Court File No. CV-21-00077187-0000

ONTARIO SUPERIOR COURT OF JUSTICE

BETWEEN:

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

Applicants

-and-

CITY OF HAMILTON

Respondent

APPLICANTS' APPLICATION RECORD

VOLUME 17 – TABS 136-143

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TAB (EXHIBIT LETTER)	Document
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136.	Affidavit of Tessa Mcfadzean, Women's Services, Good Shepherd Centres,
	Hamilton dated July 26, 2024
137.	Transcript of the Cross Examination of Tessa McFadzean dated August 22, 2024
a.	Exhibit A – CBC Article: "Mom with 5 kids speaks out after being placed in cockroach infested unit at Hamilton shelter" dated June 22, 2021
SHAWN MACK	
138.	Affidavit of Shawn Mackeigan, Mission Services dated July 29, 2024
139.	Transcript of the Cross Examination of Shawn Mackeigan dated August 21, 2024
a.	Exhibit 1 – Hamilton Spectator Article entitled "Homeless, struggling with mental illness, barred from Hamilton shelters" dated January 20, 2021
b.	Exhibit 2 - Hamilton needs an estimated \$60M to address homelessness CBC News
c.	Exhibit 3 – City of Hamilton, Emergency & Community Services Committee Agenda, March 23, 2023, video (escribemeetings.com)
JAMES MOULT	TON
140.	Affidavit of James Moulton, The Salvation Army, Hamilton dated July 31, 2024
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a.	Exhibit A – The Salvation Army: Behind the Front Lines
CITY OF HAM	ILTON EXPERT WITNESS
DR. SHARON K	OIVU
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a.	Exhibit A – Curriculum Vitae (p 21/49)
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143.	Transcript of the Cross Examination of Dr. Sharon Koivu dated Sept 6, 2024
a.	Exhibit 1 - Minutes of the Meeting of the Standing Committee of Health dated May 6, 2024

b.	Exhibit 2 - National Post Article, Dr. Sharon Koivu, special to the National
	Post, dated June 10, 2024
c.	Exhibit 3 - Canadian Affairs Article dated July 8, 2024
d.	Exhibit 4 - Toronto Sun Article, August 18, 2023
е.	Exhibit 5 - London Free Press Article, Harms of safe drug supply programs outweigh benefits: Addiction Specialist
f.	Exhibit 6 - Boston Study
g.	Exhibit 7 – NO EXHIBIT EXISTS, REPORTER MISTAKEN
h.	Exhibit 8 – Press Release dated June 25, 2024

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Applicants

and

CITY OF HAMILTON

Respondent

APPLICATION UNDER 14.05 OF THE RULES OF CIVIL PROCEDURE

AFFIDAVIT

- I, **TESSA MCFADZEAN**, of the City of Hamilton in the Province of Ontario, **MAKE OATH AND SAY:**
- 1. I am the Director of Women's Services, Good Shepherd Centres, Hamilton ("Good Shepherd"), a position I have held for nearly five years; previously, I was an Assistant Director with Good Shepherd for more than 4 years. Good Shepherd is one of the largest providers of health and human services in the Hamilton area. In my role as Director, Women's Services, I oversee the provision of shelter services to women in the City of Hamilton. As such I have knowledge of the matters set out in this my affidavit. Where I rely on the information of others, I state the source of that information and verily believe it to be true.
- 2. I make this affidavit as an update and supplement to my October 12, 2021 affidavit in this proceeding.

- 3. Starting in or about April, 2020, the City of Hamilton worked with Good Shepherd, other shelter providers and local hotels to begin providing overflow shelter capacity, as needed, during the COVID-19 pandemic.
- 4. In terms of local hotels, the City oversaw the relevant contracts. The shelter providers initially assigned staff members to liaise with hotel staff; in May, 2020, we began to directly operate the hotel spaces on a day-to-day basis.
- 5. Until September 2, 2020, Good Shepherd worked together with a downtown Hamilton hotel to provide 24 hotel rooms for single homeless women; Good Shepherd operated all of the rooms on one floor of the hotel. As of October 1, 2021, Good Shepherd began working together with a different downtown Hamilton hotel to provide 55 hotel rooms for single homeless women. In March 2022, Good Shepherd shelter overflow transitioned to the Cathedral Boys School to expand overflow shelter beds to a maximum occupancy of 100 beds. In May 2023, the Cathedral contract came to an end, and a West Avenue site to provide overflow opened thereafter. West Avenue now operates 20 overflow spaces for single homeless women (cisgender, transgender and Two-Spirit) and gender diverse individuals.
- 6. The rooms at West Avenue are communal living spaces with four or five beds to a room. Each communal bedroom has a shared washroom. Each floor is equipped with a small lounge for residents to access. The overflow shelter is staffed 24 hours per day.
- 7. Overflow shelter spaces aim to be low-barrier. The services and support provided in the overflow shelter space are very similar to those provided in Good Shepherd's other shelter environments. We do not simply provide a shelter space; we engage consistently with the residents. Our program priorities remain safety planning, harm reduction, case management and securing a stable housing situation. Referrals to other shelter locations and transportation

is available and provided. We participate in a weekly prioritization call with other shelter agencies and the City of Hamilton to identify optimal placements for clients.

- 8. The expectations and services in our hotel overflow that are in place are the same as those at Good Shepherd's homeless women's shelter (Mary's Place). This includes wellness checks twice per day. Our services are not abstinence-based programs. Employees actively engage in drug-poisoning prevention planning, monitoring and assessing safety. Harm reduction program and residential expectations are communicated to every client when they first arrive, and are consistently the subject of discussion throughout case management engagement. Overlaid on these expectations is a recognition that certain statutory rules must be observed, such as no smoking (of tobacco or other substances).
- 9. The purpose of the wellness checks, like the wellness checks in our other shelter spaces, is primarily to ensure the safety of residents, and we do engage with residents if there are issues of concern. When a resident enters the overflow shelter residents are informed about wellness checks. The frequency of wellness checks can be tailored to the unique needs of the resident.
- 10. In terms of harm reduction, each resident is provided with information at intake regarding the services and supports available to them. Drug-poisoning prevention planning will be offered at intake, and throughout the duration of the stay, and revised as necessary. Good Shepherd is a Naloxone distribution site, offering kits and education to interested residents. Naloxone kits are also available to employees for the purpose of administration in the event of a suspected drug poisoning. Further, harm reduction supplies are available 24 hours per day. In the event of a drug poisoning, staff respond/intervene until paramedics arrive for further assessment and intervention as necessary. Employees will complete referrals to community-based harm

reduction supports where there is an identified need including safe supply, opioid antagonist treatment, and safe consumption sites.

- 11. Service restrictions and/or discharges from our shelters may be imposed for breaches of shelter expectations that result in compromised safety. They are not intended to be penalties, but rather the expected result of conduct that is unsafe.
- 12. A discharge to an alternate shelter may also occur if a different setting or supports are necessary due to unique complexities the resident is experiencing. When a discharge is imminent, employees will offer support to the resident to secure alternative accommodations. When this occurs, staff will complete a safety plan with the resident (if necessary) and provide transportation to alternate accommodations. If required, the overflow shelter can temporarily store resident belongings.
- 13. A discharge may occur when a client has secured a more permanent housing alternative. In these circumstances, staff will support the resident in developing a discharge plan based on individual need. Discharge plans will consider referrals to community supports, housing needs (furniture, groceries, insurance), safety/wellness planning and transportation.
- 14. A service restriction is a period of time, varying in length depending on the underlying reason for the service restriction, in which a client will not be able to access our services. It is important to note that discharge from the overflow shelter does not always involve a service restriction.
- 15. Service restrictions are rare and, even when they are imposed, they do not apply across the shelter system. We work with clients who are service-restricted with us in order to find them another place to stay whether that is in one of our other shelters, or a program in the community If a service restriction is imposed, the resident will be notified of the decision and the length of

restriction. Shelter standards require that, If requested, the service restriction can be provided in writing. Residents have the opportunity to appeal a service restriction and are informed on the appeals process at intake, throughout the duration of stay, and upon discharge.

- 16. Instances of threats, to Good Shepherd staff and program staff, and have occurred at our shelters but they have been rare. In these circumstances, we have been able to work with the individual to address concerns, or secure an alternate emergency shelter.
- 17. Service animals are permitted in our shelters. If someone is seeking emergency shelter with a pet, Good Shepherd will assist the individual in securing alternative arrangements for their pet.
- 18. Good Shepherd serves everyone (cisgender, transgender, Two-Spirit), non-binary and gender diverse individuals of all races and ethnicities, cultural background and religious affiliations (and no religion). Individuals accessing our shelters are able to actively engage in cultural practices, and we accommodate cultural, religious and medical dietary needs. Further, private and quiet space will be made available for religious or cultural practice. Staff support residents in accessing culturally safe and responsive services through referral and advocacy. Where requested, translators are used to assist with communication and service planning.
- 19. Some individuals coming to our shelters advise that they have previously been staying in the encampments in the City of Hamilton.
- 20. COVID-19 testing remains available to any employee or resident who has come in contact with a suspected or positive COVID-19 individual, or who is exhibiting COVID-19 symptoms.

21. I make this affidavit in order to clarify and explain the background of and services provided by Good Shepherd in the City of Hamilton and for no other or improper purpose.

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

Docusigned by:

Jordan Diacur

TAMOSOFORDE CACCO

TOMOSIGNED BY

TUSSA MCFADZEAN

TESSA MCFADZEAN

Court File No. CV-21-00077187-0000

KRISTEN HEEGSMA et al.

- and - CITY OF HAMILTON

Applicants Respondent

ONTARIO SUPERIOR COURT OF JUSTICE

PROCEEDING COMMENCED AT HAMILTON

AFFIDAVIT

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File Number: H227899

COURT FILE NO. CV-21-77187

ONTARIO

SUPERIOR COURT OF JUSTICE

BETWEEN:

KRISTEN HEEGSMA, DARRIN MARCHAND, GORD SMYTH, MARIO

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MISTY MARSHALL, SHERRI OGDEN, JAHMAL PIERRE, LINSLEY
GREAVES and PATRICK WARD

Applicants

-AND
CITY OF HAMILTON

Respondent

The Cross-Examination of Tessa McFadzean, on an Affidavit dated
July 26, 2024 taken upon affirmation in the above action this,
22nd of August, 2024, conducted via videoconference hosted by
the offices of Nimigan Minalovich Reporting Inc.

APPEARANCES:
For the Applicants:

For the Hamilton Community Legal Clinic:
SHARON CROWE
CURTIS SELL

For the City of Hamilton:
JORDAN DIACUR
JOJO JOHNSON
VIVIAN CALDAS
Gowling WLG (Canada) LLP

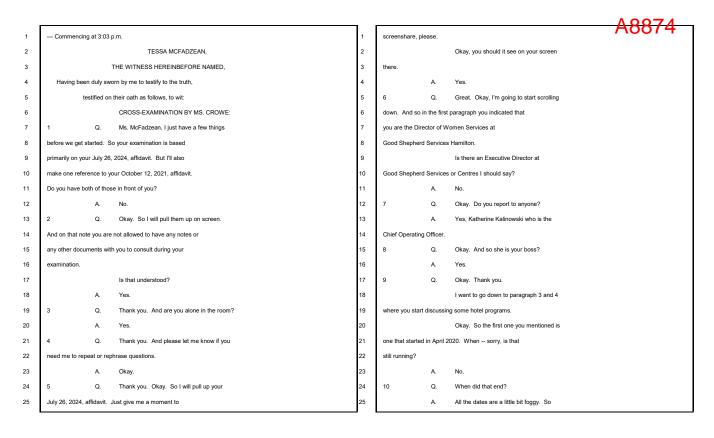
GUIDE TO UNDERTAKINGS, ADVISEMENTS, and REFUSALS:

This should be regarded as a guide and does not necessarily constitute a complete list:

UNDERTAKINGS:
None noted.

UNDER ADVISEMENTS:
None noted.

REFUSALS:
None noted.



1	in 2020, Good Shepherd became involved	in providing	1			And then when did the Crowne Plaza hotel
2	overflow response to the COVID pandemic	and that was at	2	program end?		
3	the Crowne Plaza. So we've been involved	since	3		A.	I believe it was in September when we
4	April 2020, it's just the location evolved sin-	e that time	4	transitioned to th	e Admira	ıl.
5	and changed.		5	17	Q.	Okay. And how many beds were a part of the
6	11 Q. Okay. So this	vas a special program or a	6	Crowne Plaza Ho	otel Progr	ram?
7	project that started in April of 2020. Is it st	I	7		A.	If memory serves me correctly about 24.
8	running?		8	18	Q.	Okay. And these were for single women?
9	A. In that iteration	no.	9		A.	Single women, trans, nonbinary individuals.
10	12 Q. Okay. So when	did it end in that	10	19	Q.	Okay. No couples?
11	iteration? Approximately is fine.		11		A.	No.
12	A. I would probabl	y say it would be in my	12	20	Q.	Okay. And then in paragraph 4, you talk
13	affidavit so I can't give exact dates. We tra	nsitioned	13	about local hotels. Where were these located?		
14	from Crowne Plaza to Admiral Inn and so t	nat would be	14		A.	So that is the Crowne Plaza.
15	within my affidavit.		15	21	Q.	And okay. So but then you talk about in
16	13 Q. Okay.		16	May 2020:		
17	A. Yeah.		17			"We began to directly operate the
18	14 Q. So I just want to	piece that together. So	18			hotel spaces on a day-to-day basis".
19	the April 2020 program you talk about local	hotels so is	19			So you are still talking about the Crown
20	that the Admiral?		20	hotel there?		
21	A. No. That was 0	Crowne Plaza Hotel.	21		Α.	Yes.
22	15 Q. That was Crow	ne Plaza so. When you say	22	22	Q.	Okay.
23	local hotels you meant Crowne Plaza?		23		Α.	Yes.
24	A. Yes.		24	23	Q.	And then the next paragraph
25	16 Q. I'm just going to	make note of that.	25	September 2nd,	2020. Is	this the Admiral Plaza you are

talking about? Hamilton[...]" 2 A. So, sorry, this is helpful. No. This is I believe this in context to when 3 Crowne Plaza Good Shepherd to initiated -- let me just sort of. So to provide some context, we weren't the [Reading]. only provider offering services on-site at Crowne Plaza 5 So here it references in September is when. Okay, I'm refreshed. So in May is when we 6 but we became the sole service provider. We transitioned to provide the sole service provider in May. became involved in Crowne Plaza and in September is when 8 Prior to that, YWCA was also involved in we transitioned to be the sole operator of Crowne Plaza. 9 Q. Okay. providing support on-site at Crowne Plaza. The 26 10 City of Hamilton staff were also involved in providing 10 A. And then in October, we transitioned from 11 Crowne Plaza to Admiral Inn. services on-site. So all of us were coming together to offer 12 12 27 Q. Okay. So can I clarify? 13 staff to staff the hotel to provide direct service to 13 14 individuals who were intaked into Crowne Plaza. 28 Q. In that same paragraph you've got 15 Q. Okay. So are you saying that the 15 October 2021 listed? 16 Crowne Plaza program ran until September 2nd, 2020? A. Mm-hmm A. It ran until October. It ran until October Q. Did you mean October 2020 or October 2021? 18 and then in October, we transitioned folks from 18 A. No. October 2021. 19 Crowne Plaza to Admiral Inn. And the reason for that 19 Q. Okay. So the Crowne Plaza program ran from 20 transition was to expand the amount of rooms. 20 April 2020 until October 1st, 2021? Q. Okay. So just one second. So what 21 A. Yes. 22 happened? What are you referencing when you say: 22 31 Q. And then it transitions. And during that 23 "Until September 2nd, 2020"? 23 time there were 24 hotel rooms for single women? A. Yes. A. Yes. 24 24 25 "[...]Worked together with downtown 32 Q. Okay. Thank you for helping me understand

				_	
1	that.			1	40 Q. Okay. And what was the setup in there in
2		A.	Certainly.	2	terms of where people would stay and where they would
3	33	Q.	And then it transitions October 1st, 2021?	3	sleep?
4		A.	Yes.	4	A. So prior to Good Shepherd Women Services
5	34	Q.	And you go from 24 to 55 hotel rooms;	5	taking over Cathedral Boys School there was Men Services
6	correct?			6	in and so it was set up where classrooms were turned into
7		A.	Yes.	7	dormitory-style bedrooms. The basement was where the
8	35	Q.	Okay. And then in the next sentence you've	8	servery was. There was a common area. And then there was
9	got in March 202	22.		9	also a staff office on-site.
10			So did the Admiral Hotel Program run until	10	41 Q. Okay. Thank you.
11	March of 2022?			11	And so when you are talking about this
12		A.	Yes.	12	program, you called it, so you said:
13	36	Q.	Okay. Did it continue beyond that?	13	"Good Shepherd Shelter overflow
14		A.	No.	14	transitioned to Cathedral Boys School to
15	37	Q.	Okay.	15	expand overflow shelter beds[]"
16		A.	So we moved folks from Admiral to	16	What do you mean by "overflow shelter
17	Cathedral.			17	beds"?
18	38	Q.	Okay. And then at that point there were	18	So overflow shelter beds would be overflow
19	100 beds?			19	to the permanently funded shelter beds in the system. So
20		A.	Yes.	20	the pre-existing shelter spaces.
21	39	Q.	And can you help me understand	21	42 Q. Mm-hmm.
22	Cathedral Boys	School?		22	They were temporary contracts.
23			What kind of facility was it at that point	23	43 Q. And why was it necessary to create
24	when you were u	using it?		24	overflow? What do you call it? Overflow, sorry, just one
25		A.	It was a vacant old school.	25	second. "Overflow shelter beds"?
				,	

A. The City had put out a request providers to 2 expand shelter beds to meet some more demands of the And to clarify, West Avenue didn't start in 3 May. West Avenue started in August. And, I guess, the community in terms of space, the spacing demands. Q. Okay. Thank you. Okay. And then the next missing piece there is part of that is because 5 time period you've got referenced is May 2023. And so the Dorothy Day Place opened in May and many of the folks in Cathedral program came to an end; correct? Cathedral moved to Dorothy Day Place. 6 50 Q. Okay. Thank you, okay. We will go to 8 Q. And then you moved to the West Avenue site. paragraph 6. 9 And where was that located? A. Sure. 10 On West Avenue, 46 West Avenue. Q. I'm sorry, we have covered that. Q. What kind of facility was it? Paragraph 8. Do you need a moment to review this? A. No. A. West Avenue used to be a private 12 12 Q. Okay. So you've indicated that -- I'm just 13 long-term-type residence like a long-term care residence 13 looking for -- the third line says that: 14 so it's a walkup building. Q. So if I'm reading this correctly, the 15 15 "Our services are not 16 Cathedral site had 100 beds. 16 abstinence-based programs". A. Mm-hmm. What does that been? Q. And then when that closed in May 2023, 18 18 Individuals who access our shelter spaces. 19 West Avenue opened and had 20 overflow spaces; is that 19 West Avenue or otherwise, don't need to abstain from 20 20 substance use. 21 A. Yes. 53 Q. Okay. 22 22 Q. Okay. And, again, we are using the term A. We operate from a harm reduction model. "overflow spaces". To your knowledge why were overflow 23 23 54 Q. Okay. So can people use drugs inside the 24 24 spaces being created at that time? shelters? A. In response to the need for space in the A. Individuals -- we encourage folks to 25

It willize substances outside of the space. 1 A Certainly we would want to make sure that					1 1	
A And we also wouldn't permit smoking on-site. However, it wouldn't be substance use 4 close someone was smoking in proximity to entrances and calls continued and such as no smoking in your allease, the properties of a statutory rule. close smoters close someone was smoking in proximity rule. Because you calls fill and to a subtrory rule. Because you call and your ellisters clos	1	utilize substance	s outside	e of the space.	1	Certainly we would want to make sure that
on-site. However, it wouldn't be substance use 4 close someone was smoking in proximity to entrances and 5 wouldn't be a reason for discharge or not admitting 5 exits. 6 81 Q. Okay. I think what I'm gathering is that 7 56 Q. And is that in your written policy? 8 A Yes. 8 have said "such as no smoking" in your affidavit. But are 9 57 Q. That indicates that you are allowed to use 10 drugs inside? 11 A No. So, sorry, if I gave that impression. 11 62 Q statutory rules? 12 Folks shouldn't be utilizing substances inside. 13 58 Q. So when you say that they shouldn't, they 14 are not allowed to? 15 A No. 16 to so when you are taking about responding 17 overdoses? 18 use to occur outside. 19 G. Q. Okay. And then the last sentence you have 19 64 Q. Okay. Thank you. And in paragraph 11 you start talking 20 a reference to, it states: 21 A No. 22 And in paragraph 11 you start talking 23 And in paragraph 11 you start talking 24 So first, can you give an example of what a	2	55	Q.	Mm-hmm.	2	folks aren't smoking on-site, smoking on space. We would
wouldn't be a reason for discharge or not admitting somebody into the space. 6 61 Q. Okay. I think what I'm gathering is that 7 56 Q. And is that in your written policy? 8 A Yes. 9 57 Q. That indicates that you are allowed to use drugs inside? 10 A No. So, sorry, if I gave that impression. 11 62 Qstatutory rules? 12 Folks shouldn't be utilizing substances inside. 13 63 Q. Okay. Thank you. 14 are not allowed to? 15 A No. 16 59 Q. Thank you. 17 A We would encourage any sort of substance 18 use to occur outside. 19 Go. Okay. And then the last sentence you have 19 Go. Okay. Thank you. 10 to —so when you say "drug poisoning" do you mean 17 overdoses? 18 use to occur outside. 19 Go. Okay. And then the last sentence you have 20 a reference to, it states: 10 Okay. Thank you. 21 A Yes. 22 A Yes. 33 Go. Okay. Thank you. 44 A We would encourage any sort of substance 35 A Yes. 46 Q. Okay. Thank you. 47 A We would encourage any sort of substance 48 A Yes. 49 A Yes. 40 A We would encourage any sort of substance 40 A We would encourage any sort of substance 41 A Yes. 42 A Yes. 43 A Yes. 44 A Yes. 45 A Yes. 46 A Q. Okay. Thank you. 46 A Q. Okay. Thank you. 47 A Yes. 48 A Yes. 49 Yes are going to move on to paragraph 10 and 40 A Yes. 41 A Yes. 42 A Yes. 43 A Yes. 44 A Yes. 45 A Yes. 46 A Q. Okay. Thank you. 46 A Q. Okay. Thank you. 47 Service restrictions or 48 A Yes is substances or the	3		A.	And we also wouldn't permit smoking	3	want to make sure that we were following bylaws as to how
somebody into the space. 5	4	on-site. Howeve	r, it woul	dn't be substance use	4	close someone was smoking in proximity to entrances and
7 56 Q. And is that in your written policy? 7 smoking is one example of a statutory rule. Because you 8 A. Yes. 8 have said "such as no smoking" in your affidavit. But are 9 57 Q. That indicates that you are allowed to use 9 you referencing any other — 10 drugs inside? 10 A. No. No. 11 A. No. So, sorry, if I gave that impression. 11 62 Q. — statutory rules? 12 Folks shouldn't be utilizing substances inside. 12 A. No. 13 88 Q. So when you say that they shouldn't, they 13 63 Q. Okay, Thank you. 14 are not allowed to? 14 We are going to move on to paragraph 10 and 15 A. No. 15 so in this paragraph you are talking about responding 16 59 Q. Thank you. 16 to — so when you say 'drug poisoning' do you mean 17 A. We would encourage any sort of substance 17 overdoses? 18 Use to occur outside. A. Yes. 19 60 Q. Okay. And then the last sentenc	5	wouldn't be a reason for discharge or not admitting		5	exits.	
A Yes. A Yes. A Yes. B have said "such as no smoking" in your affidavit. But are you referencing any other — 10 drugs inside? 10 A No. 11 62 Q — - statutory rules? 12 Folks shouldn't be utilizing substances inside. 12 A No. 13 63 Q Okay. Thank you. 14 are not allowed to? A No. 15 so in this paragraph you are talking about responding 16 59 Q Thank you. 17 A We would encourage any sort of substance 18 use to occur outside. 19 64 Q Okay. Thank you. 20 a reference to, it states: 20 A Yes. 21 about: 22 "Service restrictions or discharges from our shellers[]" 24 Tobacco or other substances)." 24 So first, can you give an example of what a	6	somebody into the space.		6	61 Q. Okay. I think what I'm gathering is that	
you referencing any other— fully sinside? A No. So, sorry, if I gave that impression. A No. So, sorry, if I gave that impression. Folks shouldn't be utilizing substances inside. So When you say that they shouldn't, they are not allowed to? A No. So when you say that they shouldn't, they are not allowed to? A No. Thank you. We are going to move on to paragraph 10 and so in this paragraph you are talking about responding to — so when you say "drug poisoning" do you mean The A We would encourage any sort of substance use to occur outside. B A Yes. Okay. And then the last sentence you have a reference to, it states: Overlaid on these expectation is a recognition that certain statutory rules must be observed, such as no smoking (of to bacco or other substances).* Your referencing any other— A No. A No. A No. So A No. Chay. Thank you. And in paragraph 11 you start talking So first, can you give an example of what a	7	56	Q.	And is that in your written policy?	7	smoking is one example of a statutory rule. Because you
drugs inside? A No. So, sorry, if I gave that impression. 11 62 Q statutory rules? Folks shouldn't be utilizing substances inside. 12 A. No. 13 63 Q. Okay. Thank you. 44 are not allowed to? A No. 15 so in this paragraph you are talking about responding 16 59 Q. Thank you. 17 A. We would encourage any sort of substance 18 use to occur outside. 19 60 Q. Okay. And then the last sentence you have 19 64 Q. Okay. Thank you. 20 a reference to, it states: 20 A. Yes. 21 about: "Overfaid on these expectation is a recognition that certain statutory rules 22 must be observed, such as no smoking (of tobacco or other substances)." 24 So first, can you give an example of what a	8		A.	Yes.	8	have said "such as no smoking" in your affidavit. But are
Folks shouldn't be utilizing substances inside. 12	9	57	Q.	That indicates that you are allowed to use	9	you referencing any other
Folks shouldn't be utilizing substances inside. 12	10	drugs inside?			10	A. No.
13	11		A.	No. So, sorry, if I gave that impression.	11	62 Q statutory rules?
are not allowed to? A. No. 15	12	Folks shouldn't b	e utilizin	g substances inside.	12	A. No.
A. No. 15 so in this paragraph you are talking about responding 16 to — so when you say "drug poisoning" do you mean 17 A. We would encourage any sort of substance 18 use to occur outside. 18 A. Yes. 19 60 Q. Okay. And then the last sentence you have 19 64 Q. Okay. Thank you. 20 a reference to, it states: 20 And in paragraph 11 you start talking 21 "Overlaid on these expectation is a 22 "Service restrictions or 23 must be observed, such as no smoking (of 24 So first, can you give an example of what a	13	58	Q.	So when you say that they shouldn't, they	13	63 Q. Okay. Thank you.
16 59 Q. Thank you. 17 A. We would encourage any sort of substance 18 A. Yes. 19 60 Q. Okay. And then the last sentence you have 20 a reference to, it states: 20 And in paragraph 11 you start talking 21 "Overlaid on these expectation is a recognition that certain statutory rules 22 recognition that certain statutory rules 23 must be observed, such as no smoking (of 23 discharges from our shelters[]" 24 So first, can you give an example of what a	14	are not allowed t	0?		14	We are going to move on to paragraph 10 and
17 overdoses? 18 use to occur outside. 18 A. Yes. 19 60 Q. Okay. And then the last sentence you have 19 64 Q. Okay. Thank you. 20 a reference to, it states: 20 And in paragraph 11 you start talking 21 "Overlaid on these expectation is a recognition that certain statutory rules 22 "Service restrictions or must be observed, such as no smoking (of 23 discharges from our shelters[]" 24 tobacco or other substances).* 25 overdoses? 26 A. Yes. 27 And in paragraph 11 you start talking about: 28 "Service restrictions or discharges from our shelters[]" 29 So first, can you give an example of what a	15		A.	No.	15	so in this paragraph you are talking about responding
use to occur outside. 18	16	59	Q.	Thank you.	16	to so when you say "drug poisoning" do you mean
19 60 Q. Okay. And then the last sentence you have 20 a reference to, it states: 20 And in paragraph 11 you start talking 21 "Overlaid on these expectation is a 21 about: 22 recognition that certain statutory rules 23 must be observed, such as no smoking (of 24 tobacco or other substances).* 24 So first, can you give an example of what a	17		A.	We would encourage any sort of substance	17	overdoses?
a reference to, it states: 20 And in paragraph 11 you start talking 21 "Overlaid on these expectation is a 22 recognition that certain statutory rules 23 must be observed, such as no smoking (of 24 tobacco or other substances)." 29 And in paragraph 11 you start talking 20 And in paragraph 11 you start talking 21 about: 22 "Service restrictions or 23 discharges from our shelters[]" 24 So first, can you give an example of what a	18	use to occur outs	side.		18	A. Yes.
21 "Overlaid on these expectation is a 21 about: 22 recognition that certain statutory rules 22 "Service restrictions or 23 must be observed, such as no smoking (of 23 discharges from our shelters[]" 24 tobacco or other substances)." 24 So first, can you give an example of what a	19	60	Q.	Okay. And then the last sentence you have	19	64 Q. Okay. Thank you.
22 recognition that certain statutory rules 22 "Service restrictions or 23 must be observed, such as no smoking (of 23 discharges from our shelters[]" 24 tobacco or other substances)." 24 So first, can you give an example of what a	20	a reference to, it	states:		20	And in paragraph 11 you start talking
must be observed, such as no smoking (of 23 discharges from our shelters[]" tobacco or other substances).* 24 So first, can you give an example of what a	21			"Overlaid on these expectation is a	21	about:
24 tobacco or other substances)." 24 So first, can you give an example of what a	22			recognition that certain statutory rules	22	"Service restrictions or
	23			must be observed, such as no smoking (of	23	discharges from our shellters[]"
What do you mean by "statutory rules"? 25 discharge is as opposed to a service restriction?	24			tobacco or other substances)."	24	So first, can you give an example of what a
	25			What do you mean by "statutory rules"?	25	discharge is as opposed to a service restriction?

A discharge could be that somebody secured have indicated they no longer want that bed space. 2 housing. A discharge could be that somebody was Q. What happens when someone misses curfew and 3 transitioned to hospital and it was an admittance in there is somebody waiting for the bed? hospital a discharge could be that somebody didn't return A. So typically we wouldn't intake -- well, we 5 for a lengthy period of time. do intakes in the middle of the night. But typically we Q. Okay. Are there distinctions made between 6 wouldn't discharge somebody in the middle of the night voluntary and involuntary discharges? without having a conversation. We would wait until 8 A. I mean, and involuntary discharge would be morning and we would try to make contact with the 9 individual prior to any sort of discharge occurring. one of those situations where somebody perhaps was 10 admitted to hospital unexpectedly or somebody had a And part of that is really around also warrant and was apprehended. That could be and assessing safety of individuals. Q. Okay. So I think what you are describing 12 involuntary discharge. 12 13 Q. Okay. What about if somebody missed 13 is a situation where there is a bed that is not in use, 14 curfew? there is nobody physically using it, but it's also being 15 Well, we don't discharge at curfew time. held for somebody else; is that accurate? 16 That's just not our practice. And typically if somebody It would be held for that person. 17 missed curfew, if the bed remains open, and we haven't had Q. Right. A. That same person. Yes, technically. Yeah. 18 folks calling for space, then we wouldn't discharge. If 19 that person returned, they would be welcome to that space. 19 Q. Okay. Thank you. So in paragraph 11 20 If somebody had continuously was, you know, 20 you're talking about service restrictions and when they 21 can arise and you've indicated that: missing curfew or not returning to the shelter and had 22 been absent from the shelter for quite a few days in a 22 "[...]They may be imposed for breaches 23 23 row, you know, there's a whole lot of processes that could of shelter expectations that result in 24 24 be initiated. But that could be a situation where then compromised safety." 25 they have sort of abandoned that bed space and perhaps Can you give an example of what you mean?

1	A.	If a physical fight.	1	A	λ.	Both.
2	71 Q.	Okay. Anything else?	2	77 Q	Q .	Okay. And how often does that happen?
3	A.	Significant it could be usually it's	3	A	λ.	Again, hard to quantify without data in
4	around violence so it's	usually a physical fight, death	4	front of me. It is sor	methin	g. We track any sort of
5	threats, significant prop	perty damage where, you know, we	5	incident reporting. But it is something that has occurred		
6	might have to where police or fire might respond.		6	in our shelter enviro	onment	s.
7	72 Q.	Okay. And in those examples are you	7	78 Q	Ω.	Are you aware of any situations where a
8	talking about physical f	lights between residents or against	8	death threat has bee	en ma	de between shelter residents and
9	staff or both?		9	the police has been	called	?
10	A.	It could be both.	10	A	٨.	In the past, yes.
11	73 Q.	Okay. Do physical fights between residents	11	79 Q	2.	And what about property damage? Are you
12	happen?		12	referring to property	y dama	ge to the shelter, or to other
13	A.	They have, yes.	13	residents' property,	or both	1?
14	74 Q.	Okay. How often?	14	A	λ.	The shelter.
15	A.	I can't quantify that without documentation	15	80 Q	Q .	Are you aware of any property damage like
16	in front of me. It is son	nething I could gather for you.	16	one shelter resident damaging or stealing the property of		
17	But it has happened.		17	another resident?		
18	75 Q.	Are you occurred aware of any serious	18	A	λ.	Yes.
19	injuries occurring durin	g the course of a physical fight	19	81 Q	Q .	How often does that happen?
20	between residents?		20	A	٨.	That probably happens a little bit more
21	A.	I mean there has been physical fights where	21	frequently. Again, I	can't c	quantify without data in front
22	police have responded	or EMS have responded in the past.	22	of me. But residents	ts takin	g each other's items can happen
23	76 Q.	Okay. And then you mentioned another	23	in the shelter environ	nment	
24	example as death threa	ats. Is that against shelter staff,	24	82 Q	Q .	How often do you receive threats or,
25	residents, or both?		25	sorry, reports of se	sorry, I	am mixing up threat and
)			

2 How often do you receive reports of theft 86 Q. And is it true? 3 of another resident? Α Yes A. Again, that's hard for me to quantify Q. Does that continue to be grounds for a without data in front of me. It's certainly has happened. service restriction at times? 5 6 But, again, it's very hard to quantify. A. No. And the context to this is that when Q. Okay. So when we are talking about the we were operating at Crowne Plaza it wasn't just our 8 grounds for service restrictions, I'm going to stop service providing service. There was a hotel program 9 involved and hotel owners involved and so Crowne Plaza was sharing this affidavit for a moment, and I want to draw 10 your attention to your October 12, 2021, affidavit. So also operating as a hotel that was still a hotel. just give me one moment to pull it up, please. So I think thresholds looked a little bit 12 Sure. 12 differently than perhaps some of our own Good Shepherd 13 Q. Okay. Do you see it on your screen? 13 14 A. Q. So is it your evidence that Good Shepherd 15 85 Q. Thank you. I'm going to scroll down to now have the more intensive reports necessary to respond 16 paragraph 12. I will just read out the first part of this to mental health concerns? 17 paragraph: A. I think the Good Shepherd sites all along "A discharge may also occur if more have. It's different when we are operating in somebody 18 19 intensive supports are necessary due to else's business space. So when we were operating in 20 somebody else's business space, it was not just -- it was mental health concerns (cases have been 21 building barriers inside rooms, multiple a little bit different in terms of the hotel operator's 22 calls to 9-1-1 a day, or pulling fire 22 threshold in terms of would be appropriate in that 23 alarms) and other risks (including 23 environment or not. 24 24 substance misuse)." That may not be the right wording. But it 25 Do you remember writing this? was not just up to our liberty to determine some of those

23 24

things ---REFUSAL Q. So is it your evidence today that women are BY MS. CROWE: never service-restricted from a Good Shepherd site due to Okay. I'm going to stop sharing. 3 92 Q. 4 a reason that is related to their mental health? Can you see it back on the screen? A. Not restricted. I wouldn't say that individuals are restricted solely due to their mental Okay. Thank you. 6 93 Q. health, no. Sorry, one moment, please. I would not say that. Sorry, we are going to go back up to Q. Is mental health a contributing factor? paragraph 12. So you are talking about what happens when 10 Α No. It would be the behaviours, the unsafe 10 there is a discharge or a service restriction. And you 11 behaviours occurring on-site that could be challenging in indicate that: 12 12 the environment or create an unsafe circumstance. And "A discharge to an alternate shelter 13 13 so -- and, again, it's not as simple as somebody being may also occur in a different setting or 14 service-restricted. And even in those situations, I would 15 say individuals are service-restricted. I keep repeating myself okay, my apologies, 16 They might be accessing another level of 16 we are going to go to 14. So you indicate: 17 service from another service provider and not necessarily "A service restriction is a 18 18 service-restricted. period of time, varying in length 19 19 So no, I would say mental health is a depending on the underlying reason for 20 factor for service restriction. 20 the service restriction, in which a 21 Q. When you say, "Unsafe behaviours", are you client will not be able to access our 22 services." 22 ever aware of a situation where those unsafe behaviours 23 are related to one's mental health? In your experience, what is the range of 24 MR. DIACUR: She just answered that time for which an individual could be service-restricted? 25 question. Counsel, that's a refusal, So it could be a couple hours to a

lengthier period of time. It could be a couple of months Was your answer that it is only more than a if there was an extreme act of violence that occurred couple of months if the police have imposed a trespass order or are there other scenarios where a service Q. Okay. What about longer than a couple of restriction may be more than a couple of months? A. There could be a situation where it could 5 months? A. If -- typically not. Typically not. There 6 be longer if the individuals has come back and there is a has been an incident where somebody did return following a repeat of a significant -- and were talking very violent 8 service restriction and a second extreme act of violence like a physical assault, then the length of time could be 9 occurred on-site. longer. But those are very, very rare and haven't 10 So in that instance, there's been police involvement, and a No Trespass Order. So we do have Q. Do service restrictions ever last for a 12 situations where sometimes there is No Trespass Orders 12 year or longer? 13 issued or there is certain conditions where a certain 13 I can't think of anybody offhand at the 14 individual -- imposed by police where an individual may moment that has a lengthy service restriction like that. 15 not be able to access. 15 98 Q. Thank you. 16 Q. Okay. So as I understand that you are 16 So in paragraph 15, we are still talking sitting typically not longer than a couple of months, but about service restrictions. And you refer to well, I will 18 iust read it out: sometimes? 19 MR. DIACUR: Well, I think she just "We work with clients who are 20 answered that question as well. 20 service-restricted with us in order to 21 MS. CROWE: Okav. find them another place to stay. 22 MR. DIACUR: If the police impose a 22 whether that is in one of our other 23 trespass order then they can't return. 23 shelters, or a program in the 24 24 BY MS. CROWE: community[...]" 25 Q. Okay. Well, so let's be clear about that. What do you mean by a "program in the

27 28

community"? with a solution. A. And other shelter in the community. Q. Okay. And then paragraph 16, you are Q. So does that mean that sometimes you 3 102 4 referring to incidents of threat where you have been able cannot? to work with the individual to address concerns or secure It might not be that we cannot. Sometimes 6 an alternate emergency shelter. folks may be removed by police and in those instances A. there's not an opportunity to do that problem-solving. Q. Is this always the case that you are able But where somebody is wanting that to secure an alternate emergency shelter? problem-solving, and we are able to work through that, we We have a couple of different processes 10 have been able to find another option whether it's another 11 12 shelter. So we would make calls if the individual wants 103 Q. A drop-in space? 13 us to problem solve on their behalf then we will make A. Yeah. A drop-in space that has overnight shelter? 15 Yes. Sometimes we may also look at shelter A. switches between different environments. And within the 16 16 105 Q. Every single time? 17 omen's sector, we also have a triage, a regular weekly We've been able to accommodate folks to triage call to ensure -- so it's community shelter find them space if they are willing. Yes. I mean we also 18 19 providers and the City to ensure that there are 19 may look outside of community. 20 appropriate spaces for the folks to access. This is a normal process. In terms of 21 So typically we are able to come up with a whether it's a service restriction or somebody seeking 22 solution ves 22 space that we will go through to ensure that somebody has 23 Q. Okay. Right. And I certainly appreciate somewhere appropriate to sleep 24 that it takes a lot of effort to come up with a solution. But you indicated that typically you are able to come up A. We also may be able to accommodate in one

of our other shelters. So if somebody is restricted from somebody that they believe might be connected to one of our sites, it doesn't necessarily mean they are Good Shepherd. The name was not familiar to me. restricted from our other sites. But no. I'm not aware of and would not be Q. Right. able to speak to what happens in the other departments. Q. Okay. Thank you, okay. A. So we can be accommodating that way as 113 5 6 well. We will move on to paragraph 17 where you Q. And so I just want to explore this term are discussing service animals. What does service animal "alternate shelter." Does alternate shelter include 8 means? 9 different types of shelter other than the -- types of A. A service animal so to perform or to help 10 spaces you might send someone to other than just another an individual navigate their disability. shelter or a drop-in centre? Q. And what proof or evidence is required in order to satisfy staff that the animal is a service 12 13 Q. Has Good Shepherd staff ever handed out 14 tents to women? A. So, I mean, we might be able to visibly see 15 A. Women services staff? 15 that it is a service animal performing a certain function. 16 110 Q Yes 16 If not, we might ask what function that service animal provides and/or if they have documentation 111 Q. What about Good Shepherd? to support that it is a service animal or to provide a 18 19 I couldn't answer for the broader very specific function. 20 And what kind of documentation would you 112 21 Q. Are you aware of any request made by require? 22 Good Shepherd Women Services or Good Shepherd Organization 22 A. It could be a doctor's letter. 23 Services to an organization for a tent? 23 Q. Okay. Anything else? 116 A. No. No. I did have somebody drop off a 24 24 Sometimes folks might provide 25 tent to Women Services and had indicated they spoke with certification. Typically it is a doctor's letter.

32

117 Thank you. contacts to see if they have any availability; and And then you talk about a distinction sometimes they do; and then we will present that option to the individual that is seeking space if they want to 3 between service animals and pets and indicate: 4 "If someone is seeking emergency explore that with like a vet fostering. 5 shelter with a pet, Good Shepherd will Q. Okay. So I think you anticipated my next 6 assist the individual in securing question? alternative arrangements for the pet." A. Okav. What kind of alternative arrangements are Q. Which was whether or not you have any available for their pet when an individual is looking for knowledge of how often these different services actually 10 shelter? 10 have the capacity to take people's pets? 11 So we might look at fostering programs. We I couldn't speak, again, that is something, 12 12 might contact Animal Services and sometimes they can do a I couldn't quantify. Again, we are at the mercy of the 13 temporary foster and so we would present that to the availability. We don't get these requests very often, but individual. It's not always available. But we will 15 certainly make those calls to see if it is available. And we, you know, we have been involved in Q. Okay. So when you say "fostering programs" the some of the initiatives in terms of the Safe Pet 16 17 are you talking about Animal Services? Programs in the past so we do have contacts that we will Yes. So Animal Services has had -- not a reach out to. But I can't quantify how -- the 18 A. 19 fostering, but like a sitting. The word is escaping me. availability -- yes, I wouldn't. I don't sit at the 20 ground making those calls so I couldn't quantify that 21 In the past, there has been -- but we are information for you. I could gather that information for 22 talking some time ago -- there was fostering with the Safe 22 23 Pet Program where there was fosters available or different Q. Do you know how long these pets can stay in 24 these different fostering programs? So we will still reach out to some of those 25 I couldn't answer that offhand.

Do you know if they require any up-to-date MS. CROWE: Okay. 2 vaccinations to access these programs? -- EXHIBIT NO. A: CBC Article, "Mom With 5 Kids Speaks 3 A. Again, it's out of my purview. But I'm Out After Being Placed in Cockroach Infested Unit at happy to find that information out for you. Hamilton Shelter," dated June 22, 2021. Q. Okay. Thank you, Ms. McFadzean, we are 123 BY MS. CROWE: 5 Q. Okay. So I'm going give you an opportunity 6 almost done 127 to review this. It's from 2021. So I will scroll down 8 I just have one more document I'd like you Q. and you can let me know when you are ready to move on. to take a look at so I'm going to stop sharing this 9 A. [Reading]. 10 10 You can move on. 11 Okay. Can you see a CBC article on your I've read it. 12 screen titled: 12 128 Thank you. 13 "Mom With 5 kids Speaks Out After 13 Okay. So I just want to scroll back up to 14 Being Placed in Cockroach Infested this subheading: 15 Unit at Hamilton Shelter" --15 "I feel deeply for this 16 16 family[...]" 17 -- dated June 22nd, 2021. Where the article indicates that you were 18 interviewed for this article. Do you remember being A. Yes. 19 126 Q. 20 I'd like this to be marked as Exhibit 1 to 20 Yes. A. 21 this examinations to be to this document? 129 Q. Thank you. 22 MR. DIACUR: Well, again, counsel, this 22 And were just going to go to the third 23 document is not prepared by the witness. It can be marked 23 paragraph from the bottom, where it states: 24 24 for identification, so I suggest it be marked as "She said that the women services 25 Exhibit A. side of the shelter system is full,

35

I hereby certify the foregoing is a full, true, and correct

with no open beds and more than 100 per cent occupancy at all sites." Is that what you said? 3 4 5 And was that true? 6 A. 131 Q. Thank you. Those are my questions. MR. DIACUR: Thank you, counsel, I have no re-examination for the witness. 10 --- The examination concluded at 3:45 p.m. 11 12 13 15 16 17 18 19 20 21 22 23 24 25

transcription of all of my oral stenographic notes to the best of my ability so taken at the Cross-Examination of TESSA

MCFADZEAN, given under oath before me on the 22nd of August,
2024.

Amy Armstrong, CVR-RVR

Certified Realtime Verbatim Reporter #7305

Certified Commissioner of Oaths

Certified this 30th of August, 2024

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Hamilton

Mom with 5 kids speaks out after being placed in cockroach-infested unit at Hamilton shelter

Seantelle Wynne says Good Shepherd found her a different unit in Martha House — without cockroaches

Bobby Hristova · CBC News · Posted: Jun 22, 2021 7:00 AM EDT | Last Updated: June 22, 2021



Seantelle Wynne, 34, says there was a cockroach infestation in her unit at Martha House in Hamilton. (Submitted by Seantelle Wynne)

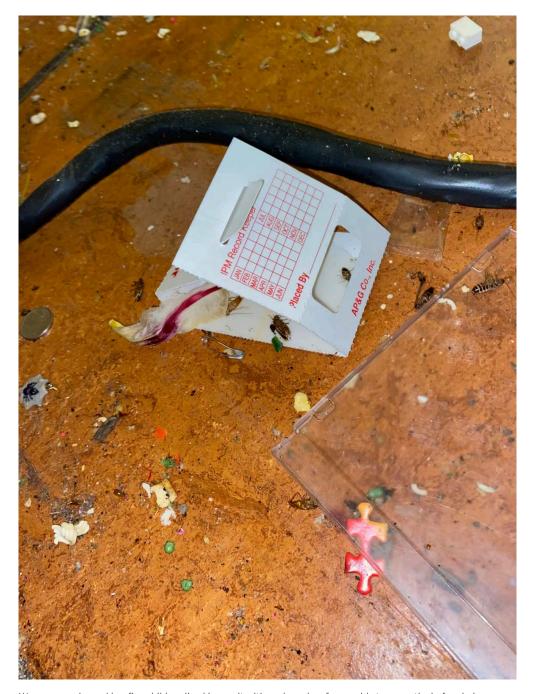
Seantelle Wynne says she was excited when she and her five children landed a spot in an emergency shelter in Hamilton in early April.

But within a week, Wynne's happiness turned into horror when she saw cockroaches on her stove and clothes, and near her children.

"I'm a young mother by myself with five little babies struggling ... this place was riddled with cockroaches," the 34-year-old said.

"I feel like I've been neglected ... my kids are scared to eat."

The family is staying at Martha House, a Good Shepherd emergency shelter for women and their children who are experiencing homelessness, and fleeing violence and abuse.



Wynne says she and her five children lived in a unit with cockroaches for roughly two months before being moved elsewhere. (Submitted by Seantelle Wynne)

Wynne said they gave her sticky pads typically used for mice and rats, but they didn't help.

In early June, with bugs still in the unit, Wynne took more pictures and approached the staff again.

That time, she said, they offered to bring in pest control and spray the unit.

A8884

Tessa McFadzean, director of Good Shepherd's Women's Services, said she couldn't comment on specific incidents, but called this one an "unfortunate situation."

"We know people are coming here dealing with so much stuff and the last thing we want them to deal with is feeling like services aren't hospitable, or dignified or that a situation isn't responded to," she said.

"I feel deeply for this family ... there's always a risk for potential pest control concerns in any of our residential settings. That said, it's a risk we take very seriously."

She said the images appear to show the aftermath of a spray, noting clusters of bugs. Wynne said the pictures were taken before pest control arrived.

McFadzean said the organization trains staff, does enhanced cleaning, has routine inspections and has a strong pest control program.

She couldn't say how many similar situations have occurred in the past month or when the last inspection took place, but emphasized there are weekly and monthly checkups.

McFadzean also encouraged people to bring up infestations if there are any, so Good Shepherd can help right away.

She said the women's services side of the shelter system is full, with no open beds and more than 100 per cent occupancy at all sites.

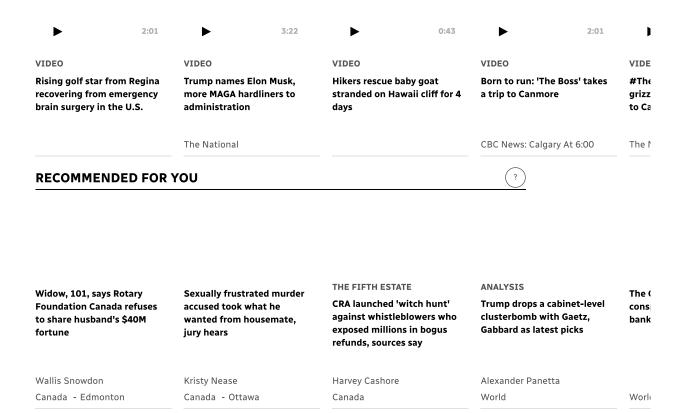
Wynne said she was given a new room this week after CBC News reached out to Good Shepherd.

"It's actually really nice. It is a lot nicer."

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TRENDING VIDEOS A8885



Court File No. CV-21-00077187-0000

ONTARIO SUPERIOR COURT OF JUSTICE

BETWEEN:

KRISTEN HEEGSMA, DARRIN MARCHAND, GORD SMYTH, MARIO MUSCATO, SHAWN ARNOLD, BRADLEY CALDWELL, CHRISTINE DELOREY, GLEN GNATUK, TAYLOR GOGO-HORNER, CASSANDRA JORDAN, JULIA LAUZON, AMMY LEWIS, ASHLEY MACDONALD, COREY MONAHAN, MISTY MARSHALL, SHERRI OGDEN, JAHMAL PIERRE, LINSLEY GREAVES and PATRICK WARD

Applicants

and

CITY OF HAMILTON

Respondent

APPLICATION UNDER 14.05 OF THE RULES OF CIVIL PROCEDURE

AFFIDAVIT

- I, **SHAWN MACKEIGAN**, of the City of Brantford in the Province of Ontario, MAKE OATH AND SAY:
- 1. I am the Associate Executive Director of Programs at Mission Services of Hamilton ("Mission Services"), and as such I have knowledge of the matters set out in my affidavit. Where I rely on the information of others, I state the source of that information and verily believe it to be true.
- 2. At present, Mission Services operates the following facilities and offers the following services:

Good Food Centre/East Hamilton Food Centre

Food security programming serving over 1,500 vulnerable families each month, ensuring they have access to nutritious food. By providing essential food resources and support, the program aims to alleviate food insecurity pressures and improve the overall well-being of the community's most at-risk members.

A4602

Willow's Place/Emma's Place

A Women's Drop-In Service, Willows's Place has a capacity 45 at a time, available 24/7. Emma's Place offers a 15-Bed Emergency Shelter, both providing critical support to homeless and vulnerable women, offering a safe space for rest, essential services, and access to resources. This program is dedicated to enhancing the well-being and stability of women in crisis, ensuring they receive the care and assistance needed to transition to more secure living situations.

Inasmuch House

A Gender-Based Violence Women's Shelter, Inasmuch House offers safe and supportive accommodation for up to 40 women fleeing abuse and violence. This shelter provides a secure environment, comprehensive support services, and resources to help women and families rebuild their lives and regain their independence.

• Men's Shelter

Our Housing Focused Emergency Shelter for men prioritizes rapid rehousing, working to ensure residents are able to access the right supports and services, and quickly transition from temporary shelter to stable housing. By coordinating access to targeted supports and resources, the housing focused approach to emergency sheltering aims to minimize the duration of homelessness and promote long-term housing stability for men in need.

Addiction Services/SUNTRAC

Community-Based Addiction Treatment Programming that offers comprehensive treatment services, including Group and Individual counselling, Addictions Supportive Housing and an Outcome-Focused Harm Reduction program. This holistic approach ensures individuals receive tailored supports while addressing their addiction, promoting long-term recovery and improved health outcomes.

Youth Programs

Our 196 series of youth programs provide Before and After School Youth Programs, along with engaging Summer Camps, providing youth with a safe, engine

environment outside of regular school hours. These programs offer educational activities, recreational opportunities, and social support, fostering personal growth and development throughout the year.

- 3. Our facilities have a 'service animal' policy permitting such trained and certified animals to attend on our sites. We do not allow pets, as they raise safety concerns.
- 4. We don't have a policy that prevents couples from staying together. However, some of our sites are gender-specific. Our Men's shelter is for males and male identifying individuals, and our Women's shelters are for females and female identifying individuals. Same sex couples have on many occasions stayed together in our shelters. The only limitation is that the spaces in our shelter operations are designed for single individuals, i.e. twin sized beds/congregate setting and semi-private spaces/communal washroom and shower facilities.
- 5. Individuals of all races, ethnicities and religions (or no religion) are welcome to make use of our facilities. We provide support in engaging in cultural or religious practices; for example, we provide prayer mats, have adjusted meal times during Ramadan, and allow Indigenous cultural practices such as smudging. We also employ in our shelters individuals of all races/ethnicities/religions and no religion.
- 6. I also make this affidavit as an update and supplement to my October 6, 2021 affidavit in this proceeding.¹
- 7. I have reviewed by October 6, 2021 affidavit and confirm that the following paragraphs remain accurate:
 - Paragraph 1, save for my length of service, which has increased;

¹ All defined terms in my October 6, 2021 affidavit have the same meaning in this affidavit.

- Paragraphs 2-11, regarding hotel spaces, to which I would add that Mission Services' 'Housing First' program has helped individuals in need secure 508 housing placements from Housing UP² between April 1, 2020 and July 5, 2024. **Additionally**, there were 256 exits to housing from Emma's Place, Inasmuch House, our Men's Shelter, East End Hotel, and our Men's Services Early Intervention program just during the period of October, 2021 to August, 2023. In each of our shelter program operations, case management staff work to coordinate access for individuals to assist in securing housing working with a Housing First program is not a pre-requisite to housing. individuals may have worked with other providers or services, but they exited for housing from our shelters with the assistance of our program staff. Also, I would add that Mission Services' hotel operation in Downtown Stoney Creek was drawn down in 2022, due to declining COVID-19 funding from government. From its peak operating capacity of 162 supported individuals, the draw down was planned and completed over the final 6 months of 2022 eventually concluding on December 13, 2022, with the last service user exit. Notably, all 96 individuals who remained at the Downtown Stoney Creek hotel as of June, 2022 were connected with or otherwise supported in their efforts to secure alternate housing over the course of those final 6 months. **None** were discharged to the street.
- Paragraphs 12-14, regarding competing philosophies, to which I would add that a problem that continues to persist within the housing and homelessness service sector is the constant conflating of literal and figurative messaging about housing. For example, community leaders, including elected officials and professionals, are often heard to say that "there is no housing". Taken literally, that is not just incorrect, it can severely harm housing outcomes. What is meant is that "there are challenges in accessing housing", but what the public and homeless individuals hear is defeatism. This misleading narrative oversimplifies the issue, ignoring that the challenges such as affordability and accessibility can be and continue to be overcome. It also undermines efforts of co-

² Housing UP is a replicable and scalable service offering that effectively and efficiently expedites housing solutions for individuals experiencing homelessness. By serving as a system outflow solution, it alleviates pressure on the emergency response system and contributes to a more effective and sustainable approach to homelessness reduction.

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ordinated access systems designed to help individuals in navigating these challenges. Such miscommunication can lead to disengagement and hopelessness among those in need, reducing their motivation to seek assistance. Effective housing solutions require accurate information and active, meaningful engagement from individuals to overcome obstacles and achieve stable housing.

- Paragraphs 15-24, regarding service restrictions, to which I would add that between October, 2021 and August, 2023, and the advent of the current Encampment Protocol, we had 493 total non-voluntary discharges from our shelters. This reflects total instances and not 'unique individuals'. Non-voluntary discharges typically occur when there is repeated non-compliance with expectations, i.e. aggressive, violent or disruptive behaviours toward staff or other residents, verbal abuse of staff, or actions that compromise the health and safety of others. Between October, 2021 and August, 2023, there were also 185 self-discharges.
- 8. I have reviewed by October 6, 2021 affidavit and confirm that paragraphs 25-29, regarding COVID-10 Protocols, are no longer accurate.
- 9. I make this affidavit in order to clarify and explain the background of and services provided by Mission Services in the City of Hamilton and for no other or improper purpose.

AFFIRMED by Shawn MacKeigan, of the City of Brantford, in the Province of Ontario, before me at the City of Hamilton, in the Province of Ontario, on July 29, 2024 in accordance with O. Reg. 431/20, Administering Oath or Declaration Remotely.

DocuSigned by:

Commissioner for Taking Affidavits

(or as may be)

Jordan Diacur

Shawn Markizan

SHAWN MacKEIGAN

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Respondent CITY OF HAMILTON - and -Applicants KRISTEN HEEGSMA et al.

