

COURT OF APPEAL FOR ONTARIO

BETWEEN:

THE ATTORNEY GENERAL OF ONTARIO

Appellant
(Intervener)

-AND-

THE REGIONAL MUNICIPALITY OF WATERLOO

Appellant
(Applicant)

-AND-

**JOSEPHINA DUGAS, TERRA-LYNN WEBER,
AVERY AMENT, AARON PRICE, JEREMY
LINTON, JEREMY NICHOL, JAMES HAMMOND,
JAKOB STUBBS, JAMES DAVIS, JASON PAUL,
NOAH HELSBY, JOSEPH BRADLEY, JOSEPH
SADLER, JULIE YOUNG, KYLE YORK, MEGAN
LOPES, STEPHANIE MCMILLAN, JEFFREY
COUTO, JORDAN CAMM, TERRANCE COLE,
XANDER HARKER, CHARLES KOCHER, ALINE
JEFFERY, MICHAEL JEFFERY , and PERSONS
UNKNOWN AND TO BE ASCERTAINED**

Respondents
(Respondents/Cross-Applicants)

**EXHIBIT BOOK OF THE
APPELLANTS (Vol. 12 of 15)**

August 7, 2026

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EXHIBIT “5”

Communicable disease among people experiencing homelessness in California

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Original Paper

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Abstract

California has a large population of people experiencing homelessness (PEH) that is characterised by a high proportion of people who are unsheltered and chronically homeless. PEH are at increased risk of communicable diseases due to multiple, intersecting factors, including increased exposures, comorbid conditions including substance use disorder and mental illness and lack of access to hygiene and healthcare facilities. Data available for several communicable diseases show that PEH in California experiences an increased burden of communicable diseases compared to people not experiencing homelessness. Public health agencies face unique challenges in serving this population. Efforts to reduce homelessness, increase access to health care for PEH, enhance data availability and strengthen partnerships among agencies serving PEH can help reduce the disparity in communicable disease burden faced by PEH.

Homelessness in the USA and in California

The definition of a person experiencing homelessness (PEH) differs by government agency. The US Department of Health and Human Services defines a homeless individual as one who 'lacks housing', which includes 'an individual whose primary residence during the night is a supervised public or private facility that provides temporary living accommodations and an individual who is a resident in transitional housing' [1]. The US Department of Housing and Urban Development (HUD) expands the definition to include people living in unstable housing arrangements such as motels, personal vehicles, and tents [2]. Causes of homelessness include lack of affordable housing, unemployment, poverty, and low wages [3].

Measuring the number of PEH is challenging, as housing status can fluctuate over time. One method of measurement is an unduplicated one-night estimate of sheltered and unsheltered individuals who are experiencing homelessness. In the USA, this is conducted yearly during the last week in January by local planning bodies [4]. In 2018, this measurement identified 553 000 PEH in the USA, of which 180 000 (33%) were individuals who are part of families with children. Of the total, 65% were sheltered (living in shelters or motels) and 60% were men. [4] From 2010 to 2018, the number of PEH declined by 13.2% nationally, but increased by 5.3% in California.

California's population of PEH is distinctive due to its size, the proportion of unsheltered individuals and proportion of chronically homeless individuals (defined as a person who is continuously homeless for greater than 1 year, or greater than four episodes of homelessness in 3 years [5]). In 2018, California accounted for 12% of the US population (40 million) [6] and 24% of the total population of PEH (129 972, or 0.3% of California's population) [4] (Fig. 1). Los Angeles County, California's largest county by population, accounts for 25% of California's total population and 32% of California's homeless population (42 079) (Fig. 2). Nearly half (47%) of the US unsheltered homeless population lives in California and more than two-thirds (69%) of California's homeless population is unsheltered (Fig. 3). Finally, 32 668 chronically homeless individuals live in California, representing 25% of all PEH in California and 37% of the US population of chronically homeless individuals [4].

Mortality is increased among PEH compared to the general population, especially among younger people and women [7]. A study of homeless youth (15–24 years) in San Francisco reported an age, race and gender-adjusted standardised mortality ratio of 10.6 (95% CI (5.3–18.9)) compared with California's general youth population [8]. Individuals who are unsheltered or chronically homeless have further increased risk of mortality [9]. Unsheltered PEH has a 2.7-fold increased risk of mortality compared to those who are sheltered [10]. Increased mortality is related to a number of causes including poisoning (medication and illicit substances), suicides, accidents, heart disease, and infections. Increased infection-specific mortality among PEH has been documented, although data are limited because of the difficulties in capturing information on PEH. Studies of human

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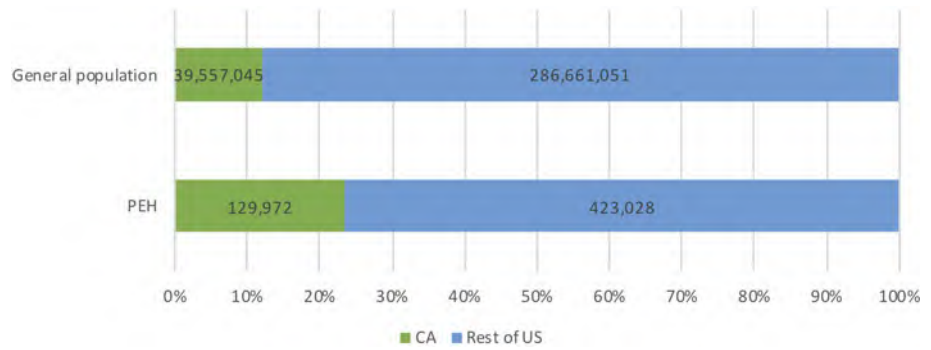


Fig. 1. California population of persons experiencing homelessness (PEH).

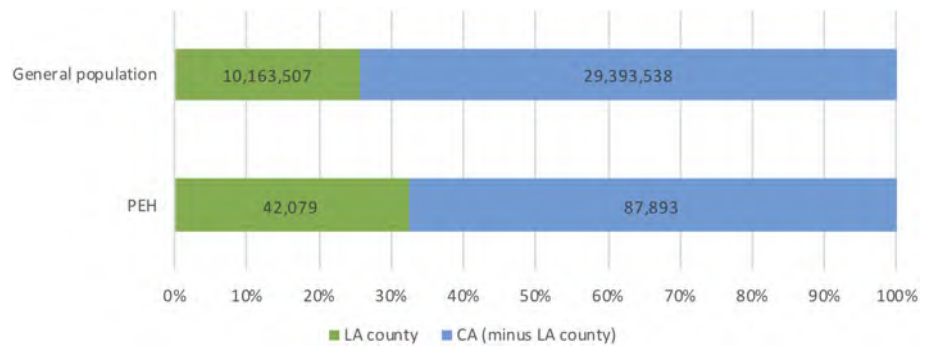


Fig. 2. Los Angeles County population of persons experiencing homelessness (PEH).

immunodeficiency virus (HIV) infection and tuberculosis (TB) among PEH come from one urban centre or from outside the US [7, 11]. HIV was the leading cause of death for PEH living in Boston during 1988–1993; the leading cause of death shifted to drug overdose and substance use disorders during 2003–2008 [11]. Among PEH diagnosed with TB in Toronto, Canada during 1998–2007, 19% died within 12 months of diagnosis compared to 7.4% of all persons diagnosed with TB [12].

The overall physical and emotional health status of PEH is worse compared to the general population and PEH suffer from a disproportionate burden of communicable diseases compared with the general population [7]. A 2012 systematic review reported an increased prevalence of HIV infection, hepatitis C virus (HCV) infection and TB prevalence among PEH across studies in multiple countries. Among US studies, the prevalence of TB among PEH was 46.7–461.2 times higher compared to the general population. Hepatitis C prevalence was 5.2–17.6 times greater than the general population and HIV infection prevalence was similar to the general population in some studies, or up to 42 times greater. There was significant heterogeneity in these studies, most likely related to differences in population sampling. All studies sampled individuals who engaged in social services, such as shelters or soup kitchens; however, these services differ substantially by location. In addition, for TB, differences in the use of diagnostic testing contributed to differences in prevalence estimates [13].

Homelessness and communicable disease risk

PEH are at increased risk of communicable diseases due to increased exposures and greater susceptibility to illness (Table 1).

PEH living in crowded conditions such as shelters have greater exposure to pathogens, which increases the risk of TB [14] and diarrheal illnesses [15]. Lack of access to hygiene facilities also

increases exposures to pathogens transmitted via faecal-oral transmission such as hepatitis A [16] and may increase exposure to vectors such as lice, which can transmit *Bartonella quintana* infections [17]. Inadequate hygiene facilities may also worsen minor wounds due to lack of adequate skin care [18, 19]. PEH may also have comorbid substance use disorders or engage in risky sexual behaviour, which can increase the risk of acquisition of infections with pathogens such as HIV, HCV, or HAV [7]. Examples of high-risk sexual behaviour include sex while intoxicated or sex in exchange for goods and services such as money, shelter, or drugs. [20]

Inadequate living situations can cause physical injuries that increase susceptibility to infections. For example, a wheelchair-bound person may develop sacral pressure injuries due to lack of an adequate place to lie down. Treatment for these wounds can be delayed due to lack of access to care, which can result in serious life-threatening infection requiring hospital admission. Increased susceptibility to infection can also be the result of poorly controlled comorbid health conditions, such as diabetes. All these environmental and host-specific risks are interrelated and may have multiplicative effects, leading to a substantial increase in the risk of disease.

Recent examples from California: communicable disease among PEH

Accurate measurement of communicable disease burden among California's population of PEH is challenging. Many communicable diseases linked to homelessness are not reportable conditions (e.g., norovirus illness). Housing status is not collected by routine surveillance systems for all communicable diseases. Nevertheless, data are available from routine surveillance at California Department of Public Health (CDPH) for several communicable diseases that illustrate the disproportionate burden of

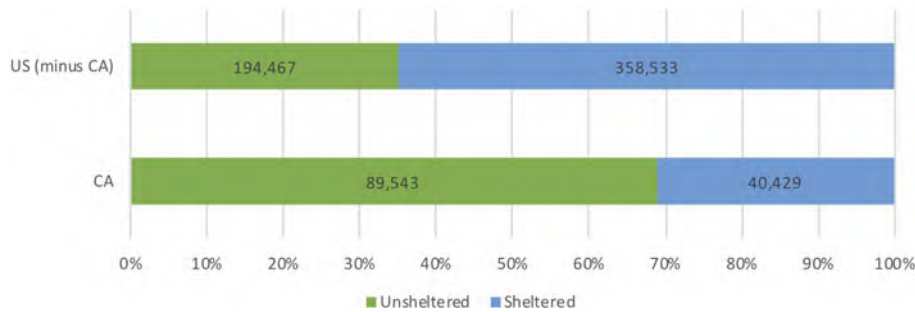


Fig. 3. Unsheltered vs. sheltered status among persons experiencing homelessness in California and the USA.

communicable diseases among PEH in California (Table 2). We summarise examples of communicable diseases among PEH in California to describe transmission dynamics, the risks encountered by PEH and the public health response. The selected examples represent common communicable diseases with available surveillance or cross-sectional data. Other diseases that disproportionately affect PEH that are not presented include louse-transmitted *Bartonella quintana* infection, which has been previously described in a case series outside of the USA [21].

Hepatitis A

Hepatitis A, caused by the hepatitis A virus (HAV), usually causes a mild, self-limiting illness for which supportive measures are the standard of care [16]. Community-based transmission is now uncommon in the US and a rapid decrease in hepatitis A incidence after the introduction of hepatitis A vaccination in 1996 suggests that immunisation played an important role [16]. However, since 2017, the Centres for Disease Control (CDC) has reported outbreaks of hepatitis A in 30 states including California among people who use drugs, people who are experiencing unstable housing or homelessness and men who have sex with men [22]. In California, the hepatitis A vaccine is universally recommended for children and adults at increased risk of infection as specified by the Advisory Committee on Immunisation Practices (ACIP). The California Department of Public Health and local health departments also use the hepatitis A vaccine to respond to hepatitis A outbreaks.

During 2016–2018, California experienced a large hepatitis A outbreak among PEH that was concentrated in San Diego County. This outbreak was the largest hepatitis A outbreak in California since the introduction of hepatitis A vaccination. Statewide, a total of 708 outbreak-related hepatitis A cases were reported, with 465 hospitalisations (66%) and 21 deaths (3%). More than half of cases (52.6%, $n = 372$) were in PEH. The outbreak did not involve the general population and predominantly affected PEH and/or who were using drugs. Of the PEH who developed hepatitis A, more than two-thirds (71.6%, $n = 263$) also reported drug use. This outbreak was notable for the high rate of hospitalisation and death [23]. For comparison, a multi-state outbreak of hepatitis A tied to consumption of frozen strawberries in 2016 was linked to 143 cases, 56 hospitalisations (39%) and no deaths [24].

Several factors drove the California outbreak of hepatitis A among PEH, including underlying risk factors, environmental sanitation, and vaccine acceptability and access. PEH were at risk for developing hepatitis A due to exposure to unsanitary conditions and concomitant drug use. PEH were at increased risk of severe disease due to underlying alcohol use disorder and chronic

HCV infection. Of people with outbreak-associated hepatitis A, 17% were positive for either HCV antibody (anti-HCV) indicating past or current infection, or HCV RNA indicating current infection. Similarly, the prevalence was high in three other states that experienced hepatitis A outbreaks that affected PEH and people who use drugs in 2017: 49% (29/59) in Kentucky, 26% (165/632) in Michigan and 21% (31/148) in Utah [25].

In the general population, the prevalence of anti-HCV and HCV RNA positivity in the USA is 1.7% and 1%, respectively [26]. Hepatitis A outbreaks are difficult to control due to the long incubation interval, long period of infectivity and a significant proportion of asymptomatic infections. Public health agencies in California used three population-level strategies to respond to the outbreak of hepatitis A among PEH: vaccination, sanitation, and education. Vaccination efforts targeted at-risk individuals (PEH or persons using drugs and living in unstable housing). During this outbreak, the CDPH expanded criteria for hepatitis A vaccination beyond ACIP recommendations, which at the time did not include PEH, to include PEH [27]. Reaching at-risk individuals required partnerships with local organisations, since many people lived in less accessible locations and experienced a lack of trust in the healthcare system. For example, San Diego County public health nurses worked with staff from homeless service providers or law enforcement to form 'foot teams' and reach at-risk individuals in riverbeds, canyons, ravines, parks, and urban encampments. In San Diego County alone, 121 921 hepatitis A vaccinations were delivered during this outbreak [28]. To support vaccination efforts, California Governor Jerry Brown declared a state of emergency in October 2017, which enabled the state to ensure adequate vaccine supply for outbreak response [29]. Sanitation interventions included increasing access to bathrooms by extending hours of bathroom facilities and setting up portable toilets and handwashing stations. Education interventions were aimed at high-risk populations, health care providers and the general public. Specific tools included pamphlets explaining the role of hygiene in interrupting disease transmission and hygiene kits. Collaboration with local media outlets was critical for the dissemination of these messages.

The California hepatitis A outbreak ended in 2018, but other outbreaks are ongoing in the USA. In February 2019, ACIP updated its recommendations for hepatitis A vaccination to include PEH [30]. ACIP recommends routine hepatitis A vaccination in children [31] and adults with risk factors, including homelessness, chronic liver disease, clotting factor disorders, men who have sex with men, work with HAV in a research laboratory, travel in countries with high or intermediate endemic hepatitis A, or close personal contact of an international adoptee [32]. Delivering the hepatitis A vaccine to this population remains a challenge, particularly given the existing challenges PEH face

Table 1. Major risk factors and communicable diseases identified among people experiencing homelessness

Risk factor	Modes of disease transmission	Communicable disease (examples)
Inadequate access to personal hygiene		
Handwashing and toilet facilities	• Fecal-oral	• Hepatitis A • Shigella • Norovirus
Bathing and skin care	• Direct inoculation	• Skin and soft tissue infections (SSTIs) • Group A streptococcal infections
Laundry	• Ectoparasite infestations • Vector-borne illnesses	• Lice • Scabies • Bed bugs • <i>Bartonella quintana</i> (louse-borne)
Inadequate access to resting places		
Pressure injury from lying on hard surfaces	• Direct contact	• SSTIs
Lower extremity stasis dermatitis from lack of places to lie flat	• Direct contact	• SSTIs
Congregate settings and increased exposures (shelters, tent dwellings)	• Droplet • Airborne • Direct contact • Fomites	• Norovirus • Influenza • Tuberculosis • Hepatitis A
Exposure to disease vectors	• Vector-borne	• Mosquito-borne illnesses, Typhus (flea-borne)
Behavioral risks		
Exchange of sex for money Sex while high Sexual assault	• Sexual contact	• Syphilis • Gonorrhea • Chlamydia • HIV • Hepatitis B
Comorbid medical conditions		
Substance abuse, including alcohol, intravenous drug use	• Blood-borne • Skin disruption	• HIV • Hepatitis A • Hepatitis B • Hepatitis C • Invasive group A streptococcal infections • Methicillin resistant <i>Staphylococcus aureus</i>
Mental illness	• Increase risk behavior • Decreased self-care • Delays in care	May exacerbate multiple conditions
Limited access to healthcare		
Limited preventive services	• Decreased vaccinations • Increased vulnerability to infections	• Shingles • Pneumonia • Hepatitis A
Poorly controlled chronic conditions	• Decreased immunity • Increased vulnerability to infections	• SSTIs
Low health literacy	• Delays in care	

(Continued)

Table 1. (Continued.)

Risk factor	Modes of disease transmission	Communicable disease (examples)
		• Pneumonia requiring hospitalisation due to late presentation
Limited medical care	• Decreased secondary and tertiary prevention • Lack of treatment due to inability to find affected individuals	• Severe sequelae of minor medical issues. For example, septic shock from cellulitis related to infected wounds from venous stasis dermatitis.

when accessing medical care. One potential delivery mechanism is via requirements imposed by California Senate Bill 1152 (SB1152), which requires hospitals to offer appropriate vaccinations to homeless patients on inpatient or emergency room discharge [33].

Syphilis

Syphilis, a sexually transmitted genital ulcerative disease caused by the bacterium *Treponema pallidum*, is associated with significant adverse consequences if left untreated with progression into secondary and tertiary syphilis. The incidence of syphilis has increased nationally and in California despite the usual efforts of public health departments, which includes contact tracing, screening, and treatment with penicillin [34,35]. In 2017, the incidence rate of primary and secondary syphilis was 16.8 cases per 100 000 Californians, up from 1.0 cases per 100 000 in 2000 [36]. Among women, cases increased by 600% during 2012–2017 [37]. Homelessness disproportionately affects people with syphilis: 7% of men and 21% of women in California with a new diagnosis of syphilis during 2017–2018 [38]. In comparison, PEH represent 0.3% of California's total population. The significant burden of homelessness in women is particularly concerning in light of the rise in congenital syphilis (CS) cases in California. Previous work in other states on mothers of infants with CS indicates that unstable housing status is associated with increased risk of CS [39, 40]. Outbreaks of syphilis have also occurred among PEH. In 2018, Sonoma County identified a cluster of syphilis cases among homeless individuals living in encampments [41]. In response, Sonoma County Department of Public Health initiated targeted screening efforts both in the field and through providers serving persons at increased risk in order to identify additional cases and provide treatment.

The association between homelessness and syphilis may be related to multiple intersecting factors. For example, substance use disorders, which are common among PEH [7] and sex while high has been associated with increased risk of syphilis in women [42]. Lack of access to care and inadequate screening and treatment, which are also common among PEH [7], may result in continued spread within sexual networks. PEH may exchange sex for services or goods [43] and these activities increase the risk for sexually transmitted infections, such as syphilis, due to a large number of partners and inability to negotiate consistent condom use [44]. Current efforts to address the rising rates of syphilis in the general population include expansion of populations screened for syphilis in screening guidelines for sexually transmitted infections and targeted screening interventions.

Current CDC guidelines recommend syphilis screening for all pregnant women, sexually active MSM, men at increased risk and HIV positive individuals [45]. One example of a targeted screening intervention that could reduce the burden of syphilis is to increase screening in the correctional system. In California state prisons all inmates are screened for syphilis and treated if syphilis is diagnosed. The California Department of Public Health encourages providers serving PEH, including hospital emergency departments, to provide sexually transmitted disease screening for PEH.

Invasive group A streptococcal infections

Group A *Streptococcus* (GAS) bacteria cause a variety of minor infections, including pharyngitis and skin infections. Invasive group A streptococcal infection (iGAS) is defined as infection with GAS isolation from a normally sterile site (blood) or wound with necrotizing fasciitis or streptococcal toxic shock syndrome [46]. The CDC tracks cases through the Active Bacterial Core surveillance (ABCs) system, which collects data on several pathogens, including Group A *Streptococcus*, from sites in 10 states, including three counties in California [47]. iGAS is associated with increased mortality (case fatality ratio 11.7%). Factors independently associated with death included increasing age and underlying chronic illness [48]. Outbreaks of iGAS have been described among individuals experiencing homelessness and/or individuals who use injection drugs in Europe [49], Canada [50] and the USA [51].

While iGAS is not routinely reportable in California, a study of 673 iGAS cases in San Francisco during 2010–2017 tracked by the ABCs system found that 34% of cases were among PEH. The incidence of iGAS increased significantly from 300 in 2010–2014 to 547 in 2017 per 100 000 population among PEH and from 5 in 2010–2013 to 9.3 in 2017 per 100 000 among people not experiencing homelessness. The iGAS incidence was greater among PEH compared to people not experiencing homelessness due to multiple risk factors, including substance use disorders and barriers to appropriate skin care [46]. Individuals who use injection drugs may develop infections from contaminated drugs, needles, or drug paraphernalia. Recent work from New Mexico evaluating risk factors for iGAS among PEH suggested that skin breakdown and barriers to appropriate skin care may increase the risk of iGAS [52]. Collaboration with organisations serving PEH and people who inject drugs, such as needle exchange organisations, is important for preventing infections in this population and for providing care to limit the severity of wounds that have already developed. For example, existing needle exchange services not

Table 2. Recent reports describing housing status and major communicable diseases in California

Category (reference)	People experiencing homelessness <i>N</i>	Homeless per cent %	People not experiencing homelessness <i>N</i>	Non-homeless per cent %	Total population <i>n</i>	Data type	Location
California population [4, 6]	129 972	0.3	39 427 073	99.7	39 557 045	Homeless point in time count, Census bureau	All California
Hepatitis A Outbreak, 2017–2018 [23]	372	52.6	335	47.4	707	Outbreak investigation	All California (84% of cases from San Diego County)
Invasive Group A Streptococcal Infections, 2010–2017 [50]	299	44.4	374	55.6	673	CDC Active Bacterial Core surveillance (ABCs)	San Francisco County
Hepatitis C 2016–2018, [67]	680	32.9	1384	67.1	2064	CDPH linkage to care demonstration project	San Francisco County, San Diego County, Los Angeles County, San Luis Obispo County, and Monterey County
Primary and Secondary Syphilis (Female), 2017–2018 [38]	207	22.0	735	78.0	942	Surveillance	California Project Area (all California counties except Los Angeles County and San Francisco County)
Primary and Secondary Syphilis (Male), 2017–2018 [38]	275	6.6	3902	93.4	4177	Surveillance	California Project Area
Tuberculosis, 2017 [55]	106	5.4	1873	94.6	1979	Surveillance	All California
New HIV diagnoses within the last 12 months, 2012–2017 [58]	378	1.3	29 826	98.7	30 204	Surveillance	All California

Data are routine disease monitoring data unless otherwise noted.

only provide needles and syringes but also educate people on appropriate skin care and harm reduction methods [53].

Tuberculosis

TB is caused by *Mycobacterium tuberculosis* and commonly causes pulmonary infections or asymptomatic latent infection. The TB incidence rate nationally among people experiencing homelessness was estimated from 36 to 47 cases per 100 000 population in 2006–2010 [54], compared to 2.8 per 100 000 population in the general population in 2017 [55]. While TB is more common in PEH than the general population, multi-drug resistant (MDR) TB was less common. MDR infections affected 1% of PEH with TB [54], compared to 1.9% of all people diagnosed with TB in the US in 2018 [56]. Among patients with TB in 2017, 5.6% of TB cases in California reported homelessness, compared to 4.6% nationally [55]. In California, using the point in time estimate of the population of PEH, the incidence rate of TB among PEH in 2017 was 94 per 100 000 population compared to 4.7 per 100 000 population in the general population.

Los Angeles County has been experiencing a large TB outbreak among PEH since 2013. Efforts to address TB among PEH in Los Angeles County have had some success; the percentage of TB cases reporting homelessness declined from 10.1% in 2013 to 7.6% in 2016 [57]. Using the point in time estimate for the denominator, the incidence of TB among PEH decreased from 132 per 100 000 population in 2013 to 89 per 100 000 population in 2016. Los Angeles County Department of Public Health has collaborated with medical providers serving PEH and shelter sites to provide TB symptom screening at shelter entry, targeted testing, and TB treatment. The Agency also has a programme to temporarily house high-risk individuals receiving latent TB infection treatment [57].

There remain significant challenges to the treatment of active TB and latent TB infection among PEH. First, current information systems may not accurately reflect a person's true housing status, especially for people with unstable housing who may be intermittently homeless and housed. Therefore, reaching exposed individuals remains a challenge as contact tracing is difficult due to the lack of or transient living addresses of PEH. CDPH has successfully used external data from the HUD's Homeless Management Information System (HMIS) to assist with locating potential contacts. However, this information is imperfect, as people change locations over time. Second, adherence to treatment is a major challenge given the extended duration of therapy. For patients with latent TB infection, short-course therapy with rifapentine can help address issues with non-adherence due to length of therapy. Finally, exposures in congregate living situations such as homeless shelters may increase the risk of TB exposure among PEH.

HIV infection

HIV infection is no longer the leading cause of death among PEH [11]. While no recent outbreaks have been reported in California, PEH experience a disproportionate burden of new HIV infection diagnoses. In California, from 2012 to 2017 across all counties, 1.3% (378/30 204) of new cases of HIV infection were in people identified as experiencing homelessness or unstable housing based on home address [58]. During the same period, 1% of people living with HIV were homeless or unstably housed [59]. Data from the Medical Monitoring Project (MMP) in California, which includes data for all counties except for San Francisco and Los

Angeles, estimates that 10.8% (95% CI 6.7–14.9%) of California adults living with HIV reported homelessness during the 12 months before the interview [60]. The difference in the estimates may be related to the differences in data collection. Surveillance data include all counties in California, while the MMP includes all counties except for San Francisco and Los Angeles. Surveillance data measure housing status at a point in time based on the classification of a patient's home address, while the MMP asks people directly about their housing status over the past year. In 2017, based on the point in time population of PEH, the incidence rate of newly diagnosed HIV infection among PEH in California was nearly fivefold that of the general population: 56 cases per 100 000 population among PEH compared to 12 cases per 100 000 population in the general population. In San Francisco, 14% of new HIV infection cases were among PEH, and PEH had delays in time to viral suppression compared to those who were not homeless [61].

Previous research demonstrates that housing decreases mortality among people living with HIV [62]. Several programmes help PEH who have HIV infection to find housing, including the Ryan White programme [63] and the Housing Opportunities for Persons with AIDS Programme administered by the US Department of HUD [64]. Collaboration with local governments and organisations is key to meeting the needs of this population. In San Francisco, the Getting to Zero initiative advocates for people living with HIV to be prioritised for housing [65]. In 2018, San Francisco Department of Public Health received CDC funding for Project OPT-IN, a 4-year demonstration project to improve HIV treatment outcomes among vulnerable populations, including PEH. Proposed services include homeless outreach and intensive care management. [66]

Hepatitis C

Hepatitis C disproportionately affects PEH [13]. In California, housing status is not routinely collected by the hepatitis C disease monitoring system. Information on hepatitis C and housing status comes from California Department of Public Health's hepatitis C testing and linkage to care demonstration projects in four sites serving five counties (San Luis Obispo, Monterey, San Francisco, San Diego and Los Angeles), which found that out of 2064 individuals who newly tested positive for HCV RNA between 1 March 2016 and 30 June 2019, 32.9% (680) were known to be unstably housed [67]. While these data are unlikely to be generalisable to all persons testing positive for HCV since they specifically targeted PEH and people who use injection drugs, they suggest that homelessness may be common among persons infected with HCV in California. Unstable housing is a common barrier to hepatitis C treatment. Collaboration with local organisations and governments is important to find innovative ways to reach PEH who have hepatitis C infection. This is already at work in San Francisco: the End Hep C SF campaign aims to ensure access to hepatitis C treatment for all people, including PEH. This collaborative effort involves the San Francisco Department of Public Health, community clinics and homeless shelters that offer on-site hepatitis C treatment. [68]

Policy implications

There are multiple potential factors that increase the risk of homelessness and potential areas in which to intervene.

Housing: Preventing homelessness and providing housing for PEH can eliminate many of the risks that PEH face. Housing decreases mortality among people with HIV [62] and programs now exist to provide housing for this population. Limited evidence suggests that housing will be beneficial for other groups as well: among chronically ill homeless adults, permanent supportive housing was associated with decreased mortality. Only 2% of the housed individuals died of infectious causes compared to 13% of unhoused individuals [69]. Permanent supportive housing programmes provide a suite of healthcare and social services to help individuals stay healthy and housed [69]. For example, treatment of comorbid substance use disorders and mental illness can help decrease the risk of communicable diseases and increase a person's capacity for self-care. [7]

States have experimented with using Medicaid dollars to pay for housing [5], but addressing the root causes of homelessness, including addressing issues of affordable housing, are fundamental for mitigating the risks to health among PEH.

Improving care for PEH: Efforts to improve access to healthcare for PEH could prevent or mitigate illness in more individuals. One strategy is recent California legislation (SB1152) which mandates hospitals to offer appropriate vaccinations and coordination of care for homeless patients on hospital or emergency room discharge. Another strategy is the California Whole Person Care pilot program that is intended to enhance coordination of health and social services for vulnerable populations including PEH.

Improving information systems: Reaching exposed or at-risk individuals remains a major challenge, especially when these individuals do not have permanent contact information. Use of information systems like the California Immunisation Registry (CAIR) [70] and the HUD's HMIS [71] could support improved information sharing between different homeless service providers and public health departments to reach people in a timely fashion and provide needed services [72]. The Health Insurance Portability and Accountability Act protects certain health information and may be a barrier for health care systems to collaborate with homeless service providers. [73]

Strengthening partnerships: Public health departments must work closely in partnership with local governments and non-governmental organisations to meet the health needs of PEH. One important group of partners are community health centres that receive funding through the federal Health Care for the Homeless program. In the case of the 2017–2018 hepatitis A outbreak, collaboration between the department of public health and local social services agencies was crucial for reaching thousands of at-risk individuals.

Summary

California has a large and growing population of PEH. Compared to the rest of the country, California's population of PEH are disproportionately unsheltered and chronically homeless. These individuals die prematurely and suffer a greater burden of illness, including communicable diseases such as HIV, hepatitis A, hepatitis C and TB. PEH are especially vulnerable due to the intersection of multiple risks, including increased exposure to pathogens, decreased immunity and decreased access to healthcare and services that would mitigate the severity of illness.

There are several important limitations to the available data on housing status and communicable disease risk. First, disease incidence among PEH may be overestimated due to undercounting of the true population of the PEH. Calculations of disease incidence

rely on HUD's yearly point-in-time counts, which may fail to include people in hard to reach locations (riverbeds, remote encampments) and people intermittently cycling between homelessness and unstable temporary housing arrangements. Second, case burdens may appear elevated due to enhanced screening among PEH. For example, targeted syphilis screening among PEH in Sonoma County may partly explain the elevated proportion of PEH among people with syphilis. Conversely, it also may be the case that PEH are not properly identified due to lack of medical care or inability to trace contacts due to lack of information. Finally, housing status is inconsistently collected across disease categories and a significant amount of housing information is missing, which can affect disease incidence estimates in either direction.

Efforts to address communicable disease risk in this population will depend on innovative strategies to overcome the unique challenges in reaching people and providing adequate treatment, as well as strategies to address fundamental causes related to access to affordable housing and treatment for comorbid conditions including substance use disorder and mental illness. While some of the root causes of homelessness lie outside the purview of public health agencies, there are opportunities for public health to support both primary and secondary prevention of communicable disease issues in PEH. Examples of primary prevention efforts by public health include immunisation, promotion of harm reduction methods including needle exchange and efforts to increase access to mental health services, substance use treatment and supportive services for PEH. Examples of potential secondary prevention interventions include supporting access to culturally competent clinical and other supportive services to reduce the complications of infections once they occur.

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EXHIBIT “6”



Needle stick injuries in the community

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Abstract

When children sustain injuries from needles discarded in public places, concerns arise about possible exposure to blood-borne viruses. The risk of infection is low, but assessment, counselling, and follow-up of the injured child are needed. This statement reviews the literature concerning blood-borne viral infections after injuries from needles discarded in the community, and provides recommendations for the prevention and management of such incidents.

Keywords: *Antiretrovirals; Blood-borne infections; Children; Needle-stick injuries*

Injury from used needles and syringes found in community settings arouses much concern, especially when children find discarded needles and injure themselves while playing with them. The user is generally unknown, and parents and health care providers fear that the needle may have been discarded by a person who injects drugs with a blood-borne infection.

Although the actual risk of infection from such an injury is extremely low, the perception of risk by parents results in much anxiety. Evaluation, counselling, and follow-up with parents and the child are needed. This statement updates a Canadian Paediatric Society document published in 2008^[1].

The important pathogens to be considered in this situation are hepatitis B virus (HBV), hepatitis C virus (HCV), and human immunodeficiency virus (HIV)^{[2][3]}. It is essential that health care providers know about the risks of acquiring these viruses following needle stick injuries as well as current recommendations for management and follow-up. The prevalence of HBV, HCV, and HIV among persons who inject drugs varies among regions in Canada and may change rapidly. In the absence of up-to-date local data, it is prudent to assume that the needle may have been contaminated with one or more of these viruses.

To date there have been very few case reports of HBV^{[4][5]} or HCV^{[6][7]} transmission and none of HIV transmission following injuries by needles discarded in the community. Most children received HBV prophylaxis, if it was indicated, while fewer than 20% received antiretroviral therapy (ART) prophylaxis^{[8]-[25]}.

Needle stick injuries can be prevented by educating children, parents, educators, and health care providers about the

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dangers of handling used needles, syringes, and other objects contaminated with blood, including sharps containers designed for used needle disposal in public places. Children need to be made aware of these rules at an early age. In the studies of injuries from discarded needles referred to above, the mean ages of children injured ranged between 5 and 8 years. In one study^[10], 15% of injuries occurred in children pretending to use drugs. **Communities are responsible for providing adequate cleanup of parks and schoolyards. Also, communities must commit to and support addiction treatment and infection prevention programs for injection drug users.**

The risk of infection from exposure to blood by a needle stick injury depends on the size of the needle, the depth of penetration, and whether blood was injected. Risk is increased with the amount of blood introduced and the concentration of the virus in that blood. Follow-up after any significant needle stick injury is essential. The clinician dealing with the initial incident should ensure that the parents and child understand the importance of follow-up testing and that appropriate arrangements are made. Parents sometimes erroneously assume that if blood tests that are performed at the time of injury are negative, there is no possibility of infection and no need for further testing.

HBV

HBV is the most stable of the blood-borne viruses and can be transmitted by a minute amount of blood. The risk of acquiring HBV from an occupational needle stick injury when the source is hepatitis B surface antigen (HBsAg)-positive ranges from 2% to 40%, depending on the source's viremia level^[2]. HBV can survive for up to 1 week under optimal conditions, and has been detected in discarded needles^{[8][26]}. In both the paediatric^[4] and the adult reported cases^[5] of acquired HBV following needle stick injuries in the community, there was no documentation of prior HBV immunization or post-exposure prophylaxis.

Although the HBV vaccine is now recommended for all children in Canada, most programs have targeted children who are older than the usual age at which they sustain accidental needle stick injuries^[27]. Thus, most children injured by needle sticks are likely to be susceptible to HBV infection. Recently introduced programs in some provinces provide HBV vaccine to infants, which will protect the age group at the highest risk of needle stick injuries. However, children not vaccinated in infancy because of jurisdictional policies or age, when infant HBV vaccination was introduced locally remain at risk, as do children whose antibody response to their first vaccine series (HBV surface antibody <10mIU/mL) is not adequately protective. For children who have not yet received the HBV vaccine, post-exposure prophylaxis with anti-HBV immunoglobulin and HBV vaccine is advised and is effective when provided promptly (Table 1)^[28].

Table 1. HBV prophylaxis

Child known to be anti-HBsAg antibody (anti-HBs) with protective titer (≥ 10 mIU/mL)	No action required.
Child known to be HBsAg-positive	No immediate action required. Refer appropriately if not already linked into specialist care
Child has not been fully vaccinated against HBV	Test for anti-HBs, HBsAg immediately. Await results if available within 48 h. If anti-HBs, HBsAg are negative: • Give HBIG immediately (ideally within 48 h of injury; efficacy unknown if >7 days after injury). Dose = 0.06 mL/kg, administered intramuscularly. • Give HBV vaccine at a different site to HBIG (as soon as possible, and at latest within 7 days of injury). Arrange to complete vaccine series. If anti-HBs-positive (protective titer), complete HBV vaccine series according to schedule. If HBsAg-positive, discontinue vaccine series. Arrange appropriate follow-up. If results are not available in 48 h: • Give HBIG immediately. • Give a dose of HBV vaccine (as soon as possible, and at latest within 7 days of injury) at different site to HBIG. • When results are available, proceed with vaccine and follow-up as above.

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Child has been fully vaccinated against HBV

Test for anti-HBs, HBsAg. If anti-HBs results are not available in 48 h, give one dose of HBV vaccine.

If anti-HBs-positive (protective titer), no further action is required.

If HBsAg-negative, and anti-HBs-negative/or insufficiently protective give (40mIU/mL) HBIG and dose of HBV vaccine at different sites.

If HbsAg-positive, arrange appropriate follow-up.

HBIG HBV immunoglobulin; HBsAg Hepatitis B surface antigen; HBV Hepatitis B virus.

Some experts also recommend anti-hepatitis B core antibody (anti-HBc) testing to allow a more comprehensive assessment but HBsAg and anti-HBsAg-antibody results influence decision. A reactive anti-HBc with negative HBsAg may reflect a false positive result, old resolved infection, or occult infection). ID consultant involvement is recommended.

HCV

The risk of acquiring HCV from an occupational needle stick injury when the source was infected varies from 3% to 10%^[2]. HCV is thought to be a fragile virus and therefore less likely to survive in the environment, but there have been case reports^{[6][7]} of HCV acquisition after an injury from discarded needles.

Although many drugs are now available for therapy of chronic HCV infection, their potential role for prophylaxis is not known. Because chemoprophylaxis is not yet available, follow-up HCV testing is important to determine whether a potential exposure results in transmission of HCV because 75% of infected children will develop chronic infection, which is usually asymptomatic. Children with chronic infection require referral to a specialist and antiviral treatment may be required^[29].

HIV

The risk of acquiring HIV from a hollow-bore needle with blood from a known HIV-seropositive source as a result of occupational needle stick injury was between 0.2% and 0.5% in prospective studies conducted before effective ART became available^{[2][30]}. The risk for transmission of HIV from a known HIV-seropositive source who is receiving ART and has an undetectable viral load is believed to be extremely low, but is likely not zero. In most reported instances involving transmission of HIV, the needle stick injury occurred within seconds or minutes after the needle was withdrawn from the source patient.

In contrast to the situation with health care workers, the source of blood in discarded needles is usually unknown, injury does not occur immediately after needle use, the needle rarely contains fresh blood, any virus present has been exposed to drying and environmental temperatures, and injuries are usually superficial. HIV is a relatively fragile virus and susceptible to drying. However, survival of HIV for up to 42 days in syringes inoculated with the virus has been demonstrated, with duration of survival dependent on ambient temperature^[31]. One study^[32] found no traces of HIV proviral DNA in syringes

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discarded by people who inject drugs, while another study^[33] found HIV DNA in visibly contaminated needles and syringes from sites with high drug injection activity.

It is extremely unlikely that HIV infection would occur following an injury from a needle discarded in a public place.

However, if the incident involved a needle and syringe with fresh blood, and if some of the blood was injected into the child, infection is theoretically possible and prophylaxis is indicated. In early studies of occupational needle stick exposures, zidovudine prophylaxis alone was shown to reduce the risk of HIV transmission from a positive source by 80%^[30]. Prophylaxis with combination ART therapy is presumed to be more effective but has not been studied. Two-drug regimens have been used for low-risk exposures in the past, but currently three drugs are recommended for all prophylaxis, based on observations in treatment of HIV infection and the assumption that maximum suppression will be most effective in preventing infection^{[2][34]}.

Other potential exposures

Although this document addresses potential exposures of children or youth to blood-borne viruses from injuries with discarded needles, the principles presented here could be extended to other potential exposures (e.g., injuries from other sharp objects contaminated with blood, sharing equipment for injection drug use, mucous membrane or nonintact skin exposure to used condoms or tampons, sexual exposure, etc.). On very rare occasions, young children have sustained a needle injury from reaching into an inappropriately accessible sharps container (e.g., one stored on the floor or table top) in various ambulatory settings. These should be considered higher-risk scenarios where post-exposure prophylaxis is administered.

RECOMMENDATIONS

In the absence of specific studies, all recommendations are based on expert opinion and extrapolations from other scientific data, with a level of evidence rating of B-III.

Prevention

- Parents, educators, and health care providers should be made aware of the problem of discarded needles.
- Children and youth should receive age-appropriate education about the potential dangers of injection drug use.
- Children should be taught not to touch or handle needles and syringes, and to report finding them to a responsible adult (a parent, teacher, or police officer), who should then arrange for the safe disposal of the needle in a puncture-proof, closed container.
- Community programs should be in place to keep parks and public places, and other public areas where children generally play, free of discarded needles^[35]. Clinical settings should ensure sharps disposal containers are kept well out of reach of children.
- Programs should be in place for the treatment and control of injection drug addiction, and to adequately support HIV prevention, HBV vaccination, HCV eradication therapy, and harm reduction programs that distribute safer drug use equipment for injection drug users.

Management

- Clean the wound thoroughly with soap and water as soon as possible after the needle stick injury. Do not squeeze the area to induce bleeding.
- Assess the extent of the wound and the probability of exposure to blood through open skin lesions or mucous membranes.
- Determine the child's immunization status for tetanus and HBV.
- Administer tetanus vaccine, with or without tetanus immunoglobulin, when indicated ^[36].
- Document the circumstances of the injury (date and time of injury or exposure, where the needle was found, how the injury happened, the description of the needle, whether a syringe was attached, whether blood was visible in or on the needle or syringe, whether the injury caused bleeding, and whether the previous user of the needle is known).
- Obtain a blood sample from the child for:
 - Baseline HBV, HIV, and HCV status.
 - In the rare instance where ART are being started, complete blood count, differential, aspartate aminotransferase, alanine aminotransferase, alkaline phosphatase, blood urea nitrogen, and creatinine.
- Testing needles and syringes for viruses is not indicated. Results are likely to be negative, but a negative result does not rule out possibility of infection.
- When the user of the needle is known, attempts should be made to assess for risk factors for blood-borne viruses and, if possible, to test for these viruses. Pending results, proceed as for an unknown source.

Table 2. Risk assessment for HIV transmission

Source	Device	Injury
Consider high risk if • Source known to have HIV • Source unknown but presumed or known high prevalence¹ of HIV in local population of people who inject drugs.	• Consider the size of needle, whether it is hollow-bore, presence of visible blood in the needle or syringe, probability of exposure to drying, heat and freezing since use. • Large lumen devices with visible blood are highest risk.	• Consider depth and extent of trauma (scratch or deep cut, injection of blood and bleeding at the site). • Injuries with actual blood injection are high risk. Superficial scratches are low risk. • If exposure limited to mucous membranes or nonintact skin, consider extent of exposure. For example, child put syringe with visible blood into mouth and possibly injected blood – high risk; suspected but unobserved splash onto eyes or lips – low risk. Splashes involving a large volume of blood (not just a few drops) coming into contact with extensive areas of nonintact skin – high risk.
<i>HIV Human immunodeficiency virus.</i> ¹>15% has been suggested [35].		

HBV prophylaxis

Refer to Table 1.

HIV prophylaxis

- Assess risk of HIV transmission (Table 2) and the risks and benefits of ART prophylaxis on a case-by-case basis, taking into consideration the ability of the child to tolerate and adhere to an ART regimen for 4 weeks. Discuss the potential benefits, adverse effects, and costs of ART prophylaxis with parents—and with the child if age-appropriate—with a view to shared decision-making.
 - Recommend ART prophylaxis only in high risk situations, when the source is considered likely to have HIV, the incident involved a needle and syringe with visible blood, and blood may have been injected.
 - Discuss but do not recommend prophylaxis in low risk situations (source unlikely to have HIV or no visible blood in the device or superficial injury). Reassure parents that the chance of their child acquiring HIV as a result of this type of injury is extremely low and has, so far, never been reported.
- If the decision is made to begin ART prophylaxis:

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- Start ART as soon as possible, ideally within 1 hour to 4 hours of the injury. Prophylaxis is not indicated if it cannot be initiated within 72 hours of injury occurrence^{[2][34][37]}.
- When parents considering prophylaxis are undecided, advise them that starting prophylaxis immediately is preferable. Prophylaxis is of no benefit after 72 hours, but treatment can be discontinued later, if they wish.
- Paediatricians unfamiliar with ART drugs may wish to consult a specialist in the care of children with HIV but consultation should not delay start of prophylaxis, when indicated.
- The ART agents recommended are those currently used for occupational and nonoccupational exposures and for HIV therapy^{[2][34][38]}
 - For young children: zidovudine plus lamivudine plus raltegravir or dolutegravir (Table 3).
 - For children at least 12 years old and weighing at least 35 kg: emtricitabine plus tenofovir plus raltegravir or dolutegravir (Table 3). For some drugs, a pharmacist may be able to prepare a suspension if the smaller tablets are not locally available.
 - If alternative ARTs are needed (e.g., because of contraindication, intolerance, or suspected drug resistance), consult a specialist in the care of children with HIV. Alternate regimens should include two nucleoside reverse-transcriptase inhibitors and one integrase strand transfer inhibitor or protease inhibitor (Table 3).
 - Other regimens may be preferred by local authorities in some jurisdictions.
 - Tenofovir is contraindicated if renal function is abnormal.
- The duration of prophylaxis is 28 days. For dosing and other details, refer to Table 3.
- Recommendations may change as new ARTs become available. For up-to-date information and information on alternative ARTs, visit: <https://clinicalinfo.hiv.gov/en/guidelines/pediatric-arv/whats-new> (<https://clinicalinfo.hiv.gov/en/guidelines/pediatric-arv/whats-new>). [Note that American drug approvals may differ slightly from those in Canada]
- ARTs, especially protease inhibitors, may interfere with other medications. Check whether the child is taking other medications and assess for possible interactions.
- Adverse effects: There are no data to suggest that a 4-week course of ARTs has serious or long-term detrimental effects (see Table 3, footnotes). Children with HIV infection have taken these drugs for years and serious side effects are rare.
- Emergency departments and clinics in which children with needle stick injuries are seen should arrange to have ‘starter kits’ available, such that prophylaxis can begin with the least delay, when indicated.
- At the initial visit, provide drugs for 2 to 3 days and schedule a reassessment immediately afterward to review adherence, check for adverse effects and arrange further follow-up.
- If the decision is made to continue prophylaxis, prescribe drugs to complete the 28-day course.

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Table 3. Antiretroviral agents recommended for post-exposure prophylaxis

Agent	Dosage and age/weight criteria	Comments
Zidovudine (ZDV) ^{[1]–[3]} (NRTI)	4 weeks to 12 years: 240 mg/M2/dose twice daily ≥12 years: 300 mg/dose twice daily	Available in oral solution 10 mg/mL; 100 mg capsules Can be taken with or without food; may be better tolerated with food.
Lamivudine (3TC) ^{[1][3]} (NRTI)	1 month to <3 months: 4 mg/kg /dose twice daily ≥3 months to 3 years: 5 mg/kg/dose (maximum 150 mg/dose) twice daily ≥3 years: 5 mg/kg/dose twice daily (maximum dose 150 mg) or 10 mg/kg/dose (maximum dose 300 mg) once daily	Available in oral solution 10 mg/mL; 100 mg, 150 mg, 300 mg tablets Can be taken with or without food; may be better tolerated with food.
Lopinavir/ritonavir (LPV/r) ^{[2][4]} (PI)	2 to 52 weeks: 300 mg LPV/75 mg r/M2/dose twice daily 1 to 18 years: 230 mg LPV/57.5 mg r /M2/dose twice daily (maximum 400 mg LPV/100 mg r/dose) >35 kg: 400 mg LPV/100 mg r twice daily	Available in oral solution 80 mg LPV/20 mg r /mL; 100 mg LPV/25 mg r and 200 mg LPV/50 mg r tablets Should be taken with a high fat meal or snack.
Tenofovir disoproxil (TDF) ^{[1][6]} (NRTI)	2 to 12 years: 8 mg/kg/dose once daily (maximum 300 mg/dose) ≥12 years and ≥ 35 kg: 300 mg once daily	Available only as 300 mg tablet. Lower strength TDF tablets (150 mg, 200 mg, 250 mg) are available through SAP for children who do not meet the weight requirements for the 300 mg tablets. Can be given with or without food.

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Raltegravir (RAL) ^[5] (INSTI)	≥1 month and ≥ 3 kg: 6 mg/kg/dose twice daily (maximum 400 mg/dose) Tablets: ≥25 kg: 400 mg twice daily Chewable tablets: 3 to <6 kg: 25 mg twice daily; 6 to <10 kg: 50 mg twice daily; 10 to <14 kg: 75 mg twice daily; 14 to <20 kg: 100 mg twice daily; 20 to <28 kg: 150 mg twice daily; 28 to <40 kg: 200 mg twice daily; ≥40 kg: 300 mg twice daily	Available as 400 mg and 600 mg tablets and 25 mg and 100 mg chewable tablets. Oral granules for suspension are available through SAP. Can be given with or without food.
Dolutegravir (DTG) ^[5]	Dispersible tablets: 3 to <6 kg: 5 mg once daily; 6 to <10 kg: 15 mg once daily; 10 to <14 kg: 20 mg once daily; 14 to <20 kg: 25 mg once daily; ≥ 20 kg: 30 mg once daily Tablets: 14 to <20 kg: 40 mg once daily ≥20 kg: 50 mg once daily	Available as 10 mg, 25 mg, and 50 mg tablets and 5 mg dispersible tablets Can be given with or without food.
Available for older children:		
ZDV+3TC ^{[1]_ [3]} (NRTIs)	>30 kg: one tablet twice daily	Combination tablet contains 300 mg ZDV plus 150 mg 3TC
FTC+TDF (Truvada) ^[6] (NRTIs)	≥12 years and ≥35 kg: one tablet once daily	Tablet contains 200 mg FTC plus 300 mg TDF.
FTC+TAF (Descovy) (NRTIs) ^[6]	≥25 kg: one tablet once daily	Combination tablet contains: 200 mg FTC plus 25 mg tenofovir alafenamide (TAF) (used for patients on INSTI-based regimens), or: 200 mg FTC plus 10 mg TAF (used for patients boosted with PI regimens)

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FTC+TAF+bictegravir (Biktarvy) (NRTIs + INSTI) ^{[5][6]}	≥25 kg: one tablet once daily	Combination tablet contains 200 mg FTC plus 25 mg TAF plus 50 mg bictegravir (BIC)
FTC Emtricitabine; INSTI Integrase strand transfer inhibitor; NRTI Nucleoside reverse-transcriptase inhibitors; PI Protease inhibitor ; SAP Special Access Program. Data drawn from references^{[31][36]}. ^[1] Dose adjustment required in cases of renal insufficiency. ^[2] Dose adjustment may be required in cases of hepatic insufficiency. ^[3] ZDV and 3TC are well tolerated. Occasionally, children experience anorexia, nausea, vomiting, diarrhea, abdominal pain, fatigue, and headache. Asymptomatic mild neutropenia, anemia, or elevation of liver enzymes may occur, which resolve after treatment is completed. ^[4] LPV/r may cause nausea, vomiting, diarrhea, or abdominal discomfort. Ritonavir component acts as a booster and is not counted as a separate antiretroviral agent. ^[5] FTC, RAL, DTG, and BIC are very well tolerated, with minimal adverse effects. RAL is licensed for age ≥2 years but chewable tablets may not be available in some locations. 600 mg tablets not used for prophylaxis. DTG licensed for age ≥4 weeks and ≥3 kg but 10 mg and 25 mg tablets and 5 mg dispersible tablets may not be available in some locations. Note: the dose of the DTG regular tablets and DTG dispersible tablets are different because they are not bioequivalent. RAL granules for oral suspension are available through Health Canada's SAP. ^[6] TDF is well tolerated. Rarely, may cause headache, diarrhea, nausea, and vomiting. Renal tubular dysfunction reported after more prolonged use (lower risk with TAF compared to TDF). Monitor creatinine and urine protein. Contraindicated in renal dysfunction. Not licensed in Canada for children <12 years old.		

Follow-up

- Arrange follow-up and advise parents of the need to monitor side-effects (if on ART prophylaxis), test for acquisition of infection and complete the HBV vaccination schedule.
- If the child is receiving ART prophylaxis:
 - Reassess at 2 to 3 days, by phone or visit.
 - Follow-up at 2 and 4 weeks for assessment of adherence, drug tolerance, complete blood count, differential, aspartate aminotransferase, alanine aminotransferase, and creatinine.
- At 4 weeks, give a second HBV vaccine dose if only one previous dose was received (consult Table 1) or if no antibody or antigen was detected on initial testing.
- At 4 to 6 weeks test for anti-HIV antibody, anti-HCV antibody, anti-HBs and HBsAg.
- At 4 to 6 months, test for anti-HIV antibody, anti-HCV antibody, anti-HBs, HBsAg and (unless previously positive)

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- At 6 months, give a third HBV vaccine dose if only two previous doses have been received.
- If anti-HBsAg antibody tests negative at 6 months, test again 1 to 2 months after the third dose of vaccine. If still negative, test for HBsAg. If negative for both, give a fourth dose of HBV vaccine and test again 1 to 2 months later. If still negative, refer to an appropriate specialist.
- If HIV, HCV, or HBV infection occurs, arrange for appropriate follow-up.

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Disclaimer: The recommendations in this position statement do not indicate an exclusive course of treatment or procedure to be followed. Variations, taking into account individual circumstances, may be appropriate. Internet addresses are current at time of publication.

EXHIBIT “7”



Impact of Encampment Sweeps on People Experiencing Homelessness

December 2022

Homeless encampments occur because there is a pervasive lack of affordable, permanent housing in our communities. As the cost of housing continues to exceed income, the number and scale of encampments is only increasing. Community responses to remove, or “sweep,” encampments are understandable because people are rightly disturbed by the existence of homelessness, especially in the United States.¹ Not only is homelessness a clear violation of human rights, it is a stark reminder of the systemic public policy failures across the housing, health care, labor, and education sectors that have produced [epidemic levels](#) of housing instability.

Encampments can be unsafe, violent, and unhealthy places, and public health officials are rightly concerned about the impact of these congregate settings on vulnerable people. In fact, public health concerns are often used to justify sweeps, especially due to lack of access to running water and bathrooms. **However, encampment sweeps are counterproductive, costly, and harmful.** As communities struggle to address homelessness, direct service providers often observe the negative impacts of sweeps first-hand but may not be in a strong position to advocate publicly against them. Health Care for the Homeless programs (and others delivering direct care to people experiencing homelessness) often must balance [multiple roles](#)—as a service provider, a community leader, and an advocate—with a wide range of community stakeholders. Although striking this balance may be difficult, the HCH community is in a unique position to educate policymakers about the negative impacts of encampment sweeps and call for more constructive, humane approaches to truly end homelessness.

This issue brief describes the impact of sweeps on encampment residents and local communities, and provides recommendations for more constructively responding to unsheltered homelessness.

Factors that Drive Encampments

It may be difficult to understand why people live in an encampment, especially if there are homeless shelters in a community. First, not every community has a full-time shelter, it may not have beds available, it may have [restrictive rules and other barriers](#) that prohibit many from entering, or it may have banned others for prior rule violations. People using shelters cannot bring all of their possessions and may only be allowed one bag. This leaves

¹ A “sweep” is defined here as the forced disbanding of homeless encampments on public property and the removal of both homeless individuals and their property from that area. This could be through an explicit or implied threat of enforcement of criminal ordinances, or use of public health, sanitation, parking enforcement, park or other public space regulations. (Sometimes sweeps are also referred to as a “clean-up.”)

them without the vital supplies they need if the shelter can only accommodate them on a short-term basis. Many shelters cannot accommodate parking, and for those that have vehicles, this jeopardizes a valuable resource needed to regain stability. Often there are requirements to participate in services that are not tailored to their specific needs, or for sobriety, which is difficult to achieve without stable housing.

Second, while some shelters are well-run and fully resourced, others can be unsafe. There are [threats of violence, theft, increased substance use](#) and [sexual harassment by shelter staff](#) and residents. Shelters can also enforce [arbitrary rules, medication requirements, and curfews](#). Shelter residents report [feeling dehumanized](#) in shelters and that shelter staff [engage in infantilization and victim blaming](#). It is understandable that couples or families would not want to be separated at a shelter, and elderly or LGBTQ people may feel especially unsafe. Sexual and economic exploitation are not uncommon. Large, congregate shelters can trigger anxiety or paranoia in those with mental health conditions, and many shelters are in settings that cannot accommodate disabilities, mobility limitations, or medical equipment (such as oxygen tanks or wheelchairs). Bed bugs, lice, and other harmful pests are common. The rigid hours to arrive/leave required by most shelters makes it difficult for people to [maintain employment](#).

For these reasons, people experiencing homelessness may have no choice but to live in an encampment, or the encampment may offer advantages that area shelters do not. Encampments can offer community, safety, security, companionship, autonomy, and pooled resources to meet other practical needs. They can allow a greater sense of agency through self-governance not available in shelter settings. Encampments prevent the need to carry around one's belongings all day and can offer a stability that overnight shelters cannot. Encampments also allow families to stay together and will accommodate pets. Hence, there are many practical, rational reasons why people would prefer to live in an encampment than stay at a shelter.

Sweeps do not end homelessness. Grassroots leaders and direct service providers understand that encampment sweeps cause four general problems:

- **Sweeps damage health, well-being, and connections to care**
- **Sweeps compromise personal safety and civic trust**
- **Sweeps undermine paths to housing and financial stability**
- **Sweeps create unnecessary costs for local communities**

Each of these problems presents significant challenges to those directly impacted by forced displacement, as well as to the service providers who care for them.

Damage Health, Well-being, and Connections to Care

Encampment sweeps damage health and disrupt connections to care in that they:

- **Destroy items needed for survival:** Tents, bedding, food, cooking equipment, clothing, shoes, and other items needed for survival are destroyed, thrown away, or removed to a storage facility that residents may not be able to access. Replacing these items may not be possible and takes time and resources away from more constructive solutions.

“Imagine someone kicking in the front door to your house, demanding that you leave, then trashing all your household possessions. That’s exactly what happens when police and city workers sweep a homeless encampment.”

~ David Peery, Co-chair, National Consumer Advisory Board

- **Cause trauma and worsen mental health conditions:** Residents report feeling dehumanized and traumatized after sweeps. Intense fear over subsequent displacement, nightmares, and sleep deprivation after sweeps all contribute to mental health deterioration. The constant fear of anticipating “the knock” of authorities coming to take them away—and never knowing when a sweep will suddenly come—contributes to anxiety and chronic stress. Sweeps also disrupt daily routines and cut off individuals from familiar surroundings and social connections, which can lead to worsening mental health symptoms and increased vulnerability. In this way, sweeps can cause the same mental health instability that policymakers use to justify the forced relocation.
- **Destroy life-saving medications and medical equipment:** Sweeps often destroy vital medications used to treat chronic and acute illnesses, as well as behavioral health conditions. Conditions such as HIV, hepatitis C, diabetes, hypertension, substance use, schizophrenia, anxiety, and depression (among many other health conditions) are especially difficult to manage absent regular medication. Unfortunately, it is often difficult to obtain replacement medications, and residents may go weeks or months without medication—leading to negative health outcomes. Medical equipment, such as wheelchairs, walkers, canes, or other assistive devices, are also lost or destroyed during encampment sweeps.
- **Sever connections to care:** Health care providers (and other direct service providers) often cannot find their patients after a sweep, and have no knowledge of where they might have gone. For some residents, outreach workers coming to an encampment may have been the only service connection that someone was accessing. Hence, the opportunity to engage someone in additional care—however tenuous that may have been—has now been lost.

“Encampment sweeps are especially hard on our pregnant patients. Imagine being pregnant, having all your possessions taken from you, and being forced to go somewhere else without regard to you or your unborn child. Even worse, it severs you from your connection to prenatal care, and increases stress and the risk of miscarriage.”

~Amy Grassetto, OB/Perinatal Scheduler, Family Health Center of Worcester, Massachusetts; former Chair, National Consumer Advisory Board; President, NHCHC Board of Directors

- **Undermine trust in service providers.** When service providers are present during sweeps to mitigate harm and attempt to soften the impact of the sweep, residents may view them as complicit. When service providers are not present during a sweep, they may be accused of abandoning their clients. This is a no-win situation for service providers, as they often have no decision-making authority over the sweep itself, yet receive blame from clients who now have difficulty trusting them and engaging in care.

"It often takes years to establish trust, and only seconds to lose it."

~ Kevin Lindamood, CEO, Health Care for the Homeless, Baltimore

Compromise Personal Safety and Civic Trust

Encampment sweeps compromise the personal safety of residents and the broader trust in law enforcement in that they:

- **Increase arrests and assaults of residents:** Encampment residents may avoid calling 911 in life-threatening emergencies to avoid police presence and triggering a possible sweep. While police presence does not necessarily (or even usually) result in increased safety among encampment residents, the inability to use existing public safety systems in emergency situations leaves encampment residents vulnerable to violence. While crime is often used to justify a sweep, crime complaints in the surrounding community have been shown to [remain the same](#) 30 days after a sweep (though former encampment residents experienced a 28% rise in arrests and a 35% increase in the risk of physical assault).
- **Contribute to drug overdoses:** Residents lose both naloxone (Narcan®) and the protective community that would administer the medication in case of overdose. Losing vital medications—such as buprenorphine and mental health medication that might have prevented withdrawal or managed mental health symptoms—may contribute to self-medication with other drugs and contribute to a relapse. Displacement may also cause disconnection from the care team prescribing buprenorphine or make it more difficult to access a methadone clinic. These are some examples why the risk of overdose increases after a sweep, and participation in substance use treatment is disrupted.

"Stigma against drug use pushes people into isolation, and that's a recipe for an unwitnessed overdose. When we take away encampments, we take away a community that can serve as a first line of defense against a potential death when an overdose happens."

~ Yoela Tepper, Substance Use Specialist, The Night Ministry, Chicago

- **Push residents into more dangerous, isolated environments:** After a sweep, residents are often pushed to more remote and isolated locations that are difficult for service providers to access. Unsafe water supply, lack of bathroom facilities, and austere terrain create additional safety risks for people who have nowhere else to go. This is especially dangerous in severe weather when the sweep likely destroyed survival

equipment such as tents, blankets, and clothing, which allowed them to be protected from weather while living outside.

