PUBLIC HEALTH TOOLKIT FOR ENCAMPMENT RESPONSES

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Table of Contents

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About this Document

This document provides approaches to supporting the health of encampment residents. It is based on a summary of experiences of Public Health Officials involved in encampments which occurred in BC between 2014 and 2019.

This document was developed in 2018-2019 and updated in 2023.

This document provides background the BC context (Part 1) and tools and resources to address public health concerns arising from encampments related to communicable disease, environmental health, and harm reduction practice in the setting of homeless encampments (Part 2).

Specifically, this document provides advice to public health staff, including but not limited to, Medical Health Officers (MHO), Environmental Health Officers (EHO), harm reduction coordinators, public health nurses and other practitioners when responding to situations and/or health hazards relating to homeless encampments. This document may also be helpful for other agencies that want to understand the roles and responsibilities of public health services.

The public health approach aims to improve conditions in communities through health promotion, protection, and prevention of disease and illness. A public health approach recognizes risk and protective factors and often emphasizes collective action on the part of diverse stakeholders including health, education, social services, justice, policy-makers and the private sector to mitigate harm while promoting positive health aspects. Additionally, a public health approach recognizes core drivers of homelessness include social, structural and systemic inequities, therefore a sustainable approach to preventing homelessness requires addressing underlying determinants.

The following principles should be considered in the application of this Toolkit:

- Safe and secure shelter and housing are preferable to people living in encampments;
- While encampments, or tent cities, can offer vulnerable people a sense of community and security, they are not a suitable or desirable form of long-term housing.
- Encampments and public homelessness are key points of contact for providers to offer people the housing, shelter and support options they need;
- Encampment management is best served through a collaborative and coordinated inter-ministry and inter-agency approach. This includes landowner and operations ministries and agencies, social service ministries and agencies and legal services;

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- A timely and coordinated response to an encampment ensures people can be connected to housing and support services and stay safe and healthy during their time in an encampment.
- People experiencing homelessness in encampments and public spaces have legal and human rights, and the right to be treated as any other citizen. Therefore a rights-based response to encampments should be adopted that is consistent with the principles identified in the report "A National Protocol for Homeless Encampments in Canada".[1]
- Not all people are at equal risk of experiencing homelessness i.e. those who are currently homeless are often those who have been systematically marginalized due mental illness, history of abuse, racism, impacts of colonialization, or other trauma, etc. Thus, they should additionally be treated with compassion and with a culturally safe and trauma-informed approach.

Acknowledgements

This document was produced through diligent work and generous sharing of experiences from the Homeless Encampment Toolkit Working Group in 2018-2019. We would like to thank the many stakeholders and external reviewers listed below who also provided important input into the document. Feedback and input does not reflect organizational endorsement of this toolkit. We would like to acknowledge the BC Environmental Health Policy Advisory Committee and the Public Health Executive Committee for their support of this endeavor.

Working Group Members (2018-2019)

Dr. Ingrid Tyler, Medical Health Officer, Fraser Health Authority

Dr. Amy Lubik, Policy Analyst, Fraser Health Authority

Jade Yehia, Built Environment Consultant, Vancouver Island Health Authority

Dr. Paul Hasselback, Medical Health Officer, Vancouver Island Health Authority

Richard Taki, Executive Director of Health Protection, Vancouver Coastal Health

Randy Ash, Regional Manager of Health Protection, Vancouver Coastal Health

Oonagh Tyson, Executive Director of Health Protection, Fraser Health Authority

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[1] UN Special Rapporteur on the Right to Adequate Housing: "A National Protocol for Homeless Encampments in Canada". (https://www.make-the-shift.org/wp-content/uploads/2020/04/A-National-Protocol-for-Homeless-Encampments-in-Canada.pdf)

_____

Dr. Michael Schwandt, Public Health Physician, BC Centre for Disease Control

Tim Lambert, Executive Director, Ministry of Health, British Columbia

Dr. Silvina Mema, Medical Health Officer, Interior Health Authority

Courtney Hesketh, Executive Director of Environmental Public Health, Interior Health Authority