Court File No. CV-21-00077187-0000

SUPERIOR COURT OF JUSTICE ONTARIO

PROCEEDING COMMENCED AT HAMILTON

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Lawyers for the respondent

File Number: H227899

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18 CITY OF HAMILTON	17
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21 This is the Cross-Examination of SHAWN MacKEIGAN, a	19
22 representative of the Respondent herein, on his	20
23 affidavit, affirmed July 29, 2024, taken via Zoom	21
24 videoconference, on Wednesday, the 21st day of August,	22
25 2024. NIMIGAN MIHAILOVICH REPORTING INC.	23
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4 JORDAN DIACUR For the Respondent	4 EXHIBITNO. 1: (For Identification) 50
5 VIVIAN CALDAS	5 Hamilton Spectator article entitled
6 _	6 "Homeless, struggling with mental
7	7 illness, barred from Hamilton
8 Also Present:	8 shelters," dated January 20, 2021.
9 Liz Marr Articling Student,	9
10 Gowling WLG (Canada) LLP	10 EXHIBITNO. 2: (For Identification) CBC 62
11	11 article titled "Hamilton needs an
12	12 estimated \$60M to address
13	homelessness," dated March 24,
14	14 2023.
15	15
16	16 EXHIBITNO. 3: (For Identification) City 77
17	17 of Hamilton, Emergency & Community
18	18 Services Committee Agenda, March
19	19 23, 2023, video
20	20 (escribemeetings.com).
21	21
22	22
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24	24
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1	Upon commencing at 3:00 p.m.	1	Willow's Place?
2	SHAWN MacKEIGAN; Affirmed.	2	A. The hours for Willow's Place are
3	CROSS-EXAMINATION BY MS. CROWE:	3	now 24 hours a day, seven days a week. Prior to
4	1 Q. Okay, MacKeigan, I'm going to walk	4	that prior to the Municipality's emergency or
5	you through your affidavit; do you have a copy of it in	5	winter response, the hours were limited. So we weren't
6	front of you? Sorry, you're muted.	6	open 24 hours a day
7	A. Yes, I believe I have a copy.	7	12 Q . Okay.
8	2 Q. Okay, great. So you're permitted	8	A prior to December 1st of 2023.
9	to have a copy of your affidavit but you cannot refer	9	Q. December 1st, 2023?
10	to any other notes or documents. Is that understood?	10	A. Is when Willow's Place moved to a
11	A . That's fine, yep.	11	24-hour drop in, yes.
12	Q. Okay, thank you. And are you	12	14 Q. Thank you. Okay. And Emma's
13	alone in a room?	13	Place is not a violence against women shelter, correct?
14	A. I am.	14	A. That's correct.
15	Q. Thank you. And, please, let me	15	Q. Okay. And can we use maybe
16	know if you need me to repeat or rephrase any	16	it's easier to say VAW going forward for violence
17	questions, okay?	17	against women; is that okay?
18	A. Okay.	18	A. Sure, of course, yes.
19	Q . So if you'll just give me a	19	16 Q. Okay, thank you.
20	moment, I'm going to screen share, so we can go through	20	A. For me, yes.
21	your affidavit. And it's up to you if you want to	21	Q. And then you mention, in the next
22	refer to what's on the screen or what's in front of	22	bullet point, "Inasmuch House." So this is, from what
23	you.	23	I understand, a VAW shelter; is that correct?
24	A. Sure.	24	A. That's correct.
25	Q. Can you see the affidavit on the	25	Q. Thank you. Do you have knowledge
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	Hamilton, Ontario - nmreporting.ca - (905) 522-1653		Hamilton, Ontario - nmreporting.ca - (905) 522-1653
	SHAWN MacKEIGAN - 6		CHAMAI MacKEICAN O
	SHAWIY MACKEIGAN - 0		SHAWN MacKEIGAN - 8
1	screen?	1	of the intake process when a woman is seeking shelter
1 2	screen? A. Yes.	1 2	
	A. Yes. Q. Okay. So, you are the executive		of the intake process when a woman is seeking shelter in Inasmuch House. A. I would describe my knowledge as
2 3 4	screen? A. Yes.	2 3 4	of the intake process when a woman is seeking shelter in Inasmuch House. A. I would describe my knowledge as high level, not intimate. The staff at Inasmuch House
2	A. Yes. Q. Okay. So, you are the executive director of Programs at Mission Services, correct? A. I'm the associate executive	2	of the intake process when a woman is seeking shelter in Inasmuch House. A. I would describe my knowledge as high level, not intimate. The staff at Inasmuch House would be much more familiar with the nuance, the
2 3 4 5 6	A. Yes. Q. Okay. So, you are the executive director of Programs at Mission Services, correct? A. I'm the associate executive director.	2 3 4 5 6	of the intake process when a woman is seeking shelter in Inasmuch House. A. I would describe my knowledge as high level, not intimate. The staff at Inasmuch House would be much more familiar with the nuance, the nuances of that intake process.
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SHAWN MacKEIGAN - 9 SHAWN MacKEIGAN - 11 1 Q. Okay. So is it fair to categorize 1 Q. Okay. Thank you. And is there a 23 that as, like, self-reporting? 2 2 working definition of violence that the shelter uses? 3 3 **A.** You, you could. A. I don't know that I could quote 4 Q. Okay. And do you have any idea 4 for you the working definition but violence does -- we 24 5 5 how much detail someone has to go into to describe certainly recognize and understand that violence does 6 their circumstances? 6 come in all forms, and it is not limited to physical, 7 7 emotional, verbal or any other. A. I don't -- I wouldn't say that I 8 8 am intimately aware of all of the details that are Q. Thank you, that's helpful. Okay. 9 explored, many of them are -- I would say many of the 9 Paragraph 3 of your affidavit, you talk about "a 10 details that would be explored would be because an 10 'service animal' policy permitting such trained and 11 individual has introduced the details. So if somebody 11 certified animals to attend on your sites, and that you 12 introduces details about their situation, we work to 12 don't allow pets, as they raise safety concerns." [As 13 explore them with them, to ensure that we understand, 13 read] 14 as best we're able, that individual's situation. 14 When did the service animal policy 15 Q. Okay. And is there a timeframe 15 begin? during which the abuse has to have happened in order 16 16 **A.** Well, the service animal policy, for someone to access a VAW bed at Inasmuch House? 17 at least the way we view it is, is that it is a legal 17 18 A. Not to my knowledge. But 18 obligation to support individuals who have registered 19 typically individuals reach out when they feel able to 19 service animals or service animals to assist them with 20 reach out. 20 a disability. Mission Services, a number of years ago, 21 21 had briefly looked, looked -- and this was before my 26 **Q**. Okay. **A.** So sometimes it is immediately or 22 22 time with Mission Services -- looked to support pets in 23 within a very short time and sometimes it is not. 23 some capacity. The policy around allowing pets existed 24 **Q.** And do you know if there -- what 24 before my time with Mission Services. 25 25 type of violence makes someone eligible to access a Q. Okay. So, do you have any idea of 33 NIMIGAN MIHAILOVICH REPORTING INC. NIMIGAN MIHAILOVICH REPORTING INC. Hamilton, Ontario - nmreporting.ca - (905) 522-1653 Hamilton, Ontario - nmreporting.ca - (905) 522-1653 **SHAWN MacKEIGAN - 10** SHAWN MacKEIGAN - 12 1 shelter bed -- and, actually, let me try to clarify 1 when this service animal policy began? 2 2 that. So is it correct to say that a report of **A.** I believe that the service animal 3 intimate partner violence would make you eligible for a 3 policy was just a -- we had just referred to what 4 bed? 4 the -- to what was required -- what was required by the 5 A. That would be accurate. 5 law. 6 6 Q. Okay. What about violence from a Q. Okay. So, when you say 34 7 stranger or an acquaintance? 7 "facilities," are you referring to, you know, the 8 A. I would say that that could be 8 drop-in centre and the non-shelter aspects of Mission 9 accurate. I think it's important to -- if -- it may be 9 Services or are you also including shelters in that 10 important to qualify that we will also support women 10 facilities' definition? 11 who experience homelessness if there is space, so it is 11 A. Well, I believe it would include shelters as well. Services animals, service animals 12 12 not exclusive to individuals experiencing violence would be welcome. 13 against women to access a violence against women 13 14 shelter. 14 **Q.** So, you mentioned that you believe 15 Q. Okay. But just to go back to the 15 that, so is that your knowledge that service animals 29 16 question --16 are allowed in shelters? 17 17 **A.** Service animals would be allowed A. Sure. 18 Q. -- do you know if violence 18 in shelters, yes. 19 experienced at the hand of a stranger or a casual 19 Q. Thank you. And are you able to 20 acquaintance would bring them within the realm of being 20 tell me anything about the type of verification or 21 eligible for a VAW bed? 21 certification that's required for an animal to be 22 A. I don't know, I don't know that I 22 considered a service animal? 23 23 could say that for certain. My belief, based on my A. Well, I think that what we 24 24 typically see is animals who have been specifically knowledge, is that, yes, gender-based violence would 25 not be limited to one's intimate partner. 25 trained to support an individual with their disability. NIMIGAN MIHAILOVICH REPORTING INC. NIMIGAN MIHAILOVICH REPORTING INC. Hamilton, Ontario - nmreporting.ca - (905) 522-1653 Hamilton, Ontario - nmreporting.ca - (905) 522-1653

SHAWN MacKEIGAN - 13 And it's usually -- so in terms of who certifies a

2 service animal, what we look for is certification. 3

Q. Okay. Certification from --A. We see cert -- we see -- I'm

trying to think how to say the certification. The only

ones that we would typically see are individuals

certified for visual impairments. We have -- so those

8 ones that are accompanied with -- I don't -- I don't

know how -- I'm trying to find a way to answer that

10 auestion.

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38 Q. Right. And I understand how it's a lot easier to make the determination with a seeing-eye dog, for example. But I'm also imagining that there are other circumstances where somebody is perhaps claiming that this is a service animal, and how

that confirmation or verification is made. A. Yes. So we ask individuals to

provide that registration, that -- or that -certification that their animal has been certified or

20 trained to support a specific disability.

21 Q. Okay. And do you know where those 22 certifications come from, like what organizations issue 23 those certifications?

A. I would say at this point that I couldn't cite that for you specifically but I could

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SHAWN MacKEIGAN - 14

1 certainly retrieve that information from the directors 2 of said sites.

Q. Okay. What about if someone had a doctor's note indicating that this was a service

5 animal?

A. The doctors' notes often don't include an outline that the animal has been

specifically trained to move about in an environment

like that. And the challenge with a doctor's note that

10 indicates that an individual requires an animal and it 11 doesn't include that is that other guests stay there.

12 So if the animal hasn't been at least trai -- trained

13 specifically to support that disability, we certainly

14 work to make sure that we -- that the environment is

15 safe for all service users and staff. So understanding

16 and being aware that the service animal has been

17 trained to move and operate in an environment like that

18 ensures that we don't experience aggressive behaviour

19

or, or other instances that might, that might follow an

20 unregistered animal or one that hasn't been trained.

21 So we have had certainly experiences with animals and

22 seeing animals that haven't been trained, and they

23 result -- can result or has -- there have been

24 examples, instances that I've observed where the animal 25

did not behave like a service animal, so aggressive NIMIGAN MIHAILOVICH REPORTING INC.

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1 actions towards other service users or -- and that's

2 not always -- so I shouldn't just say limited to

3 aggressive, sometimes it's friendly, so you have

4 jumping behaviours and barking and just different

5 things, if we're talking exclusively about dogs. But

6 it really does come to the training component. So

7 we've certainly seen doctors' notes, but the doctor's 8 note doesn't provide any verification that the animal

9 has been trained or that we can reasonably expect the

10 animal to behave --

11 41 **Q**. Okay.

12 **A.** -- the way it needs to in an 13 environment like that. I think that would be the

14 bigger challenge for us.

15 Q. Okay. And are you aware of any 16 circumstances where an animal has been designated or 17 certified as a service animal but then there's been 18 problematic aspects with its behaviour, such that you

19 can no longer allow for the service animal to remain in

20 a shelter?

A. I haven't seen instances like

22 that, no.

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23 **Q.** Okay. And are there any kind of

24 categories of animals, where even if they had this

25 service animal designation or certification, that you

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would not be able to accommodate?

2 A. Not that I can think of. If the 3 animal is a registered service animal trained to 4 support an individual -- I've seen, I've seen snakes, 5 example -- as an example used as service animals for

individuals who live with autism.

7 Q. Okay, thank you. 44 8 **A.** So, I don't, I don't know that I

would say that there are any animals that would --

that -- I don't, I don't know what the answer to that question.

12 45 Q. Okay. What about, like, large

13 breed dogs?

14 **A.** Well, again, if a large breed dog 15 is trained specifically to support an individual

16 navigate a disability, I don't know that the -- I don't

17 know that there would be an aversion to that either.

18 46 Q. Okay. Thank you. Let's move on 19 to the next paragraph, 4. Okay. I'll give you a 20 moment to read that over.

A. Sorry, thank you, yes.

22 47 Q. Great. So, you clarify that

Mission Services can accommodate same sex couples but

24 by extension a heterosexual couple, or opposite sex

25 couple, would not be able to stay together in a Mission NIMIGAN MIHAILOVICH REPORTING INC.

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	SHAWN MacKEIGAN - 17		SHAWN MacKEIGAN - 19
1	Services shelter; is that correct?	1	exited into housing during this period; is that correct?
2	A. Well, at present we run a men's	2	correct?
3	shelter and a women's shelter.	3	A. Stayed with us, yes, or accessed a
4	Q. Right.	4	service at those sites where the situation they were
5	A. So, I guess, technically that	5	looking for housing, we supported them in finding a
6	would be correct.	6	place to stay, yes.
7	Q. Thank you. We'll move on to	7	Q. Okay, thank you. And so what I'm
8	paragraph 7, and the second bullet point. And, again,	8	trying to get at is the total number of individuals who
9	I'll just give you a moment to read that over. I	9	were serviced during the same period but not
10	think, looks like, I have to scroll down for you to	10	necessarily exited into a housing program. So if 256
11	read the paragraph in its entirety.	11	people exited into housing during that period, how many
12	A. I do have a copy in front of me as	12	people were served by those same programs during the
13	well.	13	same period?
14	Q. Sorry, I forgot about that.	14	A. I would have to work to obtain
15	A. Okay. Yeah, I'm familiar with	15	that information, just how many people were supported
16	this paragraph.	16	over that length of time.
17	Q. Thank you. So, you are you've	17	55 Q. Thank you. Okay. So let's go to
18	cited that, "There were 256 exits into housing from	18	the third bullet point of the same paragraph. And the
19	Emma's Place, Inasmuch House, the Men's Shelter, East	19	portion I want to highlight is beginning at "For
20	End Hotel, and Men's Services Early Intervention	20	example," three lines down. So give me a second
21	Program from October 2021 to August 2023." [As read]	21	sorry, let me know when you've had a moment to review
22	Are you able to tell me how many people	22	that.
23	were provided shelter from these same programs during	23	 A. I'm familiar with that as well,
24	the same period?	24	yes.
25	A. I'm not sure that I understand	25	56 Q. Thank you. Okay. So, just to
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	SHAWN MacKEIGAN - 18	4	SHAWN MacKEIGAN - 20
1	the that question. Most of these individuals would	1	read it for the record, it says, "For example,
2	the that question. Most of these individuals would have exited these programs. So, Early Intervention,	2	read it for the record, it says, "For example, community leaders, including elected officials and
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2 3 4	the that question. Most of these individuals would have exited these programs. So, Early Intervention, many they would have accessed the shelter first before they had accessed those supports.	2 3 4	read it for the record, it says, "For example, community leaders, including elected officials and professionals, are often heard to say that 'there is no housing'. Taken literally, that is not just incorrect,
2 3 4 5	the that question. Most of these individuals would have exited these programs. So, Early Intervention, many they would have accessed the shelter first before they had accessed those supports. Q. Okay. So maybe you can start	2 3 4 5	read it for the record, it says, "For example, community leaders, including elected officials and professionals, are often heard to say that 'there is no housing'. Taken literally, that is not just incorrect, it can severely harm housing outcomes. What is meant
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	SHAWN MacKEIGAN - 21		SHAWN MacKEIGAN - 23
1	is this where I would mmm. Well, for instance, I	1	when we see this much, it's just the impacts that
2	would say that I had this very conversation with	2	those and I know that people aren't trying to say
3	Counsellor Cameron Kroetsch.	3	that there's literally no housing, I understand that
4	Q. Okay. So Cameron	4	the sentiments that often are working to be expressed
5	A. Would you like me to highlight	5	are figurative, I do understand that, it's just that
6	go ahead.	6	the impacts are felt very differently. And there are
7	Q Kroetsch would be one of the	7	certainly examples that we could work or I could
8	elected officials you're referring to. Who else are	8	work to deliver for you, that outline where people have
9	you referring to as "community leaders, including	9	used the expression "there is no housing"
10	elected officials and professionals"?	10	66 Q . Right.
11	A. Oh, I would like I would like	11	A when they're speaking
12	to qualify that this is a broad conversation, certainly	12	figuratively.
13	not limited to what we see in Hamilton, as we	13	Q. Okay. And these statements are
14	understand that this issue is as broad as it is. These	14	public statements not in private
15	are headlines that we cite that are picked up here and	15	A. Correct, these are public
16 17	repeated here, so I think that this conversation has	16 17	statements, yes.
18	been going. And I certainly can work to provide you all these I can certainly work to provide examples	18	Q. Okay. Thank you. Do you know what kind of timeframe you're referencing, when you say
19	for each of those	19	they often
20	60 Q . Okay.	20	A. I I would say that in my
21	A where we have seen this.	21	observation it's been pretty routine for the better
22	Q. You just gave one example of	22	part of the last four years.
23	A. Yes, I did.	23	69 Q . Okay.
24	62 Q. Sorry?	24	COURT REPORTER: Sorry, the question
25	A. Yes, I did. Sorry, yes.	25	wasn't clear on the record because there was talking
	NIMIGAN MIHAILOVICH REPORTING INC.		NIMIGAN MIHAILOVICH REPORTING INC.
	Hamilton, Ontario - nmreporting.ca - (905) 522-1653		Hamilton, Ontario - nmreporting.ca - (905) 522-1653
	SHAWN MacKEIGAN - 22		SHAWN MacKEIGAN - 24
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2	Q. Yes. Do you have any other Hamilton examples?	2	over, if you could repeat the question. MS. CROWE: I asked about the timeframe
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- 1 that is an affordability issue. If the question is, "I
- 2 can't find housing," that's not the same as there's no
- 3 housing, that's an accessibility issue. So in our
- 4 observation of all the individuals that we work with,
- 5 it is often the first obstacle that we work to overcome
- 6 if someone is pushing back on the narrative that there
 - is not any housing to be found.

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- 8 71 **Q.** Okay. But the statement that this
- 9 is severely affecting house outcomes is your
- 10 observation, you don't have data to show a clear link
- 11 between this statement -- these statements from public
- 12 officials and housing outcomes, correct?
- 13 A. Again, it would be our
- 14 observation, it is not just individuals that we work to
- 15 do this with but rather also partners inside the
- 16 private market who are renting or have units available
- 17 to rent, we see the same challenge there. So while
- 18 they're -- if they know that there's no housing, we
- 19 hear from private market landlords that they're
- 20 concerned with supporting somebody who's experienced
- 21 homelessness before. So much like the conversation
- 22 about no housing, their concern is that there isn't
- 23 enough supports or resources for individuals,
- 24 suggesting that there's a belief that everybody who's
- 25 experiencing homelessness needs these extended supports

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- 1 and resources. So we see it on both sides, both with
- 2 individuals experiencing homelessness looking for
- 3 places to move to and individuals or businesses that
- 4 have places to rent and have reservations about
- 5 individuals who have experienced homelessness because
- 6 of the narrative that has existed in the public. So I
- 7 would say that I do believe that this is a challenge
- 8 that we see routinely.

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- 9 **Q.** You believe that to be true, yes.
- 10 But I just want to narrow it down a little bit, Mr.
- 11 MacKeigan, do you have any surveys or data that you can
- 12 point to where that conclusion is found, that the
- 13 statements from public officials are leading to -- or
- having a -- are having a severe effect on housing 14
- 15 incomes [sic], do you have data and evidence to support
- 16 that, to support that conclusion?
 - A. This wouldn't have been an area where we would have worked to collect that data based
- 19 on the volume of our observation.
 - Q. Okay. Thank you. And when you state that -- sorry, let me just find it here. So you
- 22 state, "What is meant is that 'there are challenges in
- 23 accessing housing', but what the public and homeless
- 24 individuals hear is defeatism."
 - This is your opinion, correct, on what

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- the public at large and homeless individuals are 98 1
- 2 actually hearing, correct?

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- A. Well, I'm making an observation about what I believe, yes.
- 5 Q. Okay. You're not actually
- 6 claiming to speak on behalf of the public at large or 7 individuals who are homeless?
- 8 **A.** I'm not attempting to speak on
- 9 behalf of the entire public, no.
- 10 Q. Thank you. And in the next 11 sentence, you mention affordability and accessibility
- 12 challenges. What are the housing affordability to
- 13 which you refer? Sorry, housing affordability
- 14 challenges to which you refer?
 - A. If an individual's income is
- 16 \$1,000 a month and it costs \$1,250 a month to rent a
- 17 place, I would refer to that as an affordability
- challenge. 18
- 19 **Q.** And do you know who has an income 76
- 20 a \$1,000 a month?
 - A. Excuse me, I'm not sure that I
- 22 understand the question. Do I know is --
- 23 Q. So, you mentioned an income of
- 24 \$1,000 a month, where did that figure come from?
 - A. I was trying to provide you an

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- example.
- 2 Q. An example. Is that figure --78
- 3 A. You asked me, you asked me -- if
- 4 you would -- can you repeat the question then, please,
- 5 and I'll try again.
- 6 **Q.** So, you mentioned that if someone
- 7 has an income of \$1,000 a month and rent is \$1,200 a
- 8 month, that is an affordability challenge. And I'm
- 9 asking you where did that \$1,000 amount come from, is
- 10 that based on anything specific?
- 11 A. I was attempting to give you an
- 12 example from the question that you asked prior to that,
- 13 I believe.

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- 14 Q. Are those numbers, in terms of
 - \$1,000 income and \$1,200 rent, is that consistent with
- 16 what your experience has been?
 - A. No. I'm provide -- I was
- 18 providing an example to the question that you asked 19
- previous to that. So you had asked a question about
- 20 the -- you know, what affordability and accessibility,
- 21 and I was trying to give you an example of what I meant
- 22 by what an affordability challenge was.
- 23 Q. Right. But is that scenario that
- 24 you just cited, and I understand you're citing it as an
- 25 example, but is that scenario where there's potentially NIMIGAN MIHAILOVICH REPORTING TOC. 1

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SHAWN MacKEIGAN - 29 SHAWN MacKEIGAN - 31 1 a \$200 difference between someone's income and the cost 1 a landlord, they might think that they're going to be 2 of housing, is that something that you or your 2 discriminated against or feel as though they may be 3 3 colleagues at Mission Services encounter when you're discriminated against based on their status, so they 4 trying to assist someone in finding housing? 4 think that it's too challenging or don't know how to 5 5 **A.** Yes, we would encounter issues overcome that initial conversation, so we support 6 6 like that, yes. people sometimes, we'll offer to join them or we talk 7 7 Q. How often do you encounter those to them about -- or we work to a strategy that will 8 8 issues? work for them to how to have those conversations in a 9 9 A. We encounter issues of meaningful way. When they're new to somebody, 10 affordability and accessibility when we're -- with 10 oftentimes they don't know -- might not know how to 11 everyone that we have worked to house. So everyone 11 have a conversation like that, if you haven't had to 12 12 that we're supporting, of course, is experiencing have one before. 13 homelessness, which means they're navigating an issue 13 Q. Okay. And so if someone is 14 14 of some sort, and often they are boiled down to either concerned about potential discrimination because of 15 affordability, accessibility or both. So sometimes the 15 their status, what kind of status did you mean? 16 16 issue, if we were describing affordability, is an **A.** Well, if someone is homeless and example like I just gave you, sometimes it's 17 17 think that it's more likely that a landlord will rent 18 accessibility, because while we work in housing every 18 to somebody who isn't homeless, that's really the crux 19 day, we see what is available, somebody who is new to 19 of that. 20 20 homelessness might not be aware of resources, supports Q. And is that the experience of 21 21 or services that exist for individuals in their Mission Service staff? 22 situations. That's what we work to address, is the 22 A. Of the staff -- let me --23 23 88 affordability and accessibility issues. Q. Sorry, I can --24 **Q.** So maybe you can help clarify, 24 **A.** -- ask --25 25 what do you mean by accessibility challenges? Q. I can, I can rephrase the NIMIGAN MIHAILOVICH REPORTING INC. NIMIGAN MIHAILOVICH REPORTING INC. Hamilton, Ontario - nmreporting.ca - (905) 522-1653 Hamilton, Ontario - nmreporting.ca - (905) 522-1653 **SHAWN MacKEIGAN - 30 SHAWN MacKEIGAN - 32** 1 1

A. Accessibility would be -- so, for instance, if someone is experiencing homelessness and can't find a place to move to or can't find something that is affordable or can't find something that is located near them or has difficulty being engaged with prospective landlords or property managers, these all become accessibility issues that we work to help individuals navigate, whether it's through strategies in engaging individuals or, you know, working through the process of how we find places. I wouldn't -sorry, I think it -- if I could be clear, I'm not trying to use accessibility like in the disability sense but rather --Q. Right. A. -- accessible, you know, do people

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accessibility issues that we're working to navigate. Q. Right. And you just mentioned that an accessibility issue might be in navigating interactions with landlords; can you just clarify what you meant by that?

supports exist for them. I think those are the

know where resources are, are people aware of what

A. Well, there are individuals, if they are new to homelessness, have difficulty explaining or, you know, if they're going to meet with NIMIGAN MIHAILOVICH REPORTING INC.

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question. **A.** Okay. **Q.** So you're explaining a situation where someone might need help navigating a conversation with a landlord because they're concerned about being discriminated against because they are homeless. Have you or your staff ever observed that actually to be the case, that people are facing discrimination from landlords or landlords are less willing to rent to them because of their homeless status. A. I believe in my -- I would say

yes. In my previous question that -- or my previous -one of my previous answers, because we work with landlords, as well, who have expressed those very reservations. I would say that we don't witness -- we haven't -- I certainly haven't and we haven't heard 16 17 instances where people have been discriminated against. 18 The feeling often occurs in advance of those 19 conversations or in advance of those meetings, where 20 that is a feeling that someone might be concerned 21 about. So, you know, our experience with landlords 22 hasn't been negative, our experienced with landlords 23 has been trying, because our -- the effort is to help 24 people better understand the situation that we're all 25 working to navigate. So I think that our, our efforts NIMIGAN MIHAILOVICH REPORTING TO 15 Hamilton, Ontario - nmreporting.ca - (905) 522-1653

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1	are really to ensure that people understand and are	1	96 Q. Okay.
2	aware of what it is that we do and how we do it and why	2	A I think often quite high.
3	we do it the way we do it and these sorts of things.	3	97 Q. Yeah. What about a room in a
4	So I see, yes, there are concerns for individuals but I	4	rooming house?
5	haven't seen that in practice.	5	A. They vary, depending on the size
6	Q. I thought the beginning of your	6	and location, but we've seen we do still see rooming
7	response to that was that people have that concern and,	7	house prices, so 800, 750/800, up to a 1,000. And
8	yes, you have observed some of that those feelings	8	we've seen rooming house prices I don't want to say
9	or that landlords have expressed those types of	9	as high as 1,200 because it might there might be
10	concerns?	10	places that are higher but we've seen rooming house
11	 A. The landlords express concern 	11	prices that have been \$1,200 but
12	about renting to individuals who are experiencing	12	98 Q. Okay.
13	homelessness	13	A 750 to 1,200 wouldn't be
14	92 Q . Okay.	14	wouldn't surprise me if that was the price.
15	A because of the steady drum beat	15	99 Q. And those numbers are current
16	that individuals experiencing homelessness need more	16	rental prices, to the best of your knowledge, like
17	help need more supports and resources and that one	17	averages?
18	of the reasons why people are experiencing homelessness	18	 A. To the best of my knowledge,
19	is because they don't have those. So to qual for	19	that's what I I don't know if that's what
20	clarity, that when I see that what we've observed,	20	necessarily is on the market today but today, this
21	landlords have those reservations, we work to overcome	21	day, but, to my knowledge, yes, in that range is what
22	those reservations. I haven't seen landlords who	22	we've seen, but, again, there's
23	openly discriminated against individuals, because we	23	Q. Do you sorry to interrupt.
24	would take a different course of action with that.	24	A. That's okay.
25	93 Q. Thank you. That helps me	25	Q. Were you done?
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	SHAWN MacKEIGAN - 34		SHAWN MacKEIGAN - 36
1	understand. Do you have knowledge of average rental	1	A. I probably was trailing there
2	prices in Hamilton?	2	anyways, so my fault.
3	A. I have knowledge of it. I would	3	Q. And so, similarly, do you have any
4	say that I don't have intimate knowledge of what the	4	knowledge of what the average rental prices were in
5	lowest rental price is today versus the highest but I	5	2021 and 2022?
6	certainly have knowledge of it. The departmental staff	6	A. I'd have to work to provide that,
7	stay much more in tune with what we see as moving or	7	I can't remember off the top of my head what they were.
8	rolling rental prices.	8	Q. Right. Do you have any knowledge
9	94 Q. Okay. Well, just based on your	9	about whether or not they'd be higher or lower than
10 11	knowledge that you have today, what is your knowledge of the rental price for, let's say, a one bedroom unit	10 11	what they are now, or roughly the same, or you're not sure?
12	in Hamilton?	12	A. I recall when rental prices had
13	A. I don't know exactly but I thought	13	taken what felt like a significant jump. So when we
14	that it had just it had ticked down for a couple of	14	were moving the early days in COVID, we if I was
15	months, I thought that the averages had the prices	15	using just housing first as the example, we didn't
16	had come down before just returning to a place where	16	the prices seemed like they were ones we could work
17	they'd climbed a couple of percentage points but I	17	with. But then there was a climb inside the but I
18	thought it was around between 15 and \$1,600 or maybe	18	can't remember the exact sequence. My thought is that
19	just below 1,500. Can't remember exactly, I apologize.	19	they were lower in 2021 than they are today.
20	95 Q. Okay. That's all right. What	20	104 Q. Okay, fair enough. So in the
21	about for a bachelor apartment?	21	again, in this same paragraph, you state sorry, let
22	A. Slightly less but marginally. I	22	me just find it on my screen "Such miscommunication
23	didn't think I don't recall seeing a significant	23	can lead to disengagement and hopelessness among those
24	difference between bachelor and one bedrooms, it might	24	in need, reducing their motivation to seek assistance."
25	be a couple hundred dollars but	25	And I just want to clarify again, that
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1	this is your opinion or this is your impression and not	1	Q. Okay. And so in that scenario
2	based on data?	2	where someone missed a curfew and somebody else was
3	A. Yes, it's my observation based on	3	waiting for that space, would that lack of access to a
4	the work that we do.	4	bed be counted as a non-voluntary discharge or is that
			, -
5	Q. And, again, you're not claiming to	5	recorded separately?
6	speak to a global experience or perception of people	6	A. Yes, because we'd have to include
7	who are experiencing homelessness?	7	that we would have to make a note of that in the
8	A. I am not.	8	HIFIS system that the City uses to track homelessness.
9	106 Q. You are not?	9	113 Q . Okay?
10	A. I'm not trying to speak	10	A. So we would record why somebody is
11	107 Q . Okay.	11	no longer in the shelter, where the day before they may
12	A. on behalf of everyone, no.	12	have been.
13	108 Q. Thank you. Okay. So, the next	13	114 Q. Okay. And so for the and, I'm
14	bullet point, you talk about "non-voluntary discharges	14	sorry, I'm more familiar with the term "service
15	from shelters." So I just want to clarify, Mr.	15	restriction."
16	MacKeigan, are these the same as service restrictions?	16	A. That's okay, yes, we can use that.
17	A. Service re well, non-voluntary	17	Q. But for these instances where
18	discharges often synonymous with service restrictions,	18	there's a service restriction or a non-voluntary
19	yes. Well, it could be, they're not exclusively the	19	discharge, you haven't recorded in your affidavit, as
20	same. So non-voluntary discharge might include you	20	far as I can tell, the period for which there would be
21	being removed from the premises by the police.	21	a restriction or an inability to access shelter; is
22	Non-voluntary discharges might be you left via an	22	that correct?
23	ambulance and did not return. We have plenty of	23	A. What did which are what are
24	examples of that.	24	you citing, I'm sorry?
25	109 Q. Okay. Could a non-voluntary	25	Q. So we're in the same paragraph,
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	SHAWN MacKEIGAN - 39		SHAWN MacKEIGAN - 40
1	SHAWN MacKEIGAN - 38	1	SHAWN MacKEIGAN - 40
1	discharge be you missed curfew and you're kicked out or	1	the bullet point that begins, "Paragraphs 15-24,
2	discharge be you missed curfew and you're kicked out or you're not there for a bed check and you're kicked out?	2	the bullet point that begins, "Paragraphs 15-24, regarding service restrictions."
2	discharge be you missed curfew and you're kicked out or you're not there for a bed check and you're kicked out? A. In our experience, that wouldn't	2	the bullet point that begins, "Paragraphs 15-24, regarding service restrictions." A. Yes.
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2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24	discharge be you missed curfew and you're kicked out or you're not there for a bed check and you're kicked out? A. In our experience, that wouldn't be the case, no. 110 Q. So A. So curfew is not we wouldn't discharge somebody, right, we would not discharge somebody unless they didn't return. So we know we're very we've done unless there's somebody waiting for a space. So if we have 100 spaces available, and the time where we do bed checks is 10:00 p.m., if there are people waiting to see if there are any beds at 10:00 p.m. and there are individuals that have not returned, the individuals know, we apprise individuals early and often that if they don't return, that their bed may be lost to somebody who is waiting for it in their place. So we wouldn't discharge you if there was nobody waiting to take a space and we had 100 beds, zero people waiting, and an individual returned at 11:30, they would simply return at 11:30. Q. Okay. A. So, you know, missing a curfew would only be a challenge for an individual if there were other individuals waiting for a space for which they did not already have one.	2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24	the bullet point that begins, "Paragraphs 15-24, regarding service restrictions." A. Yes. 117 Q. So, what I'm wondering is, and I just want to make sure that I haven't missed that there isn't a discussion about the length of time that people are service restricted from the shelter, when these non-voluntary discharges occur? A. I did not include a discussion about the length of time, no. 118 Q. Okay. So for that number, the 493 discharges, do you have the corresponding information about the length of the service restriction recorded somewhere else? A. The City would keep that. The City of Hamilton would keep that information or have access to that information inside the HIFIS data system. 119 Q. Okay. And based on your knowledge, what is the timeframe that service restrictions are issued for? Like, what's the range of time? A. Well, the range can be the ranges are outlined in the City's service user or the

SHAWN MacKEIGAN - 41 shelter system as a whole works from, but service restrictions can range often any time from several hours all the way up to an indefinite restriction, depending on the nature of the events or the nature of what happened.

6 120 **Q**. Okay.

7 **A.** Most -- I can add, most commonly 8 they're brief.

9 121 Q. And what do you mean by "brief"?
10 A. I mean brief, they're closer to

hours than they are indefinite. So it's more often that people are restricted for, you know, a day or a few days than it would be that they are restricted indefinitely.

14 indefinitely.15 122 Q. Okay.

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16 **A.** It's significantly more often that 17 individuals it is just a day or a few days as opposed 18 to indefinite.

Q. Right. And when someone is -there's a non-voluntary discharge or a service restriction, so that means that they can't access Mission Services, correct?

23 **A.** For the -- for that period of 24 time, that would typically be correct, yes.

Q. Okay. Does Mission Services
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consult with any of the other shelters to see if that individual is able to access shelter somewhere else?

A. Yeah, that's usually what we work to do. So I'll speak -- as a practise, if we were to discharge somebody, one of the things that we work to do before the discharge is complete is find another place for the individual to go --

8 125 **Q**. Okay.

A. -- or provide options for the individual to go, before we discharge them. So that's pretty -- we've done that routinely for quite sometime, as long as I can remember. So that -- because the reality is, if there isn't somewhere to go, then we work to keep the individual 'til the next day. Like, depends on the nature of the restriction but we always work to ensure that someone has somewhere to go if they're going to be discharged non-voluntarily.

Q. Well, so you said that it's you

Q. Well, so you said that it's you usually work with other shelters, does that mean that sometimes you don't work with other shelters to make that determination?

A. No. I should say that we do that unless the circumstances are that that's not practical or possible. So if the person -- so a non-voluntary discharge, I'll use an example, and then, perhaps, if

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you ask it again, I could answer it better for you 2

But if somebody is aware of actions that have occurred

3 and they are about to be restricted for service,

4 depending on the nature of event, and assume that it's

5 a violent one or an aggressive one, before we have even

6 completed the action, the individual leaves only to not

7 return at all, there isn't any -- there isn't anything

 $8\,$ $\,$ for us to coordinate. So if there was a physical

9 altercation between two residents and one of the

10 residents left and simply did not return, then, no, we

11 wouldn't coordinate another place for them to be

12 because they haven't returned in order for us to do

13 that.

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14 127 Q. Right, that makes sense. What if
 15 the individual is still there but it has been --

A. If the individual is still there, then we work to support -- yes, we work routinely, routinely to support them finding another place. It does not mean that they want to access those options, but for as long as they're willing to be engaged in us finding them another place to go, we'll work to find them another place to go.

Q. Okay. And do you get, you know, push back from other shelters if you're saying, "We are service restricting this person because of a violent

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incident, can you take them"?

A. No. Not typically, no. And the reason we wouldn't is because oftentimes we would work to support one another. So if somebody was working to support us with an -- and support an individual who is restricted, then what we would do, if they were, you know, at or near capacity or didn't have space, then we work to support each other, so it might mean that we receive somebody from that site in order for them to support an individual in this application. Sometimes individuals have had a history or something happened at one, which means they might not be able to support us in that application, but they would work to support us in other ways, whether it's coordinating with a third shelter, where an individual might move from one to another. And that's not to say that we displace people at all hours of the day and night, we certainly don't work to do that. But the short answer is, if we need, if we need support from another shelter, no, we don't

129 **Q.** Okay. And do you track the individual or receive confirmation that they've accessed shelter somewhere else?

typically see push back in instances like that.

A. If we've made arrangements for an individual to leave our space go to another one yeah NIMIGAN MIHAILOVICH REPORTING INC.

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- 1 we work to coordinate that. And it's not uncommon,
- 2 depending on the time of year and what the individual
- 3 is or is not interested in, to support them with
- 4 transportation to get there, sometimes they're
- 5 interested in that and sometimes they're not interested
- 6 in that, but we do -- you know, that's one of the ways
- 7 we do that. And then we can see in HIFIS if they have
- 8 arrived at their destination and booked in.
- 9 Q. Okay. So if you're tracking it 10
 - and you can see in HIFIS if they've arrived at their
- 11 destination, are there times where you see that the
- 12 individual didn't make it to the referring shelter?
- 13 A. There would be times where
 - then not arrived there. And we do see those and we

individuals have opted to go to another shelter and

- 15
- 16 follow up on those to see if the individual has
- 17 arrived, because what is also come, and depending on
- 18 the time of day, is that the staff may have not had yet
- 19 an opportunity to update that HIFIS system with the
- 20 individual's data.

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- 21 **Q.** Do you encounter situations where
- 22 you are contacting another shelter for a referral and
 - the other shelter tells you that the individual is also
- 24 service restricted from that shelter?
 - A. Yeah, that can happen but we NIMIGAN MIHAILOVICH REPORTING INC.

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- 1 usually -- or depending on the staff person, staff
- 2 persons are usually able to see if such a restriction
- 3 exists, not always. Certainly in the last several
- 4 months, we've had challenges accessing HIFIS, but I
- 5 know that that's come back online. Short answer though
- 6 is, yeah, we do, we'll call another shelter and they'll
- 7 let us know that they have a service restriction. And
- 8 then what we'll work to do is see if that is something
- 9 that can be navigated or overcome.
- 10 132 Q. Okay.
 - A. Service restrictions, depends on
 - the situation, but we're always open to moving off of
- 13 the service restriction, if situations changed.
- 14 **Q.** Do you ever encounter a situation

where Mission Services service restricts an individual

- 16 and then is able to -- and then finds out that they're
- 17 actually service restricted from all shelters?
- 18 A. Their have been instances like
- 19 that, yeah. Yes, where, where -- we already -- so if
- 20 we were to take the step to service restrict somebody,
- 21 it would be known, staff would be able to see that the
- 22 individual is restricted at other spaces as well.
- 23 There would have to -- the circumstances would have to
- 24 be significant enough, that there wouldn't be another
- 25 option at one of the other two men's shelters. So then

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- 1 the situation in those instances means that there isn't
- 2 another partner around the corner that we could
- 3 support, so finding another solution for individuals
- 4 like that requires more time. And those aren't the
- 5 sorts of things that staff would typically undertake on
- 6 their own at two or three o'clock in the morning.
- 7 They're much more involved situations, if somebody is
- 8 already restricted from two other sites. Because if
- 9 they're restricted at two and we're the last one and
- 10 something has happened there that warrants
- 11 restriction -- I'll give you an ex -- I'll give you an
- 12 idea of how we might do that. Sometimes we would put
- 13 off whether or not we applied a restriction, and then
- 14 we ask ourselves whether or not one was warranted at
- 15 all or whether or not it's something that we would work
- 16 to navigate through a shift change or something like
- 17 that.

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- Q. Okay. Are there situations --134
- 19 A. So short answer is --
- 20 Q. Sorry? 135
 - **A.** Short answer is, yes, there are
- 22 instances where an individual may need to be service
- restricted or we feel they do and they are also 23
- 24 restricted at the other two men's shelters.
- 25 Q. And that you're unable to resolve 136 NIMIGAN MIHAILOVICH REPORTING INC.

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1 that by rescinding the service restriction at Mission

- 2 Services?
- 3 **A.** Oh, we would first start by seeing 4 if the restriction could first be lifted at one of the
- 5 other two sites. So if the restriction at one of the
- 6 other two sites, it would, it would be obvious that the
- 7 restriction occurred at the other two sites before the
- 8 instance that we were navigating that particular day,
- 9 so our first conversation would be with our partners
- 10 about whether or not the restriction could be adjusted
- 11 on their end in order to help us navigate the immediate
- 12 situation.
- 13 137 Q. Okay.
- 14 A. Barring that, then the
- 15 conversation becomes a managerial one, because we look
- 16 for what other options might exist or be available for
- 17 that individual if we can't accommodate them inside the
- 18 system.
- 19 **Q.** Okay. We're going to take a short
- 20 break from your affidavit, and I want to share another
- 21 document with you. I'd like this document to be noted
- 22 as Exhibit 1 to the examination.
 - MR. DIACUR: You can't do that,
- 24 counsel, until he's identified it.
- 25 MS. CROWE: Pardon?

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	SHAWN MacKEIGAN - 49		SHAWN MacKEIGAN - 51
1	MR. DIACUR: You can't mark it as an	1	are referenced in the article, yeah, I would have an
2	exhibit until it's been identified.	2	objection to you providing a summary. If the article
3	MS. CROWE: Okay, fair enough. So, I	3	specifies what it's about, then that can be put to the
4	am not a very technological person, so I can't	4	witness.
5	guarantee this will be seamless, please bear with me	5	MS. CROWE: Okay.
6	one moment, please.	6	BY MS. CROWE:
7	BY MS. CROWE:	7	Q. So, why don't we start with this:
8	Q. Mr. MacKeigan, can you see an	8	Mr. MacKeigan, do you have any memory or knowledge of
9	article from the Hamilton Spectator on your screen	9	this incident, the incident that's referred to in this
10	titled "Homeless, struggling with mental illness,	10	article?
11	barred from Hamilton shelters"?	11	MR. DIACUR: Well, in fairness,
12	A. I can see that.	12	counsel, you'd have to show him what it says, all I can
13	Q. Thank you. And can you see the	13	see is a picture of a man.
14	date is January 20th, 2021?	14	MS. CROWE: You're absolutely right, my
15	A. I can see that, yes.	15	apologies.
16	MS. CROWE: Thank you. Just one	16	BY MS. CROWE:
17	moment, please.	17	Q. What we could do is to give you a
18	So, Madam Reporter, this is the this	18	moment to read the article, if you'd like, Mr.
19	is to be Exhibit No. 1. And I will put this into a PDF	19	MacKeigan.
20	after the examination.	20	A. Sure. I mean, I would need to
21	BY MS. CROWE:	21	take a moment to read this.
22	Q. So with your	22	Q. Okay. So you let me know when you
23	MR. DIACUR: Sorry, just to be clear,	23	need me to scroll down further.
24	Madam Reporter, it's to be marked for identification.	24	A . Okay, keep going. Okay. Okay.
25	This isn't a document that was created by the witness.	25	Okay. Okay. Okay. Okay. Okay. Okay. Okay.
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	SHAWN MacKEIGAN - 50		
1	SHAWN MacKEIGAN - 50	1	SHAWN MacKEIGAN - 52
1 2	SHAWN MacKEIGAN - 50 So I want to be clear on the record that that's its	1 2	SHAWN MacKEIGAN - 52 Okay. Okay. Okay.
2	SHAWN MacKEIGAN - 50 So I want to be clear on the record that that's its purpose.	1 2 3	Okay. Okay. Okay. Okay. Okay. Okay. Okay. Okay. 146 Q. Okay, thank you, Mr. MacKeigan. I
2	SHAWN MacKEIGAN - 50 So I want to be clear on the record that that's its purpose. MS. CROWE: Thank you, Mr. Diacur.	2	Okay. Okay. Okay. Okay. 146 Q. Okay, thank you, Mr. MacKeigan. I want to go back to the portions of the article where
2	SHAWN MacKEIGAN - 50 So I want to be clear on the record that that's its purpose. MS. CROWE: Thank you, Mr. Diacur. EXHIBIT NO. 1: (For Identification)	2 3 4	Okay. Okay. Okay. Okay. 146 Q. Okay, thank you, Mr. MacKeigan. I want to go back to the portions of the article where you are it appears that you're interviewed and
2 3 4 5	SHAWN MacKEIGAN - 50 So I want to be clear on the record that that's its purpose. MS. CROWE: Thank you, Mr. Diacur. EXHIBIT NO. 1: (For Identification) Hamilton Spectator article entitled "Homeless,	2	Okay. Okay. Okay. Okay. Q. Okay, thank you, Mr. MacKeigan. I want to go back to the portions of the article where you are it appears that you're interviewed and quoted. Okay, Mr. MacKeigan, now that you have had an
2 3 4 5 6	SHAWN MacKEIGAN - 50 So I want to be clear on the record that that's its purpose. MS. CROWE: Thank you, Mr. Diacur. EXHIBIT NO. 1: (For Identification) Hamilton Spectator article entitled "Homeless, struggling with mental illness, barred from Hamilton	2 3 4 5	Okay. Okay. Okay. Okay. 146 Q. Okay, thank you, Mr. MacKeigan. I want to go back to the portions of the article where you are it appears that you're interviewed and quoted. Okay, Mr. MacKeigan, now that you have had an opportunity to read this article, do you remember it,
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SHAWN MacKEIGAN - 53 SHAWN MacKEIGAN - 55 instances would cause, I believe, would cause $\frac{1}{1}$ believe, would cause $\frac{1}{1}$ individuals to see individuals experiencing 1 interviewed with or speaking with Teviah on many 1 2 2 occasions. 3 3 homelessness differently and it would not be reflective Q. Okay. So it's dated January 20th, 4 2021. And would you agree that this article is about a 4 of individuals' experiences, it would be reflective of 5 5 man named "John Honyust" who was restricted from all instances when somebody might have been navigating a 6 6 three shelters in Hamilton New Year's Eve of 2020? particular trying time. But, again, I didn't want the 7 7 A. I would agree with that, that's -general feeling to be that everybody is -- everybody 8 8 Q. Okay. And then if we look at the does something bad or everybody does something bad or 9 9 paragraph that begins "With this deficit," I'll just everybody needs assistance with something, it's not the 10 read it out: "With this deficit, shelters indeed have 10 case, we do navigate significant instances and 11 become the 'backstop' for such societal challenges, 11 significant issues on a semi-regular basis but it is 12 says Shawn MacKeigan, a director with Mission Services 12 not reflective of everyone that experiences 13 who oversees its men's system." 13 homelessness. So where examples -- I'll stop talking 14 14 To the best of your recollection, is there, if you want. I'll certainly trail on in case --15 this an accurate representation of what you said to 15 Q. Yes, thank you, Mr. MacKeigan, I 16 Teviah Moro? 16 do appreciate that there are many nuances to shelter 17 A. Well, I mean, he's quoted 17 services, but I am actually looking for a much narrower 18 "backstop," I -- what -- I'm not sure what you mean if 18 response. I'm just seeking confirmation of what 19 it's an accurate depiction. But I would say in my 19 information was provided in the course of this 20 experience with Teviah has been pretty good. My 20 interview. 21 interviews with Teviah typically last half an hour or 21 So the next paragraph is, "But shelters 22 45 minutes. So heavily qualified conversations usually 22 aren't properly resourced to handle the most complex 23 23 boil down to a few quoted items but I'm happy to say, cases, he added." 24 yeah, looks familiar. 24 So this is not a direct quote, it is 25 25 Teviah's representation of what he believes he said to Q. Okay. Thank you. And then we'll 152 NIMIGAN MIHAILOVICH REPORTING INC. NIMIGAN MIHAILOVICH REPORTING INC. Hamilton, Ontario - nmreporting.ca - (905) 522-1653 Hamilton, Ontario - nmreporting.ca - (905) 522-1653 **SHAWN MacKEIGAN - 54 SHAWN MacKEIGAN - 56** 1 scroll down, below the photograph. The next paragraph 1 you. So I would ask you, is this an accurate 2 2 says, "Staff at shelters have a 'very high threshold' representation of what you said to Teviah? 3 for disruptive incidents. 'I can go through a laundry 3 **A.** That we aren't properly resourced 4 list of things that people do,' MacKeigan said." 4 to handle the most complex cases? 5 Is this what you said? 5 Q. That's right. 155 6 **A.** That's what -- that does appear so 6 **A.** Yes, I would agree with that. 7 what I said. I do recall saying that as well, yes. 7 Q. Thank you. And then, lastly, 8 153 **Q**. And is it true? 8 quote, We are not a medical facility. We don't have 9 9 A. I could go through a laundry list those mental-health clinicians. It is difficult to 10 10 of things that people do. I think that if I were to do support people with untreated mental illness, but I 11 11 that, it would portray people in a very negative way will tell you [that] it is absolutely common, end 12 12 and not be reflective of the situation that we auote. 13 navigate. I think specifically when we think of some 13 So is that what you said to Teviah? 14 of these disruptive instances and when I cite a "high 14 A. Yes. 15 threshold," we support -- just as our men's shelter as 15 **Q.** And --157 16 an example, where we have 100 beds, we're supporting 16 A. It is common --17 tens of thousands of unique bed nights every year with 17 **Q**. -- is it true? 158 18 what will effectively be very minimal numbers of 18 A. Yes. 19 service restrictions. So if we saw, you know, several 19 **Q.** Thank you. Okay. So I'm going to 20 20 stop sharing this article. And, again, if you'll bear hundred service restrictions against 50,000 different 21 21 bed nights that we manage and occupancy often exceeding with me for a moment, I'll pull your affidavit back up. 22 22 95 per cent, yes, I could go through a laundry list of One moment, please. 23 23 the types of things that people have done, but it Okay, I want to go back up to paragraph 24 24 wouldn't, it wouldn't serve to ad -- citing those 7, bullet 7 of your affidavit. And this is the bullet 25 point that begins with "Paragraphs 15-24, regarding 25 issues -- instances and the specifics of those NIMIGAN MIHAILOVICH REPORTING NC. UZ NIMIGAN MIHAILOVICH REPORTING INC. Hamilton, Ontario - nmreporting.ca - (905) 522-1653 Hamilton, Ontario - nmreporting.ca - (905) 522-1653

1 service restrictions: "So in the last- sorry. You cite a few examples of the kinds of people here that might thrigger a service restriction. Sir, are you with might thrigger a service restriction. Sir, are you with might thrigger a service restriction fold that on my 5		SHAWN MacKEIGAN - 57		SHAWN MacKEIGAN - 59
2 cite a few examples of the kinds of people here that 3 might trigger a service restriction. Sir, are you with 4 me on the affidavit, Mr. MacKeigan? 5 A. Trying to find that on my 6 use O. In paragraph 7? 7 O. In paragraph 7? 8 one on the screen, yes. 9 use O. Paragraph 7, yes, last paragraph 11 examples of the kinds of behaviour that might trigger a 12 service restriction, including, quote, aggressive, 13 violent or disruptive behaviours that might trigger a 13 violent or disruptive behaviour staff or other 15 compromise safety. 16 A. What do you mean by a "spectrum"? 17 describing a spectrum of behaviours in these examples? 18 A. What do you mean by a "spectrum"? 19 use O. Thank disruptive behaviour might be 20 different to aggressive behaviour? 21 A. Yes, I would agree that disruptive 22 behaviour can be different than violent behaviour. 23 that staff is observing some disruptive behaviour that might trigger a 24 service restriction, including, quote, aggressive, 25 someone has used stiff, or actions that 26 disruptive behaviour behaviour might be 27 different to aggressive behaviour? 28 behaviour can be different than violent behaviour. 29 behaviour can be different than violent behaviour. 20 different to aggressive behaviour in a shelter, does it ever happen that staff knows that we see as often the same days are behaviours that we see as often the same days. So, is that an answers my question. 21 substance use or mental health disability? 22 behaviour can be different than violent behaviour. 23 that staff in other than service restriction? 24 disability, mental health of staff, or actions that we see as 5 someone has used substances, and behaviours become a challenging behaviour of tittle, little note one day, where an individual uses substances, and behaviours become a challenging behaviour shall be a substance or think in the substance and	1		1	
same time as observing that behaviour, they also know when the affidavit, Mr. MacKeigan? A Trying to find that on my B A I can - ockay, I'm looking at the one on the serrice, vers. O Paragraph 7, yes, last paragraph to before 8. Okay. So you mentioned the kinds of some examples of the kinds of behaviour that might trigger a service restriction, including, quote, aggressive, violent or disruptive behaviours toward staff or other residents, verbal abuse of staff, or actions that compromise safety. Is this would you agree that you're describing a spectrum of behaviours in these examples? A What do you mean by a "spectrum"? Is a A. What do you man by a "spectrum"? Is a A. What do you man by a "spectrum"? A Yes, I would agree that disruptive behaviour might be behaviour in a shelter, does it ever happen that staff also know that this inclividual has a mental health to a lot the sheaviour to see heaviours of little, little note one day, where an individual existing about behaviour could lead to a service restriction. A What about in the examples have behaviour to aggressive behaviour one bedifferent than vident behaviour. A Yes, I would agree that disruptive behaviour might be behaviour in a shelter, does it ever happen that staff also know that this inclividual has a mental health or a substance use or mental health disability. A What about in the examples are behaviours become a challenging which the mental health. So I asked you if there might be disruptive behaviour and the staff knows that that in individual has a mental health. So I asked you if there might be disruptive behaviours that we see as challenging when the heaving of the same day. So, is that answers my question. A Co A Coy, A Do we see mental health — behaviours in the examples, so thertimes — I would say in the examples, so, is that answers my question. A Co A Coy, A Do we see mental health — behaviours that we believe to be the byproduct of someone's mental health condition that are challenging to support, is A Do we		•		ARMIN
4 that the individual exhibiting that behaviour has a metal health condition or disability. 5 A. Trying to find that on my 6 190 A. 1 can okay, I'm looking at the one on the screen, yes. 9 191 Q. Paragraph 7? 7 A. 1 can okay, I'm looking at the one on the screen, yes. 9 191 Q. Paragraph 7, yes, last paragraph obefore 8. Okay. So you mentioned the kinds of some 11 examples of the kinds of behaviour that might trigger a service restriction, including, quote, aggressive, violent or disruptive behaviours toward staff or other compromise safety, verbal abuse of staff, or actions that compromise safety. 13 violent or disruptive behaviours toward staff or other residents, verbal abuse of staff, or actions that compromise safety. 14 residents, verbal abuse of staff, or actions that compromise safety. 15 List his would you agree that you're describing a spectrum of behaviour in these examples of describing a spectrum of behaviour in these examples of describing a spectrum of behaviour in these examples of the staff also know that this individual has a mental health disability. 16 A. What do you mean by a "spectrum?" behaviour or all behaviour wight be described behaviour and the health of sability. 17 A. Por us It does not. 18 substance use or mental health disability. 18 substance use or mental health disability. 19 would say in the examples that I'm describing here, of behaviours of little, little note one day, where an individual uses substances, and behaviours become a challenging the next day or the same day. So, is that individual has a mental health or a substance use 19 sawering your question? 20 sawering seement health condition that are challenging th				•
6 A. Yes. 9 tel Q. Paragraph 7? 7 A. I can -rokay, I'm looking at the some on the screen, yes. 9 tel Q. Paragraph 7, yes, last paragraph 19 tel Q. Okay, So you mentioned the kinds of some 2 service restriction, including, quote, aggressive, 19 violent or disruptive behaviour starf or other 19 tessentition, including, quote, aggressive, 19 violent or disruptive behaviour starf or other 19 tessentition, including, quote, aggressive, 19 violent or disruptive behaviour, and 19 violent or disruptive behaviour might be 20 different to aggressive behaviour? 18 A. What do you mean by a "spectrum? 19 tessentition a spectrum of behaviour or might be 20 different to aggressive behaviour? 20 behaviour can be different than violent behaviour. 21 disruptive behaviour might be 21 disruptive behaviour? 21 A. Yes. 22 behaviour can be different than violent behaviour. 22 tel A. Yes. 23 tel Q. Chad when someone is exhibiting 23 tel A. Yes. 24 tel A. Yes. 25 behaviour can be different than violent behaviour might be 26 disruptive behaviour? 26 behaviour can be different than violent behaviour. 27 tel A. Yes. 28 tel Q. Okay, And so if we follow that 10 logic, someone out be be service restricted because their substance uses or their mental health disability 20 tent of disruptive behaviour might be 3 service restriction. 29 testing a spectrum of behaviour with the same of a service restriction. 20 different to aggressive behaviour? 21 testing about behaviour that's associated with substance use of the the shadour. 20 service restricted for other behaviour associated with substance use on mental health. 21 substance use on struptive behaviour and the staff individual has a mental health of a substance use as someone has used substances. That's very common to see 5 someone has used substances. That's very common to see 6 behaviours of little, little note one day, where an individual uses substances, and behaviour become a condition of the staff, and the staff in the samples are behaviour become a condition of the staff in the sampl			4	
## O. Okay, Yes, thank you. ## O. Paragraph 7, yes, last paragraph before 8. Okay. So you mentioned the kinds of ~ some examples of the kinds of behaviour that might trigger a service restriction, including, quote, aggressive, violent or disruptive behaviours toward staff or other describing a spectrum of behaviours in these examples? ## O. That disruptive behaviour in war spectrum? ## O. That disruptive behaviour in war spectrum? ## O. That disruptive behaviour in war spectrum? ## O. That disruptive behaviour might be disruptive aggressive behaviour. ## O. That disruptive behaviour might be disruptive behaviour and behaviour. ## O. And when someone is exhibiting disruptive behaviour in a shelter, does it ever happen that staff also know that this individual has a NIMIGAN MIHALOVICH REPORTING INC. ## O. That's ~ I think partially answers my question. ## O. That's ~ I think partially answers my question? ## O. What about in the context of mental health. So I asked you if there might be disruptive behaviour and the staff knows that that individual uses substances, and behaviours become a challenge the next day or the same day. So, is that answering your question? ## O. What about in the context of mental health. So I asked you if there might be disruptive behaviour and the staff knows that that individual uses substances, and behaviours become a challenge the next day or the same day. So, is that answering your question? ## O. What about in the context of mental health. So I asked you if there might be disruptive behaviour and the staff knows that that individual has a mental health condition that are challenging to support, Is ## O. Not quite. And I'm sorry if I'm do not being clear on this. ## A. Do we see mental health ~ Debaviours that we believe to be the byproduct of someones mental health toold that that individual has a mental health? ## O. Not quite. And I'm sorry if I'm do support, Is ## O. Not quite. And I'm sorry if I'm do support, Is ## O. Not quite. And I'm sorry if I'm do	5		5	mental health condition or disability.
8 A. Yes. 9 191 Q. Paragraph 7, yes, last paragraph 10 before 8. Okay. So you mentioned the kinds of some 11 examples of the kinds of behaviour that might trigger a 12 service restriction, including, quote, aggressive, 13 violent or disruptive behaviours toward staff or other 14 residents, verbal abuse of staff, or actions that 15 compromise safety. 16 Is this would you agree that you're 16 describing a spectrum of behaviours in these examples? 18 A. What do you mean by a "spectrum? 19 19 Q. That disruptive behaviour might be 20 different to aggressive behaviour? 21 A. Yes, I would agree that disruptive 22 behaviour can be different than violent behaviour. 23 19 Q. And when someone is exhibiting 24 disruptive behaviour in a shelter, does it ever happen 25 that staff also know that this individual has a 26 NIMIGAN MIHAILOVICH REPORTING INC. 27 Hamkyou. And what about so 28 we're talking about behaviour that's associated with 29 substance use or mental health associated with 21 substance use or mental health associated with 21 substance use or mental health associated with 22 behaviour and shelter, does it ever happen 23 that staff also know that this individual has a 24 NIMIGAN MIHAILOVICH REPORTING INC. 25 Hamkyou. 26 A. I t can, yes, It's oftentimes I 27 Individual uses substances, and behaviours become a 28 behaviours of little, little note one day, where an 29 individual uses substances, and behaviours become a 30 challenge the next day or the same day, So, is that 31 answering your question? 32 40 Q. That's I think partially 33 46 Q. That's I think partially 44 answering your question? 45 Individual has a mental health candition that are challenging 46 behaviours that we believe to be the byproduct of 47 someone's mental health condition that are challenging 48 Q. What about in the context of 49 subsviance use of mental health condition that are challenging 49 to support, Is 40 Q. Not quite. An I'm sorry if I'm 40 Q. Dikay Due use inside the event of the work of the work of the work of	6	160 Q. In paragraph 7?	6	A. Yes.
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21 behaviour can be different than violent behaviour. 22 behaviour can be different than violent behaviour. 23 tes Q. And when someone is exhibiting 24 disruptive behaviour in a shelter, does it ever happen 25 that staff also know that this individual has a 26 NIMIGAN MIHALLOVICH REPORTING INC. 27 Hamilton, Ontario - nmreporting.ca - (905) 522-1653 28 SHAWN MacKEIGAN - 58 29 A. It can, yes. It's oftentimes I 30 would say in the examples that I'm describing here, 40 oftentimes the examples are behaviours that we see as 5 someone has used substances. That's very common to see 5 someone has used substances, and behaviours become a 6 challenge the next day or the same day. So, is that 6 answering your question? 40 feet Q. That's I think partially 41 answers my question. 41 answers my question. 42 A. Again, for us it does not. 43 NIMIGAN MIHALLOVICH REPORTING INC. 44 Hamilton, Ontario - nmreporting.ca - (905) 522-1653 45 Les Q. And when you say "us," which 2 A. Mision Services (facilities? 46 A. Again, for us it does not. 47 Q. Okay. Harm reduction materials? 48 A. Again, for us it does not. 49 A. Again, for us it does not. 40 C. Okay. Harm reduction materials? 4 A. Again, for us it does not. 40 Naylidean materials? 4 A. Again, for us it does not. 40 Naylidean materials? 4 A. Again, for us it does not. 40 Naylidean materials? 4 A. Again, for us it does not. 4 Millidean materials? 4 A. Again, for us it does not. 4 NIMIGAN MIHALLOVICH REPORTING INC. Hamilton, Ontario - nmreporting.ca - (905) 522-1653 SHAWN MacKEIGAN - 60 11 172 Q. And when you say "us," which 2 A. Mision Services (facilities? 5 A. Not all mission sorry, I I'm 6 thinking about? All Mission services (facilities? 5 A. Not all Mission sorry, I I'm 7 thinking about? All Mission -sorry, I I'm 8 thinking about? All Mission -sorry, I I'm 9 thinking about? All Mission -sorry in the same da				
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183 Q. And when someone is exhibiting 24 disruptive behaviour in a shelter, does it ever happen 25 that staff also know that this individual has a 26 NIMIGAN MIHAILOVICH REPORTING INC. Hamilton, Ontario - nmreporting.ca - (905) 522-1653 SHAWN MacKEIGAN - 58 Substance use or mental health disability? 2 A. It can, yes. It's oftentimes I 2 A. Mission Services. Shawn Mackeigan - 60 Services someone has used substances. That's very common to see 5 someone has used substances. That's very common to see 6 behaviours of little, little note one day, where an 2 individual uses substances, and behaviours become a 3 challenge the next day or the same day. So, is that 3 answers my question. 10 see Q. What about method in the context of 6 disruptive behaviour and the staff knows that that 6 individual has a mental health or a substance use 16 disability, and you answered with respect to substance use. What about mental health? 19 A. Do we see mental health 5 behaviours that we believe to be the byproduct of 5 someone's mental health condition that are challenging 20 to support, is 19 A. I that's okay. 19 NIMIGAN MIHAILOVICH REPORTING INC. 19 A. For us it does not. 244 A. Alarm reduction materials? 24 A. Alarm reduction materials? 24 A. A. Alarm reduction materials? 24 A. A. Alarm reduction materials? 25 A. A. Again, for us it does not. NIMIGAN MIHAILOVICH REPORTING INC. 19 A.				•
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	SHAWN Machelgan - 61		SHAWN WACKEIGAN - 03
1	appropriate or safe but they're not restricted from	1	A . Okay. Δ8907
2	service if they use on property.	2	Q. Okay. So the first one is,
3	Q. Okay. How are instances of	3	"Hamilton shelter system is on the verge of collapse
4	overdoses handled at the shelters?	4	and grappling with an explosion of demand."
5	A. So, for Mission Services, if there	5	And then, "That's the message shelter
6	is an event where somebody overdoses, we call we	6	providers shared with emergency and community services
7	you know, we engage emergency services and call 911.	7	committee Thursday. Shawn MacKeigan of Mission
8	We record each of those instances when that's the case.	8	Services also spoke as a delegate on behalf of the Good
9	And these would be suspected overdoses, we don't	9	Shepherd and Salvation Army."
10	we're never certain but we certainly have a suspicion.	10	So first, Mr. MacKeigan, do you agree
11	Staff respond to those. So they always are equipped	11	with the first statement, that as of March 2023,
12	with Narcan to respond to those. Service users help	12	"Hamilton shelter system was on the verge of collapse
13	keep us apprised if they're using with someone or are	13	and grappling with an explosion of demand"?
14	aware of that, but we work to respond as effectively	14	A. I remember this time period, and I
15	and efficiently as we can in the event that there is an	15	think the context was that was a City staff person had
16	overdose.	16	shared with council maybe those sentiments, that it was
17	177 Q . Thank you. Okay, Mr. MacKeigan,	17	on the verge of collapse. I don't know that that was
18	thank you for your patience, we're almost done.	18	my sentiment exactly. I think that that was shared
19	There's one other a couple other documents I'd like	19	beforehand. We might have echoed it to a certain
20	you to look at. So I'm going to stop sharing your	20	extent that it was. But I would largely agree that the
21	affidavit. And just give me one moment, please.	21	system was being taxed pretty heavily at that time.
22	Mr. MacKeigan, can you see an	22	182 Q. Thank you. And then the next is a
23	article CBC article on your screen titled "Hamilton	23	quote, The fear and hopelessness we witness in the
24	needs an estimated \$60M to address homelessness"?	24	people we are serving is untenable, MacKeigan said.
25	A. I can.	25	Did you say that?
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	SHAWN MacKEIGAN - 62		SHAWN MacKEIGAN - 64
1	Q. Great. So I think what we'll do	1	A. Yes, I did.
2	is we'll just give you an opportunity, again, to read this article, and you can let me know when you need me	3	Q. Did you believe it to be true? A. I still do.
4	to scroll down.	4	
5	And while he's reading, Madam Reporter,	5	lack of access to emergency shelters can tear families
6	can we, please, mark this as Exhibit 2 to the	6	apart, can place people, especially women, Indigenous
7	examination, please.	7	people, members of the 2SLGBTQ community and people
8	MR. DIACUR: And, again, Madam	8	living disabilities I think that's a typo "at
9	Reporter, that's for identification purposes. Again,	9	significant risk of physical harm, violence and even
10	the witness didn't create this document.	10	death."
11	EXHIBIT NO. 2: (For Identification)	11	Did you say that?
12	CBC article titled "Hamilton needs an estimated \$60M to	12	A. I said that.
13	address homelessness," dated March 24, 2023.	13	Q. And do you believe is it true?
14	THE DEPONENT: Okay, you can keep	14	A. I believe that I was speaking
15	going. Okay. Okay. Okay.	15	about the shelter system in a whole, including
16	BY MS. CROWE:	16	gender-based, violent shelters, women's shelters, men's
17	179 Q. Thank you. All right. We will go	17	shelters. And in the context, when I was describing
18	back up to the beginning of this article. So, again,	18	this, I was describing, when we talk about shelter
19	dated March 24, 2023. Do you recognize this article?	19	access is, it is the challenges with creating
20	A. I don't know that I recognize the	20	outflow, so the lack of resources largely in outflow
21	article but I do recognize it enough. I don't	21	solutions that keep spaces accessible inside a shelter.
22	remember I obviously I don't remember speaking to	22	When the resources don't exist to help people secure
23	that reporter but I remember the article, yes.	23	permanent housing, it creates a slow down or a
24	Q. Okay. So, I want to focus on the	24	bottleneck inside the shelter system, and if the
25	first four paragraphs of the article.	25	shelter beds aren't turning over, we run into an access
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SHAWN MacKEIGAN - 61