- **Cause widespread fear:** Communities increasingly are using helicopters, drones, and other devices designed to terrorize people living outside and disperse them from the encampment. These approaches only cause pervasive fear and trauma, and should never be used to monitor and/or clear an encampment.
- **Increase hostile interactions with the police:** Sweeps erode already precarious relationships between homeless communities and law enforcement. It is not unusual for police to inconsistently enforce rules during or between sweeps. Residents have been given citations without being told what local ordinances they violated. Sweeps also put police (often armed) directly into conflict with encampment residents, who are understandably upset and defending their personal property. This dynamic dramatically increases the likelihood of incarceration and violence.

“Forced displacement of encampment residents is traumatic for both unsheltered persons and our staff. Patient care is often disrupted, and individuals are placed in more precarious and dangerous living environments. Our HCH providers struggle with the moral injury of being associated with displacing people without adequate resources. It is difficult for providers to build trusting relationships that can survive these displacements and even harder for us to continue caring for traumatized patients.”

~ Aislinn Bird, MD, Director of Integrated Care, Alameda County Health Care for the Homeless, Oakland

- **Disproportionately impact BIPOC groups and people with disabilities:** People experiencing homelessness are [disproportionately](#) Black, Brown, or Indigenous, especially those experiencing [unsheltered homelessness](#). People with disabilities comprise [24% of those experiencing homelessness](#) and often have medical conditions or mobility issues that make sweeps especially dangerous. Local officials must acknowledge the racial disparities affiliated with homelessness as well as the potential for violations of the Americans with Disabilities Act inherent in sweeps, and pursue responses that uphold principles of equity, fairness, and accommodation.
- **Violate rights:** All people living in the United States are protected under the Fourth Amendment of the Constitution from unreasonable search and seizure, and by the Eighth Amendment from excessive fines and cruel and unusual punishment. Seizing property, imposing a fine, and/or arresting someone because they are existing in a public space violates their rights.
- **Contribute to stigma:** Sweeps clearly communicate to the larger community—and to people experiencing homeless themselves—that they have little worth and are only “throw away” people. Sweeps also promote a callous societal norm toward people without homes, which makes it acceptable to not recognize the rights and value of other human beings.

Undermine Paths to Housing and Financial Stability

Encampment sweeps undermine paths to stability in that they:

- **Destroy vital records:** Residents lose driver's licenses, birth certificates, social security cards, and other vital records during sweeps, which often cannot be replaced due to cost or difficulty subsequently verifying identity. Without these documents, it is often not even possible to enter a public building to seek replacements, or apply for jobs and housing. The process of replacing vital records can take 6 to 8 months to complete. Not having identification can also cause negative police interactions.

"When someone's belongings get taken away, that sets us back in providing care. These folks are already living a difficult life on the streets so when these sweeps occur, it makes it that much more difficult to engage with our clients and continue medical services as well as case management needs."

~ Kyanna Johnson, Lead Street Medicine Outreach Worker, Night Ministry, Chicago

- **Prevent gainful employment:** Sweeps destroy tools, uniforms, and other job-related items, which often cannot be replaced and may result in job termination. Relocation can also cause loss of access to nearby transportation points and prevent people from commuting to work.
- **Create criminal records:** Arrests resulting from sweeps then create criminal records, court dates and fines, community service judgements for minor offenses, and can result in jail time. Criminal records prevent people from obtaining housing vouchers, make people ineligible for some assistance programs, and bar them from many employment opportunities. Jail time can also result in job loss and/or interrupt medical treatment.
- **Jeopardize housing opportunities:** Ironically, sweeps undermine the likelihood of obtaining permanent housing. People living in encampments have likely been assessed for housing opportunities and entered into the community's [coordinated entry system](#). After [years of waiting](#), it is not unusual for a housing voucher to become available but go unused (and then the case closed) because the encampment where the client had been living has now been cleared and residents cannot be located after being dispersed.
- **Sever connections with community:** Those experiencing homelessness are often invisible to the broader community, or [held in contempt](#). Encampments can offer a community of peers where none exists elsewhere. Sweeps destroy this community, and only further the isolation and alienation that accompanies homelessness.
- **Damage hope:** Sweeps are traumatic and dehumanizing, and they very clearly communicate to residents that they are not wanted and their lives (and their property) have no value. This is especially true when sweeps are clearly conducted for political gain, and no attempt is made to improve the quality of life for those living in the encampment. Understandably, this makes people reluctant to seek or accept services in the future. Unfortunately, it is this same dynamic that furthers the stereotype that people experiencing homelessness do not want help.

Create Unnecessary Costs for Local Communities

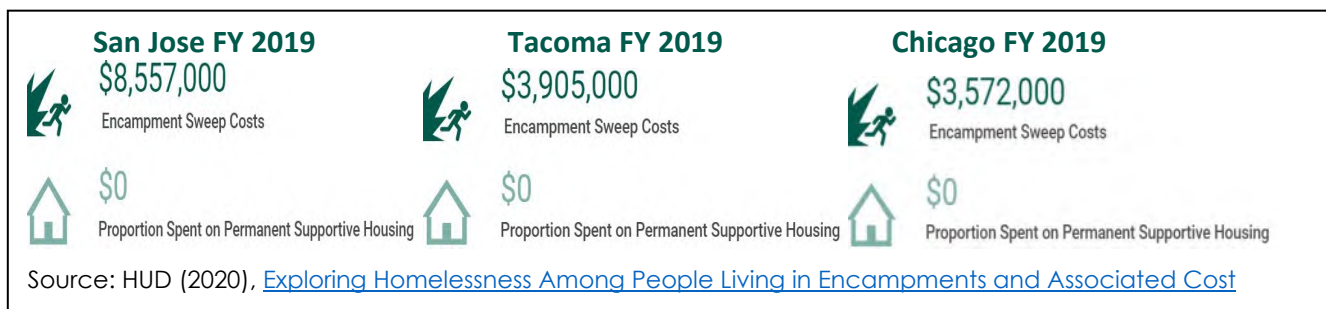
Encampment sweeps create high costs for communities and undermine broader goals in that they:

- **Cost millions of dollars:** Sweeps incur exorbitant costs for local communities, who must pay for bulldozers, city personnel, police, signs, fencing, court costs, storage of seized property (if offered), and other expenses. Unfortunately, none of these tax-payer expenditures creates new housing, nor do they solve homelessness. Health care providers and other non-profit community organizations spend thousands of dollars each year replacing identification, medications, and other items lost to sweeps.

"Every time a sweep happens, it only disrupts the health care system and adds to the criminal justice system—and that costs taxpayers a lot of money. But housing folks saves millions of dollars every day."

~ **Paul Tunison**, Housing and Community Program Specialist, Shasta County, CA

- **Divert money from solutions such as housing:** Sweeps only shift time and attention away from constructive solutions such as building affordable housing units.



- **Increase incarceration costs:** The conflicts inherent with encampment sweeps only increase arrests and court-involvement for people who are homeless. Minor offenses such as disorderly conduct and trespassing contribute to the overall high costs of incarceration. Conversely, [arrests decrease](#) after people enter supportive housing.
- **Undermine population health goals:** Health care providers are increasingly held responsible for the health care outcomes of their patients. When sweeps damage connections to care, undermine medication and chronic disease management, and compromise other health outcomes for larger groups of patients, insurers and health care providers have difficulty demonstrating improvements in care. Hospital and emergency department utilization may also rise. All these factors have financial implications for providers, the larger health care system, and public health goals.

"Encampment sweeps disrupt our ability to find our clients during outreach and often create gaps in care. The loss of medications and identifying documents—coupled with the inability to engage with their care teams—make it hard for people to get off the streets. It also has harmful effects on both the physical and mental well-being of those experiencing unsheltered homelessness."

~ **Joy Fernandez de Narayan**, Street Medicine Team Manager, Mercy Care, Atlanta

Recommendations: H.E.L.P.S.

Rather than sweep encampments, local jurisdictions should implement strategies that focus on constructive solutions to end homelessness using a H.E.L.P.S. framework:

H	House People: Housing is the solution to homelessness. Without it, forcibly displaced people still require shelter from the elements, and will only improvise new encampments to meet basic human needs. Officials should reallocate funds previously used for sweeps to low-income affordable and/or supportive housing options for encampment residents. Preserve personal autonomy and decision-making and do not force encampment residents into shelters. Importantly, shelters are <u>not</u> housing.
E	Earn Trust: Officials should involve encampment residents in all decisions that affect their safety and well-being, and engage them in inclusive community spaces free of stigma and fear. Communities should prioritize housing and demonstrate how they are meeting community needs. Providers can advocate against sweeps, and develop safety and continuity of care plans with their clients so if there is a sweep, they have a path back to treatment and a trusting relationship.
L	Limit Police: Law enforcement should not be used to clear encampments, and homelessness should not be criminalized. Minor offenses should not be used as a reason to remove someone from their residence. Law enforcement should partner with residents (and service providers, if appropriate) on conflict resolution practices and receive training on trauma-informed approaches. Take steps to use mobile crisis teams before resorting to police involvement and use 988 for mental health emergencies instead of 911.
P	Prevent Sweeps: Stop encampment sweeps because they create severe harm, are counterproductive, and victimize vulnerable people who are trying to survive. Do not remove residents' property. These actions disrupt connections to care, compromise safety and civic trust, undermine paths to independence, and create unnecessary costs for local communities. Sweeps do not end homelessness.
S	Support Service Interventions: Ensure health care and other services providers are able to maintain access and deliver care in encampments. Adopt a street medicine approach to meet people where they are and engage them in care. Do not ask them to participate in forcible relocations, or mandate they engage in treatment (or other services) as a condition of shelter/housing. Provide encampments with public restrooms, mobile showers, period products, handwashing stations, pest control, trash cans, and regular municipal trash pick-up to maintain a healthy environment. Provide access to drinking water and allow food distribution. Providers can keep copies of vital information such as birth certificates, identification documents, and Social Security cards in patient records so copies are available in case they are destroyed.

Conclusion

As communities respond to unsheltered homelessness, it may be tempting to forcibly “sweep” encampments because they can be unsafe, and are troubling reminders of nationwide systemic policy failures. Homelessness itself is upsetting, most especially to those experiencing it directly. Unfortunately, encampment sweeps do not end homelessness. Instead, they only create more problems, such as damaging connections to care, compromising safety and civic trust, undermining paths to independence, and creating unnecessary costs for local communities.

Instead, communities should consider the perspectives of those directly impacted by sweeps and the health care and other service providers who work with them. Halting sweeps in favor of providing permanent housing, limiting police involvement, and facilitating access to low-barrier services will have greater, more productive results than forcible displacement of vulnerable people.

“Displacing people from their safe spaces is literally a “Groundhog’s Day” effort with the City and County clearing encampments from one location to the other and the residents moving back and forth. Unless the bureaucrats join the effort to create more access to homes, it’s just an ongoing game of Whack-A-Mole.”

~ Rhonda Hauff, CEO, Yakima Neighborhood Health Services, Yakima

Additional Resources

There is a need for more research on homeless encampments and the harms that forced sweeps have on people experiencing homelessness as well as the larger community. In addition to the resources lined above, the publications below can offer additional information to inform community responses:

Think Tank and Journal Articles

- **SSM-Qualitative Research in Health (2022)** | [Harms of Encampment Abatements on the Health of Unhoused People](#): Describes effects of sweeps on people experiencing homelessness, including loss of property and medical necessities, relocation to isolated and dangerous environments, increased interpersonal conflict/self-policing, and greater hostile interactions with police. These effects of sweeps disrupt continuity of care and outreach workers ability to access patients and PEH are less likely to accept formal help after the trauma of sweeps. (Chang, et al.)
- **Journal of General Internal Medicine (2022)** | [Health Impact of Street Sweeps from the Perspective of Health Care Providers](#): Uses in-depth qualitative interviews with medical providers and outreach workers to discuss how encampment sweeps impact patient-provider relationships and follow up care. Describes how loss of material possessions and relocation to geographically isolated areas impact health, wellbeing, and sense of community. (Qi, et al.)

- **BMC Public Health (2022)** | [Health Risk Associated with Residential Relocation Among People who Inject Drugs in Los Angeles and San Francisco, CA: A Cross-sectional Study](#): Describes the impacts of health the 30 days following an encampment sweep or residential relocation. Discusses reduced substance use treatment, increased risk of violence and nonfatal overdose, more frequent experiences with jail/incarceration, and heightened food insecurity. (*Chiang, et al.*)
- **Journal of Evidence-Based Social Work (2022)** | [Impact of a Homeless Encampment Closure on Crime Complaints in the Bronx, New York City, 2017: Implications for Municipal Policy](#): Presents a study of crime complaints 30 days before and after an encampment sweep. Researchers found no difference in crime complaints after encampment closure. (*Alan and Nolan*)
- **Kaiser Health News (2020)** | [Sweeps Of Homeless Camps Run Counter To COVID Guidance And Pile On Health Risks](#): Discusses infectious diseases such as COVID-19 and Hepatitis A that spread and are left untreated when encampment sweeps occur. CDC guidance warned against closing encampments during the public health emergency.
- **Urban Institute (2020)** | [Alternatives to Arrests and Police Responses to Homelessness](#): Highlights examples of constructive community approaches to homelessness, examine the connection between unsheltered homelessness and the criminal legal system, explore the negative social and monetary costs of using punitive approaches, and review the evidence around the following nonpunitive responses to unsheltered homelessness. (*Batko, et al.*)
- **Urban Institute (2020)** | [Unsheltered Homelessness: Trends, Characteristics, and Homeless Histories](#): Analyzes the population and geographic trends of unsheltered homelessness, characteristics of people living unsheltered, and the costs of unsheltered homelessness. (*Batko, Oneto, and Shroyer*)
- **Housing Policy Debate (2018)** | [“It Was Like I Lost Everything”: The Harmful Impacts of Homeless-Targeted Policies](#): Contains feedback from interviews with people who had been forcibly moved and outlines interconnected ways that enforcements of sit-lie and nuisance policies harmed have homeless households. (*Darrah-Okike, et al.*)
- **City and Community (2014)** | [The New Logics of Homeless Seclusion: Homeless Encampments in America's West Coast Cities](#). Presents a study of 12 encampment sites across 8 municipalities that examined exclusionary policies. Discussion of encampment sweeps as a way to marginalize people rather than offer a solution to homelessness. (*Herring*)

Government and National Partner Publications

- **Housing Not Handcuffs (2022)** | [Policy Toolbox](#): Provides a resource toolkit about how to connect with advocacy allies in the fight against criminalization of homelessness.
- **Centers for Disease Control and Prevention (2022)** | [Guidance on Management of COVID-19 in Homeless Service Sites and in Correctional and Detention Facilities](#): Acknowledges the risk of severe COVID-19 because of underlying medical conditions

and lack of access to health care. When community rates are high, guidance recommends encampment closures should only be conducted as part of a plan to rehouse people living in encampments, developed in coordination with local homeless service providers and health departments.

- **National League of Cities (2022)** | [An Overview of Homeless Encampments for City Leaders](#): Explains why people live in encampments, community responses, challenges associated with encampment clearings, and recommendations for cities to pursue.
- **U.S. Department of Housing and Urban Development (HUD) (2020)** | [Exploring Homelessness Among People Living in Encampments and Associated Cost](#): Describes how some cities are responding to homeless encampments as of 2019, synthesizing findings from a literature review, telephone interviews with nine cities, and site visits to four cities. A major focus of the report is the strategies that Chicago, Houston, San Jose, and Tacoma are using to attempt to reduce the phenomenon of encampments and provide assistance to encampment residents, and what those cities are spending on activities related explicitly to encampments.
- **HUD (2019)** | [Understanding Encampments of People Experiencing Homelessness and Community Responses](#): Documents what is known about homeless encampments as of late 2018, based on a review of the limited literature produced thus far by academic and research institutions and public agencies, supplemented by interviews with key informants.
- **National Homeless Law Center (2017)** | [Tent City, USA: The Growth of America's Homeless Encampments and How Communities are Responding](#): Illustrates the number of encampments, city responses, best practices, case studies, and legal standards.

EXHIBIT “8”



A National Protocol for Homeless Encampments in Canada

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EXECUTIVE SUMMARY

A National Protocol for Homeless Encampments in Canada: A Human Rights Approach

Homeless encampments threaten many human rights, including most directly the right to housing. People living in encampments face profound challenges with respect to their health, security, and wellbeing, and encampment conditions typically fall far below international human rights standards. Residents are frequently subject to criminalization, harassment, violence, and discriminatory treatment. Encampments are thus instances of both human rights *violations* of those who are forced to rely on them for their homes, as well as human rights *claims*, advanced in response to violations of the right to housing.

Ultimately, encampments are a reflection of Canadian governments' failure to successfully implement the right to adequate housing.

As encampments increasingly emerge across Canada, there is an urgent need for governments to interact with them in a manner that upholds human rights. This Protocol, developed by the UN Special Rapporteur on the Right to Housing and her lead researcher, Kaitlin Schwan, with the input of many experts, outlines eight Principles to guide governments and other stakeholders in adopting a rights-based response to encampments. While encampments are not a solution to homelessness, it is critical that governments uphold the basic human rights and dignity of encampment residents while they wait for adequate, affordable housing solutions that meet their needs. The Principles outlined in this Protocol are based in international human rights law, and the recognition that encampment residents are rights holders and experts in their own lives. The Protocol is intended to assist governments in realizing the right to adequate housing for this group.

PRINCIPLES

Principle 1: Recognize residents of homeless encampments as rights holders

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

Principle 2: Meaningful engagement and effective participation of homeless encampment residents

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

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

Principle 3: Prohibit forced evictions of homeless encampments

International human rights law does not permit governments to destroy peoples' homes, even if those homes are made of improvised materials and established without legal authority. Governments may not remove residents from encampments without meaningfully engaging with them and identifying alternative places to live that are acceptable to them. Any such removal from their homes or from the land which they occupy, without the provision of appropriate forms of legal protection, is defined as a 'forced eviction' and is considered a gross violation of human rights. The removal of residents' private property without their knowledge and consent is also strictly prohibited.

Common reasons used to justify evictions of encampments, such as 'public interest,' 'city beautification', development or re-development, or at the behest of private actors (e.g., real estate firms), do not justify forced evictions.¹

Principle 4: Explore all viable alternatives to eviction

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

Principle 5: Ensure that relocation is human rights compliant

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

Principle 6: Ensure encampments meet basic needs of residents consistent with human rights

Canadian governments must ensure, at a minimum, that basic adequacy standards are ensured in homeless encampments while adequate housing options are negotiated and

¹ A/HRC/43/43, para 36.

² A/73/310/Rev.1, para 26.

secured. Governments' compliance with international human rights law requires: (1) access to safe and clean drinking water, (2) access to hygiene and sanitation facilities, (3) resources and support to ensure fire safety, (4) waste management systems, (4) social supports and services, and guarantee of personal safety of residents, (5) facilities and resources that support food safety, (6) resources to support harm reduction, and (7) rodent and pest prevention.

Principle 7: Ensure human rights-based goals and outcomes, and the preservation of dignity for homeless encampment residents

Governments have an obligation to bring about positive human rights outcomes in all of their activities and decisions concerning homeless encampments. This means that Canadian governments must move, on a priority basis, towards the full enjoyment of the right to housing for encampment residents. Any decision that does not lead to the furthering of inhabitants' human rights, that does not ensure their dignity, or that represents a backwards step in terms of their enjoyment of human rights, is contrary to human rights law.

Principle 8: Respect, protect, and fulfill the distinct rights of Indigenous Peoples in all engagements with homeless encampments

Governments' engagement with Indigenous Peoples in homeless encampments must be guided by the obligation to respect, protect, and fulfil their distinct rights. This begins with recognition of the distinct relationship that Indigenous Peoples have to their lands and territories, and their right to construct shelter in ways that are culturally, historically, and spiritually significant. Governments must meaningfully consult with Indigenous encampment residents concerning any decisions that affects them, recognizing their right to self-determination and self-governance. International human rights law strictly forbids the forced eviction, displacement, and relocation of Indigenous Peoples in the absence of free, prior, and informed consent.

Given the disproportionate violence faced by Indigenous women, girls, and gender diverse peoples, governments have an urgent obligation to protect these groups against all forms of violence and discrimination within homeless encampments, in a manner that is consistent with Indigenous self-determination and self-governance.

A National Protocol for Homeless Encampments in Canada: A Human Rights Approach

I. Introduction

1 In the face of escalating homelessness and housing affordability crises, many cities across Canada have seen a rise in homeless encampments. In various Canadian communities, people experiencing homelessness have turned to living in s, vehicles, or other forms of rudimentary or informal shelter as a means to survive.³ While they vary in size and structure, the term '*encampment*' is used to refer to any area wherein an individual or a group of people live in homelessness together, often in tents or other temporary structures (also referred to as *homeless camps*, *tent cities*, *homeless settlements* or *informal settlements*).

2 Homeless encampments in Canada must be understood in relation to the global housing crisis and the deepening of housing unaffordability across the country. Encampments must also be understood in the context of historical and ongoing structural racism and colonization in Canada, whereby Indigenous peoples have been systemically discriminated against and dispossessed of their lands, properties, and legal systems. Other groups have also endured systemic and historical disadvantage that has created barriers to accessing housing and shelters, including 2SLGBTQ+, Black and other racialized communities, people living with disabilities, and people who are criminalized. While encampments are often framed and discussed as matters of individual poverty or deficiency, they are the result of structural conditions and the failure of governments to implement the right to housing or to engage with reconciliation and decolonization materially and in good faith.

3 Homeless encampments threaten many human rights, including most specifically the right to housing. In international human rights law, homelessness - which includes those residing in encampments - is a *prima facie* violation of the right to adequate housing.⁴ This means that governments have a positive obligation to implement an urgent housing-focused response, ensuring that residents have access to adequate housing in the shortest possible time and, in the interim, that their human rights are fully respected.

4 Government responses to homeless encampments often fail to employ a rights-based approach. Residents of encampments are frequently the victims of abuse, harassment, violence, and forced evictions or 'sweeps.' In many cases, the issues

³ Encampments have arisen in cities across the country, including: Abbotsford, Vancouver, Victoria, Edmonton, Toronto, Ottawa, Gatineau, Peterborough, Winnipeg, Montreal, Nanaimo, Calgary, Saskatoon, Fredericton, Moncton, Oshawa, Halifax, and Maple Ridge.

⁴ A/HRC/31/54, para. 4.

associated with encampments are within the jurisdiction and responsibility of municipal authorities, including through bylaws specific to policing, fire and safety, sanitation, and social services. This has led to a pattern whereby municipal governments deploy bylaws, local police, and zoning policies that displace people in encampments, in turn compromising the physical and psychological health of people who have no place else to go and who rely on encampments to survive, absent accessible alternatives.⁵

5 Provincial, territorial, and federal governments have historically left engagement with encampments to city officials, who receive little (if any) guidance and support. Municipal authorities are often unaware of their legal obligations under international human rights law, including with respect to the duty to ensure the dignity and security of encampment residents.⁶ Further, accountability mechanisms with respect to the right to housing remain weak in Canada, meaning that people living in encampments have limited avenues through which to claim this right.

6 Ensuring a human rights-based response to homeless encampments should be a key concern for every Canadian city, and all governments should employ a human rights-based framework to guide their engagement with encampment residents.

II. Purpose of the National Protocol on Homeless Encampments

7 The purpose of this document is to provide all levels of government with an understanding of their human rights obligations with respect to homeless encampments, highlighting what is and is not permissible under international human rights law. This Protocol outlines 8 broad human rights-based Principles that must guide state⁷ action in response to homeless encampments of all kinds.

8 This Protocol does not attempt to foresee every possible context or challenge that may arise within encampments. Governments and relevant stakeholders must apply human rights principles as described in the Protocol to each case as it arises, endeavouring at all times to recognize and respect the inherent rights, dignity, and inclusion of encampment residents.

9 This Protocol has been developed by the UN Special Rapporteur on the right to housing in consultation with a range of experts from across Canada, including those

⁵ *Abbotsford (City) v. Shantz* (2016 BCSC 2437). Online, <https://www.canlii.org/en/bc/bcsc/doc/2016/2016bcsc2437/2016bcsc2437.html?resultIndex=1>

⁶ A/HRC/43/43, para 7.

⁷ 'State' refers to all levels and branches of government and anyone exercising government authority.

with lived expertise of homelessness, urban Indigenous leaders, community advocates, researchers, lawyers, and experts in human rights law.⁸

III. Encampments in Canada in the context of the Human Right to Adequate Housing

10 Under international human rights law, everyone has the right to adequate housing as an element of the right to an adequate standard of living.⁹ This requires States to ensure that housing is accessible, affordable, habitable, in a suitable location, culturally adequate, offers security of tenure, and is proximate to essential services such as health care and education.¹⁰ The right to adequate housing includes the right to be protected from: arbitrary or unlawful interference with an individual's privacy, family, and home; any forced eviction (regardless of legal title or tenure status); and from discrimination of any kind.¹¹

11 Homelessness constitutes a prima facie violation of the right to housing. It is a profound assault on a person's dignity, security, and social inclusion. Homelessness violates not only the right to housing, but often, depending on circumstances, violates a number of other human rights, including: non-discrimination; health; water and sanitation; freedom from cruel, degrading, and inhuman treatment; and the rights to life, liberty, and security of the person.¹²

12 Encampments constitute a form of homelessness, and thus are a reflection of the violation of residents' right to adequate housing. People living in encampments typically face a range of human rights violations and profound challenges with respect to their health, security, and wellbeing. Encampment conditions typically fall far below international human rights standards on a variety of fronts, often lacking even the most

⁸ This Protocol was prepared by: Leilani Farha and Kaitlin Schwan with the assistance of Bruce Porter, Vanessa Poirier, and Sam Freeman. Reviewers include, among others: Margaret Pfoh (Aboriginal Housing Management Association), Cathy Crowe (Shelter and Housing Justice Network), Greg Cook (Sanctuary Toronto), Tim Richter (Canadian Alliance to End Homelessness), Anna Cooper (Pivot Legal Society), Caitlin Shane (Pivot Legal Society), Emily Paradis (University of Toronto), Emma Stromberg (Ontario Federation of Indigenous Friendship Centres), and Erin Dej (Wilfred Laurier University).

⁹ United Nations Committee on Economic, Social and Cultural Rights Committee's General Comments No. 4 (1991) on the right to adequate housing and No. 7 (1997) on forced evictions.

¹⁰ United Nations Committee on Economic, Social and Cultural Rights Committee's General Comment No. 4 (1991) on the right to adequate housing. At the domestic level, adequate housing and core housing need is defined in relation to three housing standards: adequacy, affordability, and suitability. The Canadian Mortgage and Housing Corporation [defines](#) these housing standards in the following ways: "(1) [Adequate](#) housing are reported by their residents as not requiring any major repairs; (2) [Affordable](#) dwellings cost less than 30% of total before-tax household income; and (3) [Suitable](#) housing has enough bedrooms for the size and make-up of resident households, according to National Occupancy Standard (NOS) requirements."

¹¹ A/HRC/43/43.

¹² A/HRC/31/54; A/HRC/40/61, para 43.

basic services like toilets.¹³ Residents of encampments are also frequently subject to criminalization, harassment, violence, and discriminatory treatment.¹⁴

13 In the face of poverty and deep marginalization, people without homes face many untenable choices. For example, they may be forced to choose between ‘sleeping rough’ on their own (putting themselves at risk of violence and criminalization), entering an emergency homeless shelter (which may be inaccessible or inappropriate for their needs, or in which their autonomy, dignity, self-reliance, and/or independence may be undermined), or residing in a homeless encampment (in which they may lack access to basic services and face threats to their health). These choices are further narrowed for those living in communities that lack any emergency shelters, or where existing shelters are at (or over) capacity.

14 For people without access to adequate housing, the availability, accessibility, appropriateness, and adequacy of shelters plays a significant role in determining whether or not a person chooses to reside in a homeless encampment. In some cities, emergency shelters operate at 95-100% capacity,¹⁵ necessitating that some individuals sleep rough or reside in an encampment. Existing shelters may also not be low-barrier, wheelchair accessible, trans-inclusive, or safe for people experiencing complex trauma or other challenges. Homeless persons with mental health challenges, drug or alcohol dependencies, or pets may find themselves barred from shelters. Under such conditions, some individuals may prefer, or feel they have little choice but to, reside in an encampment. Encampments thus may become a necessity or the best option available for some of those the most marginalized people in Canadian society.

15 For Indigenous peoples, a desire to avoid state surveillance and a mistrust of institutional settings, including shelters, may be a factor in turning to or living in an encampment. Negative or harmful interactions with colonial institutions, such as residential schools, the child welfare system, corrections, hospitals, asylums or sanatoriums, and shelters, may be intergenerational in nature and highly traumatic. For these reasons and others, Indigenous peoples are overrepresented in homeless populations across Canada, and further to this, are more likely to be part of “outdoor” or “unsheltered” populations – including homeless encampments.¹⁶

¹³ See Cooper, A. (2020). *Why People Without Housing Still Need Heat*. Pivot Legal Society. Available from: http://www.pivotlegal.org/why_people_without_housing_still_need_heat

¹⁴ A/HRC/43/43, para 31; see also *Homelessness, Victimization and Crime: Knowledge and Actionable Recommendations*. Available from: <https://www.publicsafety.gc.ca/lbrr/archives/cnmcs-plcng/cn35305-eng.pdf>

¹⁵ Employment and Social Development Canada. (2018). *Shelter Capacity Report 2018*. Ottawa. Available from <https://www.canada.ca/en/employment-social-development/programs/homelessness/publications-bulletins/shelter-capacity-2018.html>

¹⁶ See Ontario Federation of Indigenous Friendship Centres. (2020). *Indigenous Homelessness in the 20 Largest Cities in Canada*. Submission to the Standing Committee on Human Resources, Skills and Social Development and the Status of Persons with Disabilities, Canada.

16 Regardless of the reasons why a person resides in a homeless encampment, homeless encampments *do not* constitute adequate housing, and do not discharge governments of their positive obligation to ensure the realization of the right to adequate housing for all people. Under international human rights law, “States have an obligation to take steps to the maximum of their available resources with a view to achieving progressively the full realization of the right to adequate housing, by all appropriate means, including particularly the adoption of legislative measures.”¹⁷ As part of these obligations, States must prioritize marginalized individuals or groups living in precarious housing conditions - including residents of homeless encampments.¹⁸

17 Governments have an urgent, positive obligation to provide or otherwise ensure access to adequate housing - for residents of encampments as they do for all people experiencing homelessness. Governments must act to immediately pursue deliberate, concrete, and targeted efforts to end homelessness by ensuring access to adequate housing. In the interim, governments must ensure the availability of sufficient shelter spaces - accessible and appropriate for diverse needs - where dignity, autonomy, and self-determination are upheld.

18 The fact that encampments violate the right to housing does not in any way absolve governments of their obligations to uphold the basic human rights and dignity of encampment residents while they wait for adequate, affordable housing solutions that meet their needs. The Principles outlined in this Protocol seek to support governments and other stakeholders to ensure that their engagements with encampments are rights-based and recognize residents as rights holders, with a view to realizing the right to adequate housing for these groups while respecting their dignity, autonomy, individual circumstances, and personal choices.

19 International human rights law does not permit government to use force to destroy peoples’ homes, even if they are made of canvas or improvised from available materials and constructed without legal authority or title. States may not remove residents from encampments without meaningfully engaging them to identify alternative places to live that are acceptable to them. Any such removal from their homes or from the land which they occupy, without the provision of, and access to, appropriate forms of legal or other protection, consistent with international human rights law is defined as a ‘forced eviction’ and is considered a gross violation of human rights.

20 Unfortunately, such forced evictions or sweeps have become common in Canada. Evictions have contravened international law by being carried out without meaningful consultation with communities and without measures to ensure that those affected have access to alternative housing. They have been justified on the basis that the

¹⁷ International Covenant on Economic, Social and Cultural Rights, art. 2 (1).

¹⁸ A/HRC/43/4.

residents are there illegally, are at risk to themselves, are on land that is slated for development, or are obstructing the enjoyment of the community by others. Declining conditions at encampments and public health and safety concerns are also frequently the grounds on which local governments and provinces seek injunctions for removal. The impact of municipalities' failure to proactively provide resources and services to mitigate or improve those conditions and concerns is most often ignored. Some communities have engaged bylaw officers or local police to tear down encampments at first sight.¹⁹

21 None of these reasons, however, justify forced evictions under international law. Forced evictions often have harmful or disastrous consequences for encampment residents.²⁰ Victims may face life-threatening situations that compromise their health and security, or result in the loss of access to food, social supports, social and medical services, and other resources.²¹

22 Few governments have recognized encampments as a response to violations of fundamental human rights and a response to the isolation and indignity of homelessness. They have failed to treat those living in such encampments as legally entitled to the protection of their homes and their dignity.

IV. Relevant Authority

23 Canadian governments' responsibilities and relevant authority to ensure the right to adequate housing, including for people residing in encampments, is found in: (1) international human rights treaties, (2) the *National Right to Housing Act*, (3) the *Canadian Charter of Rights and Freedoms* and human rights legislation, and (4) the UN *2030 Agenda for Sustainable Development (The Sustainable Development Goals)*.

1. International Human Rights Treaties

24 Canada has ratified multiple international human rights treaties that articulate the right to adequate housing. In 1976, Canada ratified the *International Covenant on Economic, Social and Cultural Rights*, which contains the chief articulation of the right to housing under Article 11.1 "the right of everyone to an adequate standard of living for [themselves] and [their] family, including adequate food, clothing and housing, and to

¹⁹ Ball, V. (2019). *Encampment residents fear eviction*. The Expositor. Available from: <https://www.brantfordexpositor.ca/news/local-news/encampment-residents-fear-eviction>

²⁰ A/HRC/43/43, para 36.

²¹ UN Office of the High Commissioner. (2014). *Forced Evictions: Fact Sheet No. 25/Rev.1*. Available from: <https://www.ohchr.org/Documents/Publications/FS25.Rev.1.pdf>; Collinson, R. & Reed, D. (2018). *The Effects of Eviction on Low-Income Households*. Available from: https://www.law.nyu.edu/sites/default/files/upload_documents/evictions_collinson_reed.pdf

the continuous improvement of living conditions.”²² The right to housing and the prohibition against forced evictions has been interpreted in General Comments No. 4 and 7²³ by the UN Committee on Economic, Social and Cultural Rights. In addition, Canada has ratified other treaties that codify the right to adequate housing, including:

- *Convention on the Rights of Persons with Disabilities*
- *Convention on the Rights of the Child*
- *Convention on the Elimination of Racial Discrimination*
- *Convention on the Elimination of Discrimination against Women*

25 Human rights ratified by Canada “extend to all parts of federal States without any limitations or exceptions,” thus federal, provincial/territorial, and municipal governments are equally bound by these obligations.²⁴ In interpreting the right to adequate housing, the Committee on Economic, Social and Cultural Rights has emphasized that “the right to housing should not be interpreted in a narrow or restrictive sense which equates it with, for example, the shelter provided by merely having a roof over one’s head or views shelter exclusively as a commodity. Rather it should be seen as the right to live somewhere in security, peace and dignity.”²⁵

26 Canada has also formally recognized the *UN Declaration on the Rights of Indigenous Peoples*, which also codifies the right to adequate housing and affirms that Indigenous Peoples have the right to be actively involved in developing and determining housing programmes and policies that affect them.²⁶ Further, Indigenous Peoples’ right to land and self-determination is indivisible from the right to housing under international human rights law, meaning that they “shall not be forcibly removed from their lands or territories and that no relocation shall take place without their free, prior and informed consent.”²⁷ All encampments are located on the traditional territories of Indigenous nations, including in cities, towns, and rural areas. On these territories, Indigenous Peoples’ right to land and self-determination is in effect, whether or not those lands are subject to land claims or treaty.

1. Canadian Housing Policy and Legislation

27 The right to housing has also recently been recognized in Canadian legislation. In June 2019, the *National Housing Strategy Act* (the *Act*) received royal assent in Canada. The *Act* affirms Canada’s recognition of the right to housing as a fundamental human

²² ICESCR, Article 11, masculine pronouns corrected.

²³ General Comment 4 (1991), UN Doc. E/1992/23; General Comment 7 (1997), UN Doc. E/1998/22.

²⁴ A/69/274.

²⁵ General Comment 4 (1991), para 7.

²⁶ A/74/183.

²⁷ A/74/183.

right and commits to further its progressive realization as defined under the *International Covenant on Economic, Social and Cultural Rights*.

28 The Preamble and Section 4 of the *Act* underscore the interdependence of the right to housing with other fundamental rights, such as the right to life and an adequate standard of health and socio-economic wellbeing. Specifically, Section 4 states:

It is declared to be the housing policy of the Government of Canada to:

- (a) recognize that the right to adequate housing is a fundamental human right affirmed in international law;
- (b) recognize that housing is essential to the inherent dignity and well-being of the person and to building sustainable and inclusive communities;
- (c) support improved housing outcomes for the people of Canada; and
- (d) further the progressive realization of the right to adequate housing as recognized in the International Covenant on Economic, Social and Cultural Rights.

2. The Canadian Charter and Provincial/Territorial Human Rights Legislation

29 The government of Canada's international human rights obligations must be considered by courts in Canada when determining the rights of residents of encampments under domestic law,²⁸ particularly the *Canadian Charter of Rights and Freedoms*.²⁹ The Supreme Court has recognized that the right to "life, liberty and security of the person" in section 7 of the *Charter* may be interpreted to include the right to housing under international law.³⁰ Canada has told the UN that it accepts that section 7 at least ensures access to basic necessities of life and personal security.³¹

²⁸ It should be noted that a human rights-based approach under domestic law should entail mindfulness about core human rights and equality principles, such as substantive equality and non-discrimination, which recognizes that state interventions be particularly attuned to the specific needs of particular groups, including those impacted by systemic and historical disadvantage. In this regard, a 'one size fits all' approach may not fully capture the distinct needs of groups residing within encampments.

²⁹ *R. v. Hape*, [2007] 2 S.C.R. 292, 2007 SCC 26, para 56: "In interpreting the scope of application of the Charter, the courts should seek to ensure compliance with Canada's binding obligations under international law where the express words are capable of supporting such a construction."

³⁰ *Irwin Toy Ltd. v. Quebec (Attorney General)*, [1989] 1 S.C.R. 927; See Martha Jackman and Bruce Porter, "[Social and Economic Rights](#)", in Peter Oliver, Patrick Maklem & Nathalie DesRosiers, eds, *The Oxford Handbook of the Canadian Constitution* (New York: Oxford University Press, 2017), 843-861.

³¹ Canada's commitments are described in *Victoria (City) v. Adams*, 2008 BCSC 1363 (CanLII), paras 98-99. Online, <http://canlii.ca/t/215hs>

30 In Canada, courts have considered the human rights implications of encampments, and have emphasized that Section 7 life and security of the person interests are engaged where state action poses significant harm to the health and wellbeing of persons enduring homelessness and housing insecurity. For example, Canadian courts have recognized that the daily displacement of people experiencing homelessness causes physical and psychological harm. The Court accepted in the case of *Abbotsford (City) v. Shantz*, that "the result of repeated displacement often leads to the migration of homeless individuals towards more remote, isolated locations as a means to avoid detection. This not only makes supporting people more challenging, but also results in adverse health and safety risks." The court recognized that these health and safety risks include "impaired sleep and serious psychological pain and stress."³²

31 In the case of *Victoria v. Adams*,³³ residents of an encampment challenged a bylaw that prevented them from constructing temporary shelter in a park, on the basis of which city officials had secured an injunction to evict them. The British Columbia Supreme Court agreed that while the *Charter* does not explicitly recognize the right to housing, international law is a persuasive source for *Charter* interpretation and found that the bylaw violated the residents' right to security of the person. The BC Court of Appeal upheld the decision of the BC Supreme Court and other decisions in British Columbia have followed.³⁴ In *British Columbia v. Adamson* 2016,³⁵ for example, the court found that in the absence of alternative shelter or housing for all people experiencing homelessness, encampment residents must not be evicted from their encampment. In *Abbotsford v. Shantz* 2015³⁶ the Court found that denying encampment residents space to erect temporary shelters on public property was "grossly disproportionate to any benefit that the City might derive from furthering its objectives and breaches the s. 7 *Charter* rights of the City's homeless."³⁷

32 The right to equality is also protected under the Canadian Charter as well as under federal, provincial, and territorial human rights legislation. Not all levels of government interpret or administer human rights codes in the same manner, with each province and territory administering its own human rights codes.³⁸ Regardless of jurisdiction, the UN Committee on Economic, Social and Cultural Rights has stated that the right to

³² *Abbotsford (City) v. Shantz*, 2015 BCSC 1909, paras 213 and 219.

³³ *Victoria (City) v. Adams*, 2008 BCSC 1363 (CanLII), paras 85-100. Online, <http://canlii.ca/t/215hs>

³⁴ Key examples of case law includes: *Victoria v. Adams* 2008/ 2009, *Abbotsford v. Shantz* 2015, *BC v. Adamson* 2016, and *Vancouver (City) v. Wallstam* 2017.

³⁵ *British Columbia v. Adamson* (2016 BCSC 1245). Online, <https://www.canlii.org/en/bc/bcsc/doc/2016/2016bcsc1245/2016bcsc1245.html?resultIndex=1>

³⁶ *Abbotsford (City) v. Shantz* (2016 BCSC 2437). Online, <https://www.canlii.org/en/bc/bcsc/doc/2016/2016bcsc2437/2016bcsc2437.html?resultIndex=1>

³⁷ *Abbotsford (City) v. Shantz* (2016 BCSC 2437), para 224. Online, <https://www.canlii.org/en/bc/bcsc/doc/2016/2016bcsc2437/2016bcsc2437.html?resultIndex=1>

³⁸ For an overview of provincial and territorial human rights codes, see: <https://ccdi.ca/media/1414/20171102-publications-overview-of-hr-codes-by-province-final-en.pdf>

equality should be interpreted to provide the widest possible protection of the right to housing and has urged Canadian courts and governments to adopt such interpretations.³⁹

33 While it is clear that the *Charter* provides some protection from forced evictions and sweeps of encampment residents, the extent to which it requires governments to address the crisis of homelessness that has led to reliance on encampments remains unresolved. The Supreme Court of Canada has yet to agree to hear an appeal in a case that would clarify the obligations of governments to address homelessness as a human rights violation. The Supreme Court has, however, been clear that the *Charter* should, where possible, be interpreted to provide protection of rights that are guaranteed under international human rights law ratified by Canada.

34 Governments should not use uncertainty about what courts might rule as an excuse for violating the human rights of those who are homeless. Canadian governments have an obligation, under international human rights law, to promote and adopt interpretations of domestic law consistent with the right to adequate housing. The UN Committee on Economic, Social and Cultural Rights has expressed concern that governments in Canada continue to argue in court against interpretations of the *Canadian Charter* that would protect the rights of homeless persons and residents of homeless encampments.

35 Therefore, it is critically important that, as part of a Protocol based on respect for human rights, municipal, provincial/territorial, and federal governments instruct their lawyers not to undermine international human rights or oppose reasonable interpretations of the *Charter* based on international human rights. They should never seek to undermine the equal rights of residents of homeless encampments to a dignified life, to liberty, and security of the person.

3. UN 2030 Agenda for Sustainable Development

36 In September 2015, member states of the United Nations, including Canada, adopted the *2030 Agenda for Sustainable Development (2030 Agenda)*. Target 11.1 of the SDGs specifically identifies that by 2030, all States must “ensure access for all to adequate, safe and affordable housing and basic services and to upgrade informal settlements.” This means governments must take steps to eliminate homelessness and make cities inclusive, safe, resilient and sustainable. Upgrading informal settlements

³⁹ CESCR, General Comment No. 9, para 15; E/C.12/1993/5, paras 4, 5, and 30.

includes the upgrading of homeless encampments.⁴⁰ States have affirmed that a rights-based approach to the SDG's is critical if they are to be achieved.⁴¹

V. Key Principles

37 It is critical that all levels of government in Canada employ an integrated human rights-based approach when engaging with encampments. The Principles outlined here aim to support the right to housing for all encampment residents as part of Canada's commitment to the right to housing under international human rights treaties and domestic law.

PRINCIPLE 1: Recognize residents of homeless encampments as rights holders

38 All government action with respect to homeless encampments must be guided by a commitment to upholding the human rights and human dignity of their residents. For many governments and those exercising governmental authority, this will mean a shift away from criminalizing, penalizing, or obstructing encampments, to an approach rooted in rights-based participation and accountability.⁴²

39 This will mean understanding encampments as instances of both human rights *violations* of those who are forced to rely on them for their homes, as well as human rights *claims* advanced in response to violations of the right to housing. While encampments arise as a result of governments failing to effectively implement the right to housing, they can also be an expression of individuals and communities claiming their legitimate place within cities, finding homes within communities of people without housing, asserting claims to lands and territories, and refusing to be made invisible. They are a form of grassroots human rights practice critical to a democracy such as Canada's.⁴³ For Indigenous peoples, the occupation of lands and traditional territories vis-à-vis encampments may also be an assertion of land rights, claimed in conjunction with the right to housing.

40 In recognition of encampments as rights violations and rights claims, governments must rectify the policy failures that underpin the emergence of homeless encampments, while simultaneously recognizing residents as rights holders who are advancing a legitimate human rights claim. Their efforts to claim their rights to home

⁴⁰ A/73/310/Rev.1.

⁴¹ The *National Housing Strategy* of Canada mirrors many of the commitments made in the *2030 Agenda*. However, the *Strategy* only commits Canada to reducing chronic homelessness by 50%, despite the *2030 Agenda's* imperative to eliminate homelessness and provide access to adequate housing for all.

⁴² A/73/310/Rev.1, para 15.

⁴³ A/73/310/Rev.1.

and community must be supported, not thwarted, criminalized, or dismissed as illegitimate or gratuitous protest.⁴⁴

PRINCIPLE 2: Meaningful engagement and effective participation of encampment residents

41 Ensuring encampment residents are able to participate in decisions that directly affect them is “critical to dignity, the exercise of agency, autonomy and self-determination.”⁴⁵ As rights holders, encampment residents are entitled to “participate actively, freely and meaningfully in the design and implementation of programmes and policies affecting them.”⁴⁶ Meaningful engagement must be grounded in recognition of the inherent dignity of encampment residents and their human rights, with the views expressed by residents of homeless encampments being afforded adequate and due consideration in all decision-making processes.

42 Governments and other actors must engage encampment residents in the early stages of discussion without using the threat of eviction procedures or police enforcement to coerce, intimidate, or harass.⁴⁷ Engagement should proceed under the principle that residents are experts in their own lives and what is required for a dignified life.⁴⁸ Indigenous residents of encampments should also be engaged in decision-making processes in a manner that is culturally-safe and trauma informed.

43 In the context of homeless encampments, the right to participate requires that all residents be provided with information, resources, and opportunities to directly influence decisions that affect them. All meetings with government officials or their representatives regarding the encampment should be documented and made available to encampment residents upon request.

44 Participation processes must comply with all human rights principles, including non-discrimination. Compliance with international human rights law requires:

- i. **Provision of necessary institutional, financial, and other resources to support residents’ right to participate**
In order to participate in decisions that affect them, encampment residents should be provided with financial and institutional resources (e.g., wifi/internet access, meeting spaces) that support their active participation in decision-making. Such supports should include, but are not

⁴⁴ A/73/310/Rev.1.

⁴⁵ A/HRC/43/43, para 20.

⁴⁶ Ibid. See also the Committee on the Rights of the Child’s General Comment No. 21 (2017) on children in street situations.

⁴⁷ A/HRC/40/61, para 38.

⁴⁸ A/HRC/43/43, para 21.

limited to: legal advice, social service supports, Indigenous cultural supports, literacy supports, translation, mobility supports, and transportation costs to attend consultations or meetings.⁴⁹ These resources should support democratic processes within the encampment, including community meetings, the appointment of community leaders, and the sharing of information.⁵⁰ Residents must be granted a reasonable and sufficient amount of time to consult on decisions that affect them.

ii. **Provision of relevant information about the right to housing**

Encampment residents must be provided with information about their right to housing, including information about procedures through which they can hold governments and other actors accountable, as well as specific information about the rights of Indigenous Peoples.⁵¹

iii. **Provision of relevant information concerning decisions that affect residents, ensuring sufficient time to consult**

Encampment residents must be provided with all relevant information in order to make decisions in matters that affect them.⁵²

iv. **Establishment of community engagement agreement between homeless encampment residents, government actors, and other stakeholders**

In order to facilitate respectful, cooperative, and non-coercive communication between residents, government, and other stakeholders, government may seek to collaborate with residents to create a formal community engagement agreement (when appropriate and requested by residents).⁵³ This agreement should outline when and how encampment residents will be engaged,⁵⁴ and should be ongoing and responsive to the needs of the encampment residents.⁵⁵ It should allow the residents of homeless encampments to play an active role in all aspects of relevant proposals and policy, from commencement to conclusion. Residents should be able to challenge any decision made by government or other actors, to propose alternatives, and to articulate their own demands and priorities. Third party mediators should be available to protect against power imbalances that may lead to breakdown in negotiations or create

⁴⁹ Committee on Economic, Social and Cultural Rights' General Comment No. 4, para. 12, and the basic principles and guidelines on development-based evictions and displacement (A/HRC/4/18, annex I, para. 39).

⁵⁰ A/73/310/Rev.1.

⁵¹ A/73/310/Rev.1, para 19.

⁵² A/73/310/Rev.1.

⁵³ A/73/310/Rev.1.

⁵⁴ A/73/310/Rev.1.

⁵⁵ United Nations. *Guiding Principles on Extreme Poverty and Human Rights*, foundational principles, para 38.

unfair results.⁵⁶ Relevant government authorities and professionals should also be provided with “training in community engagement and accountability.”⁵⁷

v. **Provision of equitable opportunities for the meaningful participation of all encampment residents**

As a matter of human rights law, particular efforts must be taken to ensure equitable participation by women, persons with disabilities, Indigenous Peoples, migrants, and other groups who experience discrimination or marginalization.⁵⁸ Where possible, members of these groups should be afforded central roles in the process.⁵⁹

Principle 2 in Action – The “People’s Process” in Kabul, Afghanistan

The upgrading of informal settlements was identified as a key goal in the *2030 Agenda for Sustainable Development*, committing States to “upgrade slums” by 2030 (target 11.1). As identified by the UN Special Rapporteur on the right to adequate housing, “Participation in upgrading requires democratic processes through which the community can make collective decisions.” Under international human rights law, the democratic processes required to upgrade slums mirrors encampment residents’ right to participate in plans to resolve their housing needs. As such, democratic processes implemented to upgrade informal settlements in cities around the world can provide helpful examples for Canadian homeless encampments.

One such example is the “people’s process” in Kabul, Afghanistan. This process delineates community leadership and control over the upgrading process, and includes an organizational structure that enables the community to engage different levels of government. As part of this process, “local residents elect community development councils responsible for the selection, design, implementation and maintenance of the projects.” City staff are trained to work alongside informal settlement residents to implement and complete upgrading.

⁵⁶ A/HRC/43/4, para 42.

⁵⁷ A/73/310/Rev.1, para 20.

⁵⁸ A/HRC/43/4.

⁵⁹ Committee on Economic, Social and Cultural Rights, General Comment No. 21 (2009) on the right of everyone to take part in cultural life, in particular para 16.

PRINCIPLE 3: Prohibition of forced evictions of encampments

45 Under international human rights law, forced evictions constitute a gross violation of human rights and are prohibited in all circumstances, including in the context of encampments.⁶⁰

46 Forced evictions are defined as “the permanent or temporary removal against their will of individuals, families and/or communities from the homes and/or land which they occupy, without the provision of, and access to, appropriate forms of legal or other protection ... in conformity with the provisions of the International Covenants on Human Rights.”⁶¹

47 Forced evictions are impermissible irrespective of the tenure status of those affected. This means that the forced eviction of encampments is prohibited if appropriate forms of protection are not provided – including all of the requirements described in this Protocol.⁶² It may also be considered a forced eviction when governments’ and those acting on their behalf harass, intimidate, or threaten encampment residents, causing residents to vacate the property.⁶³

48 Common reasons used to justify evictions of encampments, such as ‘public interest,’ ‘city beautification,’ development or re-development, or at the behest of private actors (e.g., real estate firms), do not justify forced evictions.⁶⁴ Evictions (as opposed to “forced evictions”) may be justified in rare circumstances, but they may only be carried out after exploring all viable alternatives with residents, in accordance with law and consistent with the right to housing, as described in this Protocol.

49 Governments must repeal any laws or policies that sanction forced evictions and must refrain from adopting any such laws, including for example anti-camping laws, move-along laws, laws prohibiting tents being erected overnight, laws prohibiting personal belongings on the street, and other laws that penalize and punish people experiencing homelessness and residing in encampments.⁶⁵

⁶⁰ A/HRC/43/43, para 34; CESCR General Comment No.7.

⁶¹ CESCR General Comment No.7.

⁶² A/HRC/43/43, para 34; also see: “Security of tenure under domestic law should not, consequently, be restricted to those with formal title or contractual rights to their land or housing. The UN guiding principles on security of tenure (A/HRC/25/54, para. 5), states that security of tenure should be understood broadly as “a set of relationships with respect to housing and land, established through statutory or customary law or informal or hybrid arrangements, that enables one to live in one’s home in security, peace and dignity.”

⁶³ UN Office of the High Commissioner. (2014). *Forced Evictions: Fact Sheet No. 25/Rev.1*. Available from: <https://www.ohchr.org/Documents/Publications/FS25.Rev.1.pdf>

⁶⁴ A/HRC/43/43, para 36.

⁶⁵ See, for example, Ontario’s *Safe Street’s Act* (1999).

Principle 3 in Action: Forced Eviction & Harassment of Homeless Encampment Residents

In cities around the world, people experiencing homelessness are frequently subject to discriminatory treatment, harassment, and extreme forms of violence because of their housing status. People residing in homeless encampments are exposed to similar or worse treatment, particularly when faced with pressure to relocate or disperse.

In some cases, local laws, policies, or practices can provide the mechanisms for this harassment. For example, in British Columbia local authorities enforced a bylaw prohibiting overnight shelters in parks by using tactics that included spreading chicken manure and fish fertilizer on a homeless encampment. Residents and allies of the homeless encampment subsequently filed a human rights complaint with regard to these practices (*Abbotsford (City) v. Shantz*), and the BC Supreme Court found that certain bylaws violated encampment residents' constitutional rights to life, liberty and security of the person.

Under international human rights law, such activities are strictly prohibited and constitute instances of forced eviction, even if they align with local laws or policies. Given this, it is critical that Canadian governments review local and national policies and laws to ensure they do not violate the prohibition against the forced eviction of homeless encampments.

PRINCIPLE 4: Explore all viable alternatives to eviction

50 Government authorities must explore all viable alternatives to eviction, in consultation with encampment residents.⁶⁶ This means ensuring their meaningful and effective participation in discussions regarding the future of the encampment.

51 Free and independent legal advice should be made available to all residents to help them understand the options, processes, and their rights. Consultations should be conducted at times and locations that are appropriate and accessible for residents to ensure their participation is maximised. Financial and other support should be available to residents so that they can fully participate in all discussions regarding the future of the encampment and so that residents can retain outside consultants (e.g., environmental engineers, architects) where needed to assist them in developing alternative options to eviction.

52 Discussions regarding viable alternatives to eviction must include meaningfully engagement with Indigenous Peoples and be grounded in principles of self-determination, free, prior and informed consent. In urban contexts, for example, urban Indigenous organisations should be engaged early in the planning process to establish service delivery roles and to ensure the availability of culturally appropriate services.

⁶⁶ A/HRC/43/4.

53 Where personal needs differ amongst residents of encampments such that a singular best alternative is not unanimous, governments will have to develop several solutions each of which is consistent with the principles outlined in this Protocol.

PRINCIPLE 5: Ensure that any relocation is human rights compliant

54 Homeless encampments are not a solution to homelessness, nor are they a form of adequate housing. Governments have an urgent, positive obligation to ensure encampment residents have access to long-term, adequate housing that meets their needs, accompanied by necessary supports. Rather than eviction, governments must engage with homeless encampments with a view to ensuring residents are able to access such housing.

55 Despite this obligation, many governments respond to encampments by simply moving residents from one bad site to another through the use of law enforcement, physical barriers, or other means, and without meaningfully engaging residents. This in no way addresses the underlying violations of the right to housing experienced by residents of encampments, is often costly, and can contribute to increased marginalization. If relocation is deemed necessary and/or desired by encampment residents, it is critical that it is conducted in a human rights compliant manner.

56 As a starting point, meaningful, robust, and ongoing engagement with residents (as defined in Principle 2) is required for the development of any relocation of homeless encampments or of their residents. Meaningful engagement with communities should ensure the development of plans that respect the rights of residents and can be implemented cooperatively, without police enforcement.⁶⁷ Considerations regarding relocation must be grounded in the principle that “the right to remain in one’s home and community is central to the right to housing.”⁶⁸ If relocation is consistent with the human rights of residents, it will almost always be achievable without the use of force.

57 If government authorities propose the relocation of residents of homeless encampments, and the residents desire to remain in situ, the burden of proof is on the government to demonstrate why in situ upgrading is unfeasible.⁶⁹

58 If, after meaningful engagement with those affected, relocation is deemed necessary and/or desired by encampment residents, adequate alternative housing must be provided in close proximity to the original place of residence and source of livelihood.⁷⁰ If governments have failed to provide residents with housing options that

⁶⁷ A/HRC/40/61, para 38.

⁶⁸ A/73/310/Rev.1, para 26.

⁶⁹ A/73/310/Rev.1, para 32.

⁷⁰ A/HRC/4/18, annex I, para. 60.

they find acceptable, residents must be permitted to remain or be provided with a satisfactory alternative location, while adequate permanent housing options are negotiated and put in place.

59 If, in the exceptional case there is no viable alternative to eviction by authorities, eviction must be compliant with all aspects of international human rights law.⁷¹ Compliance with international human rights law requires:

i. **Prohibition against the removal of residents' private property without their knowledge and consent**

The removal of residents' private property by governments and those acting on their behalf, including the police, without their knowledge and consent, is strictly prohibited.⁷² Such actions are contrary to the rights of residents and may contribute to the deepening of residents' marginalization, exclusion, and homelessness.⁷³ Governments and police must also seek to actively prevent the removal of homeless residents' private property by private actors or any other form of harassment.

ii. **Adherence to the right to housing and other human rights standards when relocation is necessary or preferred**

Adequate alternative housing, with all necessary amenities (particularly water, sanitation and electricity), must be in place for all residents prior to their eviction.⁷⁴ Alternative housing arrangements should be in close proximity to the original place of residence and to services, community support, and livelihood.⁷⁵ It is critical that all encampment residents be allowed to participate in decisions regarding relocation, including the timing and site of relocation.⁷⁶ A full hearing of the residents' concerns with the proposed relocation should be held, and alternatives explored.

⁷² A/HRC/4/18, *Basic Guidelines on Development Based Evictions*, see para 50: "States and their agents must take steps to ensure that no one is subject to direct or indiscriminate attacks or other acts of violence, especially against women and children, or arbitrarily deprived of property or possessions as a result of demolition, arson and other forms of deliberate destruction, negligence or any form of collective punishment. Property and possessions left behind involuntarily should be protected against destruction and arbitrary and illegal appropriation, occupation or use."

⁷³ National Law Centre on Homelessness & Poverty. (2017). *Violations of the Right to Privacy for Persons Experiencing Homelessness in the United States*. Available from: <https://nlchp.org/wp-content/uploads/2018/10/Special-Rapporteur-Right-to-Privacy.pdf>. See para 7: "For them, whatever shelter they are able to construct, whether legally or illegally, is their home, and their right to privacy should inhere to that home the same as it would for any regularly housed person. To deny them that right is to further marginalize and dehumanize this already highly marginalized and dehumanized population."

⁷⁴ A/73/310/Rev.1, para 34.

⁷⁵ Basic principles and guidelines on development-based evictions and displacement (A/HRC/4/18, annex I, para. 60) and A/HRC/4/18, annex I, para. 60.

⁷⁶ A/73/310/Rev.1, para 31.

iii. **Relocation must not result in the continuation or exacerbation of homelessness, or require the fracturing of families or partnerships**

Relocation must not result in the continuation or deepening of homelessness for residents.⁷⁷ Relocation must not require the separation of families or partners, as defined by rights-holders themselves, including chosen family and other kinship networks.⁷⁸ Governments should engage encampments with a view to keeping the community intact, if this is desired by the residents.⁷⁹ Governments should also ensure that relevant housing policies are supportive of the ways in which rights-holders define their own families, partnerships, communities and extended Indigenous kinship structures, and accommodate these whenever possible in public or social housing.

iv. **Access to justice to ensure procedural fairness and compliance with all human rights**

Access to justice must be ensured at all stages of government engagement with encampment residents, not just when eviction is imminent.⁸⁰ Access to justice and legal protection must meet international human rights law standards,⁸¹ including the provision of due process, access to legal aid, access to fair and impartial legal advice, and the ability to file complaints in a relevant forums (including Indigenous forums) that are geographically proximate.⁸²

⁷⁷ A/73/310/Rev.1.

⁷⁸ UN Office of the High Commissioner. (2014). *Forced Evictions: Fact Sheet No. 25/Rev.1*. Available from: <https://www.ohchr.org/Documents/Publications/FS25.Rev.1.pdf>. See para 52: “States should also ensure that members of the same extended family or community are not separated as a result of evictions.”; also, UNHR Summary Conclusions on the Family Unit, Available at <https://www.unhcr.org/protection/globalconsult/3c3d556b4/summary-conclusions-family-unity.html>, see para 8: “International human rights law has not explicitly defined ‘family’ although there is an emerging body of international jurisprudence on this issue which serves as a useful guide to interpretation. The question of the existence or non-existence of a family is essentially a question of fact, which must be determined on a case-by-case basis, requiring a flexible approach which takes account of cultural variations, and economic and emotional dependency factors. For the purposes of family reunification, ‘family’ includes, at the very minimum, members of the nuclear family (spouses and minor children).”

⁷⁹ A/HRC/43/43, para 42.

⁸⁰ A/HRC/43/43.

⁸¹ Committee on Economic, Social and Cultural Rights, General Comment No. 7, para 3.

⁸² It should be noted that broad and inclusive participatory-based processes can potentially foster access to justice for equity-seeking groups, and such processes should be responsive to the unique barriers to justice these groups face.

Principle 5 in Action - *Melani v. City of Johannesburg*

Globally, there are many compelling examples of courts upholding the rights of informal settlements or homeless encampments right to remain in place (“in situ”) in their community. One such example is *Melani v. City of Johannesburg* in South Africa. In this case, the Slovo Park informal settlement challenged the City of Johannesburg’s decision to relocate the community to an alternative location 11 km away. The court held that the Government’s upgrading policy, as required by the constitutional right to housing, envisages “a holistic development approach with minimum disruption or distortion of existing fragile community networks and support structures and encourages engagement between local authorities and residents living within informal settlements.” The Court concluded that relocation must be “the exception and not the rule” and any relocation must be to a location “as close as possible to the existing settlement.” The Court ordered the City of Johannesburg to reverse the decision to relocate the community, and mandated the city to apply for funding for in situ upgrading.

The South African approach is an example of how some national courts are making the shift to adopt a human rights-based approach to encampments. This is a shift that moves in the right direction and should be applied by all courts in Canada.

PRINCIPLE 6: Ensure encampments meet basic needs of residents consistent with human rights⁸³

60 Much of the stigma attached to residents of encampments is a result of governments failing to ensure access to basic services, including access to clean water, sanitation facilities, electricity, and heat, as well as support services.⁸⁴ These conditions violate a range of human rights, including rights to housing, health, physical integrity, privacy, and water and sanitation.⁸⁵ In these conditions, residents face profound threats to dignity, safety, security, health, and wellbeing.⁸⁶ The denial of access to water and sanitation by governments constitutes cruel and inhumane treatment, and is prohibited under international human rights law.⁸⁷

⁸³ Details regarding securing basic needs consistent with human rights can be found in Schedule B.