Dr. Rakel Kling, Medical Health Officer, Northern Health Authority

Aaron Miller, Director, Strategic Initiatives, Interior Health Authority

Jessica Bridgeman, Regional Harm Reduction Coordinator, Interior Health Authority

Reanne Sanford, Regional Nursing Lead, Harm Reduction, Northern Health Authority

Dr. Raina Fumerton, Medical Health Officer, Northern Health Authority

Elena Kanigan, Senior Policy Analyst, First Nations Health Authority

Peter Mazey, First Nations Health Authority

_____

Significant Contributors/ External Stakeholders

Bernie Pauli, Professor University of Victoria School of Nursing

Dominic Flanagan, Executive Director of Strategic Initiatives, BC Housing

Sarah Petrescu, Ministry of Municipal Affairs and Housing, British Columbia

Avery Kelly, Ministry of Municipal Affairs and Housing, British Columbia

Reviewers

Provincial

Dr. Bonnie Henry, Provincial Health Officer, British Columbia

Dr. Brian Emerson, Ministry of Health, British Columbia

Robert Cooper, Fire Services Advisor, Office of the Fire Commissioner, British Columbia

Pamela Miller, Ministry of Child and Family Development, British Columbia

Juanita Berkhout, Ministry of Indigenous Affairs and Reconciliation, British Columbia

Kendall Hammond, Ministry of Health, Indigenous Health, British Columbia

Lara Miramontes, Ministry of Health, Indigenous Health, British Columbia

Carolyn Davison, Ministry of Mental Health and Addictions, British Columbia

Lance Talbott, Ministry of Public Safety and Solicitor General, British Columbia

Health Authority

Dr. Helena Swinkels, First Nations Health Authority

Adam Finch, First Nations Health Authority

Chris Buchner, Communicable Disease Director, Fraser Health Authority

Dr. Shovita Padhi, Medical Health Officer, Fraser Health Authority

Dr. Emily Newhouse, Medical Health Officer, Fraser Health Authority

Dr. Reka Gustafson, Medical Health Officer, Vancouver Coastal Health

Chris Van Veen, Director, Strategic Initiatives and Public Health Planning, Vancouver Coastal Health

Tracy Steere, Aboriginal Health Unit, Fraser Health

_____

Michele Lane, Executive Direction, Community Health Services, Fraser Health Authority,

Meryl McDowell, Mental Health and Substance Use, Fraser Health Authority

Dr. David McVea, Medical Resident, Fraser Health Authority

Sue Noga, Housing Consultant, Fraser Health Authority

Sophie Bannar-Martin, Regional Manager - STOP HIV, Bloodborne Diseases & Harm Reduction, Vancouver Island Health Authority

<u>Municipal</u>

Marylyn Chiang, Policy Analyst, Union of BC Municipalities

Mark Griffioen, Deputy Chief, Community Risk Reduction, City of Surrey

Karen Fry - Fire Chief, City of Nanaimo

Celine Mauboules, Director of Homelessness Services, City of Vancouver

Paul Mochrie, Deputy City Manager, City of Vancouver

Tobin Postma, Director of Intergovernmental Affairs, City of Vancouver

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Part 1: An Overview of Public Health and Community Response

I.   Homelessness and Encampments in BC

The term "homeless" refers to people experiencing housing circumstances encompassing a range of physical living situations that may include being without any shelter to insecure housing. For many people homelessness is not a static state but rather a fluid experience, where one's shelter circumstances and options may shift and change quite dramatically and with frequency[2].

> BC Homeless count defined homeless individuals as not having a place of their own where they pay rent and can expect to stay for at least 30 days. This included people who: stayed overnight on the night of the count in homeless shelters, including transition houses for women fleeing violence and youth safe houses, and people with no fixed address staying temporarily in hospitals, jails or detox facilities (defined as "sheltered"); it also includes those who stayed outside in alleys, doorways, parkades, parks and vehicles or people who were staying temporarily at someone else's place (couch surfing) and/or those using homelessness services (defined as "unsheltered").