SHAWN MacKEIGAN - 63

	CHAMAI Magi/FICANI CE		CHAMAI MAAKTICAN CZ
1	SHAWN MacKEIGAN - 65	1	SHAWN MacKEIGAN - 67 191 Q. Okay.
1	problem. So I did I do agree with that, I did say	2	ARGIR
2	that.		
3	186 Q. Okay. And I certainly appreciate	3	information from staff who handle it daily but
4	that you're very well versed on this, and I was	4	192 Q. Okay.
5	wondering if you could just help me with some of the	5	A that's as far as my knowledge.
6	terms that you use. You're talking about challenges	6	Q. And so my understanding from
7	with outflow; what exactly do you mean by that?	7	this article, and you can correct me if I'm wrong, was
8	A. If an individual is staying in the	8	that this was born out of a delegation to emergency and
9	emergency shelter system, prior so you would begin	9	community services earlier on that week, in March; is
10	in a housed so say you're housed first, and then you	10	that correct?
11	lose your accommodations, and then you enter the	11	A. Yep, I believe that to be correct,
12	emergency shelter - that would be inflow. So you've	12	yes.
13	gone into the emergency system. Outflow would be your	13	194 Q. Okay. I'm going to stop sharing
14 15	exit/return to housing on the other side. So outflow	14 15	the screen. So what I want to do next, Mr. MacKeigan,
	from the system would be people exiting the emergency	16	is show you just a couple of short clips from that
16	system for permanent housing solutions. And inflow to	17	delegation and get your feedback on those clips, okay.
17	the system would be individuals, you know, exp		A. Sure.
18	pardon me, individuals who have experienced	18	Q. So, again, I don't anticipate that
19	homelessness entering the system.	19	this is going to be seamless, please bear with me. If
20 21	Q. Thank you, that's helpful. And,	20 21	I can have your indulgence and actually going off
22	again, can you just explain in plain language what are	22	record for one minute, so or two minutes, so we can
23	the barriers to people to outflow, to people	23	cue up the video.
23 24	accessing sorry, exiting the emergency shelter	24	MR. DIACUR: No problem Off-the-record discussion.
25	system? A. I would say in the plainest	25	BY MS. CROWE:
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	SHAWN MacKEIGAN - 66		SHAWN MacKEIGAN - 68
1	language, the two biggest obstacles, perhaps the only	1	196 Q . And, Mr. MacKeigan, thank you for
2	obstacles are, issues of affordability, unique to	2	your patience, we are almost done your examination.
3	individual sets of circumstances, and accessibility.	3	Okay. And I'm going to share screen. Okay, Mr.
4	So these are all dependent on individual sets of	4	MacKeigan, can you see this screen graph of a video?
5	circumstances - income is different, preferences are	5	A. I can, yes.
6	different, needs are different, all sorts of things are	6	Q. And thank you. And for the
7	different but they really, they really are issues of	7	record, the title of the document that corresponds with
8	affordability, either they do or don't have enough	8	this video is "City of Hamilton, Emergency and
9	money, or they're issues of accessibility, they can't	9	Community Services Committee Agenda," dated March 23,
10	find or can't they can or cannot find the right	10	2023. I'm going to enlarge the video. And I'm going
11	places, the right fits for them.	11	to play a couple of clips. And I'm going to do my best
12	188 Q. You talked about that income could	12	to be as precise as possible to move to the next clip.
13	be a challenge. Do you have any knowledge of ODSP or	13	So, first, Mr. MacKeigan, can you
14	rates under the Ontario Disability Support Program, for	14	confirm that this is you with the microphone?
15	a single person?	15	A. It is.
16	 A. Yeah, I have some knowledge of 	16	198 Q. Thank you. Okay.
17	that, yes.	17	Video clip played.
18	Q. How much does a single person get	18	MR. MACKEIGAN: Sharing our brief
19	from the Ontario Disability Support Program per month?	19	delegation time because this is not about a particular
20	A. I don't want to quote it exactly	20	shelter or agency but rather about an essential
21	but I want to say it was around \$1,180, maybe just over	21	community system that is facing some critical
22	that or just under.	22	challenges. Recently, the emergency shelter system has
23	Q. Okay. And what about for someone	23	been described as a system on the verge of collapse,
24	on Ontario Works?	24	and that is accurate. While those who have worked in
25	A. It might be in the mid-700s now.	25	the system know all too well the challenges we've faced
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	SHAWN MacKEIGAN - 69		SHAWN MacKEIGAN - 71
1	for years, the past three have laid bare just how dire	1	to confirm your, your adoption of those statements
2	the circumstances are that the system is attempting to	2	Okay, we'll move on just briefly.
3	navigate today. We won't be able to cover all of the	3	Video clip played.
4	pressures or challenges the system is facing but we can	4	MR. MACKEIGAN: People living with
5	touch on a few."	5	disabilities at significant risk of physical harm,
6	End of video clip.	6	violence and even death. Exits to housing are slowing,
7	BY MS. CROWE:	7	and emergency shelters and the staff delivering those
8	Q. Mr. MacKeigan, you'll have heard	8	shelter supports, long operating at or over capacity,
9	in that clip there the same expression that was used in	9	are trying to backstop pressures that are spilling over
10	the CBC article, that the shelter system was on a verge	10	from other equally challenged sectors, like health
11	of a collapse. And I'm just confirming that that was	11	care, immigration and corrections. The critical
12	you making that statement and that you agree with it?	12	staffing issues we're facing is that every time a staff
13	A. I was referencing, yes, the	13	in this system is lost, be it to low compensation or
14	comments that were made, it had been described that	14	burnout, we don't just lose the staff person, we also
15	way, I agreed with the sentiments of the individual	15	lose their capacity. We lose their knowledge, their
16	that had shared that statement. So I had agreed with	16	experience of not just their roles but of the system as
17	their sentiments, yes.	17	a whole and how best to navigate it. We cannot replace
18	Q. Thank you very much. And we're	18	those kinds of losses over night. Building back
19	just going to move forward just briefly.	19	knowledge and
20	Video clip played.	20	Video clip ended.
21	MR. MACKEIGAN: See virtually all of	21	MS. CROWE: Madam Reporter, could we go
22	the time. We are seeing an explosion in demand for	22	off record for one moment, please, because there is a
23	family shelter beds	23	clip that I'm not finding.
24	Video clip ended.	24	Off-the-record discussion.
25	MS. CROWE: Oop, I'm sorry.	25	Video clip played.
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1	SHAWN MacKEIGAN - 70	1	SHAWN MacKEIGAN - 72
1 2	SHAWN MacKEIGAN - 70 Video clip played.	1 2	SHAWN MacKEIGAN - 72 MR. MACKEIGAN: The Canadian alliance
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- was happy to deliver the message, that Katherine would
- 2 certainly be able to speak to that very, very
- 3 pointedly. But I would agree, yes, there is a
- 4 challenge with capacity but that challenge is a result
- 5 of slowing outflow from the system. So the inability
- 6 to routinely turn over beds is a challenge. We operate
- 7 over capacity but we continue to operate, we don't
- 8
- close.

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- 9 Q. Thank you. And thank you for 10 clarifying that. So that was going to be one of my
- 11 questions, that you were speaking on behalf of
- 12 Katherine Kalinowski of Good Shepherd and James Moulton
- 13 of Salvation Army and Mission Services as well during 14 that delegation?
 - **A.** We were -- we had joint -- we had collectively prepared those remarks and, I believe,
- 17 took turns responding to questions and speaking.
- 18 MS. CROWE: Thank you, Mr. MacKeigan. 19
- Okay, thank you for taking the time to speak with me, 20 those are my questions.
- 21 MR. DIACUR: Well, counsel, I think
- 22 there are a couple of things we have to put on the 23
 - record about the video that was just played. Do you

MS. CROWE: Thank you for catching

- 24 intend to mark it as an exhibit to the examination? 25
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SHAWN MacKEIGAN - 74

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11

1 that, yes, please.

- MR. DIACUR: And in order to do that, I think there are a couple of things that we're going to
- have to provide to the court reporter, given that it's
- 4 5 not a written document. So you identified the webpage
- 6 and the location where the video was shown on that page
- 7 but I think we have to identify which item that it fell
- 8 under on the record, so the link is identified. And
- 9 I've kept track of the timestamps of the four sections
- 10 that were extracted and put to the witness, and I think
- 11 that should also be put on the record. So, if you
- 12 could, counsel, I'd ask that you put the webpage back
- 13 up where the video was found and we can identify which
- 14 link was referenced on the page.
 - MS. CROWE: Certainly, I will do that.
 - I have to confess that part of my struggle in finding
 - the right clip was that my timestamps' search don't
- 18 seem to be all that accurate, but let me pull it back
- 19 up. Okay. Can you see it now?
- 20 MR. DIACUR: Yes. So, I can see that,
- 21 counsel. And this is what I mean, in the top
- 22 right-hand corner of the internet page, we can see the
- 23 video in a relatively small size, it can be expanded
- 24 from there, which was done, but we, I think, need to
- 25 identify the title on the page and the date but I think
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- we have to identify which item on the page this video 1
 - falls under, I believe it's number 7, "Delegations, but
- 2 3 I would just like to confirm that, and it may be 7.1 --
- 4 okay, no, I can see that now, it's not 7.1, so which
- 5 one is it?
- 6 MS. CROWE: Well, to your point, Mr.
- 7 Diacur, I actually struggled to find this on the agenda 8
- descriptions as well. And so I think what I would have
- 9 to do is click on. I believe it did come close to 7.1. 10 I'd have to click on it and see where that brings us to
- 11 the video. Unless you have another suggestion.
- 12 MR. DIACUR: Yeah, it's interesting. I 13 mean, it does say under the video, "7. Delegations,"
- 14 but it doesn't give any more information.
- 15 MS. CROWE: Mm-hmm.
- 16 MR. DIACUR: Well, before we start
- 17 clicking through to links, just, for the record, this
- 18 is what I have, see if it aligns with your information.
- 19 The four timestamps or clips that were played, the
- 20 first was at 1 hour 36 minutes and 28 seconds, and that
- 21 was played through to 1 hour 37 minutes and 2 seconds.
- 22 The second clip was 1 hour 38 minutes and 26 seconds
- 23 through to 1 hour 38 minutes and 46 seconds. The third
- 24 clip was 1 hour 39 minutes and 9 seconds through to
- 25 1 hour 39 minutes and 56 seconds. And the fourth clip

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11/16/2024 03:18:00 PM

- 1 was 1 hour 37 minutes and 48 seconds through to 1 hour
- 2 38 minutes and 11 seconds. So that's what I took down
- 3 as I was watching. Indeed, do you concur with that?
 - MS. CROWE: I have to confess that I
- 5 don't have the precise timestamps because -- I can say
- 6 that was generally the vicinity of them. What I had
- 7 written down, when I tried to pull it up, wasn't
- 8 exactly accurate. I'm not sure how to handle this.
- 9 MR. DIACUR: Well, no, I would just put
- 10 that on the record then as what I observed.
 - MS. CROWE: Okay.
- 12 MR. DIACUR: I mean, the record will
- 13 show that the audio was played, so I don't have an 14 issue with exactly what was said or put to the witness,
- 15 but I just wanted to put on the record that that is
- 16 what I observed when the video was playing.
- 17 So, the only other thing is in terms of
- 18 how the video is dealt with as an exhibit. Again, I 19
- would suggest it's marked for identification, because
- 20 the witness didn't create the document -- or I should
- 21 say the record, since that it's a video record. And I
- 22 believe that the entire video should be entered as the
- 23 exhibit, rather than just the extracts that were put to
- 24 the witness, so I believe that it would have to be 25

provided in that basis. As long as we have the URL for NIMIGAN MIHAILOVICH REPORTING MC: OZO

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 1
   it, I think we have all the information that we would
2
   need for identification purposes. I didn't raise that
3
    previously with the two newspapers articles because the
4
    URLs are apparent on the webpages that will be provided
5
    to the court reporter. So it's just because it's a
6
    video that I would add that additional information.
7
                  MS. CROWE: Okay. Understood, thank
8
    you.
9
                 MR. DIACUR: So, I appreciate that,
10
    thank you, counsel.
11
                  EXHIBIT NO. 3: (For Identification)
12
    City of Hamilton, Emergency & Community Services
13
    Committee Agenda, March 23, 2023, video
    (escribemeetings.com).
14
15
                 MR. DIACUR: And just to be clear on
    the record, as well, I don't have any re-examination
16
    questions for Mr. MacKeigan. So, thank you, Mr.
17
18
    MacKeigan, for attending and answering.
19
    --- Whereupon proceedings adjourned at 4:45 p.m.
20
21
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I HEREBY CERTIFY THE FOREGOING
                   to be a true and accurate
               transcription of my shorthand notes
              to the best of my skill and ability.
                  Davne Snell, Court Reporter
                   Computer-Aided Transcription
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https://www.thespec.com/news/hamilton-region/homeless-struggling-with-mental-illness-barredfrom-hamilton-shelters/article 476489b0-6e5d-534d-8ed7-9211f757b81a.html

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Homeless, struggling with mental illness, barred from Hamilton shelters

Social-service agencies say the health sector must do more to fill in gaps, but legal clinic worries about what happens before then

Jan. 20, 2021 🔲 🌃



John Honyust was restricted from all the men's shelters and spent New Year's outside. John, who has schizophrenia, managed to get into the Sandman on Centennial Parkway beside the Walmart plaza, with the advocacy of the Hamilton Regional Indian Centre and legal clinic.

John Rennison / The Hamilton Spectator

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Homelessness in a pandemic

Rise in coronavirus cases in Hamilton shelter system raises concerns Homeless man's death near shelter during curfew spurs call for resources

John Honyust is in a better place nowadays.

With the help of the Hamilton Regional Indian Centre, he has lined up a place to live in the west end.

"I'm taking my medication and I feel better," says Honyust, who has schizophrenia.

But three weeks ago, the 44-year-old's outlook was more bleak.

Honyust, who notes he has struggled with homelessness for about 20 years, found himself with nowhere to turn on New Year's Day after all three operators of men's shelters in Hamilton barred him.

But his doctor, the Hamilton Community Legal Clinic and Hamilton Regional Indian Centre stepped in.

He landed in an east-end hotel room, one of about 150 the city has booked for people who are homeless, in addition to regular shelter beds during the COVID-19 pandemic.



John Honyust was restricted from all the men's shelters and spent New Year's outside.

John Rennison/The Hamilton Spectator

"I feel better. I'm by myself," he said one afternoon during his two-week stay at the Sandman on Centennial Parkway North by the QEW after biking there from an inner-city food bank.

But Honyust's predicament — coping with a serious mental illness while banned from shelters — is "deeply concerning," says <u>Sharon Crowe</u>, a lawyer with the <u>legal</u> clinic.

"What is clear is how profoundly the shelter system has failed John, and others like him," Crowe told The Spectator in an email.

"There was not one shelter who was willing to ensure that he had somewhere safe to sleep, and didn't freeze to death on the streets."

This scenario exposes a "fundamental gap" in how the shelter system approaches people with complex mental health and substance-use concerns, Crowe wrote.

"Shelters are the end of the line for indoor space options — when people are banned from shelters, they are literally left on the streets."

Just how Honyust ran afoul of shelter rules to be barred — until the end of 2025 from one location and end of 2021 from another, he says — is unclear.

But the Oneida man contends he was treated unfairly, and that staff need to be better trained to serve people with mental illnesses, including schizophrenia.

Local social-service agencies wouldn't comment on Honyust's case, citing privacy concerns, but they said it's rare for people to be restricted from the entire network and for such long periods.

"This is the exception rather than the norm, and in our agency, this happens only in circumstances where we have assessed that there is a significant risk to health and safety," said Katherine Kalinowski, chief operating officer of Good Shepherd Centres in Hamilton.



John Honyust, left, with his buddy Derick Jones who he is trying to help. The pair have been friends for a long time, playing football together at Delta High School.

John Rennison/The Hamilton Spectator

Currently, three men are service-restricted by all shelter operators, which also include Mission Services and Salvation Army.

As of Jan. 15, 280 people were restricted from one or more shelters, but not all A8916

Last year, 855 people had that status for varying lengths of time. That was out of 2,773 people who accessed Hamilton shelters in 2020.

Shelters have rules that prohibit certain behaviour, including drug and alcohol consumption on site.

Aggression or conflict can also arise between residents and staff, which can prompt operators to temporarily bar them.

Shelter restrictions more typically last 24 to 48 hours, and two to four weeks on the longer end.

But situations are fluid, and the circumstances that make it difficult for someone to stay one night can change by the next, Kalinowski notes.

"Sometimes, it's a matter of not working out at Shelter A, but let's work with Shelter B and give it a try there and see. Sometimes, a relocation is enough to make things settle down."

Kalinowski says it's important to focus on the root of the problem: an overall gap in services for people with mental illnesses and addictions that allows them to fall into homelessness in the first place.

With this deficit, shelters indeed have become the "backstop" for such societal challenges, says Shawn MacKeigan, a director with <u>Mission Services</u> who oversees its men's system.



Jonathan Burns, who's staying at Mission Services on James North. He uses a wheelchair and couldn't initially get into the shelter because it was full.

John Rennison/The Hamilton Spectator

Staff at shelters have a "very high threshold" for disruptive incidents. "I can go through a laundry list of things that people do," MacKeigan said.

But shelters aren't properly resourced to handle the most complex cases, he added.

"We're not a medical facility. We don't have those mental-health clinicians. It is difficult to support people with untreated mental illness, but I will tell you it is absolutely common."

Jonathan Burns knows this all too well.

Burns, 51, says he quickly learned to avert his gaze from certain people in shelters when he became homeless after a house fire in May.

"I'm just going to go from one nightmare to the next," he said, while sipping a coffee across from the Mission Services men's shelter on James Street North.

Burns, who uses a wheelchair, said he was "wrongly restricted" from the Salvation Army late on New Year's Eve.

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That night, he recounted, Mission Services, Hamilton's other accessible shelter for men, was full.

"It was supercold," said Burns, whose foot was amputated after an infection. "I just wheeled around and tried to stay warm."



Jonathan Burns is staying at Mission Services on James North. He got in when the Hamilton Community Legal Clinic intervened on his behalf.

John Rennison/The Hamilton Spectator

But the legal clinic intervened on his behalf, too, and worked with Mission Services to find space at its James Street North shelter, he said.

In an email, the Salvation Army wrote its Booth Centre on York Boulevard "approaches service restrictions on a case-by-case basis, using behaviour as the determination for these difficult, but important decisions."

With shelters facing limitations, Kalinowski and MacKeigan alike say the health sector must play a greater role on the housing front, noting a need for more affordable options with support services to help people remain stable.

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"I really want us to be working further upstream and making sure, first of all, that we're doing better interventions early on," Kalinowski said.

The city doesn't expect shelter operators to fill in all the gaps for those with acute mental health and addiction challenges, said Edward John, director of housing services.

John said the city plans to soon launch a pilot project that will couple health and social support services with housing in a partnership with the local health sector.

"We don't think we can necessarily overlay the existing shelter system with those levels of supports because they are incredibly in depth."

Crowe, from the legal clinic, agrees supportive, affordable housing is a "more appropriate solution," but adds, "we are concerned about what happens in the interim."

The legal clinic's attention to shelter restrictions also coincides with a <u>rising</u> <u>number of cases of COVID-19</u> among residents and staff in the sector over the past month.

This week, the city plans to reopen its isolation shelter for homeless people who test positive at Bennetto Recreation Centre in the North End. That has space for 25 to self-isolate and prevent the virus from spreading.

Wesley Urban Ministries had taken over isolation shelter duties after the city shut down the Bennetto space in July with minimal cases in the shelter system.



Teviah Moro is a reporter and editor with the Hamilton Spectator who specializes in municipal politics, housing and homelessness. Reach him at **tmoro@thespec.com**.

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Hamilton

Hamilton needs an estimated \$60M to address homelessness

An additional \$20 million needed to address lack of housing services, city says

Samantha Beattie, Cara Nickerson · CBC News ·
Posted: Mar 24, 2023 11:28 AM EDT | Last Updated: March 24, 2023



A pile of blankets gathers snow inside a doorway in downtown Hamilton. (Dan Taekema/CBC)

Hamilton's shelter system is on the verge of collapse and grappling with an explosion of demand.

That's the message shelter providers shared with the <u>emergency and community</u> <u>services committee</u> Thursday. Shawn MacKeigan of Mission Services also spoke as a delegate on behalf of the Good Shepherd and Salvation Army.

"The fear and hopelessness we witness in the people we are serving is untenable," MacKeigan said.

"And the lack of access to emergency shelters can tear families apart, can place people, especially women, Indigenous people, members of the 2SLGBTQ community and people living disabilities at significant risk of physical harm, violence and even death."

Council decided to stay the decision to declare a state of emergency over the homelessness crisis in Hamilton and will revisit the subject at their next meeting on April 6.

Ward 9 Coun. Brad Clark said the city is undoubtedly in a crisis situation over lack of services and housing for people experiencing homelessness, but said declaring a state of emergency won't do much.

"We've already declared crises and it didn't open up any funding, it didn't open up any more support."

1,500 people experiencing homelessness in 2022

At the meeting, city staff told councillors Hamilton continues to grapple with unprecedented numbers of people experiencing homelessness, despite the city's goal to ensure all residents are housed.

That goal was set over a decade ago. However, more than 1,500 people were experiencing homelessness at the end of 2022 — up from 1,000 in 2020 and 1,200 in 2021, said a staff report.

"Despite having a comprehensive strategy with many effective interventions in place, the level of need for affordable housing and homelessness supports far exceeds available resources," the report said.

"This challenge has been exacerbated over the course of the pandemic and the homelessness sector continues to experience unprecedented demand."

- Hamilton funds overnight warming centre The Hub until March 31, 2023
- No money to fund overnight heating spaces could lead to more deaths among homeless, advocates say

The extent of this demand is demonstrated at the YMCA's men's transitional living residence on James Street South. Manny Figueiredo, president and CEO of the YMCA of Hamilton, Burlington and Brantford, told the committee that the dorm-style building houses 174 men transitioning from homelessness to permanent housing. Over 220 others are on the waitlist.

The vast majority of residents have mental illnesses, addictions and disabilities, said Figueiredo, who spoke as a delegate. They struggle to get care, with 90 per cent without a family doctor.

[&]quot;Six men died in their beds last year because of the lack of services they require," he said.

People remaining in shelter longer

In the last three years, the number of people experiencing chronic homelessness (going without a home for more than six months) has hovered around 500, said director of the city's Housing Services, Michelle Baird.

And people in shelters are staying longer — 88 days on average last year compared to 80 days in 2021 — because of "inadequate opportunities" for people to find stable housing.

City of Hamilton continues legal battle against unhoused residents over encampments

"Really we would want to see people in shelters for less than 30 days," said Baird, adding that without permanent supportive housing it is almost impossible to move people on from the shelter system.

In the 2023 city budget to be considered by council next week, \$44 million is set to go toward homelessness supports.

But staff said they require an additional \$20 million a year to end chronic homelessness by 2025. That would mean nobody in Hamilton is unhoused for longer than six months.



The city needs an estimated additional \$20 million to house Hamilton's population of people living outdoors. (Bobby Hristova/CBC)

The money would expand interventions that would prevent 600 people from becoming homelessness, provide permanent housing to 1,400 households and add 240 shelter beds, the report said.

"I don't see a path forward for this city alone," said Mike Zegarac, the city's head of finance, adding that funding from the city's reserves along with picking and choosing priorities will have to be part of the solution.

A8923

"Everyone, and I mean everyone, must get in line behind those who don't have housing and are living outside," he said.

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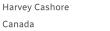
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ANALYSIS

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Alexander Panetta

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EXHIBIT 3 TO THE CROSS EXAMINATION OF SHAWN MACKEIGAN DATED AUGUST 21, 2024

City of Hamilton, Emergency & Community Services Agenda, March 23, 2023, video (escribemeetings.com)

 $\label{lem:video} \begin{tabular}{ll} VIDEO\ URL: $\underline{https://pub-hamilton.escribemeetings.com/Meeting.aspx?Id=2fccdddd-d21e-4e25-a7e0-c14b9e5f89af&Agenda=Agenda&lang=English \\ \end{tabular}$

Court File No. CV-21-00077187-0000

ONTARIO SUPERIOR COURT OF JUSTICE

BETWEEN:

KRISTEN HEEGSMA, DARRIN MARCHAND, GORD SMYTH, MARIO MUSCATO, SHAWN ARNOLD, BRADLEY CALDWELL, CHRISTINE DELOREY, GLEN GNATUK, TAYLOR GOGO-HORNER, CASSANDRA JORDAN, JULIA LAUZON, AMMY LEWIS, ASHLEY MACDONALD, COREY MONAHAN, MISTY MARSHALL, SHERRI OGDEN, JAHMAL PIERRE, LINSLEY GREAVES and PATRICK WARD

Applicants

and

CITY OF HAMILTON

Respondent

APPLICATION UNDER 14.05 OF THE RULES OF CIVIL PROCEDURE

AFFIDAVIT

I, JAMES MOULTON, of the City of Hamilton in the Province of Ontario, MAKE OATH AND SAY:

- 1. I am the Executive Director, Housing and Support Services at the Salvation Army, Hamilton (the "Salvation Army"). The Salvation Army is an international charitable organization that has grown to become the largest non-governmental direct provider of social services in Canada. The Salvation Army operates a number of 'Divisions' across Canada; the City of Hamilton is located within the Ontario Division. In my role as Executive Director, I oversee the provision of shelter services to men in the City of Hamilton. As such I have knowledge of the matters set out in this my affidavit. Where I rely on the information of others, I state the source of that information and verily believe it to be true.
- I make this affidavit as an update and supplement to my October 6, 2021 affidavit in this proceeding.

- 3. The Salvation Army was founded in London, England by William Booth in 1865. The Salvation Army began operating in Hamilton in 1904, when a shelter for men experiencing poverty, addiction and homelessness was first opened on York Boulevard in downtown Hamilton. Currently, the Salvation Army continues to offer shelter services to men at 94 York Boulevard in Hamilton, at a facility called the Hamilton Booth Centre (named for William Booth, the "Booth Centre").
- 4. All of the Emergency Shelter services offered at the Booth Centre are free, and can be accessed by individuals of all races, ethnicities and religions (or no religion).

Staffing

- 5. The Salvation Army employs a number of staff members at the Booth Centre. Staff is divided between Support staff and Program staff. Staffing levels vary by time of day, from a minimum of three to four staff members on site during the night, up to about ten staff members on site during the day. At least one manager is 'on call' 24 hours per day.
- 6. Support staff includes cleaners, who are also on site 24 hours per day, dedicated to cleaning tasks only and trained in WHMIS, and kitchen workers, including two trained chefs who prepare community meal services.
- 7. Program staff are divided between managers, shift supervisors, case workers and front desk staff. The current Program Director has a Masters of Social Work. The current Program Manager and Shift Supervisor have a Social Service Worker diploma. Many of our case workers also have a Bachelor's of Social Work, but are required to have a Social Service Worker (SSW) designation, or related education and two years of case work experience. Our front desk staff are required to have a Social Services diploma or equivalent in training and experience.

8. All of our staff members have various levels of additional training, as well, which includes at minimum non-violent crisis intervention (NVCI) training, de-escalation training, and first aid training (including mental health first aid and administration of naloxone for opiate overdoses).

Shelter Services

- 9. There are very few barriers to accessing services at the Booth Centre. We request identification (or at least a name and date of birth) from our clients, and we try to determine where they have been staying previously. We assist in various ways, depending upon the client's needs. This can include immediate needs like food, rest and a shower, as well as more long-term needs that case workers can assist with, such as: securing identification, if they do not have any; connecting with the Ontario Disability Support Program and/or Ontario Works programs; assessing health needs; directing clients to legal or immigration assistance; and locating housing.
- 10. Assisting in finding appropriate, stable housing is always a focus.
- 11. The Booth Centre uses a computer program called 'HIFIS', which stands for 'Homeless Individuals and Families Information System'. HIFIS is a comprehensive data collection and case management program. It integrates us with the other agencies operating shelters in the City, i.e. Mission Services and Good Shepherd, allowing us to share information—instantaneously, in real time—and provide it to the City of Hamilton, as well. HIFIS enables us to find another shelter for a client if the Booth Centre does not have a bed for the client. It allows all shelters to track the progress of a client with the end-goal of finding suitable more permanent housing.
- 12. The Booth Centre provides numerous services to our clients, including laundry facilities and detergent, hygiene products, clean beds and bedding, footwear and clothing, computary

access, telephone access, transportation access (including bus tickets and taxi fare), three hot meals per day, access to medical care, and a focus on locating a stable housing situation via our case workers.

- 13. The Booth Centre offers 86 beds (this includes beds recently added on a contractual basis with the City). These beds are available 24 hours a day, 365 days a year. They were recently renovated in a combination of dormitory-style spaces and individual rooms. Each of our beds comes with a locker that can be locked. An additional 13 sleeping areas are also available as an emergency overflow, if needed.
- 14. The Booth Centre has group bathrooms, much like a school, with toilets, urinals, sinks and showers. There are also several individual bathrooms.
- 15. The Booth Centre complies with all Public Health directives, and complied with those imposed during the COVID-19 pandemic, in order to make the Booth Centre safe for our clients. We consult with Public Health for this purpose.

Expectations for Clients

- 16. The Booth Centre has a series of expectations for clients. These expectations are in place to ensure the safety of all of our clients and staff. The expectations include:
 - a) Nightly check-in;
 - b) No violence, and no abuse (including shouting, threats, insults, etc.);
 - c) No theft or interference with the property of others;
 - d) No smoking in the building;
 - e) No guests; A4644

- f) No drug use or dealing drugs on site; and
- g) No animals (service animals excepted).
- 17. Our expectations are communicated to all clients upon arrival.
- 18. The Booth Centre is monitored by staff and by security cameras.
- 19. Breaches of expectations are dealt with by a progressive engagement strategy. Case workers and other staff always seek to work out an issue before any warnings are given or sanctions are imposed. There are typically many conversations before sanctions are imposed. We take into account the work done with client in the past, the seriousness of the incident, and how to best address the behaviour in question.
- 20. When breaches of expectations result in service restrictions for clients, the service restrictions are not intended to be punitive, and they are tailored to be as minimal as possible. For example, if a client is found to have shouted threats at staff or another client, that client may be asked to take a walk to calm down. If repeated, they may be restricted from accessing services for a specified period of time, or they may be transferred to another shelter.
- 21. The imposition of a full or permanent 'ban' from our services would only occur in exceptional circumstances. There is an internal appeal process, as well, which clients can access.

a. Violence and theft

22. Reports are taken of any violence or theft that occurs on the Booth Centre's premises. While acts of violence between clients can occur, staff are there to intervene and trained to deescalate/respond in accordance with our policies and procedures. Incidents of violence will

result in a time-limited service restriction from the Booth Centre. However, we work to find other available shelter spaces for the client.

23. Thefts do occur, but lockers for our clients' personal property assist in preventing theft and allow our clients to feel safe. Generally, our clients are respectful of each other. The cameras in place at the Booth Centre can assist in recovering anything stolen if a date and time of the event is known. Hamilton Police Services is called in appropriate circumstances. Staff will also speak with any individuals involved to seek to curb the behaviour and decrease risk. Our renovations have helped with his, as individual spaces do assist.

b. Drug users can access services

- 24. There is no expectation that our clients cannot be drug users, or that they will not be using drugs while accessing our services; however, we do expect that drugs will not be used or sold on site. This is for the protection of other clients who may be battling addictions and for other safety reasons. A safe injection site is available to clients in the City of Hamilton, roughly a 5-minute walk from the Booth Centre.
- 25. Many police and EMS calls placed by the Booth Centre are for suspected drug overdoses and medical emergencies.

c. Animals are not allowed (service animal excepted)

- 26. We have found it is not possible to balance the safety of our clients with allowing animals at the Booth Centre, which was not built with accommodating animals in mind, service animals excepted.
- 27. The concerns that led to our expectation that animals will not be brought on site have included: allergies, which can be aggravated in a dormitory-like setting; the creation of loud 24646

noises, particularly at night; and issues encountered with dogs (i.e. aggressive dogs, as well as fears of being near large dogs).

d. No 'curfew'

- 28. Bed checks are conducted during the night, to ensure our beds are being used. First bed check occurs at 10 p.m. This is standard across all men's shelters in Hamilton and is sometimes called a 'curfew'. However, unlike under a formal curfew, clients are not prohibited from leaving the Booth Centre after 10 p.m. Often, clients will leave during the night, for a variety of reasons. We ask that they advise whether they will be returning. If they do, their bed may be held for them. If, however, a client has left without advising that they will return, it is possible that the bed will not be held and will be reallocated to another client who needs it. A client would have to miss 2 bed checks at a minimum before the bed could be reassigned.
- 29. If a bed is reallocated, any belongings that were left behind are collected for pick up at the front desk. If a bed is not needed by another client, it may remain available. This process is intended to ensure no beds or resources are wasted.
- 30. Clients can be checked into a bed on their first night at the shelter anytime during the night.
- 31. The bed checks also serve the purpose of acting as safety checks on the wellbeing of clients.

Shelter Capacity

32. The Booth Centre works closely with shelters operated by other providers in the City of Hamilton. All of these shelters report daily on their capacity, allowing spaces to be tracked and

located when needed. Our aim is to ensure that, if our beds are full, that space is found for anyone who needs it—either in our overflow space, or in another shelter in the City.

33. I make this affidavit in order to clarify and explain the background of and services provided by Salvation Army in the City of Hamilton and for no other or improper purpose.

AFFIRMED by James Moulton at the City of Hamilton, in the Province of Ontario, before me on July 31, 2024 in accordance with O. Reg. 431/20, Administering Oath or Declaration Remotely.

Jordan Diacur

Commissioner for Taking Affidavits (or as may be)

Jordan Diacur (LSO 65860E)

JAMES MOULTON

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Respondent Court File No. CV-21-00077187-0000 CITY OF HAMILTON - and -Applicants KRISTEN HEEGSMA et al.

SUPERIOR COURT OF JUSTICE ONTARIO

PROCEEDING COMMENCED AT HAMILTON

AFFIDAVIT

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Lawyers for the respondent

File Number: H227899

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Ms. Crowe.....5

BETWEEN:

KRISTEN HEEGSMA, DARRIN MARCHAND, GORD SMYTH, MARIO MUSCATO, SHAWN ARNOLD, BRADLEY CALDWELL, CHRISTINE DELOREY, GLEN GNATUK, TAYLOR GOGO-HORNER, CASSANDRA JORDAN, JULIA LAUZON, AMMY LEWIS, ASHLEY MACDONALD, COREY MONAHAN, MISTY MARSHALL, SHERRI OGDEN, JAHMAL PIERRE, LINSLEY GREAVES, and PATRICK WARD

ONTARIO SUPERIOR COURT OF JUSTICE

Applicants

Court File No. CV-21-77187

- and -

CITY OF HAMILTON

The Cross-Examination of James Moulton, taken upon affirmation in the above action this 26th day of August, 2024, conducted via Zoom videoconference hosted by the offices of Nimigan Mihailovich Reporting Inc.

NIMIGAN MIHAILOVICH REPORTING INC.

GUIDE TO UNDERTAKINGS, UNDER ADVISEMENTS AND REFUSALS

This should be regarded as merely a guide and does not necessarily constitute a full and complete list.

Undertakings are found on the following pages:

None entered

Under advisements are found on the following pages:

None entered

Refusals are found on the following pages:

None entered

NIMIGAN MIHAILOVICH REPORTING INC.

J. MOULTON-4

APPEARANCES:

Sharon Crowe For the Applicants

Community Legal Clinic

Jordan Diacur For the Respondent

Gowling WLG

Vivian Caldas Gowling WLG

Jojo Johnson - student at Gowling WLG

EXHIBITS

Exhibit Description Page

No.

Α

"The Salvation Army: Behind the 41

Front Lines"

NIMIGAN MIHAILOVICH REPORTING INC.

NIMIGAN MIHAILOVICH REPORTING INC.

1 of 12 sheets Page 1 to 4 of 46

---UPON COMMENCING AT 3:30 p.m.

James Moulton,

having been duly affirmed, was examined and testified as follows:

BY MS. CROWE:

- 1 **Q.** Okay, Mr. Moulton, we'll get started. Sorry for the interruption. Do you have your two Affidavits in front of you from October 6th and July 31st?
- A. I don't but I can get them fairly quickly. I do apologize, I could have had those open.
- **Q.** That's no problem. So I can screen share. So you can rely on what you have or I can screen share, whatever you prefer.
- A. Either one works. It will just take me probably a minute or two to find it.
- 3 Q. Okay. That's okay. I'll just screen share. So you're allowed to consult, obviously, those Affidavits but you're not to have any other documents around you to consult. Is that all right?
 - A. Sure.
- **Q.** And you're alone in the room?
 - A. I am, yes.

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J. MOULTON-6

- **Q.** Okay, great. So let me know if you need me to repeat or rephrase any questions, okay?
 - A. Will do.
- **Q.** Okay. So we're going to be focussing on your second Affidavit from July 31st of this year so just give me a second and I will share that. Okay. Do you see it on the screen?
 - A. I do, yes.
- 7 **Q.** Great. Okay. So we're going to start off by going to paragraph five where you're describing staffing at the Booth Centre. So I just want to clarify a few things. So you've indicated that there are a minimum of three to four staff members on site during the night?
 - A. Correct.
- 8 **Q.** What's the maximum number? And it looks like my screen is frozen again. I'm sorry. I can hear so that will serve our purposes for the transcript. So what's the maximum number of staff who are present overnight?
- A. My recollection on the schedule is up to five but the normal is around four.
- 9 Q. Okay
- A. And we try to operate with a minimum of three in the overnights. Let me -- sorry, let me NIMIGAN MIHAILOVICH REPORTING INC.

J. MOULTON-7

correct. Let me just make sure I stated that 5 correctly. Yes, that is correct. Yes.

- **Q.** Okay. Okay, great. And when you say during the night, what hours are you referencing?
- A. So I'm referring -- we have three main shifts, 7:00 to 3:00, 3:00 to 11:00 and 11:00 to 7:00, so I'm referring more specifically to the 11:00 to 7:00 shift.
- Okay. And then you said up to ten staff during the day?
 - A. Correct.
- 12 Q. And -- sorry, did you hear me?
 MR. DIACUR: No. Sorry, Sharon, I
 think you broke up in asking that. We heard a
 couple of the words but not the whole question.
 Sorry.

MS. CROWE: Sorry. I can see my screen is still frozen. I'll turn off my video unless anybody has any objections.

MR. DIACUR: I don't have a problem with that, Counsel. That's fine.

MS. CROWE: Okay, great. Okay.

Hello?

THE REPORTER: Sorry, I'm not NIMIGAN MIHAILOVICH REPORTING INC.

J. MOULTON-8

hearing Sharon.

MS. CROWE: Can you hear me? THE REPORTER: I can hear you now. MR. DIACUR: I can hear you as well,

Sharon.

MS. CROWE: I'm sorry, I don't know why this is happening. There's nothing different about my set up. Just let me know whenever there's an issue with hearing me, okay?

MR. DIACUR: We didn't get the last question that you asked so if you could re-ask that, that would be helpful.

MS. CROWE: Okay, great. BY MS. CROWE:

- of staff in the evening at night and what is the minimum number of staff during the day?
- A. Approximately six because we bring our kitchen online at that time. So that would add a couple to our staffing compliment.
- **Q.** Okay. And thank you, you've anticipated my next couple of questions. So of the night staff, how many of these are cleaners?
 - A. One.
- Q. Okay. And what about cooks 4651 NIMIGAN MIHAILOVICH REPORTING INC.

- A. Zero.
- **Q.** Okay. And what about during the day, how many of those staff members are cooks and cleaners?
- A. In the kitchen, we would have approximately two at any given time and the cleaners, there's some overlapping shifts so it varies between one and two.
- that there is one manager on call 24/7 so when is a manager on site?
- A. So at Hamilton Booth, we have three program managers that would be Monday to Friday, approximately 8:00 to 4:00 for the program manager. Two program coordinators, one shift is approximately 12:00 to 8:00 and this does vary a little bit based on need, and there's a third supervisor that would normally cover the overnight shift.

If I recall, their shift does cover one day in the, in the -- sorry, one overnight on the weekend as well for that coordinator/supervisor overnight.

- **Q.** Okay, thank you. And how often are you at the Booth Centre?
 - A. It's my main office but I oversee NIMIGAN MIHAILOVICH REPORTING INC.

J. MOULTON-10

three other locations as well. So I do share my oversight between four locations.

- 19 **Q.** Okay.
- A. But to put a time, approximately 60 percent of my time.
- **Q.** Okay. And when you're there, how long are you there for?
 - A. Sorry, as in my shift?
- **21 Q.** Yes
- A. I work -- yeah, I am typically in the office from 8:00 to 5:00.

THE REPORTER: Sorry, we've lost

Sharon.

MR. DIACUR: Oh, Sharon has dropped off. If we could go off the record, Rachel. Thank you.

(OFF THE RECORD AT 3:44 p.m.)

BY MS. CROWE:

Q. Okay, so I got as far as hearing approximately what your regular shift was, Mr. Moulton, when you are at the Booth Centre.

MR. DIACUR: Back on the record?

MS. CROWE: Oh, sorry, yes.

MR. DIACUR: Just to confirm.

MS. CROWE: Sorry, yes. Back on

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record.

ord.

THE WITNESS: My normal work how are sort of an 8:00 to 5:00-type thing, give or take. So while my day looks different all the time, it's quite common for me to come to this location. If I'm here, I'll stay here for the majority of the day.

BY MS. CROWE:

- **Q.** Okay, thank you. What about night shifts?
- A. I don't normally do night shifts but I would say that to the behest of my team and my wife and my family, I consider myself on call 24/7, 365.
- Q. Okay. Okay, we're going to go to paragraph nine and you've indicated that you request identification or at least a name and date of birth for clients. Can an individual remain at The Salvation Army or continue to access services without ID indefinitely?
- A. So yes, but because the challenge of not having identification is connecting to the ultimate goal of what we do as a shelter, which is providing people or hoping to connect people to more longer-term housing, so identification is sometimes NIMIGAN MIHAILOVICH REPORTING INC.

J. MOULTON-12

J. MOULTON-11

a barrier if you can't access other services that might require an ID. So it might be less about our requirements but more about that longer term requirement.

- Q. Okay. And then at paragraph ten, you've indicated that assisting in finding appropriate, stable housing is always a focus. Are there any challenges in finding appropriate, stable housing for shelter residents?
- A. Yeah, one hundred percent, and lots of reasons for that, yeah.
- **Q.** Okay, can you explain those reasons?
- A. I can give you some of them. I mean, our clients may have, you know, they may have financial barriers, they may have -- yeah, even certain, maybe medical, mental health supports that they might need. Typically when a client or I shouldn't really use -- an individual comes to our facility, they're in crisis. So the crisis can be from a multitude of places and what our caseworkers try to do is develop an individualized plan for that particular, you know, potential resident and then find a path out of that, whatever those pieces are.

And in our community, I think I state the obvious in that there are some NIMIGAN MIHAILOVICH REPORTING INC.

affordability issues and there's even a lack of housing in general.

- 27 Q. And so when you talk about affordability issues and before you had said financial barriers, can you explain a little bit more what you mean?
- Α. Yeah. So we would say that individuals are coming probably don't have a lot of money, you know, available so when it comes to getting a first month's rent or last month's rent, that would be a challenge for some of our clients, and I would say that then the supports they have within the community can be limited at times as well.
- Okay. But do you have any knowledge of the source of income for shelter residents?
- I think the -- I don't have a breakdown specifically for right now, like, percentage-wise but generally, OW, ODSP and then some people who would have some work as well.
- 29 Q. Do you have any knowledge of the OW -- so when you say OW you mean Ontario Works and ODSP, Ontario Disability Support Program. Do you have any knowledge of the rates for a single person through Ontario Works and the Ontario Disability

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J. MOULTON-14

Support Program?

- Α. I don't have the exact amounts. My caseworkers do and particularly, they work or connect our clients with those that would be able to give them that information for sure.
- 30 Q. Okay. And you also mentioned affordability in terms of the cost of housing, do you have any idea of the cost of rental housing in Hamilton?
 - Α. Yes.
- Q. Do you know what the average 31 one-bedroom apartment would rent for?
 - Α. Yeah, so I don't --
- 32 Q. Approximately.
- Α. Yeah, I'm going to say we're in the, in the 1,400-1,500 range.
- Q. 33 Okay. What about a bachelor?
- Probably not much difference to be Α. very honest.
- 34 Q. Okay.
 - Α. Yeah.
 - Q. What about a room for rent?
- Α. So we're seeing rooms for rent anywhere as low as 900,000 upwards.
- Q. Okay. 36

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J. MOULTON-15

- Of course there's lots of -- M8937 apologies, but there's lots of variation.
- 37 Q. Mm-hmm.
- Α. I think, yeah, I'm just trying to give you a sense of what I'm aware of.
- 38 Understood. Thank you.

MR. DIACUR: Counsel, just want to clarify something on the record. It sounded like the witness said 900,000. I just want to make sure that that wasn't misunderstood and that it would be clear on the record. Could you clarify that, James, what the value of a room is?

> THE WITNESS: 900 to a thousand. MR. DIACUR: Okay. I just didn't

want that to read incorrectly.

MS. CROWE: Fair enough. That's quite a difference.

BY MS. CROWE:

- Q. Then you also mentioned a lack of available housing, can you expand on that?
- Α. As an example, we had a meeting with, I believe it was CMHC who indicated that apartment availability was in the one percent occupancy or vacancy, I'm sorry. That seems to be very, very low and for, you know, we just know that

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J. MOULTON-16

it's tough for people to find a place to stay.

- Q. 40 Mm-hmm.
 - Α. Yeah.
- Q. Thank you. And then you also mentioned that someone may need mental health supports and what did you mean by that?
- So we do find that when individuals come to stay with us, they are looking for medical supports at times. It is common to hear that they have not connected with a family doctor, for example, in recent days or maybe, maybe they haven't had access to medication, things like that.

So we try to connect people to health supports and I would say in a general sense, that's a place of support that our staff will often reach out to on behalf of our clients.

- Q. Okay. So that would, you know, I probably fell under the umbrella term of some health care supports. You had mentioned mental health supports, I just want to clarify what you meant there?
- Α. Yeah. I think, I mean, I guess technically speaking, mental health, medical health, they all fall into a similar category but our team would specifically point out mental health supports NIMIGAN MIHAILOVICH REPORTING INC.

as something that our clients would need as much as any other supports whether it's a medical diagnosis or support from something that was experienced through trauma, for example.

- **Q.** Okay, thank you. And so what is the average length of stay at the Booth Centre?
- A. Sorry, that's a good question. I don't have the specific number right now. We used to look at 60 days or so, maybe going back four or five years ago. It's moving into months.

Unfortunately, we typically get some of that data from the HIFIS system. Our data, I think, is slightly compromised because HIFIS hasn't necessarily been one hundred percent available in the last number of months so the data that I have on that is a little bit older. But I think our HIFIS system should be able to give us an indication now of the length of stays, but it's gone from a relatively short period of time that you would expect an emergency shelter to be there for clients and length of stays are definitely becoming a challenge.

Q. So going back to the objective of finding safe, appropriate -- sorry, appropriate, stable housing --

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J. MOULTON-18

- A. Yeah.
- **Q.** -- do these barriers affect the amount of time that people end up staying at the Booth Centre?
 - A. Yeah. I mean, outflow out of a system requires, like, a housing system requires a next step beyond the shelter, whether it's a transitional housing, a supportive housing, permit supported housing or, you know, market rate housing, whatever it might be. So definitely, I think it would be fair to say that our length of stays increasing are closely connected to availability.
- **Q.** Okay. So what does that do to bed availability when people are staying for longer and longer amounts of time?
 - A. Yeah, puts a lot of pressure on us.
- **Q.** Mm-hmm.
- A. Yeah. I don't have -- and I do apologize. If there's stats that can be provided later, maybe I can do that but just to say at a high-level, we would operate at a number of, in the past few years, over a hundred percent capacity. Let me explain what that means. We are contracted for a certain number of beds and then we offer overflow beds. Typically our overflow is calculated NIMIGAN MIHAILOVICH REPORTING INC.

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in the over a hundred percent.

So for example, in Hamilton, right now we have 96 contracted beds and we have 13 overflow beds that The Salvation Army offers. So those 13, when we go into the overflow, that means over a hundred percent occupancy. So it's very common for us to have been operating at or near that capacity.

- **Q.** For how long would you say?
- A. The most recent numbers have been actually slightly more encouraging that I think we actually have five or six nights this past month where we didn't go into -- didn't use overflow, which was quite unique. But I would say -- I mean, the vast majority of the last couple years we've been at or near occupancy most nights including the overflow.
- 49 Q. Thank you. Okay, I want to move on to paragraph 11 where you describe HIFIS, the Homeless Individuals and Families Information System.
 - A. Yeah.
- **Q.** And you describe being able to share information with the City and other shelters in real-time and instantaneously. What do you mean by

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J. MOULTON-20

instantaneously?

- A. So basically we have access to the same system.
- 51 **Q.** Mm-hmm.
- A. So once data is inputted by one of the service providers there are more than the ones that are listed there that data would be available to the other agency at that point in time.
- **Q.** Okay. What kind of timeframe are staff expected to input data into HIFIS?
- A. So there's kind of two -- probably two main categories of input. That would be intake and then follow-up casework and other types of things afterwards. The intake should generally be done fairly quickly because the understanding of even the availability of beds within our own facility is based on the reports that we would be doing in HIFIS.

Most of that intake is done later in the evening when, when the -- when we're actually determining how many beds we might have available. There is a possibility that there's a slight delay from when the intake occurs to when it actually gets into HIFIS but it should be fairly quick.

And I should also say that outside ANIMIGAN MIHAILOVICH REPORTING INC.

of HIFIS, it is very common for the three shelters who work with male-identified individuals, which would be us, Mission and Good Shepherd, typically are also in contact through phone systems on a regular basis.

- **Q.** Right. Okay. And is there a policy for timeframes for inputting data into HIFIS?
- A. I'd probably have to check the actual HIFIS agreement to make sure. The expectation for us is to basically do it as you're doing the intake. For casework, it's during your shift or by the end of your shift is perhaps a better way to say it.
- Just so we're clear, can you just help me understand the difference between an intake, intake data and casework data that gets inputted into HIFIS?
- A. Yeah, for sure. So it's probably better to talk about casework as mid or long-term. So once a person is intaked[sic] into the program, they would regularly meet with caseworkers to update goals and plans and have conversations. So that is the information that would go in, sort of, subsequent to the intake of the client into the program.

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J. MOULTON-22

- **Q.** Okay. And then intake is the initial, like, registration for -- that's a word I'm coming up with.
 - A. Yes, that would make sense.
- **Q.** And discharge?
- A. Yeah, yeah, for sure. Yeah, discharges would go in in a similar fashion.
- **Q.** Are they considered part of casework or intake?
- A. I mean, we look at it as a holistic approach. It's all the data that we would enter on a particular individual but I think we can, sort of, separate them out into the, a little bit of a task. The person presenting for intake into needing a shelter bed and then a person whose being discharged from the program. That's kind of the beginning and end, I guess, of the stay.
- Okay. Are there ever instances where there is a delay in reporting information into HIFIS?
- A. I'm going to say yes and my guess would be -- my initial thought would be a very, very busy night when the team is, you know, has not got the information into the system or potentially a, like an internet glitch or a computer glitch or NIMIGAN MIHAILOVICH REPORTING INC.

J. MOULTON-23

something like that that might prevent it going in the back-up is always that we are in discussions with other providers, you know, by phone or other e-mails or whatever that needs to take place in the background.

- 59 **Q.** Okay. Is anyone in charge of regularly updating HIFIS throughout the day?
- A. Sort of. Let me try to clarify.