⁸⁴ A/73/310/Rev.1.

⁸⁵ A/HRC/43/4.

⁸⁶ UN Water. *Human Rights to Water and Sanitation*. Available from: <https://www.unwater.org/water-facts/human-rights/>

⁸⁷ A/73/310/Rev.1, para 46: “Attempting to discourage residents from remaining in informal settlements or encampments by denying access to water, sanitation and health services and other basic necessities, as has been witnessed by the Special Rapporteur in San Francisco and Oakland, California, United States of

61 Canadian governments must ensure, at a minimum, that rudimentary adequacy standards are ensured in homeless encampments on an urgent and priority basis, while adequate housing options are negotiated and secured. Government's compliance with international human rights law requires:

i. **Access to safe and clean drinking water**

Water and sanitation are critical to health for all people. Through *Resolution 64/292*, the United Nations explicitly recognized the right to safe and clean drinking water and sanitation as a "human right that is essential for the full enjoyment of life and all human rights."⁸⁸ The *Resolution* calls upon States and international organizations "to provide safe, clean, accessible and affordable drinking water and sanitation for all." This obligation extends to those residing in homeless encampments.⁸⁹

ii. **Access to hygiene and sanitation facilities**

Homeless encampments must be provided with sufficient resources and supports to ensure access to hygiene and sanitation facilities – toilets, showers, hand-washing stations, for example – within the encampment, or within very close proximity. Using existing facilities that remain open to the general public will not be appropriate. Facilities should ensure the hygiene and dignity of all residents irrespective of needs or identity. Peer-led hygiene and sanitation facilities have worked well in some contexts.

iii. **Resources and support to ensure fire safety**

General safety precautions should be implemented in an encampment environment to ensure residents are safe from fire and chemical exposure. Fire Departments should assist residents in developing a harm reduction approach to fire safety.

iv. **Waste management systems**

The lack of waste management systems in encampments has serious health and safety implications. Encampments necessarily create garbage during the course of daily activities. Garbage piles can become combustible fire hazards and can increase the risk of exposure to chemical waste. Human and animal biological waste also poses a particular danger. Without sanitary facilities, accumulated fecal waste can contaminate the

America, 29 constitutes cruel and inhuman treatment and is a violation of multiple human rights, including the rights to life, housing, health and water and sanitation."

⁸⁸ A/RES/64/292, para 2. Available at: https://www.un.org/ga/search/view_doc.asp?symbol=A/RES/64/292.

⁸⁹ A/RES/64/292, para 3. Available at: https://www.un.org/ga/search/view_doc.asp?symbol=A/RES/64/292.

ground and transmit diseases.⁹⁰ The improper disposal of needles can also transmit diseases through puncture wounds or re-use of needles. It is the responsibility of governments to ensure that homeless encampments have sufficient resources for the establishment of waste management systems.

v. **Social Supports and Services**

Residents of homeless encampments should be ensured access to health, mental health, addiction, and broader social services in a manner equitable to other community residents and consistent with human rights. All supports should be culturally appropriate and anti-oppressive. Governments should consult encampment residents on how best to provide access to these services, including through approaches such as outreach and/or on-site service provision. The provision of social services should not be linked to data gathering of any kind.

vi. **Guarantee Personal Safety of Residents**

Although research indicates that unsheltered people in Canada are disproportionately targets of violence, rather than perpetrators,⁹¹ interpersonal violence and exploitation can occur within encampments. Interpersonal violence is often exacerbated when people do not have their basic needs met,⁹² thus the provision of meaningful resources and supports will likely help ameliorate issues of safety.

It is the State's duty to protect the safety of all residents, particularly those who may be particularly vulnerable to abuse, harm, trafficking, or exploitation. Responses to violence must be guided by principles of transformative justice, rather than reproduce punitive outcomes and must be based in community-developed safety protocols. Governments must recognize that engaging police or other state authorities as a response to violence in encampments may put people at increased risk of harm, including due to risks of being criminalized or incarcerated.

vii. **Facilities and resources that support food safety**

Consuming contaminated food or water can cause a variety of foodborne

⁹⁰ CalRecycle. *Homeless Encampment Reference Guide*. Available at:

<https://www.calrecycle.ca.gov/illegalDump/homelessCamp#SolidWaste>

⁹¹ Sylvia, N., Hermer, J., Paradis, E., & Kellen, A. (2009). "More Sinned Against than Sinning? Homeless People as Victims of Crime and Harassment." In: Hulchanski, J. David; Campsie, Philippa; Chau, Shirley; Hwang, Stephen; Paradis, Emily (Eds.), *Finding Home: Policy Options for Addressing Homelessness in Canada* (e-book), Chapter 7.2. Toronto: Cities Centre, University of Toronto.

www.homelesshub.ca/FindingHome

⁹² Slabbert, I. (2017). Domestic violence and poverty: Some women's experiences. *Research on social work practice*, 27(2), 223-230.

illnesses. Encampments are often more susceptible to foodborne illnesses due to a lack of storage, cooling appliances, improperly cooked foods, and limited or no access to clean water. Diseases can spread quickly in an encampment setting.

One of the best ways to prevent the spread of illness is to for governments to provide resources that enable the encampment to implement food safety measurements such as refrigeration facilities, which are also important for storing medicines.

viii. **Resources to support harm reduction**

Governments must provide encampments with the resources to implement effective harm reduction measures. Appropriate professionals should support residents to establish emergency protocols for responding to overdoses and other health emergencies.

ix. **Rodent and pest prevention**

The presence of rodents and pests can pose a significant threat to the health of residents. Appropriate prevention and treatment options should be available for pest management that are safe for use in human environments. Encampment residents should be provided with the resources to prevent and address the presence of rodents and pests.

62 In implementing these standards, it must be recognized that residents of encampments are experts with respect to their living spaces — they often know what resources are needed and how best to mobilize them. As a matter of human rights, residents must be engaged in planning and carrying out any measures developed to improve access to basic services. Practices, systems, and agreements residents have already put in place should be respected by government officials and should inform any further improvements.

PRINCIPLE 7: Ensure human rights-based goals and outcomes, and the preservation of dignity for encampment residents

63 As a matter of international human rights law, the rights and dignity of residents must be at the heart of all government engagement with homeless encampments.⁹³ Dignity is an inherent human rights value that is reflected in the *Universal Declaration of Human Rights*. As such, Canadian governments have an obligation to bring about positive human rights outcomes in all of their activities and decisions concerning homeless encampments.

⁹³ ICESCR.

64 Where Canadian governments at any level make decisions with regards to encampments, it is essential that they do so taking into account the full spectrum of human rights of residents and ensure that their enjoyment of those rights is enhanced by all decisions. Any decision that does not lead to the furthering of human rights, fails to ensure their dignity, or represents a backwards step in terms of their enjoyment of human rights, is contrary to human rights law.

65 More broadly, the Canadian government has an obligation to the progressive realization of the right to housing, alongside all other human rights.⁹⁴ A central component of that obligation is to address on an urgent basis the needs of those in the greatest need. This means that Canadian governments must move, as a matter of priority, towards the full enjoyment of the right to housing for encampment residents.⁹⁵ When governments fail to bring about positive human rights outcomes for encampment residents, they fail their obligation to progressively realize the right to housing.⁹⁶

PRINCIPLE 8: Respect, protect, and fulfill the distinct rights of Indigenous Peoples in all engagements with encampments

66 Indigenous Peoples in Canada experience some of the most severe and egregious forms of housing need, and are dramatically overrepresented in homeless populations across the country, including specifically amongst those who are sleeping rough.⁹⁷ Under these conditions, many Indigenous Peoples experience profound violations of the right to housing and the right to self-determination, as well as violations of the right to freely pursue their economic, social, and cultural development.⁹⁸

67 For Indigenous Peoples in Canada, encampments and political occupation may occur simultaneously as a means of survival and a means of asserting rights to lands and

⁹⁴ ICESCR, in General Comment No.3 on the nature of states parties' obligations under Art 2(1) of the ICESCR.

⁹⁵ ICESCR, Article 2(1).

⁹⁶ Further, if governments failed to ensure human rights outcomes were obtained for encampment residents, and residents suffered some detriment to their enjoyment of their rights (e.g., loss of dignity or ended up street homeless without any shelter at all), this might be classed as retrogression and a breach of obligations.

⁹⁷ See ESDC (Employment and Social Development Canada). (2019). *Everyone counts highlights: Preliminary results from the second nationally coordinated point-in-time count of homelessness in Canadian communities*. Retrieved from <https://www.canada.ca/en/employment-social-development/programs/homelessness/reports/highlights-2018-point-in-time-count.html#3.5>. Similarly, the [2018 Toronto Street Needs Assessment](#) documented that 16% of those enumerated were Indigenous, and 38% of those sleeping rough were Indigenous. See also Patrick, C. (2014). *Aboriginal Homelessness in Canada: A Literature Review*. Toronto: Canadian Homelessness Research Network Press. Retrieved from <https://www.homelesshub.ca/sites/default/files/AboriginalLiteratureReview.pdf>.

⁹⁸ Article 3 of the *Declaration* and article 1 of the *Covenant*.

territories within cities and elsewhere. Whatever the impetus, any government engagement with Indigenous Peoples in encampments must be guided by the obligation to respect, protect, and fulfil their distinct rights. These rights are outlined in the United Nations Declaration on the Rights of Indigenous Peoples, as well as many other international human rights treaties.

68 Under international human rights laws, the enjoyment of the right to housing for Indigenous Peoples is “deeply interconnected with their distinct relationship to their right to lands, territories and resources, their cultural integrity and their ability to determine and develop their own priorities and strategies for development.”⁹⁹ Recognition of the indivisible nature of Indigenous Peoples’ human rights, and the obligation to uphold these rights, must shape all government engagement with Indigenous encampment residents, as well as the Indigenous Peoples who own or occupy the land or territories upon which the encampment is located.

69 Compliance with international human rights law requires:

i. **Recognition of the distinct relationship that Indigenous Peoples have to their lands and territories**

In order to ensure adequate housing for Indigenous Peoples, States, Indigenous authorities, and other actors must recognize the distinct spiritual and cultural relationships that Indigenous Peoples have with their lands and territories.¹⁰⁰ This recognition includes protection for Indigenous residents of encampments, who have the right to utilize their lands and territories in line with their own economic, social, political, spiritual, cultural, and traditional practices (as defined and assessed by the Peoples themselves).¹⁰¹

Under international human rights law, governments “should respect those housing structures which an Indigenous community deems to be adequate in the light of their own culture and traditions.”¹⁰² In the context of encampments, governments must respect Indigenous Peoples’ right to construct shelter and housing in ways that incorporate their lived histories, cultures, and experiences.¹⁰³

ii. **Guarantee of self-determination, free, prior and informed consent and**

⁹⁹ A/74/183, particularly para 6: “The right to adequate housing can be enjoyed by Indigenous Peoples only if its articulation under article 11 (1) of the International Covenant on Economic, Social and Cultural Rights is understood as interdependent with and indivisible from the rights and legal principles set out in the United Nations Declaration on the Rights of Indigenous Peoples.”

¹⁰⁰ A/74/183.

¹⁰¹ A/74/183.

¹⁰² A/74/183, para 62.

¹⁰³ A/74/183.

meaningful consultation of Indigenous Peoples

Governments must ensure the participation of Indigenous Peoples in all decision-making processes that affect them.¹⁰⁴ Governments must consult with Indigenous encampment residents in order to obtain their free, prior, and informed consent before taking any action that may affect them.¹⁰⁵

Engagement with Indigenous communities should involve genuine dialogue and should be guided by “mutual respect, good faith and the sincere desire to reach agreement.”¹⁰⁶ This consultation process must engage representatives chosen by Indigenous Peoples themselves, in accordance with their own procedures and practices.¹⁰⁷ As outlined in Principle 2, governments must provide Indigenous residents with necessary institutional, financial, and other resources in order to support their right to participate.¹⁰⁸ Indigenous women and girls must be consulted on a priority basis.¹⁰⁹

iii. Prohibition against the forced eviction, displacement, and relocation of Indigenous Peoples

Indigenous Peoples’ access to and control over their lands, territories and resources constitute a fundamental element of the realization of their right to adequate housing.¹¹⁰ As such, international human rights law strictly prohibits the relocation of Indigenous Peoples in the absence of free, prior, and informed consent.¹¹¹

iv. Protection and guarantees against all forms of violence and discrimination for Indigenous women, girls, and gender diverse peoples

Indigenous women, girls, gender diverse, and Two-Spirit peoples experience particular forms of violence – including sexual violence and

¹⁰⁴ United Nations Declaration on the Rights of Indigenous Peoples.

¹⁰⁵ United Nations Declaration on the Rights of Indigenous Peoples, in particular arts. 10, 19, and 23.

¹⁰⁶ A/74/183, para 56.

¹⁰⁷ United Nations Declaration on the Rights of Indigenous Peoples, art. 18. See also Indigenous and Tribal Peoples Convention, 1989 (No. 169), art. 6(1)(b); American Declaration on the Rights of Indigenous Peoples, arts. XXI (2) and XXIII (1); and A/HRC/18/42, annex (Expert Mechanism advice No. 2 (2011)). See also Human Rights Committee, General Comment No. 23 (1994) on the rights of minorities, para 7.

¹⁰⁸ Committee on Economic, Social and Cultural Rights’ General Comment No. 4, para 12, and the basic principles and guidelines on development-based evictions and displacement (A/HRC/4/18, annex I, para 39).

¹⁰⁹ A/74/183, para 59.

¹¹⁰ A/74/183, para 51. See also A/HRC/7/16, paras 45–48; The United Nations Declaration of the Rights of Indigenous Art. 26.2: “Indigenous Peoples have the right to own, use, develop, and control the lands, territories and resources that they possess by reason of traditional occupation or use, as well as those which they have otherwise acquired.”

¹¹¹ United Nations Declaration on the Rights of Indigenous Peoples, Art. 10: “Indigenous Peoples shall not be forcibly removed from their lands or territories. No relocation shall take place without the free, prior and informed consent of the Indigenous Peoples concerned and after agreement on just and fair compensation and, where possible, with the option of return.”

homicide – in relation to the intersection of their indigeneity, gender identity, socioeconomic and cultural status, and their housing status.¹¹² Canadian law recognizes the concept of multiple and intersecting forms of discrimination, and under international human rights law all Indigenous women, girls, and those who are gender diverse or Two-Spirited “must enjoy full protection and guarantees against all forms of violence and discrimination, whether inside or outside their communities.”¹¹³

It is incumbent upon governments to provide Indigenous women and girls protection and guarantee against all forms of violence and discrimination within encampments, including from state authorities, in a manner that is consistent with Indigenous self-determination and self-governance.

¹¹² A/74/183, para 59.

¹¹³ A/74/183, para. 59.

SCHEDULE A: Select Case Law on Homeless Encampments in Canada

Victoria (City) v. Adams, [2009 BCCA 563](#)¹¹⁴

The City of Victoria made an application for an injunction to remove a "tent city" at Cridge Park. The City relied on its *Streets and Traffic Bylaw* and *Parks Regulation Bylaw*, which prohibits loitering and taking up an overnight temporary residence in public places. On appeal, the Court of Appeal established that the Victoria City bylaws violated section 7 of the *Canadian Charter* "in that they deprive homeless people of life, liberty and security of the person in a manner not in accordance with the principles of fundamental justice," and the provisions were not saved by section 1 of the *Charter* (para. 42). The Court of Appeal confirmed that the bylaw was overbroad "because it is in effect at all times, in all public places in the City."¹¹⁵

Abbotsford (City) v. Shantz, 2015¹¹⁶

The City of Abbotsford applied for an interim injunction requiring the defendants to remove themselves and their encampment from a city park. The Court concluded that the bylaws were "grossly disproportionate" because:

"the effect of denying the City's homeless access to public spaces without permits and not permitting them to erect temporary shelters without permits is grossly disproportionate to any benefit that the City might derive from furthering its objectives and breaches the s. 7 *Charter* rights of the City's homeless."¹¹⁷

The Court concluded that allowing the City's homeless to set up their shelters overnight and taking them down during the day would "reasonably balance the needs of the homeless and the rights of other residents of the City."¹¹⁸

¹¹⁴ *Victoria(City) v. Adams* (2009, BCCA 563). Online, <https://www.canlii.org/en/bc/bcca/doc/2009/2009bccca563/2009bccca563.html?resultIndex=1>

¹¹⁵ The Court of Appeal stated at para. 116 that: "The prohibition on shelter contained in the Bylaws is overbroad because it is in effect at all times, in all public places in the City. There are a number of less restrictive alternatives that would further the City's concerns regarding the preservation of urban parks. The City could require the overhead protection to be taken down every morning, as well as prohibit sleeping in sensitive park regions." This case is perhaps one of the most notable successes in homeless litigation in Canada.

¹¹⁶ *Abbotsford (City) v. Shantz* (2016 BCSC 2437). Online, <https://www.canlii.org/en/bc/bcsc/doc/2016/2016bcsc2437/2016bcsc2437.html?resultIndex=1>

¹¹⁷ Para 224

¹¹⁸ The Court stated, "The evidence shows, however, that there is a legitimate need for people to shelter and rest during the day and no indoor shelter in which to do so. A minimally impairing response to balancing that need with the interests of other users of developed parks would be to allow overnight shelters to be erected in public spaces between 7:00 p.m. and 9:00 a.m. the following day." [para 276]

British Columbia v. Adamson, [2016 BCSC 584](#) [Adamson #1] and [2016 BCSC 1245](#) [Adamson #2]¹¹⁹

The Province of BC applied for an interlocutory injunction to restrain the defendant encampment residents from trespassing on the Victoria courthouse green space. On the first application, the court concluded that the balance of convenience did not favour the granting of the injunction, stating

“the balance of convenience is overwhelmingly in favour of the defendants, who simply have nowhere to move to, if the injunction were to issue, other than shelters that are incapable of meeting the needs of some of them, or will result in their constant disruption and a perpetuation of a relentless series of daily moves to the streets, doorways, and parks of the City of Victoria.”¹²⁰

Following this, a second injunction was filed based on new evidence of the encampment deterioration conditions, as well as supporting evidence that the Province would make housing available to encampment residents. The court made an order requiring the encampment to be cleared, but granting residents to stay until alternate housing options were made available to them.¹²¹

Vancouver (City) v. Wallstam, [2017 BCSC 937](#)¹²²

The City of Vancouver applied for an interlocutory injunction requiring encampment residents to vacate and remove all tents and other structures from a vacant city lot. The Court relied on the injunction test set out in *RJR-MacDonald*.¹²³ The court noted that:

“The test requires that the *applicant* prove it will suffer irreparable harm if the injunction is not granted...When I asked counsel what harm the *City* would suffer if the injunction was not granted, he answered that not granting the injunction would mean that a ‘vital social housing project won't go ahead’ and that interferes with the public good. He also points out the timeline for development of the project requires the injunction urgently ... While everyone can agree that more social housing is an important goal, I must balance that general concern against the position of the occupants that the tent city, as it currently exists, is now providing shelter and safe living space for the occupants.”¹²⁴

¹¹⁹ *British Columbia v. Adamson* (2016 BCSC 1245). Online, <https://www.canlii.org/en/bc/bcsc/doc/2016/2016bcsc1245/2016bcsc1245.html?resultIndex=1>

¹²⁰ Para 183.

¹²¹ Paras 85-86,

¹²² *Vancouver (City) v. Wallstam* 2017 BCSC 937 at para 60. Online, <https://www.canlii.org/en/bc/bcsc/doc/2017/2017bcsc937/2017bcsc937.html?resultIndex=1>

¹²³ In *RJR-MacDonald Inc. v. Canada (Attorney General)*, [1994] 1 S.C.R. 311

¹²⁴ Para 46-47.

The court concluded that the City failed to meet the *RJR-MacDonald* test and dismissed the City's application, but without prejudice to bring it forward again on a more complete factual record.¹²⁵

¹²⁵ Para 64.

SCHEDULE B: An Elaboration on Principle 6

Ensure encampments meet basic needs of residents consistent with human rights

Canadian governments must ensure, at a minimum, that rudimentary adequacy standards are ensured in homeless encampments on an urgent and priority basis, while adequate housing options are negotiated and secured. Government's compliance with international human rights law requires:

i. **Access to safe and clean drinking water**

Water and sanitation are critical to health for all people. Through *Resolution 64/292*, the United Nations explicitly recognized the right to safe and clean drinking water and sanitation as a "human right that is essential for the full enjoyment of life and all human rights."¹²⁶ The *Resolution* calls upon States and international organizations "to provide safe, clean, accessible and affordable drinking water and sanitation for all." This obligation extends to those residing in homeless encampments.¹²⁷

To ensure access to safe and clean drinking water, governments should provide homeless encampments with resources for:

- On site/close-proximity clean and safe drinking/potable water, ensuring a sufficient number of access points for water relative to the number of residents
- Dishwashing Station(s) with clean water, sufficient in number for the number of residents

ii. **Access to hygiene and sanitation facilities**

Homeless encampments must be provided with sufficient resources and supports to ensure access to hygiene and sanitation facilities – toilets, showers, hand-washing stations, for example – within the encampment, or within very close proximity. Using existing facilities that remain open to the general public will not be appropriate. Facilities should ensure the hygiene and dignity of all residents irrespective of needs or identity. Peer-led hygiene and sanitation facilities have worked well in some contexts.

Hygiene and sanitation facilities should include:

- Washing stations, including showers with privacy and safety for women and gender diverse peoples, stocked with soap, water, paper towels

¹²⁶ A/RES/64/292, para 2. Available at:

https://www.un.org/ga/search/view_doc.asp?symbol=A/RES/64/292.

¹²⁷ A/RES/64/292, para 3. Available at:

https://www.un.org/ga/search/view_doc.asp?symbol=A/RES/64/292.

- Adequate numbers of toilets based on the encampment population which must be accessible for residents with disabilities. Every toilet station must also have a hand-washing station
- Access to cleaning and bathing supplies
- Access to free laundry facilities
- Free feminine hygiene products
- Access to clean bedding

iii. **Resources and support to ensure fire safety**

General safety precautions should be implemented in an encampment environment to ensure residents are safe from fire and chemical exposure. Fire Departments should assist residents in developing a harm reduction approach to fire safety. Residents should be provided with resources to support best safety practices, including:

- Fire-safety approved sources of heat (e.g., safe metal vessels for heat)
- Warming tents
- In-tent heat sources
- Fire-proof tents
- Fire evacuation plan
- Signage indicating evacuation plans
- Accessible information on fire safety tips and how to handle and store flammable materials (e.g., gasoline, butane, propane)
- Fire extinguishers appropriately spaced and training for residents on how to operate them
- Electricity/charging stations for phones and laptops
- On-site ashtrays or cigarette disposal posts

iv. **Waste management systems**

The lack of waste management systems in homeless encampments has serious health and safety implications. Encampments necessarily create garbage during the course of daily activities, including during food preparation or shelter building. Unwanted materials can pile up quickly when there is no waste system in place to remove garbage from the area. Garbage piles can become combustible fire hazards and can increase the risk of exposure to chemical waste.

Human and animal biological waste also poses a particular danger. Without sanitary facilities, accumulated fecal waste can contaminate the ground and transmit diseases.¹²⁸ The improper disposal of needles can also transmit diseases through puncture wounds or re-use of needles.

¹²⁸ CalRecycle. *Homeless Encampment Reference Guide*. Online at <https://www.calrecycle.ca.gov/illegaldump/homelesscamp#SolidWaste>

It is the responsibility of governments to ensure that homeless encampments have sufficient resources for the establishment of waste management systems, which should include:

- Weekly garbage and recycling (more frequent if needed)
- Regular service for waste water and portable toilets
- Independent waste bins for flammable/hazardous waste (e.g., fuel, motor oil, batteries, light bulbs)
- Large rodent-proof waste bins with tight fitting lids
- Garbage bags, cleaning supplies, hand soap, hand sanitizer
- Waste water holding tanks (if there are no sewers near encampment)

v. **Social Supports and Services**

Residents of homeless encampments should be ensured access to health, mental health, addiction, and broader social services in a manner equitable to other community residents and consistent with human rights. All supports should be culturally appropriate and anti-oppressive. Governments should consult encampment residents on how best to provide access to these services, including through approaches such as outreach and/or on-site service provision. The provision of social services should not be linked to data gathering of any kind.

i. **Guarantee Personal Safety of Residents**

Although research indicates that unsheltered people in Canada are disproportionately targets of violence, rather than perpetrators,¹²⁹ interpersonal violence and exploitation can occur within encampments. Interpersonal violence is often exacerbated when people do not have their basic needs met,¹³⁰ thus the provision of meaningful resources and supports will likely help ameliorate issues of safety.

It is the State's duty to protect the safety of all residents, particularly those who may be particularly vulnerable to abuse, harm, trafficking, or exploitation. Responses to violence must be guided by principles of transformative justice, rather than reproduce punitive outcomes and must be based in community-developed safety protocols. Governments must recognize that engaging police or other state authorities as a response to violence in encampments may put people at increased risk of harm, including due to risks of being criminalized or incarcerated.

¹²⁹ Sylvia, N., Hermer, J., Paradis, E., & Kellen, A. (2009). "More Sinned Against than Sinning? Homeless People as Victims of Crime and Harassment." In: Hulchanski, J. David; Campsie, Philippa; Chau, Shirley; Hwang, Stephen; Paradis, Emily (Eds.), *Finding Home: Policy Options for Addressing Homelessness in Canada* (e-book), Chapter 7.2. Toronto: Cities Centre, University of Toronto.

www.homelesshub.ca/FindingHome

¹³⁰ Slabbert, I. (2017). Domestic violence and poverty: Some women's experiences. *Research on social work practice*, 27(2), 223-230.

Any approach to addressing interpersonal safety within encampments must:

- Center on the most vulnerable members of the encampment, namely: BIPOC, women, trans-people and other LGBTQ2S+ persons, persons with disabilities, and other groups who experience discrimination or marginalization.
- Provide resources and supports to allow for Indigenous and other non-colonial approaches to conflict resolution.
- Provide safe, confidential, accessible, and non-coercive mechanisms through which individuals experiencing violence can report these experiences and receive trauma-informed supports and services, ensuring that these individuals are able to access alternative safe housing (as desired).

vi. **Facilities and resources that support food safety**

Consuming contaminated food or water can cause a variety of foodborne illnesses. Encampments are often more susceptible to foodborne illnesses due to a lack of storage, cooling appliances, improperly cooked foods, and limited or no access to clean water. Diseases can spread quickly in an encampment setting.

One of the best ways to prevent the spread of illness is to for governments to provide resources that enable the encampment to implement food safety measurements. This includes:

- Rodent-proof storage containers, with lids that can be sealed
- Shelving units to ensure food is stored off the ground
- Soap and sanitizer to clean food preparation surfaces
- Cooling appliance(s) to prevent spoilage
- Cooking appliance(s) to ensure food is thoroughly cooked

vii. **Resources to support harm reduction**

Governments must provide homeless encampments with the resources to implement effective harm reduction measures within homeless encampments. Appropriate professionals should support residents to establish emergency protocols for responding to overdoses and other health emergencies. Encampment residents should be provided with:

- Overdose prevention training (e.g., CPR training)
- Overdose prevention supplies (e.g., Naloxone)
- Overdose Prevention Sites, where possible
- Puncture-proof containers for needle disposal
- Harm reduction outreach supports
- Regular servicing of puncture-proof containers by a certified waste-management company

- Information about available emergency services in the event of overdoses or other health-related crises

viii. **Rodent and pest prevention**

The presence of rodents and pests can pose a significant threat to the health of residents. Appropriate prevention and treatment options should be available for pest management that are safe for use in human environments (e.g., diatomaceous earth). Encampment residents should be provided with the resources to prevent and address the presence of rodents and pests, including:

- Resources and information on rodent and pest prevention
- A bait-station to detract rodents from sleeping tents, regularly serviced and monitored
- Cleaning materials and gloves to dispose of rodents

In implementing these standards, it must be recognized that residents of encampments are the experts of their living spaces — they often know what resources are needed and how best to mobilize them. As a matter of human rights, encampment residents must be engaged in planning and carrying out any measures developed to improve access to basic services for the encampment. Practices, systems, and agreements residents already have in place should be recognized by government officials and should inform any further improvements.

EXHIBIT “9”



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Sheltered from the heat? How tents and shade covers may unintentionally increase air temperature exposures to unsheltered communities

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ABSTRACT

Objective: Heat vulnerability and homelessness are central public health concerns in cities globally, and public health implementation should address these two challenges in tandem to minimize preventable heat-related morbidity and mortality. Populations facing unsheltered homelessness use tents (or similar shelters) with shading features to minimize sun and heat exposure. This study evaluates the efficacy of different tent cover (shading) materials and how they moderate the in-tent air temperature (T_{air}) exposures of tent users during extreme summer conditions.

Study design: Within-tent T_{air} monitoring using Kestrel Drop devices occurred across three full typical summer days in Phoenix, Arizona in July 2022.

Methods: In-tent T_{air} were statistically compared between six small side-by-side identical tents with different cover materials (control (no cover), mylar, white bedsheet, tarp, sunbrella fabric, aluminum foil), as well as with ambient T_{air} .

Results: Using any tent resulted in higher daytime in-tent T_{air} than ambient T_{air} . Further, compared to a control tent, the T_{air} within tents shaded with sunbrella, tarp, and white bedsheet had significantly higher T_{air} at all times (2.36 °C, 2.46 °C, and 1.11 °C higher T_{air} , respectively), controlling for T_{air} and day/night.

Conclusion: Adding cover materials over tents may increase heat risk to an already vulnerable population at certain times of the day. Higher in-tent T_{air} is attributable to the reduced ability for heat and vapor to escape, largely due to reduced ventilation (mixing). Local authorities and welfare associations should reconsider using unventilated tents for shading and promote more widespread, ventilated tents and shade to ensure that prevention efforts do not further marginalize the most vulnerable. Future work should incorporate more comprehensive measurements of solar radiation to quantify overall heat stress for exposure reduction techniques.

1. Introduction

Those experiencing unsheltered homelessness^a are highly predisposed to severe outdoor conditions exacerbated by intrinsic socio-demographic attributes, making them highly susceptible to hazards [1–3]. For instance, those experiencing homelessness have a 17.5-year shorter life span than the general populace, thus it is critical to align public health interventions with the unique challenges of those experiencing homelessness [4]. Specifically, extreme heat events and outdoor heat exposures are central public health concerns [5–9]. In Maricopa County, Arizona, the homeless population—both unsheltered and

sheltered^b—accounted for approximately 59.7 % and 42.4 % of the total heat-related deaths for 2020 and 2021, respectively [10]. In 2020, a staggering 2.3 % of the known homeless population of Maricopa County died due to heat-related causes. Moreover, Longo et al. [11] found that the population experiencing homelessness faces 241 % higher heat stress than college students in Phoenix, Arizona. These statistics demonstrate the disproportionate heat-health outcomes among people experiencing homelessness, and any public health intervention strategy must be inclusive and comprehensive to address drivers of differential health outcomes, especially for populations underrepresented and marginalized in research. Accordingly, this study examines the effectiveness of

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^a Unsheltered homeless refers to populations sleeping on the streets or places not meant for human habitation [34].

^b Sheltered homeless refers to populations staying in emergency shelters, transitional housing, or safe haven programs [34].

tents and tent covers as a public health intervention strategy in modifying the in-tent thermal experience of people experiencing homelessness.

Factors amplifying the heat susceptibility of the unsheltered homeless include the prevalence of chronic ailments, higher rates of respiratory disorders, mental illnesses, sheltering in high-risk urban areas, inequitable policies and practices, and greater heat exposure [12–14]. Within Maricopa County, the point-in-time count of those experiencing homelessness showed a higher rate of increase of unsheltered (34 %) versus sheltered (9 %) people between 2020 and 2022, translating to increased heat risks as communities experiencing homelessness are unable to avoid direct heat exposure [7,15]. Globally, homelessness constitutes a public health challenge [16]; thus, it is crucial to investigate how certain public health interventions address the specific needs of disproportionately vulnerable groups toward strengthening subsequent public health strategies.

Climate projections indicate an increasing trend of extreme heat intensity, magnitude, and duration of heat events, which could mean a higher predisposition in the homeless community [17,18]. Climate change exacerbates heat vulnerability, especially among the socially disadvantaged, translating to increased cases of heat-related morbidity and mortality. These risks compound the vulnerability of the unsheltered homeless, amplifying heat susceptibility [19,20–22]. Therefore, there is a compelling need to understand the effectiveness of adaptation and/or mitigation strategies embraced by people experiencing homelessness. Attempts to bridge health disparities must also consider homelessness to obtain tangible solutions, as public health cannot be disassociated from the larger socioeconomic context [1,9,23,24].

The co-occurrence of heat vulnerability and homelessness remains understudied and has received minimal academic and policy interest. Heat events manifest as a multiplicity of outcomes ranging from health deterioration, decreased physical and mental well-being, increased financial challenges, mobility impairment, and impediments to social services [25,26]. In this regard, differential implications of heat exist [1, 8], which are less understood yet could have profound implications on institutional and individual response strategies. People experiencing homelessness are not well represented in disaster health planning [7], and the response/mitigation measures instituted fail to reflect their heat-hazard context [27,28]. Many response plans adopt a ‘treatment first model’^c instead of a ‘housing first model’^d [17,23,29].

Moreover, current heat alerts fail to reach the unsheltered homeless population, meaning that the nature of heat-hazard response could lead to maladaptation [1]. For instance, the homeless prevention program only served 676 individuals and families in Phoenix for the financial year 2022, yet the total number of people experiencing homelessness was 9,026, indicating that a large proportion of the most at-risk population is highly exposed to the extremely hot summer conditions [30]. More so, the legal and social invisibility associated with homelessness excludes them from conventional databases resulting in policy stigmatization, inefficiencies, and inconsideration [31,32]. Therefore, it is imperative to specifically study such marginalized groups. One strategy often used to help minimize heat exposure for unsheltered communities during the hot summer months involves providing tents of various types, and adding more material as shade to reduce sun exposure. However, the effectiveness of such a strategy in safeguarding against heat exposure has not been examined.

Accordingly, this study evaluates the efficacy of different tent cover (shading) materials and how they moderate the air temperature of tent users during extreme summer conditions in Phoenix, Arizona. Results

act as a means of informing targeted responses for the most vulnerable population. The study deviates from merely quantifying sociodemographic dimensions of vulnerability to demonstrating situational factors affecting thermal exposure in unhoused communities and providing next steps and recommendations.

2. Methods

2.1. Study site, data collection, experiment setup

Phoenix, located in the Sonoran Desert (33.44 N, 112.02 W), experiences extreme heat in the summer (June–August) with average minimum and maximum daily temperatures of ~83 °F (28.3 °C) and ~107 °F (41.6 °C), respectively (2010–2020 period) [33]. Despite these extreme conditions, the point-in-time counts of the people experiencing homelessness indicated a 22 % (total count of 9026) increase for 2022 compared to 2020. The sheltered homeless count was 3997 (9 % increase), while the unsheltered homeless were 5029 (34 % increase) [34]. Although the human services campus (a partnership of organizations with a shared goal of ending homelessness) served approximately 12, 180 individuals in 2022, the unsheltered homeless numbers continue to rise across the area while they remain highly vulnerable to hazards given that they cannot avoid the exposure. The unsheltered homeless often use tents, whose efficacy in reducing heat vulnerability has not been examined.

We considered a typical summertime period in Phoenix with data collection lasting three days and three nights (6.00 p.m. on 7/8/2022 to 6.00 p.m. on 7/11/2022), where the weather conditions fairly represented average summer conditions for the City of Phoenix. The experimental setup used six identical small tents side-by-side on an open concrete surface (basketball court) at a local school, each receiving a different cover material. The choice of identical tents allows for uniform comparison across shade types, and the tents’ design, size, and material reflect the standard tent used by people experiencing homelessness in Phoenix. The basketball court was selected as the surface of choice as it reflects nearly exact surface conditions in the streets of Phoenix (concrete or asphalt surfaces) where the people experiencing homelessness install their tents in the open air. The first tent (control) did not have any cover material. The cover materials’ albedos for tents 2 through 6 are as follows (see also Fig. 1).

- Tent 2: mylar rescue blanket, 92 % albedo
- Tent 3: white cotton bedsheet, 57 % albedo
- Tent 4: blue tarp, 43 % albedo
- Tent 5: sunbrella fabric 67 % albedo
- Tent 6: aluminum foil on corrugated cardboard (79 % albedo)

Albedos were determined by using the ratio of outgoing to incoming solar radiation with an NR01 Net Radiometer (Hukseflux, Inc.). The choices of these cover materials and the surface were informed by observations made during rescue missions at the Human Services Campus in Downtown Phoenix, whose primary objective is to provide severely needed resources for populations experiencing homelessness.

Environmental measurements were taken with Kestrel sensors^e. First, a 5400 Kestrel Heat Meter monitored ambient conditions in the areas and was situated on a tripod (1 m height) approximately 10 m from the tents (see Fig. 1). Variables used in analyses include ambient T_{air} , globe temperature, relative humidity (RH), and wind speed. Second, D2 Kestrel Drops monitored the in-tent T_{air} and RH; two devices were hung 1 foot from the top-center inside each tent using cable ties. Both sensor types collected 5-minute data (see [35] for sensor

^c Treatment first model focuses on problems associated with homelessness such as substance abuse, deteriorating health, and food [17].

^d Housing first model prioritizes secure tenancy for the affected populations, recognizing that other associated problems will not be adequately dealt with when people are on the street [17].

^e A kestrel sensor is a handheld weather station that can measure temperature, relative humidity, wind speed, and dew point among other weather parameters [42].



Fig. 1. Experimental setup of 6 identical tents, shown from left to right with different cover materials, as follows: control (no cover), mylar rescue blanket, white bedsheet, tarp, sunbrella fabric, and aluminum foil on cardboard. a: The Kestrel Heat Stress Meter (far left) on the tripod can be seen alongside the six tents. b: Side view of the six tents. c: Set up of Kestrel Drop sensors within the tents.

information).

Prior to field data collection, all Kestrels devices were calibrated in a controlled heat chamber (T_{air} of 35°C and RH of 30 %) for 2 hours at 5-min sampling intervals. Sensor-specific offsets were calculated; the average value of the offsets was used to determine deviations of each sensor and applied to the experimental data collected at the field site.

2.2. Data preparation and analysis

The average 5-min values of T_{air} and RH of the two Kestrel Drops in each tent per time stamp for the three days were used in the analysis. The unique calibration offsets were applied to each sensor before analysis.

Data analysis first entailed the computation of descriptive statistics using rain cloud diagrams and boxplots at three levels: combined day and night, daytime only, and nighttime only informed by sunrise and sunset times. Daytime occurred from 5.30 a.m. to 7.45 p.m., whereas nighttime ranged between 7.50 p.m. and 5.25 a.m. The classification translated to 517 daytime observations and 348 nighttime observations across the three days. The means and medians of each experimental tent were compared to each other using the Kolmogorov-Smirnov test and the Mann U Whitney test, respectively, to determine whether there were significant differences between the compared groups. These tests are non-parametric and sensitive to differences in shape and spread of the distribution of samples, thus critical to ascertaining whether any two samples are from the same distribution, or are significantly different [36, 37]. Bonferroni adjustments were applied to the resultant p-values, reducing the risk of obtaining a false positive result.

We conducted a series of regression analyses to account for other variables that could be influencing the in-tent temperature differences while determining specific times of the day when exposure is most severe. Specific combinations and interactions of weather variables could provide a hint as to the most crucial variables that policymakers could target to reduce in-tent temperature. The following regression models with increasing model complexity were conducted while using the control tent as the base reference: (1) Regressing tent categories against tent sensor readings to ascertain differences between the tents without accounting for any control variable; (2) Adding ambient T_{air} as a control variable to model 1 to examine the effects of T_{air} on in-tent temperature differences; (3) Adding day/night binary classification to model 2 which could inform in-tent temperature variability during the daytime and nighttime, while illuminating when the greatest opportunity to mitigate occurs; (4) Breaking day and night classifications into finer periods of 4–5 hours, which could inform the specific time of the day when optimal exposure occurs when using the tents and tent covers. For model 4, the finer time chunks were as follows: Daytime 1 (D1), 5.45 a.m.–10.30 a.m.; D2, 10.35 a.m. to 3.00 p.m.; D3, 3.05 p.m.–7.45 p.m.; Nighttime 1 (N1), 7.50 p.m. to 12.30 a.m.; N2, 12.35 a.m. to 5.25 a.m. Nighttime 2 was used as the reference time classification for model 4.

3. Results

3.1. Overview

Ambient weather conditions on test days reached an average T_{air} of 38°C (28.1 – 47.4°C min–max average) (Table 1), with low daytime RH (23 %) and variable winds, which were calmer in the nighttime (0.68 ms^{-1}) versus daytime (0.94 ms^{-1}). Skies were clear with incoming maximum solar radiation reaching 974 Wm^{-2} on the test days.

Results of average T_{air} values between tents and ambient conditions are presented in Table 1, with significance test results provided in Fig. 2, while Fig. 3 shows significance test results using the median value. The time of day is found to be an important factor in assessing the differences between the covered tents with either ambient T_{air} or the control tent. In general, the use of any tent resulted in higher daytime in-tent T_{air} than the ambient T_{air} , yet lower in-tent T_{air} at night. Further, shaded tents had equal or higher T_{air} at all times of day compared to the control tent with no additional shade.

3.2. In-tent air temperatures versus ambient air temperature

For D&N combined and daytime only, the mean in-tent T_{air} values across all tents were significantly higher than the ambient T_{air} (Table 1, Fig. 2), yet at nighttime, these differences were reversed and conditions were cooler in the tents versus ambient T_{air} . For example, overnight, the mean ambient T_{air} (34.6°C) was significantly higher than the control tent (33.4°C), white bedsheet (33.9°C), sunbrella (34.1°C) and tarp (33.6°C) tent covers. At night, the tent shaded by aluminum foil had a significantly higher in-tent T_{air} (34.9°C) than all other tents and the ambient T_{air} (see Fig. 2).

3.3. Shaded in-tent air temperatures versus control tent

Compared to the control tent, shaded tents were significantly warmer for combined D&N and nighttime, except for the tarp-covered tent overnight. Tents covered by Sunbrella fabric and tarp were respectively the warmest for combined D&N ($T_{\text{air}} = 41.8^{\circ}\text{C}$ and 41.9°C) and daytime ($T_{\text{air}} = 47.1^{\circ}\text{C}$ and 47.5°C).

The Kolmogorov-Smirnov tests (mean values) and the Mann U Whitney tests (median values) Comparisons of in-tent T_{air} against ambient T_{air} and the control tent were fairly consistent, yet had minor variations, displayed in Fig. 3.

3.4. Regression model results

The four regression models (Table 2) consistently returned the same results concerning the T_{air} differences between the tents, as detailed above. The only variation was found in the R-squared and Aiken Information Criterion values. The estimates of the tent coefficients were similar across the models, indicating uniform influences of explanatory variables across the tent covers. The in-tent T_{air} values with aluminum foil and mylar covers were not significantly different from the control tent in any of the models, whereas the remaining tents had significantly

Table 1

Descriptive statistics of the ambient temperature (°C) conditions for each tent, averaged across three days. Time classifications are presented in three chunks, including combined day (D) and night (N), daytime-only (D), and nighttime-only (N).

Recordings	Time classification	n	Range	Min	Mean	CI	Max	SD
Control	D&N	865	24.9	27.6	39.5	(±0.43)	52.5	6.46
	D	517	24.8	27.7	43.6	(±0.43)	52.5	4.97
	N	348	10.8	27.6	33.4	(±0.23)	38.4	2.22
Mylar	D&N	865	20.5	30.0	39.7	(±0.38)	50.5	5.76
	D	517	20.5	30.0	43.2	(±0.41)	50.5	4.71
	N	348	8.7	30.4	34.5	(±0.22)	39.1	2.06
White Bedsheet	D&N	865	25.7	29.2	40.6	(±0.47)	54.9	7.04
	D	517	25.7	29.2	45.1	(±0.47)	54.9	5.42
	N	348	9.05	29.4	33.9	(±0.22)	38.4	2.10
Tarp	D&N	865	30.5	29.2	41.9	(±0.59)	59.7	8.85
	D	517	30.5	29.2	47.5	(±0.61)	59.7	7.08
	N	348	8.9	29.3	33.6	(±0.22)	38.2	2.07
Sunbrella	D&N	865	27.4	29.5	41.8	(±0.55)	56.9	8.28
	D	517	27.4	29.5	47.1	(±0.57)	56.9	6.59
	N	348	9.1	29.6	34.1	(±0.22)	38.7	2.13
Aluminum Foil	D&N	865	18.3	30.0	39.5	(±0.35)	48.3	5.22
	D	517	18.3	30.0	42.7	(±0.37)	48.3	4.23
	N	348	8.9	30.7	34.9	(±0.23)	39.6	2.15
Heat Meter (Ambient air)	D&N	865	19.3	28.1	38.0	(±0.30)	47.4	4.57
	D	517	19.1	28.3	40.3	(±0.37)	47.4	4.30
	N	348	11.5	28.1	34.6	(±0.24)	39.6	2.31

n = number of observations, Min = Minimum air temperature, max = Maximum air temperature, SD= Standard Deviation, CI = Confidence Interval.

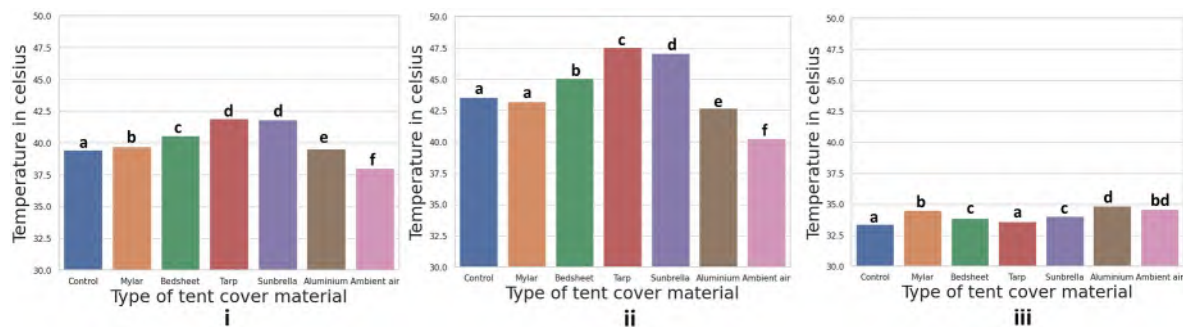


Fig. 2. Mean air temperature (°C) inside each tent and from the ambient sensor. i) Day & night combined, ii) daytime only, iii) nighttime only. Bars with the same letters (e.g., Tarp and Sunbrella in graph i) denote the means are statistically the same (or not statistically significantly different) for the given period using the Kolmogorov-Smirnov test using the mean values.

higher T_{air} than the control tent for all times of the day. Compared to the control tent, aluminum foil, mylar, sunbrella, tarp, and white bedsheets covers were associated with 0.08 °C, 0.23 °C, 2.36 °C, 2.46 °C, and 1.11 °C higher T_{air} , respectively, controlling for T_{air} and time classification as shown in model 3. Specifically, model 1 indicates that average in-tent temperatures are expected to be 39.5 °C, without adding any tent cover, corresponding to the control tent's mean value in Table 1 above. Model 2 indicates that in-tent thermal comfort is largely explained by air temperature because when we control for air temperature the expected average in-tent temperature for the control tent should be −11.9 °C.

Additionally, compared to nighttime in-tent T_{air} , daytime in-tent T_{air} was 5.01 °C higher controlling for tent cover material and ambient temperature as shown in model 3. Model 4 indicates that D2 and D3 time classifications are associated with 15.87 °C and 13.44 °C more in-tent warming compared to N2. The consistency of the results here and in the above tests—even with increasing model complexity and breaking down the time classification into finer periods—indicates that the significant differences between the tents outlined in sections 3.2 and 3.3 are strong. Given the consistency of the results across the models, model 3 parsimoniously explains the differences between the tents and the influences of ambient temperature conditions.

4. Discussion

Rising global temperatures, alongside an increasing number of people experiencing homelessness, present significant public health concerns, necessitating a thorough analysis and the development of targeted heat response strategies to safeguard human lives [38,39]. Tents are often used to help offer a place of refuge and privacy by providing a durable, lightweight, and weather-resistant personal space in place of emergency shelters. Although the provisioning of tents and tent shading is assumed to offer some form of protection against all weather extremes, results show that in the daytime, the T_{air} within a tent, whether covered or uncovered, is higher than the ambient T_{air} , yet lower at night. Thus, based on T_{air} only, tents may not protect the unsheltered homeless from extreme summer air temperatures, as all conditions would cause issues with heat stress; hence alternative sheltered accommodation, such as heat-ready housing, could be implemented as a public health measure. Further, multiple tests show that adding cover materials to shade tents during the summer may cause higher T_{air} exposures during the sweltering Phoenix summer, thus causing higher heat risk. Cooler nighttime in-tent T_{air} may be attributed to cooler in-tent surface temperatures due to shading and well as faster cooling rates after sunset of the tent/shading materials compared to concrete. Overall, shaded tents had equal or significantly higher T_{air} for combined day and night compared to the non-shaded control tent. Based on these results, there is

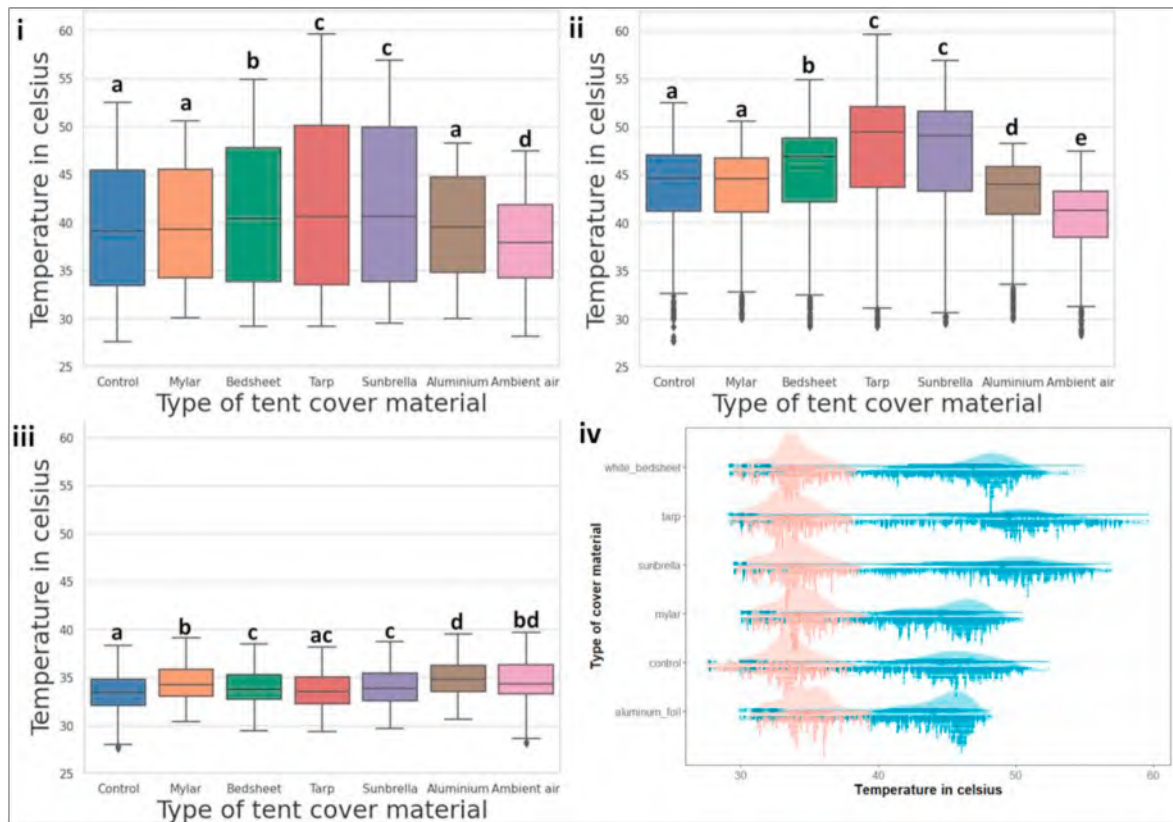


Fig. 3. (i–iii) Box and whisker plots for the combined day and night (i), daytime (ii), and nighttime (iii). Boxplots with the same letters within the graph do not have significant differences in T_{air} based on the median value using the Mann U Whitney test. (iv) Raincloud plot displaying the distribution and frequency of T_{air} values for all tents with cover and the control tent. The blue symbology represents daytime readings and the red symbology represents nighttime readings. (For interpretation of the references to colour in this figure legend, the reader is referred to the Web version of this article.)

Table 2

Summary of regression models, indicating consistency across all four models. Model 1 is a regression of tent categories against temperature values. Model 2 added ambient temperature as a covariate to model 1. Model 3 added binary time classification (day/night) to model 2. Model 4 modified the binary time classification in model 3 into finer chunks of 4–5 h.

	Model 1		Model 2		Model 3		Model 4	
	estimate	p-value	estimate	p-value	estimate	p-value	estimate	p-value
Intercept	39.462	0.000	−11.858	0.000	−2.410	0.000	32.45	0.000
Aluminum foil	0.083	0.807	0.083	0.615	0.083	0.540	–	–
Mylar	0.234	0.490	0.234	0.154	0.234	0.083	–	–
Sunbrella	2.358	0.000	2.358	0.000	2.358	0.000	–	–
Tarp	2.464	0.000	2.464	0.000	2.464	0.000	–	–
Bedsheet	1.105	0.001	1.105	0.000	1.105	0.000	–	–
Ambient T_{air}	–	–	1.350	0.000	1.023	0.000	–	–
Classification	–	–	–	–	5.010	0.000	–	–
Ambient T_{air} :classification	–	–	–	–	–	–	–	–
Classification D1	–	–	–	–	–	–	8.37	0.000
Classification D2	–	–	–	–	–	–	15.87	0.000
Classification D3	–	–	–	–	–	–	13.44	0.000
Classification N1	–	–	–	–	–	–	3.25	0.000
AIC	35,015		0.770		25,463		29,041	
R [2]	0.021		0.770		0.845		0.69	
AdjR [2]	0.020		27,503		0.845		0.69	

AIC = Aiken Information criterion; R^2 ; AdjR [2] = Adjusted R-squared.

a need for local authorities and welfare associations to reconsider how and when tents are used, as well as perform further testing to assess the entire heat exposure situation more holistically (i.e., integrating solar radiation, wind speed, and humidity into the heat exposure assessment) [40].

The uncovered tent offered cooler thermal conditions based on air temperature exposures compared to those with shade for combined D&N and nighttime. Conditions particularly worsened when using the

tarp (the most commonly used form of shade on the street, yet potentially the most hazardous), bedsheet, or sunbrella. Thus, results do not support using tents and tent covers as a mechanism to reduce daytime air temperature exposure. Although there is no other study, to our knowledge, that has examined tent cover impact on T_{air} , a study of stroller coverings was completed during warm weather in Australia [41]. These researchers found that in-stroller temperatures were substantially higher by draping a dry blanket or flannelette cloth, often used

for shade, over the stroller, thus worsening conditions for an infant. Including airflow and evaporative cooling was suggested to protect infants during hot weather. Thus, in a similar sense, although the tent covers provide shade to reduce sun exposure, the covers also result in lowered airflow, a build-up of water vapor, and an inability for long- or short-wave radiation to escape the tent. These findings may be crucial to consider for rescue missions and by local governments, public health officials, and general donors from the public to avoid adding cover materials during the summer that may worsen heat vulnerability for the unsheltered. Future research could evaluate the optimal strategies for heat protection during extreme heat which could involve a combination of well-ventilated daytime shade (tarps, trees) and, if possible, intermittent access to climate-regulated indoor areas or large, cooled, reflective tent shelters with adequate airflow. Allowing heat to escape tents through minimizing covers and opening tent windows and doors to avoid trapping heat and moisture will support cooling. However, future research must incorporate solar radiation and wind flow to assess the entire heat exposure situation (i.e., integrating solar radiation, wind speed, and humidity). Furthermore, experiments that allow the opening of tent doors and in-tent mixing of air are crucial for the overall evaluation of the efficacy of tent shading. Also, the housing-first response model guarantees protection against the extreme summer heat. Policies and guidelines related to heat vulnerability should be reviewed periodically, based on science, to ensure that heat mitigation efforts do not further marginalize the most vulnerable, such as those experiencing unsheltered homelessness.

A limitation of our study is that we used an identical series of tents; an opportunity lies in examining different tent designs across the shading materials to establish the relationships between the various configurations. Further, incorporating qualitative data detailing the attitudes and perceptions of people experiencing homelessness and public health practitioners about the use of tents and tent covers could enrich future studies.

5. Conclusion

Homelessness is both a driver and a consequence of poor health, and such populations have limited capacity to moderate their heat exposure translating to amplified heat mortality compared to the general population. This study evaluated the effectiveness of different tent cover materials used by homeless individuals for shade, personal space, and to safeguard themselves against extreme heat exposure in the summer. We established that any enclosed tent can increase daytime temperature exposures relative to the ambient air temperature and that additional tent covers for shading are associated with a higher daytime in-tent air temperature relative to a non-shaded control tent. These findings are crucial for implementing public health strategies concerning heat vulnerability, especially among people experiencing homelessness. Therefore, using tent covers as a mitigation measure may exacerbate the heat risk of the unsheltered homeless. Removing the shade covers from the tents at night would support heat removal from the tent via long-wave emission and airflow. This study supports the evaluation of heat mitigation and adaptation efforts to avoid unintended consequences of maladaptation and propagating further marginalization of the most at-risk groups. Rising global temperatures in tandem with a growing number of individuals experiencing homelessness are central public health challenges, and policy and research efforts should address these two public health concerns toward attaining health equity. Heat vulnerability policies and guidelines should be reviewed periodically to reflect research findings about the most effective passive personal heat reduction interventions. Future studies could incorporate solar radiation measurements and a mixed-method approach, where qualitative data about attitudes and perceptions about the use of tents and tent covers by people experiencing homelessness or local government officials could be captured. Testing multiple tent designs in the future could inform whether in-tent temperatures are dependent on tent design.

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Author statements

The development of the paper was a collaborative effort among the three authors, with contributions for all aspects of the paper being shared: Conceptualization, Jaime, Jennifer, and Joseph; Fieldwork, Jaime, Jennifer, and Joseph; Analysis, Joseph and Jennifer; Writing, Joseph, and Jennifer; Writing, Review and Editing, Jaime, Jennifer, and Joseph. All the authors have read and agreed to the submitted version of the manuscript.

Statement of ethical approval

Ethical approval was not required for this study, as the experimental set-up did not involve human or animal subjects.

Declaration of competing interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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Appendix A. Supplementary data

Supplementary data to this article can be found online at <https://doi.org/10.1016/j.puhip.2023.100450>.

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EXHIBIT “10”

CANADA

'Frustrating and deadly': How the extreme cold is hitting Canada's homeless

By **Naomi Barghiel** • Global News

Posted January 18, 2024 1:39 pm ▾

6 min read

Many Canadians are bundling up for warmth during this week's cold snap. But with unsafe conditions in shelters and encampments, many experiencing homelessness have nowhere to go but outside. Advocates say urgent action is needed, but is enough being done to get there? Naomi Barghiel reports – Jan 18, 2024

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Every day outreach worker Greg Cook tries to connect dozens of **homeless** Torontonians with one of the city's busy shelters, mostly, he says, without success.

Those efforts become even more difficult during weeks of freezing cold temperatures, when demand is highest but access to resources remains low.

Sometimes, Cook says the people he is trying to help die before they find a safe place to stay.

"It is definitely hard at times. Frankly, one of the things I find hardest, having done this for quite a while, is to see kind of big picture how much things are getting worse every year. It just feels bleak," said Cook, who works for Sanctuary Toronto and on the steering committee for the Shelter and Housing Justice Network.

Toronto has one of the largest shelter systems in the country, and yet shelters turned away almost 200 people every night due to a lack of capacity in December, according to data from the city's Shelter System Requests for Referral page.

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Even though demand for a shelter spot is through the roof, Cook says many will still choose to stay out in the cold to avoid overcrowding and violence that has become the norm in many shelters.

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With most warming centres closed after a certain hour of the day as well, many end up seeking warmth wherever they can, such as in buses, subways and cafes.

Some in encampments, outside of Toronto as well, are using space heaters and propane tanks to stay alive despite safety risks. One man was found dead in a tent at a homeless encampment in Edmonton earlier this month following a propane tank explosion. Soon after, the city declared a housing and homelessness emergency.

Toronto advocates and officials also sounded the alarm by declaring a homeless emergency last winter, but Cook says even that didn't spark much action.

"It's frustrating and frankly deadly for people who are outside," said Cook.

2:30

► Cold snap heats up concerns about homelessness in Peterborough

This year, Toronto added a number of action items to its Winter Services Plan that includes 180 new spaces in the shelter system. But it still expects demand to rise throughout the winter season due to insufficient affordable housing, the increasing cost of living and low wages.

Cook says these factors are all too real, and have had grave consequences for the homeless population.

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"I've been an outreach worker for almost 15 years (and) I see the waitlist for social housing just increase exponentially every year. Now, in a place like Toronto, the wait is 10 years, and many people I know die in that interim," he said. "So when somebody says 'I need housing, I'm on disability pension, I'm only able to get a minimum wage job,'... for many people, it's a death sentence."

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2 : 13

 High demand for extreme weather shelters in B.C.

Extreme cold warnings have been issued in many parts of the country this past week. Most provinces issue a warning when the temperature or wind chill is expected to reach -30 degrees Celsius for at least two hours.

The territories are not exempt from the country's homelessness crisis either, and have already issued extreme cold weather alerts this winter for temperatures reaching -50 degrees.

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Research led by St. Michael's Hospital in 2019 found that while extreme cold temperatures increase risk of hypothermia, most cases of severe injury

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death related to the cold occur in moderate winter weather, which is much more common.

Homelessness solutions start with 'dignity': housing watchdog

Toronto is only one example of a problem that spans the nation.

According to data from Statistics Canada in 2021, over one in 10 Canadians said they have experienced some form of homelessness in their life. Between 25,000 and 35,000 are homeless on any given night in Canada.

The onset of the COVID-19 pandemic exacerbated a problem already slipping from the country's grasp, leading to higher unemployment, inadequate wages, deteriorating housing affordability and ultimately more homelessness.

The federal government launched a National Housing Strategy in 2017, which is a 10-year, \$72-billion plan promising to end homelessness in Canada by 2030.

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However, multiple advocates and leaders have criticized it for its lack of concrete actions.

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Danielle Smith becomes first Alberta premier in 90 years to face citizen recall



Mississauga considering changes to Ridgeway Plaza amid complaints over noise, crowding



One of those critics is Ottawa's first federal housing advocate, Marie-Josée Houle.

She says certain weather conditions like this week's extreme cold across the country expose systemic problems that exist year-round.

1 : 40



Why Canada's in a cold snap despite El Niño

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"The fact that we have encampments in Canada means it's just a physical manifestation of exactly how broken our housing and homelessness system is," said Houle. "It not only is a violation of people's human right to housing, but a lot of other human rights, including security and dignity of the person."

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Houle says she understands adequate housing isn't built overnight, but until homes become available, governments have the obligation to work directly with people in encampments to meet their needs and ensure their safety.