The 2018 BC Homeless Count found 30% were female, 20% were seniors (over 55) and 15% were youth (under 25). Approximately one in five (20%) people experiencing homelessness reported being formally employed (6% full-time, 13% part-time), while 29% reported being self or informally employed.   Approximately 52% of respondents reported experiencing homelessness for over a year. People experiencing homelessness do not tend to migrate to new areas to live in encampments; in the 2018 BC Homeless Count, half the respondents had lived in the community for over 10 years. Only one in five had moved into the community within the past year.[2]

Indigenous (including First Nations, Inuit, and Métis) Peoples, are disproportionally represented in the homeless population. In British Columbia in 2016[3], 5.9% of the population self-identified as Indigenous, while in the 2018 BC Homeless Count 38% of respondents self-identified as Indigenous. It is important to note that these numbers may actually be higher due to individuals not wanting to be counted in general or to self-identify for reasons related to stigma.

Indigenous homelessness is a human condition that describes First Nations, Métis, and Inuit individuals, families or communities lacking stable, permanent, appropriate housing, or the immediate prospect, means or ability to acquire such housing. Indigenous

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[2] The Homelessness Services Association of BC, Urban Matters, and BC Non-Profit Housing Association (2018). 2018 Report on Homeless Counts in B.C. Prepared for BC Housing. Burnaby, BC: Metro Vancouver.

[3] Government of BC (2017). Issue 17-138: 2016 Census: Highlights from the Indigenous People in Canada Release.

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homelessness is impacted by systemic factors which may not impact the non-Indigenous population. Unlike the common colonialist definition of homelessness, Indigenous homelessness is not defined as lacking a structure of habitation; rather, it is more fully described and understood through a composite lens of Indigenous worldviews. These include individuals, families and communities isolated from their relationships to land, water, place, family, kin, each other, animals, cultures, languages and identities. Importantly, Indigenous people experiencing these kinds of homelessness may experience barriers to culturally, spiritually, emotionally or physically reconnecting with their Indigeneity or lost relationships.[4] (For information on cultural humility and cultural safety, and trauma-informed care, please refer to *Resource 1*). [5]

Homelessness is a public health issue that is a consequence of social conditions intersecting with individual situations. Homelessness is a situation in which people experience severe deficits in the basic determinants of health resulting from a combination of structural factors (e.g. poverty, lack of available and affordable housing, impacts of colonization), systemic failures (e.g. erosion of the social safety net, gaps for those transitioning from corrections, mental health and addictions treatment, out of foster care) combined with individual circumstances (e.g. injury or job loss, mental illness or addictions, domestic violence or abuse).[6] People who are experiencing homelessness often are made increasingly vulnerable to health issues, and often experience one or more chronic health issues.[7] There is strong scientific data supporting numerous associations between homelessness and poor health and social conditions such as mental illness, substance use disorder, poor nutrition, skin conditions, diabetes, as well as higher exposure to violence, exposure to weather and heat related events such as hypothermia[8,9,10,11,12]. Furthermore, people who are experiencing homelessness often face barriers to accessing the medical system leading to further health challenge[13]. Additionally, people who are homeless often

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[4] Thistle, J (2017). Definitions of Indigenous Homelessness in Canada. Canadian Observatory on Homelessness. https://homelesshub.ca/sites/default/files/attachments/COHIndigenousHomelessnessDefinition.pdf

[5] Gaetz, S.; Barr, C.; Friesen, A.; Harris, B.; Hill, C.; Kovacs-Burns, K.; Pauly, B.; Pearce, B.; Turner, A.; Marsolais, A. (2012). Canadian Definition of Homelessness.

[6] Gaetz, S., et al., The State of Homelessness in Canada 2016. (2016) Canadian Observatory on Homelessness Press: Toronto.

[7] Frankish, C.J., S.W. Hwang, and D. Quantz, Homelessness and health in Canada: research lessons and priorities. Can J Public Health, 2005. 96 Suppl 2: p. S23-9.

[8] Canadian Population Health Initiative of the Canadian Institute for Health Information, Mental Health, Mental Illness, and Homelessness in Canada (2009). 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 2.3. Toronto: Cities Centre, University of Toronto. www.homelesshub.ca/FindingHome

[9] Hwang, S. W., & Bugeja, A. L. (2000). Barriers to appropriate diabetes management among homeless people in Toronto. *CMAj*, *163*(2), 161-165.