 The caseworkers and the program team themselves, our front desk workers and our caseworkers, they would be responsible for updating the information during their shift. The program manager or the supervisor would be overseeing their work and has access to their work as well.
- **Q.** Okay. Are there ever instances where what is reported in HIFIS might not actually represent what is available?
- A. I mean, I'm going to say that potential exists and I mean, our position would be that that would be corrected as soon as it could be if there were mistakes that were found.
- Okay. If there was a mistake, can you give any examples of when or how that could happen?
 - A. I mean, it's data entry into a NIMIGAN MIHAILOVICH REPORTING INC.

J. MOULTON-24

system so someone could put in the wrong bed, for example, or perhaps identify the wrong client perhaps in doing the entries. I do know that sometimes we could have duplication of clients, maybe different names might be used or perhaps different IDs might be presented so we may end up with, you know, some data in the system. But typically, again, we -- the team is trying to identify that and would bring that to the attention of a supervisor.

- **Q.** So, and I'm sorry because I'm still trying to understand HIFIS and what exactly gets recorded.
 - A. Yeah.
- 63 **Q.** Are there ever situations where HIFIS shows a bed that is, it's recorded as available but it's avail -- if someone shows up then it's not actually available for their use?
- A. I mean, only if there was a delay in the entry.
- **Q.** Mm-hmm.
- A. But I'm trying to think of another reason. I mean, it could be an error, I guess, but typically the aim is to keep that system as updated as possible because it's part of what I'd like to NIMIGAN MIHAILOVICH REPORTING INC.

broadly say, you know, that the shelter system, you know, someone presents to us and we don't have space then part of our mandate is to try to connect people to other services within a community as well, i.e. Good Shepherd, Mission --

- 65 **Q.** Right. Has the Booth Centre ever had bedbugs?
- A. Yeah. I mean, it's rare. We have contracted services in on a regular basis to treat for pest. I can't recall of, like, what I would call on outbreak in the last -- yeah.
- 66 **Q.** Okay. So if the Booth Centre had bedbugs and you're awaiting treatment, are the beds available?
- A. I'm going to say, generally speaking, yes because we have both internal cleaning protocols but also our contractors so, you know, we would -- our cleaning team goes in and cleans and they would provide, you know, we have sprays or whatever that are available as well. So it's not common for us to have beds unavailable for long periods of time.
- 67 **Q.** Right. But does it sometimes happen?
 - A. I can't think of a time when its NIMIGAN MIHAILOVICH REPORTING INC.

J. MOULTON-26

happened but I'm sure if I were to go back through some data I would find an occasional bed that's unavailable.

- **Q.** Right. What about for a short period of time?
- A. I mean, I just can't think of a timeframe when we've had beds unavailable. Last time we had beds unavailable is actually probably going back to COVID. Early days of COVID.
- 69 **Q.** Okay. Do the beds ever get damaged by shelter residents?
- A. They can. Our bed frames themselves are quite robust. The mattresses can be but we typically have extra mattresses available.
- **Q.** Does HIFIS record when people are turned away from the Booth Centre?
 - A. Yes.
- 71 **Q.** And what information is gathered about the individual? Is their name inputted in?
 - A. Typically, if it's provided.
- **Q.** Okay. And when does this happen? Like, what kind of timeframe for recording a turn-away?
- A. Yeah, for sure. And I would probably have to clarify with the program team a NIMIGAN MIHAILOVICH REPORTING INC.

J. MOULTON-27

hundred percent but my recollection is that the 40 turn-aways are supposed to happen during the shift.

- **Q.** Inputting the turn-aways?
 - A. Correct. Yes.
- **Q.** Okay, thank you.
 - A. But I might need to confirm that.
- 75 Q. Okay. All right. So we're going to move on to paragraph 13 of your Affidavit. Okay. So you've described the set up of the Booth Centre as having 86 beds and it sounds like this is a combination of beds that are located in a dorm, dormitory-style space and individual rooms. What is the breakdown of the 86 beds between those that are in a dorm and those that are in individual rooms?
- A. I believe, if I just did a count correctly, it's about 47 in the dorms, four dorms, and then the remaining beds of the 96, so about 50 of the beds are in individual rooms. The overflow is in a common space.
- **Q.** Okay. And of those 86 beds, you've indicated that includes beds recently added on a contractual basis with the City. When were those beds added?
 - A. Four beds were added, I believe it NIMIGAN MIHAILOVICH REPORTING INC.

J. MOULTON-28

was January of 2023. That would have brought us to 86 beds and the winter response added ten beds in November of 2023.

- 77 **Q.** Okay. And when you say they're on a contractual basis, what does that mean?
- A. Sure. Actually, I suppose they're all contractual. We have a contract for 82 beds, that's been kind of our more normal occupancy, and then the 4 and the 10, adding the extra 14 beds are two additional contracts with the City.
- **Q.** Okay. So are they for a fixed term or are these permanent beds?
- A. So technically all 96 beds are. Our longest contract is 12 months so we're contracted typically from around April 1st to March 31st each year.
- **Q.** Okay. So sorry, 96 or 86?
- A. 96 includes the 14 additional. I think at the beginning it says offers 96 beds so it's 82 plus the 14.
- **Q.** Perhaps a typo. It says it offers 86 beds.

MR. DIACUR: I can put that on the

screen, James, if you need to see it.

THE WITNESS: Sure.

A4656

MR. DIACUR: This is the affirmed copy of your Affidavit. Paragraph 13 is what is referenced.

THE WITNESS: So I do apologize

because that should be 96.

MS. CROWE: Okay, thank you.

BY MS. CROWE:

81 **Q.** And how do you decide who goes into the dorm-style setting and who gets an individual room?

- A. Mostly by first come, first served.
- 82 Q. Okay. What are the other factors?
- A. There can be conflict amongst clients.
- **Q.** Mm-hmm.
- A. So we would endeavor to try and find where there might be, you know, say an emerging conflict we would perhaps try to move people to a space that's better for them.
- **Q.** Okay.

A. There may also be some unique needs. I'm just trying to think of an example, but if someone had a medical issue, perhaps they had, maybe had a recent surgery or something like that, if say an individual room was available, they might get NIMIGAN MIHAILOVICH REPORTING INC.

J. MOULTON-30

preference over an individual room.

- 85 Q. Okay. So the first scenario you were describing is, if I understood you correctly, is involving potential conflict between residents?
 - A. Yes.
- 86 **Q.** And you want to avoid the safety risk of putting those individuals together in a dorm room?
 - A. Or in the same dorm room even.
- 87 Q. Same dorm room. Okay, thank you.
 - A. Yeah.
- **Q.** Are there other types of risks that factor into who gets, say, a private room and who stays in a dorm room?
- A. I think the other example that might come to mind is if someone has a particular safety issue that they're concerned about. You know, so we -- I indicated we're a male-identified shelter so someone comes in with a very specific concern and they share that with the caseworkers, we would look to determine whether or not a different space would be more appropriate for that individual.
- **89 Q.** Okay.

A. But that's done on a case-by-case basis with the client and consultation with the NIMIGAN MIHAILOVICH REPORTING INC.

J. MOULTON-31

team.

of the drugs, does that influence whether they get a dorm room or a single room?

A. The only place where that could be a factor would be is if there was a safety concern. So as an example, our individual rooms are more private and if we were concerned about, I don't know, perhaps the person's safety, there may be more safety in a dorm, but I say that very cautiously.

You know, my goal is for the caseworkers to have those individualized conversations with clients and try to determine how best we can support them. So I'm not -- I guess my -- if I clarify that, I'm not saying it wouldn't be a factor but it's not generally, you know, they wouldn't be the primary factor, I can't imagine.

- 91 **Q.** Okay, thank you. And then you indicate that each of the beds comes with a locker that can be locked, where are the lockers located?
- A. So typically at the -- alongside of their bed.
- **Q.** Okay. And how big are they?
- A. Not sure of the dimensions but I would think high school with your own locker is NIMIGAN MIHAILOVICH REPORTING INC.

J. MOULTON-32

seven, eight-foot high.

- **93 Q.** Okay. And does the Booth Centre provide a lock?
- A. We normally don't. I would have to buy shares in lock companies, perhaps, if I did that. Most of the clients do provide their own locks.
- 94 Q. Okay. And then you indicate an additional 13 sleeping areas are available as emergency overflow. Can you describe what those sleeping areas are like?
- A. Typically they're in one of our larger, I'll call it -- we have a program room on the main floor and we would lay mats out so they're more like a --
- **95 Q.** Okay.
 - A. Yeah.
- **96 Q.** Are these considered the overflow areas?
 - A. Correct.
- 97 **Q.** Okay.
 - A. Yeah.
- 98 Q. And just going back to the second sentence of that paragraph, you say that these beds are available 24 hours a day, 365 days a year.

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What do you mean by that?

- Okay, that's actually -- I think that's misstated and I do apologize for that. So our clients have access to the beds until about 7:00 or 8:00 o'clock in the morning and then again at about 4:00 to 5:00 o'clock in the evening.
- 99 Okay, thank you. Thank you for clarifying. Okay, so paragraph 16 has a series of expectations for clients so I just want to go through your list, and I understand that these are examples.
 - Α. Mm-hmm.
- Q. 100 Okay, so the first is nightly check-in. Do residents ever miss these check-ins?
 - Α. Yes.
- Q. How often would you say? 101
- Α. It's fairly common. There is a check-in and the agreed upon check-in is three times a night. Somewhat random check-ins so it's basically a bed check. If you're not in your bed two of the three check-ins, you're often checked out so that we can utilize that bed for someone else.
- 102 When you say that they're random check-ins, what do you mean?
 - So they try to space them out by a NIMIGAN MIHAILOVICH REPORTING INC.

J. MOULTON-34

couple hours between each check-in but it's not specifically 12:00 o'clock or 2:00 o'clock or 4:00 o'clock. The team will -- I mean, it ends up being something similar to what I just said but we don't say we're going to be there at exactly 12:00 o'clock. The team will go when operationally it makes sense to go and do a check.

- 103 Q. Thank you. And then the second one is no violence and no abuse including shouting, threats, insults et cetera. How often do these behaviours occur?
- Α. Verbal would be very frequent. Daily. Violence less so. I typically get incident reports or some indication from the team. I might have to get the data on how often. It's the insults and verbal that happens pretty frequently.
- 104 Q. Okay. And these incidents, are they against shelter staff, residents or both?
 - Α. The verbal is against both for sure.
- 105 Q. Okay. What about the other incidents - violence, shouting, threats?
- Α. The threats and shouting would be clients and staff.
- 106 Q.
 - Α. Yeah. Physical violence is rare NIMIGAN MIHAILOVICH REPORTING INC.

against staff.

J. MOULTON-35

- Q. Okay. And what about thefts, 107 often does that happen?
- Theft? Yeah, so the thing is we don't really track client's belongings. We will hear from clients at times that things have gone missing and the team will do their best to support the clients. We don't have cameras and really any way of verifying a client's belongings so it's tough for me to say whether a theft is an actual theft.
- 108 Q. How often do you receive reports of theft?
- Α. So I would probably have to check with my program team one hundred percent to get that data.
- 109 Q. Okay. So you have to check with them one hundred percent to get the data. What is your impression of how often? Is it a daily, weekly, monthly thing?
- I would certainly say it's likely to perhaps experience a complaint weekly.
- Okay. And then if individuals have lockers, do you have any knowledge of how things are being stolen?
 - Α. I mean, if I can go back to some of NIMIGAN MIHAILOVICH REPORTING INC.

J. MOULTON-36

the reports that we experience, perhaps when they've left a bag out somewhere.

- Q. 111 Mm-hmm.
- Α. And left it unattended. Perhaps something like that.
- Q. 112 Do you ever receive reports that people have belongings stolen from them while they sleep?
- I mean, if they've left something out, that's a potential.
- 113 Q. What about off of their person while they're sleeping?
- Α. I don't have anything specific that I can think of on that.
- Q. Okay. How often does smoking in the 114 building happen?
- Α. It probably happens to some extent daily but our fire alarms are triggered when that happens usually. I would say it's usually our washroom where we find that people are doing the smoking.
- Q. 115 Okay. And how often do you find people bringing in guests?
- It's fairly rare. Yeah, our A4658 building is fairly secure.

- **116 Q.** Mm-hmm.
 - A. Yeah.
- 117 **Q.** And how often do you find drug use or dealing, drug dealing on site?
- A. Drug dealing is a tough one for me to quantify but drug use is, I would -- I would say it's normal. It's common.
- 118 **Q.** Okay. And what about drug use immediately outside of the Booth Centre?
- A. That would be on a daily basis for sure.
- 119 **Q.** What about drug dealing immediately outside of the Booth Centre?
- A. So the subjective of that would be fairly common.
- **Q.** Mm-hmm.
- A. Objectively, I don't think I could quantify that specifically.
- **Q.** Okay. And then you mentioned no animals with the exception of service animals?
 - A. Correct.
- **Q.** What is the process of accepting a service animal into the shelter? What kind of certification or proof is needed?
 - A. Yeah, so generally speaking, the NIMIGAN MIHAILOVICH REPORTING INC.

J. MOULTON-38

caseworkers will meet with a client if they have a service animal. They will do their best to ensure that the animal is actually a certified animal and certified for the individual. Paperwork, if available.

- **Q.** Do you know what kind of paperwork or specific certification is required?
- A. To be honest, I'm going to say no because generally speaking, when our team says that someone has a service animal, maybe I should check into this, but I just take for granted that they've done due diligence to ensure that the animal is there and also safety plans in place for the client and the animal, if possible.
- **Q.** Thank you. Okay, moving on to paragraph 21. You mentioned an internal appeal process. When is this communicated to a resident?
- A. So there's an intake process that they go through and they have client rules that they go through. Kind of house rules I would call it. And they're told that if they, typically service restrictions are applied by our frontline caseworker team and that they're told that they can appeal those to management, as required. And the clients would generally know the program manager,

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J. MOULTON-39

supervisors very, very well and would bring 943 complaints -- would ask to speak to management, for example. So it's communicated basically upon intake.

- **Q.** Okay. And if someone chooses to use this appeal process, when does it happen?
- A. So it can happen pretty much immediately. Yeah, I mean, depending on the circumstances, of course. Our policy is that our frontline workers can restrict for 24 hours or in the case of a long weekend, for example, it's basically pending management approval or referral. So it basically can be appealed fairly quickly.
- 126 **Q.** Okay. And what exactly is involved in this appeal process?
 - A. So it can be as simple as saying they want to speak to management.
- **Q.** Mm-hmm.
 - A. Yeah. And then --
- **128 Q.** Okay.
- A. Yeah, it doesn't have to be a formal, written out document. We do -- sometimes we will get a letter or e-mail that comes through but it's often just saying I want to speak to management.

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J. MOULTON-40

- **Q.** And does this appeal process always take place before a service restriction is imposed and someone is required to leave?
- A. So typically the restriction is in place before an appeal process. So we would not normally grant an appeal on a 24-hour restriction, for example. The appeal really kicks in for something of a longer duration. I guess the intention, really, is to ensure that the individual restriction, if it's too long, can be reduced.
- 130 **Q.** Okay.
- A. I should clarify just on that note, all service restrictions are available and seen by the managers as well. So it's not a singular eye to restrictions, it is the manager, supervisors have access to this so they also, as teams, review service restrictions on a regular basis.
- 131 **Q.** Okay, thank you. Okay, Mr. Moulton, we're almost done. I'm just going to attempt to screen share and hope that it works so just bear with me, please.
 - A. Sure.
- 132 Q. Okay. Can you see an article from
 Hamilton City Magazine titled "The Salvation Army:
 Behind the Front Lines"?

A. I can, yes.

133 Q. Okay, great. Dated November 10th,

2023?

A. Correct. Yes.

134 **Q.** Okay.

 $\mbox{MS. CROWE: I'd like this marked as} \label{eq:mscale} \mbox{Exhibit 1 to this examination.}$

MR. DIACUR: Counsel, I would mark it for identification, at least until the witness has had a chance to review it and can confirm that it was something he was involved in creating.

MS. CROWE: Thank you.

---EXHIBIT NO. A: "The Salvation Army: Behind the Front Lines"

BY MS. CROWE:

of all, does this look familiar to you? Do you remember this article?

A. I remember a couple pictures back in the day featuring this kettle, the larger kettle in the background.

136 **Q.** Okay. So what I'll do is I'll scroll down. It's broken down, the article is broken down by the different services offered by The Salvation Army.

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J. MOULTON-42

A. Okay.

137 **Q.** So you can review the whole thing or there's a specific section where you're interviewed specific to housing.

A. Okay.

MS. CROWE: So I will ask

Mr. Diacur, what would you like to do?

MR. DIACUR: Well, Counsel, I suggest that you go to the bit that has to do

with --

MS. CROWE: Okay.

MR. DIACUR: -- the interview from

Mr. Moulton. If he finds that reviewing the entire document is necessary then I certainly request that he be given the time to do that, but it sounds to me like if it's about the interview we should go right there.

BY MS. CROWE:

138 **Q.** Okay. So we're looking at the section titled "Helping with housing" and I just want to clarify, is this toolbar in the middle of the screen, can you see this toolbar or is that just mine?

MR. DIACUR: There's no toolbar on the screen, Counsel.

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J. MOULTON-43

MS. CROWE: Excellent.

MR. DIACUR: We have advertisements

on the right-hand side but it's all clean.

MS. CROWE: Okay, excellent. Okay.

BY MS. CROWE:

139 **Q.** So Mr. Moulton, I'll just give you a couple of minutes to review this portion of the article and you can let me know when you're ready to scroll down, okay?

A. Yeah. I'm recalling this section so I'm familiar with it, yeah.

140 **Q.** Okay. Do you need to review it or I just want to bring you to one specific paragraph?

A. You can bring me to that specific paragraph.

141 **Q.** Okay. Okay, so I'll read it out to you. "'In our facilities, historically, we have times of the year where fuller occupancy would be expected, so colder months, but now we're finding we have been full this entire summer,' adds Moulton. 'Today, we run at more than 100 percent occupancy, we're at overflow constantly. If you take the definition of emergency shelter, it is very short term, akin to an emergency room in a hospital, it's shorter stays with the goal of

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J. MOULTON-44

someone moving to a permanent housing. Now we find longer stays and that would be an indication that people are struggling to find permanent housing."

Mr. Moulton, is this an accurate quote of what you have said to the reporter?

A. That seems accurate, yes.

142 Q. And is it true?

A. Yes.

143 Q. Thank you. Those are my questions.

A. Could I just make one statement if that would be okay?

144 **Q.** Of course.

MR. DIACUR: I mean, James, if

Counsel invites you to, yes.

THE WITNESS: Okay, okay.

BY MS. CROWE:

145 Q. Go ahead.

A. The only thing I was going to say, in 2024, we have found some -- I said here a hundred percent occupancy. This past summer, last month, we didn't reach that hundred percent sometimes, but this was very reflective of the time when this article was written, yes.

146 Q. Thank you, Mr. Moulton. Thank you for taking the time to speak with me.

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A. You're welcome.

MR. DIACUR: Thank you, Counsel.

BY MR. DIACUR:

147 Q. I have some very brief

re-examination, Mr. Moulton. You were asked about the average length of a shelter stay and you said one reason that the answer was unclear was a lack of access to the HIFIS system recently. Why was HIFIS not available recently?

A. It was one of the systems that was affected, I believe, with the City IT issues.

148 Q. And do you recall when that started?

A. I believe it might have been in January of this year.

Q. Thank you. That's all the re-examination I have. Thank you, Counsel. Thank you, Mr. Moulton.

A. You're welcome.

---WHEREUPON THE EXAMINATION CONCLUDED AT 4:31 p.m.

NIMIGAN MIHAILOVICH REPORTING INC.

J. MOULTON-46

I hereby certify the foregoing to be the evidence of James Moulton, given under oath before me on the 26th day of August, 2024, recorded stenographically and later transcribed by me.

Natur frimpin

Rachel Thompson
Court Reporter
Commissioner of Oaths (expiring November 2024)

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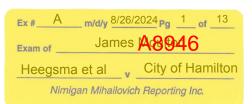














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MADE IN HAMILTON

THE SALVATION ARMY: BEHIND THE FRONT LINES

By Kathryn Dunmore / Nov 10, 2023









When thinking about The Salvation Army, the image of holiday collection kettles set up on a wintry street with some generous soul ringing a bell and asking for cash donations, might be the first (or only) thing that comes to mind. This is The Salvation Army's number one fundraiser, and the people behind the scenes are stretching each donated dollar to do the most for vulnerable people in Hamiton.

Beyond its thrift stores and food banks – The Salvation Army's most known programs – the Protestant-founded international charity has been quietly helping Hamiltonians in so many nuanced ways, with services and programs in Hamilton that weave a supportive quilt for the community.

It has been doing so for more than a century. Here are snapshots of just some of the ways The Salvation Army helps.



Christmas kettles are synonymous with The Salvation Army. Photo: Just Joy Imaging

Parenting supports

Along with those red collection kettles, think of a senior visiting a building downtown to drop off knitting, food, or a myriad of other donations to support the young parents there now because she was a young mother receiving assistance through Grace Haven decades ago.

The Salvation Army's Grace Haven, which supports young parents, goes back even farther than The Salvation Army itself - 127 years.

"It's an emotional connection that a lot of people have with Grace Haven because we have helped people for over a century," says Stephanie Amos, program manager. "We have seniors reaching out to support us because they, at one point, had their baby at Grace Haven back in the '40s. It's incredibly meaningful and there's such a rich legacy for what we do."

Now Grace Haven offers a high school education program in partnership with the Hamilton-Wentworth District School Board,

parenting preparation for soon-to-be and new parents, life navigation, personal development and wellness, support for dads, children's programs, the Take A Break Program for free childcare, and more, with the support of a diverse team including teachers, infant-parent specialists, child development workers, counsellors, addiction counsellors.

"Historically, the focus has always been on mom and baby and that goes way back to the beginning," notes Amos. "Over the years, we've evolved to meet the changing needs of the community. What used to be a maternity hospital evolved to be a residential program that provided life skills in teaching moms how to take care of babies. Then slowly introducing things like education so moms can still get their education, then addiction programs and all different types of programs were added to that."



Major June Newbury is executive director of The Salvation Army's Grace Haven. Photos: Billy Canning

In 2021, The Salvation Army closed the longstanding residential program in favour of collaborative day programs.

"Young parents have a lot of support in the community so they can live independently. The residential program wasn't an effective use of our funds ... All the programs work together to meet the varying needs of young parents and we've switched our focus from mom and baby to mom, dad, or partner in parenting role to focus on the whole family unit."

Currently, Grace Haven is supporting 38 participants with 10 registered in its school program. In the past year, the day program supported 127 young parents and children.

"We provide programs that increase their skills, equip them to better manage challenges of life and increase their parenting capacity," adds Amos. "It was a really good choice as we're so much better equipped to be able to help more people, and we're seeing the results of that, which is exciting."

One young participant who graduated with her high school diploma in June said:

"Grace Haven has a school, but it is also a community. It's a place to learn, to grow, to parent, to make new friendships and memories, a place to watch your child hit milestones, a place to ask for help when

you need it or help others when they ask, this is a place where you can focus on your education and your child."

Grace Haven's New Choices Addiction Treatment program is a residential and day treatment program and, over the years, has developed a large outreach program. For 25 years, it has existed to reduce the harmful effects of substance use either on pregnant or parenting women and their children by providing a diverse range of services and supports all in one place in the city.

"Basically, we're designed as a one-stop shop so mom can come in and receive addiction education, parenting skills, specialists who can work with the children, and more," says Kristin Baughan, program manager. "For me, it's important that we have some sort of intervention with children from zero to six (years). The important piece is keeping the attachment with mom and child, as well as the early intervention. When we have teams that work specifically on individualized (plans), I truly believe that, if you can intervene at that time, the outcomes would be exactly what we want them to be."

New Choices serves 150 to 170 women and children each year.

"My life before New Choices was confusing, miserable, tiring but that's not who I am today," says Chantel, a participant of the program. "The wonderful people who work at New Choices have made it possible for me to believe in myself and make my life a good one. All I did was follow the advice that was given while at the same time followed my heart and I couldn't be happier today."

Baughan and Amos stressed the importance of the work they do.

"Both Kristin and I are longstanding employees with The Salvation Army, and it gives us that opportunity to make a difference," says Amos. "The cool thing about what we do, because it is those early years, we know that what we do now makes a big difference in the long-term for children, their parents and families. This is what people don't see: where their money goes. All the monies collected go into this kind of work, not just Grace Haven but all the rest of The Salvation Army as well."

It's important to recognize here that although there may be perceptions about The Salvation Army's diversity and inclusivity position, the Canadian branch has been explicit that it welcomes anyone and everyone through its outreach and hiring." The Salvation Army is an innovative and inclusive partner in the city of Hamilton with its doors to life-changing services open to everyone," said Glenn van Gulik, divisional secretary for public relations for The Salvation Army's Ontario division.

"The Salvation Army does not discriminate in the delivery of our community and social services, and anyone who comes will receive assistance based solely on their need and our capacity to help, regardless of race, disability, sexual orientation, gender identity, age or religion. We uphold the dignity of all people, believing that all are equal in the eyes of God, and firmly oppose the mistreatment of any person."

Striving for senior wellbeing

In addition to those red collection kettles, think of a woman so inspired by her grandparents' stories of living in Hamilton that she chose to work with seniors as a career. Since The Salvation Army's adult day program opened in 2005, executive director Devon Howes-Jones has been dedicated to keeping seniors connected and healthy.

"Growing up in Hamilton, one of my favourite things to do was spend time with my grandparents and listen to stories of the old days in Hamilton. My nana would often reminisce about her childhood, her first job at the Royal Connaught in downtown Hamilton, how she was proud that her dad was the first mailman in Hamilton, the one and only on Hamilton Mountain. At Christmastime, I remember she would sit there and so carefully write out all her Christmas cards to her friends and family. One year, she was sitting with her cards and crying. I saw most of her family and friends were crossed off her list. She shared with me that all these people crossed off have passed away over the years. That's what started me to do what I do."

Since April, the program has served 131 clients, although numbers are lower than average as it recovers from COVID closures. It is accepting new clients.



The Salvation Army's adult day program for seniors is accepting new clients.

"Our day programs are designed for seniors living in the Hamilton community," says Howes-Jones. "Our programs touch on the five domains of health: cognitive, physical, social, emotional, and spiritual programs and we use a variety of resources to do that. When I look at Hamilton and all the amazing resources available to us in our community, we are a very safe environment so seniors can still get out, participate, and enjoy some of those resources."

The pandemic showed Howes-Jones how much the program means to the community.

"During COVID, our program experienced a lot of loss, a lot of people moved into long-term care because they declined. That was another huge eye-opener that our program really was helping people. Without the day program, our caregivers struggled, our clients declined, visiting hospitals (more) and it was a lot."

Offerings for seniors include dementia-specific services at the Meadowlands Community Church in Ancaster.

"Aging obviously comes with changes to our physical and mental capacity, and the unfortunate reality of losing our friends and family so people start to become more socially isolated," said Howes-Jones. "Our day programs provide a place for people to be able to interact in a safe environment with personal support workers. It really is amazing what



Seniors programs for The Salvation Army cover the five domains of health: cognitive, physical, social, emotional, and spiritual.

Helping with housing

Think of a man who has always had a home until this summer when he was evicted after a rent increase. Night is falling and he is scared – the day was hot, but this evening is calling for thunderstorms and he has nowhere to go.

"When people come to us, there are not a lot of options available and we're meeting people at a critical moment in their lives," says James Moulton, executive director for The Salvation Army's Hamilton, Halton and Brantford Housing and Support Services. "For some, it's more chronic but we're also helping more and more people who this is new for them. They used to be able to afford some form of accommodation, but the economy is making that more difficult."

The Salvation Army Hamilton Booth Centre is a male, or male-identified, emergency shelter and has been in Hamilton for well over a century, operating since 1904.

"In our facilities, historically, we have times in the year where fuller occupancy would be expected, so colder months, but now we're finding we have been full this entire summer," adds Moulton. "Today, we run at more than 100 per cent occupancy, so we're at overflow constantly. If you take the definition of emergency shelter, it is very short term, akin to an emergency room in a hospital, it's shorter stays with the goal of someone moving to permanent housing. Now, we face longer stays and that would be an indication that people are struggling to find permanent housing."



James Moulton, executive director for The Salvation Army's Hamilton, Halton and Brantford Housing and Support Services, says a growing number of people are struggling to keep a roof over their heads.

Hamilton Booth Centre's outreach has also increased to meet the expanding needs of those living on the streets of Hamilton, sending out a soup van into the community five nights a week to provide food, clothing and hygiene items.

"This summer, we served around 200 meals every evening. We are seeing a much greater, almost doubling of need in the program," says Jonathan Miedema, director of spiritual care. "Ultimately, the food our program provides is meant to be a conduit to having conversations with the people we support to learn their stories. The emphasis is less on serving food but getting to know the community, getting to know how we can support them beyond the food."

Despite the growing need and the constant lack of funding, The Salvation Army is making a difference, says Moulton.

"In September alone, 20 people were successfully housed. Since June, almost 60 people, in these difficult circumstances, have been helped by one emergency shelter in finding housing."

As one man who received this help said: "Thank you so much for your help and giving me the courage and motivation to be the person I want to be. Without (this) assistance, I feel I would still be in a bad state."

Creating independence and pride

Think of Katie, who has a developmental disability, coming out of an art class offered by The Salvation Army's Lawson Ministries program with a wide, proud smile. She's happy with her artwork but also her ability to get to the class independently from where she lives on her own.

"I've been with Lawson since I was 18," says Katie, who's now 30. "I've been more independent. I've been doing what independent women do. I

go out for stuff, clean, cook. My favourite thing to do is cooking. I've been taking care of everything."

With the help of several programs, such as a training program to use public transit, Katie is now able to commute from her new apartment on the other side of the city.

"Today, I just left an art class. I volunteer on Mondays. I'm going to start a Mohawk (College) program, which is going to be fun. I do my own shopping; I do all sorts of things."

Lawson Ministries supports adults with developmental disabilities with a range of residential and day programs, including DARE, which enhances literacy skills to eventually attain employment and independence in the community, and Let's Ride, where participants are provided bikes and learn how to bike around Hamilton safely.

Lawson Ministries was established in Hamilton in 1982, says executive director Deanna Finch-Smith.



Katie takes advantage of many programs at The Salvation Army's Lawson Ministries, where Deanna Finch-Smith is executive director.

"It was quite a small program when I came, there were 12 residential spots and now we have about 60, and we have day programs all over the city. Programs depend on the client's needs, which change all the time. We have two different mottos: we build it, and they will come, or they will come, and we will build it. We focus on who is at the door."

Picture Cody Roberts, a young man who has lived in Lawson's residential program for eight years and credits it with helping him manage his emotions.

"At the beginning, I was having a rough time and I got in trouble with the law," he says. "For two years straight, I had no incidents with the police, and I was able to get on the right path and do the right thing. It all started when I was shown the program of Inclusive Radio (at Mohawk College's INDI 101.5FM). It helped me free my mind, speak about my thoughts. It's what made me become a better person. It's helped me rationalize my feelings without becoming impulsively angry. I was able to channel it really great."

At Lawson's Paparella Innovative Arts Centre on King Street East, there is a range of arts programming and events, including the new Creative Studio, which provides multi-faceted sensory stimulation in a range of art media. There are also dancercise, tea socials, and spirituality programs.

"I grew up in a small town where our neighbour had a disability and I grew up with him, protected him and supported him," says Finch-Smith. "For me, it's a passion. There is always a need for somebody to help somebody. There are also, of course, lots of sad stories but definitely more success and more happy stories."



Cody Roberts, a young man who has lived in Lawson's residential program for eight years, credits it with helping him manage his emotions.

Providing hope with sustainability

Think of a young mother, who up until the pandemic, had managed to pay rent and keep food on the table. She thinks only about her small child in deciding if this paycheque goes to food or rent. She doesn't understand how it came to this, never mind where to go for help.

"Community and Family Services is primarily known for its food banks, although we do offer numerous other programs," says executive director Shirley Molloy. "The (Salvation) Army came to Canada in 1882, so the work that we do has really been going on since then."

Molloy has been with the program for more than three decades.

"I would say the need now, as it stands in 2023, is probably the most challenging that it's been and that's just because of the sheer number of people who are coming through our doors. We're coming out of COVID, which created issues for people, especially the clients we served because it was difficult for them to get to us," she says.

"What we're seeing now is the cost of living has increased, rent has gone up, food has gone up, gas has gone up, so it's just made it really difficult to keep resources in place to keep up with it. What I see most through all of this is basically people who could afford to sustain themselves, were financially able to carry themselves, are having challenges doing that as well now."



Cindy Taylor, community relations coordinator, and Shirley Molloy, executive director of Community and Family Services at The Salvation Army.

One program offered is Pathway of Hope, which focuses on identifying and addressing root cause issues for people living in poverty. It is a strengths-based case management approach to provide targeted services to people who want to break the cycle of poverty and vulnerability.

"Basically, for the duration of the program, we help them through some of the situations they've become overwhelmed with. It could be housing, it could be addiction issues, could be hoarding issues, could be they don't have enough money to make ends meet and don't know where to go to get resources," says Molloy. "So, we do a lot of sourcing for them and help them make a plan that basically is designed by them with our assistance, and we help them navigate through it to get them to a better place."

However, the importance of its food bank cannot be understated.

"With the food bank system, we are preventing homelessness in a way," adds Molloy. "If we can provide food for people, then they can use their money to keep the roof over their heads and have food on their table. Right now, with the cost of living so high, it's really challenging for families who are just scraping by. Anytime we can make a difference for somebody, then we know that it was all worth it."

So, when you drop some cash into one of those iconic collection kettles this holiday season, think of these and many more programs The Salvation Army offers to give hope to Hamiltonians in need.

To donate to The Salvation Army, visit SalvationArmy.ca or call 1-800-SAL-ARMY.



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Court File No. CV-21-00077187-0000

ONTARIO SUPERIOR COURT OF JUSTICE

BETWEEN:

KRISTEN HEEGSMA, DARRIN MARCHAND, GORD SMYTH, MARIO MUSCATO, SHAWN ARNOLD, BRADLEY CALDWELL, CHRISTINE DELOREY, GLEN GNATUK, TAYLOR GOGO-HORNER, CASSANDRA JORDAN, JULIA LAUZON, AMMY LEWIS, ASHLEY MACDONALD, COREY MONAHAN, MISTY MARSHALL, SHERRI OGDEN, JAHMAL PIERRE, LINSLEY GREAVES and PATRICK WARD

Applicants

and

CITY OF HAMILTON

Respondent

APPLICATION UNDER 14.05 OF THE RULES OF CIVIL PROCEDURE

AFFIDAVIT OF SHARON KOIVU

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

City of Hamilton Land Acknowledgement

- 2. The City of Hamilton is situated upon the traditional territories of the Erie, Neutral, Huron-Wendat, Haudenosaunee and Mississaugas. This land is covered by the Dish With One Spoon Wampum Belt Covenant, which was an agreement between the Haudenosaunee and Anishinaabek to share and care for the resources around the Great Lakes. We further acknowledge that this land is covered by the Between the Lakes Purchase, 1792, between the Crown and the Mississaugas of the Credit First Nation.
- 3. Today, the City of Hamilton is home to many Indigenous people from across Turtle Island (North America).

Background and Qualifications

- 4. I have been a physician practicing in Ontario for 39 years. I have been an Addiction Physician for 12 years. I have my Certificate of Added Competency in Addiction Medicine from the College of Family Physicians of Canada.
- 5. My work as an Addiction physician has been primarily providing inpatient Addiction Medicine Consultations for inpatients in both urban and small urban hospitals, London Health Sciences Centre (LHSC) and St. Thomas Elgin General Hospital (STEGH). The patients that I see are admitted to hospital and have a substance use disorder. The reason for the admission may or may not be related to their substance use.

- 6. From 2012-2021 I was the sole health care provider offering Addiction Medicine Consults at LHSC. From 2023-2024 I have worked as part of an Addiction Medicine Consultation Team in LHSC, and I remain the sole Addiction practitioner in the STEGH.
- 7. I also served as an acting Medical Officer of Health in Elgin-St. Thomas for 10 years and have experience in Public Health. I have been a Lawson research scientist. I am an Assistant Professor at Western University and have been responsible for teaching, Addiction Medicine, Palliative Care, Chronic Pain Management, Medical Ethics and Indigenous Cultural Safety.
- 8. I have been involved in numerous committees addressing the opioid crisis including the Community Opioid Overdose Prevention Program: Middlesex London Health Unit, Opioid Crisis Working Group: Middlesex London Health Unit, Opioid Use Disorder Standards Advisory Committee: Health Quality Ontario, Preventing and Managing Infectious Disease Among People Who Inject Drugs in Ontario: McMaster University Health Forum.
- 9. I have been a volunteer member of numerous organizations, including Street Level Women at Risk Committee, London, the London Homeless Coalition, the Sexual Assault Centre, London, Canadian Mental Health Association, St. Thomas, Violence Against Women Services, St. Thomas Ontario, Physicians for Social Responsibility the Canadian Society of Addiction Medicine.

- 10. Many the patients that I see are vulnerably housed or experiencing homelessness.

 I have seen patients who are living in homeless shelters in tent encampments and in both environments.
- 11. Additionally, I lived in a neighbourhood in London within 1 km of London InterCommunity Health Centre in which many encampments formed. I regularly walked in the area and spoke with people living in the encampments, often providing food, clothing, sleeping bags or other essentials.
- 12. A copy of my curriculum vitae is attached hereto as **Exhibit "A"**.

Duty of Expert

- 13. My executed Form 53 in respect of my opinion is attached hereto as Exhibit "B".
- 14. Additionally, I confirm I have reviewed Rule 4.1 of the *Rules of Civil Procedure* with respect to the duty of an expert.

Instructions to Expert and Scope of Opinion

- 15. I have been asked to provide my opinion, from the perspective of my area of expertise, with respect to health outcomes for people experiencing homelessness who live in encampments, as compared to in shelters.
- 16. My opinions, findings, and conclusions are set out below under three main headings, namely:

- (a) Opinion on health outcomes for people experiencing homelessness who live in encampments, as compared to in shelters;
- (b) Comments on opinion evidence (affidavits) of the Applicants' witnesses;
- (c) Final Comments
- 17. The numbered references in superscript in my opinion below correspond to the list of Works Cited attached hereto as **Exhibit "C"**.

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

- 18. Homelessness currently is a complex crisis in Canada. Encampments have developed as a response to this crisis. Unsheltered people experiencing homelessness have a 2.7-fold increased risk of mortality compared to those who are sheltered. 15 Encampments pose extensive health and safety risks to the people living in the encampments as well as public health and safety risks the community. 2,3,4,6,7,8,15,18,44,45,49 They are not a safe alternative to housing or to a shelter.
- 19. There are significant health risks to all people experiencing homelessness. There are some particularly serious risks associated with living in encampments. I would like to address risks that I have witnessed as a physician, risks that I am aware of from the literature and the media, and risks that I have observed living near encampments.
- 20. There are significant health risks to those living in encampments due to exposure to the elements. While extreme cold increases the risk, injury and death can occur in moderately cold temperatures.^{20,21,22}. I have seen numerous patients who developed

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

- 21. Hypothermia, a decrease in body temperature from exposure to cold temperatures, is a problem in encampments and can lead to cardiac arrest and death.^{24,25}
- 22. The risk of these injuries is increased in people who have a prolonged decrease level of consciousness, such as using sedating drugs including opioids, benzodiazepines and alcohol.
- 23. Trying to stay warm while in an encampment can lead to dangerous practices. I have had patients who have received severe burns from tent fires. These have included burns which have made their face unrecognizable, and have involved large areas of their body, leading to damage of function of extremities. I am aware of several people dying in tent fires. ^{26,27,28}.
- 24. Fires are also uses for cooking. This can occur all year long. People in encampments are at risk of burns from fires beyond the winter months.
- 25. I am aware of risks from propane tanks used to heat tents, including explosions causing injury and death and carbon monoxide poisoning.^{29.}

- 26. In June of this year a tent at an encampment in Hamilton was set on fire as a targeted, violent attack. It was not anti-encampment statement. It illustrates risks of violence to people living in an encampment.³⁰.
- 27. Prolonged exposure to damp and wet conditions can lead to another painful condition, a non-freezing cold injury, trench foot. I have seen trench foot complicated by skin breakdown and infection. Complications of trench foot can lead to amputation.^{31.}
- 28. Adverse weather events, including windstorms and lightning are dangerous to people living in encampments. Windstorms can destroy tents, lead to broken tree branches, and blowing debris that can cause injury and death.³³ I have had a patient who was killed by a falling branch. Lightning can strike a tent, tree, or the ground and cause harm.
- 29. Heat exposure also poses risks for people in encampments. Extreme heat can result in heat stroke.³² Heat, without accessible water can cause dehydration. Excessive heat exposure and dehydration can cause a very serious condition called rhabdomyolisis. Rhabdomyolysis is a condition in which there is skeletal muscle tissue breakdown and cell death.¹⁷ This causes the release of various substances into the blood that can damage the kidneys.
- 30. Severe dehydration and overheating accelerates muscle breakdown. Kidneys are unable to dispose of the body's waste without plenty of fluids. This can cause kidney failure.¹⁷

- 31. Rhabdomyolisis can also occur directly as a direct result of drug use such as Methamphetamine^{10,13}. The combination of heat, dehydration and Methamphetamine increases the risk of kidney failure. I have seen patients require dialysis as a result.
- 32. Tissue damage, particularly from lying in one place for an extending period, can also cause rhabdomyolisis and kidney failure. The risk of these rhabdomyolisis increases in people who have a prolonged decrease level of consciousness, such as using sedating drugs including opioids, benzodiazepines and alcohol. Complications of heat, dehydration and drug use can result in death.^{17.}
- 33. Rodents pose serious risks to people living in encampments and to neighbouring communities. I had a patient who woke after opioid use to discover that they had damage to their face. It is believed that the damage was most likely caused by a rodent attack.
- 34. People in encampments are at risk of infectious diseases carried by rodents.^{34,37,39}. Many infections are caused by exposure to rodent droppings or urine. These include Hantavirus which can cause Hantavirus Pulmonary Syndrome. Rodents can also be the source of other infections including Lyme Disease and Rat-bite fever. These harms can be spread to neighbouring communities.^{7,15,35,36}
- 35. Rodents can also be a source of rabies. Fortunately, rabies is rare in Ontario. However, I have had an unhoused patient who was bitten by a skunk and required Rabies shots.
- 36. While people have expressed the benefit of having a dog in an encampment, I have seen patients who have had serious dog bites. These have included bites to the

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

- 37. Due to lack or inadequate sanitation, people in encampments are at risk of developing infections spread through feces. There are examples of Hepatitis A outbreaks in encampments.^{2,7,41}.
- 38. Viruses, bacterial, fungal and parasitic infections can spread through feces. Some can be severe, even life-threatening, particularly combined with malnutrition or dehydration. 15,18
- 39. While living in the neighbourhood in which an encampment formed it was common to see feces on the back steps and front entrances to businesses. This puts the community at risk of acquiring infections through fecal contact.^{3,42}.
- 40. Body fluids, including blood and urine, can also spread infections. Blood is more likely to be present in areas of violent assaults such as stabbings and where there is inadequate access and disposal of menstrual products. Sharing needles and paraphernalia increases the risk of spreading blood borne infections including HIV and Hepatitis C. Improperly discarded needles and contaminated products poses a risk to people in the encampments, including people living there, working, walking through or playing in the area. While transmission of HIV or Hep. C from a needlestick injury would be much less in the community than in a hospital setting as these viruses generally do

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

- 41. In my experience injection drug use in encampments increases the risk of infectious complications, including sepsis likely because of the unsanitary conditions and the method of using the paraphernalia.^{1,48}.
- 42. While there is a lack of the environmental impact on urban homeless encampments there is an indication that they may contaminate urban surface water which can be a risk for people in the encampment and community.^{3,42}.
- 43. Porta-potties are now often installed to mitigate the risk of fecal contamination. If not kept clean they can be a site of transmission of bacteria, viruses and parasites including Ecoli, Norovirus, Salmonella and hepatitis A.^{2,7}.
- 44. There are numerous reports of people dying from overdose deaths in portapotties. 46,47,48. They get hotter than the outside air by several degrees making the risk
 higher if people take a sedating drug in a porta-potty during extreme heat. The
 municipality of London installed a porta-potty to support an encampment. It was set on
 fire shortly after the installation which created additional safety risk.
- 45. People experiencing homelessness are more at risk of developing other serious communicable diseases than the generally population. Additionally, they have a higher mortality rate from these diseases than someone in the general population who acquires the same disease.^{7,15,18,19,44,45}. Reportedly, a Thyphus outbreak have been associated with an encampment.⁷ Other illnesses include respiratory illnesses such as TB,

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

- 46. People experiencing homelessness have a higher incidence of many chronic diseases than the general population. A study in Vancouver compared chronic physical health conditions among people experiencing homelessness who were sheltered with those who were not sheltered including living in encampments. Those not in shelters has a statistically higher incidence of many conditions including neurological disorders, musculoskeletal disorders, long-term illness such as cancer, diabetes and anemia, gastro-intestinal disorders, cardiovascular disease and sensory disorders including glaucoma, cataracts and hearing loss when compared to those in shelters. There were no instances where being in a shelter posed a risk over not being sheltered. This study is consistent with my experience.
- 47. People who experience homelessness are often victims of physical violence, intimidation and threats of physical violence. While violence can happen in shelters, in my experience people living in encampments have a higher risk of violence, and the violence is more severe. 30,55,56,57,58. I have seen many patients who have been victims of stabbings and beatings. I have had many patients, particularly women and those with physical disabilities tell me that they are threatened with violence if they do not relinquish much of their prescribed opioids, "Safe Supply". I have had patients tell me that they would rather risk having an overdose death from smoking illicit fentanyl then risk getting

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

- 48. I am aware that encampments in Hamilton have been the sites of violence including stabbings, beatings, shootings, theft and a tent being set on fire.^{30,55,56}.
- 49. Sexual violence, sexual exploitation and sexual traffic are real concerns in encampments. I have had a patient inform me that they were sexually trafficked. The CEO for Oneroof, an agency that has offered youth services in Kitchener has expressed concerns that girls as young as 12 are being groomed for sexual trafficking at a local encampment. One of the negative consequences of this sexual abuse is sexually transmitted illnesses (STI's). STI'S are more common in people who experience homelessness than the general population. Among the homeless population the rates of all STI's are higher in in women and girls than among men and boys, including HIV, syphilis, chlamydia, and gonorrhea providing supporting data that women and girls are vulnerable to sexual exploitation.
- 50. While sexual violence can happen within a shelter, shelters generally are often age and gender specific and have staff available to safeguard against such occurrences.

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

52. The Homeless Hub states:

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

Homelessness, in turn, amplifies poor mental health. The stress of experiencing homelessness may exacerbate previous mental illness and encourage anxiety, fear, depression, sleeplessness, and substance use."⁵⁰.

- 53. I have witnessed problems resulting from this vulnerability. People with Mental health issues are often exploited. I have had patient with severe mental health issues who have much of their prescribed opioids taken from them. Patients with poor mental health are more likely to be sexually exploited.
- 54. The location of encampments can also be problematic. People are attracted to areas that are not safe to be, both for people living in the encampments and the

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

- 55. Homelessness, addiction and mental health are very complex and often interconnected. 50,51. A number of my patients came from middle class and affluent families locally or in other regions Ontario. Some were not able to live at home with their families. Some had relatives who wanted them to come home. Some chose encampments instead of shelters even when they were available. Some were not allowed to return to any shelter, often because of a violent history.
- 56. Frequently patients expressed being attracted to the encampments because of the lack of restrictions on drug use and absence of rules.
- 57. I observed deterioration in physical and mental health in people who moved into encampments. For many people this led to bad health outcomes and even death.
- 58. Most patients reported an increase in drug use in encampments They were also less likely to practice safe techniques when using paraphernalia or attend the supervised injection site. The amount of drug use increased. Patients reported progressing from

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

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

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

- 61. I value the knowledge and compassion expressed in the Affidavits that have been provided to me.
- 62. A list of the Affidavits that have been provided to me is attached as Exhibit "D".

- 63. Many suggest that tents are a safe, alternative to shelter. This includes the Affidavits from Kate Hayman, Stephen Hwang. The Affidavit from Aaron Orkin suggests that tents are a healthy choice.
- 64. Tents do no provide adequate protection from the environment to prevent serious harms. They also increase the risk of many infectious diseases, burns, injury from animals and rodents, sexual exploitation and assault. 2,6,7,9,15,18,19,20,21,22,24,25,26,27,28,29,31,32,34,35,37,39,40,41,42,44,45,49,52,53.
- 65. Encampments are a significant public health risk to the people living in them as well as the surrounding communities. 2,3,4,5,6,7,8,12,15,18,19,34,35,36,37,39,42,44,45,48,49,54,59,60,62,63.
- 66. The Affidavit from Claire Bodkin suggests the remaining in a tent would have prevented frostbite and its complications. The patients that I have had with severe complications of frostbite were in tents.^{20,21,22,24}.
- 67. The affidavit from Kaitlin Schwan brings up the important issue of the special needs of women and gender diverse women. She stated that some women feel safer in an encampment when compared to a shelter. Feeling safer and being safer are very different. There are very high risks for women and gender diverse persons in encampments which include sexual exploitation.^{52,53}, Additionally, women are overrepresented in the patients that I have seen with severe injuries from the elements.^{9,15}.
- 68. Andrea Sereda mentioned the important issue of community services including Home Care Nursing PSW, Physio or OT. These services are generally available only for

people with an address or people must go to services which can be difficult experiencing homelessness. Fortunately, a shelter is an address, and these services are regularly provided to people in homeless shelters. She also brought up many issues which demonstrate the challenges that health care providers working in a hospital setting face. I agree that stigmatization has been a significant problem and many marginalized patients have had experiences with health care providers that they feel are traumatic. I have also witnessed significant improvement and the vast majority of health care providers that I have worked with in a hospital are compassionate, caring individuals who provide excellent care. Hospitals can be intimidating environments. Most health care recommendations are made to improve outcomes while meeting the patient's gaols of care. For example, research showed that patients with Tricuspid Valve Infective Endocarditis, as a complication of Injections drug use, had a longer life expectancy if they did not have surgery than if they had surgery. 16 Infecting a Peripherally Inserted Central Catheter (PICC line) by injecting an unsterile drug into it could worsen outcomes as PICC line as PICC lines are inserted into a vein near the palm side of the elbow and extend to near the heart¹⁴. Unfortunately, community health care providers often do not appreciate the complexity if inpatient care. When patients return to the community, community health care providers at times promote the stereotype that hospital care is not compassionate. This can itself traumatize a patient. It would be healthier for the patient if community health care providers attempted to understand and support hospital health care providers instead of assuming and propagating a negative narrative as appears in this Affidavit.

- 69. I agree with Ameil Joseph that marginalized people require equity and equality, not further marginalization. However, I do not agree with his conclusion. Believing that encampments are an acceptable place to live is a form of marginalization and colonialization. From living in a community in which encampments formed while I was there that had not been there previously, and from seeing multiple media reports of concerns of people living near encampments, living in an encampment further alienates people, and adds to stigma.^{54,59,60,61,62,63}.
- 70. Dr. Rachel Lamont gave affidavits regarding patients she has cared for. I have not provided care for these people and have not had access to any other medical records. I do not feel that I have sufficient information to have a medical opinion. I do note that she referred to one patient as having "severe suicidal ideations" and another "contemplates suicide regularly". If she believed them to be suicidal, under the Mental Health Act of Ontario, she would be required to proceed with either a voluntary or involuntary institutionalized assessment at an appropriate facility. I do not see that that took place which would indicate she did not feel that the patients were at risk of suicide.
- 71. Jill Wiwcharuk gave Affidavits on people she has cared for. I have not provided care for these people and have not had access to any other medical records. I do not feel that I have sufficient information to have a medical opinion. She states for one patient Casandra Jordan that she a significant burn to the back of her leg. The cause is not clear but is consistent with a tent fire. She states that one patient, Cory Monahan had a "desperate desire to be housed," reinforcing the goal of housing. I note that she does not mention offering patients Buprenorphine either daily sublingual, or subcutaneous, every

4 weeks. Buprenorphine decreases the risk of overdose deaths⁶⁷ and injections every 4 weeks can be very stabilizing.⁶⁸ She does not indicate that she is an Addiction Physician. Patients with complex needs including Opioid Use disorder benefit from care from a physician who is trained in Addiction medicine and can offer a comprehensive range of treatment options.⁶⁹

- 72. Dr. Monica De Benedetti gave an Affidavit on a patient she was involved with. I have not provided care for these people and have not had access to any other medical records. I do not feel that I have sufficient information to have a medical opinion. However, that the patient, Julie Lauzon, was a 24-year-old patient. She was brought to the emergency department by her mother. I do not know the circumstances as to why she is not able to live with her mother, but it illustrates, as is my experience, that people in encampments often have families in the city.
- 73. I do not agree that encampments are a safe alternative to shelter or a healthy choice. I do not agree that encampments promote equity, equality, improve marginalization, or will help to decrease stigma. While people my feel a false sense of security, living in an encampment poses severe risks to health and safety of people living in the encampment and a public health risk to the community.

Final Comments

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

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

- 75. The conversation, and to a degree funding, has shifted away from homeless shelters, homeless hubs, housing security and appropriate housing, to a focus on encampments, their location, their size, and what services including sanitation will be provided. Those providing care to people living in encampments, may be well meaning, but are not necessarily adequately trained to meet the complex mental health and addiction needs of the people living there.
- 76. I make this affidavit for the purpose of introducing my opinion as evidence in this application and for no other or improper purpose.