Raiding encampments and forceful encampment evictions achieve the opposite outcome of what Houle is advocating for. She says police's "militaristic approach" and "declaration of war" on people in encampments "is not working."

5133

1 : 54

► Why do so many homeless resist going to shelters in Edmonton?

Last week, Edmonton clean-up crews and officers dismantled seven out of eight of its homeless encampments deemed high risk by the city and police. Personnel at the eighth encampment were met with resistance from residents and advocates, which led to multiple charges and arrests for assault.

Police said they are aware that dismantling has often led to displacement, but they are working on ways to “incentivize people to look elsewhere.”

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Except, many still end up out in the cold. The conditions in shelters across the country aren't much better. Houle says each municipality has different i

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but the lack of safety in shelters is a key, universal factor.

Reports from The Canadian Press in 2019 found that the number of violent incidents in Toronto shelters alone had more than tripled during the pandemic, partially driving an increase of outdoor encampments.

“There are reasons why people are choosing to sleep out in the cold, to be subject to police brutality, to harassment by the public, by bylaw officers. The risk of sexual violence, being robbed, and of physical violence also happens in shelters,” Houle said.

“The solution to encampments isn’t shelters, it’s homes.”

While municipalities have largely been saddled with the complex issue of encampments, Houle says it’s time that the federal government takes leadership.

“(Municipal councils) are not equipped to deal with encampments appropriately and they need support. You need leadership on this... which has to come from the federal government because it’s a national issue,” she said.

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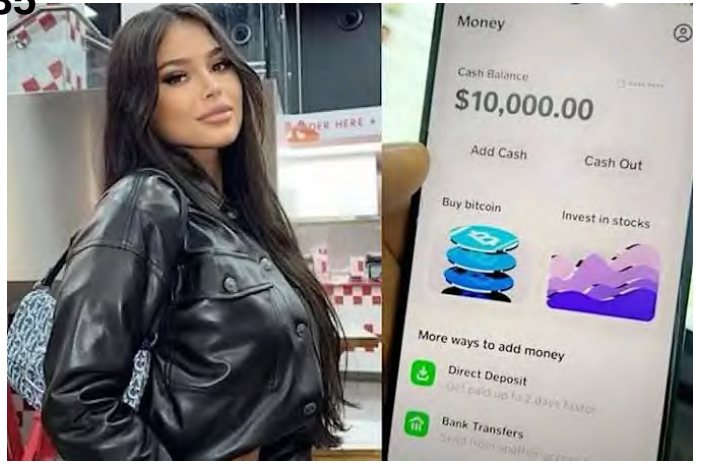
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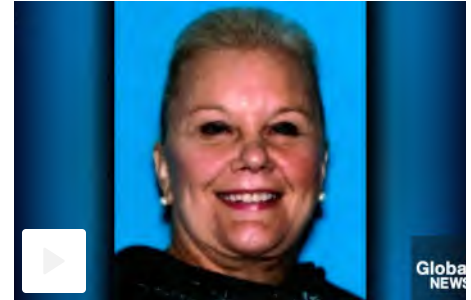
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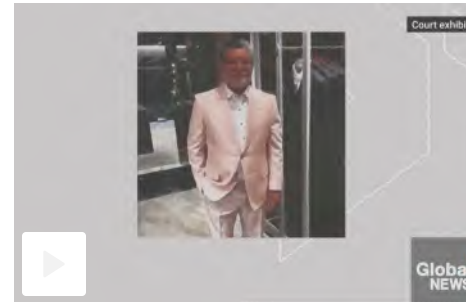
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EXHIBIT “11”



Homeless People Face Hypothermia Every Winter. Here’s How You Can Help

BY [ABBY LEE HOOD](#) | NOVEMBER 18, 2020 | [COLD WEATHER](#) | [AWARENESS](#) | [CORONAVIRUS](#)



One of the most concerning realities for homeless individuals living outdoors or who have unstable living conditions is hypothermia. [Hypothermia can set in](#) even at moderately warm temperatures in certain conditions. But living outdoors means homeless individuals often face far worse than moderate cold.

Jeremy Nicholls, program manager for the single men's and family shelters at Cornerstone Community Outreach, said hypothermia is a major threat for community members in unstable living situations. CCO is based in Chicago, which in 2017 reached record-breaking cold stretches below 20 degrees Fahrenheit for days. At least [two days wind chills](#) were between -25 degrees and -40 degrees Fahrenheit.

Nicholls shared several experiences working with homeless individuals affected by frostbite and hypothermia with *Invisible People*. One man Nicholls has known for years through CCO recently asked him for a dollar when they met on the street. As Nicholls gave it to him, he noticed the man no longer had fingers on his right hand. When he asked the man what happened, he replied simply, "frostbite."

Nicholls also spoke of a CCO community member who had puffy fingers as long as Nicholls knew him. Nicholls said the shelter once called an ambulance for the man after worrying he was succumbing to hypothermia. Since then, he has been in a nursing home and his fingers have returned to normal size.

"He's housed and looking great," Nicholls said.

In the summer, CCO acts as a cooling center for unhoused people. For the long, Midwestern winters, the facility adapts to become a warming center.

Shelter workers continue outreach, picking people up and transporting them to shelter, giving out supplies and coats, and even train cards so more people have access to transportation.

Nicholls said COVID will greatly impact the shelter's ability to help people this winter. Social distancing is difficult in tight spaces, like a cafeteria, and many seeking shelter at CCO are older and immunocompromised.

"With COVID and the need for social distancing, I don't know how we're going to be able to tackle this," Nicholls said. "We'll have the supplies to help and prevent, but space will be/is an issue."

However, Nicholls said community members can intervene in hypothermia cases and support shelters and homeless individuals. Winter donations of socks, hand-warmers, feet warmers, gloves, coats, boots, either to shelters or directly to homeless individuals, can help, as can buying people coffee and a warm meal. Nicholls also said if you see someone showing signs of hypothermia, like shaking uncontrollably, and have no way to warm them up, the best solution is to call 911 immediately.

Signs of hypothermia include:

- Shivering
- Exhaustion
- Confusion
- Fumbling hands
- Memory loss
- Slurred speech
- Drowsiness
- In babies, low energy and bright red skin can also be symptoms.

The most vulnerable populations include homeless people, elderly people and babies.

How to Help in Cases of Suspected Hypothermia

To help a person with hypothermia, the first step is getting the person to a warmer room or location. Remove any wet items of clothing they may be wearing. Warming should focus on the center of the person's body, which could include extra jackets or heated blankets. Warm drinks can also help (alcohol-free) and drinks should never be given to an unconscious person. If a person isn't conscious or doesn't seem to respond to warming, call emergency responders immediately.

In severe cases like those Nicholls described, frostbite can set in. Frostbite usually results in loss of feeling and color in the extremities, like fingers and toes. If left long enough, individuals can lose fingers, toes, or even limbs. Numbness and waxy skin are signs of frostbite and require immediate medical attention.

Hypothermia and frostbite are serious, and they're also widespread.

[According to the National Center for Biomedical Information](#) (NCBI), 25% of all hypothermic injuries and 20% of hypothermic deaths were attributed to individuals experiencing homelessness. The NCBI also states that a New York study reported a similar proportion of deaths and hospital admissions among individuals who were homeless. Mirroring Nicholl's experience with vulnerable homeless adults, the [National Health Care for the Homeless Council](#) reports that the average death of a homeless person is around 50 years old.

As winter gets closer, hypothermia will only add to the long list of problems unhoused individuals face. *Invisible People* previously covered the ways [COVID anxiety and seasonal depression](#) negatively impacts people with unstable living conditions. Left untreated, hypothermia and frostbite have serious consequences, and can even cost a homeless individual their life.

While advocates and workers like Nicholls offer help as they can, it's possible you may also encounter a homeless individual suffering from the cold. In that case, intervention is paramount. It's important for all communities to be ready to spring into action. It could save a life.

Abby Lee Hood



Abby Lee Hood is a queer, Nashville-based writer who lives with their three-legged cat and hedgehog. They write about justice and niche cultures. From time to time, they enjoy playing the fiddle or roller skating and is working on their debut novel.

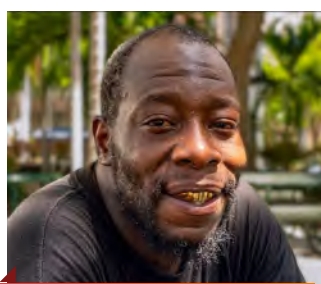
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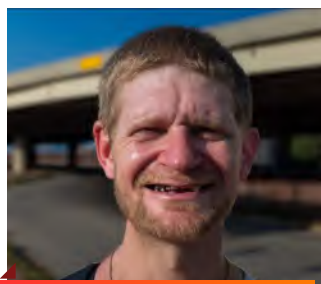
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EXHIBIT “12”

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Trench Foot

Jeffrey S. Bush; Trevor Lofgran; Simon Watson.

Author Information and Affiliations

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Continuing Education Activity

Trench foot is one of three subclasses of immersion foot, which are differentiated by the temperature of the exposure. Trench foot is caused by prolonged exposure to a cold temperature that is usually above freezing and damp, sometimes unsanitary conditions. The condition ultimately causes skin and tissue breakdown which increases the risk of infection and increases associated morbidity and mortality. This activity reviews the evaluation and management of trench foot and highlights the role of interprofessional team members in collaborating to provide well-coordinated care and enhance outcomes for affected patients.

Objectives:

- Describe the signs and symptoms of trench foot.
- Identify the population at risk for developing trench foot.
- Explain the management and treatment of trench foot.
- Outline the importance of improving coordination among the interprofessional team to enhance care for patients affected by trench foot.

[Access free multiple choice questions on this topic.](#)

Introduction

Trench foot is one of three subclasses of immersion foot and is considered a non-freezing cold injury (NFCI). It is often differentiated by the temperature of the exposure and is caused by prolonged exposure to cold but usually not freezing, damp, and sometimes unsanitary conditions. The condition will ultimately cause skin and tissue breakdown which increases the risk of infection and raises the morbidity and mortality.[1][2][3]

Etiology

Many soldiers during World War I had trench foot. Starting in 1914, trench warfare was a common strategy on the European front. During this time, the soldiers found themselves standing in waterlogged trenches at the front for long periods of time and were subjected to wet, cold, and muddy conditions. In the winter between 1914 and 1915, it is reported that over 20,000 British troops were treated for trench foot. Furthermore, it is estimated that trench foot contributed to the deaths of 2000 American and roughly 75,000 British soldiers. Interestingly, trench foot was first described in 1812 while Napoleon's army was retreating from Russia. Dr. Dominique Jean Larrey, a French army surgeon, was the first clinician to describe the condition. Although the prevention of trench foot is relatively straightforward and widely known, as recently as 1982, the British Army dealt with the condition during the Falklands War.[4][5][6]

Epidemiology

Military personnel continue to be most commonly affected population [7]. Recently, clusters of cases have been described in the civilian population during large, multi-day, music festivals where the conditions are conducive to causing the disease. In everyday clinical practice, the homeless population is also susceptible to trench foot due to lack of shelter and prolonged exposure to moist and cold environments.

Pathophysiology

Unlike frostbite, trench foot can occur without freezing temperatures. The feet can be affected in temperatures up to 16 C (60 F), and the disease can develop in as little as 10 to 14 hours.[8] With the addition of moisture to the above environmental conditions, destruction and deterioration of the capillaries can lead to degradation of the surrounding tissue. The pathophysiology is thought to be due to varying vasoconstriction and vasodilation resulting in local tissue damage.[9] Hyperhidrosis (excessive sweating) can also be a contributing factor to the development of trench foot.

History and Physical

Trench foot often begins with a tingling, itching that can progress to numbness. In the setting of cold exposure, vascular changes resulting in poor blood flow can result in the feet becoming erythematous or cyanotic. In later stages as the extremity is rewarmed hyperesthesia is often noted.[10] With prolonged exposure and poor care they may have an odor of decay if necrosis has started to set in. Significant swelling can occur, and there are some descriptions that the feet can double in size due to the edema. The disease has been known to commonly affect the heels or toes, but can extend above the foot. The skin can appear blotchy, and as the disease progresses, blisters and open sores can occur which can lead to fungal as well as bacterial infections. As the disease continues to advance, skin and tissue may slough off. If the condition is left untreated, gangrene can set in. At this point, amputation may be needed to avoid further progression of the disease and other complications such as sepsis and death. When trench foot is identified and treated early, complete recovery is expected; although, there can be a significant amount of temporary pain when sensation returns to the affected area.

Evaluation

The diagnosis of trench foot is entirely clinical. One must first identify the situations where it occurs, and a good physical examination is paramount. Underlying infections must be ruled out so a white blood cell count might be indicated. Inflammatory markers such as a C-reactive protein (CRP) or erythrocyte sedimentation rate might prove helpful, as will a radiograph or bone scan if underlying osteomyelitis is suspected.

Treatment / Management

By keeping the feet warm, dry, and clean, trench foot can be avoided. During World War I, the institution of regular foot inspections was found to decrease the incidence of the disease. The soldiers were paired up and were instructed to watch the feet of their partner. It was found that a soldier was more likely to remove his boots and dry his socks and feet if he was reminded to do so by his fellow soldier. After thousands of cases were seen, soldiers were ordered to have 3 pairs of socks with them at all times and were told to change rotate the pairs at least twice a day. Whale oil was also provided to the soldiers to rub on their feet after they were dry to help

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prevent trench foot. Historically, a battalion (up to 1000 men) at the front in World War I, could use up to 10 gallons of whale oil on any given day. To help prevent trench foot, wooden boards, known as duckboards, were used to cover the wet, muddy, cold ground in the trenches. Troop rotation was also used to limit an individual soldier's exposure. As World War I progressed, the incidence of the disease declined due to the measures mentioned above.[11][5][12]

The best treatment for trench foot is prevention. Some of these methods are outlined above. It was critical that soldiers changed their socks frequently and made sure their feet were dry to avoid the condition. During World War I, as the understanding of the disease progressed, the treatment of trench foot also evolved. Early on, bedrest was recommended, and the application of numerous different agents was tried at one time or another. Among these included a mixture of lead and opium, alcohol of different types, mercuric chloride in alcohol, tincture of iodine, oil of wintergreen, picric acid, and chloral hydrate mixed with camphor. Some powders were also used including boric acid, starch, zinc, and salicylic acid. Radiant heat, complex methods of massage, and even different types of electrical stimulation were tried in treating trench foot when the initial treatments failed. However, once the disease progressed to a severe case, the mainstay of treatment was surgical, similar to the treatment of gangrene. Many times, the patient ended up with an amputation.[13]

Current treatment recommendations are with slow passive rewarming of the affected extremity with adequate pain control with amitriptyline or other modalities for neuropathic pain.[10][8] It is important to assess for signs of hypothermia and to remove the affected extremity from any inciting environmental causes.

Differential Diagnosis

A good history and physical should allow a clinician to differentiate trench foot from frostbite, cellulitis, and other localized processes.

Prognosis

Today, trench foot is usually identified early, and the treatment is very straightforward. Keeping the feet dry and warm is imperative. Rest and elevation of the affected foot are encouraged since this will help prevent new wounds and blisters. NSAIDS will help with any discomfort the patient is having and will also help to alleviate the swelling. If the patient cannot take NSAIDS, then acetaminophen or aspirin will help with the pain but may not help with the swelling. According to the Center for Disease Control and Prevention (CDC), the prevention and treatment of trench foot are straightforward, and their recommendations are as follows:

- Take off socks
- Avoid wearing dirty socks to bed
- Wash the affected area right away
- Dry feet completely
- Apply heat packs to the area for up to 5 minutes

If the above measures do not help the condition, then the CDC recommends further evaluation by a clinician.

Complications

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Complications are uncommon and typically the result of inappropriate care. Soft tissue skin infections such as cellulitis or gangrene are possible in later stages of presentation and should be managed with appropriate antibiotics or antifungal treatments. Subacute or chronic neuropathic pain is more common and can be managed with various modalities to treat neuropathic pain.[8] In rare circumstances and if not managed/treated appropriately permanent sensory changes may be seen and or amputation may be required.

Deterrence and Patient Education

Patients should be educated in the identification of non-freezing cold injuries and associated risk factors. Recommendations should include smoking cessation, proper hydration and proper foot care as outlined above. Patients should also be instructed to avoid alcohol, vasoconstrictive medications and caffeine. [14]

Enhancing Healthcare Team Outcomes

Trench foot is usually managed by an interprofessional team that consists of an emergency department physician, nurse practitioner, vascular surgeon, internist, orthopedic surgeon and an internist. Once the diagnosis is clinically made, the treatment is urgent. The foot must be kept warm and dry. Many oils have been recommended to protect the skin and underlying tissues but no evidence supports the use of one treatment oil over another. If the foot is warm, talcum powder can be used. Radiant heat can be used to keep the foot warm. Since the skin is fragile, manipulation and massage should be avoided. The foot should be regularly assessed for infection and gangrene. Recovery occurs in most mild cases, but it is prolonged. In severe cases of trench foot, amputation may be the only option. [15](Level V)

Review Questions

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Figure

Trench Foot Contributed by Mehmet Karatay (CC by 3.0
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EXHIBIT “13”



Chronic Physical Health Conditions Among Homeless

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Chronic Physical Health Conditions Among Homeless

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Chronic Physical Health Conditions Among Homeless

Abstract

ABSTRACT

Objective: Morbidity and mortality among homeless individuals is higher than the general population. This study aims to determine the prevalence of current self-reported, chronic physical health conditions in a large sample of homeless people with sub-samples from shelters and street in British Columbia, Canada. **Methods:** Cross-sectional survey applying modified version of the 'National Survey of Homeless Assistance Providers and Clients (NSHAPC)' questionnaire in multiple sites in Vancouver, Victoria and Prince George, British Columbia, Canada. **Sample:** Five hundred homeless individuals were surveyed between May and September of 2009. A person was defined as homeless if he/she had a self-identified living status of being without permanent housing prior to study entry for a minimum duration of one month. The main outcome measures were prevalence rates of self-reported chronic physical health conditions. A chronic physical health condition was defined as a condition, expected to last or had already lasted 6 months or more, which had been diagnosed by a health professional. **Results:** The most commonly self-reported, chronic, physical health condition in this group of homeless participants was history of head injury with subsequent loss of consciousness, dizziness, confusion, or disorientation (63.6%) followed by back problems (38.8%), chronic hepatitis (34.6%), migraine headaches (29.2%), and arthritis (28.4%). Chronic obstructive lung disease was reported by 15.8% of the participants, and high blood pressure by 15.6%. 7.6% indicated they were HIV-positive and/or had AIDS. **Conclusion:** Homeless people have a high prevalence of chronic physical health condition, in the following areas: neurological, musculoskeletal, infectious and respiratory diseases. Precarious living conditions and housing, poor nutrition, psychosocial stress, smoking, and substance use are among common detrimental risk factors for many of these conditions.

Keywords: chronic disease, homeless, HIV, Hepatitis C, back pain, physical health

Keywords

chronic disease; homeless; HIV; Hepatitis C; back pain; physical health

Cover Page Footnote

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Chronic Physical Health Conditions among Homeless

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Conclusion: Homeless people have a high prevalence of chronic physical health condition, in the following areas: neurological, musculoskeletal, infectious and respiratory diseases. Precarious living conditions and housing, poor nutrition, psychosocial stress, smoking, and substance use are among common detrimental risk factors for many of these conditions.

Keywords: chronic disease, homeless, HIV, Hepatitis C, back pain, physical health

INTRODUCTION

Homelessness is an escalating global challenge especially in metropolitan areas. Absolute homelessness is defined as a living situation without physical accommodation and individuals described as being absolutely homeless often sleep outdoors, in emergency shelters or at other places not meant for human habitation (Stephen W. Hwang, 2001). Within developed countries, homelessness rates at a given time are now approximated to be near 1% of urban populations (Turnbull, Muckle, & Masters, 2007). Many efforts have been dedicated to calculating the magnitude of homelessness in Canada. One of the most recognized figures emerged from the 2001 Canadian Census, in which the size of the homeless population was reported at over 14,000, which likely is an underestimation of the actual number of homeless individuals (Patterson, Somers, McIntosh, Shiell, & Frankish, 2008).

The number of homeless people in Canada has grown in the last decade, as a result of many factors that involve Canada's urbanization practices (Frankish, Hwang, & Quantz, 2005). Recent data from a March, 2013 Ipsos Reid poll –A poll conducted by Canadian arm of the global Ipsos Group-suggests that as many as 1.3 million Canadians have experienced homelessness or precarious housing at some point during the past five years (Gaetz, Donaldson, Richter, & Gulliver, 2013). In 2007, the BC Ministry of Health assessed the number of inadequately housed people between 17,500 and 35,500 in British Columbia (Patterson, et al., 2008).

A clear association between homelessness and poor physical health has been recognized (Turnbull, et al., 2007). Homeless persons are at higher risk for morbidity and mortality, in comparison with the general population (Stephen W Hwang, Wilkins, Tjepkema, O'Campo, & Dunn, 2009; O'Connell, 2005) with higher prevalence rates of chronic physical health conditions including infections, such as tuberculosis, HIV/AIDS, hepatitis, respiratory infections, and skin infections (Grangeiro et al., 2012; Khandor et al., 2011; Plevneshi et al., 2009; Ryan, 2008; Tan de Bibiana et al., 2011; Tyler et al., 2013; Vahdani, Hosseini-Moghaddam, Family, & Moheb-Dezfouli, 2009; Wiersma et al., 2010). Noninfectious diseases such as chronic obstructive lung/pulmonary disease, unintentional injuries, cardiovascular diseases, musculoskeletal disorders, seizure disorders and cancer also greatly affect this population's physical health status (Brown, Kiely, Bharel, & Mitchell, 2013; Crowe & Hardill, 1993; Kaldmae et al., 2011; Page, Thurston, & Mahoney, 2012; Snyder & Eisner, 2004; Topolovec-Vranic et al., 2012). Consequently, adverse health conditions can contribute to the commencement of homelessness, while poor living standards exacerbate the poor health status (Frankish, et al., 2005). Poor health in homeless individuals can be aggravated further by the many barriers to accessing primary health care services, such as lack of transportation to health care facilities, access to regular family doctors and the exposure to stigmatized attitude of some health care professionals (Khandor, et al., 2011).

The BC Health of the Homeless survey (BCHOHS) was conducted to provide a detailed and accurate description of self-reported, physical health conditions among a large sample of 500 homeless people in British Columbia as planning framework for this high need population.

METHODS

Study design and population

Detailed description of sampling procedure has been presented elsewhere (Torchalla et al., 2011). In brief, this study is a cross-sectional survey sampling homeless adults 19 years of age and older recruited between May and September of 2009, from multiple sites in three cities in British Columbia, Canada: Vancouver, Victoria, and Prince George. For this study, homelessness was self-identified as living, at least within the last month, in a shelter or on the street, outdoors and in abandoned and public buildings, subways, and vehicles. Individuals living in precarious housing (e.g. single hotel rooms, substandard homes) and institutions (e.g. jails/prisons, residential treatment facilities, domestic violence centers) were excluded from the study.

Fifty percent of participants were recruited from emergency shelters and 50% were recruited from living homeless on the streets. Purposive sampling recruited a significant proportion of women, Aboriginal people, and young people, subpopulations of homeless individuals that are often underrepresented in surveys.

Two hundred females and 299 males were recruited in 2009. People who did not fulfill the inclusion criteria of homelessness, who were unable to communicate in English, and/or who were unable or unwilling to give informed consent were excluded.

Each participant received \$30 for participating in research. The Behavioral Research Ethics Board of the University of British Columbia and the Providence Health Care Research Institute approved this study.

Eligible individuals interested in participation were then provided with the goals and rationale of the study and requirements for participation. Those who were able and willing to give written informed consent attended a one-session, face-to-face, structured, clinical interview. Research team members trained in survey conduction administered the survey to each participant. This usually took place in a research office, immediately after recruitment at shelters and streets. Some participants were interviewed at the shelters and drop-in centers where they felt more comfortable.

Survey Instruments

A modified version of the 'National Survey of Homeless Assistance Providers and Clients (NSHAPC) – Health Chapter' a health status instrument that has been validated for use in homeless populations' studies, to assess recent (i.e. last 6 months) and chronic physical health conditions, health care utilization behavior, and barriers to accessing healthcare, was used. Information was assessed with single item and two response options (i.e., yes/no) (Burt, 1999).

Demographic information, including age, sex, marital status, housing situation, education, and self-identified ethnic background was obtained. The presence of self-reported, chronic, physical health conditions was determined by defining the conditions as "long term conditions", which were expected to last or had already lasted 6 or more months and that had been diagnosed by a healthcare professional. Prevalence of a current chronic physical health conditions was determined using the question, "*Do you have any of the following medical condition [diagnosed by a health professional]*" At each body system section, participants were

asked about having specific long-term physical health condition, as well as an open question to specify any other health condition in that category.

Statistical Analysis

All data were entered in Statistical software SPSS version 21.0 for Mac (SPSS Inc., Chicago, IL). Numerical variables were presented as mean (SD), while nominal and categorical variables were summarized by absolute frequencies and percentages.

The prevalence of categories of chronic health conditions was compared in different genders, age group, education level, and housing status using Fisher's exact test. P-value $\bullet 0.05$ was considered significant.

Also, prevalence was compared in different ethnicities using Chi-square test. However, since the nonwhite and nonaboriginal ethnicity subcategory had a very small size, Fisher's exact test was applied to compare each one of ethnicity groups with the other two groups for their reported chronic health conditions. Those chronic conditions with P-Value $\bullet 0.05$ in this stage would be reported as significant prevalent condition for that ethnicity.

RESULTS

Socio-demographic context of the study (Table-1)

Forty percent (n=200) of the participants who completed the study were female. The average age of participants was 37.9 years (SD=11.0) with 15% of the participants being 24 years old or younger.

Table 1- Socio-demographic characteristics of participants in BC Homeless Survey, from May to September 2009

Variable	Number (%) Total Sample N=500
Youth (Age $\bullet$ 24) ^a	75 (15.0)
<u>Gender</u>	
Female	200 (40)
Male	299 (59.8)
Missing	1 (0.2)
<u>Ethnicity</u>	
White	280 (56.0)
Aboriginal	199 (39.8)
Other ^b	21 (4.2)
<u>Current housing</u>	
Street	250 (50.0)
Shelter	250 (50.0)
<u>Education</u>	
Less than high	318 (63.6)
School education	
Married/partnered	49 (9.8)
Common law	

^a Mean Age of the surveyed population + Standard deviation is 37.9 ± 11.0

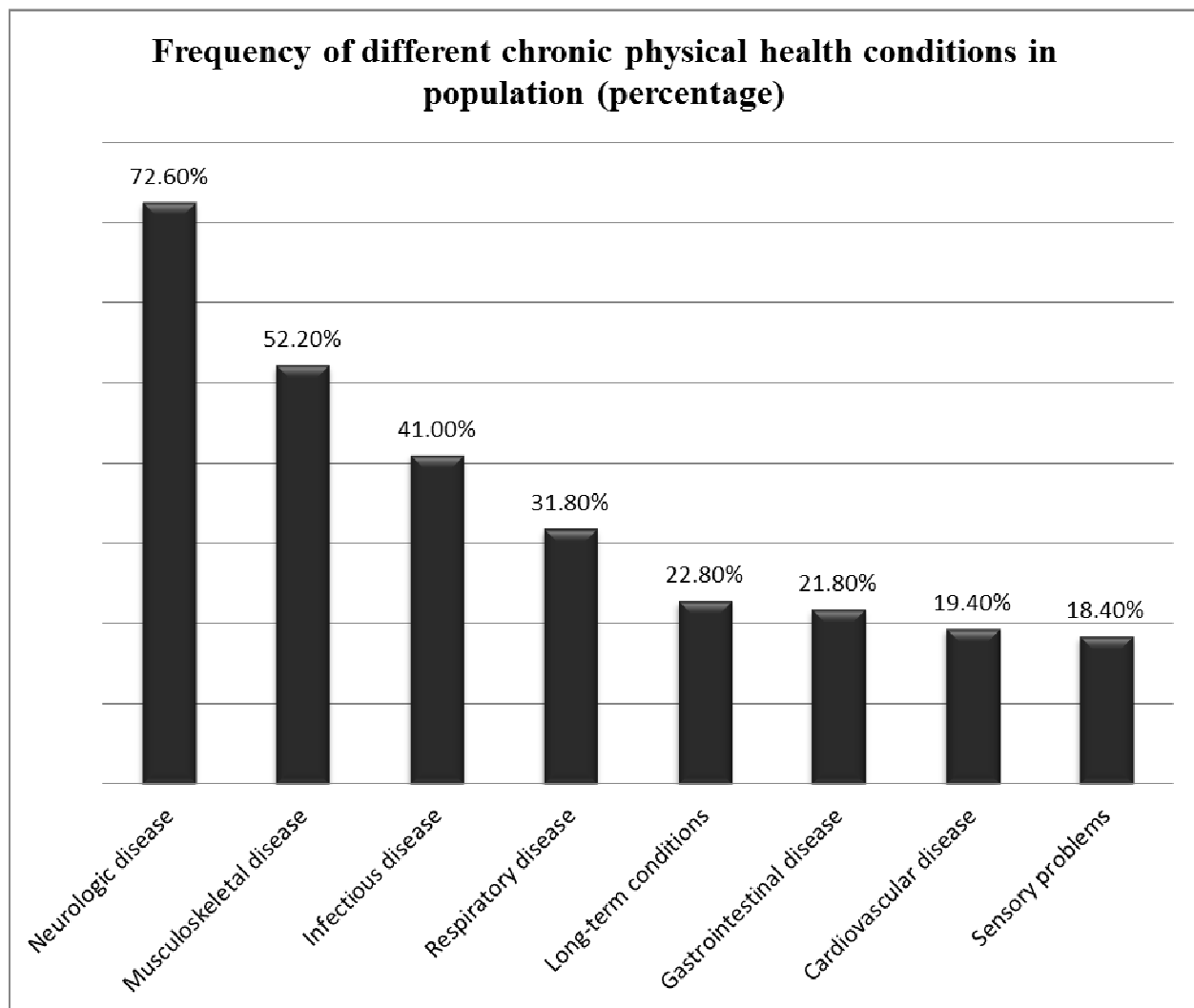
^b includes Black/African (2.2%); Asian (1.2%); Hispanic/Latin American (0.8%); ethnic background was selected as self identified from a list of categories including: European/Caucasian, Aboriginal, African, Asian, Hispanic/Latin American, and Other. The ethnic background classified as "Other", included Black/African, Asian, and Hispanic/Latin American. The participants who self-identified themselves as Aboriginal in this study, represented peoples throughout British Columbia and included: Cree, Carrier, Dene, Gitksan, Sekani, Ojibway, Coast Salish and

Metis.

Prevalence of chronic physical health conditions

Neurological (72.6%, n=363), infectious (47.2%, n=236) and musculoskeletal (41.0%, n=205) conditions were the most common chronic health conditions respectively (Figure 1), affecting homeless people surveyed in BC, in 2009. Prior head trauma/injuries with subsequent loss of consciousness dizziness, confusion, or disorientation were the most common physical conditions affecting 318 individuals (63.6%) followed in frequency by back problems (excluding fibromyalgia and arthritis) in 194 (38.8%) individuals and Hepatitis B/C in 173 individuals (34.6%).

Figure -1-Frequency of self-reported physical health conditions by 500 homeless individuals in BC Homeless Survey, from May to September 2009.



There was a high prevalence of migraine headache (29.2%, n=146) and arthritis (excluding fibromyalgia) (28.4%, n=142) in this population (Table 2).

Table-2- Frequencies and percentages of chronic physical health conditions

Chronic physical health conditions	n (%)
<u>Cardiovascular</u>	97 (19.4%)*
High blood pressure	78 (15.6 %)
Heart disease	16 (3.2%)
Other	22 (4.4%)
Specified as Heart murmur	8 (1.6%)
Not specified	14 (2.8%)
<u>Respiratory</u>	159 (31.8%)
Asthma	114 (22.8%)
Emphysema	19 (3.8%)
Chronic bronchitis	61 (12.2%)
Chronic obstructive pulmonary disease (COPD)	11 (2.2%)
Other and not specified	7 (1.4%)
<u>Gastrointestinal</u>	109 (21.8%)
Cirrhosis (Damaged liver from alcohol or drugs)	30 (6%)
Chronic diarrhea	18 (3.6%)
Intestinal or stomach ulcers	53 (10.6%)
Urinary incontinence	23 (4.6%)
Bowel disorders (Crohn's disease, ulcerative colitis, Irritable bowel syndrome or bowel incontinence)	22 (4.4%)
Other and not specified	11 (2.2%)
<u>Musculoskeletal</u>	261(52.2%)
Arthritis	142 (28.4%)
Back problems, (excluding fibromyalgia and arthritis)	194 (38.8%)
Problems in walking, lost limb, physical Handicap(s)	119 (23.8%)
Other	35 (7.0%)
Specified as "history of fracture"	10 (2.0%)
Specified as Fibromyalgia	3 (0.6%)
Not specified	22 (4.4%)
<u>Infectious</u>	205 (41.0%)
HIV infection or AIDS	38 (7.6%)
Tuberculosis exposure or positive TB test	32 (6.4%)
Hepatitis B or C	173 (34.6%)
Other	11 (2.2%)
Not specified	6 (1.2%)
<u>Neurologic</u>	363 (72.6%)
Epilepsy	17 (3.4%)
Fetal alcohol syndrome or fetal alcohol spectrum disorder	32 (6.4%)
Migraine headaches	146 (29.2%)
History of head injury with resultant	318 (63.6%)
Knock out or at least dizziness, confusion, or disorientation	
Consequences of a stroke	13 (2.6%)

Other and not specified	21 (4.2%)
<u>Sensory</u>	92 (18.4%)
Glaucoma	5 (1.0%)
Cataracts	16 (3.2%)
Hearing problems	67 (13.4%)
<u>Long-term conditions</u>	114 (22.8%)
Cancer	27 (5.4%)
Diabetes	17 (3.4%)
Anemia (poor blood, low iron)	52 (10.4%)
Skin disease (for- example, eczema or psoriasis)	44 (8.8%)
Other	18 (3.6%)
Specified as Thyroid problems	4 (0.8%)
Specified as Hypoglycemia	3 (0.6%)
Specified as Allergy	3 (0.6%)
Not specified	8 (1.6%)

*More than one response to questions in the same category (major organ system) was counted once in calculating the prevalence of the reported physical health condition in each major organ category of questions

Comparing prevalence of chronic physical health conditions for age, gender, ethnicity, education and housing categories (Table 3):

Eighty Nine percent of participants younger than 24 years of age (67/75) reported at least one chronic health condition. However, none of these self-reported categories was more prevalent compared to participants older than 24 years. Comparing for gender and education level, there was no statistically significant difference in the prevalence of reported categories of chronic health conditions. Self-reported neurologic disease and the category of long-term conditions inclusive of Diabetes Mellitus and Anemia were significantly more reported amongst White and Aboriginal ethnicities. Ninety Five percent (189/199) of aboriginal participants reported at least one chronic condition; 17.1 % (34) had one, 22.6% (45) had two and 50.3% (100) had 3 or more chronic health conditions. Also, aboriginal participants had higher frequency of self-reported infectious disease compared to other ethnicities (P-value = 0.03). Participants, who had reported street as their current housing, reported a higher prevalence of neurologic, sensory problems, musculoskeletal, cardiovascular diseases, gastrointestinal, and some other long-term conditions compared to shelter dwellers.

Table-3- Prevalence of categories of chronic health conditions compared for age, gender, ethnicity, education level and housing status.

		Neurologic	Musculoskeletal	Infection	Respiratory	Long-term	Gastrointestinal	Cardiovascular	Sensory
	Number	Number of self reported chronic health condition (%)							
Age									
≤24 (75)	75	53 (70.7)	37 (49.3)	26 (34.7)	27 (36)	9 (12.0)	10 (13.3)	17 (22.7)	15 (20.0)
>24 (425)	425	310 (72.9)	224 (52.7)	179(42.1)	132 (31)	105 (24.7)	99 (23.3)	80 (18.8)	77 (18.1)
P value*		0.68	0.62	0.25	0.42	0.02**	0.07	0.43	0.75
Gender									
Male	300	221 (73.9)	164 (54.8)	123 (41.1)	100 (33.4)	69 (23.1)	71 (23.7)	59 (19.7)	61 (20.4)
Female	200	141 (70.5)	96 (48.0)	81 (40.5)	59 (29.5)	44 (22.0)	37 (18.5)	38 (19)	30 (15.0)
P value*		0.41	0.14	0.93	0.38	0.83	0.18	0.91	0.16
Ethnicity									
White	280	212 (75.7)	149 (53.2)	103 (36.8)	86 (30.7)	60 (21.4)	58 (20.7)	57 (20.4)	53 (18.9)
Aboriginal	199	142 (71.4)	103 (51.8)	94 (47.2)	67 (33.7)	54 (27.1)	47 (23.6)	39 (19.6)	35 (17.6)
Other	21	9 (42.9)	9 (42.9)	8 (38.1)	6 (28.6)	0 (0.0)	4 (19)	1 (4.8)	4 (19.0)
P value [¥]		<0.01	0.65	0.07	0.75	0.01	0.71	0.22	0.93
Education									
Less than high school	318	239 (75.2)	169 (53.1)	124 (39.0)	107(33.6)	76 (23.9)	67 (21.1)	64 (20.1)	58 (18.2)
High school or higher	182	124 (68.1)	92 (50.5)	81 (44.5)	52 (31.8)	38 (20.9)	42 (23.1)	33 (18.1)	34 (18.7)
P value*		0.10	0.58	0.26	0.27	0.51	0.65	0.64	0.91
Housing									
Shelter	250	113 (45.2)	103 (41.2)	103 (41.2)	70 (28.0)	46 (18.4)	44 (17.6)	31 (12.4)	27 (10.8)
Street	250	250 (100)	158 (63.2)	102 (40.8)	89 (35.6)	68 (27.2)	65 (26.0)	66 (26.4)	65 (26.0)
P value*		<0.01**	<0.01**	1.00	0.08	0.03**	0.03**	<0.01**	<0.01**

* Fisher's exact test ¥ Chi-square test ** P value ≤0.05 is considered significant

DISCUSSION

Socio-demographic characteristics

The current homeless population in Vancouver includes sizable number of young adults and women compared to the previously reported populations of single adult males with alcohol and/or substance use (Turnbull, et al., 2007). Hence, a recruitment of 40% women through purposive sampling combined with the reported mean age of 37.9 years (± 11.0) having 15 % younger than 24 years makes this study more comparable to this population. Subsequently it makes it possible to have a better understanding of the specific needs of the usually underrepresented homeless women and youth (Begin, Casavant, & Chenier, 1999; Goldberg & Planning, 2005; Montgomery, Brown, & Forchuk, 2011; Quantz, 2002; Woodward, Eberle, Kraus, & Graves, 2002). Our purposive sampling method recruited 40% aboriginal participants, which concurs with studies indicating high percentage of reported aboriginal ethnicity amongst most Canadian homeless communities (Cardinal & Adin, 2005; Gaetz, et al., 2013; Goldberg & Planning, 2005; Hanselmann, 2001; Stephen W. Hwang, 2001; Quantz, 2002). 63.6% of the participants did not complete high school. Lower formal education has been suggested to be a contributory factor to homelessness (Frankish, et al., 2005; Josephson, 2004).

Physical health conditions

A history of head injury was the most prevalent neurological condition, and the most prevalent overall health condition among this population. Topolovec-Vranic, et al. 2012 systematic review found a higher frequency of traumatic head/brain injury (TBI) ranging from 8%-53% in homeless individuals, as compared to the general population. Two studies assessing the temporal relationship between homelessness and TBI showed the first incidence of TBI occurring before the onset of homelessness for the majority of participants, suggesting that TBI may be a contributory factor for homelessness. It was also suggested that homeless individuals with a history of TBI are more susceptible to subsequent injuries, causing cumulative impacts on cognitive and/or executive function with subsequent cognitive impairment, which in turn may contribute to the chronicity of homelessness (Backer & Howard, 2007; Stephen W Hwang et al., 2008; Oddy, Moir, Fortescue, & Chadwick, 2012; Topolovec-Vranic, et al., 2012). While our study finding is supporting the result of a high prevalence rate for TBI, causal relationship or the timely sequence of homelessness and TBI was not retrievable from the questionnaire used in our sample.

Migraine headaches were the second most prevalent reported neurological condition, congruent with Lee, et al. 2007 (D. F. Lee et al., 2007). History of head or neck injury, stressful life events, low socioeconomic status and depression are among the proposed risk factors for chronic migraine, which are all higher in frequency in the homeless population and therefore can be contributory to the high rate of migraine headaches in the homeless population (Cevoli et al., 2006; Couch, Lipton, Stewart, & Scher, 2007; Scher, Stewart, Ricci, & Lipton, 2003).

Finding musculoskeletal diseases as the second most prevalent reported category with back problems -excluding fibromyalgia and arthritis- as the most common health conditions is congruent with two previous reports (U. Beijer & Andreasson, 2009; van Laere, de Wit, & Klazinga, 2009). A systematic review showed a high prevalence of cognitive deficit, smoking, low education, low income, excessive alcohol consumption, depression and anxiety, as reported risk factors for musculoskeletal complaints in homeless population (Miranda, Vivielle, Machado, & Dias, 2012).

Other frequently reported conditions in our sample were Hepatitis B/C infection, HIV-infection/AIDS, 'Tuberculosis (TB) exposure and/or a positive TB test', in decreasing order of frequency. These findings are in line with a systematic review that reported the prevalence of HCV (3.9-36.2%), HIV (0.3-21.1%), TB (0.2-7.7%) and with the existing evidence on the

prevalence of HBV (3.3%- 34.7%) in homeless population (Ulla Beijer, Wolf, & Fazel, 2012; Brito, Parra, Facchini, & Buchalla, 2007; Moses, Mestery, Kaita, & Minuk, 2002; Vahdani, et al., 2009). Homelessness can be a predisposing factor for both latent and active forms of TB infection. Over-crowding, inappropriate ventilation in shelters and contact throughout large transient populations expose homeless individuals to Mycobacterium Tuberculosis, while malnutrition, alcohol use disorders and – although rare in BC - untreated HIV-infection accelerate progression of latent infection into the active form of the disease (Agustí & Barnes, 2012; Clark, Riben, & Nowgesic, 2002; Tan de Bibiana, et al., 2011). Injection drug use, multiple sexual partners, sex work and inconsistent use of condoms are suggested risk factors for blood born infections-HIV, HBV and HCV (Ulla Beijer, et al., 2012; Brito, et al., 2007; Vahdani, et al., 2009).

Asthma and obstructive lung diseases (COPD) were the main reported respiratory illnesses, congruent with Snyder & Eisner's (2004) study which determined the frequency of COPD to be 15% in the homeless population of San Francisco, California, USA, more than twice in the general US population in 2002 (Snyder & Eisner, 2004). High prevalence rates of smoking, poor nutrition and adverse environmental exposure in the homeless population can contribute to their increased rate of COPD (Agustí & Barnes, 2012; Itoh, Tsuji, Nemoto, Nakamura, & Aoshiba, 2013).

The high rate of asthma agrees with findings of two previous reports showing high prevalence of asthma in adult homeless people in Dublin, 2005, and homeless children in US (Cutuli, Herbers, Rinaldi, Masten, & Oberg, 2010; McLean et al., 2004; O'Carroll & O'Reilly, 2008). This could be the result of a possibly higher rate of respiratory infections, smoking or exposure to second-hand smoke pollution in unfavorable housing condition, all amongst proposed risk factors for asthma (Jie, Isa, Jie, Ju, & Ismail, 2013; Vernon, Wiklund, Bell, Dale, & Chapman, 2012).

Finally, cardiovascular disease, one of the leading causes of mortality in the homeless community, was reported in about 1/5 of surveyed people in this study (Stephen W Hwang, et al., 2009; Page, et al., 2012). Although high prevalence of hypertension in the homeless population has not been a consistent finding, poorly controlled hypertension is a common finding (Kim et al., 2008; T. C. Lee et al., 2005; Oliveira, Pereira, Azevedo, & Lunet, 2012). While emotional stress increases the risk of cardiovascular disease, high frequency of smoking in the homeless population can also augment their cardiovascular-related mortality (Kim, et al., 2008; Kubisová et al., 2007; Oliveira, et al., 2012).

This study evaluated the self-reported frequency of a comprehensive list of chronic physical health conditions in a unique sample of homeless individuals including a significant proportion of women, Aboriginal people, and youth subpopulations of homeless individuals that could often be underrepresented in surveys. Additionally, this unique sample consists of subpopulations of homeless people living in shelter as well as those living on the streets, which add to the generalizability of the reported findings to physical health condition of all the homeless population in general.

Compared to current prevalence of physical health conditions in general population, our survey revealed 2 times more arthritis and back pain, 3.5 times more migraine headaches, 3 times more asthma, 4 times more chronic obstructive pulmonary disease, 38 times more HIV infection, 70 times more chronic hepatitis B or C, 1000 times more Tuberculosis exposure (Bath, Trask, McCrosky, & Lawson, 2014; "Estimates of HIV Prevalence and Incidence in Canada, 2011," 2012; "Health Fact Sheets – Arthritis, 2013," 2014; "Health Fact Sheets – Asthma, 2013," 2014;

"Health Fact Sheets – Chronic obstructive pulmonary disease in Canadians, 2009 to 2011," 2012; Rotermann, Langlois, Andonov, & Trubnikov, 2013; "Tuberculosis in Canada 2012 - Pre-Release," 2014). These findings of high prevalence of treatable chronic health conditions has very strong implications for advocacy, policy making and healthcare provision priority setting as well as service delivery to homeless population regardless of the severity of their homelessness.

Interestingly, reported Diabetes Mellitus (DM) in our survey was half of the reported DM in general population. As well, Cancer was reported one eighth as common as its prevalence in general population in Canada. Meanwhile, the prevalence of hypertension was similar to its prevalence in general population ("Health Fact Sheets – Diabetes, 2013," 2014; "Canadian Cancer Statistics publication," 2013; "Health Fact Sheets – High blood pressure, 2013," 2014). These revealed low prevalence chronic physical health conditions could be a result of lower prevalence of obesity and its metabolic, carcinogenic and atherosclerotic consequences in homeless population. The irony of food instability after all has played some role that is in favor of the vulnerable homeless population.

Factors associated with increased frequency of self-reported chronic health conditions:

A high proportion of youth in our sample (89.3%) reported having one or more chronic health conditions. This is in line with the reported 74% prevalence of one or more chronic medical condition in homeless youth of British Columbia (Goldberg & Planning, 2005). This highlights the significant healthcare needs of homeless youth, which is the fastest growing homeless subpopulation in Canada (Boivin, Roy, Haley, & Galbaud du Fort, 2005; Edidin, Ganim, Hunter, & Karnik, 2012; Frankish, Hwang, & Quantz, 2005).

Comparing for gender, or education level, this study could not find any difference in prevalence of various categories of chronic health conditions. This finding is supported with the study from Los Angeles about 385 male and 144 female homeless participants (L. Gelberg & Linn, 1992). On the other hand, the study of 1,704 homeless from Stockholm; 1,364 males (80%) and 340 female, reported higher risk of diseases of blood, genitourinary system, eye, skin, as well as neoplasm and infections in homeless women. However women were reported to be at lower risk of injury/poisoning, diseases of the circulatory, digestive, respiratory system and ear (Beijer & Andreasson, 2009). This suggests the possibility of finding gender difference in chronic health conditions in a larger population of homeless people.

In this study, 95 % (189) of aboriginal participants reported at least one chronic condition; 17.1 % (34) had one, 22.6% (45) had two and 50.3% (100) had 3 or more chronic health conditions. This shows a significantly higher prevalence of chronic health conditions compared to previous studies on health status of different aboriginal subpopulations in Canada ("Inuit health: Selected findings from the 2012 Aboriginal Peoples Survey," 2014, "Aboriginal Peoples Survey, 2006: An overview of the health of the Métis population," 2006, "Aboriginal Peoples Survey 2001 - Initial Findings: Well-being of the Non-reserve Aboriginal Population, 2001). This indicates the association of homelessness with multiple chronic health conditions.

The three most common chronic health condition categories in aboriginal subpopulation in our study were neurologic (71.4%), musculoskeletal (51.8%) and infectious disease (47.2%). Also, compared to white and non-aboriginal ethnicities, participants with reported aboriginal ethnicity had a significantly higher prevalence of infectious disease. This could be explained by higher vulnerability to infectious disease reported in previous studies in aboriginal population. (Reading, 2009; Ryan, 2008).

Living on streets was associated with increased frequency of all categories of chronic health conditions except infectious and respiratory tract conditions. This is in agreement with

previous studies demonstrating poorer physical health as well as less medical service use by the people living on streets compared to their sheltered counterparts (Lillian Gelberg & Linn, 1989; Nyamathi, Leake, & Gelberg, 2000). Poorer hygiene, more severe malnourishment, more engagement in risky sexual behavior and drug use are possible factors in increasing frequency of chronic health conditions among homeless people living on streets compared to sheltered homeless individuals. Supportive housing programs could play a significant role in improving physical health of homeless population (Stephen W Hwang, Tolomiczenko, Kouyoumdjian, & Garner, 2005).

Limitations:

While including three cities strengthens the reliability of results by not narrowing our scope to only one location, it may limit the generalizability of the findings to homeless populations from other Canadian provinces or countries. Secondly, the self-reported nature of this data introduces reporting bias and recall bias, calling for an objective assessment of the physical health status of the homeless in future studies. Thirdly, selecting a representative sample of the homeless population is always difficult to achieve and possible resultant bias should be considered while interpreting results considering our purposive sampling. Finally, because the aim of this study was to determine the prevalence of all possible self-reported, chronic, physical health conditions in one survey, the questionnaire covered a broadly categorized, all-inclusive but non-exhaustive list of chronic physical conditions. This led to the inevitable formation of categories of physical health conditions, lacking in adequate details and accuracy of diagnosis for the self-reported health conditions. Hence, we suggest that future studies evaluate a more detailed, objective and specific questionnaire, to detect common medical conditions of concern within the homeless population.

CONCLUSION

Neurological, musculoskeletal, infectious and respiratory diseases were frequent self-reported physical conditions among homeless people surveyed. There was a notable prevalence of neurological conditions, especially migraine headache, and also musculoskeletal disorders, in those surveyed. These findings, call for awareness on the part of primary healthcare physicians who are in the first line of treatment. Additionally, the risk factors for many of these conditions, such as precarious living conditions, poor nutrition, psychosocial stress, smoking and substance use, can be addressed towards improving the health status of this population within different levels of the healthcare system.

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Court File No. CV-25-00000750-0000

ONTARIO
SUPERIOR COURT OF JUSTICE

BETWEEN:

THE REGIONAL MUNICIPALITY OF WATERLOO

Applicant

and

PERSONS UNKNOWN AND TO BE ASCERTAINED

Respondents

APPLICATION UNDER Rule 14.05 of the *Rules of Civil Procedure*

This is the Cross-Examination of **Peter Sweeney** on his affidavits dated June 6, 2025, July 2, 2025, July 31, 2025, and September 16, 2025, taken via Zoom video-conference on consent of the parties on December 11, 2025.

APPEARANCES:

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ASHLEY SCHIUTEMA, Ms. Counsel for the Respondents
JOANNA MULLEN, Ms.
SHANNON DOWN, Ms.
CHARLOTTE CAHILL, Ms. Student-at-law

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(i)

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1 DECEMBER 11, 2025

2
3 PETER SWEENEY, AFFIRMED

4 CROSS-EXAMINATION BY MS. DOWN:

5 1. Q. So, good afternoon, Peter.

6 A. Good afternoon, Shannon. How are you?

7 2. Q. I'm good. How are you?

8 A. I'm all good, thanks.

9 3. Q. Good. Before we get into the
10 questions, I just want to confirm that you have a copy
11 of your affidavit. So I think there's four
12 affidavits?

13 A. Yeah. That's all I have in front of me
14 are the four printed out so I can reference them or
15 you can point me in the right direction.

16 4. Q. Okay, and so you're saying you don't
17 have any other documents with you that you're
18 referring to at this time?

19 A. That's correct. That's correct.

20 5. Q. Okay. If you happen to, you know, need
21 access to another document, as long as you just let me
22 know.

23 A. Okay.

24 6. Q. I just want to also confirm that you
25 understand that once we start your cross-examination,

1 that you are not to communicate with your legal
2 counsel ---

3 A. I understand.

4 7. Q. --- while you're -- during the cross-
5 examination. Okay. And that includes if we adjourn,
6 that you're not to communicate with them during the
7 period of time that we're adjourned.

8 A. Yeah, I understand that, too.

9 8. Q. Okay. And yeah, if you need a break,
10 just let me know. But I think we'll just have a short
11 amount of time right now. And then we'll be
12 adjourning and starting again tomorrow because I have
13 to stop at 3:30.

14 A. Oh, okay, that's fine. I only have
15 until 4:00 so I'm in your hands until you're good.

16 9. Q. Okay. So I am going to start with a
17 couple of paragraphs from your third affidavit.

18 A. Great.

19 10. Q. So I'll let you get that in front of
20 you.

21 A. Sure. If you can just tell me the
22 number, the Paragraph number, that would be helpful.

23 11. Q. Yeah, so I am going to start with the
24 Paragraphs 42 and 43.

25 A. I am going to grab my glasses, just to

1 make sure. Can you say that again?

2 12. Q. Paragraph 42 and 43.

3 A. Yes, around Exhibit A, let me just make
4 sure I have Exhibit A which is going to be a municipal
5 document, correct?

6 13. Q. Yes.

7 A. Sorry, hang on.

8 MS. CAHILL: Shannon, would you like me to
9 put that up on the screen?

10 THE WITNESS: No, I've got it. So 42 to 43,
11 Shannon?

12 MS. DOWN: Yeah, that's fine.

13 THE WITNESS: Okay. Sorry.

14 MR. LOKAN: Can I ask --can I ask that it go
15 up. I seem to not have the third affidavit.

16 MS. DOWN: Okay, we can put it on -- we can
17 put the -- you want the affidavit put on the
18 screen?

19 MR. LOKAN: The document from the third
20 affidavit, if you don't mind.

21 MS. DOWN: Okay, sure.

22 MS. CAHILL: Sorry, do you want Exhibit A?

23 MS. DOWN: Yes.

24 MS. CAHILL: Okay.

1 --- SCREENSHARE

2
3 BY MS. DOWN:

4 14. Q. Okay, so you're familiar with this
5 document, Peter?

6 A. I am.

7 15. Q. Okay, and in your third affidavit at
8 Paragraph 42 and 43 ---

9 A. Yeah.

10 16. Q. --- you state that:

11 "... Encampments are not safe or
12 sustainable and should not be
13 understood as a solution to
14 homelessness ..."

15 And you reference the wording in this
16 document as guidance for that statement?

17 A. So I am reading in Section 43, Shannon,
18 a direct quote?

19 17. Q. Yes.

20 A. Yeah, so 42 just points to the exhibit
21 and 43 pulls a quote that I then say on behalf of the
22 Region we agree with. That's what we're talking
23 about?

24 18. Q. Yes.

25 A. Okay. Sure.

1 19. Q. So in that quote, part of that quote
2 states that:

3 "... Encampments do not satisfy the
4 requirements of a human right to
5 housing ..."

6 A. It says, "rarely satisfy" to be
7 accurate.

8 20. Q. Correct.

9 A. Okay.

10 21. Q. Thank you. And so, first of all, I
11 guess we agree based on that statement I think that
12 people have a human right to housing?

13 MR. LOKAN: That's for the court whether
14 there is or isn't a human right and where it
15 comes from.

16 MS. DOWN: Well, I'm asking Mr. Sweeney
17 because he references this and says that the
18 Region agrees with it.

19 MR. LOKAN: What's the paragraph that he ---

20 MS. DOWN: Paragraph 43.

21 THE WITNESS: Forty-three.

22 MR. LOKAN: And what -- I don't have that
23 before me, I'm sorry.

24 MS. DOWN: Well, I can read it to you.

25 MR. LOKAN: That would help, I'm sorry.

1 MS. DOWN: On Page 4 of that document under
2 the heading "Basic principle": the
3 engagement guide explains that "homeless" --
4 and this is in quotes:

5 "... Homeless encampments will
6 rarely satisfy the requirement of
7 the human right to housing and
8 thus should not be understood as a
9 solution to homelessness and
10 should not be permanent.

11 The Region agrees with the
12 NWGHE on this point which is why
13 it does not favour the
14 establishment of an alternative
15 site for the encampment and
16 instead is prioritizing finding
17 suitable alternative shelter for
18 those currently living at the
19 encampment ..."

20 MR. LOKAN: Okay.

21 MS. DOWN: So I am asking Mr. Sweeney to
22 confirm that the Region agrees and that we
23 agree, that people have a human right to
24 housing.

25 MR. LOKAN: I am going to say that that's a

1 question for the courts to determine. But
2 you're free to ask Mr. Sweeney about the
3 establishment of alternatives and what it's
4 prioritizing. And so on and so forth.

5 MS. DOWN: So is he -- are you going to
6 strike that part of his affidavit?

7 MR. LOKAN: This affidavit does not say that
8 there is a human right to housing as a
9 matter of Mr. Sweeney's opinion.

10 MS. DOWN: It seems to say that in this
11 paragraph. It says:

12 "... The Region agrees with the
13 NWGHE on this point ..."

14 And that point being that:

15 "... Homeless encampments will
16 rarely satisfy the requirements of
17 the human right to housing ..."

18 And that:

19 "... Should not be understood as a
20 solution to homelessness ..."

21 I think it's implicit in that,
22 that there is a human right to housing.

23 MR. LOKAN: Well, you can ask him if that
24 statement is -- it's implicit in that
25 statement or not because that statement

1 covers more than one thing.

2 MS. DOWN: Sure.

3
4 BY MS. DOWN:

5 22. Q. So, Peter, when you say in your
6 affidavit the Region agrees with the NWGHE on this
7 point, is it implicit that you agree that human --
8 people have a human right to housing?

9 MR. LOKAN: I am going to -- okay, we'll get
10 his answer on the record first. As you
11 know, there are cases from Ontario Court of
12 Appeal and elsewhere that talk about whether
13 there is or isn't a human right to housing.

14 There's the international law
15 perspective, there's whatever the Charter
16 does or doesn't say. It's not really for a
17 lay witness to get drawn into the human
18 rights debate.

19 MS. DOWN: Okay. My point is that if Mr.
20 Sweeney is relying on this statement as part
21 of his evidence in this hearing, he's making
22 -- he's made an opinion on it already in
23 this affidavit.

24 MR. LOKAN: That's a point I am sure you can
25 argue at the hearing.

1 MS. DOWN: Well ---

2 MR. LOKAN: I said if you want to ask him if
3 he's referring to the first half or the
4 second half or both, then ---

5 MS. DOWN: Okay.

6 MR. LOKAN: --- you can get an answer on
7 record that -- look, it's a question of law
8 for the court. That's my fundamental point.

9 MS. DOWN: Okay, well you've kind of led him
10 to some way of answering it anyways right
11 now, Andrew. So I appreciate that maybe
12 just let me ask my question.

13 MR. LOKAN: If they're not about human
14 rights, absolutely. Go ahead.

15 MS. DOWN: Well if his affidavit references
16 human rights, then I am going to ask him
17 about that.

18 MR. LOKAN: As I said, you can ask the
19 question.
20

21 BY MS. DOWN:

22 23. Q. So, Peter, do we agree that people have
23 a human right to housing based on the statement that
24 you've made in the -- in your affidavit?

25 A. Thanks for the question. Yeah, the

P. Sweeney (Cr.-Ex.) - 12

1 statement that we reference has a couple of points.
2 And I will say certainly the approach that we take at
3 the Region is that we believe that everybody in this
4 community should have a safe place to call home.

5 You know, to my external counsel's comment,
6 I am not technical human rights expert but I do
7 believe that what we are trying to accomplish is to
8 ensure that everybody in this community -- and I've
9 stated that many times -- has a safe place to call
10 home.

11 And that the other part of that quote from
12 the report, that a large encampment such as 100 Vic,
13 given that it's not something that we would -- we
14 would see solve some of the challenges that we know
15 people are facing which is why we are focusing on
16 alternative shelter for those who are currently living
17 rough in the Waterloo Region.

18 24. Q. Okay, so as Commissioner of Social
19 Services, are you recommending to Council that a
20 budget be passed that would provide enough funding to
21 have shelter, transitional housing, supportive housing
22 or permanent housing for all of the people living
23 unsheltered in Waterloo Region?

24 A. So the way our budget works, Shannon,
25 is the Regional Council sets the budget parameters.

1 And we, and as the Commissioner of Community Services,
2 which includes housing and homelessness, we
3 communicate to Council what level of service we can
4 provide within that funding envelope which is what we
5 do.

6 And over the last number of years, we have
7 put forward additional budget requests that have
8 nearly tripled the overall housing/homelessness budget
9 in the last four or five years.

10 25. Q. Okay, so I am not sure that you really
11 answered my question. Is the budget that's being
12 discussed, would it provide enough funding to have
13 shelter, transitional housing, supportive housing or
14 permanent housing for all people living unsheltered in
15 the Region?

16 A. The budget request from Regional
17 Council, the direction from Regional Council, is to
18 bring forward a budget motion which will go forward to
19 Regional Council next week to bring that budget motion
20 in for a tax increase of less than five percent.

21 Within that envelope and the envelope that
22 we have, we are agreed that there are currently --
23 there's more demand on the system than we have supply
24 to meet the needs of everybody that we are aware of
25 that is experiencing homelessness.

1 26. Q. Okay, so can we agree that in the
2 present and probably for the foreseeable future, there
3 will be people in the Region who cannot -- or people
4 for whom the Region cannot provide accommodation for
5 shelter?

6 A. I can comment that on -- based on the
7 current demands on the system, the homelessness
8 system, the housing stability system, there are
9 currently more people who are experiencing
10 homelessness than the Region has funding for -- that's
11 across that system. Yes.

12 I can't comment on the future state. I can
13 tell you that in the last year, we have seen through
14 the efforts of the Region and our partners, a decrease
15 in overall homelessness in Waterloo Region by eight
16 percent. And we reported that to Council back about a
17 month ago.

18 27. Q. Okay, so I think at the 2024 Point in
19 Time count, there was approximately 1,000 people or so
20 who were living unsheltered. And you're saying that
21 that number is eight percent less now?

22 A. No, I'm saying the overall -- what we
23 reported to Regional Council and, Shannon, we can -- I
24 think there's an undertaking process.

25 I won't get ahead of myself here but there's

P. Sweeney (Cr.-Ex.) - 15

1 a public report that clearly outlines. I don't have
2 that in front of me. And what we reported to Council
3 is the overall rate of homelessness has decreased by
4 eight percent from '24 to '25.

5 28. Q. Okay, but we're still dealing with a
6 very large group of people, let's say somewhere around
7 1,000 people who are living unsheltered in the Region.

8 A. The Point in Time count was November of
9 last year. It's exactly that, a Point in Time count.
10 We rely more accurately on our HIFIS system which is a
11 federal system I believe you are aware of.

12 I don't have the HIFIS numbers in front of
13 me. So I don't have the exact number relative to the
14 Point in Time count from last year.

15 29. Q. Okay, can you provide an undertaking to
16 get us the numbers for, I guess, December, November
17 from the HIFIS system on the number of people who are
18 living unsheltered in the Region?

19 MR. LOKAN: We'll give that undertaking.

20 MS. DOWN: Okay.

21 **UNDERTAKING**

22 BY MS. DOWN:

23 30. Q. And would it be fair to say that
24 Waterloo Region, in fact, has one of the highest
25 proportions of its homeless population who live

1 unsheltered or in encampments in Ontario?