[10] Cusack, L., van Loon, A., Kralik, D., Arbon, P., & Gilbert, S. (2013). Extreme weather-related health needs of people who are homeless. *Australian Journal of Primary Health*, *19*(3), 250-255.

[11] Lubik, AA, McKee, G, Chen, T, Kosatsky, T (2017). Municipal Heat Response Planning in British Columbia, Canada. BC Centre for Disease Control. Vancouver, Canada.

[12] Stares, J, Kosatsky, T (2015). Hypothermia as a cause of death in British Columbia, 1998-2010: a descriptive assessment. CMAJ. http://cmajopen.ca/content/3/4/E352.full

[13] Public Health Ontario (2019). Evidence Brief: Homelessness and Health Outcomes: What are the Associations? https://www.publichealthontario.ca/-/media/documents/eb-homelessness-health.pdf?la=en

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repeatedly experience social exclusion, stigma and discrimination in their daily lives, itself a determinant of health that limits access to needed services and supports.[14],[15] From the 2018 BC Homeless Count, 56% reported having a substance use concern, 40% mental illness, 44% a medical condition and 33% with physical disability; 29% were receiving disability benefits and 40% received income assistance[1].

There are two types of encampment:

1. Managed encampments where community partners (BC Housing, municipality outreach organizations) make a significant funding commitment to develop a particular number of units. Typically services provided include: potable water, meals, staffing on site, tarps/tents, security, garbage collection, porta potties and fencing.
2. Regular encampments that consist of a group of non-permanent outdoor shelters that are often unsanctioned by local governments or property owners, that stay in a fixed location and are not dismantled. They are typically supported through an in-reach model where a wide range of partners provide services but the services aren't attached to the site.

Encampments tend to be comprised of people who would otherwise be unsheltered (i.e. experiencing homelessness).

Encampments can offer vulnerable people a sense of community and security and act as key points of contact for providers to offer people the housing, shelter and support options they need. On the other hand, encampments frequently elicit concerns regarding personal and community safety, sanitation, and health hazards.

> Under the BC Public Health Act[16], a health hazard is defined as:
>
> (a) a condition, a thing or an activity that
> > (i) endangers, or is likely to endanger, public health, or
> > (ii) interferes, or is likely to interfere, with the suppression of infectious agents or hazardous agents, or
> (b) a prescribed condition, thing or activity, including a prescribed condition, thing or activity that
> > (i) is associated with injury or illness, or
> > (ii) fails to meet a prescribed standard in relation to health, injury or illness.

[14] Pauly, B., Homelessness, Stigma, and Health, in The Wiley Blackwell Encyclopedia of Health, Illness, Behavior, and Society. 2014, John Wiley & Sons, Ltd.

[15] Link, B. and M. Hatzenbuehler, Stigma as an unrecognized determinant of population health: Research and policy implications Journal of Health Politics, Policy & Law, 2016. 41(4): p. 653-673.

[16] Government of BC. BC Public Health Act (September 25, 2019). http://www.bclaws.ca/civix/document/id/complete/statreg/08028_01#section1

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Public health may be called on to assess health hazards within an encampment.[17] Specific responses will depend on a number of contextual factors including the size of the encampment, the type of encampment, the current and expected duration of the encampment, and the relationship with the landowner and health authority resources.

In assessing health hazards associated with any particular encampment, the goal is to advise on appropriate mitigating measures that protect and promote the health of members of the encampment.

This document provides approaches to support the health of encampment residents and to provide risk mitigation, as well as providing tools to support a public health response. Public health protection measures described in the document include: ensuring access to safe drinking water, sanitation, and food safety; waste management; measures to protect against exposure to extreme hot and cold weather; infection prevention and control and outbreak management; harm reduction and overdose prevention services; as well as decampment support that prioritizes housing individuals and/ or connection to supports.