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



Signed by:
Sharon toiwn
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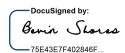
SHARON KOIVU

BEVIN SHORES (LSO No. 56161F)

A8979

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



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

Curriculum Vitae

MD, MCFP PC AM

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

A8981

APPOINTMENTS

Academic Appointments

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

Clinical Appointments

1998-2008 Acting Medical Officer of Health Elgin St. Thomas

2002-2003 Palliative Care Physician Consultant, Parkwood Hospital

2003-2008 Palliative Care Physician Consultant, St. Thomas Elgin General Hospital

2008 – 2021 Palliative Care Physician Consultant, London Health Sciences Centre

2012-present Addiction Medicine Consultant, London Health Sciences Centre

2021-present Addiction Medicine Consultant, St. Thomas Elgin General Hospital

Consulting and Academic Positions

2017 - 2020 Mentor, Medical Mentoring for Addictions and Pain Network (MMAP), Ontario College of Family Physicians

2020- 2020 Consultant Advisor and Opioid Clinical Primer, University of Toronto

2020- 2021 Consultant lead team, module development, Opioid Clinical Primer, Course 6: Treating Opioid Use Disorder: Initiating Buprenorphine in Primary Care, Emergency Department and Inpatient Settings. University of Toronto

2018 - present CPSO Peer Assessor, Palliative Care, CPSO

2016 - 2017 Medical Advisor, Government of Ontario

2014 - present Physician Lead, in-Patient Consult Addiction Service, London Health Sciences Centre, Western University

2018 Ontario Opioid Use Disorder Community Quality Standard Advisory Committee

Other Positions

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

Administrative Committees

National

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

Provincial

2016- present, Member Meta:Phi Network, Mentoring; Education and Clinical Tool for Addiction: Primary Care-Hospital Integration

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

2006 - 2007 Member, Cancer Care Ontario Southwest Alliance Planning Committee

Cancer Care Ontario

2007 - 2008 Medical Advisor, Regional Advisory Board Medication Review

Regional

2006 - 2007 Member, Southwest Palliative Care Review Team, Standardized Best Practice Pain and Symptom Management Guidelines

2000 - 2002 Member, Elgin County Working Group, Thames Valley District Health Council, London, Ontario

1995 - 1996 Vice Chair, Board of Directors, Violence Against Women Services Elgin County, St. Thomas. Ontario

1995 - 1996 Member, Sexual Assault Protocol Committee, County of Elgin, St. Thomas, Ontario

1992 - 1996 Member, Elgin County Coordinating Committee Against Women Abuse, Stop Women Abuse Now (SWAN), St. Thomas, Ontario

1992 - 1993 Member, Elgin County Review Task Force, St. Thomas Psychiatric Hospital, St. Thomas, Ontario

1991 Member, Mental Health Task Force, Thames Valley District Health Council, London, Ontario

1984 President, Board of Directors, Physicians for Social Responsibility - London Chapter, London, Ontario

Southwest LHIN

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

Hospital

London Health Sciences Centre

2015 - 2017 Founding Member, Narcotic Prescription-Quantity Committee

2015 - 2017 Founding Member, Patient Related Drug Diversion Committee

2014 Member, Cerner Optimization Assessment Project-PROVIDER round table discussions

2014 Member, HUGO Go-Live Leader Check-in

2013 - 2021 Member, Program/Division of Palliative Care within Family Medicine

2013 - 2020 Member, Planning the Work of Medicine/Family Medicine Clinical Strategy

2013 - 2014 Member, Palliative Care Accreditation Committee

2013 - 2014 Member, Dedicated Bed Model Project Team

2012 - 2020 Member, Leadership Forum

2012 - 2020 Member, Ethics Leadership Council

2012 - present Member, Palliative Care Recognition and Management Project Language Development Committee

2012 - 2014 Member, Guidelines for Peripherally Inserted Central Catheter (PICC) Line Use Committee

2012 Member, Healthcare Undergoing Optimization (HUGO), Phase 0, Impact Analysis Committee

2012 Member, Palliative Care Recognition and Management Project, Stakeholder Feedback Meeting

2011 - present Member, Palliative Care Recognition and Management Project, Policy and Form Team

2011 2010

2011 - 2019	Member, Leadership/Cultural Transformation Journey			
2011 - 2020	Chair, University Hospital Family Medicine Operations Committee			
2011 - 2020	Member, General Internal Medicine Clinical Teaching Unit (CTU) Leadership Committee			
2011 - 2014	Member, Palliative/Sub-Acute Medicine Unit (SAMU)/Continuous Quality Improvement			
(CQI) Council				
	Member, Palliative Care Program Committee			
London Hospitals				
2011 - 2021	Member, Citywide Department of Family Medicine Executive Committee			
2008 - present	nt Member, Citywide Department of Family Medicine			
St. Joseph's Health Care London				
2002 - 2003	Member, Ethics Committee, Parkwood Hospital			
2002 Member, Accreditation Planning Committee, Parkwood Hospital				
St. Thomas Elgin General Hospital				
2005 - 2008	Member, Interdisciplinary Service Delivery Advancement Project, Continuing Care Centre			
2005 - 2006	Member, Accreditation Planning Committee, Continuing Care Centre			
2005 - 2006	Member, Medication Safety Committee			
2003 - 2008	Member, Wound Care Committee			
2003 - 2006	Member, Palliative Care Core Team			
2002 - 2006	Member, Board of Directors			
2002 - 2003	Member, Accreditation Planning Committee, Continuing Care Centre			
2001 - 2008	Member, Palliative Care Consultation Team			
2000 - 2005	Member, Ethics Committee			
1999 - 2008	Medical Advisor, Medical Advisory Committee			
1999 Member, Ad Hoc Committee for the Development of a Clinical Associates Model				
1996 - 2001	Member, Infection Control Committee			
1991 - 1997	Member, Credentials and Ethics Committee			
1987 - 1991	Chair, Nursing/Medical Liaison Committee			
St. Thomas Psychiatric Hospital				
1993 Member, Duplication and Gap Sub Committee				

Member Leadership/Cultural Transformation Journey

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

PRESENTATIONS

Invited Lectures

- 1. Keynote Speaker, The Streets of London, Nursing Council, 2018 May 24, London, Ontario, Canada
- Invited Lecturer, Reducing Harm, Empowering Lives: Responding to the Needs of People who Inject Drugs during an Opioid Crisis, Pegusus, Presenters: Dr. Koivu, Brian Lester, ED. RHAC London, 2018 Apr 29, Toronto, Ontario, Canada
- 3. Keynote Speaker, Harm Reduction: Compassionate Care of Persons with Substance Use Disorder, Guelph General Hospital And Homewood Health Centre, Presenters: Dr. Koivu Madison Cruickshank, Addiction Cousellor, 2018 Apr 11, Guelph, Ontario, Canada
- 4. Invited Lecturer, Why Worry Abpout the Opioid Prescribing Crisis, 14th Annual Innovations In Palliative Care Conference, McMaster University, 2017 Nov 22, Hamilton, Ontario, Canada
- 5. Presenter, Changing the Patient Experience Through Collaborative Care, CSAM, Presenters: Dr. Gupta, Dr.Lee, 2017 Oct 21, Niagara Falls, Ontario, Canada
- 6. Presenter, Dimenhydrinate the other latrogenic Addiction, CSAM, 2017 Oct 21, Niagara Falls, Ontario, Canada

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

- 27. Invited Lecturer, Prescription Opioid Addiction-A Local Epidemic, Fanshawe College, 2015 Feb 9, London, Ontario, Canada
- 28. Invited Lecturer, Prescription Narcotic Addiction-Risks You Need to Know, Dorchester Public School, 2015 Jan 19, Dorchester, Ontario, Canada
- 29. Invited Lecturer, Attitude Addiction Recovery- Moving a Hospital to change, Medical Staff Huron Perth Healthcare Alliance, 2015 Jan 9, Stratford, Ontario, Canada
- 30. Invited Lecturer, Medical Marijuana-Risks and Benefits, Fanshawe College, 2014 Nov 21, London, Ontario, Canada
- 31. Invited Lecturer, Enhancing the Care of Patients Suffering from Intravenous Drug Addiction in the Hospital and Community, LHSC Board of Govenors, 2014 Oct 29, London, Ontario, Canada
- 32. Presenter, Palliative Equality for People with IV Drug Addiction, International Society of Addiction Medicine, 2014 Oct 5, Yokahama, Japan
- 33. Invited Lecturer, Caring for Patients with IV Drug Addiction, A Herculean Task: Transforming AMA (Against Medical Advice) to AMA (Arduous Meaningful Accomplishment), Staff Education LHSC, 2014 Sep 24, London, Ontario, Canada
- 34. Invited Lecturer, Caring for Patients with IV Drug Addiction, A Herculean Task: Transforming AMA (Against Medical Advice) to AMA (Arduous Meaningful Accomplishment), Staff Education LHSC, 2014 Sep 24, London, Ontario, Canada
- 35. Invited Lecturer, IVDU/Addiction-A Local Epidemic, My Sister's Place, 2013 Oct 22, London, Ontario, Canada
- 36. Invited Lecturer, The Role of Physicians in Social Justice and Activism, Dorchester Public School, 1, 2013 Oct 17, Dorchester, Ontario, Canada
- 37. Invited Lecturer, Prescription Narcotic Addiction-Risks You Need to Know, Dorchester Public School, 1, 2013 Oct 17, Dorchester, Ontario, Canada
- 38. Invited Lecturer, Endocarditis and Harm Reduction, London CAReS Community Committee, 2013 Sep 18, Canada
- 39. Invited Lecturer, IV Drug Addiction in Palliative Care Pilot Project, A Refresher Day in Hospice Palliative Care, 2012, London, Ontario
- 40. Invited Lecturer, latrogenic Circulatory Overload in Patients at LHSC, LHSC Board of Govenors: Quality and Patient Safety Committee, 2011 Jan 11, London, Ontario, Canada
- 41. Presenter, Perfectly Practical Pearls for Pain Management in Palliative Care, for Family Physicians, London, Chatham, Sarnia, Windsor, St. Thomas, Woodstock, 2011
- 42. Presenter, Physical and Mental Health Issues of War Resistors in Canada, 2009, London, Ontario
- 43. Presenter, Choosing Peace, Hiroshima Day, 2009, St. Thomas, Ontario
- 44. Presenter, Comprehensive Advanced Palliative Care Education (C.A.P.S.E.) Ethical and Legal Issues in End-Of-Life Decision Making, 2005, St. Thomas, Ontario
- 45. Presenter, Comprehensive Advanced Palliative Care Education (C.A.P.S.E.) Symptoms Management, 2004, St. Thomas, Ontario
- 46. Presenter, Severe Acute Respiratory Syndrome (S.A.R.S.) The Ethical Issues with Dr. Robert Butcher, Ethicist, 2004, St. Thomas, Ontario

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

- 70. Presenter, Advanced Directives, Imperial Order of the Daughters of the Empire. 2001, St. Thomas, Ontario
- 71. Presenter, Spirituality and Healing, St. John's Anglican Church, St. Thomas, Ontario
- 72. Panel Member, Communicating About Advance Directive, 2000, Union, Ontario
- 73. Presenter, Critical Thinking in Medical Ethics, 2009-2010, Central Elgin Collegiate Institute, St. Thomas, Ontario

PUBLICATIONS

- 1. Shetty N, Nagpal D, Koivu S, Mrkobrada M. Surgical and Medical Management of Isolated Tricuspid Valve Infective Endocarditis in Intravenous Drug Users. J Card Surg, 2016 Feb 1; 31 (2): 83-8
- 2. Mulling J (RN), **Baker S**, Lee L (RN). Experiencing Spirituality Smudging: A Native Cleaning and Purifying Ritual. Anthology of Reading in Long-Term Care, 3rd Edition, 2001
- 3. Mulling J (RN), **Baker S**, Lee L (RN). Experiencing Spirituality Smudging: A Native Cleaning and Purifying Ritual. Canadian Nurse 97, 2001
- 4. Weir M, Slater J, Jandoc R, Koivu S, Silverman M The risk of infective endocarditis among people who inject drugs: a retrospective, population based time series analysis *CMAJ* 2019 January 28;191:E93-9. doi: 10.1503/cmaj.180694
- 5. Silverman M, Slater J, Jandoc R, Koivu S, et al. Hydromorphone and the risk of infective endocarditis among people who inject drugs: a population-based, retrospective cohort study. Lancet Infect Dis 2020;20:487-497.
- 6. Ball LJ, Venner C, Tirona RG, Koivu S, et al. Heating Injection Drug Preparation Equipment Used for Opioid Injection May Reduce HIV Transmission Associated With Sharing Equipment. J Acquir Immune Defic Syndr 2019;81:e127-34.
- 7. Johnstone R, Khalil N, Shojaei E, Koivu S, et al. Different drugs, different sides: injection use of opioids alone, and not stimulants alone, predisposes to right-sided endocarditis. Open Heart 2022;9:e001930.
- 8. <u>Katherine J Kasper, Iswarya Manoharan, Brian Hallam, Charlotte E Coleman, Sharon L Koivu, Matthew A Weir, Johan Delport, John K McCormick, Michael S Silverman</u> A controlled-release oral opioid supports S. aureus survival in injection drug preparation equipment and may increase bacteremia and endocarditis risk <u>PLoS One.</u> 2019; 14(9): e0223079. Published online 2019 Sep 19. doi: <u>10.1371/journal.pone.0223079</u>
- 9. <u>Charlie Tan, MD</u>; <u>Esfandiar Shojaei, MD</u>; <u>Joshua Wiener, BHSc</u>; <u>Meera Shah, BMSc</u>; <u>Sharon Kovu, MD</u>; <u>Michael Silverman, MD</u> Risk of New Bloodstream Infections and Mortality Among People Who Inject Drugs With Infective Endocarditis *JAMA Netw Open.* 2020;3(8):e2012974. doi:10.1001/jamanetworkopen.2020.12974
- 10. <u>Matthew Meyer</u>, <u>Lise Bondy</u>, <u>Sharon Koivu</u>, <u>John Koval</u>, <u>Andrew D. Scarffe</u>, <u>Michael S. Silverman</u> New hepatitis C diagnoses in Ontario, Canada are associated with the local prescription patterns of a controlled-release opioid J Viral Hepat 2020 Aug;27(8):774-780.doi: 10.1111/jvh.13292. Epub 2020 Apr 8.
- 11. Meera Shah, Ryan Wong, Laura Ball, Klajdi Puka, Charlie Tan, Esfandiar Shojaei, Sharon Koivu, Michael Silverman Risk factors of infective endocarditis in persons who inject drugs Harm Reduct J 2020 Jun 5;17(1):35. doi: 10.1186/s12954-020-00378-z

ABSTRACTS

Abstracts Published

Peer Reviewed

Published

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

Posters Presented

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

HONOURS AND AWARDS

Honours

Received

2021 Certificate, Indigenous Cultural Safety Training

2019 Dana Winterburn Memorial Award, Award Chosen by members of the Dept. of Family

Medicine, London, Ontario, for outstanding physician in Palliative Care or Aboriginal Health

2016 Certificate in Added Competence, Addiction Medicine, CFPC

2014 Certificate in Added Competence, Palliative Care, CFPC

A8989

2002 The Queens Golden Jubilee Medal, For significant contribution to Elgin St. Thomas in the Field of Medicine. This was for my development of Palliative Care services and contribution to Public Health.

2002 Certificate of Achievement, From City of St. Thomas for outstanding excellence and contribution to the community

1993 Outstanding Service Award, Ontario College of Family Physicians, Peer Presenter Program

1984 Department of Family Medicine Practice Award, For the Medical Student found to be the most outstanding in Family Medicine. The University of Western Ontario

Nominated

2015 Western's Best Core Family Medicine Teaching Award, Award Chosen by Family Medicine Residents in their Graduating year, Western

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

SERVICE AND ADMINISTRATION

Professional Affiliations and Activities

Professional Associations

2013 - present
 1999 - 2001
 1997 - 2001
 Member, International Society of Addiction Medicine
 Member, Choir Group, St. John's Anglican Church
 Member, St. Thomas Hockey Mother's Association

present Member, The Canadian Society of Addiction Medicine

Member, The Canadian Society of Palliative Care Physicians Member, The Canadian Hospice Palliative Care Association

Member, The Canadian Medical Association

Member, The College of Physicians and Surgeons of Ontario

Member, The Elgin Medical Association Member. The Ontario Medical Association

Member, The College of Family Physicians of Canada Member, The Ontario College of Family Physicians

Member. The Canadian Association of Wound Care

Member, Canadian Association of Physicians for the Environment

Member, Canadian Pain Society

Member, Canadian Pain Coalition

Member, St. Thomas Walk-in Medical Clinic

Member, Professional Staff Organization, London Health Sciences Centre

Member. Physicians for Global Survival

Member, Department of Family Medicine, University of Western Ontario

Member, Society of Friends, Yarmouth Monthly Meeting

Peer Review Activities

Peer Reviewer

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

Administrative Committees

International

1977 - 1978 Member, Amnesty International, London, Ontario

National

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

1990 - 1992 Member, Board of Directors, Canadian Mental Health Association, St. Thomas, Ontario

1990 - 1992 Member, Policy and Programming Committee, Canadian Mental Health Association, St.

Thomas, Ontario

1990 - 1992 Member, Community Advisory Committee, Canadian Mental Health Association, St.

Thomas, Ontario

Provincial

2012 - present Member, Investigation and Resolution Assessor Networking Forum, College of Physicians and Surgeons of Ontario

2006 - 2007 Member, Cancer Care Ontario Program in Evidence Based Care Practitioner Feedback

Team

2006 - 2007 Member, Cancer Care Ontario Southwest Alliance Planning Committee

Cancer Care Ontario

2007 - 2008 Medical Advisor, Regional Advisory Board Medication Review

Regional

2006 - 2007 Member, Southwest Palliative Care Review Team, Standardized Best Practice Pain and Symptom Management Guidelines

2004 - 2006 Member, Symptom Control Kit Committee, Elgin County

2000 - 2002 Member, Elgin County Working Group, Thames Valley District Health Council, London, Ontario

1995 - 1996 Vice Chair, Board of Directors, Violence Against Women Services Elgin County, St. Thomas, Ontario

1995 - 1996 Member, Sexual Assault Protocol Committee, County of Elgin, St. Thomas, Ontario
 1992 - 1996 Member, Elgin County Coordinating Committee Against Women Abuse, Stop Women

Abuse Now (SWAN), St. Thomas, Ontario

1992 - 1993 Member, Elgin County Review Task Force, St. Thomas Psychiatric Hospital, St. Thomas, Ontario

1991 Member, Mental Health Task Force, Thames Valley District Health Council, London, Ontario

1984 President, Board of Directors, Physicians for Social Responsibility - London Chapter, London, Ontario

Southwest LHIN

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

Local

2011 Member, Medicine Access and Flow Retreat

2008 - present Member, Yarmouth Monthly Meeting of Society of Friends (Quaker) Peace and Social Justice Committee

2003 Member, End Racism Committee

2002 Member, Palliative Care Stakeholders Day

1993 - 1994 Member, Media Committee, Londoners Against Racism

1992 - 1993 Member, Program and Policy Committee, Sexual Assault Centre

1992 - 1993 Member, Board of Directors, Sexual Assault Centre

1989 - 1990 Member, Teen Mom's Program Advisory Committee, YWCA of St. Thomas-Elgin

1978 - 1979 Member, Jeremiah's Field Committee, Cross Cultural Learner Centre

1978 - 1979 Member, Board of Directors, Cross Cultural Learner Centre

1977 - 1979 Member, Committee in Support of Native Concerns

Centre For Organizational Effectiveness

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

London Homeless Coalition

2015 - present Member, London Homeless Coalition

Middlesex London Health Unit

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

Media Appearance

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

Symposia

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

Workshop

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

Memorial Services

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

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

Benin Shores

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

Court File No. CV-21-00077187-0000

ONTARIO SUPERIOR COURT OF JUSTICE

BETWEEN:

KRISTEN HEEGSMA, DARRIN MARCHAND, GORD SMYTH, MARIO MUSCATO, SHAWN ARNOLD, BRADLEY CALDWELL, CHRISTINE DELOREY, GLEN GNATUK, TAYLOR GOGO-HORNER, CASSANDRA JORDAN, JULIA LAUZON, AMMY LEWIS, ASHLEY MACDONALD, COREY MONAHAN, MISTY MARSHALL, SHERRI OGDEN, JAHMAL PIERRE, LINSLEY GREAVES and PATRICK WARD

Applicants

and

CITY OF HAMILTON

Respondent

APPLICATION UNDER 14.05 OF THE RULES OF CIVIL PROCEDURE

ACKNOWLEDGMENT OF EXPERT'S DUTY

- 1. My name is Dr. Sharon Koivu. I live in the City of Port Stanley, in the Province of Ontario.
- 2. I have been engaged by or on behalf of the Respondent to provide evidence in relation to the above-noted court proceeding.
- 3. I acknowledge that it is my duty to provide evidence in relation to this proceeding as follows:
 - (a) to provide opinion evidence that is fair, objective and non-partisan;
 - (b) to provide opinion evidence that is related only to matters that are within my area of expertise; and
 - (c) to provide such additional assistance as the Court may reasonably require, to determine a matter in issue.

I acknov	wledge that the duty referre	d to above prevails over any obligation which I may
owe to a	any party by whom or on wl	nose behalf I am engaged.
Date	July 26, 2024	Sharon toinu
		Signature

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

Court File No. CV-21-00077187-0000

KRISTEN HEEGSMA et al.

- and - CITY OF HAMILTON

Applicants

Respondent ONTARIO

ONTARIO SUPERIOR COURT OF JUSTICE

PROCEEDING COMMENCED AT HAMILTON

ACKNOWLEDGMENT OF EXPERT'S DUTY

GOWLING WLG (CANADA) LLP

Barristers & Solicitors One Main Street West Hamilton, ON L8P 4Z5

Tel: 905-540-8208

Bevin Shores (LSO#56161F)

Tel: 905-540-2468 bevin.shores@gowlingwlg.com

Jordan Diacur (LSO#65860E)

Tel: 905-540-2500 jordan.diacur@gowlingwlg.com

Lawyers for the Respondent

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

Benin Shores

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

Works Cited:

- Ball LJ, Puka K, Speechley M, Wong R, Hallam B, Wiener JC, Koivu S, Silverman MS. Sharing of Injection Drug Preparation Equipment Is Associated With HIV Infection: A Cross-sectional Study. J Acquir Immune Defic Syndr. 2019 Aug 1;81(4):e99-e103. doi: 10.1097/QAI.0000000000002062. PMID: 31021986; PMCID: PMC6905403. (Sharing equipment increases HIV)
- Foster M, Ramachandran S, Myatt K, et al. Hepatitis A Virus Outbreaks Associated with Drug Use and Homelessness---California, Kentucky, Michigan, and Utah, 2017.
 MMWR Morb Mortal Wkly Rep 2018;67:1210. DOI: http://dx.doi.org/10.15585/mmwr.mm6743a3
- 3. Gerrity Daniel, Papp Katerina, Dickenson Eric, Ejjada Meena, Marti Erica, Quinones Oscar, Sarria Mayra, Thompson Kyle, Trenholm Rebecca A., Characterizing the chemical and microbial fingerprint of unsheltered homelessness in an urban watershed, Science of The TotalEnvironment,Volume840,2022,156714,ISSN00489697,https://doi.org/10.1016/j.scitotenv.2022.156714.(https://www.sciencedirect.com/science/article/pii/S0048969722038116)
- 4. Haber PS, Young MM, Dorrington L, et al. Transmission of hepatitis C virus by needle-stick injury in community settings. J Gastroenterol Hepatol 2007;22(11):1882–5.
- 5. Henderson E, Continente X, Fernández E, Tigova O, Cortés-Francisco N, Gallus S, Lugo A, Semple S, O'Donnell R, Clancy L, Keogan S, Ruprecht A, Borgini A, Tzortzi A, Vyzikidou VK, Gorini G, López-Nicolás A, Soriano JB, Geshanova G, Osman J, Mons U, Przewozniak K, Precioso J, Brad R, López MJ; TackSHS project investigators. Secondhand smoke exposure in outdoor children's playgrounds in 11 European countries. Environ Int. 2021 Apr;149:105775. doi: 10.1016/j.envint.2020.105775. Epub 2020 Nov 20. PMID: 33228970.

- Kimberlin DW, Brady MT, Jackson MA, Long SS, eds. Red Book: 2021 Report of the Committee on Infectious Diseases, 32nd edn. Itasca, IL: American Academy of Pediatrics, 2021:166-9. American Academy of Pediatrics, Committee on Infectious Diseases. (Injuries from discarded needles in the community)
- Liu CY, Chai SJ, Watt JP. Communicable disease among people experiencing homelessness in California. Epidemiol Infect. 2020 Mar 30;148: e85. doi: 10.1017/S0950268820000722. PMID: 32223777; PMCID: PMC7189346. (communicable diseases, Hepatitis A)
- 8. Moore DL. Canadian Paediatric Society, Infectious Diseases and Immunization committee. Needlestick injuries in the community. Paediatric Child Health 2008;13(3):205–10.
- Nikoo, Nooshin; Motamed, Marjan; Nikoo, Mohammad Ali; Strehlau, Verena; Neilson, Erika; Saddicha, Sahoo; and Krausz, Michael (2014) "Chronic Physical Health Conditions Among Homeless," Journal of Health Disparities Research and Practice: Vol. 8: Iss. 1, Article 5. Available at: https://digitalscholarship.unlv.edu/jhdrp/vol8/iss1/5 (Chronic Illnesses, Shelter vs Unsheltered)
- 10. Nantapong Chansaengpetch, Wisarn Worasuwannarak, Suchin Worawichawong, Methamphetamine-induced profound rhabdomyolysis and myoglobin cast nephropathy: A case report and a literature review, Journal of Forensic and Legal Medicine,

 Volume

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 2023,102530,ISSN1752928X,https://doi.org/10.1016/j.jflm.2023.102530.(https://www.sciencedirect.com/science/article/pii/S1752928X23000483)
- 11. O'Shea T, Bodkin C, Mokashi V, Beal K, Wiwcharuk J, Lennox R, Guenter D, Smieja M, Bulir D, Chong S. Pandemic Planning in Homeless Shelters: A Pilot Study of a Coronavirus Disease 2019 (COVID-19) Testing and Support Program to Mitigate the Risk of COVID-19 Outbreaks in Congregate Settings. Clin Infect Dis. 2021 May 4;72(9):1639-1641. doi: 10.1093/cid/ciaa743. PMID: 32511704; PMCID: PMC7314119. (No Covid-19 outbreaks in shelter)

- 12. Res S, Bowden FJ. Acute hepatitis B infection following a community-acquired needlestick injury. J Infect 2011;62(6):487–9.
- 13. Richards JR, Johnson EB, Stark RW, Derlet RW. Methamphetamine abuse and rhabdomyolysis in the ED: a 5-year study. Am J Emerg Med. 1999 Nov;17(7):681-5. doi: 10.1016/s0735-6757(99)90159-6. PMID: 10597089.
- 14. Rodger L, Shah M, Shojaei E, Hosseini S, Koivu S, Silverman M. Recurrent Endocarditis in Persons Who Inject Drugs. Open Forum Infect Dis. 2019 Sep 9;6(10):ofz396. doi: 10.1093/ofid/ofz396. PMID: 31660358; PMCID: PMC6796994. (IE if abuse PICC line)
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- 16. Shetty N, Nagpal D, Koivu S, Mrkobrada M. Surgical and Medical Management of Isolated Tricuspid Valve Infective Endocarditis in Intravenous Drug Users. J Card Surg. 2016 Feb;31(2):83-8. doi: 10.1111/jocs.12682. Epub 2015 Dec 20. PMID: 26687478.
- 17. Torres PA, Helmstetter JA, Kaye AM, Kaye AD. Rhabdomyolysis: pathogenesis, diagnosis, and treatment. Ochsner J. 2015 Spring;15(1):58-69. PMID: 25829882;PMCID:PMC4365849.
- 18. https://www.publichealthontario.ca/-/media/documents/E/2019/eb-homelessness-health.pdf (homeless individuals experience higher rates of infectious diseases, such as tuberculosis, hepatitis and HIV compared to the general population)
- 19. Institute of Medicine (US) Committee on Health Care for Homeless People. Homelessness, Health, and Human Needs. Washington (DC): National Academies

- Press (US); 1988. 3, Health Problems of Homeless People. Available from: https://www.ncbi.nlm.nih.gov/books/NBK218236/
- 20. https://www.cbc.ca/news/canada/london/homeless-encampment-fire-1.6688483 (Fire or Frostbite)
- 21. https://www.thestar.com/news/gta/dennis-chantiloupe-fell-asleep-and-lost-all-his-fingers-to-frostbite-as-homelessness-soars-more/article_8fc10c48-95d4-11ee-9bfb-8335f24c6c4a.html
- 22. https://www.cbc.ca/news/canada/new-brunswick/frostbite-amputated-homeless-saint-john-jamie-langille-catherine-driscoll-1.7094514 (Frostbite)
- 23. https://www.thestar.com/news/gta/dennis-chantiloupe-fell-asleep-and-lost-all-his-fingers-to-frostbite-as-homelessness-soars-more/article_8fc10c48-95d4-11ee-9bfb-8335f24c6c4a.html (frost bite)
- 24. https://globalnews.ca/news/10235191/homeless-protections-extreme-cold-canada/ (hypothermia)
- 25. https://invisiblepeople.tv/homeless-people-face-hypothermia-every-winter-heres-how-you-can-help/ (hypothermia)
- 26. https://www.cbc.ca/amp/1.7174695 (tent fire death)
- 27. https://www.cbc.ca/amp/1.7174695 Fire destroys structure)
- 28. https://www.thestar.com/news/gta/this-kind-of-living-arrangement-outside-is-not-safe-acting-fire-chief-says-as-toronto/article_5a956cac-651a-5c4d-9b3a-5d30a6a92d61.html (Fire)
- 29. https://www.cbc.ca/news/canada/london/watson-street-park-london-ontario-homelessness-1.7205391 (Propane tank explosion)

- 30. https://www.cbc.ca/news/canada/hamilton/tent-arson-1.7242387 (Tent set on fire in Hamilton targeted, not a Hate Crime)
- 31. https://www.cbc.ca/amp/1.6923018 (Trench foot London)
- 32. https://atlantic.ctvnews.ca/homeless-population-hardest-hit-during-hot-weather-souls-harbour-1.6955692
- 33. https://globalnews.ca/news/10121319/grand-parade-halifax-tents-wind-storm/ (Windstorm destroys encampment)
- 34. https://kitchener.ctvnews.ca/paramedic-union-raising-concerns-about-rats-at-kitchener-encampment-1.6285151?cache=/7.572778/7.315126/7.3151269rats Waterloo encampment)
- 35. https://www.thepeterborough-news/peterborough-region/peterborough-homeless-encampment-had-been-overrun-by-rats/article_034aa81c-45bb-5c83-b163-3e369271baf9.html (Rats)
- 36. https://www.cbc.ca/amp/1.7241369 (rats in Etobicoke neighbourhood)
- 37. https://atlantic.ctvnews.ca/halifax-s-victoria-park-tent-encampment-dealing-with-rat-problem-
 https://atlantic.ctvnews.ca/halifax-s-victoria-park-tent-encampment-dealing-with-rat-problem-1.6776767#:~:text=Wheelock%20says%20tent%20encampments%20are,With%20 rats%20comes%20health%20risks. (rats Halifax encampment)
- 38. https://www.environmentalpestcontrol.ca/blog/what-diseases-do-rodents-carry
- 39. https://search.app/d5whhvkH4zXRCJsd9 (Seattle PH rodents, needlestick)

- 40. https://www.thefreepress.ca/news/dog-bites-bylaw-officer-at-maple-ridge-homeless-camp-5115761 (dog bites bylaw officer)
- 41. https://www.homelesshub.ca/about-homelessness/health/infectious-diseases
- 42. https://globalnews.ca/news/10403413/kelowna-encampment-cleanup-displaces-people-homelessness/ (Contaminated site)
- 43. https://search.app/E4R5TyGXgjeZS8rT9 (Needlestick in Community)
- 44. https://www.cdph.ca.gov/Programs/CID/DCDC/CDPH%20Document%20Library/lemmunization/2016-18CAOutbreakAssociatedDrugUseHomelessness.pdf
 (Hepatitis A)
- 45. https://www.google.com/search?q=Hepatitis+A+Outbreak+Associated+with+Drug+Use+and+Homelessness+in+California%2C+20162018+Final+update+as+of+April+11%2C+2018.&rlz=1C1CHBF_enCA807CA807&oq=Hepatitis+A+Outbreak+Associated+with+Drug+Use+and+Homelessness+in+California%2C+20162018+Final+update+as+of+April+11%2C+2018.+&gs_lcrp=EgZjaHJvbWUyBggAEEUYOdIBCDU3ODJqMGo3qAllsAlB&sourceid=chrome&ie=UTF-8(Hepatitis A)
- 46. https://london.ctvnews.ca/mobile/homeless-man-dies-of-overdose-in-city-porta-potty-1.4941526?referrer=https://www.google.com/ (overdose death in porta-potty)
- 47. https://bc.ctvnews.ca/mobile/calls-for-more-checks-on-city-toilets-after-2-deaths-1.4909594?referrer=https://www.google.com/ (Deaths in porta-potty)
- **48.** https://atlantic.ctvnews.ca/more/drug-paraphernalia-open-bathroom-use-at-encampment-worrying-for-dartmouth-n-s-residents-1.6953403

- 49. https://www.homelesshub.ca/blog/top-ten-health-issues-facing-homeless-people (Health issues Homeless Hub)
- 50. https://www.homelesshub.ca/about-homelessness/topics/mental-health Mental Health Homeless Hub)
- 51. https://ontario.cmha.ca/documents/housing-and-mental-health/ (Housing and Mental Health CMHA)
- 52. https://www.therecord.com/news/waterloo-region/youth-and-children-are-exposed-to-drugs-and-sex-trafficking-at-tent-cities-local-agencies/article_d7c26953-ea61-54d4-bf64-41bd3de69671.html
- 53. https://edmonton.citynews.ca/2024/06/14/man-charged-in-connection-to-sexual-assaults-at-encampments/
- 54. https://torontosun.com/news/local-news/levy-it-took-court-action-for-toronto-to-admit-

tentcitiesareproblematic?_gl=1*1jflomh*_ga*OTA1ODA2NDIzLjE3MTA3MjQwNDI.*_ga_72QH41ZTMR*MTcyMDQ4MjcxMi44LjAuMTcyMDQ4MjcxNC41OC4wLjA.*_gcl_au*MTI0NTUzMDY3OC4xNzE5OTI2MjUw*_ga_CNZCQVF8JD*MTcyMDQ4MjcxMi44LjAuMTcyMDQ4MjcxMi4wLjAuMA..&_ga=2.67181331.323584746.1720482712-905806423.1710724042 (Human Trafficking, Needles, Violence)

- 55. https://www.cbc.ca/news/canada/hamilton/encampment-assaults-1.6909809 (man stabbed at Hamilton Encampment)
- 56. https://www.thespec.com/news/hamilton-region/violence-has-erupted-in-and-around-hamilton-encampments-why-and-what-s-being-done-to/article_8683a3c0-2e2a-5e17-8126-652245f38058.html (Violence Hamilton Encampment)

- 57. https://globalnews.ca/news/10607361/crab-park-stabbing-spree-sentence/ (Stabbing spree BC encampment)
- 58. https://www.niagarafallsreview.ca/news/man-jailed-for-encampment-stabbing-in-niagara-falls/article-49d0e9c8-49f2-5631-aa6a-9feffb18d42a.html (encampment stabbing Niagara Falls)
- 59. https://www.cbc.ca/news/canada/london/londoners-air-frustrations-as-city-officials-reveal-plan-for-homeless-camps-1.7210755
- 60. https://london.ctvnews.ca/council-seeks-greater-distances-between-homeless-encampments-and-schools-homes-other-sensitive-sites-1.6932356
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This is **Exhibit "D"** referred to in the Affidavit of Sharon Koivu affirmed before me at the City of Hamilton, in the Province of Ontario, on July 26, 2024 in accordance with O. Reg. 431/20, Administering Oath or Declaration Remotely.

DocuSigned by:

Benin Shores

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

List of Affidavits Reviewed:

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

Court File No. CV-21-00077187-0000

KRISTEN HEEGSMA et al.

- and - CITY OF HAMILTON

Applicants

Respondent

ONTARIO SUPERIOR COURT OF JUSTICE

PROCEEDING COMMENCED AT HAMILTON

AFFIDAVIT

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Lawyers for the Respondent

File Number: H227899

COURT FILE NO. CV-21-77187 ONTARIO SUPERIOR COURT OF JUSTICE BETWEEN: KRISTEN HEEGSMA, DARRIN MARCHAND, GORD SMYTH, MARIO ${\tt MUSCATO, SHAWN\ ARNOLD,\ BRADLEY\ CALDWELL\ CHRISTINE\ DELOREY,}$ GLEN GNATUK, TAYLOR GOGO-HORNER, CASSANDRA JORDAN, JULIA LAUZON, AMMY LEWIS, ASHLEY MACDONALD, COREY MONAHAN, MISTY MARSHALL, SHERRI OGDEN, JAHMAL PIERRE, LINSLEY GREAVES and PATRICK WARD Applicants -AND-CITY OF HAMILTON Respondent

The Cross-Examination of Dr. Sharon Kolvu, on an Affidavit dated July 26, 2024, taken upon affirmation in the above action this, 6th of September, 2024, conducted via videoconference hosted by the offices of Nimigan Mihaillovich Reporting Inc.

APPEARANCES: For the Applicants: SUJIT CHOUDHRY Haki Chambers Global For the Hamilton Community Legal Clinic: SHARON CROWE CURTIS SELL For the Community Legal Clinic of York Region: MICHELLE SUTHERLAND NONYE OKENWA BENJAMIN HOGNESTAD For the City of Hamilton: BEVIN SHORES JOJO JOHNSON Gowling WLG (Canada) LLP

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GUIDE TO UNDERTAKINGS, ADVISEMENTS, and REFUSALS: This should be regarded as a guide and does not necessarily constitute a complete list: UNDERTAKINGS: (None noted). UNDER ADVISEMENTS: (None noted). REFUSALS: [1] 68/11.

--- Commencing at 9:35 a.m. take a moment. DR. SHARON KOIVU, 2 As I believe you've been asked, but I will THE WITNESS HEREINBEFORE NAMED. 3 ask you to confirm on the record, can you confirm you only 4 Having been duly sworn by me to testify to the truth, have your affidavit and exhibits in front of you? A. Yes. 5 testified on their oath as follows, to wit: Q. And you have no other -- sorry? CROSS-EXAMINATION BY MR. CHOUDHRY: 6 Q. Good morning, Dr. Koivu. As we discussed A. Yes. That's all I have. Now, I have on 8 off the record, I'm going to go through a number of the screen my affidavit, right, with us. I have a hard logistical issues that I think you've been given advance 9 copy of the affidavit, just my part, in case there was an 10 notice of. And this is sort of a standard spiel I use to Internet problem, but there's nothing else on it, and I 11 begin with all of my cross-examinations in this matter. wasn't going to refer to it unless we had some kind of So I will begin by introducing myself. My 12 problem with the internet. But I don't have anything else 13 name is Sujit Choudhry, and I am one of the lawyers for 13 14 the Applicants. Q. And, to be clear, Dr. Koivu, you're free to review to either the electronic copy of the affidavit or 15 As you know, I am cross-examining you on 15 16 your affidavit, which has been filed by the the written copy, whatever you want. 17 City of Hamilton in a court case regarding homeless A. Okay. I wasn't sure. Q. No. That's fine. The only thing you're 18 encampments. Your affidavit and this cross-examination 18 19 will be put into evidence before the Court and so it's not able to have are notes of any kind. And you can 20 therefore important to tell the truth and you affirmed 20 confirm that that's the case? 21 that you will do so. A. Yes, I can absolutely confirm that that is 22 If you would like me to repeat a question, 22 the case. please do so. If you would like a moment to collect your 23 23 5 Q. Okay. And also can you confirm that you 24 24 thoughts to answer a question, please take it. Although are alone? 25 we know your time is valuable, it's not a race, so please Yes. I'm in my house, and I kicked my

1	husband out, so I am very alone.	1	A. Yes.
2	6 Q. Okay. Good. Thank you. I appreciate it.	2	12 Q. Can you please explain what you understand
3	And so I understand you've been a witness on a virtual	3	your role to be in this proceeding?
4	cross-examination before; is that right?	4	My role is to give fair, unbiased,
5	A. Yes, that is correct.	5	nonpartisan opinion based on my experience and my
6	7 Q. So I'm not sure what the lawyers in the	6	knowledge of the situation. And it's particularly
7	other case did, but in this case, if I put materials to	7	pertaining to encampments versus shelter.
8	you that you don't have with you, or even if you do have	8	It's very important that what I say I
9	them with you, I will put them up on the screen for screen	9	answer truthfully and unbiased, with an unbiased
10	share with zoom.	10	perspective and will answer truthfully to your questions.
11	And please when I do, I don't know how big	11	And I made sure that that was mandatory for me to take
12	12 your screen is, so if you can't read it, tell me and I		this.
13	will enlarge it.	13	I will just say that when I was asked to be
14	A. Okay.	14	a witness, I realize now that that is also obviously part
15	8 Q. If you want me to scroll up and down the	15	of being a witness, but it is very important to me that I
16	document, I can.	16	give you a fair, unbiased and answer honestly to all of
17	A. Okay.	17	the questions.
18	9 Q. And if you need time to review it, I will	18	And everything that I do is based on that.
19	proactively offer you time, and if you need more time,	19	13 Q. Okay. Good. Thank you.
20	just tell me. Okay? Great.	20	And so I'd like to take you to you
21	A. Mm-hmm.	21	Exhibit A of your affidavit. So I'm going to use the
22	10 Q. So let's begin. So you have you are a	22	screen share function now. So if you will give me a
23	witness in this hearing; correct?	23	second, please.
24	A. Yes.	24	A. Absolutely.
25	11 Q. In this matter?	25	14 Q. Can you read the document on the screen?

I'm going to increase it a bit. Can you see that? Q. And can you confirm that this is your 2 curriculum vitae? A. One second. Let me see if I can increase 3 my screen somehow with the view options. A. Yes. 4 MS SHORES: So, counsel, what I see on your Q. So I'd like to just go through -- I'm going screen is Dr. Koivu's affidavit, but not Exhibit A. to enlarge this a bit. Can you read that? 5 MR. CHOUDHRY: Yeah, I'm not there yet, but A. Yes. 6 7 I just want to just make sure that she can see the Q. So I'd like to go through your clinical appointments, if I could. 8 affidavit, and then I will take her to Exhibit A. 9 Can you see this, Dr. Koivu? A. Okay. 10 THE WITNESS: I can see it, but I can't 10 Q. Okay. So it says that -- here that your 11 first clinical appointment was in -- was as the read it, and for some reason you are really small on my 12 screen, and I'm trying to make you bigger. Medical Officer of Health in Elgin St. Thomas; is that 13 MR. CHOUDHRY: Can we just go off the 13 right. I am just highlighting it here. 14 A. I was working in St. Thomas Elgin record for a second? -- OFF THE RECORD --15 15 General Hospital prior to that, so from 1985 to 2002 I 16 BY MR. CHOUDHRY: also had privileges at St. Thomas Elgin General Hospital and worked at St. Thomas Elgin General Hospital. 17 Q. So, Dr. Koivu, do you see on your screen 22 Q. Well, let's get into that, because I don't 18 vour affidavit? A. Yes, I do. 19 see that on your CV, so we just want to make sure we have 20 Q. Okay. So, Dr. Koivu, I'm just going to use 20 your complete background. In that --MS SHORES: I think it is under "other 21 the table of contents here and take you to Exhibit A, 22 22 which is your curriculum vitae. positions," counsel. 23 23 THE WITNESS: It might be under "other Q. Do you see this document? 24 24 17 positions." 25 A. Yes.

1	BY MR. CHOUDHRY:	1	A. Yes, that is correct.	
2	23 Q. I see. Back here. Down here. Sorry. So	2	27 Q. Am I correct in assuming that in 2008 you	
3	these are the other positions you are referring to?	3	moved to London Ontario to take up this position?	
4	A. Yes.	4	A. No.	
5	24 Q. So you were a family practice physician	5	28 Q. Okay.	
6	A. Yes.	6	I didn't move. I was commuting at that	
7	25 Q from 1985 to 2002. And that was at	7	time.	
8	it doesn't indicate here that that is at	8	29 Q. I see. Okay. And did you move to London	
9	St. Elgin Hospital, as you described it.	9	at some point?	
10	Is that where you were?	10	A. Yes, I moved to London in 2013.	
11	My family practice was private, but during	11	30 Q. Okay. And so it says here on your CV that	
12	that time I had privileges at St. Thomas Elgin	12	you were from 2008 to 2021 you were a palliative care	
13	General Hospital, and I continue to have privileges at	13	physician consultant at the London Health Sciences Centre;	
14	4 St. Thomas Elgin General Hospital.		is that correct?	
15	Working in an independent family practice,	15	A. Yes, that is correct.	
16	I didn't think of it as a clinical appointment, but all of	16	31 Q. Are you no longer a palliative care	
17	us at the time had privileges at the hospital. We ran the	17	physician consultant at the London Health Sciences Centre?	
18	emergency department. I did all my own OB. It was a	18	A. That is correct. I am no longer a	
19	completely comprehensive family practice.		physician consultant at London Health Sciences Centre.	
20	So in the statement of a family practice,		And actually, if you keep going, I am now not working as	
21	it included a comprehensive family practice, which	21	of this June, which is after well, July, after this was	
22	included working at St. Thomas Elgin General Hospital.	22	written, I am no longer working at	
23	26 Q. Okay. So in 2008, you began working at the	23	London Health Sciences Centre.	
24	London Health Sciences Centre; correct? The London Health	24	I have I did not renew my privileges to	
25	Sciences Centre?	25	work at London Health Sciences Centre, and I am working	
25	Sciences Centre?	25	work at London Health Sciences Centre, and I am working	

exclusively in St. Thomas at this time. General Hospital. Is that still the case? 2 Q. I see. Okay. So let's just get some A. Yes. That is still the case. 3 updates to this, if we could, because that's important for 37 Q. So just to summarize here, is it fair to me to understand. say that your addition medicine practice as a consultant is now based at St. Thomas Elgin General Hospital? So it states on your -- so it states here That is fair to say, yes. on this CV, which was attached to your affidavit sworn in 6 July of 2024, that you are at present, as of the time of Q. Okay. And are you able to explain why you left London Health Sciences Centre -- or pardon me, why 8 swearing this affidavit, an addiction medicine consultant 9 at the London Health Sciences Centre. you did not renew your privileges at the 10 That information is out of date? London Health Sciences Centre? A. That information is out of date. I am very A. I would say it is multifactorial. One is 12 sorry about that. that I now live in Port Stanley. I wanted to spend more 13 Q. That's fine. It happens. So just so we time with my family, particularly with my mother, who was 14 can get on the record, so you were an addiction medicine needing help. 15 consultant at the London Health Sciences Centre until what 15 I also wanted to be able to speak freely on 16 16 issues that I felt were important, and I felt that it was A. Until June 30th. very important to me that I have that freedom within Q. Of 2024? St. Thomas. And in London, there was a request for me to 18 19 2024. Yes. That's right. speak through the Public Relations Committee. 20 And so are you able then -- and so do you I felt that overall there were many reasons for leaving. I loved my position. I loved my job. I 21 currently have privileges at the 22 London Health Sciences Centre? 22 loved the team that I was working with, but felt that at 23 this present time in my age and practice, I wanted to Q. It states in the CV that you are an 24 focus my practice in St. Thomas, which has a very 25 addiction medicine consultant at St. Thomas Elgin different approach to addiction.

16

I would like to be able to expand my 41 0 And when you say "questions that came up," practice in St. Thomas and felt that this was really where questions posed by whom? I wanted to put my energy at this time. A. Questions that could be posed by 3 4 Q. So, Dr. Koivu, you used the phrase issues particularly -- I'm going to say particularly if the media that were important to you; is that correct? asked me questions, I wanted to feel free to respond, but Yes. not limited to that. 6 A. Can you please explain what you mean by Q. There can be -- even something such as issues that were important -- that are important to you? being able to freely express myself in any forum, in A. I think that issues that are important to medical forums. I just felt very supported in St. Thomas 10 me include things around problems that I'm seeing related 10 and felt that I didn't feel comfortable running -- I 11 to diverted drugs, being able to respond about things such didn't feel comfortable running through the Public 12 as supervised injection sites, which I do support. Relations Committee in London Health Sciences Centre to be 13 There are many issues in addiction that -having approval of things I say when a board member on the safe supply is one of them, but not limited, that I felt London Health Sciences Centre who, by virtue of being the 14 15 that I really wanted to be able to respond to questions chief of nursing, is also on the board of London Intercommunity Health, and I felt that there was a 16 about them if they came up and felt very supported by my colleagues, but also recognize that in conflict of interest there that could affect my ability to 17 London Health Sciences Centre, those things need to be run speak freely. 18 19 by PR. 19 42 Q. Okav. 20 It was one of many factors that made me A. Not my conflict of interest, but the board 21 make the decision that a good place for me to be working -- the London Health Sciences Centre. Q. Okay. Thank you for that. We will come 43 22 is in St. Thomas, which has had a very different approach 23 to homelessness. It's had a different approach to people back to that in a moment. 24 suffering with opioid use disorder. And this to me was an So I want to just focus in a bit on the important fit for me. time that you were at London Health Sciences Centre where

Q. Exclusively, okay. you were both a palliative care physician consultant and 46 2 an addiction medicine consultant. And if I understand And so, again, I would like to come back to correctly, that would have been from between 2012 and 2021 that. And so just to be clear, I don't see on your CV any 3 where you practiced in both areas; is that right? practice experience in the City of Hamilton; is that A. Yes. right? 5 A. I have not done medical practice in the Q. And during that time, what percentage of 6 7 your practice would you say was devoted to palliative care City of Hamilton, that is right. 47 Q. Okay. Thank you. 8 and what percentage was devoted to addiction medicine? 9 A. At the beginning of that time period, more So I would like to scroll down to your 10 of my practice was devoted to palliative care. It was presentations, if I could. And I'm sorry if this gives actually in palliative care that I became interested in you a bit of nausea. Sometimes it does. 11 A. Yes, vertigo. 12 addiction. 12 Q. Yeah. Okay. Sorry. So do you see the 13 I started seeing people who were dying from 13 14 title "Presentations" here? infectious complications of injection drug use and 15 recognized that we had a -- in spite of being a tertiary 15 A. Yes. 16 care centre, there was very limited addiction support at 16 49 Q. Okay. And I see that the last presentation -- or the most recent presentation on this 17 18 So initially, my involvement was highly list is the 24th of May, 2018? A. Well, that's for an invited lecture as a 19 palliative care, and over time, it became almost 20 exclusively addiction until it was exclusively addiction. 20 keynote speaker. That's very different from 45 Q. Okay. We will come back to that as well. presentations. 21 50 22 And then -- so in your role as an addiction medicine 22 Q. Oh, so you've given other presentations 23 23 consultant at London Health Sciences, is it fair to say since then? A. I think if you keep scrolling down, you 24 24 that your practice was an in-patient practice? A. Exclusively. 25 will see them.

	51 Q. I didn't see them.		MORIODEO VIV. OF COMMISSION
1		1	MS SHORES: Yes. Of course.
2	A. Oh, okay.	2	UNDERTAKING
3	52 Q. Well, if you can direct me to it, I would	3	MR. CHOUDHRY: Thank you.
4	be happy to take you there. And you are free	4	BY MR. CHOUDHRY:
5	Dr. Koivu, you are free to refer to your CV, because it is	5	57 Q. So, Dr. Koivu, I want to ask you about a
6	an exhibit to your affidavit.	6	presentation that you gave recently to the House of
7	I am just scrolling through here as well.	7	Commons Standing Committee on Health on May 6, 2024.
8	I see media appearances. I see symposia. Is this what	8	Do you remember that?
9	you are referring to? And workshops? This is on the last	9	A. Yes, I do.
10	page of your Exhibit A.	10	58 Q. And so, Dr. Koivu, I'm going to put up on
11	A. Can you go back to the top of where that	11	this screen and we will mark this as Exhibit 1 to the
12	is, "invited lecture"?	12	cross-examination. This is the Standing Committee
13	53 Q. Sure. I'm just going to scroll up. You	13	these are the minutes of the Standing Committee of Health
14	4 tell me when I'm going to take you where I think you		of May 6, 2024.
15	are referring to, and you can tell me if that is right.	15	MS SHORES: So let me just interject with
16	A. I have given talks since 2017 or '18.	16	the respect to the marking of exhibits. We will mark this
17	54 Q. Oh, you have?	17	for identification, and you can put the question to
18	A. Yes, I have.	18	Dr. Koivu to authenticate the document if she is able to
19	55 Q. So this CV is not up-to-date?	19	do so.
20	A. Yes, I am missing talks that I have given.	20	EXHIBIT NO. 1: Minutes of the Meeting of the Standing
21	I have given presentations since that time.	21	Committee of Health dated May 6, 2024.
22	56 Q. Okay. So it would be helpful so,	22	BY MR. CHOUDHRY:
23	counsel, we would like an undertaking to provide	23	59 Q. Sure. So, Dr. Koivu did you testify before
24	Dr. Koivu's updated CV that contains any missing	24	the Standing Committee of Health of the House of Commons
25	information.	25	on May 6, 2024?

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1		A.	Yes, I did.	1	that you gave? (Or do you	recall it?
2	60	Q.	Have you ever seen these minutes?	2		A.	Okay. Everything on the screen I can see.
3		A.	No, I haven't.	3	66	Q.	Okay. I'm going to scroll to the next
4	61	Q.	You haven't. Okay. So, Dr. Koivu, these	4	can you go to the	next pa	ge?
5	are on the House	e of Com	mons website, and they are official	5		A.	Yes.
6	minutes of the H	louse of (Commons Committee of Standing	6	67	Q.	Okay. So I've got the top half of the
7	Health, and they	include	your remarks and questions and	7	page, and when	you are r	eady, I can move down.
8	answers.			8		A.	[Reading].
9			And so because you haven't seen these, I'd	9	68	Q.	Okay. Can I scroll down?
10	like to give you a	minute t	to refresh your memory of what	10		A.	Yes.
11	you might have said. And so I'm going to enlarge this			11			This is not me.
12	here. Can you read that?			12	69	Q.	No, it's not. So to the bottom of the
13		A.	Yes.	13	left-hand column	is you. /	And then I'm going to move up,
14	62	Q.	Right. I'm sorry. I can't	14	if I could, Dr. Koi	vu. You	continue your remarks. So
15		A.	It's now too big, actually.	15	what's reported t	o be you	remarks are here up to this
16	63	Q.	It is? Okay. So, fine. So tell me	16	point on the right	-hand co	lumn.
17	tell me when h	now is tha	at?	17		A.	[Reading].
18		A.	I think yes, that's fine.	18			Okay.
19	64	Q.	Okay. So it begins here:	19	70	Q.	Okay. Have you reviewed your remarks as
20			"Dr. Sharon Koivu, addiction physician	20	reported?		
21			as an individual."	21		A.	Yes, I have. And
22			Correct?	22	71	Q.	I'm sorry. And
23		A.	Yes.	23		A.	Yes, I have. I'm moving out, because
24	65	Q.	Okay. So, Dr. Koivu, would you like a	24	I'm sorry. Okay.	Yeah, I	believe I have reviewed my
25	minute to just re	fresh you	r memory about this testimony	25	remarks.		

minutes are these minutes accurate? A To the best of my recollection. A To the best of my recollection. A To the best of my recollection. A Yes. Statement here that I'm going to highlight. And for the record, it reports you as having said: Thave decided to speak out to bring a voice to the horrific suffering I have witnessed from safe supply.* Do you recall making that statement? A Yes. 2 came to testify before the Standing Committee of Health. Were you issued an invitation A Yes. 78 Q by anyone to testify? Sorry. 6 A I believe so, yes. 79 Q. And, Dr. Koivu, I'm sorry. I know you want to answer, and it's we're in a conversation. 9 A Sorry. 10 80 Q. No, it's fine. I actually do it too much myself. But if you can just wait until I'm finished, and 11 myself. But if you can just wait until I'm finished, and 12 A Yes. 13 it helps the court reporter get the transcript down. So I	ĺ		
4 73 Q. Okay. And so I want to take you to one 5 statement here that I'm going to highlight. And for the 5 78 Q by anyone to testify? Sorry. 6 record, it reports you as having said: 6 A. I believe so, yes. 7 79 Q. And, Dr. Koivu, I'm sorry. I know you want 8 bring a voice to the horrific 8 to answer, and it's we're in a conversation. 9 A. Sorry. 10 supply.* 10 80 Q. No, it's fine. I actually do it too much 11 Do you recall making that statement? 11 myself. But if you can just wait until I'm finished, and 12 A. Yes. 13 74 Q. I want to ask you a question about the term 13 it helps the court reporter get the transcript down. So I	came to testify before the Standing Committee of Health.		
statement here that I'm going to highlight. And for the record, it reports you as having said: 6 A I believe so, yes. 7 Page Q. And, Dr. Koivu, I'm sorry. I know you want bring a voice to the horrific 8 to answer, and it's we're in a conversation. 9 Suffering I have witnessed from safe 9 A. Sorry. 10 Supply.* 10 Bo Q. No, it's fine. I actually do it too much 11 Do you recall making that statement? 11 myself. But if you can just wait until I'm finished, and 12 A. Yes. 13 The same for you. And if I don't, I'm sorry. But 14 I'm sorry. But 15 It helps the court reporter get the transcript down. So I			
record, it reports you as having said: 7			
7 79 Q. And, Dr. Kolvu, I'm sorry. I know you want 8 bring a voice to the horrific 8 to answer, and it's we're in a conversation. 9 suffering I have witnessed from safe 9 A. Sorry. 10 supply." 10 80 Q. No, it's fine. I actually do it too much 11 Do you recall making that statement? 11 myself. But if you can just wait until I'm finished, and 12 A. Yes. 12 if I do the same for you. And if I don't, I'm sorry. But 13 74 Q. I want to ask you a question about the term 13 it helps the court reporter get the transcript down. So I			
bring a voice to the horrific guffering I have witnessed from safe guffering I have witnessed from safe guply.* 10 80 Q. No, it's fine. I actually do it too much myself. But if you can just wait until I'm finished, and 11 A. Yes. 12 if I do the same for you. And if I don't, I'm sorry. But 13 74 Q. I want to ask you a question about the term 13 it helps the court reporter get the transcript down. So I			
9 suffering I have witnessed from safe 9 A. Sorry. 10 supply." 10 80 Q. No, it's fine. I actually do it too much 11 Do you recall making that statement? 11 myself. But if you can just wait until I'm finished, and 12 A. Yes. 12 if I do the same for you. And if I don't, I'm sorry. But 13 74 Q. I want to ask you a question about the term 13 it helps the court reporter get the transcript down. So I			
supply." 10 80 Q. No, it's fine. I actually do it too much 11 myself. But if you can just wait until I'm finished, and 12 A. Yes. 13 74 Q. I want to ask you a question about the term 14 supply." 15 80 Q. No, it's fine. I actually do it too much 16 myself. But if you can just wait until I'm finished, and 17 if I do the same for you. And if I don't, I'm sorry. But 18 it helps the court reporter get the transcript down. So I			
11 Do you recall making that statement? 11 myself. But if you can just wait until I'm finished, and 12 A. Yes. 13 74 Q. I want to ask you a question about the term 13 it helps the court reporter get the transcript down. So I			
12 A. Yes. 12 if I do the same for you. And if I don't, I'm sorry. But 13 74 Q. I want to ask you a question about the term 13 it helps the court reporter get the transcript down. So I			
13 74 Q. I want to ask you a question about the term 13 it helps the court reporter get the transcript down. So I			
14 that you used here, "speak out." When you used the term 14 will pose the question again.	will pose the question again.		
15 "speak out" here, do you do mean speak out directly to 15 Were you invited to testify before the			
parliamentarians about safe supply? 16 Standing Committee on Health?	Standing Committee on Health?		
17 A. In the term I'm using here, yes. 17 A. I'm trying to get the I mean, I want to			
18 75 Q. Okay. In the term you are using here. Do			
19 you mean you use the term "speak out" elsewhere as well? 19 requested to speak to the Committee, and then they invited			
20 A. No. I don't believe that that is elsewhere 20 me.			
21 in this document. 21 81 Q. I see. So do you remember when you			
22 76 Q. Okay. And do you believe by speaking out 22 contacted the Committee?			
here, do you mean speaking out on the public record about 23 A. It was definitely before I think it was			
24 safe supply? 24 last oh, gosh. I'd have to look back. I think it was			
25 A. Yes. That would be accurate. 25 early on it feels like, I'm going to say, even December			

of last year that I contacted the Committee. 2 Q. So you contacted the Committee in That's fine. A. December of 2023? 86 3 0 And so these are academic publications; A. I think so. I'm not -- to be honest, I'm not sure of that. I'm not sure of the accuracy of that. 5 That is correct. A. 87 6 I know I contacted the Committee at a time when you were Q. So you haven't listed on your CV any able to contact the Committee, and I don't remember newspaper publications that you have; correct? 8 A. I don't consider those -- I don't consider exactly when that was. 83 Q. And can you explain why you contacted the those my publications at all. 9 10 Committee to offer to testify? 10 A. I think my understanding of this committee 11 A. And they aren't in the sense of basically 12 was that it was going to be reviewing safe supply and that 12 when you are talking to the press, they don't -- they 13 it was -- my understanding was that it was a health 13 print things sometimes limited, sometimes out of context. 14 committee and that it was going to be reviewing safe I wouldn't refer to things in the press as publications, 15 supply and it was going to be looking at the risks and 15 and certainly they are not medical publications. 16 benefits of safe supply, and I felt that I had important 16 Q. Okay. Well, let me take you to an article in the National Post. And so this is an article that we 17 information to contribute. Q. Okay. Thank you. 18 will mark for identification purposes as Exhibit 2. And 19 So, Dr. Koivu, I'd like to refer you back it's dated -- do you see at on your screen? 20 to your CV, if I could. So I'm going to go back. And 20 -- EXHIBIT NO. 2: National Post Article, Dr. Sharon 21 there are a number of publications listed, which I will Koivu, special to the National Post, dated 22 take you to in a moment. 22 June 10th, 2024. 23 23 THE WITNESS: Yes, I do. Do you see that on your screen? A. Yes. 24 BY MR. CHOUDHRY: 24 Q. And it says: 25 85 Q. Is it too large or too small, or is it 25 90

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1		"Dr. Sharon Koivu, special to the	1	96	Q.	Well, let's just look at what has been
2	National Post."			printed here. And	printed here. And I'd like you to indicate if this is, in	
3		Do you see that?	3	fact, what you wro	act, what you wrote.	
4	A.	Yes.	4			So I think we will give you time to read
5	91 Q.	Did you write this article?	5	this again. So I'm	n starting	here on page 2. So tell me
6	A.	Let me see what the article is. I have	6	when you have fir	nished re	ading this.
7	written one op-ed in my li	ife, and I wrote it to the	7		A.	[Reading].
8	National Post, so I'm ass	uming that's what this is.	8			Okay.
9	92 Q.	Sure. We can take a minute to have you go	9	97	Q.	Okay. And this I will go to page 3.
10	through it. And so for the	e record, do you see that it	10		A.	Okay.
11	states here that it's publis	shed on June 10th, 2024?	11	98	Q.	And I'm going to scroll down to page 4.
12	A.	Yes.	12		A.	[Reading].
13	93 Q.	And the title of this article is:	13			Yes.
14		"Dr. Sharon Koivu: 'Safe supply'	14	99	Q.	And I'm going to scroll down again. Sorry
15		Has Only Worsened The Addiction Crisis	15	This begins at the	e this is	s how this was printed.
16		In London Ontario."	16		A.	[Reading].
17		Correct?	17			Okay. We can move on.
18	Α.	That's what it states. That is not the	18	100	Q.	Sure. This is the next tranche of text.
19	title I wrote. That is the t	itle that the editor wrote.	19		A.	[Reading].
20	94 Q.	I see. What was the title that you wrote?	20			Okay.
21	A.	I don't remember, to be honest, but that is	21	101	Q.	Okay. And I'm going to continue until we
22	not the title that I wrote.		22	finish. I'm sorry it	comes i	n dribs and drabs like this.
23	95 Q.	Okay.	23		A.	[Reading].
24	A.	As I say, things that go in a paper are	24			Okay.
25	edited.		25	102	Q.	Okay. And then this is where the article

put to you about this article. The first is on page 2. 2 And it's this paragraph that I've highlighted just to aid A. [Reading]. you a bit. And I want to ask you a question about the 3 Yes. Okay. Q. Now, Dr. Koivu, you've now refreshed your last sentence. And it says: 5 memory. These are just kind of comments and garbage that "I feel compelled to speak out about it printed off. So that's the end of the article. Okay? the harm safe supply is causing in my 6 A. Okay. community." 8 Q. So, Dr. Koivu, I will now ask you this Did you write those words? 9 question again. Do you recognize this article? Yes, I did. 10 10 Q. Can you please -- in this context, by Q. Did write the words in this article? "speaking out" did you mean speaking out publicly? A. Yes, it does. 12 12 Yes, I did. Q. And was it your hope in writing these words 13 106 Q. And you stand by what you said in this 13 14 or making a submission to the National Post that your article? 15 A. I think there was some editing, but I do 15 views would be read by members of the public? 16 stand by this article. A. Yes. 17 Did you approve the publication of this Q. I would now like to take you to page 7. 18 article? And, again, I'd like to take you to just the final 19 paragraph in your op-ed. 20 So I want to ask you -- and you didn't And I want to ask you a question about this object to its publication after the edit? 21 sentence here. And it states, for the record: 22 22 A. No. I did not. "To prevent further harm, a 23 No, you did not; is that correct? 23 moratorium on funding and expansion of 24 24 I did not object. 'safe supply' programs must be put in 25 110 Okay. So I have two questions I want to

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1			Did you write those words?	1	July 8, 2024.		
2		A.	Yes.	2			Dr. Koivu, have you read this article
3	114	Q.	Is it your understanding that the	3	before?		
4	provincial govern	ment fu	nds safe supply program?	4		A.	No.
5		A.	Oh, goodness, no. It's a federally funded	5	118	Q.	You haven't. Do you recall being
6	program.			6	interviewed by M	lr. Hunt?	
7	115	Q.	Federally funded. And so were you	7		A.	Yes, I do.
8	advocating that t	he fede	al government impose a moratorium	8	119	Q.	Do you happen to recall when you were
9	on funding and e	xpansio	n of safe supply programs?	9	interviewed by hi	im?	
10		A.	Yes.	10		A.	I would say likely in June of 2024.
11	116	Q.	Thank you. Okay. So, Dr. Koivu, with the	11	120	Q.	Okay. So, Dr. Koivu, because you haven't
12	2 caveat you've just given that you can be at times			12	read this, I'm happy to kind of let you read the article		
13	3 misquoted in the press, I'd like to put to you other			13	again before I ask you questions about it, if you would		
14	instances of speaking out, to use your words, just to kind			14	like. Would you prefer that I do so? But I have some		
15	of have you conf	irm whe	ther, in fact, what you are quoted	15	very specific questions. It's really your choice.		
16	as having said is	accura	e or not.	16		A.	I guess
17			So I'm now going to take you to an article	17			MS SHORES: I think she should be given the
18	that we will mark	for ider	tification purposes as	18	opportunity to rea	ad the ar	ticle, counsel.
19	Exhibit 3.			19			BY MR. CHOUDHRY:
20	EXHIBIT NO. :	3: Cana	dian Affairs Article dated	20	121	Q.	Of course. Absolutely. And that's why I
21	July 8, 2024.			21	offered.		
22			BY MR. CHOUDHRY:	22			So, Dr. Koivu, I'm going to begin. We are
23	117	Q.	It's an article that is entitled that	23	going to have to	scroll thr	ough this again. So you can
24	appears in a pub	lication	called Canadian Affairs. And	24	see, this is page	1. So ju	st tell me when you have
25	it's an article writ	ten by N	fr. Liam Hunt, and it is dated	25	finished reading	the head	ine and subtitle and then I can

take you through it. a passage that begins -- two paragraphs, one that's at the 2 A. Okay. bottom of page 4. 3 122 0 Okav? A. Yes Yeah. Q. And one that runs from page 4 to page 5. Q. 5 123 Okay. So I'm just going to go here. And So I just want to put those to you and ask you some 6 tell me when you finish this screen, and I will continue questions about them. to scroll down. So the author attributes the following view 8 to you. The author states: [Reading]. A. 9 Yes. "Koivu considers herself a 10 10 lifelong progressive and has Keep going. 11 Okay. historically supported the 12 A. Okav. 12 New Democratic Party." 13 125 Q. Okay. I will stop here. 13 Is that a fair characterization of your 14 A. [Reading]. views? 15 Okay. 15 Well, I am going to say yes, historically, 16 126 O Okay. I have supported the New Democratic Party and that I have 17 [Reading]. felt that -- I think that is accurate. Q. Did you state that? Do you recall stating 18 Okav. 131 19 127 Q. Okay. And then you go there. 19 that to the author? 20 [Reading]. 20 I'm sure that's a paraphrase, but I grew A. 21 up -- my dad ran for the NDP in 1974. I knew Okay. 22 128 0 Okay. And then we will go to the end. 22 Tommy Douglas, David Lewis, Ed Broadbent. So yes, I have 23 [Reading]. traditionally been involved in what would be referred to as left-wing and particularly in the NDP. 24 Okay. Q. The author states then: 25 129 0 Okay. So, Dr. Koivu, I want to take you to

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"But she is concerned many left Do you recall making that statement to the leaning politicians have ignored criticism 3 of safer supply." Yes. A. 4 Did you express that view to the author of 135 Q. I'd like to now take you to another 5 this article? newspaper article that attributes quotes to you, and I 6 Yes. That would be consistent with what I want to confirm whether they are accurate or not. So this is an article from the Toronto Sun. expressed. Q. Then there is a quote that is attributed to for the record. We will mark it for identification 9 you in the next paragraph. The quote begins: purposes as Exhibit 4. -- EXHIBIT NO. 4: Toronto Sun Article, August 18, 2023. 10 "I went to a hearing in Ottawa 10 11 of a standing committee to talk about BY MR. CHOUDHRY: 12 Q. And the title here is: addiction,' she said." 12 136 13 13 Do you recall stating that to the author? "LILLEY: Addictions specialist calls 14 I would have said that it was -- that I on Ford to clean house at SRCHC." 15 went to the hearing in Ottawa to discuss safe supply, but, And it's dated -- it states here that it is 16 you know, meaning that I might have -- to be honest, 16 published on August 18, 2023. 17 that's consistent with what I may have said. Dr. Koivu, for the record, have you ever 18 Q. And then the author continues to quote you. 18 read this article? 19 19 Quote: A. No. 20 "We had five minutes to give a talk 20 BY MR. CHOUDHRY: 21 and then two hours to answer questions." 137 You have not? Q. And then there's the author's words: 22 22 A. No 23 "But I didn't receive any 138 Q. So, Dr. Koivu, because you haven't, I think 24 questions from the NDP or from the it's only fair to let you read it before I ask you questions about it. I'm sorry. This will take time. liberals." 25

So, Dr. Koivu, I'm going to begin -- we tell, this is just stuff that turned up on the PDF 2 will follow the same procedure. I'll put what I can on afterwards. 3 the screen, let you read it, and when you are done, we A. Okav. will move on to the next set of text. 145 Q. So now, I want to ask you some questions 5 So this is the beginning of the article. about this article, if I could. Can you read it? Is that too big or is that fine? Do you recall -- as I've stated before, the 6 A. That's fine. author of this article is a Mr. Brian Lilley. 8 Q. Yes. Okay. A. 9 [Reading]. Q. Do you recall being interviewed by A. 146 10 Okay. 10 Mr. Lilley? 11 Q. Okay. Yes, I do. A. 12 A. Keep going. 12 147 Q. Do you happen to recall when you were 13 141 Q. Okay. 13 interviewed by Mr. Lilley? 14 A. [Reading]. A. In 2023, shortly after the shooting that 15 Okay, okay. 15 led to the death of the woman in front of the South 16 142 0 Okay. Riverdale. So I think August would likely be accurate, [Reading]. August of 2023. Q. Okay. Thank you. So I'd like to take you 18 148 Okav. 19 Q. Okay. Okay. And this is the end. And I to a couple of statements that are attributed to you, or 20 will show you the rest of it is just material that turns views that are attributed to you. The first one is here at the bottom of page 3. 21 up on PDFs. So why don't we finish here, and then I will 22 scroll through the rest of this so you can see the rest of 22 A. 23 the page or the document. 23 Q. Mr. Lilley attributes the following view to 24 24 Okay. you: 25 144 Q. And so then, Dr. Koivu, as far as I can "Specifically, Dr. Koivu takes

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issue with the Centre's of philosophy This statement is accurate. It's somewhat 2 published on the SRCHC website." out of context, but it's accurate. Did you take issue with the Centre's 152 Q. And so I'd like to -- yes, ma'am. Go 3 4 philosophy on its website in your interview with ahead. 5 A. Can I -- I mean, the part of the statement 6 that I have a problem with, and I said this, is A. Yes. 150 Q. I'd now like to take you to a quote that's specifically the no desire for people to stop using drugs. attributed -- first of all, a quote from the SRCHC. Just I support no judgement, no expectations -- I support no for context, it says: judgement absolutely, but no expectations and no desire 10 "It is a philosophy about being 10 for people to stop using drugs was the part of the 11 simply respectful of and to people who philosophy that I took issue with. That is not clear in 12 that statement. use drugs. No judgement, no 13 expectations, and no desire for people Q. Okay. Thank you for that clarification. 14 to stop using drugs." I'd like to now take you to another quote that is 15 And then there's a statement -- there's a attributed to you. And this is on page 5 of the document. quote attributed to you immediately after that which says For the record, it says, quote: 16 the following, quote: 17 "With this policy, South 18 "That is like a cancer doctor 18 Riverdale Community Health Centre is 19 19 refusing to offer a patient not working to improve lives, 20 chemotherapy because it might be 20 Dr. Koivu said." 21 uncomfortable, Dr. Koivu said." Let's stop with that. Do you recall making Do you recall making that statement to 22 22 that statement? 23 Mr. Lilley? No, I don't. But it's quoted, so I'm going 24 to say that I made the statement. I don't recall it Q. specifically, but it is a quote here. 25 151 And that statement is accurate?