2 A. No, I have no data to affirm or deny
3 that statement.

4 31. Q. Okay, I am going to ask, Charlotte, can
5 you put up the exhibit. I think it's entitled,
6 "Francisco Truong" and it's a LinkedIn post. Can you
7 put that up on the screen?

8
9 --- SCREENSHARE

10
11 32. Q. Now, I don't know if you've seen this
12 post. Francisco, I understand is -- works for the
13 Region in the housing support group?

14 A. That's correct.

15 33. Q. Okay, I'll give you a moment if you
16 like to read what he has written here.

17 A. Okay, I am assuming Fran's pulling this
18 from the PiT count? I don't understand what -- I am
19 not sure what the source is.

20 34. Q. Well, it seems like he ---

21 A. (Indiscernible).

22 35. Q. Because he does reference it.

23 A. Okay. So that looks like it's public
24 data, Shannon. So ...

25 36. Q. Okay. So this chart seems to be

1 showing that Waterloo Region, 43 percent of the people
2 who are homeless are living unsheltered. That would
3 be that 1,000 or so people.

4 A. Relative to the November 2024 Point in
5 Time count?

6 37. Q. Yeah.

7 A. That appears to be what this is, yes.

8 38. Q. Okay, and it seems to be suggesting
9 that Waterloo Region is -- has got the highest
10 percentage of these municipalities. So it references
11 Niagara, Hamilton, Simcoe, Middlesex, Halton, Ottawa,
12 Toronto and Peel.

13 A. Yeah, I can see it.

14 39. Q. Okay. And so you agree that this is
15 the percentage, at least on the face of it, looks like
16 we have an extremely large percentage of people,
17 amongst the people who are counted as homeless who are
18 living unsheltered.

19 MR. LOKAN: Just to be clear, Shannon.

20 You're putting to him an article he doesn't
21 recognize and he has no idea whether the
22 facts here reported are true or not. And
23 there was no effort by your clients to put
24 forward this evidence. So you're giving him
25 a random LinkedIn post that he doesn't know

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1 if this is accurate or not.

2 MS. DOWN: Let's ask him about that. I'll
3 ask him about that.

4
5 BY MS. DOWN:

6 40. Q. Do you have any -- do you have reason
7 to think that Francisco's post is not accurate, Peter?

8 A. No, I work with Fran. I would have no
9 reason to believe that the data that you're presenting
10 to me here today appears to be pulled from the
11 November 2024 Point in Time count. Which is one
12 dataset set that attempts to enumerate the level of
13 homelessness in communities across Ontario.

14 41. Q. Okay, and it's an important dataset.
15 Like it's one that the Region relies on fairly
16 heavily?

17 A. It is a -- it is a dataset that we use.
18 I would suggest that given that it happens every four
19 years, we take it seriously. And there are other
20 datasets that we continue to use on a more daily
21 basis.

22 42. Q. Okay, but was there another Point in
23 Time count that happened this fall?

24 A. A federal Point in Time count? No, I
25 don't have ---

1 43. Q. No, a local ---

2 A. (Indiscernible).

3 44. Q. A local one. Sorry, a local one.

4 A. I am not aware of a formal Point in
5 Time count. There may have been -- again, actually I
6 don't. I am not familiar with a formal Point in Time
7 count being conducted. That's every four years that's
8 called ---

9 45. Q. Okay.

10 A. --- the PiT count.

11 46. Q. So when you say the HIFIS numbers, you
12 would rely on those as well. How do the HIFIS numbers
13 relate to the Point in Time count? So are they
14 updating the Point in Time count, are they -- do they
15 start with the Point in Time count as the basis for
16 the numbers in HIFIS?

17 A. No, my understanding, Shannon, is that
18 the HIFIS is a real-time count of individuals that are
19 connected in with the Region's service system manager
20 role for whom we have information about -- and there's
21 personal information obviously there.

22 And this data is inputted by providers and
23 shelter operators as the such. And so it is a -- as
24 real-time picture of the individuals that are
25 requiring service in our community at any given time.

1 Whereas the Point in Time count is exactly that, it's
2 a span of a couple days and every four years.

3 47. Q. Okay. With the HIFIS -- would you say
4 HIFIS would be as extensive or as inclusive as the
5 Point in Time count in terms of the effort to get the
6 broadest picture of homelessness in the Region?

7 A. I would say from my understanding,
8 HIFIS is a more timely picture. Is about as a real-
9 time picture of housing and homelessness in our
10 community that we have.

11 48. Q. But it would employ a different
12 methodology than the Point in Time count. Is that
13 correct?

14 A. That's my understanding, yes.

15 49. Q. So it doesn't really replace the Point
16 in Time count per se. Because it might not reach some
17 of the people. So, for example, my understanding of
18 the Point in Time count is that on those days that are
19 being counted, there's a group of people who are out
20 in the Region who are connecting with a variety of
21 individuals.

22 You know, as many settings as possible to
23 gather data on the -- whether or not they are
24 experiencing homelessness and what they are -- whether
25 they are accessing shelter, they're living

1 unsheltered, etcetera.

2 A. Mm-hmm.

3 50. Q. Sorry, you're saying HIFIS is more
4 people who are connecting with the system.

5 A. Yes.

6 51. Q. And the data, the data from those
7 connections?

8 A. Yes, what I'm -- can you form that in a
9 question so that I can help you here?

10 52. Q. Yeah, so I'm just -- you see, my
11 understanding is that the Point in Time count is a
12 much more comprehensive, broader sort of look at
13 homelessness at a particular point in time.

14 But what you're telling me is HIFIS is a
15 snapshot of what the Region's -- people who are
16 connecting with the Region through your various
17 services at any given time.

18 A. I am still not -- so I heard you make
19 an assumption about PiT and then make an assumption
20 about HIFIS. I'm ---

21 53. Q. Yeah, HIFIS -- HIFIS is more focused
22 ---

23 A. Can you frame it in a question so I can
24 help, so I can answer?

25 54. Q. So is HIFIS more focused than -- I

1 guess, you're saying HIFIS -- I am trying to
2 understand whether HIFIS really encapsulates like
3 updates to the Point in Time count or if it's just
4 something completely different, the numbers, the data?

5 A. So the HIFIS system is the most up-to-
6 date accurate representation of individuals in our
7 community that we know of that are experiencing
8 homelessness and, in some cases, where people are
9 currently residing or not.

10 55. Q. Okay, would it miss people that the
11 Point in Time count would catch?

12 A. I don't know. Potentially; potentially
13 not. I can't say definitively that that is the case.

14 56. Q. Okay. We'll move on from there. I'd
15 like to put up for an exhibit, the next exhibit. So I
16 guess it would be Exhibit B.

17 MS. SCHIUTEMA: So I don't think this one
18 was marked. Sorry to interrupt you.

19 MS. DOWN: Okay. Sorry, so we'll mark the
20 first one I guess Exhibit 1?

21 MR. LOKAN: No, it's Exhibit A.

22 MS. DOWN: Sorry, Exhibit A.

23
24 EXHIBIT NO. A: LinkedIn post
25

1 EXHIBIT NO. B: Region's winter-warming package

2
3 MS. DOWN: And, Charlotte, if you could put
4 up on the screen Exhibit A from Sara
5 Escobar's second affidavit from the reply
6 motion record?

7
8 BY MS. DOWN:

9 57. Q. And so I'll give you a second just to
10 take a look at this. I can tell you it's -- this is a
11 press release from the Region talking about winter-
12 warming packages and the program that the Region funds
13 related to that.

14 A. In 2022?

15 58. Q. Yes.

16 A. Okay.

17 59. Q. Is this a program that still exists?

18 A. Winter-warming?

19 60. Q. Winter-warming packages, yes.

20 A. Yeah, we have a winter-warming -- I
21 believe the packages are still distributed. I don't
22 know how they relate off-hand between now and 2022.

23 61. Q. Okay.

24 A. It's still something that we're doing.

25 62. Q. Okay. And, Charlotte, if you can

1 scroll down to Exhibit B. Just keep scrolling because
2 it's the chart that I am mostly interested in.

3 Sorry, this is a series of emails about the
4 program. But I just want to show you there's a
5 document. There we go. Winter-warming package. So
6 this is an example of the winter-warming packages that
7 get handed out to people?

8 A. Mm-hmm.

9 MR. LOKAN: To help us figure out where we
10 were later, is it possible to give a page
11 number either from the PDF or the -- or the
12 reply record?

13 MS. DOWN: Charlotte, do you have the page
14 number there?

15 MS. CAHILL: This is -- it looks like Page
16 30 on the PDF.

17 MR. LOKAN: Thank you.

18
19 BY MS. DOWN:

20 63. Q. Okay, so this is a document that just
21 talks about some of the equipment that the Region
22 provides in these winter-warming packages. And my
23 understanding -- and maybe you can confirm or deny
24 this -- is that this is still -- this program is still
25 happening.

The Region funds a variety of organizations to hand out these packages to people who are living unsheltered. And it provides them with a number of pieces of survival equipment essentially, candles, tarps, bungy cords, socks, boots.

A. So can I just ask, is this list from 2022 or is it from -- is it this year?

A. Yeah, we can certainly do that ---

UNDERTAKING

65. Q. Can you tell me a little bit about this program, Peter?

1 survival equipment, it's funded by the Region and
2 people are handed out these packages with this
3 equipment.

4 So is it -- are people given tents as well?

5 A. I don't know, I'd have to confirm
6 whether that's -- whether those are available or not.

7 67. Q. Okay.

8 A. So we fund -- we fund the agencies to
9 put together and I'll -- the Working Centre is an
10 example -- to put these together and distribute them.
11 So I would have to -- I would have to confirm with
12 staff what the most up-to-date contents of those are
13 for this ---

14 68. Q. Okay.

15 A. --- current time. Yes, happy to do
16 that.

17 69. Q. Thank you. And what is the purpose of
18 the program?

19 A. So the purpose of the program is to
20 work with our partners who are in the community to
21 provide those that are sleeping rough or unsheltered
22 in some way, shape or form with some items relative to
23 staying warm if they're still outside.

24 70. Q. Okay. So ---

25 A. Hence (indiscernible) winter-warming.

1 71. Q. Okay, so these items, you know, boots,
2 sleeping bags, tarps are considered important survival
3 equipment for those people?

4 A. Yes, so the program has been updated --
5 again, I'd have to go back and check for you, Shannon
6 -- in the last few years to respond to partners
7 indicating what, in their experience, would be most
8 useful in these kits.

9 And so what is provided is a representation
10 of what our partners are telling us that would be most
11 useful for the individuals that they are connecting
12 with who are -- who are, unfortunately, outside.

13 72. Q. Okay. And so if tents are one of the
14 things that are provided, I mean, can we -- would you
15 agree that tents would be an important piece of
16 survival equipment for those people who are living
17 unsheltered in the winter time?

18 A. So first of all, can I just ask a
19 qualifying question, technically? Is -- if I can
20 confirm on the tenting piece is that something I can
21 come back to you for tomorrow or do we have to do an
22 undertaking? I don't know what the ---

23 73. Q. You can come back to me tomorrow. If
24 you can get an answer to that, that would be great.

25 A. I can certainly do that.

1 MR. LOKAN: Shannon, normally, the caution
2 on evidence is not discuss your evidence
3 with anyone. But you are I think suggesting
4 that you're fine with Peter talking to staff
5 in the Region to find out the answer to this
6 question?

7 MS. DOWN: This specific question, yes, I'm
8 fine with that because I think it would
9 assist us.

10 MR. LOKAN: Okay.

11
12 BY MS. DOWN:

13 74. Q. Okay. So I'm going to jump a little
14 bit around here. In your second affidavit, if you can
15 pull that up.

16 A. Yeah. Okay, go ahead.

17 75. Q. If you want to take to a look at
18 Paragraph 13. Charlotte, you can stop the
19 screensharing, we can just -- I can just ask him about
20 this.

21 So at Paragraph 13 you mention the Code of
22 Use By-law and state that it applies to regional
23 properties, you know, broadly. Though it -- and the
24 Region still is enforcing that presumably?

25 A. Yes, again, I don't have any

1 responsibility in my portfolio for enforcement but
2 there is a Code of Use By-law which I reference. And
3 it's right there and it applies to all other regional
4 lands. That's my -- that's correct.

5 76. Q. Okay, okay.

6 A. I have no area of responsibility on
7 enforcement.

8 77. Q. Okay, but this touches on areas that
9 relate to the work that you do because it involves
10 people who are experiencing homelessness. I am
11 assuming that you have some base level of knowledge
12 about how this works.

13 A. About the Code of Use By-law?

14 78. Q. Yes, how it applies to the homeless
15 population that you serve?

16 A. Well, yeah, I mean, it's right there.
17 So again, can you help me by asking something ---

18 79. Q. Sure.

19 A. --- specifically?

20 80. Q. Would you agree that ---

21 A. The By-law is in place, that's all I
22 have. Yes, okay.

23 81. Q. Okay, would you agree that the By-law
24 prohibits erecting a tent on regional property?

25 A. If somebody could put the By-law up on

1 the screen; I don't have the By-law memorized.

2 82. Q. Yes, we can put it up on the screen.

3 Do you need help finding it, Charlotte?

4 MS. CAHILL: Yes, please.

5 MS. DOWN: Sorry, I mean I (indiscernible)
6 though we were going to have this
7 (indiscernible) ---

8 MS. CAHILL: That's okay.

9 MS. DOWN: I assumed that this would be non-
10 controversial. I got ---

11 MR. LOKAN: So I'm actually just ---

12 MS. DOWN: Just a second.

13 MR. LOKAN: I am actually just finding it
14 for you to sort of cut through -- the Page
15 39 of the affidavit, 49 of the record,
16 Schedule B, Prohibited Activities number
17 2(2)(t) says:

18 "... Erecting without authorization
19 any tent, any structured tent or
20 temporary shelter ..."

21 That's the reference you're
22 looking for?

23 MS. DOWN: Yeah.

24 MR. LOKAN: So that's what the Code of Use
25 By-law says in that provision.

1 BY MS. DOWN:

2 83. Q. Okay, so, can you confirm, Peter, that
3 that's your understanding that the By-law prohibits
4 erecting a tent on regional property?

5 A. My understanding.

6 84. Q. Okay. So just in terms of once --
7 let's just imagine hypothetically that 100 Victoria
8 Street is closed. Is there anywhere where people
9 would be able to legally set up a tent on regional
10 property based on your understanding of this By-law?

11 A. So my understanding of the By-law based
12 on what I just said, is that absent any changes in the
13 By-law, setting up a tent or a structure on any
14 regional land would be in contravention of the current
15 By-law.

16 85. Q. Okay.

17 MR. LOKAN: And, Shannon ---

18 MS. DOWN: But that ---

19 MR. LOKAN: Sorry, you put that in terms of
20 is there anywhere someone legally could
21 erect a tent? It is of course always
22 possible but there's a higher authority than
23 the Code of Use By-law that might make it
24 legal. But if ---

25 MS. DOWN: I'm asking him with referencing

1 the Code of Use By-law.

2 MR. LOKAN: Okay, great. Thank you.

3 MS. DOWN: Okay.

4
5 BY MS. DOWN:

6 86. Q. And I know that you work for the Region
7 but I am assuming that you have some familiarity as
8 Commissioner of Social Services with sort of the
9 second-tier municipalities, the way they approach
10 these issues.

11 And is it fair to say that there would be
12 similar by-laws, whether it's the City of Kitchener,
13 Waterloo or Cambridge in terms of -- people can't just
14 put up a tent on properties that are belonging to
15 those municipalities either?

16 A. Yeah, I can qualify by saying I don't
17 have chapter and verse of specific municipal by-laws.
18 But my broad understanding working in this space is
19 those provisions such as that exist at the area
20 municipality level as well.

21 87. Q. Okay. And I think we would agree that,
22 I mean, people can be removed by the police if they
23 camp on private property. So if it's, you know,
24 property owned by a business or an individual, they
25 could call the police and they can have someone

1 removed?

2 A. That's what ---

3 88. Q. Is that what your ---

4 A. --- (indiscernible) through the TPA, is
5 my understanding.

6 89. Q. Correct. And so really, 100 Victoria
7 Street right now, is the only place that they have
8 some protection, some legal protection because of the
9 previous *Valente* decision on that property if they
10 want to set up a tent?

11 A. My understanding of the *Valente*
12 decision and what's been in practice since that time
13 is that the Code of Use -- the current Code of Use By-
14 law is not enforceable at 100 Victoria. That's my
15 understanding, correct.

16 90. Q. Okay. So once 100 Victoria Street is
17 closed presumably at some point for the Metrolinx or
18 the Kitchener Transit Hub, what is the plan for the
19 people who are living outdoors? Like what is the --
20 your group's plan for those people?

21 A. Well, the plan as it's stated is the
22 plan to end chronic homelessness by 2030. And so the
23 work and the activities that are in the plan to end
24 chronic homelessness, is the plan to support all
25 individuals who are experiencing homelessness in

1 Waterloo Region, whether they be at 100 Victoria or
2 elsewhere.

3 91. Q. But that's like a long-term plan,
4 right? Like that talks about ending chronic
5 homelessness by 2030 and working towards that goal
6 between now and then. But I'm talking about like the
7 next day, what is the -- what is the Region of
8 Waterloo's plan for those people on the day after the
9 encampment closes?

10 A. So ---

11 92. Q. Where do they go, what are their
12 options?

13 A. So with the resources that we have
14 available, our plan is to -- for all the resources
15 that are provided to us through the provincial
16 government, the federal government and our municipal
17 council, to continue to work directly with individuals
18 who are experiencing chronic homelessness.

19 And to the best of our ability, find them
20 alternative indoor shelter where we can, within the
21 confines of the resources that we have available to
22 us.

23 93. Q. But we know that there's a thousand
24 people who are not sheltered who are living outside
25 who don't have access to the emergency shelter system.

1 Where do they go?

2 A. So I think that's the challenge of this
3 work, Shannon, in that we are in a situation where
4 chronic homelessness in this community, in this
5 province and in this country, is at significant
6 levels. And in communities across the country, the
7 demands for space outstrips supply and Waterloo Region
8 is no different.

9 And so we will continue to support people as
10 best we can with the budget that we have significantly
11 increased much more so than many other municipalities
12 across Ontario, to support as many people as we can
13 with the limited resources we have.

14 94. Q. Okay, so when you're supporting those
15 people, let's look at somebody, you know, a person
16 who's got a tent and has been moved off of the
17 encampment site. But can't -- there is no shelter
18 space for them. If they're asking one of the
19 unsheltered workers, like where do I go? The shelters
20 are full. Where can I go? What is the Region's
21 response?

22 A. The Region's response in a situation
23 like that, is an unfortunate one that we are dealing
24 with in Waterloo Region and across the province and
25 across the country. There are occasions where there

1 are -- that we are at a full capacity.

2 I will tell you that in our experience,
3 generally-speaking, there are -- there is capacity
4 within our housing stability system, almost every
5 night. Some nights less so than others.

6 But we also know that sometimes for some
7 folks what we have to offer is not what they're
8 willing to accept. And people -- people make those
9 decisions in those cases to -- to continue to find
10 their own way through sleeping rough, finding a place
11 where they can. And do what they need to do. And so
12 -- yeah that's ---

13 95. Q. So are there nights when the system is
14 completely full?

15 A. There -- it's -- it's conceivable that
16 the system is conceivably full. I don't remember the
17 last time we had 100 percent. We do have a winter
18 surge capacity and so we're in that now. And so as of
19 November 1st, we've added winter-warming overnight
20 spaces both in Kitchener and Cambridge. And we do
21 know that the system gets -- gets strained.

22 96. Q. Okay, so when the system is full and
23 somebody is, you know, walking around, they've got
24 their tent, their backpack, they're looking for
25 somewhere to go, I am asking you what is the USW going

1 to say to them?

2 A. So USW is either going to say, I have
3 -- based on the system, we have a shelter bed, a motel
4 or something available for you through the housing
5 stability system, if they have that.

6 And if there's a scenario where there is
7 zero bed capacity, they will continue to try and do
8 our best. We have occasions where we go over-
9 capacity, and there are occasions, Shannon, as you
10 know, where there is no capacity and people are forced
11 through circumstance to make alternative arrangements.
12 And that often is people that would be sleeping rough
13 in this community.

14 97. Q. So we have already established that
15 there's really -- there's nowhere for them to legally
16 put up a tent. Because the Code of Use By-law covers
17 the Region's properties, the lower-tier municipalities
18 have similar by-laws, private property is off limits
19 because people could just call the police.

20 So where could -- you know, I guess my point
21 is you're saying encampments -- we don't -- we don't
22 support an alternative encampment site but we also --
23 there's nowhere for people to go if the system is
24 full. Does that not seem like you're creating a
25 situation where people have zero option?

1 A. So ---

2 98. Q. In that, you know, in that
3 circumstance.

4 A. Yeah, and we also know quite
5 pragmatically that despite the scenario that you've
6 just described in this community and in other
7 communities where by-laws exist, people do choose to
8 tent in places that are sometimes more visible than
9 others. But we know that that happens.

10 99. Q. Okay. I think I'm going to have to
11 take a break there because I have another meeting I
12 have to get to. But we'll start again tomorrow. So I
13 think the plan is to start tomorrow at 10:00.

14 As I said, if you want to reach out to your
15 staff to find out if tents are provided, I would
16 appreciate that.

17 But other than that, I would ask that you
18 not discuss anything with your counsel or with other
19 members of regional staff, other than that specific
20 item.

21 A. Understood.

22 MR. LOKAN: We've explained to Peter he
23 should not be discussing his evidence
24 already given with anyone and he certainly
25 will not be discussing his evidence with

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counsel.

MS. DOWN: Okay, thank you. Appreciate that
and I will see you tomorrow at 10:00.

THE WITNESS: See you tomorrow at 10:00.

Thank you.

MS. DOWN: Thank, you.

THE WITNESS: Bye-bye.

MS. DOWN: Sorry, Barbara, we'll adjourn for
today.

MADAM REPORTER: All right, we'll see you in
the morning, 10:00.

MS. DOWN: Thank you.

MS. CAHILL: Thank you.

--- ADJOURNED

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THIS IS TO CERTIFY that the foregoing
is a true and accurate transcription of
my recordings and notes, to the best of
my skill and ability.



Barbara A. Pollard
Certified Court Reporter

Photostatic copies of this transcript are not
certified and have not been paid for unless they bear
the original signature of Barbara A. Pollard, C.C.R.,
and accordingly are in direct violation of Ontario
Regulation 587/91, Courts of Justice Act, January 1,
1990.

EXHIBIT “A”

**Francisco Truong MSW, RSW** • 2ndSupervisor, Housing & Support Providers
3w • Edited • 

WOW! 43% of Waterloo's homeless population live OUTSIDE IN ENCAMPMENTS & UNSHELTERED, the HIGHEST in Ontario, with Toronto at 10% (PiT count data, focused on large municipalities over 500,000).

Waterloo Region also had one of the highest total enumeration of people living unsheltered and in encampments at 1,009 people, eclipsed only by Toronto with 1,615, however Toronto had much more total homelessness (15,418) compared to Waterloo (2,371) but also had a much larger population (3.2 million in 2024) compared to Waterloo (706,875 in 2024).

Smaller Regions and Municipalities (under 500,000) are more challenging to compare given the significantly smaller total enumerations. Taking the Region of Wellington-Guelph (265,513 population in 2024), this smaller population counted only 335 experiencing homelessness but had 44% unsheltered which is about 100 people. Every Region and Municipality is difficult to compare with another due to so many unique social and political challenges, whether looking at Toronto with its massive population and dense urban core, or Peel with its proximity to the airport and support provided to asylum claimants or rural areas where small municipal populations and large distances from resources create nuances uncomparable to larger Municipalities.

Why is it important to highlight the Unsheltered populations such as those living in Encampments? They have much more unique experiences and needs, often requiring greater focus on basic needs, dignity, safety and thus, HUMAN RIGHTS, in addition to their housing needs and preferences.

In Waterloo Region, the needs of unsheltered folks are so significant and pressing for the Housing Stability System, that there is a team dedicated specifically to the unsheltered population, which is distinct but complimentary to the existing Street Outreach teams. The work of the Unsheltered Support Team has become vital and critical to the needs of what is reported as 43% of the homelessness population or, 1,009 individuals.

What is the experience of unsheltered homelessness in your community? How significant and pressing are the challenges for your Housing Stability System?

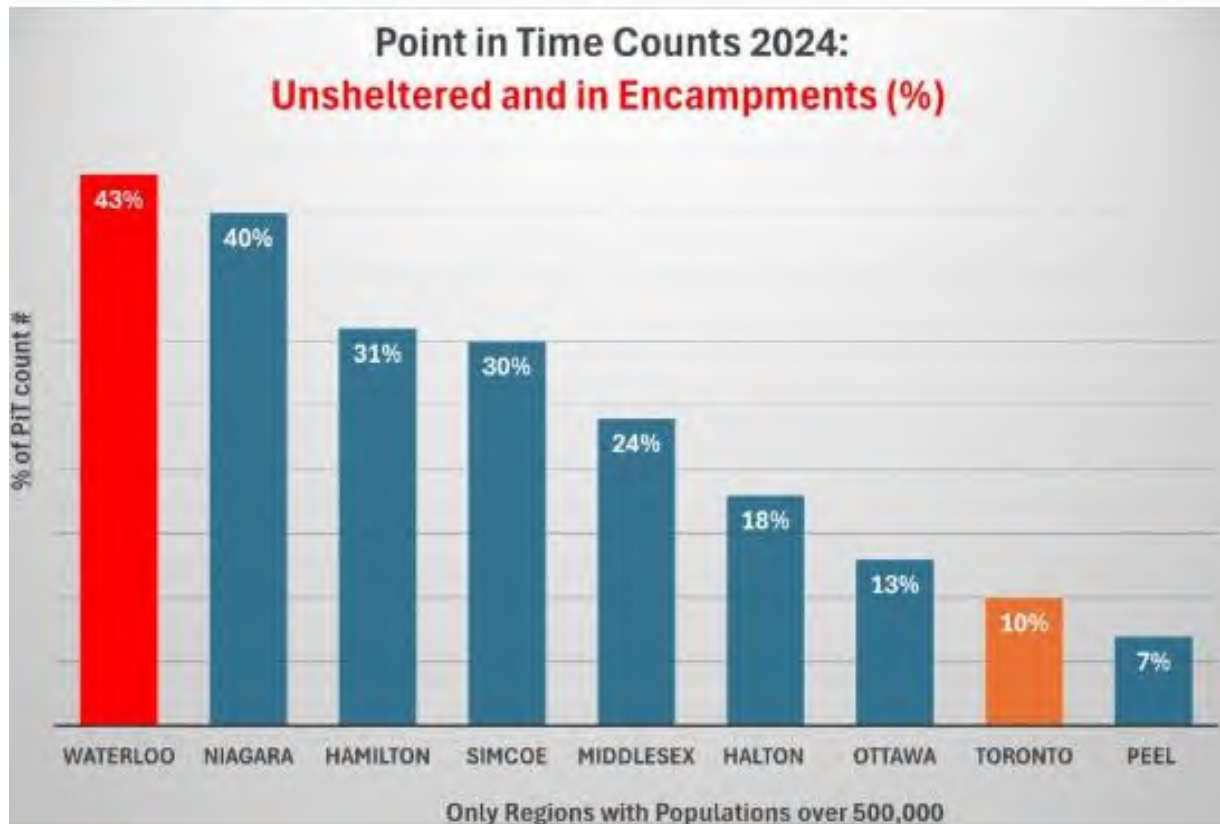
With all the data posted on my feed regarding PiT counts, it might be time to talk about how Housing First approaches can supercharge Housing and Homelessness systems.

Stay Tuned...

Data is reported from published Point in Time (PiT) Count numbers ONLY for larger Regional areas and Municipalities where there is a population of 500,000 people or greater AND where those Region's published their data breakdowns inclusive of "Unsheltered and in Encampments".

Population data from: StatsCan and PiT data from publicly reported 2024 Municipal PiT counts.

#homelessness, #housing, #pitcount, #unsheltered, #encampments, #waterlooregion, #toronto



👍👍👍 23

13 comments · 5 reposts

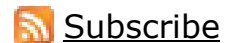
EXHIBIT “B”



Region of Waterloo

Region to Provide Winter Warming Packages

Posted on Wednesday December 14, 2022



Waterloo Region – With colder temperatures approaching, the Region of Waterloo is partnering with The Working Centre to provide Winter Warming Packages for people experiencing unsheltered homelessness.

"Our first priority is always to connect individuals to safer indoor shelter spaces and support services," said Councillor Jim Erb, Chair of the Community and Health Services Committee, Region of Waterloo. "Extreme winter weather conditions pose serious risks for those experiencing unsheltered homelessness. The Winter Warming Packages will provide cold weather supplies and a connection to support services as we continue work to transition people into housing."

The Working Centre and other community partners are working hard to sign people up and order the supplies as quickly as possible. The limited number of packages will include winter clothing, a warm sleeping bag, an insulated sleeping pad, and other outdoor winter supplies. Packages will be given to individuals staying in encampments or living rough in Kitchener, Waterloo and Cambridge while supplies last.

"Responding to health and safety concerns, the Region hosted community partners exploring a plan to support people living outdoors during the winter months," said Stephanie Mancini, co-founder of The Working Centre. "We have been working with Mountain Equipment Company, whose expertise is outdoor living to create the Winter Warming Packages. This is a combined effort to keep people as safe as possible, while we still work forwards on finding more indoor sheltering/housing options."

The Region recognizes the support of Mountain Equipment Company, the City of Kitchener and the Cambridge Food Bank for this project.

The Region has an extreme weather protocol. It provides support to emergency shelters and drop-in programs to adjust services and expand hours of operation during periods of extreme cold, adhering to health and safety processes and protocols, and depending on the program staffing ability.

Chat

The Interim Housing Solutions strategy is working to address unsheltered homelessness across Waterloo Region.

[Chat](#)

challenge of
visit,

engagewr.ca/interim-housing-solutions.

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[Chat](#)

Winter Warming Package

To help keep warmer while in encampments this winter, a package is being prepared.

Items available:

Artic Lantern

Artic Candles

Gloves

Toque

Tarps

Space Blankets

Bungee cords

Tuck Tape

Hand Warmers

Socks

Winter Boots

Long Johns

Please circle which of the above items that would be useful for you.

Please fill out the below form for sizing and requests for items not listed.

Your Name				
Encampment Location				
Contact Info				
Boot Size	Women's Size		Men's Size	
Glove Size	Small	Medium	Large	X-Large
Other Items requested				
Notes				

Court File No. CV-25-00000750-0000

ONTARIO

SUPERIOR COURT OF JUSTICE

BETWEEN:

THE REGIONAL MUNICIPALITY OF WATERLOO

Applicant

and

PERSONS UNKNOWN AND TO BE ASCERTAINED

Respondents

APPLICATION UNDER Rule 14.05 of the *Rules of Civil Procedure*

This is the continued Cross-Examination of **Peter Sweeney** on his affidavits dated June 6, 2025, July 2, 2025, July 31, 2025, and September 16, 2025, taken via Zoom video-conference on consent of the parties on December 12, 2025.

APPEARANCES:

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GRETA HOAKEN, Ms.	

ASHLEY SCHIUTEMA, Ms.	Counsel for the Respondents
JOANNA MULLEN, Ms.	
SHANNON DOWN, Ms.	
CHARLOTTE CAHILL, Ms.	Student-at-law

MERCEDES PEREZ, Ms.	Amicus Curiae
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Certification 144

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1 DECEMBER 12, 2025

2
3 PETER SWEENEY, PREVIOUSLY AFFIRMED

4 CONTINUED CROSS-EXAMINATION BY MS. DOWN:

5 1. Q. Good morning, Peter.

6 A. Hi, Shannon.

7 2. Q. We're back to reconvening your cross-
8 examination so I'll just remind you that you're still
9 under oath. And I am just going back to my notes.

10 So I think -- so first of all, I did reach
11 out to someone who was familiar with the winter
12 packages. And they confirmed that tents are provided
13 as part of those packages. Is that your understanding
14 as well?

15 A. Yeah, so I also did, with permission of
16 -- you know, within the rules of engagement here,
17 that, yeah, so there's a \$150,000 budget allocation
18 that's been in place for a few years now.

19 That money flows the -- an MOU to a number
20 of community partners. And they are the ones who both
21 purchase and distribute packages according to the
22 folks that they're interacting with. And tents are
23 one of the things that they, in their discretion, can
24 distribute with those funds.

25 3. Q. Okay. Thank you. And I think we're --

P. Sweeney (Cr.-Ex.) - 5

1 when we left off yesterday, we were talking about, you
2 know, I had asked you about what the short-term,
3 immediate plan was once the encampment is closed. And
4 in a world where there is no alternative encampment in
5 sight.

6 And I had asked you like what happens if one
7 of the 1,000 unsheltered people who are looking for a
8 place to stay, what happens to them? And, you know,
9 in a situation where the shelters are full.

10 I think, you know, you provided me with a
11 response but I am going to suggest that in your
12 response -- your response was essentially -- and I am
13 paraphrasing -- but that this is the -- this is the
14 difficulty of the situation we're in. That there
15 isn't -- there aren't options for people, those, you
16 know -- the Region has limited resources.

17 So I am going to suggest to you, is it fair
18 to say that there is no short-term, immediate plan?
19 Like there is no plan for what happens to the people
20 who are outside unsheltered once this encampment is
21 closed.

22 A. So I would say -- I would -- so I would
23 agree that we have capacity challenges. And there are
24 instances as you've described. We have both short,
25 medium and long-term plans to support people who are

P. Sweeney (Cr.-Ex.) - 6

1 experiencing homelessness. That are plans that are
2 aligned with the Council-approved budget and service
3 levels.

4 4. Q. Okay. So -- sorry, someone's just
5 ringing my doorbell. Sorry, can I just take a very
6 brief break?

7 A. It was on drop-off.

8 5. Q. I don't know what it is. One second.

9
10 --- OFF THE RECORD

11
12 BY MS. DOWN:

13 6. Q. So you were saying there is a short,
14 medium and long-term plan?

15 A. Yes, correct. We have -- we have plans
16 within our existing funding envelope and service-level
17 framework that Council sets for us.

18 And, you know, as we move through the next
19 number of months and years, we will continue to
20 implement that plan. That includes additional new,
21 net-new, supportive housing. As you know, across the
22 street at the Working Centres coming on ---

23 7. Q. I'm just going to interrupt you there
24 because I'm really asking you something that is very
25 specific. I think you're talking in generalities. So

1 I am asking specifically what is the short-term plan
2 for people who are unhoused who say have been given a
3 tent, what is the short-term plan for where they can
4 go?

5 A. So the short-term plan that I can give
6 you is a plan that is in existence right now that has
7 limited resources relative to the demand that we see
8 in this community, have continued to see in this
9 community.

10 And our long-term plan is to get to a point
11 where we have a functional ---

12 8. Q. I'm talking about the immediate short-
13 term. So I just want to know in specifics what's the
14 immediate short-term plan for someone who has been
15 given a tent, who cannot access shelter and who is
16 outside? Where can they go?

17 A. So if there's no capacity within the
18 system and the resources that I -- my team has
19 responsibility for -- we have situations as you know
20 where people are left to make their own decisions.
21 And we know in this community that some people in
22 those situations sleep outside.

23 9. Q. Yeah, and I'm asking like is -- what is
24 the Region's response to that, though? Because right
25 now you have a Code of Use By-law that says you cannot

1 camp on regional property. And we went through
2 yesterday, there's really nowhere where people can
3 camp.

4 So what is the Region's response to that
5 situation?

6 A. So the Department of Community Services
7 for whom I can speak on behalf as the person
8 responsible for that, is to support as many people as
9 we can with the resources we have. And I ---

10 10. Q. So I am going to suggest there is no
11 plan for those people. There is no direction that you
12 can provide to those people to say here's where you
13 can go?

14 A. We are not -- my staff team are not in
15 a position to recommend or tell people that they can
16 sleep outside in a specific area in this community.

17 11. Q. Okay, so there's no like protocol or
18 policy or, you know, direction with respect to people
19 who are in those circumstances?

20 A. And the "circumstances" you mean
21 specifically those who are -- who would be ---

22 12. Q. Unsheltered with a tent looking ---

23 A. Okay.

24 13. Q. --- for somewhere to stay?

25 A. So I believe the question is, is there

1 a protocol for those situations in a ---

2 14. Q. Yes.

3 A. --- (indiscernible) currently? There
4 is not.

5 15. Q. Okay. And so you said yesterday you
6 said it would rarely happen that there isn't space in
7 the shelter system. We were talking about the
8 situation where someone can't access it.

9 And so I just want to look at a document and
10 I am going to ask Charlotte if she can put it up on
11 the screen. It's -- the document is titled, it's a
12 slide deck from the "November 2025 Co-creators
13 meeting, HSS data update."

14
15 --- SCREENSHARE

16
17 A. Sorry, just give me a second. I'm --
18 oh, you're putting it up on that ---

19 16. Q. Yeah.

20 A. Hang on, I'm just waiting.

21 MS. CAHILL: Can you see that on the screen?

22 MS. DOWN: Yes. I can.

23
24 BY MS. DOWN:

25 17. Q. Peter, can you see it?

1 A. I can, yeah. Now I can, yeah, it's
2 popped up.

3 18. Q. Okay, so this is a document produced by
4 regional staff, is that correct?

5 A. It would appear that way, yes.

6 19. Q. Okay. And have you seen this document
7 before?

8 A. I don't recognize this slide deck, no.

9 20. Q. Okay. I want to turn to slide -- are
10 these -- sorry. Maybe just -- is this -- have you
11 seen other slide decks of HSS data updates that are
12 provided to the community? Is this something that is
13 a regular occurrence?

14 A. So can you just remind me. This was a
15 slide deck presented by regional staff to co-creators?

16 21. Q. Yes.

17 A. Yes, so my understanding is that would
18 naturally occur as a part of that process. But I
19 don't recognize this data or this particular slide.

20 22. Q. Okay. But you're not challenging that
21 is -- that it's a regional document?

22 A. No.

23 23. Q. Okay. I just ---

24 A. No, it's the numbers at the bottom --
25 the numbers at the bottom are a bit of a ---

1 24. Q. A giveaway?

2 A. Yeah, a bit of a tell.

3 25. Q. Okay. I want to turn ---

4 A. But go ahead.

5 26. Q. Charlotte, if you can move down to
6 slide No. 8.

7 So when I look at this slide it's entitled,
8 "Reasons for Turn-aways."

9 A. Turn-aways, yeah.

10 27. Q. Yeah. And so it's talking -- turn-
11 aways would be people who are -- and correct if I am
12 wrong but my understanding is turn-aways are people
13 who are turned away from emergency shelters for a
14 number of reasons.

15 A. Yeah, and I -- again, I think this is
16 either -- yes, that's my understanding.

17 28. Q. Okay.

18 A. Yeah.

19 29. Q. So it seemed to be saying at -- that
20 there were -- I am not sure, it looks to me like at
21 the bottom, it says, "26 unique turn-aways." But at
22 the bottom it says, "Total of 59 ---

23 A. Fifty-nine?

24 30. Q. --- turn-aways," for the month of
25 October 2025.

1 A. Yeah.

2 31. Q. So that would mean in October 2025,
3 there were 59 people turned away from the emergency
4 shelter system.

5 A. Yeah, I don't -- I can't say I
6 understand the relation between the 26 and the 59.

7 32. Q. Yeah, the 59 actually seems to
8 correlate more to the specific numbers that are in the
9 slide.

10 A. Yeah.

11 33. Q. So, okay. So that's -- I mean, would
12 you agree with me that that seems like a significant
13 number of people who are turned away for the month of
14 October.

15 MR. LOKAN: Shannon, if I can -- you and the
16 witness are both looking at a document that
17 the witness hasn't seen before. And you're
18 asking him to interpret it. So we're kind
19 of speculating as to what it means. And I
20 only say that because it occurs to me, you
21 say 59 people but it could be the same
22 person who is successively turned away from
23 different sites. So ---

24 MS. DOWN: It could be.

25 MR. LOKAN: But that's 26 versus 59, I don't

P. Sweeney (Cr.-Ex.) - 13

1 know -- I don't know if that's important to
2 your question. But the assumption that
3 there's 59 people is one that I don't see
4 anywhere in the document.

5 MS. DOWN: Okay, and that could be -- it
6 could be not 59 people. I am not sure it
7 matters. I mean, whether it's 26 or 59,
8 that seems to me that that's a significant
9 number of people being turned away for the
10 -- like in one month from the emergency
11 shelter system.

12
13 BY MS. DOWN:

14 34. Q. It's indicating that the system must be
15 operating at a pretty high capacity. Is that fair to
16 say?

17 A. Absolutely.

18 35. Q. Okay. And so it doesn't seem to me
19 like this is -- I mean, is this a rare occurrence then
20 that people are turned away? Or is this ---

21 A. I can't ---

22 36. Q. Because this happened fairly recently.

23 A. Yeah, I can't comment on frequency.
24 I'd be happy to endeavour get some data to show how
25 often this happens to give an accurate data-informed

P. Sweeney (Cr.-Ex.) - 14

1 place. I will say is we are responsible for the
2 housing stability system. This system, which we have
3 significantly increased over the last number of years.

4 And, yeah, there are situations and
5 occasions where we are over-capacity. And that's a
6 really -- that's a really unfortunate place to be and
7 it's not something that we want to operate in that
8 environment.

9 37. Q. Okay. So I would ask for an
10 undertaking that we get the data on the number of
11 turn-aways for, say, from April until current day,
12 this month.

13 MR. LOKAN: Looks like it goes by months so
14 that would be ---

15 MS. DOWN: Up until the end of November, I
16 guess. So that's a yes?

17 MR. LOKAN: Subject to Peter confirming it's
18 something that can be obtained, I have no
19 problem with the undertaking.

20 THE WITNESS: And my assumption is we pulled
21 this data, you know, obviously for a slide.
22 So that should not be -- like the data
23 clearly exists.

24 **UNDERTAKING**

25 MS. DOWN: Okay. And could we ---

1 THE WITNESS: As it should.

2 MS. DOWN: And could we mark this document,
3 the slide deck, as an exhibit? I think
4 we're on Exhibit 2 or 3?

5 MR. LOKAN: Yes, on the basis that if we
6 have any reason to -- you're going to send
7 us a copy of this document and we can check
8 against the Region's files. And if we have
9 any reason to doubt it, we'd let you know
10 but provisionally, that's fine.

11 MS. DOWN: Absolutely.

12 MR. LOKAN: Yeah.

13 MS. DOWN: I am going to refer to it again,
14 so we'll look at some of the other pages.

15 MR. LOKAN: We can give it a number on that
16 basis.

17 MS. DOWN: Yeah. I think -- Charlotte, are
18 we on No. 2?

19 MS. CAHILL: For numbered, maybe one,
20 because we have -- I think we had a lettered
21 one.

22 MS. DOWN: No, we had a numbered one
23 yesterday. So I think this is No. 2, so
24 we'll mark it as Exhibit 2.

25 MR. LOKAN: The reporter will let us know.

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1 I didn't have anything else marked as a
2 numbered exhibit but we'll figure it out
3 from the transcripts.

4 MS. DOWN: Okay.

5 MADAM REPORTER: Well, actually I hate to
6 interrupt, Charlotte was right. There was a
7 lettered, there was an Exhibit A yesterday.
8 But there was no number or lettered exhibit.
9 So it should be No. 1.

10 MS. DOWN: I thank you, Barbara.

11
12 EXHIBIT NO. 1: Slide deck

13
14 MADAM REPORTER: Sorry.

15 MS. DOWN: That's okay, thank you.

16
17 BY MS. DOWN:

18 38. Q. So I just want to think about the
19 circumstances of someone who is going, you know, in
20 the month of October calling First Connect to get a
21 shelter bed and getting turned away.

22 And I can -- because I'm thinking about -- I
23 wanted -- I want to talk a little bit about shelter
24 capacity and the numbers and why someone -- and we
25 talked a little bit yesterday about people choosing

1 not to go into shelters. So I just want to explore
2 that a bit with you.

3 And I don't know, would you agree that if
4 you were one of the people who was turned away, so if
5 you tried to get a space and you were turned away, you
6 might make the decision the next day to set up a tent
7 somewhere to -- because at least in that situation you
8 would know you have somewhere to stay, right?

9 Because if you were -- if you're calling and
10 getting turned away, you know, I'm going to be
11 thinking am I going to get turned away tomorrow night
12 as well? And I just -- I want to know I've got
13 somewhere to lay down and rest and sleep.

14 So it's possible that someone might not
15 access a system for a very valid reason because it's
16 been -- it's been full to them, they've been turned
17 away from it. And that would be a very valid reason
18 not to -- not to access shelter.

19 A. So I will agree with you that that
20 scenario that you just described in terms of somebody
21 calling, not being able to access a shelter bed and
22 then making a different decision the next day because
23 of that experience, is a possibility.

24 39. Q. Right. So just because there is space
25 in shelter doesn't mean that there aren't people out

1 there who might otherwise want it. I mean, it could
2 be that they -- they have tried to access shelter in
3 the past, they were unsuccessful and they've given up.
4 That's a possibility. Is that -- is that your
5 understanding?

6 A. I would agree that's a possibility.

7 40. Q. Okay. And it's not really -- I mean, I
8 think we can -- I'm hoping we can agree that in that
9 circumstance, it's not really choosing to stay in a
10 tent. It's not like it's, you know, I'm choosing to
11 stay in an Air BnB instead of a hotel.

12 It's, you know, they just don't have any
13 real options in those circumstances.

14 A. Oh, yeah, I mean, I will agree that the
15 reasons for individuals spending the night or multiple
16 nights in a tent, sleeping rough, are varied and
17 unique. And agree that the word "choice" is a
18 relative -- relative thing for folks.

19 41. Q. Right, it's -- I mean, I think choice
20 -- I would almost -- would you agree that "choice" is
21 somewhat misleading because it suggests that they have
22 like a, you know, a breadth of options.

23 A. I would agree that some people in these
24 circumstances have fewer choices than others.

25 42. Q. Right, some of them may have almost no

1 choice.

2 A. I would agree that there are scenarios
3 where people feel that they don't have any other
4 choice.

5 43. Q. Okay. So can we agree that encampments
6 of some kind are necessary in the current system.
7 Like someone needs to -- live if they're being turned
8 away, they need to exist, right? And it's winter, you
9 know. I am going to suggest that they need the
10 ability to be able to put up a tent somewhere.

11 A. So, sorry, can you phrase the -- there
12 was a lot there, Shannon.

13 44. Q. Yeah, I am saying in these ---

14 A. I want to be sure I answer the
15 question.

16 45. Q. --- circumstances -- yeah. So in these
17 circumstances, this situation of October 2025, you
18 know, 26 or 59 people being turned away, that
19 encampments are necessary. Like someone -- people
20 need -- the Region's handing out tents. I am assuming
21 that's for the purpose of someone to be able to put
22 that tent up somewhere in this circumstance where
23 they're being turned away.

24 MR. LOKAN: Shannon, I just would ask you to
25 be a little careful with the evidence

P. Sweeney (Cr.-Ex.) - 20

1 because you build in assumptions. First,
2 you said there's 59 people, we discussed
3 that. Second, you said ---

4 MS. DOWN: I said 26 or 59.

5 MR. LOKAN: That's not what I heard, maybe
6 I'm wrong. But you also said the Region
7 hands out tents, when the witness' evidence
8 is that the Region gives grants to the
9 partner organizations that, at their
10 discretion, choose to provide tents.

11 You know, I don't want to be pedantic
12 but let's stick to the evidence as it was,
13 if we can.

14
15 BY MS. DOWN:

16 46. Q. Okay, so the Region funds people --
17 funds organizations to hand out tents. In these
18 situations, I'm saying doesn't that show that
19 encampments are necessary in this current situation
20 that we're in?

21 A. I would say my response to that,
22 Shannon, is that encampments are a reality in our
23 current situation.

24 47. Q. Okay. And I just -- I don't
25 understand, how can the Region not have a plan that

P. Sweeney (Cr.-Ex.) - 21

1 addresses that reality then. That people have to
2 shelter outdoors. It isn't a choice because they
3 don't have -- there isn't space for those 1,000 people
4 who are unsheltered and the shelters are full. So ---

5 A. So ---

6 48. Q. --- you know, how can the Region not
7 have a plan that addresses that when you're
8 responsible for the -- for homelessness, for
9 addressing homelessness and providing solutions to it?

10 A. Yeah, so the Community Services
11 Department for which I am responsible has a mandate
12 and a source of funding and service levels that we can
13 operate within. And there also exists, as we
14 discussed yesterday, a Code of Use By-law.

15 And so I don't have -- we don't have, my
16 department, my team, does not have the authority or
17 mandate to provide direction where people currently in
18 this community can tent in a way that is not in
19 violation of some by-law or other upper-tier or lower-
20 tier level.

21 49. Q. Okay, but your department, you work
22 with other departments. You're, you know, you
23 coordinate and collaborate, I am assuming, with the
24 other groups of the Region.

25 Is it something that either you have in the

1 past or you could recommend like that there be some
2 sort of protocol for addressing this situation?

3 A. So the only way we could move a
4 protocol -- and why don't we just call it what we're
5 talking about is a safe-tenting protocol, I believe is
6 what you're referring to? Can we just clarify?

7 50. Q. Yes. Yes.

8 A. So the only manner in which that would
9 be something that could be considered is if there was
10 a direction from our collected Council to change by-
11 laws. And I don't have that direction.

12 51. Q. Right, and would -- is that something
13 like Council just comes up with that on their own?
14 Because my understanding is it's usually staff
15 presents recommendations to Council. And then Council
16 votes on it and provides their direction back.

17 MR. LOKAN: Shannon, I am going to object to
18 any question which is about staff -- the
19 content of staff recommendations to Council.
20 That is something that occurs within a
21 deliberate and secrecy context. I'm not
22 objecting to ---

23 MS. DOWN: But I'm asking -- I'm not asking
24 ---

25 MR. LOKAN: --- (indiscernible) nature of

P. Sweeney (Cr.-Ex.) - 23

1 whether encampments are needed, whether, you
2 know, Peter and his group's reaction to the
3 scenarios you propose, all that is fine.
4 All of that is factual. But if you want to
5 get into the process of staff
6 recommendations to Council and how all of
7 that works and the deliberative secrecy
8 aspects, I am going to object. Just to let
9 you know.

10 MS. DOWN: Are you telling me that the
11 process itself is secret?

12 MR. LOKAN: So if you want to ask about a
13 general process unconnected to any specific
14 recommendation, I don't have a problem with
15 that. Because that doesn't require -- that
16 doesn't require getting into deliberative
17 secrecy.

18 If you want to start asking about
19 content, I am going to object.

20
21 BY MS. DOWN:

22 52. Q. So in a general sense, Peter, does
23 Council come up with directions on how to provide
24 social services or does social services come up with
25 the plans and present it to Council? What's the

1 order?

2 A. In my -- so in my experience in the
3 last three and a half years, Shannon, is policy
4 direction can come both ways.

5 53. Q. All right.

6 A. I have seen policy -- I have seen and
7 experienced policy direction come both ways.

8 54. Q. So just hypothetically, if an
9 encampment, a safe-tenting policy was going to be
10 proposed, it could be proposed by social services and
11 suggested to Council. You wouldn't have to wait for
12 Council to provide that direction?

13 A. The -- there is ---

14 MR. LOKAN: You can answer that without any
15 reference and ---

16 THE WITNESS: Yeah, that's what I'm ---

17 MR. LOKAN: --- (indiscernible) without any
18 reference to a particular policy.

19 THE WITNESS: I don't -- I don't want to be
20 obtuse here but I do actually would like an
21 opportunity to have a conversation with my
22 legal counsel. Given the recent
23 conversation that many people in this room
24 have been privy to in a confidential manner,
25 I am feeling -- I am feeling like I'm -- I

P. Sweeney (Cr.-Ex.) - 25

1 need to take a break and I want to have --
2 can I do that?

3 MR. LOKAN: So here's what we'll do.

4 Shannon, you're skating on thin ice and I am
5 going to object to this line of questioning.
6 You asked about how in general terms
7 recommendations can go and got the answer it
8 could come in either direction.

9 But I would ask you to go no further,
10 please.

11
12 BY MS. DOWN:

13 55. Q. So, I mean, you talk about it in your
14 third affidavit -- I am just going to ask you about --
15 you talk about the practical non-feasibility of an
16 alternate encampment site. And essentially reject --
17 that's at Paragraph 41.

18 A. Okay, just give me a second here.

19 Yeah.

20 56. Q. So essentially you reject the premise
21 of an alternative encampment site or sites. And I am
22 going to suggest to you that really isn't consistent
23 with the reality of the situation that we have.
24 Where, you know, people are being turned away from
25 shelters and provided with tents.

1 A. So I will -- I would like to clarify
2 that as I reference in this affidavit, I am referring
3 specifically to an alternate encampment site that
4 would simply be 100 Victoria as is on another
5 location. It is a -- that is a specific one-for-one
6 reference in that context.

7 57. Q. Okay. I am going to turn now to your
8 second affidavit at paragraph -- well, you mention in
9 this one that you stand by your statement. Sorry, you
10 stated in your second affidavit at Paragraph 32 -- so
11 we'll turn to that first.

12 A. Can you give me a second, please?

13 58. Q. Yeah.

14 A. Okay, go ahead.

15 59. Q. So you state there that you stand by
16 your statement in your earlier, your original -- your
17 affidavit that:

18 "... An alternative encampment site is
19 inconsistent with the goals of the PECH
20 ..."

21 And that is, you know the goal of PECH
22 is to end chronic homelessness in Waterloo Region.
23 You go on to say that:

24 "... Encampments are precisely the kind
25 of emergency-based non-permanent

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1 housing that PECH is seeking to move
2 away from ..."

3 And you -- I'm assuming you still agree
4 with that statement in your affidavit?

5 A. I do.

6 60. Q. Okay. But would you agree that motels
7 and emergency shelters are also emergency-based, non-
8 permanent responses to homelessness?

9 A. They were certainly -- sorry, they are
10 non -- emergency-based and non-permanent, I would
11 agree with that, yes.

12 61. Q. Okay. Which is the wording that you
13 used to describe encampments and said that that's
14 inconsistent with PECH. But you're not suggesting
15 that the Region would stop funding those in the short
16 term because they're inconsistent with PECH?

17 A. No, I'd like to point out that the
18 affidavit in its entirety says it is precisely the
19 sort of emergency-based and non-permanent housing-
20 focused response that the PECH is seeking to move away
21 from.

22 62. Q. Right.

23 A. Yeah.

24 63. Q. Yeah, that's what I'm saying, in the
25 short-term ---

1 A. Yes.

2 64. Q. In the short-term you -- would you
3 agree that motels, emergency shelters are necessary?

4 A. They are a necessary part of our
5 housing stability system where we are today.

6 65. Q. Right. And somewhere down the road, if
7 PECH is achieved, we end chronic homelessness. They
8 might not be necessary or maybe they'll only be
9 necessary in a very diminished capacity?

10 A. That would be the goal. Yes.

11 66. Q. Wouldn't the same be said of
12 encampments?

13 A. In a world where we are successful in
14 meeting the functional zero target of the PECH, then,
15 you know, in that world, people would not need to be
16 sleeping outside.

17 67. Q. Right. But you stated that you are --
18 you say that encampments are inconsistent with PECH
19 where we don't want to have them. But you're not --
20 what I am suggesting is that in that analysis, motels
21 and short-term emergency shelters are also
22 incompatible given sort of the way you framed that.

23 We're not getting rid of those in the short-
24 term because you recognize that they're necessary. So
25 are you agreeing that encampments are also, in the

1 short-term, a necessary feature of the housing
2 stability system?

3 A. I believe your question is premised on
4 an equivalency between an encampment at 100 Vic with a
5 motel and a shelter. And I do not agree with that
6 equivalency.

7 68. Q. But I'm saying they're -- so much like
8 a motel and an emergency shelter, are not an ideal
9 state for people to be in. They are not permanent,
10 there's no security of tenure, congregate housing,
11 people don't want to stay there. Much like -- those
12 aren't ideal solutions but they're necessary. I'm
13 saying an encampment is similar to those in that
14 sense.

15 A. I'm -- again, I feel that you're --
16 this is premised some level of equivalency. And I ---

17 69. Q. In the sense that I've just described.
18 That they're not ideal but they're necessary because
19 we don't have functional zero.

20 A. If we have -- if we had resources -- if
21 we had the resources to provide people who are
22 sleeping outside to enter into a shelter or a motel,
23 we feel is a better alternative given their -- those
24 options are inside and there's levels of safety and
25 staff involved versus the encampment at 100 Vic which

1 has none of those things.

2 70. Q. But that's not the reality of the
3 situation we're in. We don't have shelter beds for
4 everybody.

5 A. Yes, I agree, it doesn't. Yes, I
6 agree.

7 71. Q. Okay. So, I mean, I'm just suggesting
8 that, again, encampments are a necessary in the short-
9 term give the disparity between the number of
10 unsheltered people and the availability of permanent
11 housing. Until we get to that functional zero state.

12 A. And I will say I acknowledge what
13 you're suggesting.

14 72. Q. Okay. Was it the lack of a plan to
15 address the situation of people needing to put up a
16 tent somewhere and not having any sort of policy or
17 protocol? Isn't that harmful to people because it
18 will result in them having to constantly set up, take
19 down their tents, be harassed by by-law, be moved on?
20 Isn't that going to cause harm?

21 A. There are a few questions there.
22 What's the -- can you be specific, please?

23 73. Q. Is it harmful to people to not have
24 some sort of protocol that allows them to set up a
25 tent somewhere? Because it's going to subject them to

1 harassment by by-law in having them to set up their
2 tents, take them down, move around?

3 A. I can't comment on what is or is not
4 harmful at an individual level. And I've already
5 addressed the question around safe tenting in terms of
6 what would need to be in place from what isn't
7 currently in place.

8 74. Q. So you don't accept that people being
9 displaced continually is harmful to them?

10 A. I acknowledge that any scenario where
11 individuals in this community don't have a safe place
12 to sleep at night can be very harmful.

13 75. Q. Okay, so you're -- that's a "yes" to
14 that question.

15 A. No, it's how I phrased it.

16 76. Q. I want to talk about chronic
17 homelessness because we talked about -- I want to look
18 at Paragraph 9 of your third affidavit. I'll let you
19 turn to that.

20 A. Yeah.

21 77. Q. So here you say that 23 of the
22 individuals ---

23 A. Can you remind me -- can you remind the
24 -- where's the date. I'm trying to ---

25 78. Q. Of your third ---

1 A. Yeah.

2 79. Q. --- affidavit?

3 A. Because I know -- this is a Point in
4 Time, I just want to make sure I'm mentally ---

5 80. Q. It is ---

6 MR. LOKAN: It's July 31st.

7 THE WITNESS: Okay, so these are numbers at
8 the end of July?

9 MS. DOWN: Yeah.

10 THE WITNESS: Okay. Thank you. Okay, go
11 ahead.

12

13 BY MS. DOWN:

14 81. Q. I know -- sorry, I know this is -- I
15 think this has changed since then but I just -- we can
16 talk about this and then we can talk about some of the
17 ---

18 A. Sure.

19 82. Q. --- the newer numbers. But so as of
20 July 31st, I think it -- there is a total of 23
21 individuals you said who were residing at the
22 encampment who had been assisted by the Region in
23 accessing alternate arrangements.

24 And I just wanted to know, do you know of
25 those -- the alternate arrangements, are any of those

1 permanent housing? Or what number of permanent
2 housing versus shelter and motels?

3 A. I don't have that information. I would
4 need to go and get that information.

5 83. Q. Okay.

6 A. I don't have information on individual
7 cases, Shannon.

8 84. Q. I'm not really interested in the
9 individual cases; I'm just wanting to know like what
10 the breakdown is ---

11 A. And I don't have that.

12 85. Q. --- between people -- okay. Is that
13 something you could undertake to get?

14 A. Yeah, we would keep track of where
15 folks moved onto.

16 86. Q. Okay. I mean, I don't think -- it's
17 unlikely that those are all permanent housing. Is
18 that fair to say?

19 A. That's fair.

20 87. Q. Okay. And would you expect that a
21 significant number -- just rough guesses -- would a
22 significant number of them not be permanent housing?
23 Like ---

24 A. Based on what I understand, Shannon,
25 how this is rolled out over the last number of months,

1 I would agree that the vast majority of individuals --
2 and I don't have a number, but I can get it for you --
3 who have been supported off of 100 Vic have been
4 supported into non-permanent transitional
5 accommodations of some sort.

6 88. Q. Okay. And in Paragraph 10 you talk
7 about the fact that ---

8 A. Can I also just -- can I also just add?
9 All of those, in each of those situations, those
10 decisions would have been made within -- with consent
11 from the individuals moving from 100 Vic to wherever
12 that would be.

13 89. Q. That's fine. So in Paragraph 10, you
14 talk about the fact that these alternate arrangements
15 are not time-limited, there's no expiry date by which
16 these individuals need to leave. And I just want to
17 clarify that statement.

18 That doesn't mean, though, that they have
19 any kind of security of tenure in those non-permanent
20 -- like if it's not permanent housing.

21 So if people had been put in shelters or
22 motels, there's no suggestion by you that they have
23 any security of tenure in those situations?

24 A. And security of tenure as you relate it
25 to the Act?

1 90. Q. Well security of tenure meaning like if
2 you -- if I'm in an emergency shelter and I do
3 something that's against the rules, I can just be
4 kicked out.

5 A. Mm-hmm.

6 91. Q. And I could be barred. If I'm in a
7 motel and the motel owner says I don't like what
8 you're doing, I can be kicked out. If I'm a tenant in
9 an apartment, there's a process. I have to be ---

10 A. Yeah.

11 92. Q. --- provided with notice, I can ---

12 A. Yes.

13 93. Q. --- challenge the notice, like, you
14 know.

15 A. Then, yes.

16 94. Q. There's a whole system.

17 A. Yeah.

18 95. Q. Okay. So you're not -- I just want to
19 clarify you're not suggesting that there's any
20 security of tenure. Like you said there's no --
21 there's no time limit but there's no security for
22 them. So they -- it's not permanent.

23 A. So, yes, so as you've defined security
24 of tenure, no, I am not suggesting that is the case.
25 The point of paragraph -- what are we on? Ten? No,

1 what are we on?

2 96. Q. Ten.

3 A. Ten.

4 97. Q. Just 10, yeah.

5 A. Sorry, you've got 9 there. Ten was to
6 make clear that we were not putting an artificial
7 time-constraint on individual stays in any of those
8 options.

9 98. Q. Okay, and I am going to talk to you a
10 little bit about the funding attached to that later
11 but I ---

12 A. Yeah.

13 99. Q. --- just want a couple more questions
14 about that. So, and in fact, would you agree that
15 people do get kicked out of shelters and motels and
16 end up back on the streets with some frequency?

17 A. I will acknowledge that that happens.

18 100. Q. I just want to go back to that slide
19 deck that was the Co-creators' slide deck. And ---

20 MR. LOKAN: Shannon, I can do this in re-
21 examination or you can consider it now. I
22 think there's something that you haven't
23 covered which is what happens in those -- on
24 those occasions when somebody finds that
25 they are no longer welcome at a hotel or a

1 shelter. And that is a question I'd ---

2 MS. DOWN: Sure, we can explore that.

3 MR. LOKAN: I think it might be better from
4 your point of view to do it at this point.

5 MS. DOWN: Sure.

6
7 BY MS. DOWN:

8 101. Q. So what happens to those people when
9 they get kicked out of the shelter or the motels?