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[17] Pauly, B, Gagnon, M (2018). Tent Cities: Open Letter Calls for Public Health Approach to Reducing Health and Safety Risks. https://mailchi.mp/600e0d6bfc79/publichealth_tentcities

II.   Partnerships for Health and Safety at Encampments

When an encampment arises, a number of concerned parties may be involved in ensuring health and safety of the public. Public health has a role to work collaboratively with partners, including other health services, fire, local police, local government/landowners, BC Housing, community partners, Indigenous support organizations, and people living in the encampments to coordinate activities and communication. Provincial and Federal Corrections are also suggested partners due to the correlation between incarceration and experiencing homelessness; however, that is beyond the scope of this document.

In addition to a committee of external partners, public health may be part of an internal health authority team, including executive decision makers, primary care services, mental health services, substance use services, a Medical Health Officer, harm reduction and health protection. Teams might also benefit from the expertise of health authority risk management, occupational health, communications, and finance staff.

Figure 1: Partnerships for homeless encampment response.

RESOURCE 1 is intended to assist public health practitioners in understanding possible roles and responsibilities of various partners and partnerships that could be established for coordinating actions, based on BC experiences. The descriptions have been reviewed by

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collaborators listed at the beginning of the document and are not meant to be prescriptive, as the context and partners of each encampment will be unique.

III.   Considerations for Public Health Response

Not all encampments will require a public health response. Public health has an important leadership role to work with partners to make recommendations, to provide support and infrastructure to improve health, hygiene and safety conditions within encampments. Additional roles may include consultation regarding location, site plan and operations in relation to environmental health concerns (e.g. hygiene, sanitation, food safety, drinking water and infection control), conducting site visits to provide environmental health recommendations and minimize related risks, and when available, offering best practice priorities for safe decampment into alternate housing as well as advocating for longer term solutions.[18] Specific responses will depend on a number of contextual factors including the type of encampment, the current and expected duration of the encampment, and the relationship with the landowner and health authority resources. For most encampments, a public health assessment of the need for involvement at the encampment and extent of response may be undertaken early after establishment of an encampment.

The decision on whether and how frequently to visit the site must be based on in the context of the encampment. Considerations for making these decisions may include size of camp, number of occupants, known illness or disease transmission, severe weather events, change in weather or season, reports of ongoing issues and/or deteriorating conditions in the camp.

Potential Roles and Responsibilities of Key Public Health Practitioners

The essential functions of public health include describing and monitoring health status, health protection, health promotion and disease prevention[19] and emergency management. Public health practitioners can provide guidance related to health hazards, infection prevention and control, and harm reduction. In general:

- Public health practitioners may provide local governments, residents of the encampment or other partners listed above, advice on mitigating health risks related to water, food, sanitation, waste, exposure, disease transmission and/or harm reduction as informed by the specific context of each site.

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[18] Yehia, J. Environmental public health guidance for encampments during the COVID-19 pandemic. National Collaborating Centre for Environmental Health. Accessed online Oct. 9 2020 at: https://ncceh.ca/documents/guide/environmental-public-health-guidance-encampments-during-covid-19-pandemic

[19] Centers for Disease Control and Prevention (2018). The Public Health System & the 10 Essential Public Health. Services. USA. https://www.cdc.gov/publichealthgateway/publichealthservices/essentialhealthservices.html

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- Public health practitioners may advise on mitigating health risks until the need for use of the *Public Health Act* and pursuant regulations are deemed necessary.

- Public health practitioners may act as health advocates within the context of their role to promote harm reduction, mental health and health protection supports, and culturally safe, trauma-informed care, as well as advocating for longer term solutions (such as specialized, supportive and good quality housing).

- Public health practitioners may act to link encampment occupants to health- care services as part of a health authority response.

All practitioners should incorporate cultural sensitivity and trauma-informed care into practice to minimize stigma of people experiencing homelessness and promote their safety (see RESOURCE 2). Cultural safety is defined as "an outcome based on respectful engagement that recognizes and strives to address power imbalances inherent in the health system;" whereas, cultural humility involves examining your own values, beliefs, experiences, and biases through self-reflection and lifelong inquiry, and being curious and open to learning about clients' values, beliefs, and experiences in order to develop mutual understanding, successful partnerships, and cultural safety.[20,21]

Need for the following interventions should be assessed on a case by case basis and provided as resource capacity allows. Part 2 of this Toolkit can assist public health practitioners in developing any recommendations related to encampments.

