cardiac effect and sometimes death, and people need to choose between those two options, and it's up to the person to make an informed choice of what they think is the greater danger to their health.

298 Q. So, if I scroll down to paragraph 26(2), there is, under the heading "Connection to Pets," a number of statements about people with pets and their inability to find shelter space that will accommodate their animals.

A. Yes.

299 Q. You would agree that a pet, as opposed to a service animal, don't have any sort of training?

A. Correct.

300 Q. Or socialization?

A. My pets have incredible socialization, as do many of my patients.

301 Q. Would you agree that pets may be aggressive?

A. Pets may be aggressive whether they belong to housed or unhoused people.

302 Q. And anyone can bring an animal into an encampment, is that right?

A. That is -- to my knowledge, I don't see anything that would stop them from bringing an animal to an encampment, other than whether the community is willing to accept than within the encampment.

303 Q. Even an aggressive animal?

A. I feel like you're asking me to speculate on this. Aggressive animals can be taken almost anywhere in our community, whether that's on suburban streets or encampments.

304 Q. So to return to the hierarchy of needs for a moment, again, if there's a risk of freezing to death outside, it would be better to be warm and indoors than freezing to death outside with their pet?

A. That would be a person's choice. Again, their pet may be such an integral part of their experience, it may be their, you know, social and emotional support, it may represent ties to their family or their previous housed experience, that the person decides that the emotional needs tied to that pet are a greater risk to them than whatever the temperatures are, and people make that informed and educated choice in their own lives.

305 Q. If we go to paragraph 26(3) --

A. Uh-huh.
306 Q. -- there is the heading "Continuity and Ability to plan," and you state here:
"Shelter stays are inherently unpredictable and precarious."
And you -- actually, I should say you go on to say:
"Many people can find themselves abruptly evicted onto the street at any time of day and with any weather conditions"
Do you have any direct knowledge of that ever having occurred in the City of Hamilton?
A. In Hamilton? No.
307 Q. If you go to paragraph 26(5), which is on the next page, page 25 of your affidavit, which I'll scroll to now, there's a heading: "Relief from physical burden of leaving and entering shelter every day." Do you have that?
A. Yes.
308 Q. And you reference -- and in fact, at the bottom of the next page, which I'll go to slowly, a footnote. So there's a footnote citing:
"The Street Health Report 2007, The Health of Toronto's Homeless

Population,"
And there's a PDF link and a page reference.
A. Yes.
309 Q. And this is again the health of Toronto's homeless population based on a study of, as it says in the title, Toronto's homeless population; correct?
A. That is correct. When reading the Street Health Report, I find that its observations and conclusions are consistent with my 14 years of experience in London.
310 Q. Okay. And so that's the reason for citing that report?
A. Yes.
311 Q. And again, that's not a study or a report based on a Hamilton population?
A. I dot not believe there's any Hamilton residents included in that, no.
312 Q. And if I scroll back up just to paragraph 26(6), "Restrictive rules regarding substances," you state here:
"Drug use can be rampant in shelters."
Again, that's based on your London,

Ontario experience?
A. Yes.
313 Q. And then you're not aware of that being true in Hamilton?
A. I'm not aware of the Hamilton situation. It is consistent, however, with my colleagues and other clinicians in other cities with which I collaborate and do research with.
314 Q. And if I understand this subparagraph, not allowing drug use in a shelter is bad because it does not allow for supervised use and harm reduction, but allowing drug use in a shelter is also bad because it threatens sobriety; is that correct?
A. Yes, both things can be true at the same time.
315 Q. So that sounds a bit like a Catch-22 to me, whichever choice shelters make, allowing or disallowing drug use on-site, it would be the wrong choice; is that correct?
A. No, that does not need to be correct. There are shelters that have different sections, for example, for men or for women; there are -- is a shelter within London that has a sober living floor; so sometimes those can exist within the

same building. Often however, having multiple options where people, based on where they are in the spectrum of their substance use or their recovery, could be the safest option for them. People need choice and people need autonomous informed choice.
316 Q. Thank you, that's helpful.
If we go to paragraph 26(7), there's the heading "Shelters can be re-traumatizing," and you indicate:
"People have a valid fear of being a victim of an assault or sexual assault in shelter."
You already told me that risk of assault or sexual assault increases as a result of the fact of being unhoused, is there any research that you can point to that indicates that there's a higher risk of assault or sexual assault in a shelter than among the unhoused population generally?
A. No, I do not have research for that.
317 Q. If anything, the presence of staff in a shelter may make it less likely that there would be crimes committed in the shelter; is that fair?
A. That is not my direct

experience.

318 Q. But again, that's based in London, Ontario?

A. Yes.

319 Q. And then I'd like to move on to paragraph 27 of your affidavit; this the heading "Experience Attempting to Access Shelter for my Patients."

And in paragraph 27, you mention:

"Clients with complex medical needs secondary to their experience of living rough are often precluded from accessing shelter supports as their needs are often interpreted as outside the scope of these shelters where the norm is to provide a bed and a space for the night with discharges often early in the morning."

A. Yes.

320 Q. And so you're referring here again to shelters you're familiar with in London; correct?

A. That is correct.

321 Q. And you're not familiar with the

scope of shelters that operate in Hamilton; is that right?

A. That is correct, but I believe my evidence here is consistent with evidence provided within the applicants' affidavits of their experience.