I don't recall specifically, but it is 2 A. I do recall the next part, which is that quoted, so I'm going to say I made that statement. 3 159 Q. Okay. And then I would like to take you to they are promoting dependency on a service that should be meant to help them, that no expectation and no desire to the next quote. stop using drugs, my concern is that they were promoting a "Unfortunately, once people have drunk 5 the Kool-Aid and think this is a good 6 dependency on the service and not facilitating patients to access recovery and treatment programming, as is indicated thing, it's hard to have the same workers 8 in supervised injection sites. recognizing the importance and value of 155 9 Q. Okay. And so, Dr. Koivu, before making facilitating a journey to recovery." 10 this statement, or since then, have you visited the 10 Do you recall making that statement? South Riverdale Community Health Centre? 11 A. No. 12 12 160 Q. And then finally, I would like to take you 13 Q. No. Have you met with the physicians who 13 to -- I would like to just ask you a question. So you've 14 are on staff at that centre? said that you haven't -- you had not visited the SRCHC 15 A. No. prior to giving this interview and making these 16 157 Q. Have you met with any patients who have -statements; correct? 17 or any individuals who have -- who are clients of that A. That is correct. 18 centre? 18 161 Q. And you have and done so since then: 19 A. No. 19 correct? 20 Q. So I'd like to continue then to these 20 A. No, I haven't. 21 quotes that are attributed to you. And these are on Q. And you haven't made an academic study of 162 22 page 7. The first quote is: 22 the work at the SRCHC, have you? 23 23 "There has to be a complete A. No, I haven't. 24 change in leadership, Dr. Koivu said." Q. Okay. So one more media quote here, 163 25 Do you recall making that statement? Dr. Koivu, and then we will get back to your affidavit.

1	And I should also tell you at some point, if you need to			1			a national political debate over
2	take a health break or get a glass of water or so forth,			2			opioid program said she had no
3	just we are about to be at a natural time where you			3			intention of becoming a talking point
4	could if you wan	t to, but i	t's really up to you. I'm	4			for the federal Conservative party."
5	happy to continu	ue as wel	l.	5			The author of this article is a Mr
6		A.	You can continue right now.	6	pardon me is Ra	andy Ric	chmond. Do you recall being
7	164	Q.	Okay. But let us know if that changes.	7	interviewed for this	s article	?
8	Okay?			8		A.	Yes, I do.
9		A.	Yeah. Thank you.	9	168	Q.	Have you read this article before?
10	165	Q.	So, Dr. Koivu, this last article is in the	10		A.	No, I haven't.
11	London Free Press. And I'm sorry that it's not can you			11	169	Q.	Okay. So we are going to follow the same
12	read that?			12	procedure.		
13		A.	Yes, I can.	13			I'd like to take you through the article so
14	166	Q.	It's an article in the London Free Press	14	you can read it be	fore I as	sk you some questions about it.
15	that we will mark	k as Exhi	bit 5 for the purposes of	15	So can you confirm that you have read this page?		
16	identification.			16		A.	Yes, I have.
17	EXHIBIT NO.	5: Lond	on Free Press Article, Harms of	17	170	Q.	Okay. I'm going to scroll down now. Okay.
18	safe drug supply	progran	ns outweigh benefits: Addiction	18	And I'm very sorry	And I'm very sorry about the way that this has come	
19	specialist.			19	formatted. Can yo	ou read	that? The article begins here.
20			BY MR. CHOUDHRY:	20		A.	Yes.
21	167	Q.	The title is:	21	171	Q.	Okay. Can you read that?
22			"Harms of safe drug supply programs	22		A.	Yes.
23			outweigh benefits: Addictions specialist."	23	172	Q.	So let's tell me when you've finished
24			And then it states:	24	this screen, and I will continue to scroll down.		
25			"A London doctor at the centre of	25		A.	[Reading].

her message beyond them to party 2 173 Q. Okay. 3 Did you tell the journalist that you had [Reading]. approached local NDP and liberal MPs? Okay. 5 174 Well, actually it's -- the NDP is an MPP. Q. Okay. A. 6 Okay. Okay. 177 Q. Oh, I see. 7 175 Q. Okay. So I have a couple of questions NDP is liberal. So in the writing -- in 8 about the sentence that I have side-barred here in the the same writing that I did speak to the liberal MP and final page of this article. The first sentence states: the NDP MPP. And had I spoken to an NDP MP, it was 9 10 "Meanwhile, Koivu is calling for specifically in the writing of London. 11 a moratorium on funding until there's Q. So you approached the local NDP MPP and the 12 more public discussion of the 12 local MP? 13 13 Yes. That is correct. 14 That's a statement or a view that's 179 Q. And you approached them? 15 15 attributed to you. Do you recall making a statement like A. Yes. 16 that to the journalist? 16 180 Q. And then it says here: 17 A. Yes, I did state that there should be a "But can't get her message beyond them 18 to party leaders." 18 moratorium on funding safer supply -- or safe supply 19 19 Did you ask want -- did you ask them to 20 Q. The next sentence -- and I believe this is 20 convey your message to party leaders? a typo. It says "Koivus," but it should be "Koivu." But 21 A. I would say, yes. Certainly with speaking 21 22 22 with the liberal MP, I felt that it was very important for 23 23 the federal government to understand concerns that were "Koivus [sic] said she approached 24 24 local NDP and Liberal MPs, who happening in London. So yes, he had been initially very 25 consider her opinions, but can't get

1	And I have known both of those men for	1	Is that a question? I'm not sure.
2	quite a while and have had a very good relationship with	2	186 Q. No. I'm trying to characterize the body of
3	both of them and spoke to both of them about this. And	3	your research. I count here one so Article 1, then
4	yes, I was hoping that they would speak beyond the local	4	Article 4, Article 5, Article 6, Article 7, and then
5	level.	5	Articles 8, 9 8 and 9, and then Article 11 as all being
6	181 Q. Okay. Thank you. So, Dr. Koivu, I'd like	6	about the health effects of injecting drugs; is that fair?
7	to go back to your affidavit. And I'm on Exhibit A.	7	That would be more accurate than I think
8	Again, these are your publications. Do you recognize this	8	the first way you put it, so, yes.
9	publication list?	9	187 Q. Okay. And would you say that that is the
10	A. Yes, I do.	10	principal focus of your research?
11	182 Q. And so there I see here 11 publications.	11	That has been the principal focus of the
12	Is that list up-to-date?		research that I have been involved in.
13	A. I believe there are more. I think I have	13	188 Q. When you say you "have been involved in,"
14	about 14 publications, but I believe there are about 14		what do you mean by that?
15	publications at this time.	15	That I am involved in all of those studies,
16	183 Q. And those additional publications would be	16	so, yes, I have research is I am a clinician and do
17	on the CV that we will be getting from you soon?	17	research. And the research I have been involved in has
18	A. Sure.	18	which has been supported that doesn't sound right.
19	184 Q. Sure.	19	So, yeah. I guess the answer is, yes. The
20	A. I will put them on.	20	research I have done has been primarily around the
21	185 Q. Okay. And so, Dr. Koivu, I looked at the	21	complications of injection drug use.
22	list of publications, and it seems I want to put to you	22	189 Q. Okay. So, Dr. Koivu, I'd like to take you
23	that these publications are principally about drug use,	23	to your affidavit now. Excuse me. I'm going to scroll
24	about addiction and so forth. If you'd like, I can put	24	up. And you are free to have it in front of you, as I
25	specific article titles to you.	25	have said before.
!		,	

So I just want to take you to paragraph 5. is not a trick question. I'm just trying to understand 2 what the scale is of the patient population you have seen. And so this paragraph describes your work as an addiction Thousands of patients. 3 physician? Q. And just so I understand the logistics of 5 Q. And just to confirm, it states that you've how this works, because you are an inpatient addiction primarily been providing inpatient addiction medicine consultant, is it correct to say that patients are 6 consultations; correct? admitted to hospital by a different service, so by 8 general --A. Yes, correct. 9 Q. And then it says here: A. Yes. 10 "The patients that I see are 10 Q. Sorry. Go ahead. 11 admitted to hospital and have a A. Sorry. Yes. So, for example, they could be admitted by 12 substance use disorder." 12 197 Q. 13 Do you see that sentence? 13 14 Yes, I do. A. Yes. 15 Q. Okay. And so are you able to estimate how 15 198 Q. Or they could be admitted by psychiatry? 16 many patients you have seen as an inpatient addiction 16 17 consultant between St. Elgin General Hospital and Q. And then they are referred to the addiction 18 London Health Sciences Centre? consultant team? A. You mean altogether? 19 A. Well, originally referred to me, and then 20 Could you estimate over the course of --20 when we got a team, they were referred to a team. 21 200 Q. Okay. So they would be referred to you, or 22 A. It's a hard question if you're looking at 22 when you had colleagues, to you or your colleagues on the number of consults versus number of patients, because some 23 23 addiction consultant team; correct? A. Yes. 24 24 patients come in -- okay. Q. Could you give both figures, perhaps? This 25 201 Q. And your role, your treatment mandate is to

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1	treat those patients for their addiction issues?	1	A. No, I do not.		
2	My treatment mandate includes meeting the	2	206 Q. Okay. And so in your role as an inpatient		
3	patients where they are, helping to keep them out of	3	addiction specialist, what percentage of your patients		
4	withdrawal, helping to support them in hospital so that	4	would you estimate are unhoused or homeless?		
5	they can stay in hospital for the treatment that is	5	That has increased over time. Initially I		
6	required, and to help facilitate addiction treatment and	6	would say that the number was fairly small. I would say		
7	addiction recovery	7	that that number has risen to close to 40 per cent.		
8	202 Q. Sorry. Go ahead.	8	207 Q. Okay.		
9	I help facilitate addiction treatment and	9	A. In London, before I left London.		
10	recovery, therapy or I see people with multiple types of	10	208 Q. I see.		
11	addiction. So depending on the type of addiction, it is	11	In St. Thomas, it would be a different		
12	about trying to help, meeting the patients where they are,	12	number.		
13	helping them to be able to stay in hospital, and helping	13	209 Q. What would the number be?		
14	them to facilitate treatment, helping to coordinate with		In St. Thomas it is a smaller number. I		
15	community organizations and agencies and helping to	15	would say most of the patients I see in St. Thomas are		
16	facilitate their journey into recovery if possible.	16	housed.		
17	203 Q. Okay. But you don't treat them for their	17	210 Q. And when you see homeless patients, you see		
18	other medical issues?	18	them in the hospital; correct?		
19	A. Generally not.	19	A. Yes, that is correct.		
20	Q. So you don't treat them for their and	20	211 Q. So you don't attend on them in shelters;		
21	you are not a psychiatrist, are you?	21	correct?		
22	A. No, I am not.	22	I do not attend on them medically in		
23	205 Q. Okay. And so and because you see these	23	shelters, no.		
24	patients on an inpatient basis, you don't follow up with	24	212 Q. No. And you don't attend on them medically		
25	them in the community on an outpatient basis, do you?	25	in encampments, do you?		

living in an encampment and living outside but not in an 2 encampment, so specifically not living in a tent. Q. Okay. So, Dr. Koivu, there's a term that is sometimes used in the medical literature and also in 3 Is that clear? this policy area called "living rough." Are you familiar A. Okay. If that's how you will use the term with that term? living rough to mean living on the street or living 5 A. Yes, I am. outside of a tent or an encampment --6 Q. So I'm going to put to you -- what do you Q. Yes. 8 understand that term to mean? A. -- which are both different, but okay. 9 A. I think it has various meanings. So your 217 Q. That's correct. Just to be clear. Okav. 10 meeting would be helpful, but living rough tends to mean And so I want to take you to paragraph 10. And you state living outside of a shelter. 12 So living rough can include living -- being 12 "Many the patients that I 13 homeless and living outside of a shelter system, outside 13 see[...]" 14 of -- that would not include couch surfing or that sort of I assume you meant "many of." 15 15 thing. It would be about living either -- it can refer to "So many of the patients that I see 16 living in encampments, tents. It can refer to living 16 are vulnerably housed or experiencing outside, without the aid of tents or encampments. homelessness. I have seen patients who are 18 Sometimes people will use it specifically 18 living in homeless shelters in tent 19 to mean outside of even encampments. So how it is used 19 encampments and in both environments." 20 20 215 Q. So, Dr. Koivu, that's very helpful. And 21 21 Yes. 22 I'm glad we are clarifying this. 22 218 Q. Okay. What proportion of your addiction 23 So in this cross-examination, I'm going to 23 practice is devoted to shelter residents? A. So of the homeless patients that I see --24 24 use living rough in a narrower sense than you did. And so 25 I will draw a distinction in some of my questions between and so the question is, how many are in shelters? So

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1	40 per cent. That also has definitely changed over time.	1	222 Q. Okay. And so you have not been asked to
2	Initially most of the homeless patients I saw would have	2	provide your opinion on the health outcomes for people
3	been living in shelters.	3	experiencing homeless or comparing the health outcomes
4	That has changed. I'm going to say it's	4	of people experiencing homelessness living rough compared
5	about 50 per cent are living in shelters, and	5	to those living in encampments or living in shelters?
6	50 per cent are living mostly in encampments.	6	No. Not as you have defined it, no.
7	I do not have a population of patients that	7	223 Q. Okay. I'd now like to take you to
8	I see that I would say are specifically living rough	8	paragraph 18. And so here I'm going to highlight the
9	219 Q. Okay.	9	first sentence. It states pardon me. Sorry, the first
10	A as you have defined it.	10	two or three sentence I have highlighted. I'd like to ask
11	220 Q. Thank you. That's helpful. I want to take	11	you about the third sentence.
12	you to paragraph 15. And it's about the scope of your	12	A. [Reading].
13	expert opinion. And so it says here:	13	Yes.
14	"I have been asked to provide my	14	224 Q. Okay. And so I'd like to ask you about
15	opinion from the perspective of my	15	the so the third sentence states for the record:
16	area of expertise with respect to	16	"Unsheltered people experiencing
17	health outcomes for people	17	homelessness have a 2.7-fold increased
18	experiencing homelessness who live in	18	risk of mortality compared to those
19	encampments, as compared to in	19	who are sheltered."
20	shelters."	20	Correct?
21	Can you confirm that that is what you were	21	A. Yes.
22	asked	22	225 Q. And you cite to that for that reference
23	A. Yes.	23	for that proposition footnote 15; correct?
24	221 Q to provide?	24	A. Yes. That is the Boston study.
25	A. Yes.	25	226 Q. That's the Boston study. Okay. So I'm

going to take you to the Boston study. And so if you will also read it more recently when I was doing my affidavit. 2 give me a second. And I'm going to put it up here. So I'm going to say around the -- as I was doing my We will mark this as Exhibit 6 to the affidavit, this was one of the articles that I read. 3 cross-examination. Q. Okay. So I would like to take you to two 5 -- EXHIBIT NO. 6: Boston Study. parts of the study. So scrolling down here. So the first BY MR. CHOUDHRY: is -- so this is page 2 of the article. And I will just 6 Q. Can you read that for identification? Do 7 reduce it a bit so it is all on one screen. 8 you recognize this paper? Do you see that? 9 A. Yes. Yes, absolutely I recognize the Yeah, but --A. 10 It's too small? I can --Q. And so this is a paper that was published I can read it, but I'm --11 12 in JAMA Internal Medicine. The title is: 12 233 Q. No. no. 13 "Mortality among unsheltered 13 -- going to be staring closely. It's --14 homeless adults in Boston, 234 Q. That's not the intention. So let me 15 Massachusetts 2000-2009." 15 increase the size. Is that better? 16 You referred to this as the Boston study. A. 17 Is this the Boston study? All right. A. Yes. This is the study that I am referring 18 18 A. Now I can only see one part, though. 19 to that I am calling the Boston study, yes. 19 236 Q. That's what I was trying to avoid, but 20 Q. Okay. And so I'd like to take you to a 20 let's do it this way. 21 couple -- did you review this article before reading --A. Can you scroll it up a little bit? 22 22 before preparing your affidavit? 237 Q. Of course. 23 23 Yes, I did. A. If you scroll the other way. 24 24 Q. Do you remember when? Scroll down? 230 238 Q. 25 I've -- I mean, I've read it previously. I I guess down, yes.

				1 '					
1	239	Q.	Yeah.	1	A.	Okay.			
2		A.	I might be now I can't quite get	2	248 Q.	It begin	is at the bottom of the left column		
3	240	Q.	Can you see the bottom, Dr. Koivu?	3	and it goes up to the ri	ht column.			
4		A.	I'm missing the top. I'm not quite able to	4	A.	Yes.			
5	see the whole th	ing.		5		[Readin	ng].		
6	241	Q.	Okay. I know. Unfortunately, I can't do	6		Okay.	Yes.		
7	that and have yo	u make i	t readable. So	7	249 Q.	Okay.	And so would you agree that the		
8		A.	No, you can go smaller. I can still read	8	authors of the article d	not break	down the unsheltered		
9	it. You can go si	maller th	an that and I should be able to	9	homeless population -				
10	still read it.			10	A.	Absolut	tely.		
11	242	Q.	Okay. Tell me when to stop.	11	250 Q.	to the	ose living rough and living in		
12		A.	Okay. Yes. I can read both parts. I can	12	encampments?				
13	read both parts.			13	A. Absolutely. That is one of the, for lack		tely. That is one of the, for lack		
14	243	Q.	Okay. Dr. Koivu, I'd like to take you to	14	of the better word, weaknesses of this article is that				
15	the method secti	on of the	article.	15	they didn't break it dov	n. Absolute	ly.		
16		A.	Yes.	16		I compl	letely agree with you that a problem		
17	244	Q.	It starts here.	17	with this article, with th	study is th	nat they did not		
18		A.	Yes.	18	break down what you	ould describ	be as living rough versus		
19	245	Q.	Do you see that?	19	encampment.				
20		A.	Yes.	20		So this	is not you are right.		
21	246	Q.	And I'd like to take you to the study	21	Absolutely.				
22	population			22	251 Q.	Okay.			
23		A.	Yes.	23	A.	That is	a flaw of this study or a		
24	247	Q.	paragraph. Can you just refresh your	24	limitation, I guess, is th	right word	that I'm looking		
25	recollection by reviewing that paragraph?			25	for, in the study.				
	1			, ,					

252 Well, on the topic of limitations, I want English, if I could. So let me suggest something to you. And please let me know if this is accurate. 2 to take you to the limitation section of the study. And Are the authors stating here that they did 3 so I'm scrolling down. And so this begins on page 5 of the PDF with the title "Limitations." not control for the comorbidities of the two homeless populations, those who are living in shelters and those 5 Do you see that? A. Yes. living outside shelters? 6 7 Q. I want to take you to a passage on the A. I don't think this was a study where you 8 limitation section on the next page. May I do that, or control that in the sense that it's not a randomized 9 would you like to read this first? controlled study. So I'm not sure "control" is the word, 10 A. No, that's fine. You can take me to the but I don't think they factored in or had the ability to know what the comorbidities and even the chronicity. 11 Q. Okay. Great. And so I want to take you to 12 254 12 So I would say it's more things that could 13 this sentence here. Additional limitations. And it 13 be -- contribute to living in a shelter or not living in a 14 reads, for the record: shelter, those sorts of comorbidities were not taken into 15 "Additional limitations included 15 consideration during this study. 256 16 a lack of information about individual Q. That's very helpful, Dr. Koivu. Let me 17 comorbidities or the chronicity of kind of, again, in layman's terms, layperson's terms, put 18 being homeless before and during the that point to you and see whether it's fair. 19 observation period. Both could have Is it fair to say that the authors did not 20 contributed to a more nuanced 20 observe chronicities or comorbidities and therefore could 21 understanding of mortality risk in not factor those into their analysis of health outcomes? 22 this population." 22 A. Well, I wouldn't say they didn't observe 23 Do you see that? 23 them. They just didn't observe them before the observational period so that they couldn't say how they 24 Yes, absolutely. 25 255 Okay. And so I want to put this into plain contributed to them.

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1	So how this words is that they weren't able	1	A. Yes, that is correct.			
2	to say or they didn't observe prior, so specifically	2	261 Q. Okay. Thank you.			
3	before you know, before or during, so they weren't	3	I will take you back to your affidavit.			
4	observing them.	4	I think what is relevant in this study is			
5	So I'm not so I think I'm agreeing, but	5	those are the limitations. What is relevant in the			
6	not exactly. I think it is a wording thing. But, yes.	6	study and I think you bring up a very good point,			
7	They weren't the comorbidities and the chronicity of	7	and I think you're going to be able to make that point			
8	the illnesses weren't part of what they were looking at in	8	with any study that we are extrapolating data and how we			
9	the study and could be contributing factors that they did	9	have that data interpreted. And there's going to be, I'm			
10	not take into consideration.	10	sure, more opportunities for you to do that.			
11	So I think we are saying the same thing. I	11	I think what is also the strength of this			
12	just	12	study is that all of the people in the study had access to			
13	257 Q. Well, Dr. Koivu, just on that last point,	13	the same services.			
14	did the authors not state that they didn't observe those	14	So this is an American study. The types of			
15	either before or during?	15	services that they had access to are going to be maybe not			
16	A. Yes. It says before or during their	16	similar to services in Canada, per se, but I think what			
17	observational period. Yes. So, yes, that's correct.	17	was relevant about this study Is that they had access to			
18	258 Q. So they didn't observe the comorbidities or	18	the same services and yet found that 2.7-fold difference			
19	chronicity during the observation period?	19	in mortality.			
20	A. No, that is correct.	20	So there are limitations, I absolutely			
21	259 Q. So they had no information about them?	21	agree with you, there are limitations to the study. And			
22	A. Yes, that is correct.	22	you've pointed out limitations to the study. But I think			
23	260 Q. And so they couldn't draw any conclusions	23	the thing that for me is the strength of the study that			
24	about the role or lack of role of those chronicities or	24	makes it worth noting is that the people in the study were			
25	comorbidities on the outcome they observed; correct?	25	given access to the same services.			

So it's not a matter of not having access. when I went back to that paper, I think it's the number 5, 2 It is not a matter of people who were in a shelter had Liu paper, they are actually -- they use the same statement about mortality, the 2.7. I even think I saw 3 access to certain services that the other population that in some of the affidavits. And I think that is what makes this study a But when you look at the references, they 5 valuable study. You are absolutely correct about the 6 are referring to that study, the same study. So I've seen it in other articles. The one -- I think it's number 5, Q. And just to pick up on the point that you 8 that is from Liu is the author, I believe. 9 raised, this is an American study? But if you actually read beyond their 10 A. Yes, absolutely. And I think that that is 10 statement of the 2.7, they are getting it from the same a really important point, because American healthcare is study. Q. Are you aware of any Canadian data? 12 different from Canadian healthcare. 12 264 A. No. No, I'm not aware of any. I think --13 And the -- so you are absolutely correct 13 14 that being able to completely extrapolate what happens in unfortunately, I'm not aware of -- I'm aware of the 15 Canada versus the States in many aspects are going to be Canadian study that looks at -- is the one from 16 Vancouver -- sorry, British Columbia, the Nikoo study that I think what makes this study, as I say, looked at comparing sheltered to unsheltered, but that was 18 the most important part of the study is that people had specifically about chronic illnesses. It is not about 19 access to the same services, regardless of whether they 20 were sheltered or unsheltered. And I think that is the 20 Q. I see. Okay. part that's important. Those services may be somewhat A. I do not know of a study -- I would love to 21 22 different, but that is the part that is most important. 22 see one -- I do not know of a study that is specific to 23 Q. And just to go back to your affidavit, this Canada. So that -- that is referencing the Boston study. 24 is the only study you cite for this statement. And any other references that I saw do go back and circle A. Yes. It's actually in another paper, but 25 back and they are referencing the same study.

1	266	Q.	Okay. Good. And so thank you, Dr. Koivu.	1	There's a way you can propose that to the				
2	I'd like to now take you to paragraph 20 of your			2	witness that is both fair and proper and doesn't require				
3				3	her to speculate on shelter policies.				
4	aniuavit, wilicii i		Yes.	4	· ·				
		Α.			BY MR. CHOUDHRY:				
5	267	Q.	Just to refresh your memory.	5	273 Q. Well, Dr. Koivu, I would put it to you that				
6		A.	Sorry. I'm looking at the wrong paragraph.	6	shelters do not operate they do not offer shelter				
7	268	Q.	That's okay. Can you see it here,	7	24 hours a day?				
8	paragraph 20? I	t begins	here.	8	MS SHORES: That's a refusal, counsel.				
9		A.	Yes.	9	Again, you can put that proposition to her without asking				
10	269	Q.	Okay. And so this paragraph, it's fair to	10	her to comment on shelter policies.				
11	say, is about the risk of frostbite?			11	REFUSAL				
12		A.	Yes.	12	BY MR. CHOUDHRY:				
13	270	Q.	That you and it's your evidence that	13	274 Q. Well, Dr. Koivu, if an individual do you				
14	there are significant risk of frostbite to persons living		14	want to say something, Dr. Koivu?					
15	in encampments; correct?			15	A. I'm waiting for the question.				
16		A.	Yes.	16	275 Q. So, Dr. Koivu, if an individual were				
17	271	Q.	But, of course, you are aware that shelters	17	outside during the day, would they not also experience the				
18	don't provide 24/	7 accom	modation, are you?	18	risk of frostbite?				
19			MS SHORES: Well, hang on, counsel. I	19	A. Yes. The risk of frostbite, however, is				
20	don't know that t	hat's bee	en established.	20	increased with the amount of exposure, the length of				
21			BY MR. CHOUDHRY:	21	exposure, the ability to also access a warm building, for				
22	272	Q.	Well, Dr. Koivu, what's your understanding	22	example. People who are outside during the day could also				
23	of the shelter acc	commod	ation?	23	go to a library during the day that isn't available at				
24			MS SHORES: She is not being presented as	24	night.				
25	an expert on the shelter accommodation.			25	So, yes, the longer you are outside, the				
				, ,					

more likely you are to have problems such as frostbite. in the rough? 2 It also is worsened in environments in which the cold is A. No. I have absolutely no data to support 3 sort of maintained that. If anything, if you are living in a tent, So -- and you could -- well, I guess in especially a small, domed tent, then your own body heat is going to be creating condensation on the tent, which can 5 answer to your question, if you are outside at any time of 6 the day for a long period of time, particularly if during actually increase moisture in the tent, which can be a that period of time you are not conscious, such as being problem that can increase the risk of things, particularly 8 asleep or taking a sedating medication, you are at risk of trench foot. getting frostbite at any time of the day. 9 But the amount of protection in a tent --10 Frostbite is not limited to nighttime. at least the tents that I've -- tents are not designed to However, the temperatures tend to be different at be able to withstand temperatures to make a significant 12 different times of the day, as well as accessing warm difference once we are talking about freezing 13 structures is different at different times of the day. temperatures. 14 Q. And, Dr. Koivu, to be clear, you haven't Q. Have you -- can you cite a study for what you've just said? 15 provided any evidence about access to warm structures 15 16 during the day, have you? 16 A. What I can say is I know of no study that A. No, I haven't, and that's not my intent. shows that tents are safer, that provide safety outside. 18 I'm just pointing out that when you're -- to the question And having been someone who's done an extensive amount of 19 that you asked about daytime, I don't know the policy of camping, which does not make me an expert on tents, I am 20 shelters. And I would say that access -- accessing a warm well aware of the limitations of a tent and do not know of any study that would support what you have stated, which 21 environment decreases your risk of getting frostbite, and 22 not accessing a warm environment increases your risk of 22 is that a tent will offer an advantage over not being in a 23 getting frostbite, regardless of the time of the day. tent once you are reaching the types of temperatures in Q. And, Dr. Koivu, would you agree that being 24 which frostbite can occur. Q. Oh, interesting. 25 in a tent reduces the risk of frostbite relative to living 279

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1		A.	I am not a tent expert.	1	environment are what I was referencing.		
2	280	Q.	Thank you for clarifying that.	2	284 Q. Dr. Koivu, you've referred more than once		
3			Counsel sorry. Dr. Koivu, I'd like to	3	to condensation and body heat		
4	take you to paragr	aph 27,	which is about trench foot. Do	4	A. Yes.		
5	you see it?			5	285 Q from living in tents. Is that anywhere		
6		A.	Yes, absolutely.	6	in your evidence?		
7	281	Q.	All right. And so you don't refer	7	No. But my specific topic was about being		
8	specifically here to	the risl	k of contracting trench foot	8	in a tent and not comparing it to outside of a tent.		
9	inside or outside a	tent, de	o you?	9	So, no, this is in answer to your		
10		A.	No.	10	questions.		
11	282	Q.	No?	11	286 Q. And is it a topic of your research		
12		A.	No.	12	expertise?		
13	283	Q.	Okay. All right.	13	A. No, it is not, and I am not a tent expert.		
14		A.	But my topic was specific to people who	14	This is from my experience of being in a tent and from my		
15	were in tents. So I was not making a comparison to people			15	understanding of condensation and how condensation works.		
16	who were not in te	nts.		16	287 Q. Sure. And, Dr. Koivu, just to be clear,		
17			As I have mentioned, the risk of being in a	17	you're here to provide expert evidence based on your		
18	tent, particularly be	ecause	of how tents work where you get	18	professional experience and research capabilities, not in		
19	condensation from	body h	eat that's going to be	19	your personal experience living in a tent. Can we clarify		
20	affecting essentially hitting the side of the tent and		20	that?			
21	creating moisture within a tent sleeping bags, for		21	A. Absolutely.			
22	example, can become quite moist just from body heat.		te moist just from body heat.	22	MS SHORES: Well, counsel, I'm going to		
23			That's fairly standard. So absolutely the	23	interject, because she's here for a cross-examination on		
24	risks of developing	trench	foot within a moist	24	the expert evidence that she has given in her affidavit.		
25	environment and tents can be a very moists			25	And as the witness just said in her		
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previous answer, she's answering the question that you now, counsel. BY MR. CHOUDHRY: 2 posed to her. MR. CHOUDHRY: Well, actually she has Q. Good. And I'm glad we've got it on the 3 290 answered the question by reference to knowledge that she 5 shouldn't be relying on to answer. So, Dr. Koivu, I'm going to take you now to paragraph 58. You state here: 6 It's presupposing that any question put to 7 an expert witness that they should only answer based on "Most patients reported an increase in 8 their expert -- on their expertise, not their personal drug use in encampments." 9 Do you see that statement? experience, counsel. 10 BY MR. CHOUDHRY: 10 Q. So, Dr. Koivu, going forward, let's stick You don't cite any research to support that 12 to your expertise, if we could. 12 statement, do you? MS SHORES: Well, counsel, she'll answer 13 13 No. This is specifically patients have 14 the questions as best she can. And if there are disputes reported to me. 15 over what's within her expertise, those can be dealt with 15 292 Q. Okay. 16 16 And so this is --I think she explained what the limitations 18 of her expertise were in answering your question. And if A. -- my experience, absolutely. This is not 19 you're going to put a question to her, then you should 19 something that I can say that has been well studied. 20 expect that she's going to give an answer to it. 20 Q. And how many patients are "most patients"? BY MR. CHOUDHRY: 21 A. I am going to say every patient that we had 22 22 Q. And so, Dr. Koivu, just for the record, the discussion with about their use within encampments 23 you're not an expert on tents? stated that they had an increase in drug use in the No, I'm not an expert on tents. 24 encampments. MS SHORES: She has said that several times 25 So of the people that were in encampments,

1	that conversation probably happened at least 75 per cent			1	paragraph 49 of	your affid	lavit. I won't put it back up on		
2	of the time.			2	the screen just n	the screen just now unless you would like me to.			
3	295	Q.	But you don't provide any evidence about	3		When we last broke, or when we broke before			
4	the rates of drug us	se in si	helters, do you?	4	the break, I was	asking yo	ou about the three references you		
5	,	A.	No.	5	cited in footnotes	s 52, 53, a	and 54; correct?		
6	296	Q.	Okay. I'd like to take you to	6		A.	Yes.		
7	paragraph 49. Do	you se	e that paragraph? It's about	7	300	Q.	I would like to take you to those		
8	sexual violence, se	exual e	xploitation, and sexual traffic.	8	references, if I m	nay.			
9	,	A.	Yes.	9		A.	Sure. Yes.		
10	297	Q.	Dr. Koivu, I want to you cite the	10	301	Q.	Okay. So I'm going to share with you a		
11	only source you cite in this paragraph are the notes that			11	different a brow	different – a browser. And I have bookmarked these			
12	are marked as notes of 52, 53, and 54; is that correct?		12	pages. So if you	pages. So if you will bear with me, I will pull them up.				
13	,	A.	Yes, that is correct.	13	So, Dr. Koivu, this is at footnote 52 of		So, Dr. Koivu, this is at footnote 52 of		
14	298 Q. Okay. I want to take you to those sources		14	your affidavit you provided a hyperlink.					
15	first, if I could. So I'm going to stop this screen			15		A.	Right.		
16	share.			16	302	Q.	And the hyperlink takes us to this article?		
17			And, Dr. Koivu, at this time, if you would	17		A.	Yes.		
18	like to take a break	t, this v	vould be an opportune moment,	18	303	Q.	Do you recognize this article?		
19	or if you would like to continue, we can do so as well.		tinue, we can do so as well.	19		A.	Yes, I do.		
20	,	A.	Okay.	20	304 Q. Okay. And so this is an article in the		Okay. And so this is an article in the		
21	1 RECESSED AT 11:27 a.m.		21	Waterloo Region	Naterloo Region Record; correct?				
22	RESUMING AT	11:38	a.m.	22	A. Yes, it is.		Yes, it is.		
23			BY MR. CHOUDHRY:	23	305	Q.	And it's dated December 12, 2022?		
24	299	Q.	We are back on the record, Dr. Koivu.	24		A.	Yes.		
25			So, Dr. Koivu, I want to take you back to	25	306	Q.	And this is a story about the risk of		
,									

grooming for sex trafficking in Waterloo; correct? assault is from this story? 2 A. Yes. That is correct. Q. And do you have any first-hand knowledge of Q. Okay. Dr. Koivu, I'd like to take you now 3 307 315 4 the risk for sex trafficking in Waterloo discussed in this to the reference of footnote 54. Dr. Koivu, do you see this article? 5 article? A. Not specifically about Waterloo, no. A. Yes, I do. 6 308 Q. And is your only knowledge of the risk of Q. It's in the Toronto Sun. It's dated 7 316 sex trafficking in Waterloo from this article? October 1st, 2020, this title is: 8 9 A. Yes. "Levy: It took court action for 10 Q. Okay. Dr. Koivu, I'd like to now take you 10 Toronto to admit tent cities are 11 to the reference cited in footnote 53. This is an article problematic." 12 12 that is from Edmonton City News. Do you see this? Do you see that? 13 13 Q. Is this the article -- is this the web 14 317 Q. Is this the article you cited footnote 54? story, pardon me, that --15 A. I don't -- it could be. I am --15 16 A. Yes. 16 318 Q. Should I put --Q. -- you cited in footnote 53? A. I will go with yes. I know I cited this A. Yes. article. So I'm assuming that it was number 54. 18 18 319 Q. Okay. And Dr. Koivu, just to be clear, I 19 Q. And so is this story about a sexual assault 20 of a minor in an encampment in Edmonton? 20 just took these links from your affidavit. A. Yes, it is. A. Yeah. Yeah. And I'm sure then that it is 21 22 22 Q. Do you have any first-hand knowledge of the the right number in the right place. I have definitely 23 sexual assault discussed in this article? 23 A. No. I do not. 24 320 Q. Okay. And so you remember reading this 24 Q. So your only knowledge of this sexual 25 article, do you?

			1 1				
1	A.	Yes, I do.	1	And then you provide three footnoted			
2	321 Q. And so this article, you would agree, is			references, 26, 27, and 28; correct?			
3	about human trafficking	in an encampment in Toronto?	3	A. Yes.			
4	A.	That is correct.	4	327 Q. Okay. So, Dr. Koivu, I'd like to take you			
5	322 Q.	And you don't have any firsthand knowledge	5	to the those references are in your affidavit, if I			
6	about the human traffick	king discussed in this article, do	6	could scroll down. Excuse me. Just give me one second			
7	you?		7	here. Are in Exhibit C and 26, 27, 28 are listed here.			
8	A.	No.	8	Do you see those?			
9	323 Q.	Your knowledge about human trafficking	9	A. I think 27. I have the wrong link. If I			
10	0 discussed in this article is from this new story?			remember right			
11	A.	Yes, that is correct.	11	328 Q. Oh.			
12	324 Q.	Dr. Koivu, I'd like to take I'd like to	12	A there are a couple places where I have			
13	13 stop this screen share for a moment. And I'm going to			the wrong link, and that is yeah, that's one of them,			
14	4 take you back to your affidavit for a minute, if I may.			because if you look at 26 and 27, they are the same. They			
15		Do you see that?	15	are actually the same article.			
16	A.	Yes.	16	So unfortunately, I had the wrong link for			
17	325 Q.	Okay. I'd like to I'm going to take you	17	that. So 27 is the same as 26. There is no extra link			
18	back I'm going to take	e you up in your paragraph	18	there. That was the wrong link that I added.			
19	pardon me up in your	affidavit to paragraph 23.	19	329 Q. Sure. So we will take the links as they			
20		And I'd like to take you to the last	20	are, because this is in your affidavit. So the link for			
21	sentence in paragraph 2	23. Do you see it?	21	27 is incorrect; is that correct?			
22	A.	Yes.	22	A. Yes, you are correct. The link for 27 is			
23	326 Q.	So you state there:	23	incorrect.			
24		"I'm aware of several people	24	330 Q. So I'd like to take you to the link for the			
25	25 dying in tent fires."			articles that are listed correctly on your evidence in			
			J				

ı								
1	footnotes 26 and 28, if I may. Okay. So I will just go			1	A. No, I did not know the deceased. I knew			
2	back to the brow	vser.		2	people who knew her, but I did not know her.			
3	Dr. Koivu, is this the article you cited		3	339 Q. Okay. And so your only knowledge about				
4	correctly in footr	note 26?		4	this death is from this online news story?			
5		A.	Yes.	5	No, that is not correct. I also knew			
6	331	Q.	It's a CBC article from London; correct?	6	people who knew her.			
7		A.	Yes.	7	340 Q. But your only direct knowledge of this			
8	332	Q.	And it says here it's dated April 16, 2024?	8	death is from this online you have no direct knowledge			
9		A.	April 15th, but yes.	9	of this death. You've learned about her death from other			
10	333	Q.	Pardon me.	10	individuals or from this new story?			
11		A.	Sorry. The article is April 16th. The	11	I do not have direct knowledge of the			
12	woman died on April 15th.		12	death. I have learned about it from other individuals in				
13	334 Q. Right. And so actually, Dr. Koivu, does		13	London, as well as from the new story. I already knew				
14	the article not say that the death occurred on			14	about the death before the news story, but I did not know			
15	April 15, 2023?		15	her. I did not witness it, nor see it individually.				
16		A.	Yes, that is correct.	16	341 Q. Thank you.			
17	335	Q.	Okay. And so	17	And so now I would like to take you to			
18		A.	This is referencing the memorial that they	18	another to the link that I believe is cited in			
19	had for this won	nan.		19	footnote 28. Do you recognize this story?			
20	336	Q.	I see. I see. And so were you an	20	A. Yes.			
21	eyewitness to th	is fire?		21	342 Q. And this is the story you cited in			
22		A.	No. I was not an eyewitness to this fire.	22	footnote 28; correct?			
23	337	Q.	Did you treat the deceased?	23	A. Yes.			
24		A.	No.	24	343 Q. And so this is a Toronto Star story on a			
25	338	Q.	And did you know the deceased?	25	tent fire death in Toronto; correct?			

1		A.	Yes.	1	350	Q.	Okay. And so I'm going to take you to that		
2	344	Q. Were you an eyewitness to the fire?		2	article. Dr. Koivu	article. Dr. Koivu, can you read that article?			
3		A.	No.	3		A.	Yes.		
4	345	Q.	Did you treat the deceased?	4	351	Q.	Let me increase the size. Is that easier?		
5		A.	No.	5		A.	Yes.		
6	346	Q.	Is your only knowledge about this event	6	352	Q.	And so, Dr. Koivu, is this the article that		
7	from the news st	ory?		7	you cited in footne	ote 29?			
8		A.	Yes.	8		A.	Yes.		
9	347	Q.	Thank you.	9	353	Q.	And this is a CBC story on the propane		
10			I'd like to now go back to your affidavit	10	explosion?				
11	and take you bac	k take	you to paragraph 25. Do you see	11	A. Yes.				
12	that?			12	354	Q.	Were you an eyewitness to the explosion?		
13		A.	Yes.	13		A.	No. I was not.		
14	348	Q.	And your evidence there is or you state:	14	355	Q.	Did you treat the injured?		
15			"I am aware of risks from propane	15		A.	It is possible that I treated people who		
16			tanks used to heat tents, including	16	were injured from	this exp	losion, but I do not know that		
17			explosion causing injury and death and	17	specifically. I have certainly treated people with burns,				
18			carbon monoxide poisoning."	18	that have been ac	that have been admitted to the hospital with burns. I			
19			And you cite, again, to a footnote,	19	cannot say specif	ically to	this article.		
20	footnote 29; corre	ect?		20	O 356 Q. So you can't confirm that you treated		So you can't confirm that you treated		
21		A.	Yes.	21	individuals that w	ere injure	ed in this incident referenced		
22	349	Q.	Okay. I'd like to take you to Exhibit C	22	in this article?				
23	where you list for	tnote 29	. And, Dr. Koivu, is it true	23		A.	That is correct.		
24	that this source h	ere is a	CBC news article; correct?	24	357	Q.	Okay. Dr. Koivu, I'd like to take you back		
25	A. Yes.			25	to your affidavit. And I'm going to take you to				

paragraph 70. as having suicidal ideations; correct? 2 A. Yes. And there were more than one patient And so do you see that paragraph? that she stated had suicidal ideations, but in my 3 A. Yes. Q. Okay. So I want to take you to these affidavit I have referenced one. 362 Q. I see. And you no reason to disagree with 5 two -- this -- these two sentences. You stated that: "I have not provided care for 6 her diagnosis, do you? A. No, I do not. I don't know -- well, the these people and have not had access 8 to any other medical records." same patient that she referenced as having severe suicidal 9 Correct? ideations was also seen by Dr. O'Shea, and he did not 10 mention suicidal ideations in his affidavit. 11 Q. And: That doesn't -- I can't -- if it was -- the 12 "I do not feel that I have 12 way it was worded by Dr. Lamont made it sound like it was 13 sufficient information to have a 13 a very significant part of her experience. 14 medical opinion." It wasn't mentioned by Dr. O'Shea. There 15 Correct? 15 is a discrepancy, but I do not have enough information to 16 know where the discrepancy is or exactly what that 17 Q. And so, Dr. Lamont -- sorry. Pardon me. discrepancy is, but I did note that there was a 18 Dr. Koivu, just for the record, and so you would agree discrepancy between the two. 19 that without access to the medical records, you could not 363 Q. I see. But you have no reason to doubt 20 provide a medical opinion on Dr. Lamont's care of these that Dr. Lamont diagnosed the patient as having suicidal 21 patients: correct? ideations, do you? 22 22 A. That is correct. A. Well, she may have -- yes, I will say that Q. Okay. Now, you have -- and so I have no reason to doubt that she diagnosed them with 23 23 Dr. Lamont -- you describe Dr. Lamont's evidence and where suicidal ideations, as she stated that she diagnosed them 24 she states that one patient -- she referred to one patient with suicidal ideations.

1	364 Q. Dr. Koivu, you refer to the	1	suicidality is very important to the context, but I cannot				
2	Mental Health Act here.	2	say - I cannot say more than that it is concerning that				
3	A. Yes.	3	someone with severe suicidal ideations would meet the				
4	365 Q. Are you familiar with the	4	threshold.				
5	Mental Health Act's requirements for involuntary	5	I'm aware that the threshold is there				
6	institutionalized assessment?	6	is definitely the bar for that threshold is high to				
7	A. My I believe I am familiar with it.	7	have involuntary institutionalization.				
8	366 Q. Have you ever committed a patient for	8	369 Q. So, Dr. Koivu, I'm not quite understanding.				
9	involuntary assessment?		How is what you said not a medical opinion?				
10	A. Yes.	10	It's not an opinion about that particular				
11	367 Q. You have. And so you know that the	11	patient, and it's just an observation that Dr. Lamont is				
12	threshold for involuntary assessment is very high?		stating that people have severe suicidal ideations, but				
13	A. Yes.	13	has not felt that they were suicidal enough to feel that				
14	368 Q. And so do you know that it's possible	14	they needed to have a voluntary or involuntary assessment.				
15	wouldn't you agree that it's possible that a patient could	15	So I'm just commenting on her reference to				
16	have suicidal ideations without meeting that threshold?	16	severe suicidal ideations and balancing it with the fact				
17	A. I think it's possible, but once you start	17	that although she has used that word, she also did not				
18	using words like "severe," I feel that I would have	18	feel they were severe enough to require				
19	difficulty knowing why the word "severe" because people	19	institutionalization and institutionalized assessment.				
20	can have suicidal ideations, but to contemplate suicide,	20	I and just pointing out that fact. That's				
21	suicidality, and to have severe suicidal ideations would		not a medical opinion about this case.				
22	seem to be approaching the threshold.		370 Q. Well, I guess that will be for the judge to				
23	And it's that relevant to that person's	23	decide.				
24	experience that is noted would make it seem like those are	24	So, Dr. Koivu, I'm going to take you to				
25	very relevant factors in this patient, that this patient's	25	paragraph 71. And so, again, I want to note that you				
		l l					

repeated here that you haven't cared for the people she City of London where I know you practiced medicine until describes in her affidavit; correct? 2 very recently. A. Yes. And it's about the City of London's 3 Q. You don't have access to their medical encampment's policies. Are you familiar with those at 5 records; correct? A. Yes. That is correct, yes. A. They have been changing -- they have 6 Q. And so, therefore, you don't have changed over time, so I'm not sure to what you are -- so I 8 sufficient opinion to give a medical opinion; correct? would not state that I know the current -- currently what 9 A. Absolutely. That is correct. the encampment policies are. 10 Q. But then don't you go on here then -- you I do know that currently where I have seen 11 state here that: a number of patients that had been in encampments behind the pharmacy that I referenced, they are no longer able to 12 "The cause is not clear but is 13 consistent with tent fire." be there, and if they are there, they are removed. 14 Don't you? I have seen them as recently as in August, 15 A. Yes. 15 but I also am aware that they are removed. At the time 16 Q. So aren't you speculating here about the that I wrote this and am referencing that, those 17 cause on a burn on the back of that patient? encampments were present, but I do know that that has Yeah, absolutely. And that's probably -- I 18 changed with the new guidelines. 19 definitely speculated based on what she wrote. That is MS SHORES: Counsel, I'm going to interject 20 absolutely speculation on my part. 20 before your next question. I've been giving you quite a Q. Okay. And so -- but you would have no way lot of leeway in this examination, and I will continue to 21 22 of knowing that for sure, would you? 22 do so, but I do not see the relevance of the City of 23 No, absolutely not. London's encampment policies. So perhaps you can help me Q. So, Dr. Koivu, I just want to take you to with where you are going. 24 25 one last set of questions. And this is about the MR. CHOUDHRY: Sure. I'd like to know what

			_			
1	Dr. Koivu Dr. Koivu has offered a r	number of views. Her	1		A.	No.
2	affidavit is about encampments and t	2	379	Q.	You are not?	
3	she they pose. And I'd like to ask	her for her views	3		A.	No.
4	about the City of London's encampm	ent policy and	4	380	Q.	Okay. So you are not aware of any so
5	whether		5	didn't offer any v	iews abou	ut this to London City Council?
6	MS SHO	RES: That's completely irrelevant.	6		A.	No.
7	MR. CHO	DUDHRY: Well, I disagree, counsel,	7	381	Q.	And you weren't aware of it?
8	so I will put the question to the witner	ss, and you can	8		A.	No. And I'm not sure that that is current,
9	then decide if it's relevant or not.		9	but		
10	MS SHO	RES: Very well.	10	382	Q.	Well, Dr. Koivu, since you raise the
11	BY MR. 0	CHOUDHRY:	11	question of curre	ncy, it sa	ys Tuesday, June 25th, 2024.
12	377 Q. So, Dr. K	oivu, this is a I've put on the	12	And then it state	s here:	
13	screen we'll mark this as Exhibit 8	13			"London City Council has endorsed	
14	purposes.		14			the Community Encampment Response
15	EXHIBIT NO. 8: City of London		15			Plan."
16	Community Encampment Response	Plan, dated June 25th.	16		A.	Okay.
17	MS SHO	RES: It will only be marked for	17	383	Q.	And this is the latest document I could
18	identification.		18	find.		
19	MR. CHO	DUDHRY: Yeah.	19		A.	Okay. There's lots in the paper that seem
20	BY MR. 0	CHOUDHRY:	20	to make that s	eem like	things are changing and that
21	378 Q. It's a stat	ement, and it seems to be a	21	it's		
22	public announcement from the City of	f London website about	22			MS SHORES: I'm going to interject again,
23	a Community Encampment Response Plan, dated June 25th.			because the poli	cies that i	may or may not be in place in
24	Are you f	amiliar with the Community	24	the City of Londo	n or how	they may or may not be evolving
25	Encampment Response Plan?	25	is completely irre	levant to	the issues in Hamilton.	
			•			

BY MR. CHOUDHRY: 2 Q. Okay. And so, Dr. Koivu, just again, just 3 to confirm, this is for Exhibit 9, the Community Encampment Plan, you haven't seen this before, have you? A. No, I have not. 5 Q. Okay. 6 385 MS SHORES: Exhibit 9, again, will only be marked for identification. The witness has just said 8 9 she's never seen this before. 10 And I'm again going to state that the 11 policies regarding encampments in the City of London are 12 MR. CHOUDHRY: Thank you. 13 14 Dr. Koivu, those conclude my questions. 15 Thank you very much for your time. 16 MS SHORES: All right. Off record. ---The Examination concluded at 12:00 p.m. 17 18 19 20 21 22 23 24

25

I hereby certify the foregoing is a full, true, and correct

transcription of all of my oral stenographic notes to the best of my ability so taken at the Cross-Examination of DR. SHARON KOIVU, given under oath before me on the 6th of September, 2024.

Amy Armstrong, CVR-RVR

Certified Realtime Verbatim Reporter #7305
Certified Commissioner of Oaths
Certified this 9th of September,2024

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Heegsma et al ______ City of Hamilton

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44th PARLIAMENT, 1st SESSION

Standing Committee on Health

EVIDENCE

NUMBER 114

Monday, May 6, 2024

Chair: Mr. Sean Casey

Standing Committee on Health

Monday, May 6, 2024

• (1545)

[English]

The Chair (Mr. Sean Casey (Charlottetown, Lib.)): Welcome to meeting number 114 of the House of Commons Standing Committee on Health.

Before we begin, I would like to remind all members and other meeting participants in the room of the following important preventative measures.

To prevent disruptive and potentially harmful audio feedback incidents that cause injuries, all in-person participants are reminded to keep their earpieces away from all microphones at all times. As indicated in the communiqué from the Speaker to all members on Monday, April 29, the following measures have been taken to prevent audio feedback incidents.

All earpieces have been replaced by a model that greatly reduces the probability of audio feedback. The new earpieces are black in colour, whereas the former earpieces were grey. Please use only an approved black earpiece. By default, all unused earpieces will be unplugged at the start of the meeting. When you are not using your earpiece, please place it face down on the middle of the sticker for this purpose, which you will find on the table, as indicated. Please consult the cards on the table for guidelines to prevent audio feedback incidents.

Also, the room layout has been adjusted to increase the distance between microphones and reduce any chance of feedback from an ambient earpiece.

These measures are in place so that we can conduct our business without any interruptions and to protect the health and safety of all participants, including the interpreters. Thank you for your co-operation

In accordance with our routine motion, I'm informing the committee that all remote participants have completed the required connection tests in advance of the meeting.

I would like to welcome our panel of witnesses.