Minister of Health

- To promote and protect health and well-being
- To identify and address the health needs of particular groups within the population, including Indigenous peoples
- To prevent and mitigate the adverse effects of diseases and disabilities, syndromes, psychosocial disorders, injuries and health hazards
- The minister may by order require a public body to make, in respect of a specific issue or geographic area, a public health plan. The public body could be a local government where the encampment is located (*Public Health Act*, Division 1.3)

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[20] Population Health Promotion, BC Children's Hospital. Culturally Connect Resources Webpage. https://www.culturallyconnected.ca/
[21] BC Patient Safety & Quality Council (2019). Cultural Safety & Humility Resources. https://bcpsqc.ca/improve-culture/cultural-safety-and-humility/

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Medical Health Officer

- May provide specialist medical services in public health preventive medicine to support the community's health and the health of residents of the encampment
- May act as primary or supporting health system contact for partners, including municipalities, local government services, housing, community agencies, and other government agencies
- May recommend the of health identification of health needs and the ongoing monitoring of health status
- Has the discretion to issue orders under the *Public Health Act*
- May advocate for action to address underlying drivers contributing to homelessness, as well as to decrease stigma and discrimination

Environmental Health Officer

- May assess the encampment for public health hazards in order to provide support on mitigation
- May assist the occupants, property owner and other agencies in identifying what is necessary to mitigate any identified public health hazards.
- May work with other agencies to minimize environmental risks
- Has the discretion to issue an order under the *Public Health Act*

Public Health Nursing

- May provide onsite immunization
- May support communicable disease control including testing for tuberculosis, HIV, Hep B, Hep C
- May support sexual health services including contraception and barrier protection, and supporting encampment residents to be tested for STIs and treatment of STI cases and contacts
- May support people who are pregnant in the encampment and prioritize for more appropriate housing.
- May support children and youth residing or frequenting the encampment in conjunction with Ministry of Children and Family Development.
- May support personal hygiene
- May provide nursing assessments for encampment members and dispense medications as needed
- May provide harm reduction supplies e.g. needle distribution and recovery
- May provide OAT
- May connect people to primary care and social supports
- May provide linkages to Aboriginal/Indigenous Health services

Harm Reduction Personnel

- May support overdose prevention services within the encampment through formal or informal response structures such as observed consumption, education or provision of supplies
- May coordinate with community partners to provide harm reduction services at camp
- May ensure that naloxone is available in proximity and sufficient number of on-site responders are trained to recognize and respond to overdoses
- May support needle distribution and recovery and outreach to help people access substance use services
- May also provide outreach to help with access to opioid agonist therapy (OAT) and substance use services such as pharmacy, as encampment residents may not want to leave the site and risk losing their belongings.
- May provide support with overdose prevention services, Take-Home Naloxone, and drug checking, and strategies for acute overdose risk case management at encampments

Part 2: Tools and Resources to Support a Public Health Response

A. General Site Visit Principles

i. Prior to initial site visit, public health practitioners could attempt to identify the jurisdiction of the land on which the camp is situated, and/or the landowner, including the traditional stewards of the land. This is important in order to get to know their perception and understanding of the encampment, what information they have about the residents, and how much they may be willing or able to support services for encampment residents. If it resides on First Nations land, it will be important to understand protocols and work with partners who have established trusting relationships.

ii. Prior to initial site visit, public health practitioners could attempt to contact other agencies that may be attending the encampment (e.g. police, fire, BC Housing etc.) in order to understand the history of the encampment, the conditions in and size of the encampment, any safety concerns they may have, and their plans for any ongoing attendance at the encampment.   The elements of a checklist for use when conducting a site visit can be found in TOOL 1.