322 Q. Yes, no, I understand that. And so you've reviewed those affidavits, that's the limit of your experience with anything to do with the shelter system in Hamilton, is that right?

A. That is correct.

323 Q. Okay. And if I scroll down to paragraph 28 of your affidavit -- I'll put that on screen now -- you reference the institutional structure --

A. Uh-huh.

324 Q. -- of institutional shelter programs, and you state:

"Clients packed into these 'spaces' may respond defensively, but that this may be interpreted as aggression."

Again, you're not suggesting that you have personal knowledge of anyone being packed into any spaces in any shelter in Hamilton, correct?

A. Not in Hamilton, no.

325 Q. Or anyone in Hamilton, including the applicants having their behaviour misinterpreted by a hypothetical shelter employee?

A. I believe there are actually numerous examples in the Applicants' affidavits where they state that they were falsely accused of behaviours in shelter.

326 Q. Yes, but of aggression that was due to a defensive response, you're telling me that there are references like that in the Applicants' affidavits that you can point me to?

A. Pardon --

327 Q. I'm sorry?

A. I just didn't hear your last comment, sir.

328 Q. Yes, that there are comments that that specific thing, aggression that was actually defensive after being packed into a space in a shelter in Hamilton, you're telling me you can point me to examples in the Applicants' affidavits?

A. Those exact words are not present in the Applicants' affidavits, but the theme of that experience is.

329 Q. Oh, I see. Okay. Thank you.

And so, if I scroll down to paragraph 29 of your affidavit, and, in fact, it goes through to paragraph 33 on the next page, there are a series of issues that you discuss having noted in navigating the London shelter system for homeless people?

A. Yes.

330 Q. And again, all of your comments in these paragraphs are based on your experiences in London, Ontario and not Hamilton; correct?

A. Yes.

331 Q. You have no experience trying to find shelter for patients in Hamilton, Ontario?

A. No.

MR. DIACUR: All right. Well, thank you very much, Doctor, those are all of my questions for you. I appreciate you attending and answering.

WITNESS: Okay.

MR. CHOUDHRY: Mr. Diacur, I'd like to just take a moment to collect my notes and to review the situation, so I propose that we take a break.

Doctor Sereda, you're still under oath.

WITNESS: Yes.

MR. CHOUDHRY: So you have to remain

by yourself, not communicate with anyone, not be in touch with anyone and remain available.

WITNESS: Okay.

MR. CHOUDHRY: And when we reconvene, then we will, we might, I might have what's called a re-direction towards you.

WITNESS: Okay. Can I, can I acknowledge a time constraint that I have?

MR. CHOUDHRY: All right.

WITNESS: I was booked from 1:00 to 2:00 p.m., and I need to leave to pick up my daughter by 3:30, so that is a time limit I have.

MR. CHOUDHRY: So, Dr. Sereda, speaking for myself, I don't see us keeping you nearly close to that, and I'm sorry that we have taken on past 2:00.

WITNESS: That part was totally fine.

MR. CHOUDHRY: If it makes you feel any better, that is kind of a theme --

WITNESS: Uh-huh.

MR. CHOUDHRY: -- for the last couple of weeks, and so we will -- just give me about ten minutes, okay, at most, and I'll try to come back earlier if I can, all right?

WITNESS: Sounds good. May I go off cameras to have a drink, is that fine?

MR. CHOUDHRY: Mr. Diacur, is that fine with you?

MR. DIACUR: That's fine with me, I've got no issues with that.

MR. CHOUDHRY: And Mr. Beebe, I think, as it were, unless Mr. Diacur objects, we can go "off the record" --

MR. DIACUR: Yes.

MR. CHOUDHRY: -- during this break and we'll come back on within five to ten minutes and I'll be as quick as I can, okay?

MR. DIACUR: Yeah, that's not -- no, no problem at all, thank you.

MR. CHOUDHRY: Thank you.

(Off record at 2:30 p.m.)

(Resumes at 2:35 p.m.)

MR. CHOUDHRY: We have no questions for this witness.

MR. DIACUR: Okay.

MR. CHOUDHRY: So we can conclude this cross-examination from our perspective.

MR. DIACUR: Thank you very much. So off record.

(Adjourned at 2:35 p.m.)

I HEREBY CERTIFY THE FOREGOING
to be a true and accurate
transcription of my shorthand notes
to the best of my skill and ability.

MARC BEEBE, O.C.R.
Computer-Aided Transcription

Heegsma et al
Applicants

-and-

CITY of HAMILTON
Respondents

Court File No. CV-21-00077187-0000

Ontario
Superior Court of Justice

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COMMUNITY LEGAL CLINIC OF YORK REGION
21 Dunlop Street, Richmond Hill, ON L4C 2M6
Sharon Crowe (LSO# 47108R)
sharon.crowe@yr.clcj.ca

Michelle Sutherland (LSO# 70159T)
michelle.sutherland@yr.clcj.ca

Curtis Sell (LSO # 84128A)
curtis.sell@yr.clcj.ca

HĀKI CHAMBERS
319 Sunnyside Avenue, Toronto, ON M6R 2R3
Sujit Choudhry (LSO# 45011E)
sujit.choudhry@hakichambers.com

ROSS & MCBRIDE LLP
1 King Street West, 10th Floor, Hamilton, ON L8P 1A4
Wade Poziomka (LSO# 59696T)
wpoziomka@rossmcbride.com

Counsel to the Applicants