10 A. So as I said, I am aware that those
11 scenarios do occur. And, you know, through our work,
12 our outreach work, either our own regional staff or
13 with our partners, we do our best to re-engage. And
14 try to find folks yet another additional alternative
15 location or we work with the service provider on
16 service restrictions.

17 102. Q. Okay.

18 A. So we -- they come back and, in some
19 cases, we start that conversation again.

20 103. Q. Okay, is that always successful in
21 finding those people another spot to stay?

22 A. I don't have the success rate,
23 transition rate handy.

24 104. Q. Okay, but is it possible like does it
25 happen that sometimes people are barred system-wide

1 from any emergency shelter?

2 A. I don't know.

3 105. Q. I have heard that, you know, I've heard
4 workers talk about the fact that there are system-
5 wide. So maybe can you confirm through an undertaking
6 whether system-wide ---

7 A. Occur?

8 106. Q. Yeah.

9 A. I can ask.

10 107. Q. Okay, thank you.

11 **UNDERTAKING**

12
13 108. Q. So if we go down to Slide 7. So this
14 is talking about the emergency shelter service
15 restrictions. So in the month of October it's saying
16 that there were 45 issued across eight shelters. And
17 that the median length of restriction was four days.

18 So this, I mean, this slide seems to be
19 suggesting again that this happens with some
20 frequency. Is that -- would you agree?

21 A. Again, I can't speak to frequency
22 without seeing it relative to other data points.

23 109. Q. Okay.

24 A. But it clearly happens. I think we all
25 know it happens.

1 110. Q. Okay, and that median length of
2 restriction is four days. But my understanding is
3 that the restrictions can be -- like they can be days,
4 weeks or months; is that your understanding?

5 A. I don't know the range but I will also
6 point out that the service restrictions themselves and
7 the length of time are determined by the operator, the
8 independent organizations that we fund. They are not
9 mandated or directed by regional staff or policy.

10 111. Q. Okay, does the Region -- and when
11 you're funding shelters, do you have any sort of set
12 of standards that you ask shelters to abide by? Like
13 are there shelter guidelines that the Region produces?

14 A. Yeah, we have MOUs with each of the
15 partners. I -- yeah, we have MOUs and contracts and
16 service-level expectations around -- around those
17 contracts. In my ---

18 112. Q. Okay.

19 A. Yeah.

20 113. Q. Okay. But there's -- I mean, clearly,
21 you know, these restrictions whether it's the Region
22 -- even if it's not the Region, these restrictions are
23 happening and people then could be barred from one or
24 more shelters for a number of days.

25 A. Yeah, we know that individuals within

1 this particular population sometimes behave in ways
2 that are deemed to be -- well, you see the top three
3 reasons right there. And there are occasionally
4 consequences for that kind of behaviour, that ---

5 114. Q. Okay.

6 A. --- we understand ---

7 115. Q. And ---

8 A. Yeah.

9 116. Q. Okay, and so the people who are being
10 moved out of 100 Victoria Street into motels or
11 shelter are subject to this risk as well. That they
12 could be -- they could be barred, they could be kicked
13 out, they could end up having to go back to an
14 encampment?

15 A. I'd say anybody, regardless of where --
16 where you're coming from, whether it be 100 Vic or
17 elsewhere, individuals who enter into the housing
18 stability system, this is -- this is a reality in the
19 shelter system that ---

20 117. Q. Okay.

21 A. --- certain behaviours are -- can
22 result in service restrictions.

23 118. Q. Which is a big -- like which really
24 distinguishes it from permanent housing. So it's not,
25 you know, I'm just -- part of what I'm -- I want to

1 make the point of is that these options are not a
2 substitute for permanent housing because there is no
3 security of tenure.

4 A. Yeah, I would say we don't ever try to
5 suggest that an emergency shelter is an equivalent of
6 permanent housing ---

7 119. Q. Okay.

8 A. --- which is why we insist on having
9 housing plans.

10 120. Q. Okay. And yesterday at one point, I
11 think you mentioned that -- and correct me if I get
12 this number wrong -- I think you said that you've seen
13 an eight percent decrease in overall homelessness
14 recently?

15 A. Yeah, we sent a report to Council. I
16 did not go look it up because I didn't think I was
17 allowed. We sent ---

18 121. Q. Okay.

19 A. --- a report to Council and we reported
20 a decrease in overall experience of homelessness based
21 on our data by eight percent.

22 122. Q. Okay. And I'm just going to turn --
23 ask Charlotte, can you turn to Slide 11 from this
24 slide deck? So I don't know if it -- maybe we have to
25 go to the previous slide for a second.

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1 So I think it's showing trends on PATH, the
2 PATH system. And so if you go back to No. 11, my
3 understanding of this slide is it's showing a six-
4 month trend between inflow into chronic homelessness
5 and outflows into housing. And that explains
6 somewhere but I don't know if that's at the bottom
7 where it's not showing on my screen right now.

8 Charlotte, is there a way to go down on that
9 slide? Because it doesn't say that but I know when I
10 looked at it, I think it actually ---

11 MS. SCHIUTEMA: Is it a note to the slide?

12 MS. DOWN: It might be.

13 MS. CAHILL: Is there a way to see the notes
14 from this viewer app or ...?

15 MS. DOWN: Yeah, there doesn't seem to be.

16
17 BY MS. DOWN:

18 123. Q. Anyways, I mean it is showing an inflow
19 and outflow. I can -- I mean, maybe we can -- I can
20 ask for an undertaking that you clarify what this is
21 showing.

22 But my understanding is that it's showing
23 that for these months between May and October, that
24 there is an inflow of like 27, 23, 25, 16, 21, 30
25 people into chronic homelessness. And then the green

1 line was the outflow of people from the system into
2 housing.

3 So sort of comparing like who is coming in,
4 who is going out. And it seemed to be showing that
5 there's -- there's a greater inflow except for the
6 month of August and the month of September where it's
7 equal.

8 There seems to be a trend towards a greater
9 inflow into the system than there is an outflow. Does
10 that -- is that what you're seeing as well?

11 A. I mean, you're asking -- you're making
12 a bunch of assumptions on a slide deck I've never
13 seen.

14 124. Q. Okay.

15 A. And so, I'm you know, I'm not going to
16 go on a record and analyze data I have not seen.

17 125. Q. Okay. Can you -- I mean ---

18 A. I'm happy to take it away but that's
19 ---

20 126. Q. So, I mean, I guess I'm asking -- maybe
21 I'll just ask you like are you getting reports of this
22 from your staff? Like the influent of chronic
23 homelessness is increasing overall? Or -- because
24 that eight percent number that you're saying, I am
25 just trying to understand that. Like that makes it

1 sound like things are improving.

2 A. Yeah, we ---

3 127. Q. This slide seems to be telling me
4 something else that ---

5 A. So look, a) I don't know what we're
6 counting here. You've made the assumption that it's
7 chronic homelessness. I don't know that. What I can
8 tell is what we were -- most publicly reported is an
9 overall -- and I am on the record somewhere on YouTube
10 or one of my staff is -- an overall decrease in the
11 rate of homelessness by eight percent.

12 And while chronic homelessness continues to
13 be on the rise, it is rising at a decelerated rate
14 than it has been for the last number of years. I
15 don't have that number. I have a number in my head
16 but I don't have the report so I don't want to quote
17 it.

18 128. Q. Okay.

19 A. We know -- so what we're -- never mind,
20 I'll just leave it there.

21 129. Q. Okay.

22 A. But I can't go any further on this
23 particular dataset without more information.

24 130. Q. That's fine. Yeah, that's fine,
25 though. But your understanding is that chronic

1 homelessness is on the rise, although you said at a
2 decreased rate. But it is still rising?

3 A. Yes, that's -- that's the trend that
4 we've reported to Council and the community.

5 131. Q. Okay. And the chronic homelessness is
6 -- my understanding of the definition is that you've
7 been homeless for six months of the last 12 or 18
8 months sporadically over a three-year period. Is that
9 your understanding as well?

10 A. That's my understanding of how we
11 define it as well.

12 132. Q. Okay. And can we agree that chronic
13 homelessness happens when people just don't have any
14 exits out of the emergency shelter or the non-
15 permanent housing stability system into permanent
16 housing?

17 I just -- like they're kind of -- they're
18 stuck in the washing machine, the rinse and repeat
19 cycle?

20 A. Yeah, absolutely. I mean, I think we
21 -- it's well-understood that ---

22 133. Q. Yeah.

23 A. --- that's the case.

24 134. Q. Okay. And so, the people from the
25 encampment who have been offered alternate

1 accommodation that isn't permanent housing ---

2 A. Mm-hmm.

3 135. Q. --- they're still in that chronic
4 homelessness, potentially, situation where they're not
5 -- like I -- it seems like for a lot of people, the
6 prospect of them actually getting permanent housing is
7 remote. Because there is this rising trend of people
8 who are experiencing this long-term chronic
9 homelessness; that the exits are just not available
10 particularly for a lot of our clients who are on like
11 social assistance if you're on Ontario Works or ODSP.
12 Is that a fair statement?

13 A. Yeah, I think it's a fair statement
14 without -- you know, we -- the plan to end chronic
15 homelessness has -- is designed for two things. It's
16 to slow the inflow through upstream prevention as much
17 as possible. And to increase the outflow that
18 requires an entire systemic response.

19 And also acknowledges that the reasons for
20 chronic homelessness are multi-factorial. And, you
21 know, in a lot of cases, that there's a lot -- there's
22 a lot that individuals are facing all at the same
23 time.

24 136. Q. Okay. And if we turn to Slide 15 of
25 this exhibit, it's showing us a percentage of chronic

1 homelessness in adult shelters. So it's saying that
2 the people who are in the shelter, this is the
3 percentage who are considered chronically ---

4 A. Considered chronic?

5 137. Q. Yeah.

6 A. Okay.

7 138. Q. It seems like those numbers are very
8 high to me, like the overall number is 74 percent, 67.
9 Like November there's a slight dip in October.

10 But, you know, it's ranging between 67 and
11 74 percent which is significantly more than half of
12 the people who are in the shelter system who are
13 chronically homeless. So they've been homeless for
14 like a long period of time.

15 A. Mm-hmm.

16 139. Q. Would you agree that that's a pretty --
17 it's a large -- like it -- I was shocked when I saw
18 this number. It seems like a very large number.

19 MR. LOKAN: Again, Shannon, I'm just
20 wondering about the assumptions. Because I
21 see Erbs Road with 96 percent. And just
22 looking at the face of this document -- and
23 again, this witness has not previously seen
24 this document. So I am wondering whether it
25 is capturing when people enter into they

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1 were chronically homeless or people who are
2 established there are chronically homeless.

3 And the reason I ask that question is
4 just because Erbs Road, my understanding is
5 that that is longer-term.

6 MS. DOWN: It's not permanent housing
7 though.

8 MR. LOKAN: Okay.

9
10 BY MS. DOWN:

11 140. Q. It's transitional housing so people
12 could still be there and be considered chronically
13 homeless. Is my understanding. Is that correct,
14 Peter?

15 A. Yeah, I believe if you're sort of in
16 the housing stability system, that that doesn't
17 automatically sort of shift you from a category. So
18 ---

19 141. Q. You're not in permanent housing, you're
20 still ---

21 A. You're not in permanent, yeah. So what
22 was your question about this? Just my response ---

23 142. Q. No, I'm just -- I'm just like -- I
24 mean, I'm just asking -- I'm saying this is a pretty
25 high number. I guess like the conclusion that I come

1 to is that it's -- it seems like it's -- there's a
2 large number of people who are in the system who are
3 chronically homeless.

4 Which means, it's not like -- it's not a
5 short -- it's not a short stay for them in the
6 emergency shelter system. They're there for many
7 months or years, potentially, before they're getting
8 permanent housing.

9 A. Yeah, we've been, again, very clear and
10 transparent that in an environment where chronic
11 homelessness in this community, in this province, in
12 this country is accelerating, in some cases
13 exponentially, that emergency shelters have become
14 long-term transitional housing for a lot of people.
15 We are -- we've acknowledged that that is a challenge
16 in this work.

17 143. Q. Right, and they weren't really -- that
18 system wasn't really designed to act in that way. So
19 I mean, it's not really a system that's -- that's
20 designed to make people feel comfortable in those
21 circumstances. Is that accurate?

22 A. Yeah, my understanding is that, you
23 know, the system in which we all operate, again,
24 provincially, locally, nationally, was designed around
25 instances of homelessness that was rare, brief and

1 non-reoccurring. Which is why we're trying to get
2 back to that.

3 144. Q. Right, so if you're someone who is
4 chronically unhoused and you're in the emergency
5 shelter system, so that could mean that you're
6 spending months in a situation where you're living in
7 congregate settings.

8 So you might be -- you might have a bed in
9 that space with 60 other people every night. You
10 don't have any privacy; you don't have any place to
11 really -- or very minimal space to store your
12 belongings.

13 It's not -- it's not really designed for
14 people to be there for long-term. Would you agree?

15 A. I would agree.

16 145. Q. And so that could be -- that's a
17 significant factor in why people might end up in an
18 encampment like 100 Victoria Street.

19 A. Yeah, again, I think well-documented
20 that we know from conversations with people why the
21 current emergency shelter system is not -- doesn't
22 meet everybody's needs. We know that, you know,
23 people have told us that. That's one of the reasons
24 why we started Erbs Road was to add a new element to
25 this, as an example. That's why we're building --

1 trying to build affordable housing.

2 146. Q. Okay. I want to go back to the issue
3 of whether there's any of the alternative
4 accommodations, time-limited. And I think it might be
5 helpful to take a look at the staff report ---

6 A. Yeah.

7 147. Q. --- from the April 23rd Council meeting.

8 A. Yes.

9 148. Q. Because that has the budget for those
10 items. Charlotte, if you can put that up on the
11 screen.

12 MS. CAHILL: Maybe take down screensharing
13 and try again because it doesn't seem to be
14 loading.

15 MS. DOWN: Thanks.

16 MS. SCHIUTEMA: And I am wondering if we're
17 waiting for the document to be loaded, we
18 said we'd take a break around 11:00. Should
19 take a short break?

20 MS. DOWN: Sure we can do that. Do you want
21 to take a break now and then we'll come back
22 and we'll get that document on the screen?

23 THE WITNESS: Sure, whatever.

24 MS. DOWN: Okay, should we take a -- how
25 much, 10 minutes, 5 minutes? Ten minutes?

1 THE WITNESS: Sorry, ten?

2 MS. DOWN: Ten. We'll be back at -- how
3 about we say we come back at 11:10.

4 THE WITNESS: Okay.

5 MS. DOWN: Thanks.

6
7 --- BRIEF RECESS

8
9 --- SCREENSHARE

10
11 MS. DOWN: So, Charlotte, if you can go
12 down, there's -- I think it's a couple of
13 pages down, there's the budget.

14 THE WITNESS: Is this when the by-law came
15 out?

16 MS. DOWN: Yeah.

17 THE WITNESS: Okay.

18 MS. CAHILL: Is this the page?

19 MS. DOWN: Page 6?

20 MS. CAHILL: You said Page 6?

21 MS. DOWN: Yeah.

22
23 BY MS. DOWN:

24 149. Q. This question is around the statement
25 that you made in your -- I think it's the fourth

1 affidavit or the third affidavit. I can't remember
2 which one. About the -- not being time-limited.

3 A. Time-limited?

4 150. Q. Yeah. So I just want to clarify
5 because my understanding was that when the -- this
6 budget was produced, that the amount for the motels
7 was only for 2026. Has that changed?

8 A. No, for this specific allocation, like
9 new hotel funding, the proposal to Council was just
10 for 2026 and not itemized in the 2027 at the time of
11 consideration.

12 151. Q. Okay, so is that -- does that suggest
13 then that the 23 people who had been placed in
14 alternative accommodations, none of them were placed
15 in motels then? Because you made the statement that
16 none of that was time-limited.

17 A. Yeah, so I understand why you're asking
18 this question so I will do my best to clarify for you.

19 The individuals -- any individual who
20 receives an offer of a motel and accepts, will not, on
21 an individual level, be removed from that motel by the
22 Region with no other place to go. So that's -- that
23 is a true statement.

24 The budget here considers that at the time,
25 if you recall in April, we were considering that there

1 were 40 people, roughly, on the site, the budget
2 considers supporting 40 individuals. And considers
3 that motels are designed to be a first step in some
4 cases to different levels of transitional housing.

5 And knowing that we have transitional and
6 supportive housing units coming online, the plan would
7 be that those individuals would not -- we would be
8 able to be in a place to offer those individuals
9 something next on their journey before the end of
10 2026. So that's the -- that was the logic behind.

11 152. Q. Okay. So the new transitional housing
12 in its -- people from motels would be transitioned
13 into them?

14 A. That's ---

15 153. Q. The ---

16 A. That's the logic behind the budget,
17 yes.

18 154. Q. Okay, but is that for sure like they
19 will get those beds in the transitional housing?

20 A. No, I think what's important to
21 consider here is that we're talking from a system
22 perspective. And so we allocate the resources on a
23 system-wide basis. And from a budgeting perspective,
24 we have to think about it from a systems perspective.

25 So that's the logic behind this.

1 155. Q. Okay.

2 A. But at an individual level,
3 hypothetically, if there's somebody from 100 Vic who
4 is offered and takes a place in a motel with the
5 social supports, if at the end of 2026 they don't have
6 another alternative, we will not be -- the Region
7 would not move them into homelessness.

8 156. Q. I mean, in -- so like in that
9 hypothetical situation, if shelters were full at that
10 time, and these transitional housing units aren't
11 available, what would happen?

12 Like is there going to be more money that's
13 going to be allocated for motels at that time then?

14 A. So I don't have the actual number but
15 this -- this is not the full motel allocation across
16 the Region's housing and homelessness budget. This is
17 an addition to that budget.

18 157. Q. Okay. But my understanding -- and you
19 can correct me if I am wrong -- is that that overall
20 motel budget is based on like estimates. And there
21 have been times where the Region has run out of
22 funding under those -- that allocation for motels
23 during -- like during the fiscal year.

24 Is that -- has that happened?

25 A. So it's not uncommon in our work or in

1 most organizations that the budget allocations on a
2 line-by-line basis don't have some variance.

3 We're required to live within the global
4 envelope of the housing and homelessness budget. And
5 so if there's situations where we need to move things
6 around, and we can, we do that.

7 158. Q. Right, but I -- that's what I was
8 asking about. Was for the motels, like have there
9 been situations where the Region has run out of
10 funding for motels like during the year before a new
11 allocation -- like before the next budget cycle starts
12 or the next fiscal year starts the budget cycle, the
13 next fiscal year starts.

14 Like there's a certain amount allocated. So
15 do you run out and then there's like -- well, there's
16 no more money for motels for the next two months
17 because we have used up all our motel funding for this
18 year.

19 A. So in my time at the Region, there has
20 never been a time -- a situation where we've had to
21 say there's no money left for this specific item.
22 What we do is we -- we live within the global
23 envelope.

24 159. Q. Okay.

25 A. So if we have -- if we have an

1 overspend in one area, it's incumbent upon me and my
2 staff to live within the funding envelope and that's
3 what we try to do.

4 That doesn't mean that every line item goes
5 off exactly on budget. I would say I've never seen an
6 organization that can do that.

7 160. Q. Okay. As you said, this was premised
8 on the original plan of there being 40 original ---

9 A. Correct.

10 161. Q. And no new inflows after the by-law was
11 passed. That obviously didn't come to pass because of
12 the injunction motion. Has there been an adjustment
13 to this plan because of the injunction and the fact
14 that there are new residents or new encampment
15 residents coming on a continual basis?

16 A. So we haven't -- Council did not add
17 any further resources to our 2025 operating budget.
18 And so, individuals who have arrived at 100 Vic will
19 continue to be supported by our system as -- as we can
20 and as we're able. Much -- regardless of whether
21 they're at 100 Vic or whether they would have shown up
22 somewhere else in the system across the community.

23 162. Q. Okay, so there is no new money.

24 A. Correct.

25 163. Q. Or to sort of to make up for the fact

1 that this plan is -- is no longer the plan because of
2 the injunction?

3 A. Council has not added any further
4 funding beyond what you see here to the '25 ---

5 164. Q. Okay.

6 A. --- operating budget.

7 165. Q. Okay. And so there -- I mean, that
8 obviously will have implications for what can be
9 offered to the people who are there at the encampment
10 in terms of there might not be hotel beds available
11 for the new residents who are coming into the
12 encampment because they -- that wasn't budgeted for?

13 A. Yeah, I think that's no different than
14 any other year where we are trying to support as many
15 people we can with limited resources, and capped
16 resources.

17 166. Q. Okay, but in this specific -- like we
18 know that there's a deadline that people are going to
19 be, at some point, that they -- according to the
20 Region, there's a deadline at some point that you need
21 this property by. And that you're going to be looking
22 to move people on.

23 There isn't going to be funding for the
24 additional people who have moved in to go into motels.
25 So if there's no new shelter beds, what's -- what will

1 happen to those people at that time?

2 A. So one of the things that we continue
3 to try to do is, (indiscernible) for a system, is to
4 move people where we can through a system. And we
5 will -- we will max out the resources that we have for
6 as many people as we can.

7 167. Q. Okay. And obviously, in a situation
8 where you -- we've looked at, you know, this problem
9 of more people becoming chronically homeless, more
10 people sort of -- which means there are more people
11 getting stuck in the system, that your ability to
12 actually implement something -- like it's one thing to
13 say we're going to try. But we're seeing a system
14 that's it become increasingly, if I can use the term,
15 "clogged up."

16 So it's going to become even more
17 challenging as time goes on to find somewhere to put
18 those people. Because people aren't moving out of the
19 system; there's more people coming in and then
20 becoming chronically homelessness.

21 A. Which is why our plan to end chronic
22 homelessness is also buttressed with building better
23 futures and looking to add both affordable and
24 supportive housing net new units. It's -- the plan is
25 to ideally address both the inflow and the outflow.

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1 168. Q. And that's the plan -- I don't have the
2 paragraph in front of me right now -- but that's the
3 plan to add, I think it's 2,500 units over ---

4 A. (Indiscernible).

5 169. Q. --- by 2030. And, I mean, you know I
6 think that everyone agrees that that's great. But
7 we're also in a situation where I think the housing
8 waitlist is -- I don't know what the number is. I
9 haven't looked at it recently. I didn't have a chance
10 to look it up. But something like 7,000 households on
11 the -- 7, 8,000 households on the housing waitlist?

12 A. Yes, so we're moving from a place where
13 traditionally at a municipal level we were adding, I
14 believe before I arrived, before Building Better
15 Futures, 50 units a year to 500 units a year. And
16 we've been very transparent to say that without
17 stemming the inflow and preventing chronic
18 homelessness in the first place, it'll be continuing
19 to be a challenge to ensure that everybody does have a
20 safe place to call home.

21 170. Q. Right. So that, I mean, even though
22 the 2,500 number is a good number, it's not going to
23 -- it's not going to solve the problem when you have 7
24 or 8,000 households on the housing waitlist.

25 A. Not in and of itself.

1 171. Q. Okay.

2 MR. LOKAN: Can you first, Shannon, perhaps
3 let us know where the 7 or 8,000 number
4 comes from?

5 MS. DOWN: Sure.

6
7 BY MS. DOWN:

8 172. Q. Peter, does that number -- it comes
9 from the -- I actually looked on the Region's website
10 to see if I could find the number, and I couldn't find
11 it easily this morning.

12 A. Yeah. I don't know where we publicized
13 -- I can't even speak, sorry.

14 173. Q. I wish it was on the Region's website.

15 A. It's going to be a long day. I don't
16 have the number handy. I actually believe it's higher
17 than what you've referenced. There's a lot.

18 174. Q. Okay, can we get an undertaking ---

19 A. Sure.

20 175. Q. --- for you to provide that, the number
21 of households who are on the housing waitlist? Yeah,
22 I kind of wish it was on the -- easily -- easily
23 located but it wasn't.

24 **UNDERTAKING**

25 A. I'll get on that.

1 176. Q. So I am going to -- I want to talk a
2 little bit about consultation -- issues around
3 consultation ---

4 A. Sure.

5 177. Q. --- because that's in your affidavit as
6 well. And I just -- like just generally to start
7 with. I think -- like when I think of consultation in
8 the context of policy issues, so we're not talking
9 about consultation at your doctor's office. We're
10 talking about consultation with government bodies
11 about decision-making on policies or other decisions.

12 I think that involves inviting people to
13 share their views like on an issue to help inform the
14 decision-making. Is that -- does that definition
15 resonate with you?

16 A. Yeah, I mean, I think there's a
17 continuum of consultation and, yeah, I mean, ideally,
18 it's listening to voices.

19 178. Q. Okay. And I'm going to suggest that
20 ---

21 A. Can you point me to what affidavit
22 we're going back -- like probably the first one,
23 right?

24 179. Q. I think this is on ---

25 A. I think we talked about this in the

1 first cross, my memory.

2 180. Q. I think this consultation part is on --
3 in your fourth affidavit.

4 A. Oh, okay.

5 181. Q. Give me one moment.

6 A. Sure.

7 182. Q. No, it's your third affidavit. So it
8 starts at -- the discussion on consultation starts on
9 page ---

10 A. Page or paragraph?

11 183. Q. Page 7, Paragraph 22.

12 A. Okay, if I can just go there.

13 184. Q. I have some general questions before we
14 get into the specifics. But that -- if you need a
15 second to ---

16 A. No, no, go ahead.

17 185. Q. --- (indiscernible). So and I mean I
18 think for consultation to be meaningful, I am going to
19 suggest that it needs to be somewhat open-ended and it
20 has to be, you know, on the one side, the ability to
21 share information. On the other side, a genuine
22 interest in receiving that feedback and taking it into
23 consideration.

24 A. Yeah.

25 186. Q. And there have not been any

1 consultations directly with a group of encampment
2 residents about the closure of the encampment, have
3 there?

4 A. With the development of the by-law?

5 187. Q. Yes. And like the plan to close the
6 encampment.

7 A. Yes, so I think we talked about this in
8 our first cross. And, you know, I am happy to have
9 this conversation about consultation broadly and
10 specifically.

11 In this specific case of the by-law, which
12 is what I believe we're uniquely talking about here,
13 I'm on the record and will continue to be on the
14 record to say that we shared, from a Community
15 Services and Housing and homelessness perspective what
16 we could, when we could. And there were other things
17 I ---

18 188. Q. That's not what I asked though. I
19 asked if there have been any consultations directly
20 with the encampment residents about the plan to close
21 the encampment?

22 A. There have been -- I have not
23 personally had direct conversations with encampment
24 residents.

25 189. Q. I am not asking you if you personally,

1 I am asking you if the Region has had any
2 consultations, held any consultations directly with
3 the encampment residents ---

4 A. Yeah ---

5 190. Q. --- about the closure of the
6 encampment?

7 MR. LOKAN: So, Shannon, are you including
8 or excluding in your question encampment
9 residents who spoke on the April 13th --
10 April 23rd meeting?

11 MS. DOWN: I'll get to that; I am talking
12 about consultations. That's a delegation
13 and I think that's something distinct from a
14 consultation.

15 MR. LOKAN: Well, your definition a minute
16 ago was the ability to share views with the
17 ability to influence decisions. And ---

18 MS. DOWN: Okay.

19 MR. LOKAN: --- you know, if you've got a
20 public meeting before the passage of a by-
21 law, that seems to fit squarely within your
22 definition.

23 MS. DOWN: Well, let ---

24 MR. LOKAN: I am asking you whether you are
25 including or excluding it in your ---

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1 MS. DOWN: I'll ask Mr. Sweeney about that.

2 But I'll get there but you're just going to
3 have to be patient.

4 MR. LOKAN: And you are going to have to be
5 accurate.

6
7 BY MS. DOWN:

8 191. Q. Yeah, I am asking if there was any --
9 excluding the delegation, were there any direct
10 consultations with the encampment residents about the
11 plan to close the encampment?

12 A. There were no, to my knowledge, direct
13 conversations with encampment residents about the by-
14 law prior to it becoming public.

15 192. Q. Okay, and have there been consultations
16 with the group of people who are living at an
17 encampment since the passage of the by-law about the
18 plan to close the encampment?

19 A. So on an individual level, our
20 unsheltered workers were and have been having
21 conversations about the potential for the encampment
22 no longer being an available place for folks. And to
23 engage with individuals on how that might impact them
24 on a specific individual level. And that has been
25 happening since April 16th.

1 193. Q. And so what was the feedback from that
2 consultation then?

3 A. Well, I don't have the case-by-case
4 feedback so I can tell you of the original residents
5 on April 16th, the vast majority of them have accepted
6 offers to go elsewhere.

7 194. Q. That's not what I am asking though.
8 Like so if you're ---

9 A. Well, it is what you're ---

10 195. Q. If you're ---

11 A. --- asking.

12 196. Q. --- characterizing -- no, I'm saying if
13 you're going to characterize individual conversations
14 with people as consultation, I think there needs to be
15 -- like if you're government, you're the Region, if
16 you're doing a consultation with people, I would
17 expect there to be some sort of record of that
18 consultation. Some sort of capturing of the feedback
19 that you're getting from people.

20 Like if you're saying that sort of
21 consultation with the people at the encampment about
22 the plan, I am asking you for what was the feedback
23 and where was that captured?

24 A. So -- and I will just go back and
25 clarify that your definition of "consultation" must

1 include the ability for an individual or a group to
2 influence a decision.

3 And in my role, I do not always have the
4 ability to offer individuals the ability to consult on
5 the outcome of a decision. And that decision is
6 squarely in the hands of an elected body.

7 So we had conversations with the residents
8 after the by-law was posted about how this might
9 impact them. And individual conversations about how
10 to navigate that decision by an elected body.

11 197. Q. But I thought you were at some point
12 said that there were conversations before about the
13 plan to close the encampment, individual conversations
14 with residents about the plan, before the by-law was
15 passed?

16 A. We have been -- in my reference that I
17 believe you're making -- I can't even speak -- it is
18 -- remains true that we have been -- both me
19 personally and the Region and individual staff on the
20 record -- since the day that 100 Vic became an
21 encampment, that this was a non-permanent solution.

22 And that at some point, the Region would
23 legitimately require this land for something else.
24 And when we knew that to be true, we would -- we would
25 tell people and we did that.

1 198. Q. Okay, so that's not really a
2 consultation, though. Just saying like this is our --
3 we have a plan to do this, this is what's happening.
4 That's not a consultation, is it?

5 A. So you're characterizing the
6 conversations and the things that we've said. In one
7 way, I am not consulting ---

8 199. Q. So you consider that ---

9 A. I am telling you ---

10 200. Q. --- a consultation?

11 A. I am telling you the conversation that
12 we had and what we committed to the community. And we
13 stuck to that.

14 201. Q. Okay. So what I am suggesting is that
15 prior to the by-law being passed, there was no sort of
16 attempt to consult with the people who were living at
17 the encampment, gather their feedback and use that
18 feedback to inform the process. I don't think that
19 process happened, did it?

20 A. The -- there was no conversation with
21 existing residents in the context of the Region
22 bringing forward a proposed by-law specifically to
23 weigh-in on that specific by-law.

24 There is, in my world right now, no
25 mechanism -- there was not a mechanism for that to

1 occur within the confines of a development of a by-
2 law, of this specific by-law.

3 202. Q. So you're saying it wouldn't have been
4 possible in your view to do that?

5 A. Given the constraints that are -- were
6 on me relative to confidential conversations that
7 Council holds, we shared what we could, when we could.

8 203. Q. So like at Paragraph 33, you say:
9 "... Based on the above, I would say that
10 the Region is consistently consulting
11 with those experiencing homelessness
12 and their advocates ..."

13 And I am focused mostly on the people
14 experiencing homelessness for the time being. But I
15 am trying to understand how you've come to that
16 conclusion when you're telling me that there was no
17 opportunity for the people in the encampment to
18 provide any kind of input on the plan to close the
19 encampment ---

20 MR. LOKAN: Shannon ---

21 MS. DOWN: --- prior to the by-law.

22 MR. LOKAN: --- to be fair to the witness,
23 you should give him the opportunity to look
24 over Paragraphs 23 to 32 before the one
25 where he says, "Based on the above." So

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1 that he's not ambushed.

2 MS. DOWN: So, I mean, he can look over
3 those, yeah, absolutely.

4 THE WITNESS: Yeah, I believe from ---

5 MS. DOWN: Because I don't see anything in
6 there where it talks about direct
7 consultation with the people who are living
8 at the encampment. There's discussion about
9 Co-creators group.

10 MR. LOKAN: Yeah ---

11 MS. DOWN: The Lived Experience Working
12 Group.

13 MR. LOKAN: Yes.

14 MS. DOWN: Other groups but not -- not
15 specifically the people who are living at
16 the encampment.

17 THE WITNESS: So, you know, I signed an
18 affidavit. I made a series of statements
19 and then at the end of it, I said what I
20 said on Paragraph 33, relative to sections
21 23 to 32, I guess.

22
23 BY MS. DOWN:

24 204. Q. But you used the words, "Those
25 experiencing homelessness," so which like -- which

1 people experiencing homelessness were you consulting
2 with?

3 A. So I will give an example. The
4 services being offered at 100 Vic as they are, the
5 provision of waste removal, the provision of toilets,
6 the provision of additional lighting, all came from
7 the voices of those who were actually living on that
8 site. And so that is an example that I am referencing
9 in specifically 32.

10 205. Q. Okay, and I am going to suggest that I
11 think there's a difference between responding to
12 complaints about the lack of services and having a
13 consultation. Because I think a consultation is
14 broader, it's not just "we don't have this, can you
15 provide it?" "Sure."

16 It's about the bigger issues, the policy
17 decisions. So that's what I am talking about really
18 when I am talking about consultation. I think -- I
19 mean, maybe we disagree on this but I think a true
20 consultation would be more than responding to specific
21 complaints about the lack of toilets or the lack of
22 garbage bins.

23 A. And I would say that the manner in
24 which the Plan to End Chronic Homelessness was
25 created, the lived expert mechanisms within that, I

1 would say represent a -- an example of what it looks
2 like to engage with and consult those with lived
3 experience.

4 206. Q. Yeah, and actually in PECH I was
5 reading that yesterday, reviewing it. And it talks a
6 lot about having direct -- doing direct consultation
7 with the people who are experiencing homelessness. So
8 to me that would be the people who are living at 100
9 Victoria Street.

10 So that's what I am trying to understand.
11 Why there wouldn't have been you know, why the Region
12 wouldn't have, say, had a public meeting with the
13 people at the encampment to talk about "here's what
14 we're planning to do."

15 I mean, there were meetings with the Co-
16 creators, there were meeting with Ally (ph). There
17 were meetings, other meetings that talked about it.
18 So it was -- obviously, it was something you felt
19 comfortable engaging with those groups. But it didn't
20 happen with the group at the encampment.

21 A. So, I mean, I guess I'm just going to
22 go back to like my earlier comment. In this specific
23 case, specifically about the development of this by-
24 law, we -- my team and myself, shared what we could,
25 when we could. And I don't know what else to say.

1 207. Q. Okay, but it wasn't with the group of
2 people who were living at the encampment. So you
3 shared stuff about the plan what you could and when
4 you could with other groups, but not with the people
5 who are living directly at the encampment. Is that
6 ---

7 MR. LOKAN: Which ---

8 MS. DOWN: Is that accurate?

9 MR. LOKAN: Sorry, which other groups are
10 you referring to, Shannon?

11 MS. DOWN: The co-creators, there was the
12 Lived Experience Working Group. There was a
13 number of meetings that took place talking
14 about ---

15 THE WITNESS: And I think we -- I would
16 characterize those conversations as an open
17 acknowledgment that there will come a time
18 when the Region, writ large, will
19 legitimately require that specific piece of
20 land and the encampment at 100 Vic will no
21 longer be available to people. And when and
22 if that time comes, we will share what we
23 can, when we can. And there was -- and we
24 did that as broadly as we could.

1 BY MS. DOWN:

2 208. Q. Okay, but not broadly enough that it
3 would include the people who are living at the
4 encampment?

5 A. So our outreach workers also had that
6 same knowledge and they may or may not have shared
7 that same messaging on an individual basis with
8 individuals. I have no -- I have no ability to say
9 one way or the other.

10 209. Q. Right, so you can't really claim that
11 that was consultation on those things.

12 A. I don't believe I claimed that. Could
13 you point to me where I claimed that?

14 210. Q. So you seem to be saying that -- I
15 mean, you do talk about the fact that the USWs are
16 engaging with them on a daily basis and that you
17 consider that to be, I think, consultation in this
18 affidavit. Because you say:

19 "... At the most direct level they're
20 engaging with them on a daily basis.
21 Doing so, they directly work with and
22 hear from an unhoused individual about
23 their needs and preferences ..."

24 And so I guess what I'm querying is, if
25 that's -- if that's going to be what's considered

1 consultation, I would expect there to be some sort of,
2 you know, this is what we've heard, this is the
3 feedback that we're receiving from people about this
4 plan and what, you know, as a group, their needs are.
5 And here's how that's going to influence what we're
6 doing.

7 A. Okay.

8 211. Q. But that doesn't -- I mean, I ---

9 A. All I can say is that ---

10 212. Q. --- haven't heard that that's what
11 happened.

12 A. I can only say I acknowledge what you
13 just stated. And your opinion on what I've got in my
14 affidavit that that's ---

15 213. Q. But you don't -- you don't think that
16 was, you know, a necessary step in this process to
17 consult with them directly about the plan either
18 before or after?

19 MR. LOKAN: Shannon, sorry, it ---

20 MS. DOWN: (Indiscernible) either.

21 MR. LOKAN: --- (indiscernible). This is an
22 objection.

23 THE WITNESS: Okay, thank you.

24 MR. LOKAN: It's the characterization of the
25 evidence that the witness has already given

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1 that I ask you to be accurate with. And he
2 has given evidence on -- in both of his
3 affidavit and in his answers on the
4 mechanism of USWs talking with individual
5 members.

6 And then your question blew right past
7 that and assumed that that hadn't happened
8 or didn't count.

9 MS. DOWN: But he said he's acknowledged
10 that ---

11 MR. LOKAN: If your point is that there was
12 no public meeting at the encampment with
13 residents en masse, sure, ask that factual
14 question. And then make whatever you want
15 with it in the argument of the case.

16 But the -- what you put to him just
17 now, with respect, was not a fair reflection
18 of the evidence he gave either in his
19 affidavit or in answering you just now. But
20 there was (indiscernible) with individual
21 members.

22 MS. DOWN: But he said that he doesn't know
23 whether -- he acknowledged that he doesn't
24 know what was discussed by the USWs with the
25 individual people. So he can't really

1 confirm that those discussions did take
2 place.

3 MR. LOKAN: Well, no, he confirmed the
4 discussions took place in his affidavit.

5 MS. DOWN: But he doesn't know what they
6 talked about. And there's no record --
7 there's no record of the feedback. So, I
8 mean ---

9 MR. LOKAN: Why don't you ask him if there
10 is any record of feedback?
11

12 BY MS. DOWN:

13 214. Q. Is there any record of the feedback
14 that the USWs would have received from the individuals
15 at the encampment about the plan to close the
16 encampment?

17 A. After the announcement that the by-law
18 was announced.

19 215. Q. Before or during or after?

20 A. So there wouldn't have been a
21 conversation about the specific by-law prior to it
22 being disclosed publicly by anybody. And then
23 afterwards, it's conceivable that there are case notes
24 from USWs on the nature of their conversations with
25 individuals after that.

1 216. Q. Okay, and were the contents of those
2 case notes provided to you in a rollup of any kind or
3 reported to you in some sort of systematic fashion so
4 that you could receive that feedback? Given that this
5 is potentially a consultation and use that feedback to
6 inform the decision-making?

7 A. So I think, you know, through affidavit
8 evidence, it's clear that there are individuals that
9 feel that there could have been further -- more
10 communication prior to the development of the by-law.
11 I think I've acknowledged that.

12 217. Q. I don't think you answered my question.
13 So you're saying that there could be -- there could be
14 information in the case notes from case workers. So
15 we're talking about consultation. And we're talking
16 about -- you're saying, well, USWs were engaging with
17 people about these issues. And there could be
18 information in the case notes.

19 What I'm asking you is if the Region was
20 treating this as consultation, that would imply that
21 there would have to be some mechanism for receiving
22 that information and pushing it up the chain of
23 command, up towards you on an aggregate basis.

24 Like I'm assuming that -- like if the
25 process is the USWs are going and talking to people

1 and putting it in their case notes and nobody's
2 reading it, then how is that a meaningful
3 consultation?

4 A. So, Shannon, can I ask you to please
5 point to me where I am on the record as saying that we
6 consulted with residents of 100 Victoria on the by-law
7 and the contents of that by-law before it became
8 public?

9 218. Q. I am not even asking about before but
10 we're talking about even -- so you're saying no, it
11 didn't happen before. I am asking after. So if those
12 conversations happened after the encampments being
13 closed, what do you think about that? What are your,
14 you know, how is this affecting you?

15 All of that is information. Like how is
16 that -- if you're saying those individual
17 conversations -- my understanding is you're trying to
18 say those individual conversations with the USW are
19 the Region consulting with individuals about this plan
20 after the by-law has been passed. Is that fair?

21 A. So I'm -- what I'm saying is the
22 decision to draft and propose a by-law was made
23 independently by Regional Council.

24 Once that became public through the regular
25 process, we were in a position to go and have

1 conversations with both the community and individuals
2 about what that means for them. Which is why we also
3 included in the by-law a significant length of time
4 and new resources.

5 Because we knew, through consultation and
6 conversations in general with those with lived
7 experience, that if this was going to be the case, we
8 would need both time and additional resources to
9 support the individuals living on the site. That came
10 from our understanding and our conversations with the
11 lived experts and our professional work.

12 219. Q. Okay, so those consultations and
13 conversations with the people who are living at the
14 encampment after the by-law was passed ---

15 A. Shannon, I have not used the word
16 "consultations."

17 220. Q. You just did.

18 A. I said "conversations."

19 221. Q. You actually added the word
20 "consultations" as well. So that's fine. If you're
21 saying it wasn't a consultation, let's agree that
22 there was no consultation with the people at the
23 encampment either individually or as a group before or
24 after the by-law.

25 MR. LOKAN: Shannon, the facts are for the

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1 -- inferences for the facts are for counsel.

2 MS. DOWN: I'm asking about specifically
3 whether something took place. It's not an
4 inference. I'm asking whether the Region
5 consulted with the people at the encampment
6 either individually or as a group, before,
7 during, or after the passage of this by-law.

8 MR. LOKAN: And the answer ---

9 MS. DOWN: It's a simple question. It's a
10 simple question.

11 MR. LOKAN: The answer -- instead of in
12 detail, factually over the last 20, 30
13 minutes and in the affidavit, here's all the
14 things the Region did. And you've asked him
15 to explain what happened. Sure ---

16 MS. DOWN: But he's ---

17 MR. LOKAN: --- ask him (indiscernible)
18 fine.

19 MS. DOWN: --- not answering -- he's not
20 actually answering the questions. Like this
21 is my -- maybe we can go off record for a
22 second.

23 MR. LOKAN: Okay.

24
25 --- OFF THE RECORD

1 MADAM REPORTER: We're back on.

2 BY MS. DOWN:

3 222. Q. In the notes that the USWs, has there
4 been any attempt to take what's in the USW's notes
5 based on those conversations they've had with the
6 people from the encampment, and provide it to
7 leadership at the Region to provide some information
8 about those conversations?

9 A. The feedback that I've received is
10 based on conversations that our outreach staff had
11 with individuals living at 100 Vic at the time that
12 the by-law came out, was that, generally-speaking, the
13 additional time and the additional resources were what
14 was going to be necessary to support the individuals
15 who are residing at 10 Vic at that time.

16 And so it affirmed the approach that we were
17 taking in that from a community services perspective,
18 we suggested, and ultimately were successful in
19 including in the by-law.

20 223. Q. Was there any other feedback from those
21 conversations that was passed along?

22 A. There was feedback, specific feedback I
23 both think in the affidavits and that I heard relative
24 to the day -- the day that the by-law got posted
25 around -- so that's the specific feedback. But

1 relative to the housing plans? No.

2 224. Q. The affidavits are not -- I mean, what
3 we're talking about -- we're not talking about our
4 affidavits.

5 A. (Indiscernible).

6 225. Q. We're talking about -- we're talking
7 about -- you're saying USWs have conversations with
8 people and that's forming the feedback that the Region
9 is taking into consideration. So I am asking you
10 about that. Is there any other feedback other than
11 the timing?

12 A. The timing ---

13 226. Q. Was there any other feedback that was
14 received from those conversations with people at the
15 encampment?

16 A. Not specifically that I can recall
17 beyond the affirmation that the additional resources
18 and the additional time were both necessary
19 ingredients that were going to be required to support
20 people.

21 227. Q. Were USWs given specific direction to
22 engage in questions that were related to a, like a
23 consultation-type of process with the people at the
24 encampment?

25 So were they told we want you to go and talk

1 to your clients and find out how is this affecting
2 you? What do you think about this? What are your
3 thoughts?

4 A. I don't have -- I am not aware of
5 specific direction one way or the other given to -- I
6 don't -- I don't direct the USWs. And so I don't have
7 that information.

8 228. Q. Okay. And presumably then, there
9 wasn't any direction for them to provide that feed --
10 you know, if there wasn't a -- if you're not aware of
11 any direction to them, then I am assuming there wasn't
12 -- you are not aware of any sort of results of any of
13 those other than the very limited part you just told
14 us about, the timing?

15 A. Yeah, the direction -- the job
16 description of the USWs didn't change. The direction
17 to the USWs was to increase their frequency at 100 Vic
18 and to take the time and resources that had been
19 allocated by Council. And to do their best to build
20 those relationships and provide people with
21 opportunities to go to an alternative location.

22 229. Q. Okay. And you state in Paragraph 39 of
23 that -- of your third affidavit ---

24 A. Third again?

25 230. Q. Sorry, 39.

1 A. Yeah.

2 231. Q. And you say that you -- your view is
3 that:

4 "... The Region did not need to undertake
5 specific consultations with community
6 members ..." ---

7 I'm assuming that means community
8 members not community team members:

9 --- "... to know that there would be
10 opposition to the closure in the
11 encampment ..."

12 A. Yeah, that's what I wrote and signed
13 off on.

14 232. Q. Okay. And so there was, in your view,
15 there was no point to talking about alternatives or
16 options?

17 A. No, but the affidavit is making a very
18 clear statement that I, personally, professionally and
19 my team knew and knows, that there would be opposition
20 in some corners of the community to enclosure of the
21 encampment.

22 233. Q. Okay, would there have been value to
23 having consultations about the way in which it was
24 going to be closed?

25 A. Sorry, would there be value?

1 234. Q. Yes.

2 A. We had -- I believe there were
3 conversations along the way. Yeah, so sorry, I'm done
4 going down a rabbit hole in my own head.

5 Sorry, what was the question? Can you
6 repeat?

7 235. Q. Would there have been value in having
8 consultations about the way in which the encampment
9 was going to be closed? If not the fact of it, just
10 the way that it was done?

11 A. There are always alternative options
12 available. Again, when it came to this specific by-
13 law, we were limited on what we could and could not
14 say publicly. So we did what we could.

15 236. Q. This might be a good time to take a
16 break because I think the next questions I'm getting
17 into are on a different topic. So maybe we want a
18 break early for lunch. And then when we come back, we
19 can get into the next ---

20 THE WITNESS: Sure.

21 MR. LOKAN: Okay. Off record.

22
23 --- LUNCHEON RECESS

24
25 MADAM REPORTER: We're on, Ms. Down.

1 BY MS. DOWN:

2 237. Q. Okay, so I am going to turn to your
3 fourth affidavit.

4 A. Yeah.

5 238. Q. I know we're flipping back and forth
6 here but ---

7 A. Okay.

8 239. Q. --- in Paragraph 7, if you want to turn
9 to that.

10 A. Yeah. So this is just the part of your
11 affidavit that it's talking about the evidence from
12 ---

13 A. Yeah.

14 240. Q. --- Leanne Hundt.

15 A. Yeah.

16 241. Q. And just talking about Indigenous
17 funding that the Region does for Indigenous-related
18 housing initiatives.

19 And so you mention in that paragraph that
20 the Region provides housing to Crow Shield Lodge as
21 well as Healing of the Seven Generations for
22 Indigenous-led housing and homelessness initiatives.

23 Can you just confirm that neither of those
24 involve funding for Indigenous-specific emergency
25 shelter beds?

1 A. That's correct.

2 242. Q. And the funding that's provided to the
3 KW Urban Native Wigwam Program, it does not involve
4 funding for Indigenous-specific emergency shelter beds
5 either?

6 A. That's correct.

7 243. Q. Okay. And the Region as a funder of
8 housing projects you don't operate these projects but
9 you still exert control over how funds are used which
10 would be in accordance with the funding agreements
11 that is tied to those funds?

12 A. Yeah.

13 244. Q. Okay. And so, is it fair to say that
14 it would be within the Region's ability to fund
15 Indigenous-specific emergency shelter beds if it so
16 chose?

17 A. If there was an opportunity and
18 resources to do so, yes. There's nothing preventing
19 that within our mandate.

20 245. Q. Okay. But those currently don't exist?

21 A. Agreed.

22 246. Q. Okay. And outside -- sorry, maybe just
23 another general question. Outside of the
24 organizations that we've discussed, there aren't any
25 other Indigenous-specific emergency shelter services

1 provided by other organizations?

2 A. In Waterloo Region?

3 247. Q. Yes.

4 A. Not that I am aware of.

5 248. Q. Okay. And now I just want to talk a
6 little bit about options for women and gender-diverse
7 individuals.

8 A. Mm-hmm.

9 249. Q. Sorry, just before we go to that, just
10 one last question. And I think it's acknowledged and
11 uncontroversial to say that the Indigenous population
12 is disproportionally represented in the homelessness
13 population in reference to their numbers in our
14 population in general?

15 A. Yeah, I believe that's true here in our
16 community and elsewhere across the country.

17 250. Q. Okay. Thank you.

18 A. Yeah.

19 251. Q. So in your fourth affidavit you also
20 talk about the Region's options for women and ---

21 A. Yeah.

22 252. Q. --- gender-diverse individuals at
23 Paragraphs 39 and 40.

24 A. Yeah, go ahead.

25 253. Q. So my understanding is that there's two

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shelters currently, the YWCA of Cambridge has the 20-bed facility?

A. In Cambridge, correct.

254. Q. And then there's the former YW
Kitchener-Waterloo building on Frederick Street that
the Region now owns and operates that is -- has 66
beds, is that -- is that number still accurate?

A. It is.

255. Q. Okay. And you mentioned the other -- the Coalition of Muslim Women, a facility, is that open?

A. Yes, but I am not sure of their current capacity, Shannon. I would have to go check.

256. Q. Okay, can we get an undertaking just to provide that?

UNDERTAKING

257. Q. Are there any other specific emergency
bed -- or emergency shelter beds that are only for
women or gender-diverse individuals in the Region
that's not encapsulated in this ---

A. No.

258. Q. --- tally? Okay, so if that number is accurate in terms of the number of beds that you've indicated, the 28 beds at the Polish and the Muslim

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1 women facility, that would mean that there was a total
2 of 95 beds specifically for women and gender-diverse
3 individuals? If I've done my math correctly.

4 A. Yeah, either in -- up and operating or
5 within -- within the plan, yes.

6 259. Q. Okay.

7 A. Approximately, right.

8 260. Q. Okay, and so I am just going to ask
9 Charlotte just to pull up the October 2024 Point in
10 Time count infographic.

11
12 --- SCREENSHARE

13
14 261. Q. I guess we should make this an exhibit. I
15 know it's in the materials but we'll make it an
16 exhibit, a number or letter we're at. This would be
17 Exhibit B, I think?

18 MR. LOKAN: You can give it a number if you
19 like. It is ---

20 MS. DOWN: Okay.

21 MR. LOKAN: --- in the record.

22 MS. DOWN: Yeah, let's -- so I think we're
23 at 3 or 4, whatever the number is we'll ---

24 MADAM REPORTER: Exhibit 2.

25 MS. DOWN: Okay. So if you can just scroll

1 down, Charlotte.

2
3 EXHIBIT NO. 2: Point in Time count, October 2024

4
5 BY MS. DOWN:

6 262. Q. So this doesn't give us a specific
7 number for gender identity on this infographic but it
8 says, "34 percent women" and ---

9 A. Yeah.

10 263. Q. --- "2 percent trans, two-spirit and
11 non-binary" out of the group that was measured. So I
12 just -- I did do a little bit of math. So if it's 36
13 percent, it would mean there are approximately 853
14 women at the time of the count, women or gender-
15 diverse individuals at the time of the count that
16 would be 36 percent of the overall number of people
17 experiencing homelessness.

18 So that -- is that -- if my math is correct,
19 is that -- are you in agreement with that assessment?

20 A. Yeah, on the assumption that the pie
21 chart is a representation of the total PiT, then, yes,
22 I guess it's just a math exercise.

23 264. Q. Okay. So given that, there is
24 approximately one bed for every nine women or gender-
25 diverse individuals who is homeless. Though I do

1 agree that there is a large gap between the number of
2 homeless women and gender-diverse individuals and the
3 options available for them.

4 MR. LOKAN: Shannon, the first part of that
5 builds in assumptions but maybe just ask the
6 large gap question. Because ---

7 MS. DOWN: Okay. Do you agree there ---

8 MR. LOKAN: --- the (indiscernible) there is
9 a way of ---

10 MS. DOWN: --- is a large gap?

11 MR. LOKAN: --- (indiscernible), right?

12 THE WITNESS: Yes, I acknowledge there is a
13 gap ---

14 MS. DOWN: Okay.

15 THE WITNESS: --- within the system which is
16 (indiscernible).

17
18 BY MS. DOWN:

19 265. Q. Okay. And I am just saying that
20 there's limited options available because we really
21 only have -- there's two shelters that are sort of
22 generally available.

23 And then I should point out that my
24 understanding is that the shelter that the Coalition
25 for Muslim Women is specifically targeted towards

1 women and gender-diverse individuals who are
2 racialized. Is that correct?

3 A. That's correct.

4 266. Q. Okay. And you talk about motels and
5 hotels as an option for women in Paragraphs 44 and 45
6 of your fourth affidavit? I'll just let you turn to
7 that.

8 A. Sorry, 45, yeah. And ---

9 267. Q. Forty-four and 45.

10 A. Forty-four and 45, yes.

11 268. Q. And you say that that's an alternative
12 if someone is not comfortable attending a gender-
13 specific shelter because they've got some additional
14 privacy.

15 Is the Region aware of concerns regarding
16 heightened risks of sex-trafficking and sexual
17 exploitation of women at motels and hotels?

18 A. I am aware of concerns relating to
19 those specific challenges within the hotel/motel
20 system, generally-speaking.

21 269. Q. Okay.

22 A. Like as criticisms of the use of hotels
23 and motels, that is true. I've heard that.

24 270. Q. Okay, so you've heard it as criticism.
25 Has that -- is that something that has been discussed

1 or addressed in Community and Social Services as a
2 concern or has that been something that's brought up
3 by staff?

4 A. So I -- can you -- you specifically
5 said concerns around trafficking ...?

6 271. Q. And sexual exploitation at motels and
7 hotels.

8 A. So, no, I haven't. Again, I've heard
9 that the concerns that hotels and motels are at risk
10 of offering that. But I don't have a specific
11 instance of trafficking and sex exploitation in
12 specific incidents coming to my attention.

13 272. Q. Okay. I am going to ask that an email
14 be put on the screen. Can you put, Charlotte, the
15 email from Jakara Droog on the screen? So this is an
16 email dated September 18th and it's addressed to you.

17 A. Yeah.

18 273. Q. So, first of all, do you recall
19 receiving this?

20 A. I do.

21 274. Q. Okay, and so can we mark this as
22 Exhibit 3? B? 3?

23 MADAM REPORTER: If it's numbered, it's 3.

24 MS. DOWN: Three.

25 MADAM REPORTER: Yeah.

1 MS. DOWN: Three. Okay.

2
3 EXHIBIT NO. 3: Email from Jakara Droog

4
5 BY MS. DOWN:

6 275. Q. And so in the first paragraph, I'm
7 focusing mostly on the first paragraph.

8 A. Yeah.

9 276. Q. So Jakara says that:

10 "... There have been numerous reports of
11 women who have been sexually coerced or
12 exploited by motel staff and then with
13 eviction being used as a threat if they
14 refuse ..."

15 And then she specifically points to the
16 Weber Inn and mentions that this was raised to USWs on
17 September 10th and that, according to this email, the
18 response indicated that they were aware of this issue.

19 So first of all, when you received this, did
20 you take any actions with respect to this email?

21 A. Yes, I did. I believe I acknowledged
22 it. I would have to check my email records. To
23 Jakara and I brought it to my staff.

24 277. Q. Okay, and what -- and so when you
25 brought it to your staff, what did you hear back?

1 A. I heard that there were some concerns
2 raised about the behaviour of an individual at the
3 motels. And my direction at that time was to, at that
4 time, to pause any further intakes into the motel
5 system which I believe we communicated to our system
6 partners of women and fem-identifying.

7 278. Q. Okay. And what about -- was there any
8 actions taken in terms of like the women who were in
9 the motels at that time? Like you weren't bringing in
10 any new people in but what about the people who were
11 already placed there?

12 A. So the question I asked and was told
13 that each of the existing women in the motel system
14 were connected within safety plans, would be put in
15 place for all of them.

16 And if there were any concerns around
17 illegal activity, that they should be directed to the
18 police.

19 279. Q. Okay. And was it just the Weber Inn or
20 was there other -- were there concerns with other
21 motels that were being used by the Region?

22 A. So the specific concern that I believe
23 was raised to me was around the Weber Inn,
24 specifically. But given that the -- my understanding
25 is that the owners of the Weber Inn also own other

1 motels.

2 And the information I received is that we
3 did not have similar concerns about the other hotels
4 owned by that same organization.

5 280. Q. Okay. And what's the status of this
6 issue currently? Like are there still -- so are those
7 motels being used now? After the pause, did they go
8 back into use or is it still on pause?

9 A. I believe that the motels are still
10 being used and my understanding is that the -- I would
11 have to go back and look to see if any new women have
12 been placed in any of those motels.

13 But I believe the direction is that that is
14 not the case. And that any woman who is being offered
15 a motel, needs to be accompanied with a safety plan
16 and that we are, I believe, not -- not adding offers
17 of motels at that particular one.

18 And I believe there's been a communication
19 with the motel ownership. And I believe that there
20 has been communication with WRPS.

21 281. Q. Okay, and was there direction provided
22 to the USWs with respect to this -- the heightened
23 risk of this sort of issue at the motels?

24 A. Yeah, the direction -- the immediate
25 direction was to cease intakes and to put a safety

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1 plan in place for anybody that was still and to move
2 anybody who was not feeling safe.

3 282. Q. Okay, and could I get an undertaking to
4 get a copy of that direction that was provided to
5 USWs? You can redact any identifying ---

6 A. Sure.

7 283. Q. --- information to make sure that the
8 privacy of the person -- the people involved is
9 protected.

10 MR. LOKAN: Yeah, no problem.

11 **UNDERTAKING**

12 BY MS. DOWN:

13 284. Q. Okay. And has there been any -- so, I
14 guess, as a bigger -- to step back a little bit on
15 this issue. Like is there -- has there been any
16 attempt to like work with -- because I know the police
17 are very involved in sex trafficking work and
18 prevention of sex trafficking.

19 Has there been any collaboration or outreach
20 to the WRPS to talk about this issue on a more
21 systemic basis as opposed to the individualized basis?

22 A. So my understanding, just to clarify is
23 that the concern that was raised was not related to
24 trafficking. That was not brought to my attention.

25 The overall concern around trafficking is

1 something I believe we are always cognizant of,
2 including at encampments. And if there is ever
3 suggestion or worries or evidence of such a -- such
4 behaviour, they are -- they are immediately escalated
5 to the police.

6 285. Q. Okay. I am going to turn to looking at
7 some of the IHPs. And we're going to put them up on
8 the screen but we've redacted the names just so that
9 we're talking about them just generally, not people-
10 specific information ---

11 A. Sure.

12 286. Q. --- isn't identifiable.

13 MR. LOKAN: Can we go off the record for a
14 moment, Shannon?

15 MS. DOWN: Sure. Sure.

16
17 --- OFF THE RECORD

18
19 MS. DOWN: Okay, so we're back on record.
20 We're just flagging that the next exhibits
21 are going to be potentially -- we'll have a
22 discussion about potentially sealing them or
23 the possibility that they might be sealed.
24 And we'll just flag that as an issue for
25 counsel to determine at a later date.

1 MR. LOKAN: And together with this section
2 of the transcripts.

3 MS. DOWN: Yes.

4
5 --- SCREENSHARE

6
7 BY MS. DOWN:

8 287. Q. So this is -- do you recognize this
9 document, first of all, Peter, like the general form
10 of the document?

11 A. (Indiscernible).

12 288. Q. Okay, and this is an example of an
13 individualized housing plan that's developed by the
14 Region for people who are experiencing homelessness?

15 A. Yes.

16 289. Q. Okay. And so I just -- you've talked
17 about I think numerous points in your various
18 affidavits. There's references to IHPs as being, you
19 know, really critical pieces of the work that is done
20 by the Region and the USWs in making sure that trying
21 to connect people with housing supports.

22 So just as an example, like in your first
23 affidavit, we look at Paragraph 15. You talk about
24 how in developing an IHP, USWs will consider how an
25 individual initially became unhoused.

1 Specific factors in their life which have
2 prevented them from accessing housing. The needs and
3 preferences of that individual in accessing housing.
4 And then work with them to try to match them with
5 appropriate housing to the extent possible. That was
6 what you said about them in Paragraph 15.

7 And then you go on and you talk about in
8 Paragraph 17 and 18 of your -- sorry, Paragraph 17
9 that IHPs are best developed over time, weeks or
10 months as the individuals and USWs interact. They're
11 going to build trust and identify the barriers to
12 entry that are specific to that individual. And so
13 it's vital that USWs have the necessary time and
14 access to the unhoused individuals to develop those
15 needs.

16 So when I look at this, I see like in the
17 column to the left there is housing needs, goals and
18 it has sort of three categories, shelter options.
19 Number 2 is a CHAC, the C-H-A-C or the PATH program so
20 that's the Community Housing Access. I can't remember
21 what the last, what "C" stands for. Community Housing
22 Access, something?

23 A. Something.

24 290. Q. And then PATH which is the
25 prioritization list.

1 A. (Indiscernible).

2 291. Q. And then Number 3, seems to be
3 referring to income -- what kind of income support?

4 A. Yeah.

5 292. Q. And then we see Next Steps. And then
6 progress notes and then there's this checkbox "Housing
7 Progress Steps," 1 to 10.

8 And so for this individual, it seems to be
9 indicating that they've declined shelter options
10 because they have a partner. And so that would, I
11 mean, can you -- someone with a partner, what options
12 would there be for them in terms of shelter options in
13 the Region currently?

14 A. So the current 24/7 shelter system, I'm
15 actually, not sure I'm accurate here. I believe under
16 the current model, partners need to access those
17 systems separately as opposed to being able to access
18 them as a partnership.

19 293. Q. Okay. And in terms of options, like
20 the normal emergency shelter, the co-ed system, there
21 wouldn't be -- like you'd be placed in a -- it's like
22 a ---

23 A. Right.

24 294. Q. --- co-ed congregate setting. So
25 there's no like private rooms for people who are

1 couples. Is that fair?

2 A. That's currently true.

3 295. Q. Okay, so in this case, this person like
4 they're saying they're declining shelter options
5 because they have a partner.