We have with us here in the room Dr. Sharon Koivu, addiction physician. Online is Dr. Bernadette Pauly, scientist with the Canadian Institute for Substance Use Research and professor at the School of Nursing, University of Victoria. By video conference, representing the Thunderbird Partnership Foundation, we have Dr. Carol Hopkins, chief executive officer. Finally, also by video conference, representing the Vuntut Gwitchin First Nation, is Chief Pauline Frost.

To all of our witnesses, thank you for being with us.

Parliament Hill is a place where rumours are a constant. I heard a rumour today that there's going to be a vote in roughly 45 minutes. If that happens, the meeting is likely to be interrupted, and we will be asking you to stay a little later than you might have anticipated. If you are able to stay with us to ensure that everyone gets a chance to fully converse on these matters, it will probably result in your time with us being extended from 5:30 until 6 o'clock or a little later. I'll give you a heads-up for that.

We can now go ahead with our opening statements, beginning with Dr. Koivu.

You have the floor for the next five minutes. Welcome to the committee.

Dr. Sharon Koivu (Addiction Physician, As an Individual): Thank you, Mr. Chair and members of the committee.

I have been a physician for 39 years. I have my certificate of added competence in palliative care and addiction medicine from the College of Family Physicians of Canada. I began working in addiction medicine in 2012. Until 2021, I was the sole health care provider offering comprehensive consultations in addiction medicine at the London Health Sciences Centre, where, in 2023, an interprofessional addiction team was established. I also provide addiction consultations in St. Thomas.

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

Early in my addiction career, I identified a link between injecting long-acting hydromorphone capsules and developing a heart valve infection. An infectious disease specialist I worked with found a link between injecting these capsules and getting HIV. When this specialist and the department chair took our findings to the community agencies, we were initially criticized and called fearmongers.

HESA-114

Fortunately, we established community engagement and developed an integrated response. As part of the response, in 2016, the London InterCommunity Health Centre developed a program that provided high-risk sex workers using hydromorphone capsules with short-acting hydromorphone tablets, also called Dilaudid. This was the inception of the safe supply program in London. I initially supported the program. It is important to note that we did not have a problem with illicit fentanyl at this time.

Prior to the safe supply program, I rarely saw people with spine infections. In the following summer, I saw five patients in one month. The numbers continued to climb. The common thread among patients was that they were injecting Dilaudid tablets. Many told me they were buying Dilaudid diverted from the safe supply program.

Some patients were in the program. I had patients who were housed, using clean equipment and only injecting Dilaudid developing horrific infections. Spine infections cause perhaps the worst suffering I have ever seen. Not only are they unbearably painful, but they can also cause paraplegia or quadriplegia.

In June 2018, I had my first patient tell me that he left his apartment to live in a tent near the pharmacy, close to the safe supply clinic where much diversion takes place, because the safe supply pills were cheaper and more abundant near the source. I lived in the neighbourhood and watched this encampment grow.

Since safe supply began, I have been involved in about 100 hospitalizations of patients with spine infections. That's currently about one per month. However, spine infections are only a small part of the suffering we see. About 30 patients per month are admitted with another severe infection. Of patients admitted with opioid use disorder, 25% were receiving a safe supply prescription and 25% reported using diverted Dilaudid. Only 4% of the consultations we did were for unintentional overdose.

Generally, in hospital, we start patients on home medications. If we did this for safe supply patients, the results could be fatal. This is dangerous for patients and very stressful for health care providers.

For example, patient one was prescribed eight milligrams of Dilaudid, D8s, which was 40 tablets per day, along with 100 milligrams of long-acting morphine in nine capsules per day. When they were given less than half of their prescribed dose, they had a severe respiratory depression—that is, toxicity. Patient two has frequent admissions requiring intubation. They were prescribed 28 D8s per day. They tolerated about six to eight and said they never took more than 12 in a day.

The patient population has changed. I see more young patients and many more men. Now, most start opioids recreationally and not with a prescription for pain, as was the case in 2012. I am also repeatedly hearing disturbing stories that people with prescriptions are vulnerable to violence.

Importantly, as I mentioned previously, when safe supply started in 2016, we did not have a problem with illicit fentanyl. We do now. Many patients have told me that they sell or trade much of their prescribed safe supply to buy fentanyl. Others not in the pro-

gram have told me that their dealer has claimed to be out of Dilaudid and has sold them fentanyl, starting them down this path.

(1550)

Safe supply appears to be contributing to the illicit fentanyl crisis. Safe supply is not reducing illicit fentanyl or its harms within a community. Our hospital experience also shows that safe supply is preventing patients from choosing opioid agonist therapy and the opportunity for recovery.

I would like to mention a program that is showing significant benefits. The Central Community Health Centre in St. Thomas has a low-barrier approach using subcutaneous buprenorphine, also called Sublocade. They are having success serving a very similar population to that of the London InterCommunity Health Centre, without the unintended side effects. It should be a model that we are discussing.

Of note, while I have broad shoulders, I found some of the comments made by Dr. Sereda on February 26 about me and cardiac surgeons to be misleading, and I look forward to an opportunity to address this.

Thank you for your work and your time. Meegwetch.

The Chair: Thank you, Dr. Koivu.

Next is Dr. Pauly for five minutes.

Dr. Bernadette Pauly (Scientist, Canadian Institute for Substance Use Research, and Professor, School of Nursing, University of Victoria, As an Individual): Good afternoon. Thank you for the opportunity to be here.

I am Dr. Bernadette Pauly. I'm a professor in nursing at the University of Victoria and a scientist at the Canadian Institute for Substance Use Research. I'm a member of the research team conducting the B.C. provincial evaluation of prescribed safer supply.

Prior to the introduction of the prescribed safer supply policy, evidence of the need for that intervention was well demonstrated by the overdose deaths caused by the unregulated drug market. However, it's critical to generate evidence of ethically justified interventions and determine whether or not prescribed safer supply reduces overdose risk. To answer that question, our team designed a rigorous mixed methods study using state-of-the-art approaches combining administrative and primary data.

In January 2024, the team led by Dr. Slaunwhite and senior scientist Dr. Nosyk published the first-ever population-level study in the British Medical Journal, a high-impact journal. Everyone receiving risk mitigation safer supply prescriptions was included in the study and was carefully matched with people not receiving them on multiple variables, including receipt of opioid agonist treatment. For those receiving opioids through this program, the risk of dying from any cause was reduced by 61% and the risk of dying of an overdose was cut in half. If they received four days or more, their overdose risk was further reduced to 89%. This is known as a dose-response relationship, and the finding was independent of opioid agonist treatment. A similar pattern was found for stimulants, but the sample size was smaller so there was less certainty. This protective effect continues week after week as long as they're able to access a prescription.

However, only 7.6% of those with an opioid use disorder and less than 3% of those with a stimulant disorder received the intervention during the period of study. There was limited implementation, with implementation occurring mainly in urban areas like Vancouver and Victoria and among prescribers who had larger caseloads of people with substance use disorders and more complex problems. While the intervention did not fix all their issues, nor was it expected to, it was protective for reducing risk of overdose death and all causes of death.

In a qualitative analysis, we found that prescribers were hesitant to take up the intervention out of fear of audit from regulatory colleges, as well as criticism and censure from colleagues. Where there were networks of prescribers who had support, there was increased continuity of prescribing. However, prescribing alone is an inadequate response to a systems issue, namely prohibition and an unregulated, unsafe supply of drugs.

The intervention was often difficult to access. Participants in the qualitative arm of the study reported the need to climb a steep staircase with many steps. Often, potential participants did not know about the risk mitigation guidance or safer supply. When they got their hopes up, they had to find a prescriber and navigate highly medicalized systems to get an appropriate prescription, and then pick it up daily to keep it. This required self-advocacy and fortitude. In a primary survey of 197 people, less than half of participants received a prescription sufficient to reduce withdrawal. Reducing withdrawal is a minimum requirement, so there's room for improvement.

Prescribed safer supply is a not a competitor to OAT or any form of treatment. It provides a pathway for people to access a life-saving intervention as part of individual recovery journeys. It does not replace or threaten the need for treatment. In fact, as part of a system of care, treatment options must be available for people if and when they are ready. In spite of this, the number of people dispensed a prescription in B.C. is decreasing.

Fears of diversion causing death are unfounded. Hydromorphone was detected in 3% of overdose deaths in 2023. It's unregulated fentanyl that's responsible for 85% of the toxic drug deaths. The root problem driving this emergency is toxic drugs, which is a consequence of prohibition. The unregulated market is accessed by those with substance use disorders and those without.

• (1555)

We need to expand access to alternatives beyond the health care system to ensure safe and regulated access to substances of known safety, quality and composition. We should be scaling up, not scaling back, safer alternatives to the unregulated drug market and looking to end prohibition.

Thank you. I look forward to the questions and comments.

The Chair: Thank you, Dr. Pauly.

Next, on behalf of the Thunderbird Partnership Foundation, we have Dr. Carol Hopkins.

Welcome to the committee. You have the floor.

Dr. Carol Hopkins (Chief Executive Officer, Thunderbird Partnership Foundation): [Witness spoke in Lunaape]

[English]

I'm Carol Hopkins of the Lenape nation in southwestern Ontario. I'd like to acknowledge the lands that you are joining us from and that we're all coming together on today.

In 2023, the number of first nations deaths due to drug poisoning was 36 times those in the general population in Ontario. In eight short years, from 2016 to 2023, first nations deaths due to the toxic drug supply grew at a rate of 33 times those seen in the Ontario population.

During the pandemic, from 2019 to 2022, 28% of first nations people used opioids in a harmful way, and 18% used methamphetamines to survive in an environment where there were no resources for housing, food security or income security. Those who reported food insecurity were two times more likely to use methamphetamine, according to a survey that Thunderbird ran. Forty per cent of first nations people reporting methamphetamine use felt hopeless to change their lives. It was this hopelessness that increased their risk for using opioids in a harmful way.

This population also reports a high rate of trauma, grief and loss, with a lack of resources close to home to support their mental wellness. The use of fentanyl, benzodiazepines and xylazine has been increasing across all regions of Canada, including in first nations. They are core to the opioid and toxic drug crisis that we are talking about today. The impact of these drugs requires community-based health resources that often first nations communities lack. First nations communities that declare a state of emergency report no capacity for preventing deaths due to the toxic drug supply. They also report their vulnerability to gangs, gun violence and murders, as well as human trafficking, which is now present in many first nations communities for the first time.

The war on drugs, including the criminalization of people for their health and social needs, has been a long-standing experience of first nations people in Canada, who are only 5% of the population yet represent 32% of those incarcerated. Indigenous women represent 50% of the incarcerated population. The war on drugs and incarceration have not increased safety from the toxic drug supply, have not reduced crimes of survival for people who live with opioid dependency and have not eliminated the illicit and toxic supply.

Indigenous Services Canada does not provide for physician or pharmacy services in first nations communities. We know those things are the responsibility of the provinces and territories. In this context, the opioid crisis and toxic drug crisis do not depend on geography. Rural and remote first nations communities are not exempt from the toxic drug supply or opioid crisis. The crisis is about a lack of equitable, available and accessible health care for first nations, with access to primary health care, physician services, pharmacies and public health resources. These are all necessary components of a response to the toxic drug crisis. Live-in drug treatment aimed at abstinence is not the evidence base for addressing opioids, and it is not the first line of evidence-based intervention. Abstinence-based programs will not change drug dependency or address physical withdrawal from opioids.

Where live-in treatment programs have additional resources—for example through provincial health authorities, harm reduction networks and first nations-governed culture-based and land-based services—and have options for readmitting or keeping first nations people on a continuous basis, clients have gone on to gain employment, obtain housing and maintain their own wellness.

Buprenorphine treatment is initiated by the community's primary care physician, when they are lucky enough to obtain a partnership; by addictions physicians through telemedicine; or by fly-in locums, who dispense daily under supervision. It has proven to be effective, along with a recovery program involving community mental health workers who provide both conventional counselling and culturally relevant healing practice. This comprehensive approach has enabled many patients or first nations people to stop or manage their opioid use and return to work, school and family. A year after such programs have been initiated, criminal charges and medevac transfers decreased, the needle distribution program dispensed less than half its previous volume and rates of school attendance increased.

• (1600)

Addressing the opioid crisis has been challenging for first nations communities, most significantly because of inconsistent support and resources to community-governed and culturally relevant treatment. One study of community-based opioid misuse reported that among adults aged 20 to 50, 28% were on buprenorphine or naloxone, double the rate of adults in the community living with type 2 diabetes.

First nations people have the right to live—to live life. They have the right to the sacred breath of life, and that has to be our focus in any drug policies that are humane and sensible for first nations communities.

First nations communities require increased capacity for reducing harms related to opioids, opioid analogs, methamphetamines and xylazine, such as consistent support; access to prescribers, pharmacies, safe housing, food security and medication to address withdrawal; and a choice to continue to use drugs safely. Harm reduction kits and resources are needed. Human resources are also needed—

The Chair: Dr. Hopkins, I'm sorry to interrupt. If I could get you to wrap up, you will get a chance to expand on your presentation in questions and answers.

Dr. Carol Hopkins: Human resources are needed in community. The existing resources of treatment centres can also play a role, but they need additional resources and capacity.

Thank you.

• (1605)

The Chair: Thank you.

Last but not least, from the Vuntut Gwitchin First Nation, we have Chief Pauline Frost.

Thank you for being with us. You have the floor.

Chief Pauline Frost (Vuntut Gwitchin First Nation): Thank you. I appreciate the opportunity today.

I am the chief of a very small community—

The Chair: Excuse me, Chief Frost. I'm sorry. The bells are ringing, and that means we're obligated to vote unless we have unanimous consent to continue.

Do we have unanimous consent to allow Chief Frost to finish her opening statement before we head off to vote?

Some hon. members: Agreed.

[Translation]

Mr. Luc Thériault (Montcalm, BQ): Mr. Chair, while we're at it, to avoid interruptions, could the volume in the room be lowered a bit so that I can hear the interpretation better without having to turn up the sound? It's too loud in the room.

We should be doing tests at the beginning of every meeting to solve the problem. This isn't the first time I've had to intervene. I haven't interrupted the witnesses more often out of courtesy. However, the discussion is becoming difficult to follow.

[English]

The Chair: Okay.

Chief Frost, I'm sorry for the interruption. Go ahead and finish your opening statement. We'll likely suspend once you're done.

You have five minutes.

Chief Pauline Frost: Okay. Thank you.

As the former minister of health and social services for the government of the Yukon, I was responsible for identifying the opioid crisis, as well as the COVID pandemic. At the same time, I worked as a lead negotiator for my first nation, a small, isolated aboriginal community in north Yukon. We signed our self-government agreement 30-some years ago. We exercise our inherent right to self-determination. We have responsibilities for the general welfare of all citizens, our community, the land and the resources. As an isolated community, we're a resilient people, resilient in that we are connected to our roots, our traditions. At the same time, we are deeply affected by the opioid crisis and the toxic drug overdoses in the Yukon and across this country.

The serious challenges that we face and the high cost of living.... Food security is huge. Fiscal capacity is limited in our communities, causing significant challenges in addressing mental health. Substance use challenges have arisen in our history due to colonialism, racism and intergenerational trauma. All of this is a priority for my community.

In April 2020 and 2023, we declared a state of emergency and substance use crisis in my community. The reason is that we've suffered significant loss due to opioid, alcohol and drug use and abuse. Over the last five years, we've lost 15 Vuntut Gwitchin citizens linked to substance use.

Because of the small community, this is very complex, and it affects everybody, with compound impacts and effects. Every person in my community has been affected in one way, shape or form. Because we're an isolated community, our citizens are required to travel out of the community for amenities and medical supports. Therefore, we tend to see impacts and effects when they get to the city. There's an urban centre effect on average on northern isolated people.

We have worked tirelessly to support our citizens the best we can with healing and wellness. Our approach has been comprehensive and non-judgmental. We commit to facilitating easier access to treatment services. We set aside, last year, almost a million dollars for supporting our citizens to access treatment programs. That

comes out of our FTA base funding that we get for programs and services.

Ensuring consistent availability of counsellors both locally and remotely is a priority for me as a chief. We are developing aftercare programs that provide supports to our community.

What I'm saying here is that we are working hard to combat substance use in our communities. We are utilizing the Yukon's Safer Communities and Neighbourhoods Act to address and combat drug trafficking and bootlegging. We've asked for changes to the security designation for our northern airports so they can implement passenger baggage and freight screening for northbound routes, equivalent to what's seen southbound. In other words, the drug traffickers can come into our community without restrictions whatsoever because we're remote fly-in.

Our tools are limited, but we are making significant headway, and we have sent over 70 people to a treatment facility in the southern parts of B.C. because the Yukon is not equipped. Treatment options are not available to us in the Yukon; we have limited availability. We need more. My first nation needs support to implement programs and improve the wellness of my people.

As we are on the ground, we know what's happening. We have the flexibility, but we are also trying to address the crisis. Adequate and secure funding for life-saving interventions is not going to save us. It's not going to help us. We need more supports in addressing the illicit drug overdoses and for program services.

We looked at a piecemeal funding program available to us through the federal government and the territorial government, which is not sufficient. We just asked last year, at the Prime Minister's forum, for direct access to funding and support. Put it in our base, and let us provide services. We don't have that flexibility. There needs to be consideration of the political, social, economic and cultural pressures that we're facing.

 \bullet (1610)

I want to quickly say that we've just finished a coroner's inquest in the city of Whitehorse, Yukon, for four overdose deaths at the emergency shelter facility. Two of those individuals were residents of my community.

We are proud of our community, because we are resilient. We've done amazingly. We own an airline. We don't have a housing crisis. However, our people are directly affected. We have to make a meaningful difference in the services that are provided, and the only way forward is by working together and jointly addressing this. We have looked at options, like a safe exchange in our community. We've educated our citizens. We have looked at alternative options. We are looking at recovery withdrawal supports in our community. We also have to look at a distribution program.

Everything we need to do is about building on healthier families and healthier communities. For the first time, we are actually focusing on our young people now, and we have a youth wellness program. We're bringing our youth together, and facilitators are coming in—

The Chair: Thank you.

Chief Pauline Frost: Marsi. I appreciate this time.

The Chair: Thank you, Chief Frost. We're going to suspend now to allow members to vote.

You can expect the suspension to last for about half an hour. Then there will be probably about an hour of questions, more or less. Stretch your legs. We'll be back once we've voted.

The meeting is now suspended.

• (1610)	(Pause)

(1700)

The Chair: I call the meeting back to order.

We've finished the opening statements and are now ready to move to rounds of questions.

We're going to begin with the Conservatives for six minutes.

Dr. Ellis.

Mr. Stephen Ellis (Cumberland—Colchester, CPC): Thank you very much, Chair.

Thank you to the witnesses for their patience.

Dr. Koivu, I listened carefully to your opening statement. When we look at patients—you described a couple of them—we're really not offering them any therapy other than opioid therapy. Perhaps there are other things in addition to that.

For the sake of those listening at home, we all know that people who take opioids will eventually get habituated or used to the dose they're on and will require escalating doses. If that's the kind of medicine we're going to provide, is it not fair to say that we're providing these folks with palliative care?

Dr. Sharon Koivu: Absolutely. That is one of the significant problems with opioids. As you take them, your brain has changes in neurochemicals. What you're taking, your brain becomes used to. That becomes your normal. To get the same effect, you have to increase the dose you're taking. To get the same euphoria, you have to continue to increase the dose.

Perhaps even more importantly, when your brain readapts to this new level of normal, you have to take opioids. If you miss them,

your brain will miss them and you'll go into what's called withdrawal, which is a horrific experience. You get severe pain, anxiety, nausea, vomiting and diarrhea. You can feel like you're literally going to die. You keep thinking you need more and you need a higher dose. Whenever you're in a scenario where you're taking an opioid regularly, you're always chasing the high, your dose continues to escalate and you're always trying to medicate away from the withdrawal.

An important thing that isn't always mentioned, which I want to add, is that as your brain regulates and gets used to a certain amount of opioids, you can generally tolerate it if you're well. If you develop pneumonia, endocarditis or any other illness that affects your cardiorespiratory system, that same dose can be toxic or fatal. When you're taking an opioid, it could be that you're always taking the same dose of your Dilaudid or fentanyl, but if you develop pneumonia or sepsis, that dose could become toxic because your brain wants more than what your body can tolerate.

When you are in a position of getting a treatment that's given to you daily to keep you going from one withdrawal to another, it's not allowing your brain an opportunity for recovery. You're staying in a cycle in which you are absolutely dependent on the medication, and you can be at risk of developing tolerance, needing a higher dose and needing a dose that will eventually be more than you can handle. From the cases that I mentioned in hospital, patients were being prescribed substantially more than they could tolerate when we had them in a position where we could see what they were taking. Had we given them the amount they were prescribed, it would have been fatal for them.

Mr. Stephen Ellis: Thank you very much for that, Dr. Koivu.

It's interesting that you started talking about dosages. When we looked at patient 1—I wrote this down—they had 900 milligrams of morphine and 320 milligrams of hydromorphone. Using an opioid calculator to look at the overall dose of milligrams of morphine, that would be equivalent to about 2,500 milligrams of morphine. Is that correct?

• (1705)

Dr. Sharon Koivu: That is correct.

Mr. Stephen Ellis: Looking at that for the average Canadian and again doing the math, that's about 640 Tylenol 3s. You don't have to trust me on that, but I used the same calculator to do it.

The reason I talk about this is people often think it's just one tablet of eight milligrams of Dilaudid. It's a bit concerning that for those who don't use opioids on a regular basis, even though it's one tablet, it's still a significant amount of opioid.

Maybe, Dr. Koivu, you can talk a bit about that.

Dr. Sharon Koivu: Absolutely.

One tablet is also equivalent to four Percocet or 20 milligrams of OxyContin. Those are doses we consider fairly high during the opioid crisis. Taking two of them would essentially be considered relatively safe for most people. Even one can be considered toxic if someone is not used to taking it.

The numbers we're seeing are substantially higher than the milligram equivalent of morphine that I was seeing during the time when people were prescribing heavily for chronic pain. These are the highest doses I've ever seen.

Mr. Stephen Ellis: Very quickly, Dr. Koivu, if we're talking about 2,500-milligram morphine equivalents, what would be the recommended amount that a prescriber should be very cautious about going over? I realize this is a different patient population from even the usual chronic pain population, but what would be a guideline for Canadians listening out there?

Dr. Sharon Koivu: The guideline is the equivalent of 100 milligrams of morphine per day or less.

Mr. Stephen Ellis: And these people are receiving up to 2,500.

Dr. Sharon Koivu: Yes—or more.
Mr. Stephen Ellis: Thank you.

The Chair: Thank you.

We'll go now to the Liberals.

Dr. Hanley, you have the floor for the next six minutes.

Mr. Brendan Hanley (Yukon, Lib.): Thank you very much.

Thanks to all the witnesses for being here.

I'm speaking today from the traditional territory of the Kwanlin Dün First Nation and the Ta'an Kwäch'än Council in Whitehorse, Yukon.

Dr. Hopkins, I want to address the bulk of my questions to you.

Unfortunately, Chief Frost had to leave early during our vote, but I noticed that you were listening acutely to her testimony and you were nodding. I wonder if you can indulge me. Was there anything in particular that resonated, based on your knowledge and experience, from Chief Frost's testimony as chief of an isolated northern community?

Dr. Carol Hopkins: We typically assume that the issue with resources and capacity to respond to the toxic drug supply is remoteness, that it's geographical. We are not asking for or expecting hospitals to be built in every one of our communities, but the Canada Health Act says there should be universal access to health, and its objective is accessible health care without barriers to our wellness.

I mention this because there are lots of Canadians who live in rural and remote communities, but we are talking specifically about first nations people. They have a right to access health care close to home, where they need it. When it's not available there, they will find it someplace else, which often draws them to urban environments.

In urban environments, they don't always have access to the appropriate health care they need when they have opioid dependency or addictions to methamphetamine or other stimulants or even to sedatives like benzodiazepines, which I mentioned, or the "trang"

drug xylazine, which is not a controlled substance. All of them have substantial effects on people when they don't have any health care resources close to home.

That isn't just because of geography. That has to do with decision-making. If the Canada Health Act says there should be universal access to health care for every resident in Canada no matter where people live, then where are the policies that ensure access to physician care, prescribers, nurse practitioners, pharmacies, public health resources and harm reduction resources when they exist for the rest of the population? Why are those not made available to Canadians and first nations populations no matter where they live?

Often this is referred to as a jurisdictional issue. Who's responsible? The Canada Health Act is clear: Our rights as defined in treaties, the Constitution and now the UN Declaration on the Rights of Indigenous Peoples do not erase our rights under the Canada Health Act. This is a decision, a policy decision, not just a matter of geography.

● (1710)

Mr. Brendan Hanley: If you don't mind, I'll jump in there, because my time is limited.

One thing Chief Frost referred to was having spent a million dollars of base funding from the VGFN to, in this case, send people out for treatment. I can't speak specifically to the number of individuals, but I think she mentioned 70.

We know that often when people go outside for treatment and come back into a community, they are at high risk not just for overdose but for relapse because the community supports—the after-care—aren't there. Following up on your previous point, do you know of or could you describe models of care that work within a small community? Maybe there are success stories you know of or have seen about how care can be delivered within a community so that you have continuity through aftercare.

HESA-114

Dr. Carol Hopkins: There are communities, no matter how big or how small, remote or isolated, that have partnerships with local health authorities, physicians, prescribers and nurse practitioners, who deliver services by flying into the community from time to time or by monitoring their patients through video conferencing. There are partnerships with the chief and council and direction through a band council resolution on how health services are operating through the health centre, as well as these kinds of partnerships with elders and cultural practitioners. It's clinical support and medication, together with culture-based resources, that have made a difference.

I gave an example of a community in northern Ontario where that significantly reduced crime and the number of kids going into child welfare. Kids showed up to school with food in their stomachs, houses were filled with furniture, toys and food, and life returned to normal, because it's a whole-of-community approach and because the community, through a number of partners, had the resources it needed to respond to the whole population. It's not just about the impacts on the individual who uses drugs. It's about the impact on the family and the whole community.

The Chair: Thank you, Dr. Hanley. That's your time.

[Translation]

Mr. Thériault, you have the floor for six minutes.

Mr. Luc Thériault: Thank you, Mr. Chair.

Thank you to the witnesses for being here.

Personally, I have no preconceived ideas about the crisis we're trying to understand and fix by means of recommendations. In listening to the various witnesses, though, I end up feeling a little confused. There seems to be no scientific consensus. In fact, increasingly, there appears to be a division within the scientific community or among the professionals working in the field.

Professor Pauly, you talked about safe supply, which saves lives. I guess that was the purpose.

First, does safe supply necessarily have to be temporary? If so, how can we assess that?

Second, why is access to opioid agonist therapy at odds with the impact of safe supply?

• (1715)

[English]

Dr. Bernadette Pauly: These are two very important questions.

I just want to speak for a second about the split in scientific evidence that the member referred to. There isn't actually a split when you look at what is considered peer-reviewed evidence or evidence that's been reviewed by multiple scientists in the field.

Our team did a study where we looked at all of the evidence for safe supply. There are close to 40 of these types of peer-reviewed articles, and the evidence is overwhelmingly positive: It connects people to a safer alternative, reducing overdoses; connects them to health care and other types of supports, as needed, like housing; and reconnects them back to family and community. I just wanted to mention that evidence.

Should safe supply be temporary? This is a good question, because when it was introduced in British Columbia, it was introduced as a temporary measure. However, it became clear that we needed it as part of a systems response. I really want to emphasize this piece about a systems response. In British Columbia, we had some evidence early on that when we combined multiple interventions, like take-home naloxone with opioid agonist treatment and overdose prevention, it showed some really good results. However, it wasn't enough. Safer supply comes in as another form of intervention within a comprehensive approach.

As to your question about why there's opposition, I personally don't understand why safer supply is being scapegoated, because the real harms here are coming from a very toxic and unregulated drug market. That is what's killing people.

[Translation]

Mr. Luc Thériault: For example, what's your opinion on Dr. Koivu's statement regarding scientific consensus around safe supply?

[English]

Dr. Bernadette Pauly: Our evidence has shown that it reduces overdose deaths, and I can point to other studies where it has not been shown to increase rates. Rates of addiction have not been increasing since we introduced safer supply. The description that Dr. Koivu gave is about the ever-escalating need for increasing dosages. That's not what I see happening in the way that prescribers in British Columbia are practising. In fact, in our study, we found that safer supply medications were, at least in the first 18 months, at a lower dose than we see with traditional opioid agonist treatment.

I do a lot of qualitative research. I interview people who are receiving safer supply, and I often ask them about their goals. I would say that, frequently, what they talk about is the goal of getting off safer supply. That might include using safer supply for a period of time and maybe transitioning to OAT, but they have a plan because they too want to live a full life and have a high quality of life. Those kinds of goals are, I think, really important.

That's some of the reality that I see within the work I'm doing.

● (1720)

The Chair: Thank you, Dr. Pauly.

Next is Mr. Johns, please, for six minutes.

Mr. Gord Johns (Courtenay—Alberni, NDP): Thank you all for your testimony.

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I'll start with you, Dr. Pauly.

You heard from Dr. Koivu. She raised concerns about infectious complications for people using safer supply. Is this something you found in your research with people who were injecting fentanyl and then switching over to safer supply, or people who started on safer supply? Is this what you're seeing in your research as well?

Dr. Bernadette Pauly: I'll give you a bit of background. When people are injecting from the unregulated and toxic drug market, there are additives. My colleagues on the panel have spoken to this and to how harmful the additives in the unregulated market are. They often cause abscesses and injections.

I believe the committee had a brief submitted by Dr. Gomes, who looked at administrative data for people receiving safer supply—this was in Ontario—and the rate of infections went down when they went into a safer supply program, likely because they were no longer injecting toxic substances from the unregulated market. However, they also would have had a connection to health care, and that's a really positive outcome of safer supply types of programs. In British Columbia, we have more injectable formulations, so if there is a concern about injection-related infections, that may be why those are being used more in British Columbia.

Mr. Gord Johns: Dr. Koivu, given what Dr. Pauly said, could you please submit, within 14 days, your own research to this committee that supports your claims on infections caused by hydromorphone?

Is it the will of the committee to get support for that?

Did the witness agree, Mr. Chair?

Dr. Sharon Koivu: I can-

The Chair: Well, if you've asked her to provide it and she agrees to provide it, I don't think you need everyone else's opinion.

Mr. Gord Johns: I wanted to make sure that was on the record.

Thank you so much.

I'm going to go to Ms. Hopkins.

You were a co-chair on the expert task force on substance use. The expert task force was unanimous in recommending that we scale up safer supply, stop criminalizing people who use substances and ramp up treatment on demand, recovery, prevention and education

You had a really wide spectrum on the expert task force on substance use. Can you speak about your disappointment, maybe, with the government not following through with the recommendations and your experience with how important it would be to reinstate the expert task force and implement those recommendations?

Dr. Carol Hopkins: We're talking about using evidence, and the question is about whose evidence is more credible. That's quite a common conversation when it comes to first nations people, whose world view and culture-based evidence are typically set aside. However, that does not mean, for example, that culture and safer supply are completely incompatible.

Safer supply is one more tool in the tool box. There is no silver bullet. There is not one medication. There is not one strategy, method or form of care that will solve the opioid crisis or the toxic drug supply. There are many strategies that have to be used together in combination, like—

Mr. Gord Johns: I don't know if the question was heard properly. I apologize for that.

We just heard from the First Nations Leadership Council and the B.C. First Nations Justice Council. They're calling for an emergency cross-governmental and multilateral strategy that ensures the safety of people who use drugs.

Dr. Sayers, a BCFNJC member, said that "the toxic drug crisis needs to be treated and addressed as a public health issue, not a criminal justice issue." Grand Chief Stewart said that how we're proceeding right now is "very much wrapped up in the destructive impacts of colonialism."

Can you add your thoughts on those statements?

(1725)

Dr. Carol Hopkins: I just want to emphasize the importance of safer supply. That's one tool that needs to be available to everybody.

In addition to understanding the context of first nations people, as I said earlier, we do not have the community-based resources necessary to address the impacts of opioid toxicity or the toxic drug supply. We don't have services close to home where people need them, when they need them. That often leads them to move, travelling off reserve for periods of time. Often, the crowds they find most welcoming are those involved in selling illicit drugs. Then they come back into the community, and now we're creating a new relationship that has significant impacts on families and the whole community.

For the first time ever, first nations communities are reporting murders, not by first nations people murdering first nations people, but by gangs from large urban environments coming onto reserves and committing these crimes. Gun violence and human trafficking have increased.

If we look at what the perception of that is, we could say that because of racism in Canada, first nations people will be blamed for those kinds of activities; they did this to themselves. That's the same sentiment for people who use drugs. They should just stop; they can just decide to. Why don't they choose something different when they're losing all these things? We're blaming the victims without supporting their right to health and social services.

The United Nations—

HESA-114

The Chair: I'm sorry. Thank you, Dr. Hopkins.

We'll go to Mrs. Goodridge, please, for five minutes.

Mrs. Laila Goodridge (Fort McMurray—Cold Lake, CPC): Thank you, Mr. Chair.

I want to thank all the witnesses for being with us and for being patient. It's unfortunate that Chief Frost had to leave us before we got a chance for questions. I found her testimony incredibly insightful

Dr. Pauly, did the study you cited look at diversion as an issue?

Dr. Bernadette Pauly: That's such an important question, because it's definitely the issue that I would say is creating the most controversy.

I will speak to two ways in which.... While the study didn't directly look at diversion—

Mrs. Laila Goodridge: It didn't look at diversion.

Dr. Bernadette Pauly: No. I will explain-

Mrs. Laila Goodridge: It's yes or no. We have very limited time and I asked a very short question. The convention in this committee is that witnesses answer for about the same amount of time that the question took to ask.

Did diversion get looked at?

Dr. Bernadette Pauly: Diversion was not apparent, because there was a dose-response relationship. In other words, if people got more days of the medication, there was less risk of overdose, which suggests they were taking their medications.

There was a dose-sensitivity relationship. Higher doses meant less risk.

Mrs. Laila Goodridge: Thank you.

Dr. Bernadette Pauly: What this led to was people taking their meds in many cases.

Mrs. Laila Goodridge: Dr. Koivu, I'm sure you've seen the proposals coming out of the city of Toronto asking to move toward decriminalization for that city. Do you think that will have impacts on communities like London?

Dr. Sharon Koivu: I think anything that happens in Toronto is definitely going to have an impact on London. What we're seeing in London has been largely affected, I think, by decriminalization as it is

We're certainly seeing a lot more open drug use. It's very common to see people injecting in parks, smoking fentanyl in parks and injecting Dilaudid in public spaces already, so I think that's something we'll have a problem with.

Mrs. Laila Goodridge: Really quickly, have you seen a change in the drug deaths in London since the so-called safer supply program came in?

Dr. Sharon Koivu: Absolutely.

I don't know how to answer that very quickly, but the first thing I'll say is that in 2016, our overdose deaths were equal to the province's. In 2022, for which we have information, the provincial rates went up by about 2.7% and London's went up almost fourfold.

There's a significant increase in overdose deaths compared to the provincial average. There's also a significant increase in overdose deaths compared to the other community I work in just south of there, which had exactly the same rate in 2016 and now continues to be the same as the provincial average.

The other place where I see significant change is in youth. If you look at the youth population—this data is all available on Public Health Ontario's opioid tool—for people 15 to 24, London's rate was lower than the provincial average in 2016 and now it's substantially higher. It's the same with people 25 to 44. When I'm looking at people I would consider young, there has certainly been an increase in deaths.

The other thing is that hydromorphone is absolutely more common. It's twice as common to find hydromorphone in deaths in London than in the provincial average. Often, the provincial averages dilute things. If you go to Ontario, you'll find that where safer supply has been available, there are increases over provincial averages.

(1730)

Mrs. Laila Goodridge: Thank you. I appreciate that.

I'm now going to move a motion that I put on notice on Friday. It says:

That the committee invite the Minister of Mental Health and Addictions and Associate Minister of Health before the committee for no less than two hours; and that the study of the opioid epidemic and toxic drug crisis in Canada be extended by six meetings to invite further witnesses.

I think it is absolutely incumbent on us, as we've been hearing testimony and seeing the entire situation shift, that we have more witnesses come so we can explore some of the public safety and other aspects that we have not been able to fully explore through this committee. I understand that we've had some conversations about amendments.

With that, I will cede the conversation.

The Chair: Thank you, Mrs. Goodridge.

The motion is in order. The debate is on the motion.

Dr. Ellis has the floor.

Mr. Stephen Ellis: Thank you very much, Chair.

I appreciate the comments from my colleague on the need to continue this discussion. It's important that we underline for Canadians the fact that some controversy exists here. Not all of it is based on science and much of it is based on opinion, which is not necessarily helpful when we know there are good scientific-based arguments. Many of my colleagues may not like that those exist, but they do.

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It's important to continue on this road to enable this committee to understand that some of the science that has been referenced here does not answer the questions that we need answers to. It's also important to understand that the Government of British Columbia has asked for an end to the decriminalization experiment, which has certainly been outlined by communities such as New Westminster, Richmond, Campbell River, Kamloops and Sicamous. As Canadians hear more and more about the experiment, Canadians are fearful for their own communities. They're fearful for their communities because of contamination from used paraphernalia. They are concerned because of the potential for exposure of drugs to children, and we've heard even to pets in some areas.

The other thing that I've heard directly from Canadians is they are concerned about the loss of accessibility to their downtowns. That's a concern that we heard very clearly from a deputy chief constable in Vancouver, who testified at this committee not that long ago. She made it very clear that the decriminalization experiment has led to the loss of downtowns. Substances are being used outside of businesses, outside of residences, on transit and near schools, parks and beaches. The deputy chief constable's testimony noted that police were powerless to stop this type of activity.

The Minister of Mental Health and Addictions has spoken very forcefully about this in the House of Commons and in the media in attempting to explain away the request by the Government of British Columbia to end the experiment. I find that interesting, because it was the Government of British Columbia that came to the federal government asking for the experiment, but we all know, even though this is not scientific in a sense, that when an experiment is going awry and the people in charge of the experiment say they need to end it, it needs to end. When doing a scientific experiment such as a randomized controlled trial, if the lead investigators understand that something has gone awry, they don't continue the experiment. They stop it, and they don't wait for days and days to stop it. They stop it immediately when those signals are out there.

I'm very disappointed in the NDP-Liberal government, and specifically in the Minister of Mental Health and Addictions. The British Columbia government has asked for the experiment to end, and now there are negotiations with the NDP-Liberal government to continue the experiment. If we want to talk about this and we use the metaphor I used, even though I realize it's not scientific, then we know clearly that the experiment must end now for the betterment of this country, because it's a failed experiment. We've heard that over and over. We know it's a failed experiment. The B.C. government knows it's a failed experiment.

The question that I have—

• (1735)

Mr. Gord Johns: I have a point of order, Mr. Chair.

Mr. Stephen Ellis: —is this: When will the NDP-Liberal government will know it's a failed experiment?

The Chair: Dr. Ellis, there's a point of order from Mr. Johns.

Mr. Gord Johns: Mr. Chair, just for clarification, the B.C. government has not asked to stop decriminalization in British Columbia—

Mr. Stephen Ellis: Excuse me, Mr. Chair, but that's not a point of order.

The Chair: Thank you, Mr. Johns. That is not a point of order. It's a question of debate, so I'm going to cut you off there.

Mr. Gord Johns: Mr. Chair, I think it's been ruled by the chair—

Mr. Stephen Ellis: Thank you very much, Mr. Chair.

When my colleague wants to have the floor, he can raise his hand and have his turn. He should know that. He's been here long enough. Even though perhaps he is ideologically motivated by his wacko comments, we need to continue on with this.

That being said—

Mr. Gord Johns: Mr. Chair, on a point of order, it is completely unacceptable for a member to be calling another member wacko.

The Chair: Mr. Johns, please contain yourself. He said that your comments were wacko. That may be unpleasant to hear, but it wasn't an attack on you. Your interruptions do not constitute points of order. I would ask that you wait your turn. You are on the speaking list; you're third.

Dr. Ellis, go ahead.

Mr. Stephen Ellis: Thank you very much for that, Mr. Chair.

I don't mean to disparage the member. As I said, his comments are wacko. I think it is important to understand that the citizens of this country no longer want to tolerate ongoing difficulties with the experiment. It has been termed by my friend and colleague Dr. Hanley from the Liberals as an experiment from the outset. It was part of the motion of this study here at the health committee.

I'll end my comments there. Thank you, Mr. Chair.

The Chair: Thank you, Dr. Ellis.

Madam Brière, please go ahead.

[Translation]

Mrs. Élisabeth Brière (Sherbrooke, Lib.): Thank you, Mr. Chair.

First, Dr. Ellis is clearly conflating decriminalization with drug use in public spaces.

Second, the government of British Columbia didn't request an end to decriminalization. Rather, it asked that its request be reviewed.

Regarding the motion, since the minister has already appeared before the committee and there will be a four-hour committee of the whole in the House before the end of the month, and given our upcoming trip next week during which we'll have the opportunity to meet people on the ground and ask all our questions, I suggest amending the motion to read as follows: "that the study of the opioid epidemic and the toxic drug crisis in Canada be extended by two meetings to invite further witnesses."

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[English]

The Chair: All right, we have an amendment. The amendment is in order. The effect of the amendment is to replace identifying the minister and the number of meetings, simply bringing it down to two additional meetings to hear from witnesses.

The debate is now on the amendment, and Mr. Vis has the floor.

Mr. Brad Vis (Mission—Matsqui—Fraser Canyon, CPC): Thank you, Mr. Chair.

I won't take too much time. I am a British Columbian, and it's nice to see you again. It's been a few years.

The Leader of the Opposition mentioned the Abbotsford Soccer Association in question period today. My son was playing on the weekend, and I asked Coach Gill, the youth coordinator for the first kicks program, about what was taking place and the letter that was featured widely in our local regional media.

Decriminalization in British Columbia has led to widespread chaos. There were kids who saw a woman get raped at our soccer field last year, and she was on drugs when it happened. The stuff is devastating. My office is adjacent to Haven in the Hollow, which was a homeless shelter that became a safe injection site. During the pandemic, it became a place where people could openly do any drugs they wanted and consume alcohol. It brought chaos to the neighbourhood where my office is. The Legion came to me a few weeks ago. It's less than a block away from the site, and every day they have to ask people not to consume meth, crack and other hard drugs on site.

The decriminalization order put forward by the government was very clear that it wouldn't apply to those types of places, but since it has been unleashed, the consequences have been grave for the residents of the Fraser Valley. I'll note as well, in the context of decriminalization, that in the health region where I reside, the Fraser Health region, we had, I believe, last year—and don't quote me on this—one of the highest per capita death tolls after Northern Health in British Columbia. At the same time as we had a record number of deaths proportionate to the rest of the population in British Columbia—the second- or third-highest number—there was no increase in funding to help people get clean and help people access a detox bed and a site that would give them the treatment they needed.

Decriminalization is killing a lot of British Columbians, and I would encourage everyone to vote for this motion. I think it's a good one.

Thank you for your time.

(1740)

The Chair: Thank you, Mr. Vis.

Next we have Mr. Johns, and then it's Dr. Powlowski and Monsieur Thériault.

Mr. Gord Johns: Thank you.

First, in terms of extending the number of meetings, there are lots of reasons why we should have more meetings.

I look at Fort McMurray. They had an all-time high drug poisoning death rate in the last year. Alberta's death rate from toxic drugs has gone up 17% over the last year. They're on a trajectory to pass British Columbia by June. There are 43.3 deaths per 100,000. British Columbia is at 46.6 deaths per 100,000. Lethbridge has triple the toxic drug death rate of British Columbia. That's all without decriminalization and without safer supply. Regina has a 43% greater death rate per 100,000 than British Columbia.

It is absolutely a tragedy what is happening in the provinces without safe supply and without decriminalization. We are seeing a literal disaster happening. It's a health emergency. In fact, up in Alaska, which neighbours those provinces, there was a 45% increase in toxic drug deaths last year. It's a Republican state without safe supply and without decriminalization.

We're constantly hearing about the need to.... We heard from the police chiefs association that the diversion of safer supply is not what's killing people; it's deadly fentanyl. We heard from Dr. Pauly today that 85% of deaths are from fentanyl, and only 3% of people who died had traces of hydromorphone.

The police were clear that criminalizing people who use substances causes more harm. That's what we heard from the expert task force and the police chiefs association, and what we continue to hear from chief medical health officers, including every single chief medical health officer on Vancouver Island. They have been unequivocally clear that criminalizing people causes more harm and that safer supply reduces deaths.

We have peer-reviewed data that the very small amount of safe supply that is used to replace toxic street drugs—which are unregulated, and manufactured, marketed and sold by organized crime—reduces the risk of toxic overdose deaths. We have had a multitude of reports. I believe the chief medical health officer for Toronto is also asking for the government to consider decriminalization.

We've heard from the police chiefs association repeatedly about the fact that there is no going back on criminalizing people. "Those days are gone." That is a quote from the president of the British Columbia Association of Chiefs of Police. They were looking for tools in British Columbia to move people out of public spaces so that they could make sure the public felt safe. At the same time, they were clear that they want to see more safe consumption sites.

I'm disappointed that we won't be in Lethbridge, because Lethbridge is where they closed a safe consumption site, and Lethbridge is ground zero in Alberta. It has the highest death rate in the province of Alberta. It has three times the toxic drug deaths that we're seeing in British Columbia. In Medicine Hat, there are 63 deaths per 100,000. That is almost 40% greater than the death rate we're seeing in British Columbia, and it's almost the highest death toll we've seen in any health authority in British Columbia.

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I just wanted to highlight these really important reasons why we need to have more meetings. I support having two more meetings. I hope we can centre one of those meetings on getting a purely indigenous perspective. I think we should invite Ms. Hopkins back, out of respect, since this meeting might be cut short and her testimony might be cut short and minimized. I would hate to see that happen, especially when we know that indigenous people in my home province are seven times more likely to die from a toxic drug overdose. In her community, it was 36 times more.

(1745)

We also heard from Ms. Petra Schulz from Moms Stop the Harm, when she testified, that the recovery model in Alberta is just a name. We heard that for a nation south of Lethbridge that was promised a therapeutic treatment centre, the only shovel that's gone in the ground was a ceremonial one three years ago. People are waiting. They're waiting up to six months to get help in certain parts of Alberta. That's if they want help.

The goal should be to keep people alive. Harm reduction, treatment and recovery go hand in hand. We don't need to have one without the other. This is a crisis that is ravaging North America. It is skyrocketing in Conservative provinces and Republican states. We need to change direction. We need to work collectively.

In Portugal, politicians were successful when they got out of the way and let the experts lead with evidence-based policy, evidence-generated policy and peer-reviewed research. That's how they moved forward. I can't think of another health issue where politicians are having their say like this and interfering with what is truly a health issue.

I support going to two meetings. I also wanted to make sure that my comments were on record.

The Chair: Thank you, Mr. Johns.

Dr. Powlowski, please go ahead.

Mr. Marcus Powlowski (Thunder Bay—Rainy River, Lib.): I would like to get back to the expert witnesses we've invited here and not listen to other MPs wax on about their views on this subject. I was certainly tempted to move a motion to adjourn debate, but I won't.

Can we not all decide to vote on this? There seems to be unanimity. Let's vote and let's get back to the witnesses. We are doing a study on this subject. We invited these people here to ask their opinions, and I'd like to get their opinions.

Thanks.

The Chair: Thank you, Dr. Powlowski.

[Translation]

Mr. Thériault, you have the floor.

• (1750)

Mr. Luc Thériault: Mr. Chair, I find it quite ironic that a motion is being tabled to hold more meetings and hear from further witnesses, while our witnesses are being sidelined today. We had many questions to ask them.

I'll be brief, so as not to contradict my previous statement. I said I was willing to extend the duration of this study. I believe we can trust ourselves. We want to present recommendations that will matter and not just be shelved. We'll be going to see what's happening on the ground. I would have been very comfortable with extending our study. If, one day, we realize that we need four meetings, we'll hold four meetings.

However, for today, I would like to hear what the witnesses have to say. This isn't the first meeting that has been interrupted by a motion. We should perhaps take a look at how the committee works. I would rather discuss our business in a subcommittee than during a study, where we make a spectacle of ourselves in front of witnesses about our understanding of the issue. I find it disrespectful. I'll stop there.

I'm ready to hear any proposals. However, when we have witnesses with us, let's ask them questions so that they can provide information.

In two and a half minutes, I would like to ask the remaining witnesses what they think of the situation in Vancouver and what they think of criminalization being reinstated in British Columbia.

The Chair: Thank you, Mr. Thériault.

[English]

There are no further speakers on the list. I presume that we are ready for the question.

The question is on the amendment. Just to be specific, the amendment is to delete the following words from the motion: "That the committee invite the Minister of Mental Health and Addictions and Associate Minister of Health before the committee for no less than two hours; and". It would also change the word "six" to "two".

The amendment would be the following: "That the study of the opioid epidemic and toxic drug crisis in Canada be extended by two meetings to invite further witnesses."

All those in favour of the amendment?

(Amendment agreed to)

(Motion as amended agreed to)

The Chair: The motion is adopted unanimously.

Thank you, everyone. That brings us back to the witnesses.

Mrs. Goodridge, you have 47 seconds left in your turn.

Mrs. Laila Goodridge: Thank you for that, Mr. Chair.

I'll go really quickly to Dr. Pauly.

More people are dying in British Columbia despite both safe supply and decriminalization. Why do you think that is?

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Dr. Bernadette Pauly: They're dying because 85% of deaths are caused by a toxic, unregulated drug market, and we haven't adequately scaled up interventions like harm reduction and treatment. It's a combination of those things that will reverse the trend.

Mrs. Laila Goodridge: Do you believe recovery from addiction is possible?

Dr. Bernadette Pauly: I believe recovery is absolutely possible, and it is an individual journey. There are many pathways to recovery.

The Chair: Thank you, Mrs. Goodridge.

I'll go to Dr. Powlowski, please, for five minutes.

Mr. Marcus Powlowski: Dr. Pauly, I'm sorry for putting you on the spot, but help the committee out. In response to Mr. Thériault, who said that the experts seem to have different opinions as to the evidence for safe supply, you said that you did a peer review and it seemed to pretty overwhelmingly show the benefits of safe supply.

Let me just point out what else our committee has heard. We asked Health Canada to appear before the committee. We had the experts who I think were behind approving B.C.'s request, and they seemed to be in favour of safe supply. They themselves admitted that there wasn't very good evidence for the benefits of safe supply. I would note the B.C. health officer, in a review of prescribed safer supply, said:

Most of the limited published peer-reviewed studies lack a control or comparison group and the actual intervention received by study participants is in most cases a combination of broader access to wrap around health services including [safe supply]...and primary care, making it difficult to attribute any benefits to PSS alone.

They suggested that they need to have more studies.

The Stanford-Lancet commission, which looked at the opioid crisis—and I would point out that these aren't a bunch of right-wing fanatics—in their study said, "the evidence clearly shows the folly of assuming that population health inherently improves when healthcare systems provide as many opioids as possible with as few possible regulatory constraints as possible." They, too, were against safe supply. We talked to the head of that commission, and he said the problem with safe supply is that basically you're replicating what has caused the problem to begin with, which was doctors prescribing too many narcotics, people getting on them and then people having trouble getting off them.

Do you continue, though, to say that no, the evidence is clear that safe supply is good?

• (1755)

Dr. Bernadette Pauly: I really appreciate that question about the science, because it has been very confusing and disturbing to see the way that some of the debates have played out.

To begin, many of the citations that you provided preceded 2020 and were from the very early days of the development of the body of evidence on safer supply. Since 2020, it's doubled. In fact, some of the strongest evidence has emerged in about the last six to 12 months. Our team is obviously at the forefront of producing evidence in British Columbia, where we are seeing positive impacts.

Yes, I stand by my statement. After a review of over 40 studies, the findings were overwhelmingly positive. What I really want to urge this committee to do is separate ideology from evidence. I don't think any of my colleagues wouldn't say we need more treatment, yet we know there are still challenges with treatment. People come out of treatment and do relapse. We need to look at what kind of comprehensive system we're creating instead of creating these ongoing tensions.

I'll stop there if you have a follow-up.

Mr. Marcus Powlowski: The B.C health officer's report was quite recent, as was Health Canada's, and after looking at the evidence, I certainly wasn't overwhelmed with it. However, let's change the subject.

Your study wasn't a randomized control trial, which is the gold standard, and the validity of your results depends on how well you matched the people getting safe supply with those who weren't getting safe supply.

One of my concerns with your study—and you can correct me if I'm wrong—is the comparison group, the people who weren't in safe supply. You got those names from various places, one of them being the discharge abstract database, which, in my understanding, is from hospital records of people who had been admitted for either a diagnosis or something to do with using opioids. My concern is that in your comparison group, you have a sicker population, because they've been in the hospital recently, either because they overdosed—

The Chair: Dr. Powlowski, you're out of time. If you could get to a question, we can get a short answer.

Mr. Marcus Powlowski: She's heard my question. I guess I get no response for her answer, but am I wrong?

Dr. Bernadette Pauly: Is it possible for me to answer?

The Chair: Do so as succinctly as possible, Doctor.

Dr. Bernadette Pauly: Okay. Thank you.

Our study came out after the provincial health officer's report, as did a number of other studies. On the control group, multiple linked databases were used to generate, through two different methods, the control group, matching on multiple variables. I'd be happy to refer you to Dr. Nosyk's seminar, which explains extremely well how the matching occurred and the similarity between the two groups.

• (1800)

[Translation]

The Chair: Mr. Thériault, you now have the floor for two and a half minutes.

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Mr. Luc Thériault: Thank you, Mr. Chair.

In a previous meeting, we heard from Dr. Morin, who told us that addictions are complex chronic diseases. This complicates matters because multi-pronged action is required. Furthermore, we're told that relapse is part of the process. British Columbia is trying to correct course, in a manner of speaking.

My question is for Ms. Hopkins, but Ms. Pauly can also weigh in if there is time.

How do you see the situation in British Columbia, and what do you think about the government's desire to correct course? In your opinion, must this lead to "recriminalization"?

[English]

Dr. Carol Hopkins: Absolutely not. Thank you for the question.

The expert task force on substance use and mental health recommended safer supply and decriminalization, but they also said that it should be within a full spectrum of supports for people who use drugs or substances, or who wish to enter into a recovery journey.

The task force clearly recommended a more comprehensive and responsive system. When you provide people with the medication they need to live life every single day but they don't have a home, they don't have income security or food security, and they don't have people they can rely on to support them.... Every person needs another person to support them and to be a champion for their belief in their ability to succeed in life, whatever that means from their perspective. Those comprehensive supports are absolutely necessary as an addition.

As I said, there's no silver bullet. There are many instruments that will support change and will keep people alive. Safer supply and decriminalization are not a silver bullet. They're not meant to end the opioid crisis and the toxic drug supply, but they will keep people alive. They will ensure that human beings have the right to live life. That should be our goal: to make sure that human beings can continue to live life. There are many tools. There have to be many tools.

This is not an easy answer, and it's not an easy solution, but what we're seeing is a focus on one technique, one answer, and on criticizing it without considering the other resources that are necessary. When those other resources are in place, we've seen positive changes that have impacted families, their children and their communities. They increase safety, decrease the number of kids in child welfare, increase the number of kids going to school and increase safety in the community. I can't stress enough that a comprehensive approach is necessary.

The Chair: Thank you, Dr. Hopkins.

Dr. Carol Hopkins: Thank you.

The Chair: We'll go to Mr. Johns, please, for two and a half minutes.

Mr. Gord Johns: Dr. Pauly, you talked about the effectiveness of safer supply, and you cited some really important information. Can you also talk about why safer supply hasn't been scaled up? What are the barriers you're seeing?

Dr. Bernadette Pauly: This is a really important question. Without a doubt, part of the barrier is the politicization of safer supply and blaming it for what is a problem of the toxic and unregulated drug market. Safer supply is part of a comprehensive solution.

Some of the challenges related to increasing access—

The Chair: Excuse me, Dr. Pauly, but we're having a problem hearing you here.

Dr. Bernadette Pauly: I'm sorry. Is that any better?

(1805)

The Chair: Yes. Please go ahead.

Dr. Bernadette Pauly: What I was saying is that part of the reason that safer supply hasn't been scaled up is it's been highly politicized. That's a harmful narrative when the real problem is a toxic and unregulated drug supply.

In terms of scaling up, we've had quite a lot of insight from the research we've done around prescribers, and particularly the idea of prescribers not being attacked or feeling criticized by their colleagues and recognizing the importance of the intervention and the support of regulatory colleges. One interesting finding is that nurse practitioners are three times more likely to prescribe safer supply. In that finding, there are opportunities to remove barriers, particularly in rural and remote communities. I'd also mention that in British Columbia, the First Nations Health Authority has a virtual substance use and addiction program, which was found to facilitate access for people in rural and remote communities.

We haven't talked much about non-prescriber-based models, but I wanted to highlight that in British Columbia, only a portion of the people who died of an overdose actually had an opioid or substance use disorder. We have to remember to consider alternatives that provide access and that are appropriate and well regulated for people who are accessing the toxic drug market and don't necessarily meet that criteria.

The Chair: Thank you, Dr. Pauly.

Thank you, Mr. Johns.

Next we will go back to Dr. Ellis for five minutes.

Mr. Stephen Ellis: Thank you very much, Chair.

I know it's been a bit of an up-and-down meeting for the witnesses. I appreciate your patience with all of us.

Dr. Koivu, I'd like to go back to the concept of safe supply. Maybe you could, for the benefit of Canadians out there, talk a bit about the specific difference between opioid agonist therapy and safe supply. Of course, we know that opioid agonist therapy has a significant amount of scientific literature supporting it. Could you explain the difference? I think that would be important to Canadians.

Dr. Sharon Koivu: Thank you for that question.

Opioid agonist therapy is about having people on a treatment that can stabilize them neurochemically, having them not chase what we talked about earlier with withdrawal and really allowing for recovery. The two main types of opioid agonist therapy are methadone, which has been around for years, and buprenorphine. Buprenorphine was not available at the time the study in London was started.

Buprenorphine is a chemical, an opioid. As to how it works, as you increase the dose, you don't get an increase in negative effect. It is the drug most proven to decrease the risk of overdose. When people are on it, they have a decreased risk of overdose from taking it and from taking other substances.

Buprenorphine now comes in a daily sublingual formulation. It also comes in an injectable formulation that is usually referred to as Sublocade, which is given every four weeks. This is a game-changer because it allows people to get their lives back and get back to the community. Not having to worry about accessing a pharmacy daily is certainly helpful in remote communities as well. It provides a healing of the brain to allow people to have recovery and function normally.

Safer supply programs are about continuing to give opioids at doses that aren't witnessed. I think it's important to recognize that when people are started on methadone and Suboxone, we check what they're able to take. We understand their tolerance. We work with them as we're witnessing what they're taking and we know what they're taking. When people are started on safe supply, that is not the case.

I'm going to be a bit more specific about my own community. A dose can continue to go up without reflection on whether it's a safe dose for a person or a safe dose for the community. It's generally given to them on a daily basis. Sometimes it's every few days. Then the dose is escalated. In my community, generally that's at request, without any evidence that it's what they need. Even when there is evidence that they don't tolerate their dose, it isn't necessarily decreased.

People will continue to have to go to a pharmacy, usually on a daily basis. It means that they're continuing to, from a neurochemical perspective, chase withdrawal. It is about continuing somebody in an addiction. They're maintaining their addiction. They're being maintained in a state where they are addicted to the medication.

• (1810)

Mr. Stephen Ellis: Thank you very much for that, Dr. Koivu.

I have a final question. I'm not sure if you know the answer to this or not, Dr. Koivu.

Our understanding from other testimony is that the street price of Dilaudid at eight milligrams has dropped significantly, which is evidence—perhaps not scientific—of diversion. Is that the experience in your community as well? Maybe you could talk about the price.

Dr. Sharon Koivu: Absolutely.

It's a market-driven economy. As there has been more diversion and more available.... My understanding from patients and from living in the area is that in 2016, a D8 was about \$20. If you're

close to the supply—close to where more diversion takes place or the core of London—then it varies, but it's usually about one to two dollars. As you get farther away, it's more expensive.