6 A. Yeah.

7 296. Q. So there's really -- it seems like --
8 I'm assuming that there's no options available for
9 them that would take -- allow them to stay together
10 with their partner. And that might be the reason
11 they've declined it. Although we don't have notes to
12 understand the specifics of that.

13 MR. LOKAN: And just again, Shannon, are you
14 excluding Erbs Road and motels? Or are you
15 going to get to them or ...?

16 MS. DOWN: Well, I mean, it's ---
17

18 BY MS. DOWN:

19 297. Q. So if Erbs Road was an option, would
20 this -- would you expect that to be listed here as an
21 option for the person or if a motel is -- like I'm
22 trying to understand if the USW is working with this
23 person, I don't see any mention of Erbs Road, I don't
24 see any mention of motels. So I -- so would those
25 have been normally provided and written down if they

1 were being offered?

2 A. So I -- I can say that if there was
3 availability, motels are often an option for couples.
4 It's one of the -- it's a flexible part of the motel
5 program that we have.

6 Erbs Road, couples are permitted but they
7 have their own cabin so they're not -- they don't
8 sleep in the same cabins. Well, sorry. Let me
9 rephrase that. They are offered two cabins.

10 298. Q. Okay. But if those were options, would
11 those be included in the IHP? Like would that be
12 something that would be, you know, indicated by a USW
13 in the IHP that Erbs Road is being offered, a motel is
14 being offered? That would usually be encapsulated in
15 this document, would it not?

16 A. Again, this is a very specific one, so
17 I don't have insight onto the conversation between
18 Nichole and whoever this person is. But I can say
19 definitively that where available, our USWs have a
20 suite of options to offer on any given day.

21 299. Q. Okay, and maybe let's just step back.
22 So the purpose of this IHP is to keep a record of what
23 those conversations are between -- I understand it's
24 not case notes but it's the plan, right? Like it's
25 part of the housing plan. So like where is this

1 person going to go?

2 So I would assume that those housing options
3 -- like one of the purposes of this is to make sure
4 that all the housing options that have been explored
5 or are a potential are captured here?

6 A. So that's the intention of the IHP as a
7 part of a -- the broader case management.

8 300. Q. Mm-hmm. Okay, so if it's not here,
9 does that suggest to you that it's not an option for
10 these people? Because if it was an option, wouldn't
11 it -- shouldn't it be listed here on the IHP?

12 A. Without, you know, actually having a
13 conversation with Nichole about this particular case,
14 I can't assume why something is or is not included on
15 the IHP.

16 301. Q. Okay. And we don't know when that --
17 when those shelter options were declined, like when it
18 was offered or when it was declined. And I don't see
19 any progress notes, so we don't know whether that was
20 like revisited at some point.

21 Because I think we got these documents in
22 September, at the end of September. So it's hard to
23 tell from this, you know, is this a one-conversation
24 or was it multiple conversations. Is that fair to
25 say?

1 A. Yeah, I think it's indetermined or
2 undetermined, you know, how many conversations had
3 here. I don't see an indication of how many
4 conversations on this ---

5 302. Q. Okay.

6 A. --- (indiscernible) one. So I can't
7 guess. I don't know.

8 303. Q. Okay. And it says that they had
9 already completed an application for community housing
10 back in 2021 and a PATH intake. It doesn't say when
11 and they were just waiting on the housing list, and
12 that they're getting ODSP.

13 It doesn't -- like I don't see here where
14 it's sort of giving me a sense of what the barriers
15 are for this person to get housing. Or like some of
16 the things you're talking about, identifying the
17 barriers to entry that are specific to that
18 individual, or the use of the IHPs recognize that
19 individuals might require staged approaches. It's not
20 talking about that.

21 And I understand that each one will be
22 different but it just -- this seems very sparse.

23 A. Yeah, my affidavit refers to what the
24 IHPs can be used for and they're not all going to look
25 the same. And it's entirely dependent on the nature

1 of the conversation that an individual has with the
2 USWs, and they're willingness to share.

3 304. Q. Right. And so then this checkbox
4 towards housing progress, it looks like check, step 1,
5 step 2 and 3 were completed. And then step 4.

6 So like sort of the starting points of an
7 attempt to get housing but kind of -- at some point,
8 it just -- it stops. So maybe this work is
9 continuing. So if we -- we do expect that if we got
10 an updated IHP for this individual, that it would have
11 some more information filled in on it?

12 A. My assumption would be if Nichole in
13 this particular case -- if this particular person was
14 still engaging with, in this particular case, Nichole,
15 and there was new information shared that would inform
16 a possible housing plan, then my assumption is that
17 this would be updated in some way, shape or form. But
18 again, without knowing the specifics of this
19 relationship, I can't -- I can't make ---

20 305. Q. Okay.

21 A. --- a prediction on this particular
22 file.

23 306. Q. Okay. And being on the housing
24 waitlist is a long process. So waiting on -- if
25 you're on that housing list, it can -- is it fair to

1 say that it can take many years to gain housing
2 through that list?

3 A. Yes.

4 307. Q. If you're just -- if you're not in a
5 priority status?

6 A. Yeah, that's unfortunately true.

7 308. Q. Okay. If we can look at -- turn to the
8 next one, Charlotte?

9
10 --- SCREENSHARE

11
12 So this one has a little more information.
13 It seems to be slightly further along. Again, it
14 talks about being on the wait list, that this person
15 is on OW. Under the progress notes, under options, it
16 says:

17 "... No affordable housing due to income
18 level of OW ..."

19 So, I mean, I think -- is this -- this
20 is pretty typical, right? Of someone who if they're
21 on OW, they're not going to -- they're not likely to
22 find community housing options because of the low-
23 income level that OW provides for housing?

24 A. Oh, yeah, I think we know that the OW
25 rates are a challenge. And without access to RGI or

1 other supplements, it's very difficult, if, frankly,
2 it's very difficult for people who are on OW to find
3 market rent.

4 309. Q. Okay, so I guess the point being that
5 like an IHP doesn't really solve that issue of like if
6 you're extremely low income, your housing options are
7 going to be very limited. So, you know, it's all very
8 well and good to have a plan but if it's not ---

9 MR. LOKAN: Shannon, this particular case,
10 it looks like a person might be over 65
11 because of the records to CPP and OAS and
12 maybe Guaranteed Income Supplement. There
13 might be other sources.

14 If the question is general, it can be
15 put generally but ---

16 MS. DOWN: Mm-hmm.

17 MR. LOKAN: --- this particular one, there
18 is a little more information on the form.

19 MS. DOWN: Sure, but it's saying they're --
20 right now they're on OW so their options at
21 this point like, you know, it's not -- it's
22 not clear if they're a), if they're
23 eligible for a CPP and OAS, they may or may
24 not be. Not everybody is, right?

1 BY MS. DOWN:

2 310. Q. So if we can switch to the next one.
3 And again, before we leave this one, it just looks
4 like steps 1, 2 -- preliminary and 1 and 2 have been
5 filled out and step 4 but none of the rest.

6 So again, I am assuming that at some point,
7 there may be some other steps. Like if we were to
8 check in a month or two for this person that the IHP
9 would be -- would be different.

10 A. It would be different if there was
11 different information shared.

12 311. Q. We'll just look at one last one and
13 then we'll move on.

14
15 --- SCREEN SHARE
16

17 312. Q. So again, this one under next steps,
18 they've taken a space at the Weber Inn, declined other
19 shelter options because they have a partner and a dog.
20 So again, just sort of reiterating that it's
21 challenging for people who have partners or pets to
22 find spaces. Is that fair to say?

23 A. It is.

24 313. Q. Okay. Do you know which of the shelter
25 options actually accept people with pets?

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1 A. I don't, actually. I can find out.

2 314. Q. Okay, if we can have an undertaking ---

3 A. Yes.

4 315. Q. --- to provide that, that would be
5 great.

6 **UNDERTAKING**

7 A. Erbs Road, for sure.

8 316. Q. Okay.

9 A. And I can give you the other ones. I'd
10 have to -- I don't want to give you wrong information,
11 Shannon.

12 317. Q. Fair enough. And then again, this
13 person has applied for community housing back in 2017
14 and is waiting on the housing waitlist and has
15 completed PATH.

16 So again, it doesn't seem like there's a lot
17 of specifics available for this person in terms of
18 what, you know, what that next step is to reaffirm
19 non-permanent housing which the Weber Inn would be, to
20 some form of permanent housing. Is that fair to say?

21 A. Yeah, it's a challenge. Yes.

22 318. Q. Okay. Okay, so, I mean, I guess, you
23 know, when I look at these IHPs the overwhelming
24 impression I get from reviewing all the ones that we
25 had for our clients, is that while in theory the IHPs

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1 are a good idea, the reality is that a lot of these
2 people have very few or any -- if any, options because
3 of their low income and the lack of affordable
4 housing. Is that fair to say?

5 A. Well, I think what you're seeing is an
6 example obviously of somebody whose option was a
7 motel. The IHPs are also a tool that allow us to
8 support individuals off the street and into inside
9 into safer options. And we're doing that on a regular
10 basis into the system that we have.

11 319. Q. Right. But the goal would be
12 eventually to get people hopefully into permanent
13 housing, not just into some form of shelter and non-
14 permanent housing.

15 So I guess that's where I am -- it seems
16 like the IHPs, like are aspirational if not realistic,
17 is that fair to say?

18 A. They, to the best of our ability,
19 identify what a plan could look like and we are always
20 subject to resource constraints and availability.

21 320. Q. Okay. But the process of filling out
22 an IHP isn't necessarily going to -- it may or may not
23 move you any closer to getting housing if the barrier
24 is your income. It's just too low.

25 A. No, the IHP in and of itself isn't --

1 is not the lever to access housing. With or without
2 one, it's a tool that we use to support individuals
3 and engage with folks.

4 321. Q. Okay. I want to turn to the issue of
5 Housing First which you talk about I think in your
6 fourth affidavit at Paragraph 21.

7 A. Sure.

8 MS. SCHIUTEMA: Can I interrupt for one sec.
9 I don't know if you made those exhibits and
10 I think I might have missed the conversation
11 at the beginning about if you wanted them
12 made exhibits.

13 MS. DOWN: Yes, I do. But we did have a
14 conversation about it. We're going to make
15 them exhibits but were -- the possibility
16 that they might be sealed because we just
17 need to have the conversation about the
18 privacy issues.

19 MR. LOKAN: So that would be 4, 5 and 6 or
20 do you want to do them as a bundle?

21 MS. DOWN: We could just do them as a
22 bundle, I think it's No. 4.

23
24 EXHIBIT NO. 4: IHPs, bundle
25

1 BY MS. DOWN:

2 322. Q. So if you turn to your fourth
3 affidavit, starting at page -- sorry, Paragraph 21.

4 A. Yeah.

5 323. Q. You sort of -- like affirming that the
6 Region's committed to housing first. And maybe it's
7 just helpful for us just to have a brief, you know,
8 discussion about what that means.

9 And you mention in that first paragraph,
10 that it's contrasted with the Housing Readiness model
11 and so Housing First and I'm just -- I am going to
12 speak in just simple, general terms.

13 A. Right.

14 324. Q. Housing First is just a philosophy that
15 people just -- people need to be housed. That there
16 shouldn't be any -- even if you have mental health
17 issues, if you have addiction issues.

18 If, you know, you're -- I don't know, you
19 have whatever your issues, that housing should be
20 available to everybody. Because it's the method
21 through most people -- through which most people would
22 gain stability in their lives and be able to address
23 those things.

24 Is that -- is that your ---

25 A. That's ---

1 325. Q. --- understanding?

2 A. --- my understanding of Housing First
3 as well.

4 326. Q. Okay. And Housing Readiness model is
5 sort of more like you have to meet some sort of
6 criteria in order to qualify for housing?

7 A. Yes.

8 327. Q. Some intermediate steps?

9 A. Yeah. Yeah, yes, that's my
10 understanding as well. Specifically as it relates to
11 that response here in this affidavit.

12 328. Q. Okay. And in Paragraph 23, you say
13 like you didn't -- the Region does not employ a
14 Housing Readiness approach and it's committed to
15 Housing First model. And that's reflected in the Plan
16 to End Chronic Homelessness?

17 A. Mm-hmm.

18 329. Q. And that there's various references in
19 the Plan to End Chronic Homelessness as Housing First
20 is the preferred approach.

21 So I just -- I want to clarify because
22 there's a few statements from your first affidavit
23 that I think are -- contradict that.

24 A. Okay.

25 330. Q. And I just want to go through those

1 just to clarify.

2 A. Okay. So, sorry, we're going to go
3 back to my first one?

4 331. Q. Yeah, so if you can just pull that one
5 out.

6 A. Okay, go ahead.

7 332. Q. So if you look at Paragraph 18.

8 A. Yeah.

9 333. Q. It says that:

10 "... Individuals experiencing
11 homelessness commonly required staged
12 approaches to reintegration into more
13 permanent forms of housing. And these
14 staged approaches commonly rely on the
15 individual also receiving concurrent
16 care and treatment from health
17 providers, addiction specialists and
18 social workers ..."

19 A. Yeah.

20 334. Q. So when I read that, it seems to me
21 that that's suggesting that people need to get
22 services or need to do something before they're ready
23 for housing.

24 A. No, I understand where you're coming
25 at. I don't see that as a contradiction. This is

1 specific -- so I'll go back to your earlier comment.
2 Housing First is a principled approach, an
3 aspirational approach.

4 And what we're -- what I am acknowledging in
5 affidavit No. 1, point No. 18, is that we know through
6 experience that some individuals require additional
7 social, health, mental supports and that can be
8 offered in a supportive housing model, as opposed to a
9 permanent tenancy-based affordable housing model.

10 And so all we're saying is that we recognize
11 that there are individuals who have needs, significant
12 needs, that would likely preclude either like jumping
13 from, an example, living on the street for potentially
14 a long time, straight into an independent affordable
15 housing or an independent permanent housing situation
16 without any supports.

17 335. Q. Could they not be put into permanent
18 housing with supports?

19 A. Certainly, if available. I mean, I
20 think that's -- I mean, we would -- I would call that
21 supportive housing.

22 336. Q. Okay, but that's more about the system
23 than it is about the individual. I guess that's just
24 a distinction I'm making. I think Housing First says
25 that individuals do not need interventions before they

1 can be housed.

2 A. Hmm.

3 337. Q. And the system -- like what I'm
4 contrasting that is, the system doesn't have
5 supportive housing so we're going to put you in some
6 other non-permanent housing. Because it's just not
7 available as opposed to you require it.

8 A. So I've -- you've kind of lost me on
9 the journey here. I think we agree on Housing First.
10 And I believe -- but I am not sure what -- you framed
11 it as a contradiction. Can you just be really clear
12 so I can ---

13 338. Q. Just that ---

14 A. --- (indiscernible). Because we know
15 ---

16 339. Q. People require ---

17 A. --- (indiscernible) for supports. We
18 know ---

19 340. Q. Right, but that doesn't mean they can't
20 be housed, I guess is what I am saying. They may --
21 they need supports but they need housing.

22 A. I -- yes, I'm not -- I don't think I'm
23 saying anything contradictory.

24 341. Q. Okay, because this says:

25 "... They require staged approaches to

1 reintegration ..."

2 So that seems to say you've got to go
3 through this step before you can get to this step,
4 before you can get to this step.

5 A. Mmm.

6 342. Q. The "staged approach," I am trying to
7 understand what that means.

8 A. Well, I think it's -- I mean, I'll
9 compare it to a hospital stay. Some people require a
10 stay at intensive care unit before they can go to the
11 general ward, before they can be discharged, medically
12 and clinically. We know that there are some
13 individual cases that present that by their own case,
14 some people require very intensive supports which is
15 why we try to offer them what they need. It's not
16 about a forced ladder.

17 343. Q. So if someone needs supports, I'm
18 saying why do they need the staged approach, why can't
19 they be housed with supports?

20 A. I think we're saying the same thing.
21 That would -- to me, that would be -- that would be an
22 example of staging. But ---

23 344. Q. Isn't that just housing them, though?

24 A. I think housing people who have ---

25 345. Q. Like what is a "stage," I guess?

1 What's the first stage?

2 A. It's recognizing that -- it's mostly
3 around, in some cases if there's not permanent housing
4 available right off the bat, but we have a place at a
5 motel that is inside where they can lock the door and
6 have a shower and have a bed, that is an example of a
7 staged approach.

8 It's not required, they don't have to say,
9 "yes." But that would be a stage, that's why it's a
10 continuum.

11 346. Q. Okay, but what I am suggesting to you
12 is what you're calling a "staged approach" is really
13 about the unavailability of permanent housing. So
14 we're going to provide you with something other than
15 that because that's all we have.

16 A. Yes, like we're agreeing on that,
17 Shannon.

18 347. Q. Okay. But that's different than saying
19 someone needs to -- so I am just going to -- in
20 Paragraph 19 ---

21 A. Okay.

22 348. Q. You say:

23 "... For example, a first step can be to
24 assist an individual who is living
25 rough including in an encampment, into

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1 the Region's shelter system and then
2 from there into more forms of housing
3 ..."

4 So I am just trying to understand. Do
5 they need to go into the shelter system before they
6 can go into other forms of housing?

7 A. No, that's a case of managing and
8 supporting people within a system that's constantly in
9 flux. And so we're ---

10 349. Q. Okay.

11 A. We're offering people what we can based
12 on their needs and what we have available.

13 350. Q. So you're not saying that anyone needs
14 to go into either a shelter or motels before they can
15 be housed?

16 A. Like clinically?

17 351. Q. Yes.

18 A. No. I am not saying that.

19 352. Q. Okay. So that -- I agree with you
20 then. That is a Housing First. Because if you were
21 saying that first of all you need to like stabilize in
22 transitional housing or a shelter or a hotel, that's
23 not -- that is not Housing First?

24 A. I agree.

25 353. Q. Okay.

1 A. Yeah, we're not (indiscernible).

2 354. Q. We are in agreement.

3 A. Okay. Takes us a while, sorry. I am
4 not that thick.

5 355. Q. I just -- so I am going to jump to
6 Paragraph 38 of your affidavit.

7 A. No. 1?

8 356. Q. Yeah.

9 A. Okay. Go ahead, sorry, 38?

10 357. Q. Yeah, I think this is helpful. This is
11 clarifying. So it says:

12 "... We expect these housing plans for
13 some individuals will be staged meaning
14 they may require several supportive
15 steps before being able to live
16 independently ..."

17 A. Okay.

18 358. Q. "... My team is acutely aware that not
19 every person is ready to transition
20 into long-term housing for a variety of
21 reasons ..."

22 A. Mm-hmm.

23 359. Q. So I am trying to understand that
24 statement in the context of Housing First.

25 A. So again, I think we agree that we

1 don't force people into a staging approach that is not
2 consistent with their needs.

3 We recognize that some people have a variety
4 of needs, clinically, socially, emotionally and where
5 we have resources to support them with that, we do so.
6 It's why we have supportive housing as an example.

7 360. Q. Okay, but if ---

8 A. It's not requiring people to go through
9 a laddering exercise. So to me, that is consistent
10 with Housing First.

11 361. Q. Okay, because my -- like when I read
12 that, it seems like it is requiring people to
13 transition through a number of stages before they can
14 be housed.

15 A. No, it says, "May require several
16 supportive steps." So to me, it's a clinical
17 approach. Their clinical condition or their social
18 condition may require a series of interventions that
19 we have available to us and sometimes we don't. And
20 we provide that where we can.

21 362. Q. But if they -- but if they need
22 supportive -- so supportive housing, just to be clear.
23 Supportive housing is permanent housing as opposed to
24 transitional housing and motels or (indiscernible).

25 A. Okay, fair enough. Yeah.

1 363. Q. So if they needed supportive housing,
2 that would be like the first and only step they need
3 to make, is that -- they don't need to go into a motel
4 first, they don't need to be in a shelter first. They
5 can go into supportive housing.

6 If supportive housing isn't available, like
7 if it's not an option because it's full, then I
8 understand you might place them in a motel. But it's
9 not that there's steps that they need to take before
10 they get to supportive housing, is that fair to say?

11 A. That's accurate.

12 364. Q. Okay. Because it's a bit confusing the
13 way you have it written there. It sounds like there's
14 ---

15 A. I've never written affidavits ---

16 365. Q. -- supportive steps before they are
17 being able to live independently. I mean, it's
18 usually -- people are usually, you know, they can live
19 independently or they need supportive housing or they
20 live independently maybe with some supports. But
21 there's no reason for them not to be housed under a
22 Housing First model.

23 A. I agree.

24 366. Q. Okay.

25 A. And I apologize for any confusion in

1 the first ever affidavit I've ever written.

2 367. Q. That's okay, I just want to make it --
3 I think it's an important step. Because, you know, if
4 you're reading your affidavit and the impression is
5 we're not providing housing to people, we're providing
6 them -- putting them in a motel or into emergency
7 shelters because we feel that that's a necessary step
8 for them before they can be housed.

9 I think that's a very different -- that's a
10 very different approach than a Housing First approach
11 which says anyone can be housed. They might need
12 supportive housing but anyone can be housed. And then
13 all those other things can be addressed once they are
14 housed.

15 A. So let me, for the record, agree with
16 that statement.

17 368. Q. Okay. Thank you. And so in 84,
18 Paragraph 84, it says:

19 "... IHPs also recognize that not all
20 individuals are ready to move into
21 permanent housing. For many, accessing
22 a shelter, motel room or other
23 transitional living arrangement, is a
24 necessary first step to obtaining the
25 stability to move into a more long-term

1 housing arrangement ..."

2 I think after what we've talked about,
3 you would disagree with that statement in 84?

4 A. No, what I'm -- no, I wouldn't disagree
5 with it. I am not being contradictory; I'm clarifying
6 that I agree that these are not mandated required
7 steps. It's an attempt to recognize that individuals
8 have unique needs. And some individuals will benefit
9 from some sort of support, whatever we have available
10 to us prior to.

11 So to be clear, if the alternative is a
12 person is outside, and we don't have supportive
13 housing, we believe that offering them a motel, if
14 they so choose, where they can come inside and lock
15 their door, is, in this specific case, a necessary
16 first step for them to consider. Because I don't have
17 anything else to offer. So (indiscernible) ---

18 369. Q. Great. But that's not what this
19 paragraph says so, I mean, if we're being accurate, it
20 says:

21 "... Not all individuals are ready to
22 move into permanent housing ..."

23 So it's not saying we don't have
24 permanent housing for people so therefore it's
25 necessary to put them into -- it's saying they need

1 stability and they need -- they're not ready for
2 permanent housing.

3 A. Some people clinically are not ready
4 for permanent housing without supports.

5 370. Q. Okay, but that's supportive housing.

6 A. Fair enough.

7 371. Q. So you're saying -- so some people are
8 not ready for supportive housing?

9 A. No, I am not saying that.

10 372. Q. Okay, so I just want to make it clear.

11 Like this is confusing, then, from a Housing First
12 perspective. Because you're saying individuals are
13 not ready to move into permanent housing.

14 You're not saying like, I mean, Housing
15 First principle says, yes, they are. If we don't have
16 supportive housing, then we can't give them supportive
17 housing. That's not their fault. It's not about
18 their readiness. It's about the system's lack of
19 resources.

20 A. Yes, so I am not trying to be
21 confusing.

22 373. Q. Okay, I just -- would you agree that
23 this Paragraph 84 seems to be muddying the waters on
24 the Housing First?

25 A. Well, I would say it's muddying the

1 waters between you and me.

2 374. Q. Okay, so you think that 84 encapsulates
3 what the Region sees Housing First does?

4 A. I am reading it again:

5 "... IHPs also recognize that not all
6 individuals are ready to move into
7 permanent housing ..."

8 That could be edited to say, "permanent
9 housing without supports." I'll concede that.

10 375. Q. Okay.

11 A. And I believe that's where we're
12 muddying the waters.

13 376. Q. And then so for this second sentence:

14 "... For many, accessing a shelter, a
15 motel room or other transitional living
16 arrangement, is a necessary first step
17 ..."

18 Is it a necessary first step for them?

19 A. It's ---

20 377. Q. If there was supportive housing
21 available?

22 A. It's a necessary first step in a system
23 like ours which is constrained by availability.

24 378. Q. Okay, so that's an important qualifier

25 ---

1 A. Okay.

2 379. Q. --- that's not in that paragraph.

3 A. I concede that, sure.

4 380. Q. Because this seems to be suggesting we
5 can't put you in permanent housing. You're not ready
6 for it yet. You need to go into a motel or other
7 transitional to get stable before we can put you into
8 permanent housing.

9 And I think we've agreed that that isn't
10 Housing First and you've said that the Region is
11 committed to Housing First.

12 A. Yeah, I'll concede that.

13 381. Q. Okay. So in your third affidavit ---

14 A. Okay.

15 382. Q. Fourth.

16 A. Fourth.

17 383. Q. Sorry.

18 A. Yeah, no, okay.

19 384. Q. So at Paragraph 27, so you talk about
20 your operating options for individuals experiencing
21 homelessness that are not long-term, that fact alone
22 doesn't mean that the Region isn't committed to a
23 Housing First approach.

24 Indeed, the Region's made it so the
25 encampment would be inconsistent with the Housing

1 First approach from the sole fact that options other
2 than long-term arrangements are seen as being
3 incompatible.

4 So I think -- I mean, I think you're trying
5 to -- I don't think the criticism of those sections
6 that are -- where there seem to be difference of
7 opinion. It wasn't that there wasn't the existence of
8 shelters or motels or other non-permanent, that the
9 Region uses those options, it was just a suggestion
10 that those options are a necessary first step as
11 opposed to just part of a system where there isn't
12 necessarily direct entry into permanent housing. Or a
13 direct entry into permanent supportive housing.

14 A. Are you clarifying what the Gaetz
15 (indiscernible) ---

16 385. Q. So do you agree -- yeah, so I mean that
17 was ---

18 A. Sorry, there was a lot there. I was
19 waiting (indiscernible) ---

20 386. Q. I don't think the Gaetz -- I don't
21 think the Gaetz' affidavit is saying there's anything
22 wrong with shelters, motels, non-permanent housing.

23 A. Right.

24 387. Q. It's the suggestion that people are --
25 need that before they can be permanently housed either

1 in supportive or non-supportive housing.

2 A. Right, and I would say I'm not trying
3 to the make the point that there is a needed,
4 required, mandated step for people to access permanent
5 housing.

6 388. Q. Okay, and in fact, in an ideal world,
7 where we were at functional zero, we wouldn't have the
8 need for any emergency shelter system or very minimal
9 one. And people would be directly housed either in
10 supportive housing or regular housing.

11 A. I hope we can toast that day.

12 389. Q. I hope so, too. So have you had any --
13 I'm actually getting close to the end so we may end up
14 finishing up a little bit early.

15 Have you had any updates? Okay, you're on
16 the -- let's go back. You're on the leadership team
17 for the Region when it comes to this issue with the
18 encampment?

19 A. Like, yeah, I am on the leadership team
20 at the Region, yes. Yeah.

21 390. Q. Okay. And so have you been made aware
22 of any updates to the Metrolinx timelines as -- have
23 there been any communications about that?

24 A. Not that I am aware of. My
25 understanding is the -- the latest documentation

1 remains the April 1st.

2 391. Q. Okay. So you haven't had any
3 conversations or meetings which have changed that?

4 A. No.

5 MR. LOKAN: Shannon, I am going to suggest
6 that that might be an area that's better for
7 Mr. Spooner in January.

8 MS. DOWN: Yeah, and we'll focus on that
9 with him but I just wanted to ask Mr.
10 Sweeney as well since I have him here.

11 Can we just take a short break, like
12 ten minutes and then I'll just make sure
13 that I haven't missed any of my questions.

14 THE WITNESS: Sure.

15 MS. DOWN: I anticipate that we can -- we'll
16 come back for a pretty short amount of time.

17 THE WITNESS: Okay.

18 MS. DOWN: Maybe reconvene at five-to?

19 THE WITNESS: Yeah.

20 MS. DOWN: Thanks.

21
22 --- BRIEF RECESS

23
24 MS. DOWN: Okay, we're back. Sorry for the
25 delay.

1 MR. LOKAN: No problem.

2 MS. DOWN: For keeping you waiting, Peter.

3 Thank you for your patience.

4 THE WITNESS: No worries.

5 MS. DOWN: I just have a couple of quick
6 questions just to clarify a couple of
7 things.

8 THE WITNESS: Sure.

9
10 BY MS. DOWN:

11 392. Q. One quick thing, and it relates to our
12 discussion that we just had around Housing First and
13 housing -- or versus Housing Readiness.

14 And I think you said something about
15 sometimes there's a clinical approach may require a
16 series of interventions for a particular individual.

17 I am just trying to understand what -- can
18 you provide some clarity about what that means?

19 A. Oh, okay. Yeah, fair enough. I used
20 the clinical just from my background in health care.
21 It just means that we understand that when I say it
22 like that, that individuals will often require some
23 help and social supports. And had those health and
24 social needs that wrap-around supports are required.
25 That was all I meant.

1 393. Q. Okay, "required" like before they're
2 housed, is that (indiscernible) or just ---

3 A. In addition.

4 394. Q. --- as part of housing?

5 A. Yeah, that's correct.

6 395. Q. Okay, so sort of concurrently with
7 their being housed?

8 A. Yes.

9 396. Q. Okay.

10 A. Yes.

11 397. Q. Okay, so it's not a -- is you're going
12 to affirm me, it's not a requirement for them to get
13 those interventions before they're housed?

14 A. That's correct.

15 398. Q. It just may be something that goes
16 hand-in-hand with housing them?

17 A. That's ---

18 399. Q. Providing them some supports or, yeah,
19 services.

20 A. Yeah. Okay.

21 400. Q. Okay. And then in terms of the IHPs
22 and developing them, have there been -- I mean,
23 obviously, there's some challenges with doing that
24 with someone who has serious mental health issues who
25 may not have capacity to make decisions.

1 How is the Region approaching those
2 situations?

3 A. So the -- the outreach workers or USWs
4 are all professionally-designated and, you know, they
5 have the training to support. And, you know, I don't
6 have specific examples but my -- my understanding is
7 that when an outreach worker would interact with
8 somebody that was either displaying or had documented
9 challenges around capacity, that appropriate steps
10 would be taken to make sure that we're gaining
11 consent, if we're looking for consent.

12 Yeah, these are trained professionals who do
13 their best in those challenging situations.

14 401. Q. Okay, so would that involve like
15 getting family members or a substitute decision-maker
16 is involved or ---

17 A. It might. It might, Shannon. I don't
18 know, I'd have to -- frankly, I'd have to ask a very
19 specific question ---

20 402. Q. Okay.

21 A. --- about that. But my assumption is
22 those things would all be on the table.

23 403. Q. Or working with the public guardian and
24 trustee?

25 A. In some cases, probably, yeah.

1 404. Q. Okay.

2 A. Yeah.

3 405. Q. And is that -- maybe just an
4 undertaking to find out if that's part of the process
5 for working with people with mental health issues
6 where capacity is ---

7 A. Yeah.

8 406. Q. --- a concern.

9 A. Okay.

10 **UNDERTAKING**

11
12 407. Q. And then -- oh, I just wanted to -- can
13 I get an undertaking just to confirm that since --
14 specifically -- of the communication that you had with
15 your -- or the information that came from your staff
16 about Weber Inn, that there had been no women or
17 gender-diverse individuals placed at that facility
18 since that time.

19 A. Yeah, I will -- we can do an
20 undertaking. I don't know, I'll look to my -- to
21 Andrew for direction on how best to address that.

22 MR. LOKAN: So since the -- you say the
23 Weber Hotel incident, can we take the date
24 of Jakara Droog's email or ---

25 MS. DOWN: Well, I don't know -- I don't

1 know whether that email was the first time
2 that it came to Peter's attention or because
3 you mention ---
4

5 BY MS. DOWN:

6 408. Q. Was it after -- so I guess, was that
7 the first time that that issue came to your attention?

8 A. Yes, and I responded to her.

9 409. Q. Okay, since that time that email was
10 sent which was -- I can't really -- I don't have it in
11 front of me right now but I think

12 MS. CAHILL: September 18th ---

13 MS. DOWN: September 18th. Just an
14 undertaking to confirm that no women or
15 gender-diverse individuals have been placed
16 at the Weber Inn since that time.

17 MR. LOKAN: I assume you mean, self-
18 identified as gender-diverse individuals?

19 MS. DOWN: Yes.

20 MR. LOKAN: What I think makes sense, is
21 yes, we'll give that undertaking but in the
22 event that anyone has, we'll accompany with
23 an explanation.

24 **UNDERTAKING**
25

1 MS. DOWN: Okay. But just whatever
2 information you can provide with respect to
3 that.

4 MR. LOKAN: Okay.

5 MS. DOWN: Those are my questions.

6 MR. LOKAN: So I have a little bit in re-
7 examination.

8
9 RE-EXAMINATION BY MR. LOKAN:

10 410. Q. Peter, you were asked by Shannon a
11 number of questions about where do people go or where
12 could people go or where -- what is available on a
13 closure of 100 Vic.

14 As a factual matter, are there other
15 encampments in the Region?

16 A. There are other encampments in the
17 Region. I don't have the exact number.

18 411. Q. Are you able to give any kind of a
19 range?

20 A. No, I'd have to ask. Again, it's a
21 pretty fluid situation. I -- my USW staff would be
22 able to give me specifics, what they know of.

23 412. Q. Okay. You were asked about a scenario
24 where an unhoused person is placed in a motel and it
25 doesn't work out. And you talk about the engagement

1 that might follow that.

2 I just want you to tell us, not in that
3 situation, but somebody is in a motel for a while.
4 Are there other kinds of housing that people move onto
5 after a motel stay?

6 A. Yes, certainly. So a motel could be a
7 stop in the continuum. There are -- there are other
8 options including transitional congregate settings,
9 traditional -- or not congregate but like multiple
10 units in a building, transitional supportive housing
11 and permanent housing.

12 And so, yeah, there are options when there
13 is availability.

14 413. Q. And are those time-limited?

15 A. They are not.

16 414. Q. Okay. You were being asked a number of
17 questions about where people could go. And I think
18 you started saying something about the Working Centre?
19 I wonder if you could just explain that reference?

20 A. Oh, there's a number of new initiatives
21 coming online across the continuum. And the Working
22 Centre is a 44-bed supportive and transitional housing
23 program that is actually located right across the
24 street from 100 Victoria. It's at 97 Victoria.

25 415. Q. Okay, you were asked about the Council

1 report that accompanied the site-specific by-law and
2 about the additional funding that was set aside under
3 that Council report, together with the site-specific
4 by-law.

5 What did that funding do in terms of
6 capacity?

7 A. That funding unlocked additional
8 capacity mostly in the -- in the provision of
9 additional motel spaces as they were available. And
10 allowed us to proceed with supporting specific
11 individuals residing at 100 Vic as of April 16th of
12 which there are only three or four people left.

13 416. Q. And in terms of the number of people or
14 capacity of the number of people that could be
15 supported?

16 A. That was based on 40.

17 417. Q. So the budget allocation was a plan to
18 provide accommodation for about 40 people?

19 A. That's correct.

20 418. Q. And how many people were there at the
21 encampment as of the date of the by-law? Roughly. I
22 think we have that.

23 A. I think it's roughly 40.

24 419. Q. Okay. Thanks, so those are my
25 questions in re-exam. You're done.

P. Sweeney (Re-Ex.) - 143

1 A. Okay.

2 MS. DOWN: Thanks, Peter.

3 MR. LOKAN: Checked, nothing from the
4 Amicus?

5 MS. PEREZ: Yeah, nothing.

6 MS. DOWN: Oh, sorry.

7 MR. LOKAN: Yeah.

8 THE WITNESS: Okay, thanks everybody.

9
10
11
12 --- ADJOURNED
13
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25

THIS IS TO CERTIFY that the foregoing
is a true and accurate transcription of
my recordings and notes, to the best of
my skill and ability.



Barbara A. Pollard
Certified Court Reporter

Photostatic copies of this transcript are not
certified and have not been paid for unless they bear
the original signature of Barbara A. Pollard, C.C.R.,
and accordingly are in direct violation of Ontario
Regulation 587/91, Courts of Justice Act, January 1,
1990.

EXHIBIT “1”

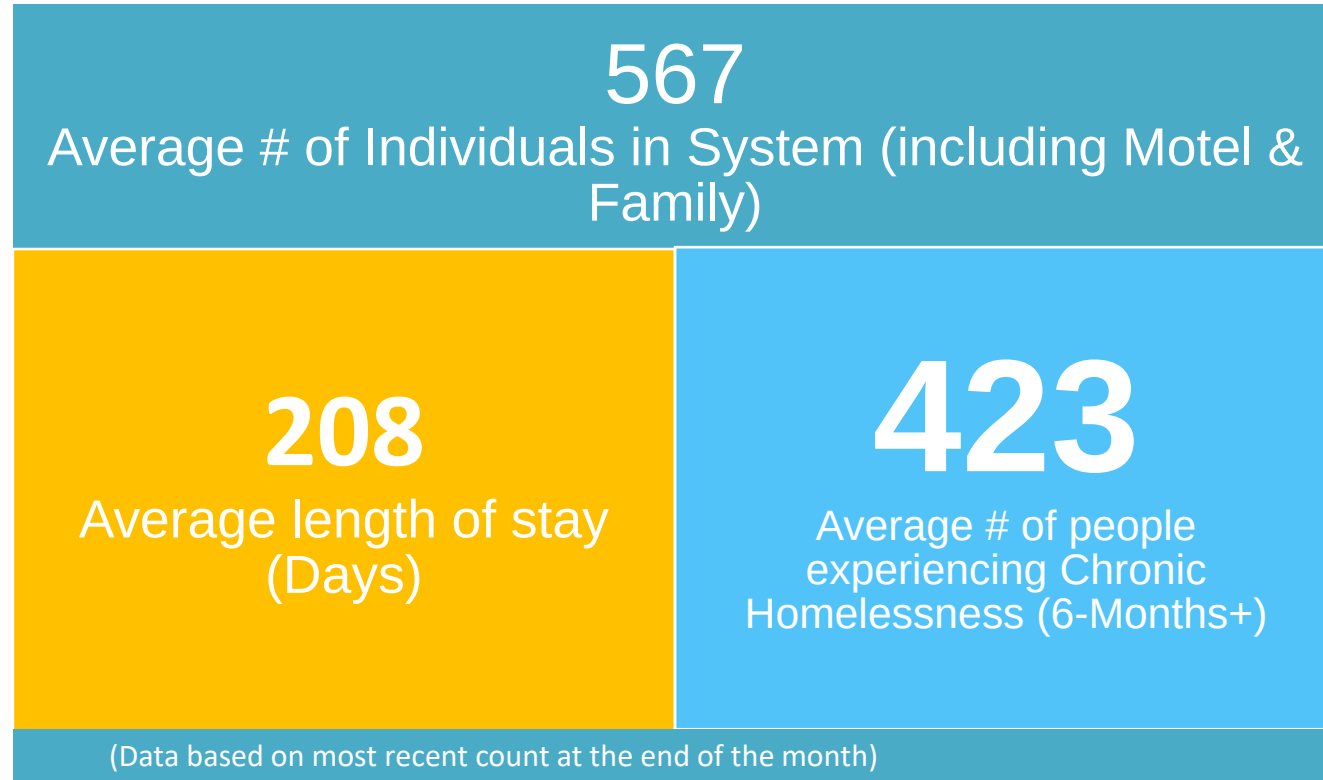
5359



Region of Waterloo

November 2025 HSS Data Update

Waterloo Region System Data – October 2025



94% Average
Occupancy

34 Average Daily
Beds
Available

** Please note that **the Average Occupancy %** and **the Average Daily # Beds Available** are calculated based on the system's average occupancy, **excluding Motel and Family programs**, as these do not have clearly defined capacity limits.*

Beds Availability - By Provider

5361

Provider	Average Daily # Beds Available	Average Occupancy %
CSC	5	93.35%
Erb's Rd	1	98.65%
Kinsmen	5	66.53%
oneRoof	4	83.60%
SafeHaven 2.0	5	50.00%
ShelterCare	2	98.39%
SHIP 84 Frederick	6	87.44%
SHIP Edith MacIntosh	-7	124.09%
YWCA Cambridge	0	99.03%
Life Launch	2	66.67%
Marillac Place	2	82.00%
UA	9	89.27%

System Details - By Program Type⁵³⁶²

	Average # of Individuals	Average Daily # Beds Available	Average Occupancy %
Emergency Shelter	356	21	94.5%
Transitional Housing	83	13	87%
Motel	81	/	/
Family	59	/	/

** Please note that the Motel and Family programs do not report an average daily number of beds available or occupancy rate, since these programs do not operate with fixed capacity limits.*

System Details – By Location

	Cambridge	Kitchener					Waterloo		
	Total / ES	Total	ES	Motel	Family	TH	Total	ES	TH
Average # of Individuals in System (Occupancy)	105	255	103	81	59	12	219	148	71
Average Daily # Beds Available	11	12	8	\	\	4	11	2	9
Average Occupancy %	91%	91%	93%	\	\	73%	95%	99%	89%

**Program types are shown by location, and only those available at each location are displayed.*

**Motel and Family programs don't have fixed capacity limits, so only their average occupancy is included for fair comparison.*

Summary of Top 5 Book out reasons (212)

- Chose to stay somewhere else (63)
- Missed Nights (36)
- Whereabouts unknown (26)
- Service Restriction (18)
- Housed (16)

Emergency Shelter Service Restrictions

- 45 issued in the month of October across 8 shelters
- Median length of restriction: 4 days
- Top 3 reasons
 - Violence
 - Harassment, bullying, threats
 - Non-compliance with rules/regulations

Reasons for 26 Unique Turnaways (plus 10 anonymous callers) October 2025

Reason

No men's beds at time of call (18) No women's beds at time of call (1)

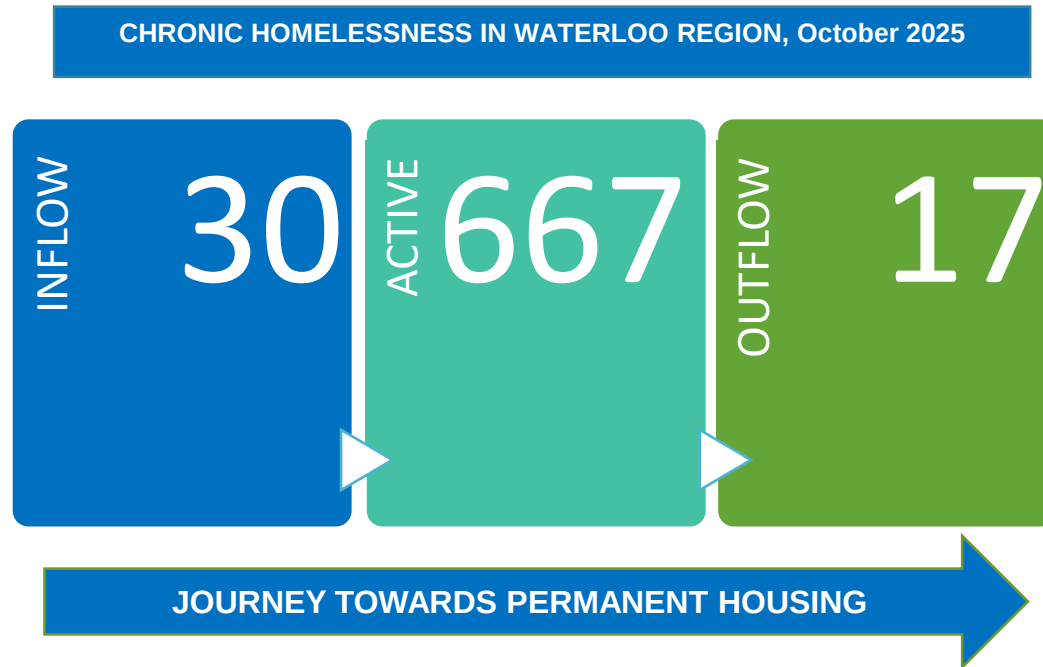
Restricted from 1 Emergency Shelter (23)

Restricted from 2 Emergency Shelters (15)

No pet friendly shelter (2)

Total = 59 turnaways

Chronic Homelessness



Inflow

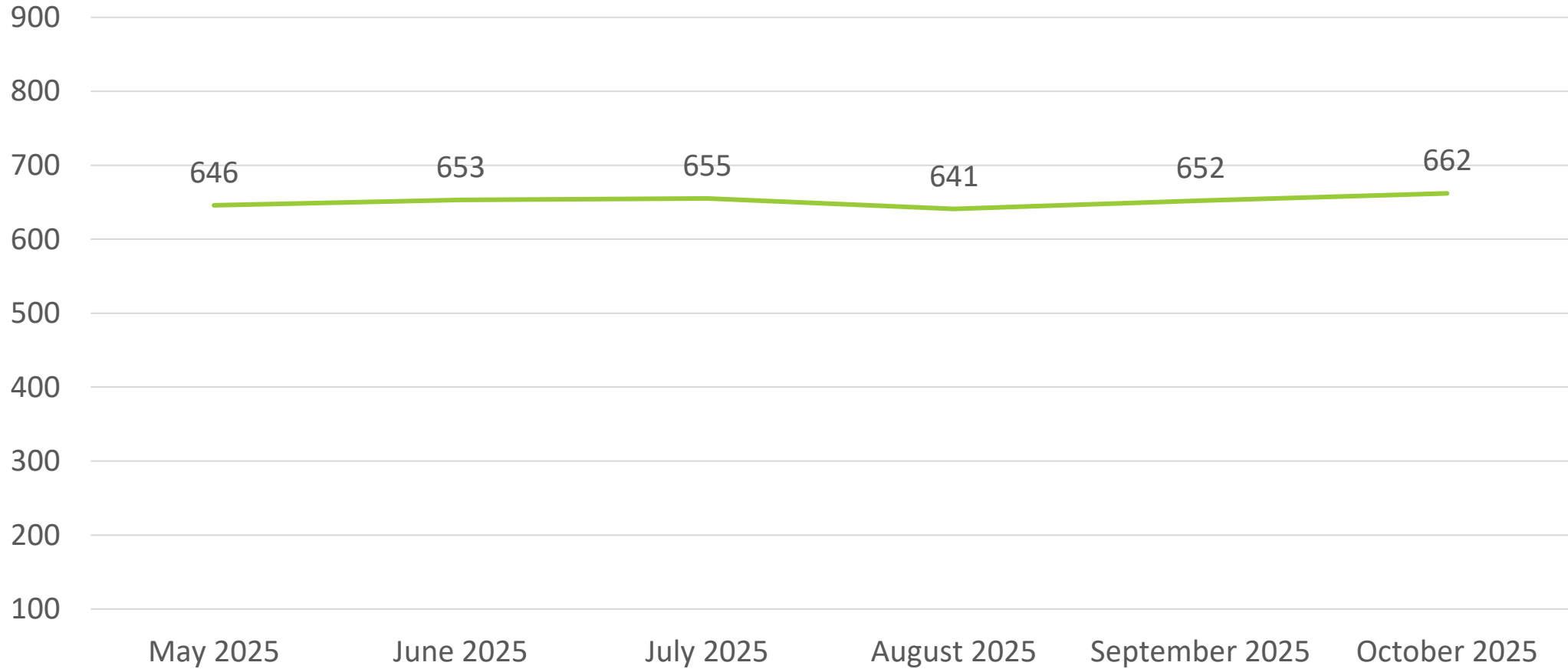
- Aged-in: **30**
- Returned from Inactive: 0
- Returned from Housing: 0

Outflow

- Housing: 15
- Inactive (No Contact/Moved): 1
- Inactive (Deceased): 1

6 Month Trends

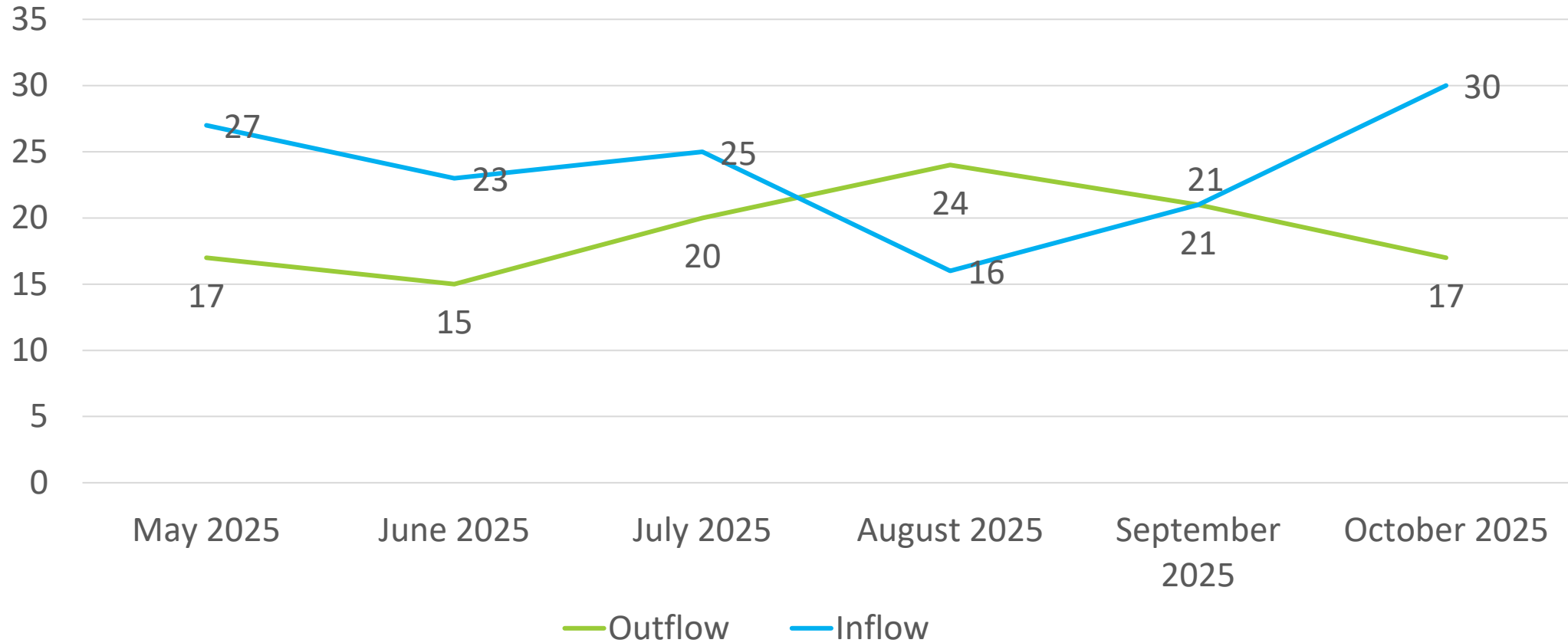
Active on PATHS



6 Month Trends

5369

Inflow & Outflow



Current Active on PATHS: 667

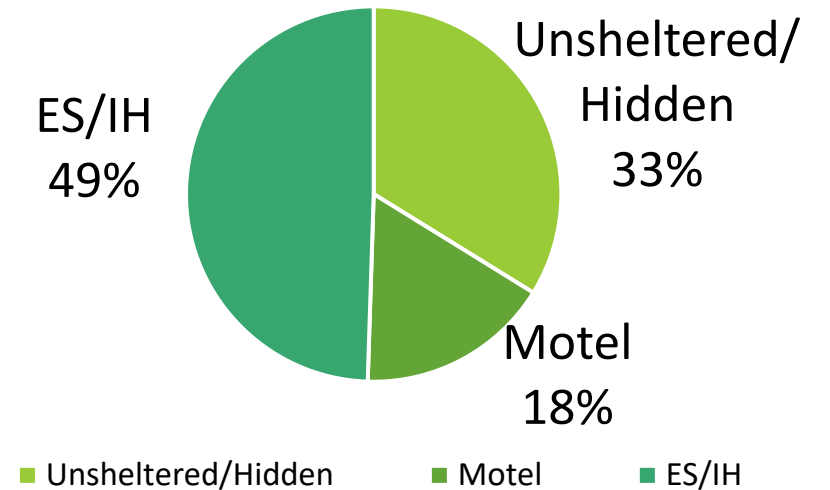
Demographics

- Age:
 - Youth: 17
 - 26-40: 291
 - 41-50: 196
 - 51-65: 150
 - 65+: 13
- Gender-id.:
 - Men: 66% (440)
 - Women: 33% (220)
 - Gender Diverse: 1% (4)
- Year that people were added to PATHS
 - 2025: 208
 - 2024: 188
 - 2023: 94
 - 2022: 65
 - 2021: 40
 - 2020: 35
 - Pre-2020: 37

Most recent stay

- Emergency shelter / Interim housing: 251
- Motel: 82
- Unsheltered / hidden: 166

Most Recent Stay



Family Shelter Data October 2025

71

People accessed the Family Shelter in
October 2025

29 adults (26+)
15 youth (16-25)
27 children (0-15)

3

Families housed
from
homelessness in
October

67

Average days in
Emergency
Shelter (Q2)

****Note:** The above data was calculated by family unit.

Demographics in Adult Shelter, Bed Availability

	Total occupied beds/ total beds available; Oct. 14	Total occupied beds/ total beds available; Nov. 18
Cambridge Shelter	95%	100%
HoF Shelter Care	101%	102%
SHIP- Edith Mac	95%	100%
SHIP- 84 Frederick St	85%	91%
YW Cambridge	95%	95%
OneROOF	88%	75%
BridgeCare	86%	71%
Erb's Road	98%	98%
Total % of Chronicity in ES system	95%	95%

Cismen, transmen, 25/26+:
0 beds available

Ciswomen, transwomen, and gender
diverse individuals, 25/26+:
5 beds available

All genders, 18-25:
6 beds available

All genders, 26+, medically complex:
4 beds available* no intakes

All genders, 25+, outdoor shelter:
1 bed available

Chronic Homelessness in Adult Shelters

	Total Chronic Homeless Pop. / bed occupancy; July 22	Total Chronic Homeless Pop. / bed occupancy; Aug.20	Total Chronic Homeless Pop. / bed occupancy; Sept. 17	Total Chronic Homeless Pop. / bed occupancy; Oct. 14	Total Chronic Homeless Pop. / bed occupancy; Nov. 18
Cambridge Shelter	60%	50%	59%	46%	59%
HoF Shelter Care	88%	89%	85%	80%	88%
SHIP- Edith Mac	58%	76%	68%	60%	57%
SHIP- 84 Frederick St	68%	74%	73%	63%	74%
YW Cambridge	63%	80%	85%	63%	79%
OneROOF	50%	29%	38%	38%	44%
BridgeCare	86%	79%	77%	75%	70%
Erb's Road	96%	96%	96%	96%	96%
Total % of Chronicity in ES system	74%	67%	74%	67%	74%

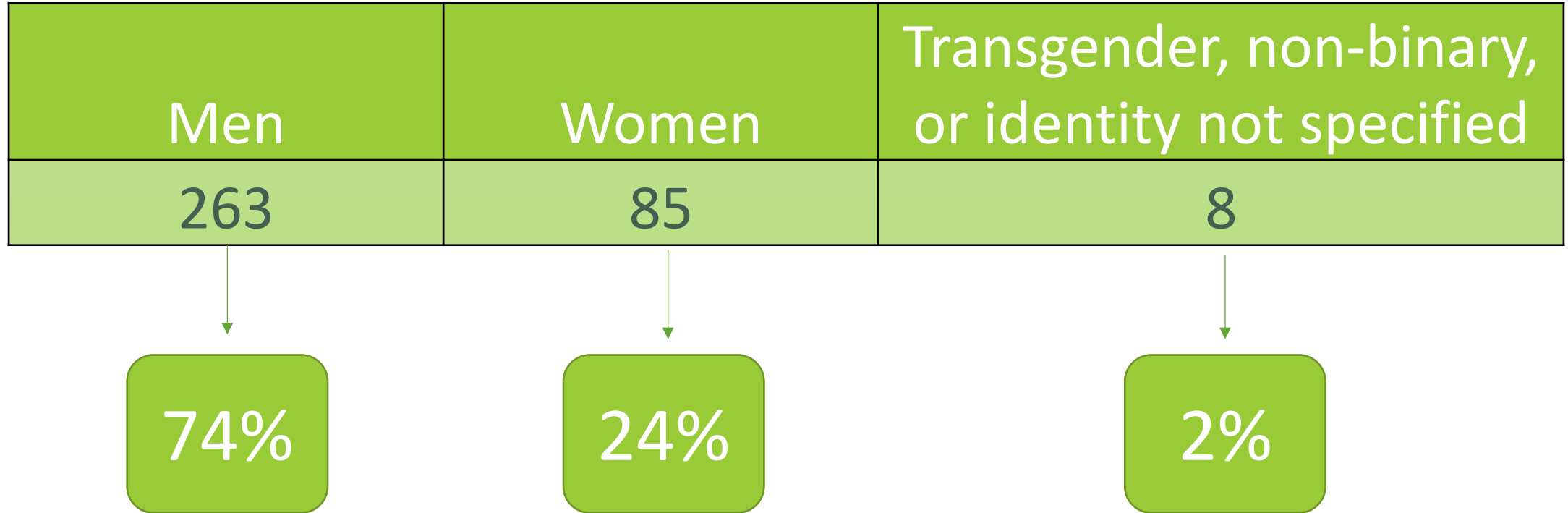
Age Demographics in Adult Emergency Shelters

5374

18-24	25-29	30-39	40-49	50-59	60-64	65+
14	22	94	77	81	42	23



Gender in Adult Emergency Shelters



Of the individuals who identified as transgender, non-binary or their identity was not specified, 50% were experiencing chronic homelessness.

Citizenship and Immigration Status in Adult Emergency Shelters

5376

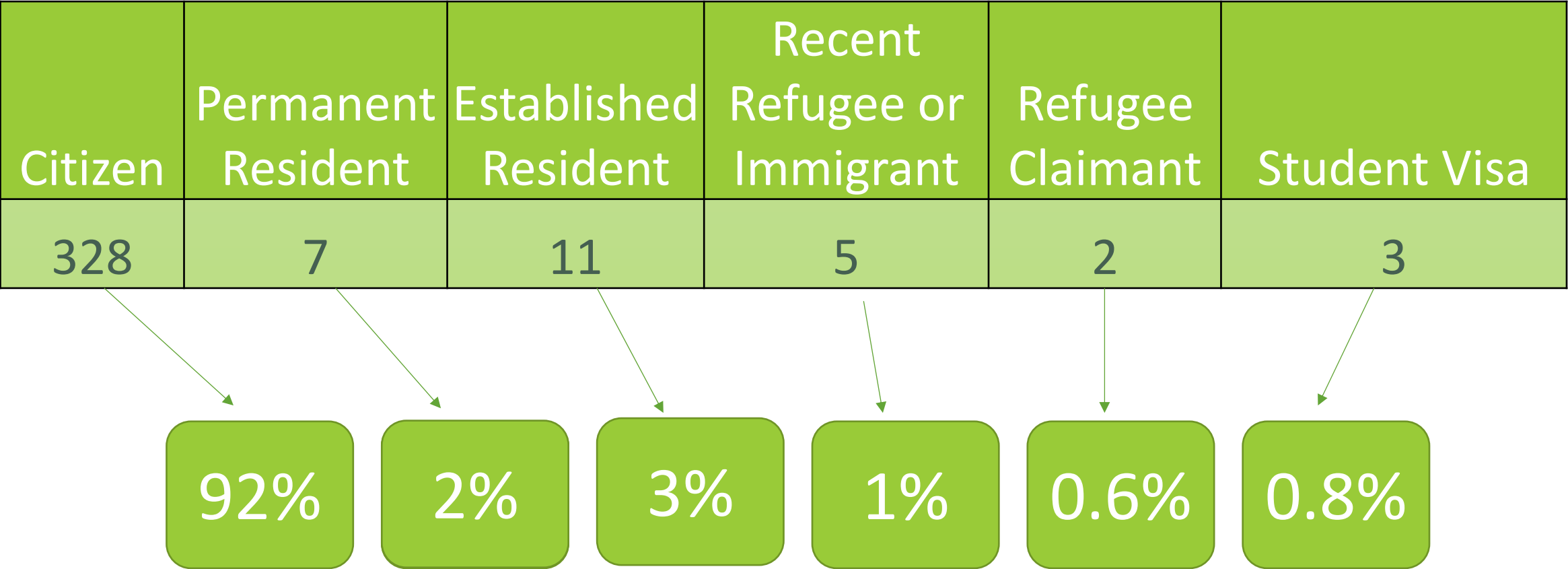


EXHIBIT “2”

2024 Point in time count findings



Region of Waterloo
COMMUNITY SERVICES

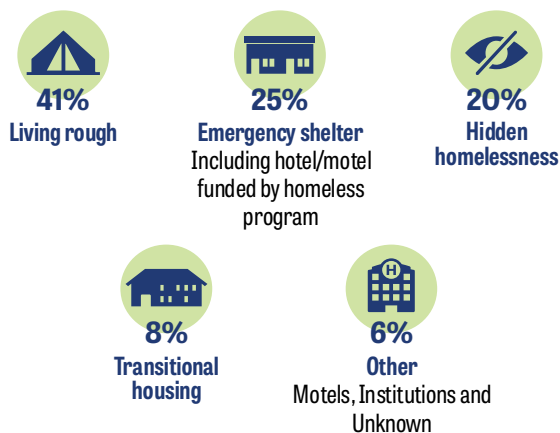
2371 people
experiencing any
type of homelessness
were counted on
October 22, 2024.

1009	people living rough (living in encampments, on the street, or staying in their vehicle)
446	people staying in an emergency shelter
353	people experiencing hidden homelessness (staying with friends or family, or temporary accommodations)
221	people staying in transitional housing
153	people staying in a motel funded by the Region
100	people in institutions (hospital, police custody)
89	people staying in unknown or undisclosed locations

1790 people included in the **point in time count** filled out a survey. A summary of the responses they shared is outlined below.

WHERE/HOW LONG

Where people are experiencing homelessness*



78%
of people surveyed
said they experienced
chronic homelessness

Racial identity

26%

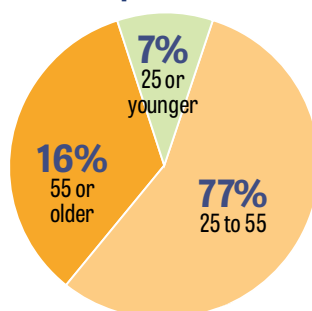
Identified themselves as members
of a racialized community

17%

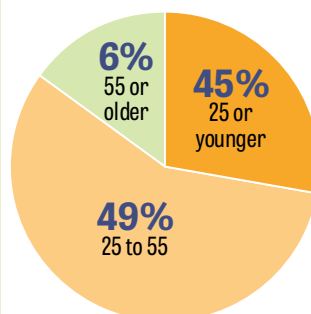
Identified themselves as First Nations,
Inuit, or Métis

WHO

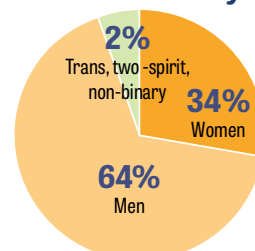
Age of survey
respondents



Age when people
first experienced
homelessness



Gender identity



* The number of people experiencing homelessness in these locations differs from the numbers reported at the top of the page as this section reports on where survey respondents are experiencing homelessness - not everyone experiencing homelessness filled out a survey. Not everyone who participated in the survey answered every question. The percentages above are based on total responses for each question.