It really is about supply and demand. As the supply has gone up and there's more and more Dilaudid available in London, and from the amount of tolerance people have compared to what they're prescribed, certainly the amount I'm hearing about.... The numbers are certainly over a million D8s in a year, and as that number has gone up, the price has definitely gone down.

The Chair: Thank you, Dr. Koivu.

[Translation]

We will now move on to the last speaker.

Ms. Brière, you have the floor for five minutes.

[English]

Mrs. Élisabeth Brière: Thank you, Mr. Chair, and thank you to all of our witnesses.

Dr. Hopkins, I have one question for you. What does supporting the voice of people who use drugs mean to you?

Dr. Carol Hopkins: Many people who are experts in their field have expertise and know the science behind their expertise. They publish. They know their work very well. We rely on them often for evidence so that we make informed decisions. We don't typically understand or give credit to the experience of living life every day with the types of conditions we're talking about: living with a dependency on opioids, having to survive the processes of coming to the right dosage for them and how people feel about that. Every person's being, their physical being, is different from every other person's. The type of medication needed, the amount of medication needed to address the issues of dependency, and the neurotransmitters that are significantly changed because of the types of drugs being used are all in the story of lived and living experience. It's a credible source of evidence.

If you listen to people who use drugs, you will find similarities. Whether you're talking to somebody in Vancouver's Downtown Eastside or somebody from a first nations community in northern Ontario, they've never met each other, but they will describe the same experiences of withdrawal. They'll talk about their tolerance of incremental increases to their addictions medicine. That's credible evidence.

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Listening to their voices means that we give credit to people, not because of their status in life because they're using and not because we're judging them or discriminating against them. We're listening to them because they can tell us a real story that is mimicked across the country. That's important evidence. Listening to those voices is just as important, if not more substantial, to the decisions that need to be made about the health care system and the wraparound services that are provided to any population of people to ensure they can continue living life without the mental anguish and physical anguish that go with withdrawal.

People don't wake up every morning wanting to die. They get to those hopeless stages when we have opinions that form decisions and when we make decisions without looking at all the variables that impact something like we are talking about: safer supply and the toxic drug crisis. We can look at any one perspective and say that one perspective is credible evidence, and it may be, but if we don't look at it in the context of the determinants of health, for example, and how people learn to survive every day, then we're short-sighted and we end up making decisions as though we're God. Not one of us has the right to decide who gets to live, who is expendable and who should die.

(1815)

[Translation]

Mrs. Élisabeth Brière: Thank you.

You say that every individual is different and needs to follow their own path.

Do you think that a more holistic approach, which includes the four pillars, is the best option for responding to the current overdose crisis?

[English]

Dr. Carol Hopkins: Absolutely. We need every tool and every strategy that is instrumental for ensuring life. Not one individual

can live on this earth all by themselves. We live in relationship to others. We live in relationship to the land and the environment. We have to consider those elements and those four pillars.

HESA-114

We have a substance use strategy in Canada that includes harm reduction. Now we have to figure out what that means. We have to ensure harm reduction, but not only for individuals. We have to ensure we make decisions, policies, resources and programs that reduce harms to families and communities. That does not mean erasing the right to medicine, the right to mental wellness, the right to live and the right to the sacred breath of life. We have to provide and look at life from a holistic perspective. We can't afford to say, "You as a population don't have the right to life" or "You as a population, because you use drugs, don't have the right to health."

The outcome of the UN declaration on the world drug problem—which Canada supported—was that, instead of a war on people, we had to ensure the right to prevention and treatment. Unfortunately, we couldn't get harm reduction in the declaration at that point. However, this year, the UN Commission on Narcotic Drugs had a vote that passed, putting harm reduction in international drug treaties. Now it matches what Canada has said, and we have to invest

The Chair: Thank you, Dr. Hopkins, Dr. Pauly and Dr. Koivu.

When we invited you, we told you that we would have you out by 5:30. You've been very generous and patient with your time and very thoughtful in your presentations. Our study will be better because of your contributions. Thank you so much for being with us here today.

Is it the will of the committee to adjourn the meeting?

Some hon. members: Agreed.

The Chair: The meeting is adjourned.

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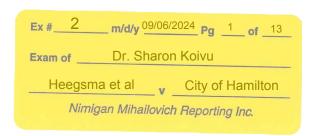
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Dr. Sharon Koivu: 'Safe supply' has only worsened the addiction crisis in London, Ont.

Since the program started in 2016, patient deaths and infections have shot up, and prescriptions have been diverted to the streets

Dr. Sharon Koivu, Special to National Post

Published Jun 10, 2024 • Last updated Jun 10, 2024 • 5 minute read

Join the conversation



A woman prepares to inject Dilaudid at her Windsor, Ont. residence on March 24, 2017. PHOTO BY DAN JANISSE/WINDSOR STAR

I have been a practicing physician in Ontario for 39 years, the last 16 of which have been in London. I have served in many capacities, including having a family practice and working as an acting medical officer of health. Since 2012, I have worked in addiction medicine. I feel compelled to speak out about the harm "safe supply" is causing in my community.

London is home to Canada's first "safe supply" program that started at London InterCommunity Health Centre in 2016. It was, in part, a response to a public health emergency of tricuspid valve endocarditis, HIV and hepatitis C related to the injection of hydromorphone capsules. The goal was to provide high-risk sex workers using these hydromorphone capsules with an alternative: short-acting hydromorphone tablets, also known as Dilaudid.

STORY CONTINUES BELOW

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I lived close to the health centre, and I initially supported the program. We did not have a problem with illicit fentanyl at the time.

The program later expanded to include people potentially at risk of overdose from illicit drug use. Clients are often prescribed 30 to 40 Dilaudid pills per day, many of which are being diverted. This is fuelling the use of illicit fentanyl, which began appearing on the streets of London in 2018, leading to an increase in overdoses. I am repeatedly hearing disturbing stories that people with prescriptions are vulnerable to violence. Diversion appears to have shifted from being sold to individuals to being sold to organized crime as more is appearing in large amounts in police seizures.

It is also causing significant harm to the patients I serve. From 2012 to 2017, I rarely saw patients with spine infections. In the summer of 2017, I saw five patients in one month. The numbers continued to climb. The common thread among most of them was that they were injecting Dilaudid tablets. Most told me that they were buying diverted Dilaudid from clients of the "safe supply" program, while others were in the program directly.



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I had patients who were housed, using clean equipment and only injecting Dilaudid, developing horrific infections. Spine infections cause perhaps the worst suffering I have ever seen. Not only are they unbearably painful, but they can also cause paraplegia or quadriplegia. Since 2017, I have been part of the care team in about 100 hospitalizations of people with injection drug-related spine infections.

In June of 2018, I had my first patient tell me that he had left his apartment to live in a tent near the pharmacy and "safe supply" clinic from which much diversion takes place. This was because "safe supply" pills were cheaper and more abundant near the source. After he moved to this encampment, he, too, developed a spine infection from injecting Dilaudid.

Over the past year, we have seen about one patient per month with a spine infection. Half of these were receiving a "safe supply" prescription and half reported buying diverted Dilaudid. About 30 people per month are admitted with another severe infection. Of patients admitted with opioid use disorder, 25 per cent were receiving a "safe supply" prescription and 25 per cent reported using diverted Dilaudid. Only four per cent of our consults were for an unintentional overdose.

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The failure of "safe supply" was predictable. Purdue Pharma's OxyContin helped start the Addiction crisis, and Dilaudid, which is also manufactured by Purdue, is an even stronger and more addictive

opioid. I and many of my addiction physician colleagues have been warning about the pending harms from the start.

<u>Public Health Ontario data</u> shows that the harms we've been warning about are very real. Prior to the start of the "safe supply" program, the Middlesex-London area was principally less than or equal to the provincial average rates for measured harms from opioid toxicity (i.e., emergency room visits, hospitalizations and deaths). Since the "safe supply" program started and expanded, the harms experienced in Middlesex-London have escalated substantially, beyond the rates experienced in the rest of the province.

The rate of death from opioid toxicity is of utmost concern. In 2014, Ontario had a rate of death from opioid toxicity at 4.9 per 100,000 people. Middlesex-London had a rate of death from opioid toxicity that was much less, at 2.8 per 100,000 people — that's 43 per cent lower than Ontario's average. In both 2015 and 2016, London and the province of Ontario experienced equal rates of death from opioid toxicity.

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Since the onset of "safe supply," the rate of death from opioids has escalated at a much greater rate in Middlesex-London and has consistently remained higher than the Ontario rates. By 2022, opioid-related mortality in London had risen more than four times higher than the rate in 2015, 40 per cent higher than the rate for the province of Ontario.

This has particularly affected youth and young adults, ages 15 to 44. Lives lost in these age groups were generally less than the provincial average, but since "safe supply," they are much greater.

It has also been costly to the emergency department. In 2014, emergency department visits were lower than average. In 2015, they were five per cent higher in Middlesex-London than the rest of

Ontario. From 2020 to 2022, emergency department visits were, on average, 80 per cent higher

Interestingly, London Health Sciences Centre has a <u>\$76 million deficit</u> even after receiving a \$95 million bailout from Queen's Park. While hospital budgets are complex and multifactorial, this deficit parallels the expansion of London's "safe supply" program. Instead of saving health-care dollars, "safe supply" is costly.

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Importantly, as I referenced previously, when "safe supply" started in 2016, we did not have a problem with illicit fentanyl in London. We do now. Many patients have told me they sell or trade much of their prescribed "safe supply" to buy fentanyl. Others, not in the program, have told me that their dealers have sold them fentanyl after claiming to be out of Dilaudid, starting them down that path.

Our hospital experience shows that "safe supply" is also preventing patients from choosing opioid agonist therapy and the opportunity for recovery.

Additionally, the percentage of people found to be positive for fentanyl at death has been very similar in Middlesex-London and the province of Ontario. However, in Middlesex-London, the percentage of people positive for hydromorphone has been 200 per cent higher than the provincial average.

The Public Health Ontario data is conclusive. "Safe supply" programs, evident from the London experience, are not effective at addressing illicit fentanyl or the tragic addiction crisis. "Safe supply" is not safe, and in fact, it substantially contributes to societal harm.

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We need a comprehensive, collaborative recovery-focused approach to the addiction crisis, including the expansion of evidence-based treatments that do not contribute to harm. To prevent further harm, a moratorium on funding and expansion of "safe supply" programs must be put in place. Finally, those currently in "safe supply" programs need the support of an effective exit strategy.

National Post

Dr. Sharon Koivu has been a physician in Ontario for 39 years and worked as an addiction medicine consultant for 12. In addition to front-line health care, her career has spanned teaching, research, leadership and advocacy.

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Adam Zivo: Tales of a safe-supply child soldier







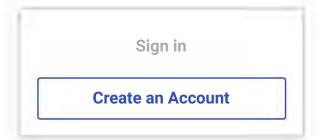




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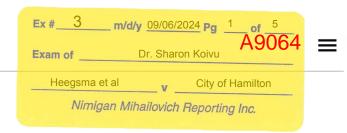
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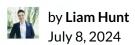
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Community

Leading addiction doctor warns of Canada's 'safer supply' disaster

Addiction physician Dr. Sharon Koivu has seen the effects of safer supply programs in her clinical practice and personal life — and is sounding the alarm





(Dreamstime)

Read: 4 min

Dr. Sharon Koivu, an addiction physician and parent, believes her son might not have survived

1 of 5

to adulthood if Canada's "safer supply" programs had been in effect during his adolescence.

Having worked on the front lines of Ontario's opioid crisis, she views these programs as a catastrophic failure.

In an extended interview, Koivu explained the unintended consequences of these programs, which offer free tablets of hydromorphone — an opioid about as strong as heroin — to vulnerable patients with a history of addiction. While advocates of safer supply claim these programs mitigate the use of more dangerous illicit substances, there is evidence that most users divert — that is, sell or trade — their hydromorphone to acquire stronger substances.

Safer supply was first piloted in London, Ont., in 2016, before being widely expanded across Canada in 2020 with the help of **generous federal grants**. While the program looked good on paper, Koivu, who provides addiction consultation services at a London-based hospital, saw a different reality: her patients were destabilizing, relapsing and fatally overdosing because of safer supply.

Koivu says that "one hundred percent" of her colleagues working in addiction medicine have noticed safer supply diversion. Some patients have told her they have been threatened with violence if they do not procure and divert these drugs. She estimates that, because of safer supply, tens of thousands of diverted hydromorphone pills — also known as "Dilaudid," "dillies" or "D8s" — are flooding into Canadian streets every day.

For context, just two or three of these pills, if snorted, are enough to induce an overdose in a new user.

This influx has caused the drug's street price to crash by as much as 95 per cent. While eight-milligram hydromorphone pills used to sell for \$20 each several years ago, they can now be bought for as little as a dollar or two. These rock-bottom prices have ignited a new wave of addictions and relapses, and lured opioid-naive individuals into experimenting with what is essentially pharmaceutical heroin.

Koivu estimates that 80 per cent of her opioid-using patients now take diverted hydromorphone.

"The biggest harm is that we've turned on the tap and we've made everything cheap which is leading to a large increase in the number of people becoming addicted and suffering," she said.

"It is the most serious issue that I've seen in my lifetime."

Safer supply programs seem to regularly overprescribe opioids without considering patients' actual needs, Koivu says. Patients have come into her hospital with prescriptions that provide 40 eight-milligram hydromorphone pills a day, even though they can only tolerate 10 pills.

'That attraction is horrific'

Throughout the first few decades of Koivu's career, almost "everyone" in her patient pool developed addictions due to childhood traumas or from mishandling opioids prescribed for chronic pain.

Since the advent of safer supply, the origins of new opioid addictions have shifted toward social or recreational exposure. Concerningly, this exposure often occurs in patients' adolescent years.

"I'm seeing an increase in youth becoming addicted," said Koivu, who has had patients as young as 15 tell her their addictions began through diverted hydromorphone.

"Almost everyone I see who's started since 2018 started recreationally. It started as something that was at a party. It's now a recreational drug at the youth level."

Parents often seem completely unaware of the problem. Some have told Koivu they overheard their children discussing the availability of "D8s" at their high schools, only to later realize — when it was too late — they were referring to opioids.

"You can't walk into your house with a six-pack of beer. If you're smoking weed, people can smell it. But you can walk into your house with a lot of [tablets] in your pocket. So, it's cheap, really easy to hide, and is even called 'safe' by the government. I think that attraction is horrific."

A4782

"Our youth are dying at a higher rate ... and we have a lot more hydromorphone found in [their

bodies] at the time of death."

A9067

While safer supply programs claim to make communities safer, Koivu's lived experiences suggest the opposite. She used to reside in London's Old East Village, where the city's first safer supply program opened in 2016, but moved away after watching her neighbourhood deteriorate from widespread crime, overdoses and drug trafficking.

"I moved there to support a supervised injection site," said Koivu. "Then I watched that community drastically change when safer supply was implemented. ... I would go for walks and directly see diversion taking place. Homelessness is very complicated, but this has absolutely fueled it in ways that are unconscionable."

Koivu characterizes the evidentiary standards used by advocates of safer supply as "deeply problematic." She says many of the studies supporting safer supply are qualitative — meaning they rely on interviews — and use anecdotal data from patients who have a vested interest in perpetuating the program.

While Koivu has been blowing the whistle on safer supply programs for years, her concerns largely went unnoticed until recently. She has faced years of harassment and denigration for her views.

"When I came to say I'm concerned about what I'm seeing: the infections, the suffering, the encampments ... I was literally told that I was lying," she said.

Last month, the London Police Service provided the National Post with data showing that annual hydromorphone seizures <u>increased by 3,000 per cent</u> after access to safer supply was significantly expanded in 2020. The newspaper has since raised questions about why this data was not released earlier and whether the police stonewalled attempts to investigate the issue.

Koivu considers herself a lifelong progressive and has historically supported the New Democratic Party. But she is concerned many left-leaning politicians have ignored criticism of safer supply. Many seemingly believe that opposition to it is inherently conservative.

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

had five minutes to give a talk, and then two hours to answer questions, [but] I didn't receive any questions from the NDP or the Liberals."

Although Koivu believes safe supply can play a role in the continuum of care for opioid addiction, she says it must be executed in a meticulous manner that prevents diversion and emphasizes pathways to recovery.

"It needs to be part of a comprehensive strategy to help people get their lives back. And right now, it's not."

Above all, it is Koivu's experience as a mother that drives her to criticize safer supply. One of her sons struggled with addiction as a young adult. Although he eventually recovered, the experience could have killed him.

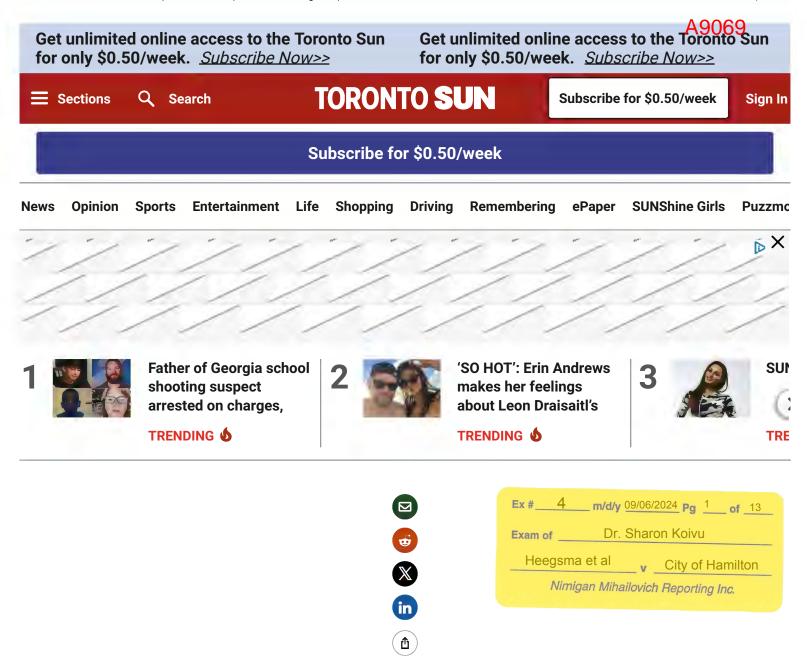
"Had this program been around ... my family could have been another statistic from a drug death. That drives me. Because it's very real, and it's very personal."

Editor's Note: This article has been updated to say Dr. Sharon Koivu provides addiction consultation services at a London, Ont., hospital. An earlier version said she managed an addiction clinic at the hospital. We regret the error.

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A4784



Ontario / Toronto & GTA / Columnists

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

Safe injection site tied to shooting and arrest of suspect has lost the plot by refusing to offering addiction treatment and recovery.

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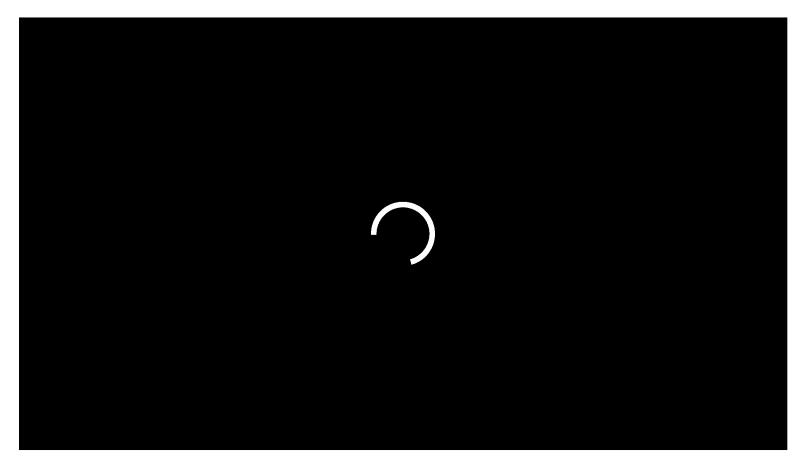
Published Aug 18, 2023 · 3 minute read





The South Riverdale Community Health Centre and safe injection site at 955 Queen St. E. on Friday, July 14, 2023. PHOTO BY JACK BOLAND /Toronto Sun

A doctor specializing in addictions says the ideology on display by the South Riverdale Community Health Centre shows it's time to replace the leadership of the organization. The SRCHC has been in the news for all the wrong reasons lately, starting with a shooting that took the life of an innocent woman on July 7 and the arrest of one of their safe injection workers on charges related to that shooting earlier this week.



They are currently under review by both the <u>Ontario Ministry of Health</u>, and as has been confirmed to the *Toronto Sun*, by Health Canada which grants them an exemption to dispense opioids as part of a "safe supply" program. It's the centre's stated philosophy though that has one addictions specialist concerned and calling for changes.

<u>Dr. Sharon Koivu</u>, a physician who helped open a safe injection site in London, Ont., and has shepherded many clients to treatment and recovery, says the people at the top of SRCHC have lost sight of the real goal.

Specifically, Dr. Koivu takes issue with the centre's philosophy published on the SRCHC website.

STORY CONTINUES BELOW A9072



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

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

She added that while treatment for addictions can be uncomfortable and painful at times, they save lives and that should be the focus of organizations dealing with addicts, not just

keeping them addicted. Dr. Koivu said the entire reason for bringing safe injection sites into being was to help guide people towards treatment, something the SRCHC policy would appear to abandon.

"With this policy, South Riverdale Community Health Centre is not working to improve lives," Dr. Koivu said. "They are promoting a dependency on a service that should be meant to help them."

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The philosophy, which has been posted to the organizations social media accounts and printed on official materials, is also contrary to provincial regulations for what the government calls "Consumption and Treatment" sites. According to provincial rules, such sites are required to offer "onsite or defined pathways to addictions treatment services."

The latest <u>annual report issued by the centre</u> boasts about the 868 visits per month for "safe drug consumption" with 129 overdoses reversed, just two calls to EMS and no calls to police. What the centre doesn't boast about is how many clients were directed to an addiction treatment or recovery program.

This philosophical break from provincial regulations and best practices for such sites should be enough to shut this facility down. If the Ford government isn't ready to go that far, they need to force out CEO Jason Altenberg, the entirety of the senior leadership in the harm reduction programs and demand the resignations of board members starting with chair Mike Wilson.

STORY CONTINUES BELOW

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"There has to be a complete change in leadership," Dr. Koivu said, adding that some community level workers may need to be replaced as well.

"Unfortunately, once people have drunk the Kool-Aid and think this is a good thing, it's hard to have the same workers recognizing the importance and value of facilitating a journey to recovery."

RECOMMENDED FROM EDITORIAL

LILLEY: Doug Ford needs to shut down or take over safe injection site

Ontario Premier Doug Ford has long been skeptical of safe injection sites and capped the number in the province at 21. He's spoken out in favour of more treatment, something that clearly goes against the philosophy of the SRCHC, and many other activists on this file.

Seems some of those activists are deeply embedded in Ontario's Ministry of Health where multiple sources claim the health bureaucracy is pushing back against requests for options and action from Health Minister Sylvia Jones.

The Ford government, including the premier and minister Jones, need to find the strength

to do the right thing and either shut this facility down or fire everyone at the top. Anything short of that sends the message to the other facilities that following the rules and helping people get into treatment is no longer a priority.

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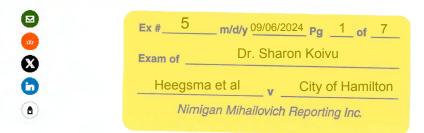
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News / Local News

Harms of safe drug supply program outweigh benefits: Addictions specialist

A London doctor at the centre of a national political debate over opioid programs says she had no intention of becoming a talking point for the federal Conservative party.

Randy Richmond

Published May 20, 2023 • Last updated May 20, 2023 • 4 minute read

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(File photo/Postmedia Network)

A London doctor at the centre of a national political debate over opioid programs says she had no intention of becoming a talking point for the federal Conservative party.

A 9083



But remaining silent isn't an option in the face of evidence the program is harming people, says Sharon Koivu, an addictions specialist and researcher at London Health Sciences Centre.

"I've done a lot of work in social justice, advocacy work, for essentially all my life. So, I've never been associated with anything right wing. I don't consider my position to be a political one, just a voice of concerns for the suffering that I've seen," Koivu told The London Free Press.

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Koivu's views on London's safer supply program recently were <u>published in a National Post story</u> and reiterated in recent attacks from Conservative Leader Pierre Poilievre on the federal Liberal addictions policies.

Poilievre introduced a motion in the House of Commons Thursday <u>calling for an end to safe supply programs in Canada</u>, saying funding should go to treatment instead.

"Crime and chaos, drugs and disorder rage in our streets. Nowhere is this worse than in the opioid overdose crisis that has expanded so dramatically in the last several years," Poilievre said.

About 473 people have died from opioid-related problems in London and surrounding Middlesex County from 2016 to the middle of 2022, with annual deaths increasing from 30 in 2016 to 130 in 2021, according to Public Health Ontario.

The safer opioid supply (SOS) program at the London InterCommunity Health Centre began in 2016 with a small group of street level sex workers and has increased to about 300 patients. The program provides patients with pharmaceutical grade hydromorphone, in the form of Dilaudid pills, so they can avoid dangerous street drugs.



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Research has shown safer supply programs can keep patients healthier as they work to their individual goals around addiction. A study released last fall concluded London SOS patients had fewer infections than people injecting drugs who were not in the program.

But Koivu said since London's safer opioid supply program began in 2016, the rates of infections in her patients and deaths among injection drug users have gone up. Dilaudid also has fuelled an increase in the use of fentanyl, including among younger people, and homelessness in London, Koivu contends.

"I believe the harms of the program outweigh the benefits. I believe the harms of putting all this money into the program at the expense of other programs outweighs the benefits. I want people to discuss it and decide as a society what's best," she said.

Safe supply supporters say they have research that shows the programs save lives and help people to stop injecting drugs, and in some cases, stop using at all.

Opponents have no statistics to back up their claims, supporters say.

RECOMMENDED FROM EDITORIAL



Poilievre slams 'so-called experts' pushing for government-funded supply of drugs to stop opioid crisis

Koivu questioned the research methods backing safe supply and said some statistics show at least a possible link between Dilaudid use and infections.

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The rate and number of invasive infections among people with opioid use disorders in London has jumped since 2016, while rates in Toronto and Ottawa have increased at a much smaller rate, she said, citing records from the Office of the Chief Coroner of Ontario.

Koivu said she was an early supporter of the safe supply program when it first started.

"But I began seeing a significant increase in infections that were related to injection drug use, and specifically infections of the spine, some of them leading to some very significant consequences: paraplegia and quadriplegia. Eighty to 90 per cent of the patients with these infections were injecting Dilaudid," she said.

"The majority of the patients I saw were telling me they were buying diverted Dilaudid and that they were thinking it was safe."

She counted more than 100 patients with the infections in 2017, the first year after the safe supply program began, Koivu said.

She suspects Dilaudid crushed and injected contains particles in the suspension that cause damage to blood vessels, but doesn't have the research to back that up, or the research dollars to find out, Koivu said.

Dilaudid also leads to people seeking a greater high, and that has led to the spread of the more powerful fentanyl in London, she said.

"A lot of places where fentanyl is a problem also have safe supply programs. Trying to fix the problem of fentanyl by throwing more drugs at it is not working. It's not working for the people in the program, and it's not working for the community."

STORY CONTINUES BELOW

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A leading drug researcher and a London streetfront doctor are firing back at a recent surge of criticism — echoed by a city councillor and the leader of the Conservative party — about safer opioid supply programs: https://t.co/gwJzgViu3z#LdnOnt #cdnpoli

- London Free Press (@LFPress) May 18, 2023

Supporters of safe supply refute pretty much all of what Koivu says.

A9086

London's problem with homelessness has much do with an acute lack of shelter and supportive housing – both targets of a new community strategy developed over the winter – safe supply supporters say.

There's no empirical evidence of diversion being a large problem or Dilaudid causing infections, they say.

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

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

Without the support from other parties, Poilievre's motion is bound to fail in a vote in the Commons.

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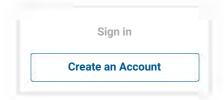






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JAMA Internal Medicine | Original Investigation

Mortality Among Unsheltered Homeless Adults in Boston, Massachusetts, 2000-2009

Jill S. Roncarati, ScD, MPH, PA-C; Travis P. Baggett, MD, MPH; James J. O'Connell, MD; Stephen W. Hwang, MD, MPH; E. Francis Cook, ScD; Nancy Krieger, PhD; Glorian Sorensen, PhD, MPH

IMPORTANCE Previous studies have shown high mortality rates among homeless people in general, but little is known about the patterns of mortality among "rough sleepers," the subgroup of unsheltered urban homeless people who avoid emergency shelters and primarily sleep outside.

OBJECTIVES To assess the mortality rates and causes of death for a cohort of unsheltered homeless adults from Boston, Massachusetts.

DESIGN, SETTING, AND PARTICIPANTS A 10-year prospective cohort study (2000-2009) of 445 unsheltered homeless adults in Boston, Massachusetts, who were seen during daytime street and overnight van clinical visits performed by the Boston Health Care for the Homeless Program's Street Team during 2000. Data used to describe the unsheltered homeless cohort and to document causes of death were gathered from clinical encounters, medical records, the National Death Index, and the Massachusetts Department of Public Health death occurrence files. The study data set was linked to the death occurrence files by using a probabilistic record linkage program to confirm the deaths. Data analysis was performed from May 1, 2015, to September 6, 2016.

EXPOSURE Being unsheltered in an urban setting.

MAIN OUTCOMES AND MEASURES Age-standardized all-cause and cause-specific mortality rates and age-stratified incident rate ratios that were calculated for the unsheltered adult cohort using 2 comparison groups: the nonhomeless Massachusetts adult population and an adult homeless cohort from Boston who slept primarily in shelters.

RESULTS Of 445 unsheltered adults in the study cohort, the mean (SD) age at enrollment was 44 (11.4) years, 299 participants (67.2%) were non-Hispanic white, and 72.4% were men. Among the 134 individuals who died, the mean (SD) age at death was 53 (11.4) years. The all-cause mortality rate for the unsheltered cohort was almost 10 times higher than that of the Massachusetts population (standardized mortality rate, 9.8; 95% CI, 8.2-11.5) and nearly 3 times higher than that of the adult homeless cohort (standardized mortality rate, 2.7; 95% CI, 2.3-3.2). Non-Hispanic black individuals had more than half the rate of death compared with non-Hispanic white individuals, with a rate ratio of 0.4 (95% CI, 0.2-0.7; P < .001). The most common causes of death were noncommunicable diseases (eg, cancer and heart disease), alcohol use disorder, and chronic liver disease.

CONCLUSIONS AND RELEVANCE Mortality rates for unsheltered homeless adults in this study were higher than those for the Massachusetts adult population and a sheltered adult homeless cohort with equivalent services. This study suggests that this distinct subpopulation of homeless people merits special attention to meet their unique clinical and psychosocial needs.

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Supplemental content

Exam of _____ Dr. Sharon Koivu

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paucity of literature exists regarding the health status of unsheltered, urban homeless adults, also known as "rough sleepers." These elusive, yet highly visible unsheltered individuals eschew organized shelters and choose to sleep on park benches, in back alleyways, in doorways, under bridges, near train stations, and in abandoned cars.

In the United States, the unsheltered population constitutes more than a third of the overall homeless population, with an estimated 192 875 people sleeping unsheltered on a single night in January 2017. Most of these individuals were men 24 years or older of white or non-Hispanic race/ethnicity. Despite their visibility, this population wanders across our urban landscapes, and data on these individuals are difficult to gather. Previous studies of mortality have focused on the homeless population who primarily sleep in shelters, and these studies have found higher rates of death in homeless populations compared with nonhomeless populations.²⁻⁹ Studies from the 1980s showed common causes of death to be from substance use disorders and unintentional injuries.3-5 Studies from the 1990s revealed HIV/AIDS, when combined, to be a leading cause of death.^{6,7} More recently, unintentional overdose was shown to have replaced HIV/AIDS as a leading cause of death in the homeless population. 10 Literature on the unsheltered population has shown that they have more risk factors for death, more behavioral health issues, more trauma, and poorer health than their sheltered counterparts. 11-13 However, these studies have not looked specifically at mortality outcomes for unsheltered individuals, whose unique blend of comorbidities and environmental exposures may place them at higher risk for death.

A better understanding of the demographics, mortality patterns, and causes of death among unsheltered individuals could inform social policy and clinical practice initiatives to improve outcomes in this vulnerable population. To address the current gap in the literature about this unique subpopulation, we conducted a 10-year, prospective cohort study using an unsheltered cohort from Boston, Massachusetts, that was established in 2000 and followed up through the end of 2009. We described the unsheltered cohort, examined causes of death, and calculated age-specific rate ratios and agestandardized all-cause and cause-specific mortality rates and compared this cohort with both the nonhomeless adult population living in Massachusetts and a cohort of homeless adults living in Boston who primarily slept in emergency shelters. We hypothesized that the unsheltered cohort would have higher all-cause and cause-specific mortality rates than the nonhomeless and sheltered homeless populations, and that those unsheltered homeless individuals would die prematurely from common but preventable and treatable causes, such as cancer, heart disease, and substance use disorders.

Methods

Study Population

The study population consisted of adults living outside who were primary care patients of the Boston Health Care for the Homeless Program's (BHCHP's) Street Team. Eligibility criteria for the study included the following: (1) sleeping outside for 1 or more nights

Key Points

Question What are the mortality patterns for unsheltered homeless adults who primarily sleep outdoors?

Findings In this 10-year cohort study of 445 unsheltered homeless adults, the age-standardized all-cause mortality rate was almost 3-fold larger than that for a cohort of homeless adults primarily sleeping in shelters and nearly 10-fold larger than that for the adult population of Massachusetts; both represented significant differences. Common causes of death were cancer and heart disease.

Meaning Interventions and models of care need to address the unique needs of the unsheltered homeless adult population to improve outcomes.

during 2000; (2) 18 years or older by January 1, 2000; (3) at least 1 face-to-face encounter with the BHCHP's Street Team staff during 2000; and (4) a first and last name and either a date of birth or a Social Security number in the study database. Participants were excluded if there was a lack of identifying information in the study database. Of 568 records in the BHCHP's Street Team database, 445 unsheltered adults (78.3%) met the eligibility criteria. The study was approved by the institutional review board of Boston University Medical Center, Boston, Massachusetts. Participant informed consent was waived by BHCHP. The study posed minimal risk to privacy.

Study Design and Data Collection

We conducted a 10-year prospective study from January 1, 2000, through December 31, 2009. Data analysis was performed from May 1, 2015, to September 6, 2016. Data from face-to-face encounters with the BHCHP's Street Team were used for the study and stored prospectively. Face-to-face encounters for primary care consisted of a BHCHP's Street Team clinician meeting an unsheltered individual on the street or at an outside location during a daytime or nighttime clinical session. The clinicians of the BHCHP's Street Team documented these encounters on paper at the time of the visit and the notes were later transcribed by a research assistant into a database (Microsoft Office Access; Microsoft Corporation). Data collected at the initial and subsequent visits included the following information: first and last names, date and location of the encounter, date of birth, Social Security number, sex, race/ethnicity, medical and behavioral health diagnoses, and the name of the clinician performing the visit. Any new data, such as a date of death, was added to the database. The cohort had no known duplicates, and no individual was added to the cohort after December 31, 2000. Everyone in the cohort was alive at the time of enrollment.

After the study concluded, the database was matched to BHCHP's electronic medical record to confirm data such as the correct spelling of the first and last name, sex, race/ethnicity, date of birth, and Social Security number. The records were then matched with the Massachusetts Department of Public Health death occurrence files from 2000 to 2009 (received on CD from Massachusetts Department of Public Health; November 3, 2014) in the manner described below to confirm deaths, add the dates of deaths if they were previously unknown, and

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add the underlying and multiple causes of death. Over the course of the study, reports were requested from the National Death Index¹⁴ in 2006 and in 2011 to investigate the possibility of a death occurring outside the state for a proportion of the cohort whose whereabouts were unknown. Data extracted from the National Death Index¹⁴ reports included the date of death, the state in which death occurred, and the underlying and multiple causes of death.

All data describing the causes of death were in the format of the International Statistical Classification of Diseases and Related Health Problems, Tenth Edition (ICD-10) diagnosis codes. The data identifying the underlying and multiple causes of death taken from the Massachusetts Department of Public Health and the National Death Index¹⁴ were previously processed by the National Center for Health Statistics using well-established computer algorithms to select the underlying cause of death from conditions reported on death certificates. Underlying causes of death codes were used for this study and grouped based on previous literature. 7,10,15,16 Definitions of codes from the Centers for Disease Control and Prevention (CDC) Wide-Ranging Online Data for Epidemiologic Research (WONDER) were also used for interpretation of the ICD-10 codes.17 The ICD-10 groupings, terminology, and definitions used to combine the ICD-10 categories can be found in the eTable in the Supplement.

Race/ethnicity categories created by BHCHP were as follows: non-Hispanic white, non-Hispanic black, and persons of color/unknown identified as Asian, Hispanic, American Indian, or unknown race/ethnicity. Age categories included 18 to 44 years, 45 to 64 years, and 65 to 84 years. Sex was dichotomous without unknowns. There were 2 variables with missing data: Social Security number was missing in 15 of 445 records (3.4%) and race/ethnicity, 7 of 445 records (1.6%).

Comparison Groups

Two comparison groups (the Massachusetts population and a sheltered homeless cohort from Boston) were used to calculate the standardized mortality ratios (SMRs). Data for the Massachusetts population were taken from the CDC's WONDER for ages 18 to 84 years from 2000-2009. The Massachusetts population was chosen as a comparison group because our study methods were analogous to methods used in a 2013 study by Baggett et al, 10 who also used the Massachusetts population as a comparison group.

Data for the adult homeless cohort were obtained from the 2013 study by Baggett et al. 10 They retrospectively assembled a homeless cohort of 28 033 adults 18 years or older who had 1 or more encounters with a BHCHP clinician between January 1, 2003, and December 31, 2008. 10 The comparison cohort included homeless adults who were seen by BHCHP from 2003 to 2008. 10

Matching Data

Link Plus 2.0, a probabilistic record linkage program developed at the CDC Division of Cancer Prevention and Control in support of the CDC's National Program of Cancer Registries, was used to match BHCHP's data to the Massachusetts Department of Public Health data. Each match was manually reviewed. A death record was accepted as a match if it had the same data on 1 or more of the following: Social Security number; first and last name and month and year of birth within a range of 1 year; or first and last name and month and day of birth. 7,10,14 The algorithm was similar to that used by the National Death Index¹⁴ to match records and has been reliably used by previous researchers who studied mortality among homeless populations.7,10,14

Statistical Analysis

We described the demographic characteristics of the unsheltered cohort overall and by subgroups, including sex and vital status (whether the cohort member was alive or dead and information about the decedent). Among those in the cohort who died, we noted the place of death and whether an autopsy was performed.

Crude mortality rates for all-cause and cause-specific mortality were calculated using the number of deaths in each category divided by person-years of observation for that category to create incident rates, expressed as events per 100 000 person-years. Strata-specific incident rate ratios were calculated by taking one crude mortality rate within a stratum and dividing it by another crude mortality rate within the same stratum. For rate ratios, women, non-Hispanic white, and the young age category (18-44 years) were used as reference groups.

Age-standardized all-cause and cause-specific mortality rates were calculated using indirect standardization, with the unsheltered cohort as the standard population. The SMRs were calculated as follows: by creating age-specific mortality rates per person-year for young (18-44 years), middle (45-64 years), and old age (65-84 years) categories for both the Massachusetts population and the adult homeless cohort; by multiplying the age-specific mortality rates by the age-specific personyears from the unsheltered cohort; by summing the 3 age-specific results to determine the expected number of deaths; and then by dividing the number of observed deaths by the number of expected deaths. The SMRs were calculated when the number of deaths in a category was 5 or more.15

Statistical analyses were performed using Stata, version 14 (StataCorp) and Microsoft Excel 2013 (Microsoft Corporation) and consisted of calculating incidence rates, rate ratios, and SMRs. Corresponding 95% CIs for rates and ratios were calculated using OpenEpi (Open Source Epidemiologic Statistics for Public Health), version 3.01.18 A 2-sided significance level of <.05 was used for testing.

Results

Cohort Characteristics

The study cohort comprised 445 unique unsheltered adults who were followed for a total of 3608.7 person-years (mean, 8.2 years; range 0.1-9.9 years). The mean (SD) age at enrollment was 44 (11.4) years with a range of 18 to 81 years. Of 445 participants in the cohort, 299 (67.2%) were non-Hispanic white and 322 (72.4%) were men (Table 1).

Decedent Characteristics

Of the 445 unsheltered adults, 134 died during the study period. A total of 122 deaths were confirmed through linkage with the Massachusetts Department of Public Health data, and an additional 12 records were manually matched to the National Death

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Table 1. Characteristics of the Unsheltered Cohort, 2000-2009

	No. (%)							
Characteristic	Unsheltered Ad	ult Homeless Cohort	Sheltered Adult	MA 2000 Census				
	Full Cohort (N = 445)	Men (n = 322)	Women (n = 123)	Decedents (n = 134)	Homeless Cohort ≥18 y (n = 28 033) ^a	Population ≥18 y (n = 4849 033) ^b		
Age, y								
18-44	248 (55.7)	165 (51.2)	83 (67.5)	56 (41.8)	17 298 (61.8)	2 569 111 (53.0)		
45-64	176 (39.6)	140 (43.5)	36 (29.3)	65 (48.5)	9924 (35.4)	1 419 760 (29.3)		
≥65	21 (4.7)	17 (5.3)	4 (3.3)	13 (9.7)	811 (2.8)	860 162 (17.7)		
Race/ethnicity								
Non-Hispanic white	299 (67.2)	223 (69.3)	76 (61.8)	108 (80.6)	11 912 (42.5)	4 180 644 (86.1)		
Non-Hispanic black	94 (21.1)	62 (19.3)	32 (26.0)	15 (11.2)	8066 (28.8)	236 027 (4.9)		
Persons of color or unknown ^c	52 (11.7)	37 (11.5)	15 (12.2)	11 (8.2)	8055 (28.7)	432 362 (8.9)		
Sex								
Men	322 (72.4)	NA	NA	116 (86.6)	18 612 (66.4)	2 289 671 (47.2)		
Women	123 (27.6)	NA	NA	18 (13.4)	9421 (33.6)	2 559 362 (52.8)		

Abbreviations: MA, Massachusetts; NA, not applicable.

^c Individuals who identified as Asian, Hispanic, American Indian, or whose race/ethnicity was unknown.

Table 2. Stratum-Specific Mortality Rates and Rate Ratios of Unsheltered Cohort, 2000-2009

Characteristic	Deaths, No. (%)	Person- Years, No.	Mortality Rate, Deaths per 100 000 Person-Years (95% CI)	Rate Ratio (95% CI)	P Value
Overall	134 (100)	3608.7	3713.2 (3110.9-4397.5)	NA	NA
Age, y					
18-44	56 (41.8)	2124.6	2635.8 (1990.7-3422.2)	1 [Reference]	NA
45-64	65 (48.5)	1350.3	4813.8 (3716.0-6136.9)	1.8 (1.3-2.7)	<.001
65-84	13 (9.7)	133.8	9715.9 (5165.6-16589.9)	3.7 (1.8-6.8)	<.001
Race/ethnicity					
Non-Hispanic white	108 (80.6)	2325.2	4644.7 (3810.5-5608.3)	1 [Reference]	NA
Non-Hispanic black	15 (11.2)	835.4	1795.5 (1005.4-2962.9)	0.4 (0.2-0.7)	<.001
Persons of color or unknown ^a	11 (8.2)	448.1	2455.1 (1225.7-4393.3)	0.5 (0.3-1.0)	.03
Sex					
Women	18 (13.4)	1130.6	1592.1 (943.2-2515.3)	1 [Reference]	NA
Men	116 (86.6)	2478.1	4681.0 (3868.2-5614.7)	2.9 (1.8-5.1)	<.001

Abbreviation: NA, not applicable.

Index¹⁴ reports. The mean (SD) age at death was 53 (11.4) years. Of the 134 decedents, 116 (86.6%) were men and 108 (80.6%) were non-Hispanic white. A mean (SD) of 13 (3.4) deaths per year occurred throughout the study. Most deaths (87 of 134 [64.9%]) occurred inside a health care facility (ie, inpatient wards, outpatient clinics, emergency departments, and nursing homes), and 48 (35.8%) resulted in an autopsy.

Mortality Rates

The crude mortality rate overall was 3713.2 (95% CI, 3110.9-4397.5) deaths per 100 000 person-years (Table 2). The race/ethnicity specific mortality rate ratio for non-Hispanic blacks was 0.4 times the rate ratio of death for non-Hispanic whites (95% CI, 0.2-0.7; P < .001) (Table 2). The SMR for the unsheltered cohort was 9.8 (95% CI, 8.2-11.5) relative to the Massachusetts population and 2.7 (95%CI, 2.3-3.2) relative to the sheltered adult homeless cohort (Table 3).

Causes of Death

Thirty-nine deaths (29.1%) were directly attributable to substance use disorders and unintentional overdose (Table 3). Nonpoisoning injuries represented 19 of the 134 deaths (14.2%). Mortality rates in the unsheltered cohort for HIV/AIDS (10 of 134 deaths [7.5%]) were considerably higher than rates in the Massachusetts population and in the sheltered adult homeless cohort, and SMRs were significantly elevated among the unsheltered cohort when compared with both the Massachusetts population (SMR, 63.8; 95% CI, 32.4-113.8) and the sheltered adult homeless cohort (SMR, 3.4; 95% CI, 1.7-6.0). The one exception was drug overdose, which did not differ between the unsheltered cohort and adult homeless cohort (SMR, 0.9; 95% CI, 0.4-1.7). No deaths occurred from diabetes or tuberculosis. External causes, such as suicide, homicide, and hypothermia, which were included in the nonpoisoning injury category, accounted for fewer than 5 deaths each.

Discussion

All-cause mortality rates in the unsheltered cohort were nearly 3 times greater than those in an adult homeless cohort and almost 10 times greater than in the Massachusetts population. Our causespecific mortality findings underscore a high burden of substance

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 $^{^{\}rm a}$ Adult homeless cohort from the study by Baggett et al. $^{\rm 1O}$

^b Based on US Census Bureau data. ¹⁹

a Individuals who identified as Asian Hispanic, American Indian, or whose race/ethnicity was unknown.



Table 3. Age-Standardized All-Cause and Cause-Specific Mortality Ratios for the Unsheltered Cohort (2000-2009) Compared With the Massachusetts Population (2000-2009) and With a Sheltered Adult Homeless Cohort (2003-2008)

		SMR (95% CI) ^c			
Underlying Cause of Death ^b	Overall Deaths, No. (%) (n = 134)	Unsheltered Homeless Adults vs MA Population	Unsheltered vs Sheltered Homeles Adults		
All causes for entire cohort	134 (100)	9.8 (8.2-11.5)	2.7 (2.3-3.2)		
Natural causes					
Cancer	21 (15.7)	4.8 (3.1-7.3)	2.8 (1.8-4.2)		
Heart diseases	18 (13.4)	6.4 (3.9-9.9)	2.4 (1.4-3.7)		
Chronic substance use	16 (11.9)	88.9 (52.7-141.5)	4.2 (2.5-6.7)		
Chronic liver disease	15 (11.2)	32.2 (18.7-51.9)	4.5 (2.6-7.3)		
HIV/AIDS	10 (7.5)	63.8 (32.4-113.8)	3.4 (1.7-6.0)		
Ill-defined conditions	5 (3.7)	26.8 (9.8-59.3)	NC		
External causes					
Nonpoisoning injuries ^d	19 (14.2)	33.3 (20.7-51.1)	7.1 (4.4-11.0)		
Drug overdose	8 (6.0)	14.1 (6.5-26.7)	0.9 (0.4-1.7) ^e		
Substance use disorder causes	39 (29.1)	43.6 (31.4-58.9)	2.5 (1.8-3.3)		
Alcohol use disorder	30 (22.4)	110.2 (75.7-155.3)	NC		
Opioid use disorder	9 (6.7)	15.7 (7.6-28.8)	NC		

Abbreviations: ICD-10, International Statistical Classification of Diseases and Related Health Problems, Tenth Revision; MA, Massachusetts; NC, not calculated; SMR, standardized mortality ratio.

^d Nonpoisoning injuries (*ICD-10* diagnosis codes): transportation accidents (codes VO1-V99), other external causes of accidental injuries (codes W00-X59, except X40-X49), and events of undetermined intent (codes Y20-Y34, except Y10-Y19). Methodology in combining the *ICD-10* categories were based on the Health of Boston 2014-2015 report.¹⁵

use in this population. In addition to the deaths directly attributable to substance use, many of the deaths due to nonpoisoning injuries, which primarily included motor vehicle crashes, falls, and drownings, have been shown by previous researchers to be related to alcohol or other drug use. 20-22 The SMR for nonpoisoning injuries was high for the unsheltered cohort compared with the adult homeless cohort; these results may indicate a possibly greater risk of death for rough sleepers, but more research is warranted. Other common causes of death, such as cancer and heart disease, have a strong link to cigarette smoking, which is highly prevalent among homeless people. 20 To effectively decrease morbidity and mortality in the unsheltered population, it is necessary to have fully integrated clinical outreach teams to meet rough sleepers where they live on the streets in order to establish and maintain continuity of care. 13,23,24 Addiction treatment and recovery programs should be readily available, with treatment on demand to support motivation for action and prevent further morbidity and mortality. Future research should include harm reduction policies, such as managed alcohol programs or supervised injection sites within shelters and homeless programs, which might make shelters more tolerable for those who currently fear substance abuse withdrawal. 25,26

Higher rates of death among non-Hispanic white individuals compared with non-Hispanic black individuals and persons of color have been consistently observed in previous studies of homeless persons, and the causes for this phenomenon are likely multifactorial. ^{2,4,5,7,8,10} Similarly, studies have shown that homeless men have higher rates of death than homeless women. Non-Hispanic white individuals and men, on average, have more economic resources than non-Hispanic black individuals and women and are less likely to have experienced adverse social and

economic effects due to bias or discrimination.²⁷ Thus, non-Hispanic white individuals and men may, on average, have reached a higher threshold of comorbidities at the time that they become homeless compared with non-Hispanic black individuals and persons of color. Men, whether or not they are homeless, are at a higher risk of death at an earlier age than women because of risk-taking behaviors related to the male sex. However, more research with empirical data needs to be conducted to fully understand these disparities among the unsheltered homeless.

Limitations

Although the study was subject to some biases that we could not control, we believe the influences were minor. Some unsheltered adults living on the streets of Boston may not have been seen by BHCHP's Street Team during enrollment and were not included in the cohort, which created a potential selection bias toward those homeless adults who sought health services. Since Boston is a moderately sized city with an extensive network of outreach services provided by the BHCHP's Street Team and their community partners, the number of individuals not served by BHCHP during enrollment was likely to have been small. Additional bias could have occurred if someone entered the cohort and then traveled to another state and died while living in another state. Obtaining National Death Index¹⁴ records improved our ability to detect deaths that occurred outside the state. The BHCHP's Street Team database contained 123 records with insufficient identifying information to be included in the study. These excluded individuals could be systematically different from individuals included in the study in important ways, such as their level of illness or the length of time that they were homeless. Based on our clinical experience, an alternative explanation was that most of these rec-



^a Adult sheltered homeless cohort from the study by Baggett et al. ¹⁰

^b There were no unknown causes of death, and fewer than 5 deaths in each category were suppressed.

 $^{^{\}rm c}$ The SMR was calculated when there were 5 or more deaths in each category.

^e The SMR was not significant.

ords with insufficient identifying information were duplicate records of identified cohort members because a new record was opened, rather than an existing one updated, when identifiers were learned.

Additional limitations included a lack of information about individual comorbidities or the chronicity of being homeless before or during the observation period; both could have contributed to a more nuanced understanding of mortality risk in this population. Some causes of death were too rare to ascertain mortality rates. A larger cohort would be required to address this limitation in future studies. Some overlap of the 2 homeless cohorts may have occurred, but the overlap was believed to have been small because BHCHP's data on sleeping location from 2008 showed that the proportion of patients sleeping outside was small (1%-3%) and the time frames of the 2 cohorts were not exact. If there was overlap, estimates of mortality using the sheltered adult homeless cohort as a comparison would be conservative.

Choosing Massachusetts as a comparison population instead of Boston could be considered a limitation of the study; however, some of our methods were based on those used by Baggett et al¹⁰ in their 2013 study, in which the Massachusetts population was the comparison group. In addition, during the time frame of the study, the age-adjusted, all-cause mortality rate in Boston (687 per 100 000 population) was only slightly higher than the ageadjusted, all-cause mortality rate for Massachusetts (669 per 100 000 population). 15,28 We anticipated that confounding by race/ethnicity would be minimal given that the study cohort was disproportionately of non-Hispanic white race/ethnicity as was the Massachusetts population.

Generalizability to cities outside Boston could be affected by difference in access to homeless shelters, health insurance, and health care. Boston guarantees each homeless person access to emergency homeless shelters each night.²⁹ Not every city across the United States makes this guarantee, and the homeless people accessing shelters in Boston may differ from the homeless accessing, or not accessing, shelters in another city. Most of Boston's shelters have few limits on the length of stay and have little to no requirements regarding sobriety. These shelters accept individuals struggling with alcohol and other drugs, an important factor in minimizing the number of unsheltered individuals in Boston. Shelters in many cities have limits on the length of stay or requirements for sobriety and do not allow individuals with active substance use disorders, which increases the number of homeless people living outside. Access to health care and health insurance were available to our cohort, but it was not uniform across the United States, particularly during the time of the study. These factors could influence mortality for those individuals sleeping outside in different locations and thereby influence the generalizability of our results. Our study provides important insights about mortality patterns in this previously overlooked group of highly vulnerable individuals.

Conclusions

Our study results showed that unsheltered adults had a higher all-cause mortality rate than a mostly sheltered homeless adult population in Boston, a finding that to our knowledge is not previously reported in the literature. The unsheltered cohort died at a relatively young age of both noncommunicable and substanceattributable causes of death. Access to a patient-centered, outreach service model with integrated medical and behavioral health care delivered directly to the unsheltered population is necessary to begin to address these disparities. A better understanding of the social and supportive services is necessary to augment an integrated outreach team. Services such as harm-reduction models; greater availability and access to substance use disorder treatment, including smoking cessation; and a continuum of housing models with flexible social services to meet individual needs for successful tenancies and improved health are also needed to ultimately improve health disparities borne by those sleeping outside.30

ARTICLE INFORMATION

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Concept and design: Roncarati, O'Connell, Hwang, Cook, Krieger, Sorensen.

Acquisition, analysis, or interpretation of data: Roncarati, Baggett, Hwang, Krieger. Drafting of the manuscript: Roncarati. Critical revision of the manuscript for important intellectual content: All authors. Statistical analysis: Roncarati, Cook. Administrative, technical, or material support:

Supervision: O'Connell, Hwang, Krieger, Sorensen.

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Invited Commentary

Death Among the Unsheltered Homeless Hidden in Plain Sight

Michael Incze, MD, MSEd; Mitchell H. Katz, MD

In early 2018, a United Nations special rapporteur on adequate housing made headlines during an unofficial visit to San Francisco and Oakland, California, by comparing the living conditions for those people residing on the streets of these cities

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with what she had observed in Mumbai, India, and by calling this state of affairs a vio-

lation of international human rights law. Indeed, it is hard to explain how, in one of the wealthiest regions of the world at a time of human history when the overall standard of living has

never been higher, we have encampments of people living without toilets, sinks, showers, refrigerators, or cooking facilities.

There are an estimated 190 000 homeless persons in the United States living outside rather than in shelters, exposed to the elements, and removed from health care and case management resources.² In this issue of *JAMA Internal Medicine*, Roncarati et al³ report the results of a 10-year prospective study of a cohort of unsheltered individuals in Boston, Massachusetts, that found a 3-fold increase in mortality for unshel-

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City Council endorses Community Encampment Response Plan - Part of Health & Homelessness Whole of Community System Response

Ex# 8 m/d/y 09/06/2024 Pg 1 of 3 Exam of _____ Dr. Sharon Koivu Heegsma et al _____ City of Hamilton Nimigan Mihailovich Reporting Inc.

TUESDAY, JUNE 25, 2024

London City Council has endorsed the <u>Community Encampment Response Plan</u>, which is the remaining strategy component of the Health and Homelessness Whole of Community System Response, following the previously endorsed <u>plan for highly supportive housing</u> and <u>plan for hubs offering transitional housing and health supports.</u>

The <u>Community Encampment Response Plan</u> is grounded in a human rights-based approach that supports individuals in encampments, and outlines transactional outreach and transformational case-management to support an individual's pathway out of homelessness and into housing and indoor spaces. The Community Encampment Response Plan includes safety protocols for individuals living in encampments to support wellness within encampments as well as the surrounding community.

The community-led plan was developed in consultation and collaboration with frontline sector experts and leadership, first responders, City of London staff, and with support from members of the community with lived and living experience. During community engagement opportunities hosted in May, over 200 Londoners joined in-person community engagement sessions to learn more about the plan and give feedback on its proposed safety protocols and guidelines.

"Cities across Canada, as well as smaller communities, are all dealing with the realities of unsheltered homelessness and encampments, and London's Community Encampment Response Plan does not simply acknowledge this harsh reality, but provides a strategy for how we can manage the impacts and support individuals to move indoors through a balance of compassion, community safety, basic needs provisions, and increasing our housing supply." – Mayor Josh Morgan, City of London

"As we make progress toward creating and opening highly supportive housing programs and hubs within London, it's important that the relationship-building and support work starts before opening those program doors. The Community Encampment Response Plan outlines how this transformational outreach works, and how each intentional engagement with an individual living unsheltered is to eventually support a transition into housing." – Chantelle McDonald, Director of Service, London Cares, Co-Chair of Encampments Strategy Table

"The Community Encampment Response Plan is rooted in the principle that housing is a fundamental human right and a critical determinant of health, and this is a fundamental shift in how we address homelessness in London. Another key element of the plan is outreach workers who can do the transformation.

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work of connecting individuals within encampments with tailored service pathways to help them makened safe and stable indoor spaces, whether it is a shelter, a hub, or highly supportive housing." - Greg Nash, Director, Complex Urban Health, London InterCommunity Health Centre, Co-Chair of Encampments Strategy Table

"The Community Encampment Response Plan is a key part the overall Whole of Community Response strategy in that it provides a balanced response to the encampment situation in London, recognizing the need to focus on housing solutions while providing interim safe and appropriate measures that support basic human needs until people can exit homelessness." – Kevin Dickins, Deputy City Manager, Social and Health Development, City of London

"The supports proposed in the Community Plan for Encampments strengthen the Hubs Implementation Plan by helping unsheltered individuals achieve a greater state of health, wellbeing, and dignity than what is available today, so they can better transition into Hubs, which are spaces designed to enable the next steps toward housing. This means individuals can be more ready than ever to continue their journeys toward housing, whether that be in private market, rent-geared-to-income, supportive, highly supportive or otherwise." – Chuck Lazenby, Executive Director, Unity Project, and Co-Chair of Hubs Implementation Table

About the Health and Homelessness Whole of Community System Response

London, like many cities in Canada, is facing a health and homelessness crisis. In 2023 Londoners came together from organizations and sectors across the city and developed the Health & Homelessness Whole of Community System Response – a new way to support the most marginalized Londoners experiencing homelessness and reduce strain on our health care and judicial systems. The approach being implemented by the Whole of Community System Response is to help Londoners with the highest needs move safely inside; help them get stabilized, wrap around them with supports, connect them to the right type of housing, and help them stay housed.

City Council endorsed the Whole of Community System Response approach in March of 2023. Since then, two hubs have been established, as well as 93 highly supportive housing units, with 50 more units in development, toward a goal of 600 highly supportive housing units within three years. The City's plans for hubs and housing were shaped by previous community engagement sessions held in summer and fall of 2023.

For more information on the Whole of Community System Response, visit: **london.ca**

Last modified: Thursday, July 04, 2024

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Court File No. CV-21-00077187-0000

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