EXPERIENCES OF HOMELESSNESS

Top 5 reasons people said caused their experience of homelessness

Not enough income for housing **(44%)**

Conflict with spouse / partner **(18%)**

Landlord / tenant conflict **(13%)**

Unfit / unsafe housing conditions **(12%)**

Substance use issues **(11%)**



Health challenges reported by survey respondents

72%
Substance use

70%
Mental health

44%
Illness / medical condition

29%
Physical limitation

28%
Acquired brain injury

Top 10 services that would be helpful



Finding affordable housing
(76%)



Housing search support
(54%)



Bus pass
(53%)



Finding a job
(49%)



Accessing income support (e.g. OW, EI)
(45%)



Internet access
(42%)



Getting ID
(41%)



Outreach workers
(41%)



Secure storage
(39%)



Washrooms, showers
(39%)



Top 10 challenges to finding safe permanent housing

Low income **(80%)**

Rent too high **(78%)**

Addiction **(33%)**

No income assistance **(32%)**

Poor housing conditions **(31%)**

Mental health issues **(29%)**

Discrimination **(27%)**

Criminal history **(19%)**

Family breakdown / conflict **(18%)**

Physical health issues, accessibility **(16%)**

EXHIBIT “3”

From: [Jacara Droog](#)
To: [Peter Sweeney](#)
Subject: Urgent concerns regarding motel placements and security at 100 Vic
Date: September 18, 2025 12:27:25 PM

This message was sent from outside of Legal Aid Ontario. Please do not click links or open attachments unless you recognize the source of this email and know the content is safe.

Hi Peter,

I am reaching out to bring some pressing concerns to your attention.

1) There are numerous reports of women and femme residents offered motel rooms by the Region and then being sexually coerced and/or exploited by motel staff, with eviction being used as a threat if they refuse. The most recent report took place at the Weber Inn, but volunteers have heard similar accounts from people who were at other motel locations. The heinous Google reviews of some of the motels corroborate that this is occurring, and someone attempting to run a legitimate business would have appealed to get them removed. This issue was raised to USWs on Sept 10, and their response indicated that they were aware of this issue. I am concerned to hear that a femme resident of 100 Vic was placed at a motel this week following that conversation, considering there seems to be an awareness about these unsafe environments. Can you clarify how this issue is being dealt with to ensure the safety of residents offered in motels?

2) Security continues to facilitate public searches of 100 Vic. On Sept 14, around 3pm, a group of random men came on site and immediately walked up to the security vehicle. One of the security guards, Karan Gulati, escorted two of the men around the site. I'm not sure if you recall, but I previously flagged this issue on June 30, of security guards escorting members of the public around site, and you had assured me that security guards are not to be doing that. It's upsetting that security continues to help people disrespect the privacy of residents and their outdoor shelters. I would greatly appreciate if you could reach out to your colleague responsible for the Region's contract with Barber-Collins to reiterate that it's not security's role to escort people around the encampment.

Thank you for your attention to these issues,
Jacara

Jacara Droog
BA, BSW, MSW, RSW
Pronouns: They/Them

I acknowledge with humility that I exist on the traditional land of the Anishinaabe, Chonnonton (also known as Neutral), and Haudenosaunee peoples. As an uninvited white settler, I am grateful for the opportunity to learn, live, and work on this land. Understanding the inherent connection between colonialism and all forms of violence is critical to my praxis, therefore, I bear the responsibility of (un)learning the true history of so-called Canada and challenge my current participation in colonization. I recognize the enduring presence, history, unwavering resistance, resurgence, emotional labour, and contributions of First Nations, Métis, and Inuit peoples and other Indigenous Peoples across Turtle Island. I extend deep gratitude to the land and water defenders of the Wet'suwet'en First Nation at the frontlines of the climate crisis, standing firm to protect the biodiversity of this sacred and finite earth.

EXHIBIT “4”

5383

Individual Housing Plan

Housing Plan for: [REDACTED]

Completed by: Nicole

	Housing Needs/Goals Identified (CHAC/PATHS/SH/OW/ODSP/Shelter Offers, etc.)	Next Steps (client & Staff) And Barriers/challenges	Progress/Notes	Checkbox Housing Progress (Steps 1-10)
1.	<i>Eg. Shelter options</i>	-Declined all shelter options as he has a partner		☒ Preliminary Step: Review Potential Housing Options ☒ Step 1: Get Income ☒ Step 2: Get Identification
2.	<i>Eg. CHAC, PATHS</i>	-Completed an application for Community Housing on November 2, 2021 -Completed PATHS intake	-Waiting on CHAC	☐ Step 3: Get Housing and Credit References ☒ Step 4: Identify housing stability needs, preferences, waitlists
3.	<i>Eg. OW/ODSP</i>	Income Source ODSP		☐ Step 5: Search Vacancies for Budget ☐ Step 6: Contacting Landlords
4.				☐ Step 7: Housing Viewings ☐ Step 8: Sign Lease ☐ Step 9: Paying Rent & Setting up Utilities
5.				☐ Step 10: Moving in and Home Set-up.

5384

Individual Housing Plan

Housing Plan for: [REDACTED]

Completed by: Nicole

	Housing Needs/Goals Identified (CHAC/PATHS/SH/OW/ODSP/Shelter Offers, etc.)	Next Steps (client & Staff) And Barriers/challenges	Progress/Notes	Checkbox Housing Progress (Steps 1-10)
1.	<i>Eg. Shelter options</i>	-Accepted a space at Erbs Rd shelter- Left after 1 night as not a good fit -Declined all shelter options	-Completed intake and interview assessment Veterans Program -No affordable housing due to income level of OW – Continuing to try and find suitable/affordable room rental.	✓ Preliminary Step: Review Potential Housing Options ✓ Step 1: Get Income ✓ Step 2: Get Identification ☐ Step 3: Get Housing and Credit References ✓ Step 4: Identify housing stability needs, preferences, waitlists ☐ Step 5: Search Vacancies for Budget ☐ Step 6: Contacting Landlords ☐ Step 7: Housing Viewings ☐ Step 8: Sign Lease ☐ Step 9: Paying Rent & Setting up Utilities ☐ Step 10: Moving in and Home Set-up.
2.	<i>Eg. CHAC, PATHS</i>	-Completed an application for Community Housing on March 1/25 -Completed PATHS intake	-Waiting on CHAC	
3.	<i>Eg. OW/ODSP</i>	-Applied for OW	On OW, working towards applying for CPP and OAS.	
4.				
5.				

5385

Individual Housing Plan

Housing Plan for: [REDACTED]

Completed by: Nicole

	Housing Needs/Goals Identified (CHAC/PATHS/SH/OW/ODSP/Shelter Offers, etc.)	Next Steps (client & Staff) And Barriers/challenges	Progress/Notes	Checkbox Housing Progress (Steps 1-10)
1.	<i>Eg. Shelter options</i>	-Accepted a space at Weber Inn -Declined all shelter options as he has a partner and Dog	-Maintaining Motel stay and engaging with USWs	☒ Preliminary Step: Review Potential Housing Options ☒ Step 1: Get Income ☒ Step 2: Get Identification ☐ Step 3: Get Housing and Credit References ☒ Step 4: Identify housing stability needs, preferences, waitlists ☐ Step 5: Search Vacancies for Budget ☐ Step 6: Contacting Landlords ☐ Step 7: Housing Viewings ☐ Step 8: Sign Lease ☐ Step 9: Paying Rent & Setting up Utilities ☐ Step 10: Moving in and Home Set-up.
2.	<i>Eg. CHAC, PATHS</i>	-Completed an application for Community Housing on March 9, 2017 -Completed PATHS intake	-Waiting on CHAC	
3.	<i>Eg. OW/ODSP</i>	Income Source ODSP		
4.				
5.				

Court File No. CV-25-00000750-0000

ONTARIO
SUPERIOR COURT OF JUSTICE

BETWEEN:

THE REGIONAL MUNICIPALITY OF WATERLOO

Applicant

and

PERSONS UNKNOWN AND TO BE ASCERTAINED

Respondents

APPLICATION UNDER Rule 14.05 of the *Rules of Civil Procedure*

This is the Cross-Examination of **Dr. Bernie Pauly** on her affidavit dated August 14, 2025, taken via Zoom videoconference on consent of the parties on December 15, 2025.

APPEARANCES:

ANDREW LOKAN, Mr. Counsel for the Applicant
GRETA HOAKEN, Ms.

JOANNA MULLEN, Ms. Counsel for the Respondents
CHARLOTTE CAHILL, Ms. Student-at-Law

KAREN STEWARD, Ms. Amicus Curiae

(i)

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1 DECEMBER 15, 2025

2
3 DR. BERNIE PAULY, AFFIRMED

4 CROSS-EXAMINATION BY MR. LOKAN:

5 1. Q. Good morning, Dr. Pauly.

6 A. Good morning.

7 2. Q. So I'm Andrew Lokan and I am counsel
8 for the Regional Municipality of Waterloo. And so I
9 have some questions for you on your affidavit that you
10 have provided in this proceeding. And I'll make sure
11 I get the date right. I believe it to be August 14,
12 2025. Do you have that before you?

13 A. I do, yes.

14 3. Q. Okay. And just to check, you don't
15 have any other materials in front of you at the
16 moment, do you?

17 A. No, only my affidavit.

18 4. Q. Okay. I know you've been a witness
19 before, so this will hopefully just be a few quick
20 reminders.

21 First is that we should try really hard not
22 to talk over each other. So if you're talking and I'm
23 talking, one or both of us should stop because it's
24 very difficult for the court reporter to make out the
25 transcript, okay?

B. Pauly (Cr.-Ex.) - 4

1 A. Yes.

2 5. Q. And, related to that, there are certain
3 things that don't show up on the transcript such as
4 you nodding your head or if you answer a question with
5 "Uh huh," or, "Uh-uh." Both of those come out the
6 same on the transcript so we try to stick to "Yes," or
7 "No," or other actual words. So try to remember that
8 and if you don't, I'll try to remind you. Okay on
9 that?

10 A. Yes, I understand.

11 6. Q. Thank you. So I just have a few
12 questions about your affidavit. In the first part,
13 you write about the composition of demographics of
14 people experiencing homelessness. Do you recall that
15 in your affidavit?

16 A. Yes, that's correct.

17 7. Q. Now I just want to be sure of this.
18 You haven't made a specific examination of the
19 composition of demographics of the encampment at 100
20 Victoria Street North in Kitchener, have you?

21 A. No, but the cities included in the
22 national Point-in-Time Count do include Waterloo.

23 8. Q. Right, and I'll go into that in a
24 minute. You haven't ever visited the encampment, have
25 you?

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1 A. No, I have not.

2 9. Q. If you were to do that this time of
3 year, you would be exposed to southern Ontario
4 winters. It can be quite a bit colder out here than
5 in British Columbia, wouldn't you agree?

6 A. Yes. And it's a pleasant day here in
7 Victoria, as well, so I appreciate that.

8 10. Q. And I take it that you haven't spoken
9 to any person residing or occupying the encampment.

10 A. I have not.

11 11. Q. Okay. Thank you. Now you point out
12 that, in paragraph 10 of your affidavit, and you can
13 have a look at it if you like, this is what you just
14 referred to, the Point-in-Time Count?

15 A. Correct.

16 12. Q. So the first sentence of your
17 affidavit, paragraph 10, you say:

18 "Nationally, the last coordinated
19 Point-in-Time Count was 2020 to 2022 in
20 which data from 72 communities,
21 including the Waterloo region,
22 highlighted numbers and characteristics
23 of homeless persons based on
24 enumeration and survey data."

25 That's from your affidavit. That, then, does not

B. Pauly (Cr.-Ex.) - 6

1 include the 2024 -- I'm going to use the word "PiT
2 Count", P-I-T Count. Can you just confirm that's the
3 case?

4 A. Yes. Because it was released almost, I
5 think it was released August -- around August 15th. So
6 it's probably more accurate to say that was the most
7 current count at the time of the affidavit.

8 13. Q. Okay. In any event, you were able to
9 include Waterloo region as one of the 72 communities
10 from the 2020 to 2022 PiT Count, but you weren't able
11 to include Waterloo's data from 2024. Is that fair?

12 A. Not quite. Just to clarify, the 2024
13 PiT count which was released after my affidavit was
14 sworn also includes Waterloo in their national Point-
15 in-Time Count.

16 14. Q. Right. But that wasn't the one you
17 used for your affidavit.

18 A. That's correct. I used the one that
19 was most current at the time, which was 2020 to 2022.

20 15. Q. And that's averaged across the whole
21 country?

22 A. That's across the whole country.
23 Correct.

24 16. Q. Okay. You don't have any specific
25 knowledge, for example, of Indigenous over-

B. Pauly (Cr.-Ex.) - 7

1 representation at 100 Victoria Street North, do you?

2 A. Of the specific encampment, no, but of
3 provincial-level, national-level data, it's pretty
4 consistent that there's over-representation of
5 Indigenous people in encampments in Canada.

6 17. Q. And I'm just going to use the term,
7 "100 Vic," so I don't need to give the full name of
8 the encampment each time.

9 A. Right.

10 18. Q. You say in paragraph 17 that people of
11 older age are among the fastest growing segment of the
12 homeless population and you refer to the national
13 homeless count -- I take it that's, again, the 2020 to
14 2022?

15 A. Correct.

16 19. Q. And you say, "People between the ages
17 of 50 to 64 comprise 24% of the homeless population."
18 This is in paragraph 17. Do you see that?

19 A. Yes, I do.

20 20. Q. But you're not, here, saying that -- or
21 you don't actually know if that's an over-
22 representation of that segment of the population
23 nationally, do you?

24 A. It's a representation of a trend that
25 is an increase among homeless populations.

1 21. Q. Right. So what you're saying is that
2 older, 50 to 64, which doesn't sound quite so old to
3 me, but older, 50 to 64, that segment is growing, not
4 necessarily that it's overrepresented. Is that fair?

5 A. It's increasing in representation. I
6 think you're referring in terms to how does it compare
7 to the general population of seniors.

8 22. Q. Yes.

9 A. I think that's the focus of your
10 question and I would say that sentence -- that
11 paragraph does not speak to that. You're correct.

12 23. Q. Okay. Thank you. And, again, you're
13 not aware of the specifics of the over 50 population
14 at 100 Vic?

15 A. That's correct.

16 24. Q. Okay. I take it, also, I will get the
17 same answer, that you're not aware of the specifics of
18 the LGBTQ2S+ population at 100 Vic?

19 A. Not -- not at that specific encampment
20 but in terms of national and provincial
21 representation, I am familiar.

22 25. Q. Okay. You've been involved in some
23 previous cases, correct? Involving encampments.

24 A. That is correct, yes.

25 26. Q. And you were an expert witness in a

1 case involving an encampment at Abbotsford in 2016?

2 A. In Abbotsford in 2016?

3 27. Q. I may have the wrong case. Maybe it's
4 a case called *Adamson*.

5 A. *Adamson* was a very early case.

6 28. Q. 2016.

7 A. 20 -- we're in 2025, so ---

8 29. Q. I know, but the first of these cases
9 came 2008, didn't it?

10 A. That'd correct.

11 30. Q. (Indiscernible).

12 A. So *Adamson* was 2016, you are correct on
13 that. Yes, sorry.

14 31. Q. You were an expert witness in the
15 *Adamson* case?

16 A. Yes.

17 32. Q. Okay. I'm going to come back to that a
18 little later. You were also an expert witness in a
19 case in 2018 involving an encampment in Nanaimo?

20 A. That's correct.

21 33. Q. And in that case, you were put forward
22 as an expert, but you were found not to be in
23 compliance with the requirements for opinion evidence,
24 so you ---

25 A. That was ---

1 34. Q. You weren't actually qualified as an
2 expert in that one, correct?

3 A. No, that's incorrect. I was
4 disqualified on the basis of some filing of paperwork
5 that the lawyers were responsible for. And if you
6 need to know the exact name of it, it was something
7 that was a piece of paperwork that had to be filled
8 out to say that, yes, I was an expert.

9 35. Q. Okay. You're not disagreeing with me
10 that you were not qualified to be an expert before the
11 Court in the Nanaimo case in 2018?

12 A. I did not have -- I did not act as an
13 expert witness because paperwork that was required was
14 not completed by the lawyers as a technical point.
15 And this is quite important, actually, so I appreciate
16 you asking about it because there's a difference
17 between my qualifications to testify and whether or
18 not a piece of paperwork was filled out, so I
19 appreciate the opportunity to clarify that.

20 36. Q. Right, and that difference is a legal
21 difference. So you're explaining the legal system to
22 me?

23 A. No, I am explaining my academic
24 qualifications and ability to act as an expert witness
25 as I was poised to do so. And I certainly would leave

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1 it to you as to the technicalities of the legal system
2 as to how certain paperwork is required and if it's
3 not completed would then disqualify me, which is what
4 happened in this case.

5 37. Q. So in 2020, you were also an expert
6 witness in the Fraser Port Authority case. Do you
7 recall that?

8 A. Yes, correct.

9 38. Q. And your evidence was subject to some
10 criticism. You were told that much of your affidavit
11 amounted more to argument than opinion evidence. Do
12 you recall that?

13 A. Yes.

14 39. Q. Okay. Thank you. It was also observed
15 by the Court in that case that you're passionate about
16 the plight of the homeless. Would you accept that
17 that's a fair description of you?

18 A. I would accept that as a researcher who
19 has done research in this area, it is clear to me that
20 the conditions in which people who are homeless live
21 are unsafe, untenable. And so I definitely have
22 geared my research to support the calls of many,
23 actually, including our national housing advocate of
24 the importance of permanent housing, and I think
25 that's a fairer statement of my position.

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1 40. Q. And you're passionate about it, aren't
2 you?

3 A. Yes. A lawyer once said to me -- a
4 lawyer actually once said to me, "When you know the
5 evidence, how could you not be?"

6 41. Q. That was a lawyer who was an advocate?

7 A. It was a legal lawyer who was
8 representing their clients to their best ability, yes.

9 42. Q. And acting for -- in one of those cases
10 for the group of unhoused residents?

11 A. Yes, which were their clients, and
12 which is considered appropriate legal representation,
13 I'm sure.

14 43. Q. Was it Cathy Boies Parker?

15 A. Is this -- I'm trying to understand and
16 I'm just pausing for a moment to understand.

17 MS. MULLEN: I'm going to object because I
18 don't understand how this is relevant at all
19 to the case that he had.

20 MR. LOKAN: Just interested in her
21 (indiscernible) as this person's been before
22 and is an authority on whether people should
23 or shouldn't be passionate or if you know
24 the facts, how can you not be.
25

1 BY MR. LOKAN:

2 44. Q. Do you recall who it is? Who it was?

3 A. I do.

4 MS. MULLEN: Again, I would object that I
5 just don't think that this is relevant.

6 MR. LOKAN: I'll withdraw as long as we know
7 that it was someone whose job it was to
8 advocate for the Court for the people
9 experiencing homelessness in that case.

10
11 BY MR. LOKAN:

12 45. Q. You say in the second part of your
13 affidavit that there are a number of harms associated
14 with evictions and displacement.

15 A. Yes.

16 46. Q. At around paragraphs 20 to 23. I'm
17 just interested in one of your references, and we
18 might want to bring that up. Paragraph 20, sub-E, I
19 wonder if you can just look at that?

20 A. Yes.

21 47. Q. So that is a paper by Barocas and
22 others. Do I have that pronunciation?

23 A. Yes, I think you're very close.

24 Thanks.

25 48. Q. Okay. And that is a 2023 paper,

1 "Population Level Health Effects of Involuntary
2 Displacement of People Experiencing Unsheltered
3 Homelessness Who Inject Drugs in U.S. Cities."

4 A. Correct.

5 49. Q. Am I to understand that that was
6 restricted to those who inject drugs in U.S. cities?

7 A. Yes.

8 50. Q. Okay. And the way you characterized
9 the paper, you say that the authors predicted that
10 involuntary displacement or "sweeps" of people
11 experiencing homelessness would increase overdose,
12 deaths, hospitalizations, and reduced access to opioid
13 agonist therapy?

14 A. Yes.

15 51. Q. It's characterised as a prediction. So
16 this was not based on having studied and found in the
17 past that these harms had occurred, it was a
18 prediction based on data for the future. Is that
19 fair?

20 A. That's correct. And I'd just like to
21 add a bit of nuance to that. So it's an example of a
22 rigorously designed quantitative study that looks at
23 the data for individuals in those 23 cities.

24 52. Q. Yes.

25 A. And then, as you noted, it does -- it

1 looks at the past mortality data and then it looks at
2 two models: one where there's displacement and one
3 where there's not. And so that is how they come to
4 those conclusions.

5 53. Q. Okay. And I'm going to ask -- and we
6 may be able to pull this up from the study. There's a
7 particular paragraph describing the kind of
8 displacement that is being referred to in the article.
9 And I'm just going to check whether we're able to get
10 that on the share screen.

11 Okay. So we've highlighted a paragraph in
12 the article. I'll just give you a moment to read it.
13 Can you see that?

14 A. Yes, thank you.

15 54. Q. And I'm going to read it into the
16 record so that it's there on the transcript:

17 "Across the U.S., involuntary
18 displacement that forces people
19 experiencing homelessness to regularly
20 relocate from one temporary location to
21 another is common. Involuntary
22 displacement may be operationalized or
23 labelled differently depending on the
24 city. Sometimes referred to as
25 "sweeps," "clearings," or "clean-ups,"

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1 displacement is often done without
2 connecting people to services or
3 housing and without regard for past
4 trauma. People experiencing
5 homelessness are often forced to
6 disperse away from services, resulting
7 in loss of personal belongings,
8 medications, identification cards, and
9 social support. Involuntary
10 displacement may disproportionately
11 impact people experiencing homelessness
12 who use non-prescribed drugs because it
13 can affect access to sterile injection
14 equipment, naloxone, and medications
15 for opioid use disorder, decreased
16 access to support services, and life-
17 saving medications, may increase
18 overdose risk and death. This model
19 and study aimed to better understand
20 the potential long-term health effects
21 of involuntary displacement among
22 unsheltered people experiencing
23 homelessness who inject drugs in 23
24 U.S. cities."

25 So have I read that accurately?

1 A. Yes.

2 55. Q. Okay. Thank you. So what this article
3 is referring to is what's commonly regarded as
4 "sweeps," as it says. Is that fair?

5 A. I think -- it says, "sweeps," but it
6 also includes, "clearing," and "daily displacement,"
7 and I think ---

8 56. Q. Yes.

9 A. --- it's important to keep all those in
10 the mix.

11 57. Q. And they are or can be characterized by
12 authorities just swooping in, moving everybody along
13 without regard to where they're going to go next,
14 correct?

15 A. I think it's -- that is one form, yes.

16 58. Q. And according to this article, a
17 relatively common form.

18 A. Yes, common form in the -- or it's
19 maybe better to say that was the form that they
20 identified. Yes.

21 59. Q. Okay. In the U.S.?

22 A. In the U.S., but it also, as you know,
23 happens in Canada as well.

24 60. Q. And so we're talking about, in most
25 cases, dispersing people without keeping track of them

B. Pauly (Cr.-Ex.) - 18

1 and without providing them with alternative
2 accommodation, correct?

3 A. That's difficult to discern, mainly
4 because, often, municipalities will offer some form of
5 accommodation. It may be done in that way. And I
6 would just like to sort of characterize, which is --
7 you know, "sweeps," which is something that can happen
8 after maybe months of an encampment or it may happen
9 on a more regular basis. Those kind of big sweeps,
10 it's not uncommon for municipalities to visit or have
11 workers or outreach workers who visit an encampment
12 and offer housing and then that housing may or may not
13 come to be when the sweep actually happens. So it's
14 -- that's a more planned example.

15 61. Q. Right. And so what you're pointing to
16 is that there could be a lack of follow-through. An
17 outreach worker talks to an individual at the
18 encampment and says, "Look, we could find a place for
19 you," but then the sweep happens and that placement
20 never occurs. That's what you're saying is one
21 possibility?

22 A. Yes, that's one possibility. It also
23 may be that housing isn't available or the housing
24 that's offered may not be suitable for the individual.

25 62. Q. Right. And neither may encampment be

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1 suitable for an individual.

2 A. Encampments are -- and I think you've
3 seen the article that -- that I co-authored that was
4 included in the affidavit, encampments are a last
5 resort often when other suitable options aren't
6 available.

7 63. Q. Right, right. I mean, for example, you
8 can have things like murders in encampments. You've
9 heard of that, right?

10 A. Yes. I think we've heard of murders in
11 many settings, right? They can happen -- I've heard
12 it happen in all kinds of settings, housing shelters
13 (indiscernible)...

14 64. Q. Including encampments.

15 A. Yes, including -- well, I'm wonder --
16 I'm just trying to think and many you have a more
17 specific example. I don't -- and I don't know that we
18 need examples but is it -- I don't have evidence that
19 it's any more prevalent in an encampment than in other
20 settings.

21 65. Q. As far as examples go, and you may not
22 be aware from where you are, but there was an
23 allegation, at least, in Barrie, that one encampment
24 resident murdered two others and dismembered their
25 bodies. Is that something that's come to your

B. Pauly (Cr.-Ex.) - 20

1 attention?

2 A. I mean, I certainly -- I haven't seen
3 that particular example in the news, but I think ---

4 66. Q. Okay.

5 A. --- we need to be aware of how those
6 kinds of situations -- I don't know if it was proven
7 in the Court of Law. Anyways, that's a different
8 issue.

9 MS. MULLEN: I don't think that's on the
10 record anywhere. You know, we don't have
11 any evidence of that before the Court.

12 MR. LOKAN: Well, we do have something on
13 the record, but we can take that offline.

14 MS. MULLEN: So an instance in Barrie ---

15 MR. LOKAN: I won't trouble -- we don't need
16 to trouble Dr. Pauly with this. She's said
17 she's not aware of the allegations, so we
18 don't need to go any further with that.

19
20 BY MR. LOKAN:

21 67. Q. So just looking at your paragraph 20 in
22 the harmful impacts that you say can arise from sweeps
23 or clearances of encampments, I just want to see if I
24 can understand a couple of them. You talk about loss
25 of survival items, and that certainly is mentioned in

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1 the literature including that paper that we just
2 looked at, right?

3 A. Correct.

4 68. Q. So during a displacement event, people
5 can have belongings confiscated including survival
6 gear, but you could -- if you did a transition from an
7 encampment better, you could avoid or mitigate that
8 harm, couldn't you, by storing people's belongings?

9 A. That is the theory, you are correct
10 that people will say, "We'll store your belongings."
11 The reality is, is that often storage, depending on
12 who's -- there's two things that immediately need to
13 be considered.

14 One is that, first, sometimes items are
15 discarded before they're stored, and that can be for a
16 variety of reasons. People may not realize, you know,
17 for example, one woman, and this was a fairly common
18 (indiscernible) case, had the ashes of a loved one
19 thrown out mainly because I don't think, you know, it
20 was recognized what the item necessarily was and then
21 ---

22 69. Q. Again, that wouldn't be a harm unique
23 to an encampment, would it? I mean, that happens in
24 funeral homes, for example.

25 A. I think, though, the intent -- and I

B. Pauly (Cr.-Ex.) - 22

1 don't know about funeral homes, I'm sorry ---

2 MS. MULLEN: Yes, I think that's outside of
3 Dr. Pauly's evidence. She can not comment
4 on what funeral homes do.

5
6 BY MR. LOKAN:

7 70. Q. Okay. But certainly you would agree
8 with me that the inadvertent disposal of ashes is
9 something that could happen anywhere, not just in an
10 encampment.

11 A. I don't know the extent to how it
12 happens. I can speak to the impact of that on
13 individuals. And I just want to ---

14 71. Q. It would be devastating for anyone,
15 wouldn't it?

16 A. I just want to clarify that the
17 question that I'm answering is not -- it's specific to
18 the storage of belongings, correct, as a mitigation
19 strategy for lost items? Is that the question?

20 72. Q. The question started with, "You could
21 have arrangements to store belongings made in a
22 commitment to the Court, for example." And you're
23 saying, "Well, things can still go wrong." And I
24 accept that, but that can happen anywhere
25 (indiscernible).

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1 A. It can still go wrong in the sense that
2 I want to mention my first point was around things
3 being discarded that are considered to not be of
4 value, and my second point is the length of time that
5 storage is available is often limited.

6 Sometimes there's expectations that
7 individuals pay for storage and have to -- or it could
8 be in a place that's difficult or requires
9 transportation to access, so there's a number of
10 barriers that are highlighted. And I think those
11 should be considered as well.

12 73. Q. Okay. So you would recommend, then, if
13 there was going to be storage of items, that it not be
14 for a brief period and that it not require payment,
15 for example.

16 A. Sure. And be able -- relatively easy
17 for people to access. So for example, if the storage
18 facility is, you know, an hour bus ride away or even a
19 significant distance away, that would also be
20 problematic.

21 72. Q. Okay. And you say in paragraph C,
22 20(c), there can be increased stigma and disruption of
23 community connections. But again, these are harms
24 that could either avoided or mitigated. In the event,
25 for example, that the municipal authorities took care

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1 to ensure that people were going to a placement and
2 that their connections were maintained.

3 A. Yes, if those placements are available
4 and it's an option that is suitable for the
5 individual.

6 73. Q. Okay. And loss of medications and
7 medical equipment, that's a sub-category of loss of
8 belongings. A very important sub-category.

9 A. That's correct.

10 74. Q. And for that one, you'd want to take
11 special care to ensure that things were not discarded
12 by mistake and that they were treated with respect and
13 kept safely. Is that fair?

14 A. I would say it is fair. Those things,
15 people need to have with them.

16 I think it's also important to remember that
17 if someone is provided with a placement that's at a
18 distance from their primary care clinic or where they
19 access other kinds of services, that makes it
20 extremely difficult for them to continue to receive --
21 to have those connections and receive the medical care
22 and prescriptions that they require.

23 75. Q. So if a municipal government had its
24 eyes on those items and wasn't just, for example,
25 putting people on a bus and sending them to another

1 part of the country, that's a harm that could be
2 mitigated.

3 A. It's a harm that could be mitigated
4 with permanent housing in a -- yes, in a neighbourhood
5 that is -- those services are accessible.

6 76. Q. Or even if it's to transitional housing
7 for which people graduate to permanent housing.

8 A. I'm not sure if we will get to this in
9 your next set of questions, but there's quite -- I
10 think there's an important conversation about
11 transitional to permanent and what the evidence says,
12 but I don't want to jump ahead, so ...

13 77. Q. Right. You may be referring to housing
14 first?

15 A. Correct.

16 78. Q. Okay. And there may be a
17 misunderstanding because it's the region's evidence
18 that it agrees with housing first and has never meant
19 to suggest otherwise. So we may need not get to that.

20 A. Just a comment on that, because many
21 regions have housing first philosophies or policies,
22 but what it means is that people are moved into
23 permanent housing immediately. They are not expected
24 to go through other forms of temporary housing. And I
25 think the reality for many municipalities is that the

1 permanent housing is often not available. It's at a
2 premium or, you know ---

3 79. Q. Right.

4 A. --- there's no vacancy. So I just want
5 to raise that to ensure it's on the record. Thank
6 you.

7 80. Q. Yes. It may well be the case that
8 there's simply not enough permanent housing to be able
9 to place everybody in permanent housing immediately,
10 so that's what you're referring to.

11 A. That is correct. Thank you.

12 81. Q. Okay. And you refer in paragraph 20(e)
13 to matters such as not having naloxone available in
14 your new location, and that's one of the things that
15 was cited in the study, that we looked at the
16 definition of sweeps or the reference to sweeps. So
17 naloxone, access to naloxone would be a factor.

18 A. I think the reference would be to the
19 fact that it can be discarded as well as people who
20 can help to administer the naloxone, you could be
21 disconnected from those individuals as well in a
22 sweep. And so it's a loss of two things: it's the
23 naloxone itself and someone who is able to administer
24 it, which may be someone else that's in your
25 community.

1 82. Q. Right, and ideally someone who has the
2 qualifications to administer naloxone.

3 A. Naloxone training is available to
4 everyone in the public and it's very accessible
5 training.

6 83. Q. So someone who had done the training,
7 for example.

8 A. Or who has been -- many, many people in
9 encampments have received instruction on how to use
10 naloxone. It's not a -- I guess what I'm trying to
11 get at, it's not, you know, a course that's days long
12 in a classroom. It's actually a relatively simple
13 matter, somewhat similar to when -- I don't know if
14 anyone has an allergic response and requires
15 epinephrine, it's a fairly simple procedure that could
16 be taught by laypeople to laypeople.

17 84. Q. And you would expect that the people in
18 social services have had that training?

19 A. Yes, I would.

20 85. Q. Thank you. And, again, this is a harm
21 where as long as people remain connected to a supply
22 of naloxone and remain connected to people who can
23 administer it, that's another harm that can be
24 mitigated or avoided.

25 A. I would say that, yes, with a

1 qualification, is that stigma, and I think we're all
2 familiar with the degree of stigma related to
3 substance use that often means people, when they're
4 removed from people who they know, who they feel safe
5 with, may not -- maybe someone isn't available or they
6 may not feel safe to call on someone because of the
7 wide-ranging stigma in society that people are very
8 cautious about. And it takes time to be able to trust
9 people.

10 86. Q. Okay. I want to go back to the *Adamson*
11 case. And you're aware that in that case an
12 injunction was eventually granted to allow the
13 dismantling of the encampment?

14 A. I am.

15 87. Q. Okay. And I just want to see if we can
16 look a little bit at the terms that occurred there.
17 And so if we're able to pull up paragraph two of that
18 decision?

19 So the date, here, of the decision, shows up
20 on the first page. And it looks like it was decided
21 on July 5th of 2016. And that's in the top right-hand
22 corner. And I only mention that because of the terms
23 of an order later, but as I understand the case -- and
24 this was around, too, there was an initial injunction
25 that was denied, correct?

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1 A. That is correct. Thank you for
2 bringing that up.

3 88. Q. And in the second injunction, and this
4 is an injunction where the city that's moving -- I
5 know it's the Province of British Columbia that is the
6 moving party, and in the second injunction
7 application, the Commons was granted the injunction
8 with certain terms. And is that your recollection?

9 A. Yes.

10 89. Q. Okay. And part of the set-up here was
11 that for those who were resident at the encampment,
12 there were three choices or three possible forms of
13 accommodation that were provided. So there was a
14 transitional home, a central care home, and a female-
15 specific facility, the Atira Women's Resource Society
16 in Vancouver. Do you have knowledge of that, or do
17 you have recollection of that?

18 A. Yes, I do.

19 90. Q. Okay. And then if we go to paragraph
20 86, we can see the order the court eventually made.

21 Okay. So the way this is set up is that
22 "Within three days of the order ..." that is, within
23 three days of July 5th, "The defendants ..." and that
24 would be those residing at the encampment:

25 "... At the date of the order who did not

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1 have access to housing elsewhere and who
2 wished to transition to new housing must
3 identify themselves and provide a picture
4 ..."

5 Et cetera, et cetera.

6 And clause B, "They must identify what are
7 their possessions." I'll skip over C for now, but go
8 to D:

9 "As housing becomes available and by no
10 later than August 6th (indiscernible) of
11 August 8th ..."

12 Sorry, that's about five weeks just to --
13 "they shall remove all tents, structures, shelters,
14 objects," et cetera, et cetera.

15 And then E:

16 "For the purpose of ensuring compliance with
17 the order, the province is authorized to
18 remove or cause to be removed items that are
19 not claimed by any of the defendants."

20 So if you are a qualifying defendant, your
21 stuff, it looks like -- the intent is that it be
22 looked after, that you be transitioned to other
23 facilities. But if not, other materials can be
24 disposed of. And, of course, if there's a violation
25 of a fire commissioner's order, that would also have

1 its own consequences.

2 So were you generally aware of the terms of
3 this order when the encampment was dismantled?

4 A. Yes, I was, generally.

5 91. Q. Okay. And I appreciate that from your
6 position you, would not have liked to see this happen
7 but you were aware of the terms of this.

8 And if we can go back to C, you're also
9 aware that as part of it the province was permitted to
10 prevent any new occupants or residents from coming
11 into the encampment so it could be dismantled over
12 time. And you are aware of that as well?

13 A. Yes. And, in fact, there is now a
14 playground there.

15 92. Q. Okay. So, I mean, just looking at the
16 things that were done here, there does look like there
17 is a provision of different types of shelter to those
18 who were resident as of the day of the order. And
19 you'd agree that that part is appropriate, right?

20 A. Actually, I would say the -- the fact
21 that the -- and I'm just going to explain the decision
22 as I understand it ---

23 93. Q. Sure.

24 A. --- was that they couldn't simply be
25 displaced in -- with this decision, there had to be

1 some sort of housing available to them. And is it
2 possible to just scroll back up in the judgment where
3 it lists the three options for individuals?

4 94. Q. Sure. That would be back at paragraph
5 2.

6 A. So the choice is transitional home,
7 which was a new reclaimed space that had previously
8 been a youth detention centre came available and that
9 was, as noted here, offered to individuals. A concern
10 that was raised is that many individuals have
11 themselves spent youth in detention and to be in a
12 former detention centre or some had experiences with
13 other types of situations as youth, that this was not
14 considered an appropriate -- it's also a location that
15 is quite far from the services that many of them would
16 have been available and I'm speaking there about
17 health services, food banks, those kinds of -- of
18 things. So that's the first one.

19 The second one, the central care home, had
20 been a decommissioned senior's building that had not
21 been operating for a number of years. And I honestly
22 don't know what -- what the plans were for it, but
23 it'd been sitting empty for some time. And I would
24 point out, of note, that the fire alarm system wasn't
25 working properly. The stairwells were locked in that

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1 building. There were some grave concerns about the --
2 and I'll just quickly reference here the seven
3 criteria of adequate housing.

4 So there was concerns about the ---

5 95. Q. Dr. Pauly?

6 A. Yes?

7 96. Q. I don't think we need to get dragged
8 into the weeds of the particular choices there because
9 these are not the choices that are at issue in our
10 case. Especially because, while you may not have
11 agreed with it, the court actually did endorse the
12 closure of this encampment with the transitioning of
13 the residents to one of these three options.

14 MS. MULLEN: (Indiscernible).

15 MR. LOKAN: I'm just saying that that's what
16 the court endorsed.

17 MS. MULLEN: You're asking for her opinion
18 about what was offered to the residents and
19 what the court endorsed. She should be
20 allowed to provide her opinion on the
21 options.

22
23 BY MR. LOKAN:

24 97. Q. My question was if there are options
25 that are offered and there's a choice of options that

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1 see people placed in choices appropriate for them,
2 then you don't -- you wouldn't say that it's wrong, in
3 principle, to transition people out of an encampment,
4 would you?

5 A. If there are options that are -- meet
6 the seven criteria for adequate housing which include
7 permanency ---

8 98. Q. I know you want to (indiscernible) ---

9 A. --- (indiscernible) and so on.

10 99. Q. --- criteria, and those I take it are
11 from a document in the national housing strategy. Is
12 that right?

13 A. That's correct, yes. The *National*
14 *Housing Strategy Act*, the seven criteria. So my ---

15 100. Q. (Indiscernible) the *National Housing*
16 *Strategy Act*, the long and the short of it is that
17 these three ones you thought were inadequate.

18 A. These three ones didn't -- correct.
19 These three ones did not meet those criteria.

20 I think, just to your question -- I really
21 want to make sure I answer your question because I
22 think it's choices that meet those criteria but are
23 also suitable for individuals, and so, for example,
24 offering someone a place in another city -- maybe
25 that's suitable for some but not for all. So I think

1 I just want to raise the suitability of the options,
2 not that there's simply options.

3 101. Q. Okay. But you would like to see that
4 they are no worse than the encampment environment.

5 A. I would like to see them meet the
6 criteria for adequate housing.

7 102. Q. Okay. So you may have disagreed with
8 the judge and what the judge did in that particular
9 case in terms of the options, but going back to
10 paragraph 86 in the terms, I think you've agreed with
11 me that storage of belongings is an important thing
12 that you want to do. And ...

13 A. If -- regarding storage of belongings,
14 if someone is being moved into an adequate option, I
15 do not see the need for storage because, for example,
16 things can be packed up and the person moved with
17 their belongings, as -- which cuts out the need for
18 storage and actually reduces a lot of the -- not only
19 cost, but time and energy on the behalf of everyone
20 involved.

21 103. Q. So if there's permanent housing
22 available, it may not be necessary. But in that case,
23 you would need assistance with transportation of
24 belongings, right?

25 A. Yes, that's correct. And if I may say,

1 to not limit. So in some scenarios, people are told
2 you can have two totes or three totes, but I think we
3 need to respect just as all of us would want respect
4 for our possessions.

5 104. Q. Okay. You also, I take it, would agree
6 with the proposition that if you're going to close an
7 encampment and transition people away from an
8 encampment, you would want to give plenty of notice?

9 A. I would say the first thing would be to
10 ensure there's a relationship with -- I would follow
11 the national protocol for encampments as a process.
12 It's not simply giving people notice but, yes, time
13 and attention to the national protocol, which outlines
14 the involvement of people in the encampment in those
15 decisions.

16 105. Q. So how much notice do you think a
17 population at an encampment should have of when the
18 eventual closure date would be?

19 A. Enough time to ensure that suitable
20 permanent options are available.

21 106. Q. So only when they're permanent?

22 A. Based on the best evidence, or -- I --
23 or I would add if someone is offered an option such as
24 a transitional housing and they see that as a viable
25 option, that would make sense. So individuals --

1 that's the reason why I speak to the national protocol
2 for encampments and the importance of individuals
3 being involved in those choices and the options that
4 are offered.

5 107. Q. Okay. So you want to see people
6 involved in their own options and if they can't be put
7 in permanent housing, that would be okay as long as
8 they agreed? Does that summarizes what you just
9 explained to me?

10 A. If they agreed and they weren't being
11 forced.

12 108. Q. Okay. So it's never okay to force
13 somebody to go anywhere other than permanent housing
14 if you have to close an encampment?

15 A. I mean, I think it's a -- you know,
16 we're getting into tricky grounds around it.

17 109. Q. We most certainly are, yes.

18 A. Around enforcement, we see enforcement
19 happen in many different ways, so I'm not sure if you
20 can clarify or maybe restate or expand the question
21 you'd like me to answer here.

22 110. Q. So I think what I'd asked you is, in
23 your view, it's never okay to force someone to leave
24 an encampment if they don't agree to leave the
25 encampment. Is that correct?

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1 A. Individuals should have a say in the
2 options that are available to them, and they should be
3 able to exercise choice ---

4 111. Q. Yes.

5 A. --- in choosing the place to which they
6 are accommodated. And ---

7 112. Q. And if they don't want any of them, the
8 encampment just should never be closed? Is that what
9 you're telling us?

10 A. You know, it's interesting. I really
11 appreciate your question because I think there's not a
12 good understanding, necessarily, of why someone would
13 refuse the options available to them. And it, you
14 know, it could be a variety of reasons but the one I
15 want to point to is a lack of trust.

16 You know, people in encampments may have had
17 difficult life experiences with systems through their
18 whole life, whether it's been school systems, legal
19 systems, healthcare systems, where they've faced a lot
20 of challenges. And so it does take time for people.
21 And, you know, there's various strategies such as
22 allowing people to see, for example, the options that
23 are available, making sure they have all the
24 information, and working with someone. Because I --
25 you know, I think under the housing first philosophy

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1 it is -- and it is very much that housing is something
2 that everyone should have. It isn't -- it's a right,
3 so ---

4 113. Q. No, I understand your point of view on
5 that, and we have some questions around that as well.
6 But just going back to what you said.

7 So you would recommend if people -- if an
8 encampment has to close and people have to be
9 transitioned, you recommend that they are able to
10 spend a lot of time, for example, with an outreach
11 team. That people can work with them over time to
12 earn their trust, to explain their options, get them
13 comfortable with their options, and hopefully get them
14 to a place where they choose one of them?

15 A. Yes.

16 114. Q. Is that fair? Okay.

17 A. Yes, that's fair.

18 115. Q. And from your point of view, that's a
19 process that, ideally, should take place over, what,
20 several months?

21 A. Yes. I don't know that I can quantify
22 a time for some individuals.

23 116. Q. Okay. So for some really -- I mean, we
24 know that encampments, the needs of the occupants can
25 vary greatly and there can be some people who are

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1 extremely difficult to accommodate in another setting.
2 Is that fair? There can be very high-need
3 individuals.

4 A. I think it's fair to say that settings
5 may not be prepared to meet the needs of everyone.

6 117. Q. Right. And so, I mean, given that in
7 an ideal world, permanent housing for everyone. But
8 in the circumstances where an encampment has to close,
9 sooner or later, and you may have some high-need
10 individuals, are you telling me that even if it takes
11 a year or two to get their trust and get them
12 comfortable with one of the options you should take
13 that year or two?

14 A. I think you have to take the time it
15 needs. And I just want to raise another thing ---

16 118. Q. Even if it's three years?

17 A. If an encampment is closed, I just want
18 to spell a little trajectory out. So if an encampment
19 is closed as you're outlining ---

20 119. Q. Yes.

21 A. --- and some individuals, and hopefully
22 all of them move into a form of adequate housing, you
23 know, there are some individuals who, yes, it will
24 take longer. And if they're not housed appropriately,
25 they will simply end up back on the streets and be in

1 another location and it becomes kind of a constant
2 cycling which is very negative where people are
3 cycling from the streets and through hospitals and
4 jails and shelters, you know. And this, we've
5 documented this and other examples where they're not
6 getting the proper care and services that they need.

7 120. Q. Right. And so if it might take not
8 just months but years and it may not always work, and
9 somebody might find themselves back into the unhoused
10 population, would you agree that if you're required to
11 close an encampment, there's going to come a point
12 when you're just going to have to say, "We can't allow
13 new occupants to establish themselves because we
14 really have to work with the existing population to
15 get everybody placed however long it takes." Would
16 you agree with that?

17 A. No, because it's extremely problematic.
18 What you're describing is that individuals who are
19 homeless and in need of housing ---

20 121. Q. Yes.

21 A. --- although they are not residing in
22 this specific encampment, also need that housing as
23 well. So I'm not sure what kind of mechanism or
24 system ...

25 122. Q. You can only close one encampment if

1 you can meet the needs of the entire unhoused
2 population. Is that what you're telling me?

3 A. I would -- in your -- in any region,
4 there are people who are living in an encampment and
5 there are people who are living unsheltered. So
6 encampments are a form of unsheltered living, as you
7 well know.

8 123. Q. Yes.

9 A. So in -- maybe you can clarify. When
10 you say, "Closing an encampment," closed to support
11 and services, closed in terms of the actual space ---

12 124. Q. The actual site must be used for
13 something else. And I'm not asking you for your
14 opinion on whether this site must or must not be used
15 for something else.

16 But you're probably aware that the reason
17 for this case is that the region has advised that it
18 requires this property to construct a transit system.
19 So, again, not asking you for your opinion on whether
20 that's true or not, that's for others. But I would
21 like you to make the assumption that this encampment
22 must come to an end, and it's all about -- my
23 questions are all about how you go about doing it.

24 A. Mm-hmm.

25 125. Q. And so what I have from you so far is

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1 that you would want to have a team of people offering
2 supports and earning the trust of the residents, able
3 to help them understand their options and transition
4 them out. I also have from you that it will take --
5 could take months. And for some it could take longer
6 than that.

7 And then my next question which we're having
8 a bit of difficulty with is, wouldn't it also follow
9 that you would need to be able to prevent newcomers
10 from coming in and becoming established during that
11 period or you'll never be able to wind down the camp.
12 You'll always have the problem of people facing trauma
13 because they came in shortly before the closure.
14 Isn't that fair?

15 A. I think the situation that you've
16 described is accurate, that there may be newcomers
17 entering into the site. And I think that is, you
18 know, as a -- so I am here as an expert witness, as a
19 researcher.

20 126. Q. Yes.

21 A. and so on that point, then, it would be
22 that individuals in the community have access to
23 resources and supports to be able to access evidence-
24 based housing first options. So ---

25 127. Q. So -- so you ---

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1 A. I can't speak to the municipality's
2 decision as to what they need to do with the space.

3 128. Q. Okay. No, I'm not asking you to speak
4 to that. I'm just asking you to assume that the space
5 is needed for something else.

6 So this isn't just any old park or any old
7 property, this is one where the region needs it for
8 specific use at a specific time. And so I think I
9 understood from your answer, what you're saying is the
10 only way you can do that is if you, at the same time,
11 make sure that you have adequate housing for the rest
12 of the unhoused population in the region. Is that
13 what you've told me?

14 A. As an evidence-based response, assuming
15 that if we're talking about individuals who are coming
16 to that encampment -- because some may never come,
17 right?

18 129. Q. Yes, but what I put to you was that,
19 really, you would have to restrict new entrants if you
20 were going to be able to have an orderly wind-down of
21 the encampment. And I said wouldn't you agree with me
22 on that, and I think you disagree.

23 MS. MULLEN: Andrew, I think she's provided
24 her answer twice now.

25 MR. LOKAN: I don't think so, because I'm

1 still confused.

2 THE WITNESS: Is it okay if I just restate?

3
4 BY MR. LOKAN:

5 130. Q. Sure.

6 A. If new people come to the site in the
7 period of time for the closure, evidence would -- as a
8 scientist, as a researcher, the evidence would say
9 they need access to resources and supports to also
10 gain access to permanent housing.

11 131. Q. The evidence would say that every
12 single unhoused person in the region should have
13 access to those supports and to permanent housing.
14 Isn't that the case?

15 A. That's true. And I think ---

16 132. Q. So here's the ---

17 A. --- you're speaking only about
18 individuals who may come to the encampment.

19 133. Q. Right, but if you have an encampment
20 that, for example, the court may or may not accept but
21 the court may accept that the encampment needs to be
22 closed as of a certain date, wouldn't it also follow
23 that as of a certain point, maybe not today but maybe
24 a few months before, you would need to restrict new
25 entrants from becoming established at the encampments?

1 Because that process of finding options and earning
2 trust and transitioning out, there's just not going to
3 be time, is there?

4 A. I'm not -- unfortunately I'm not a
5 municipal policy maker. This is a practical -- I
6 definitely agree, this is a practical issue.

7 134. Q. Yes.

8 A. I'm speaking as a researcher and the
9 need for mechanisms for individuals to access support
10 and transition to adequate housing.

11 135. Q. Right. So you would say -- you will
12 not agree with me that the -- in a practical sense,
13 the region may have to restrict new entrants if it is
14 to be able to close the encampment by a certain date.

15 A. That's correct.

16 136. Q. Okay. Have you ever seen an encampment
17 closure that you thought was done adequately?

18 A. No.

19 137. Q. Okay. Could I ask you to look at
20 paragraph 27 of your affidavit?

21 A. Yes.

22 138. Q. Now I referred earlier to there
23 possibly being a misunderstanding that the region, in
24 fact, endorsing housing first and we had an exchange
25 about how sometimes there is not enough resources,

1 what that can mean. But what I see you say in the
2 middle of the paragraph is you say, "While this is
3 still a common belief among housing providers and
4 policymakers in North America," and that is sort of a
5 housing readiness approach that you're not ready for a
6 permanent until you've been through some other stages.
7 "While this is still a common belief," you say, "it's
8 inconsistent with human rights and evidence. And then
9 you say, "In Canada, there's a legislative right to
10 housing." Do you see that?

11 A. Yes.

12 139. Q. Okay. So you're not yourself a lawyer
13 or legally trained, are you?

14 A. I am not.

15 140. Q. Okay. And you wouldn't hold yourself
16 out as a human rights lawyer or a constitutional
17 lawyer?

18 A. No, I am not.

19 141. Q. Okay. So you wouldn't claim any
20 expertise in, for example, the division of powers
21 between the federal and provincial governments?

22 A. As a researcher who works on issues
23 related to housing and homelessness, I have an
24 understanding of the roles and responsibilities of the
25 federal and provincial governments as it relates to

1 housing and also healthcare, but that's not of
2 relevance so much here.

3 142. Q. Right, but you don't have any
4 understanding of the legal obligations.

5 A. The -- and I will clarify when I say,
6 "The legislated right," and you'll see what I've
7 referenced is the *National Housing Strategy Act* ---

8 143. Q. Yes.

9 A. And so I'm referencing an Act ---

10 144. Q. Yes.

11 A. --- which is part of the federal
12 government -- lays out the federal government role,
13 position, responsibilities.

14 145. Q. Right, binding on the federal
15 government.

16 A. That's binding on the federal
17 government. And there's been researchers who have
18 articulated the role of municipalities relative to
19 that.

20 146. Q. Right, and they would be basically
21 zero.

22 A. They ---

23 147. Q. Are these legal scholars you're talking
24 about?

25 A. These are housing scholars. So I take

1 ---

2 148. Q. Not legal scholars?

3 A. I take your point in terms of
4 legislative rights to municipalities, however you,
5 yourself, had said, and it's not uncommon for
6 municipalities across the country to say, "We endorse
7 the right to housing," and they embrace that within
8 their either philosophy or position statements and so
9 on. So they're not naïve to the importance of the
10 right to housing.

11 149. Q. Right, if it is a right at all.

12 A. It's laid out as a right in a number of
13 U.N. documents to which Canada is a signatory as well
14 as in the *Housing Strategy Act*.

15 150. Q. There's the international rights aspect
16 of that and an international human rights lawyer with
17 that expertise may be able to speak to that, but
18 that's not you, correct?

19 A. It is not.

20 151. Q. Okay. And you're aware that the
21 national *Housing Strategy Act* says that it's the
22 housing policy of the Government of Canada that
23 there's a national right to housing.

24 A. Yes.

25 152. Q. Thank you. And so that's the federal

1 government, it's not any other body.

2 A. Correct.

3 152. Q. Okay. Would you agree that if the
4 federal government declares it to be a national right
5 -- there to be national right to housing, the federal
6 government should be providing the resources to
7 implement that right?

8 A. This is very much an important
9 question, and I think you're probably aware of the
10 changes in funding to provincial governments. And you
11 have pointed to the crux of a huge issue, which is
12 the, you know, fact that it's a responsibility of
13 provincial and -- primarily provincial governments to
14 -- sorry, I should clarify the federal government in
15 those changes has down-loaded the responsibility onto
16 provinces and I think that's a matter of, yes,
17 resources. It doesn't give municipalities and
18 provinces necessarily the right to displace people or
19 to say, "We don't have housing available," because
20 they have, as we've already discussed, themselves,
21 embraced a right to housing.

22 153. Q. Whatever is meant and in whatever
23 circumstances that may have been said. What I'm
24 asking about is just more simple. If the federal
25 government declares it to be a right throughout Canada

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1 to have housing, as you pointed to in your affidavit,
2 don't you think the federal government should be
3 providing the resources to implement that right?

4 A. It's a combined responsibility between
5 three levels of government.

6 154. Q. So if there's a shortfall, then she
7 federal government should be increasing its resources
8 that it dedicates to housing?

9 A. I'm not -- I think what you're asking
10 me about is the role of the federal government, and
11 I'm ---

12 155. Q. I'm asking you whether the federal
13 government, in your view, should be increasing the
14 amount of money that it's devoting to housing, to
15 address the housing -- the homelessness crisis.

16 A. I would agree, but it doesn't give
17 provinces and municipalities no responsibilities, to
18 be clear.

19 156. Q. I just asked the question of should
20 they be increasing and you said yes, as I understood
21 you.

22 A. Yes, and it doesn't denigrate the
23 responsibilities of municipalities and provinces.

24 157. Q. Can we go to the paper at exhibit B?

25 MS. MULLEN: Andrew, I'm just wondering,

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1 we've been at this for an hour. I'm
2 wondering if, Dr. Pauly, would you like to
3 take a break? How much longer do you think
4 you'll be?

5 MR. LOKAN: I don't expect to be very much
6 longer, but ...

7 MS. MULLEN: Okay.

8 MS. PAULY: Yes. I'm okay, thanks.
9

10 BY MR. LOKAN:

11 158. Q. So at exhibit B, you have a paper that
12 you co-wrote, "Forced to Become a Community."

13 A. Yes, correct.

14 159. Q. And I'm just looking at -- we can
15 probably pull this up if you want to see it, but it's
16 a short passage. The second page of your article, you
17 say:

18 "Homelessness arises from a complex
19 interplay of multiple structural,
20 systemic, and individual factors."

21 That's on the bottom ---

22 A. Yes.

23 160. Q. You would agree with me that
24 homelessness is a complex problem?

25 A. Yes, it's a complex public health

1 problem.

2 161. Q. And that the solutions to homelessness
3 are also complex?

4 A. I think that's where it gets
5 interesting because, you know, we try to understand
6 the causes of homelessness which is -- which are
7 complex and varied, and I think the evidence around
8 solutions and the pathways out are less -- are much --
9 are not as complex because they are housing plus
10 supports.

11 162. Q. So as long as you have enough money to
12 get permanent housing and appropriate supports, the
13 problem could be solved. Is that the gist of what
14 you've told me?

15 A. I would agree with that, yes.

16 163. Q. Okay.

17 A. And the political will to do those
18 things, but that's apart from this.

19 164. Q. Okay. Later on, over the next page,
20 you said:

21 "Homelessness can be understood as a
22 consequence of multiple policy
23 decisions at every level of
24 government."

25 And I think you've accepted that it's a

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1 responsibility of every level of government to address
2 homelessness?

3 A. Yes.

4 165. Q. Okay. You say on the same page, page
5 126, middle of the right-hand column, "There has been
6 limited Canadian research on encampments."

7 A. At the time of writing this, that was
8 true.

9 166. Q. But this was from 2023, this article,
10 right?

11 A. It was 2023, but it was -- yes, that's
12 correct. It was 2023. But there's been work
13 published since then.

14 167. Q. There's some work ---

15 A. Yes.

16 168. Q. --- published since then.

17 A. Yes.

18 169. Q. It's still generally limited though,
19 isn't it?

20 A. I would say comparatively speaking to
21 the U.S., we are -- absolutely have less on the
22 impacts of those. The Centre for Urban Health in
23 Toronto would be an example of a centre that's done
24 research on encampments.

25 170. Q. Okay. If we go to page 127, you have a

1 description of what the methodology was here.

2 A. Mm-hmm.

3 171. Q. So you say:

4 "For this paper, we conducted a
5 secondary analysis of legal affidavits
6 using a thematic analysis approach as
7 outlined by (indiscernible) to
8 identify, analyze, and report patterns
9 with the data. The data set was
10 comprised of 47 affidavits taken from
11 33 people of Super In Tent City, SIC,"

12 And that's essentially 30 residents and one
13 part-time resident.

14 A. Correct.

15 172. Q. Okay. And that's the -- this is the
16 same case as the *Adamson* case we were referring to
17 earlier, is it?

18 A. Yes.

19 173. Q. Okay. So these are the affidavits
20 submitted for that case by residents of the encampment
21 plus a couple of other people, correct?

22 A. Yes, correct.

23 174. Q. And under limitations, you have on page
24 131 -- you mention as a limitation that:

25 "The data for this paper were drawn

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1 from affidavits whose original purpose
2 was to inform the courts about the
3 experience of residents living in the
4 encampments and the benefits afforded
5 over other potential but unavailable
6 spaces. Thus, the affidavits have the
7 limitation of not specifically
8 addressing or highlighting challenges
9 associated with living in encampments
10 as the focus of the affidavits was to
11 speak against an injunction to displace
12 the camp."

13 So you saw as a limitation, as a research
14 instrument, the fact that these were affidavits
15 designed to resist an injunction, correct?

16 A. Yes, and as a researcher, I am
17 transparent about the purpose for what the data was
18 collected. People did speak to the challenges of
19 living in the encampment, however had I asked them
20 directly, you know, what are the challenges, they may
21 well have told me many more things. So, yes, that is
22 an appropriate limitation as a ---

23 175. Q. As a researcher?

24 A. As a researcher and to ensure
25 transparency in your work.

1 176. Q. Right. And I take it that these
2 affidavits were prepared with the assistance of
3 lawyers?

4 A. As -- to my knowledge, yes.

5 177. Q. I mean, they'd need to be, right?
6 Because there are many in an encampment who find it
7 difficult to create written documents.

8 A. Yes. Yes, of course.

9 178. Q. Right. And so they may have included,
10 would you agree, an element of advocacy?

11 A. I think ---

12 179. Q. Arguing against a result? I'm not
13 saying there's anything wrong with that, but that they
14 may have included that.

15 A. I think, you know, I think your
16 question is really important and I want to be
17 thoughtful in my answer because sometimes I hear the
18 word "advocacy" used as if it's a bad thing. I think
19 in this scenario, individuals were living in a
20 situation where they had formed a community that was
21 providing an alternative when none others were
22 available. And so they were speaking to their
23 experiences in terms of the options, the systemic
24 situations and the options that were best for them.
25 And I guess you can call that advocacy, but they were

1 speaking to their experiences in that -- in that
2 sense, and the reality of what was available to them.

3 180. Q. And these particular affiants were
4 opposing the injunction?

5 A. Yes, correct, because it was not in
6 line with -- they did -- and, remember, they did not
7 have options available to them. You'll notice the,
8 you know, one of the findings of this was that the
9 encampment was a last resort.

10 181. Q. Yes. Yes. And on page 134, you
11 actually criticize the decision of -- you and your co-
12 author of the Chief Justice, Chief Justice Hinkson in
13 allowing the injunction on the second round. You
14 refer to *British Columbia v. Adamson*, "Adamson of
15 BCSC-1245."

16 A. I wonder if you can just scroll to
17 where that sentence is ...?

18 182. Q. Yes.

19 A. So I'm sure that I know what you're --
20 there we go. Thank you so much.

21 183. Q. Instead of reading public health
22 arguments.

23 A. Sorry, it just jumped again.

24 184. Q. Yes. We wanted to make it a bit bigger
25 for you.

1 A. Yes. There we go.

2 185. Q. So I just wanted to confirm that
3 *Adamson BCSC-1245*, that's a reference to the second
4 decision that granted the injunction on terms?

5 A. Yes.

6 186. Q. And it's fair to say that you were
7 critical of that as outlined in the article?

8 A. Yes, to -- for, exactly, based on the,
9 you know, the discussion that we've had here today
10 about the options being suitable and available for the
11 needs of the individuals.

12 187. Q. Okay. I'm going to ask that we take a
13 five-minute break now and go off the record.

14

15 --- OFF THE RECORD

16

17 MR. LOKAN: I have no further questions.

18 MS. MULLEN: May I just have another five
19 minutes, then, to prepare redirect, if any?

20 MR. LOKAN: Sure.

21

22 --- OFF THE RECORD

23

24 MS. MULLEN: Hi, again. Good afternoon. I
25 just have, I think, one very brief question

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1 for redirect, if we're back on the record,
2 Barbara?

3 MS. POLLARD: We're back on.
4

5 RE-EXAMINATION BY MS. MULLEN:

6 188. Q. All right. So, Dr. Pauly, you were
7 asked about the evidence under the Fraser Port
8 Authority case. How is the evidence in this matter
9 different from that previous affidavit? You're muted,
10 Dr. Pauly.

11 A. Sorry, just to clarify, you're speaking
12 about the evidence that I've submitted?

13 189. Q. That's right. For this matter.

14 A. I would say one of the differences is
15 there's been an evolution of -- maybe, "evolution"
16 isn't the right word, but there's been additional
17 research that's been published on -- particularly on
18 the harms of displacement and I would say a growing of
19 the evidence on housing first. So the affidavit that
20 I prepared for this case would have more recent
21 evidence.

22 MS. MULLEN: All right. Those are all of my
23 questions. Thank you.
24

25 --- ADJOURNED

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THIS IS TO CERTIFY that the foregoing
is a true and accurate transcription of
my recordings and notes, to the best of
my skill and ability.



Barbara A. Pollard
Certified Court Reporter

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1990.

**THE ATTORNEY GENERAL OF ONTARIO AND
THE REGIONAL MUNICIPALITY OF
WATERLOO**

Appellants

PERSONS UNKNOWN AND TO BE ASCERTAINED

Respondents

	COURT OF APPEAL FOR ONTARIO Proceedings commenced at Toronto
	EXHIBIT BOOK (VOL. 12 OF 15)
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