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iii. To maximize feelings of safety for all parties involved, site visits should be conducted either with a supervisor or another staff who has cultural safety and trauma-informed care training in attendance. Site visits may also be carried out in conjunction with fire, police, or other partner organizations.

iv. When visiting encampments, attempt to identify a "person(s) in charge" and to explain the purpose of the site visit. It may be helpful to connect with other organizations that have been present longer at the encampment for introductions, if possible. It is advisable to work with a peer / person with lived experience to assist in brokering access and communicating intent, which may increase support for health activities / interventions.

v. When interacting with encampments, public health practitioners may reassure residents that they are there to make sure the residents are safe
   - Public health officials should understand that there may be a real or perceived power imbalance between themselves and encampment residents. Interactions should be approached with a cultural safety and humility perspective. More resources can be found in *RESOURCE 2.*
   - Public health officials should be able to answer questions about why they are conducting a site visit; however, if possible, having a checklist/ clipboard should be avoided to lower tensions; if possible, findings could be recorded for documentation when off site, including the needs of residents.
   - Public health officials should be aware that encampment residents may ask for resources, such as access to water or soap; public health should be mindful that what they and other partners can provide to residents will depend on the jurisdictional situation.

vi. In terms of monitoring, the length and frequency of visitations depend on the camp structure and residents. For sites that need more public health help, experience in BC suggests that once or multiple times a week may be optimal, while others may not need to be attended as frequently. In some cases, health professionals may be more inclined to set up a weekly check in with other partners regarding managing potential issues.

vii. While working with encampments, public health officials may be approached by media, community groups, and other parties regarding perceived or real issues to do with encampments. Guidance on messaging that does not perpetuate potential fear and stigma, and that can help frame homelessness as a public health crisis, and housing crisis in many jurisdictions, can be found in RESOURCE 3.

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viii.   For more information regarding encampments, an annotated bibliography is provided in RESOURCE 4.

B. On Site Visit and Response

The decision to conduct an on-site visit may depend of the size of encampment, and/or the nature of the complaints or requests for support and/or other variables. Best practice would be for an MHO, EHO, and EHO supervisor to make a joint decision on actions are warranted under the specific circumstances.

The role of Environmental Health Officers is to conduct a site visit and offer guidance and consultation for health concerns. Recommendations on appropriate mitigation measures are provided to minimize related risks and to inform best practice priorities to protect and promote the health of encampment residents. Information gathered on-site is used for guidance to coordinate with other health services and may also be used to advocate for longer-term solutions in line with public health objectives.

TOOL1: ON-SITE VISIT CHECKLIST
Initial and subsequent on-site visits would document information in the following areas:

Category	Specific Considerations
Identification	Site identification, site contact information, participants in site visit
General Information	Geographic location, population size and demographics, type and number of shelters
Drinking water	Source of potable water (standpipe, fountain, nearby facility, storage) Availability of non-potable water
Personal Sanitation	Availability and type of washrooms, handwashing stations and showers Maintenance of facilities Accessibility for those with disabilities
Food Safety	Availability of food services Facilities to perform food preparation on site Distribution of food donations on site Dishwashing facilities
General Sanitation	Availability of garbage, recycling and compost bins Site maintenance Pest control
Infection control	Availability of first aid supplies, sharps containers, monitoring for illness transmission in residents

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Access to Services	Availability of health care services, MHSU services, social services, harm reduction services and supplies
Extreme Temperature	Availability of facilities to respond to extreme heat or extreme cold
Safety	Presence of hazards on site, pets, fire extinguishers
	Access to site by emergency responders

The exact form for the checklist will be determined by the information system being used by the regional program.

i. Safe Drinking Water

Based on the working group experience, water supply can be highly variable across encampments. [22] Some encampments have collected water from municipal sources such as churches, gas stations, others have used the collection of grey water, and others have had a combination of both. There have been cases of collection into large communal containers without proper treatment or sanitation protocols, and where water source and supply have been even more tenuous.

In addition to mitigating communicable disease and dehydration risks, provision of potable water helps prevent the stigmatization of unsheltered people and build trust with encampment residents. [14] In Tacoma, WA, city officials drilled a water line into an encampment to bring hand washing stations and toilets into the area. Provision of facilities helped gain trust of the residents, which assisted with moving many residents into more stable housing.[23]

Suggested Questions:
- Is there access to potable water on the site?
- How is the water stored? How is it dispensed?
- Any sharing of open water source?
- If plumbed, how many outlets
- If carried, where is the source and can storage vessels be filled without risk of contamination?

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[22] Ministry of Health (2017). Small Water System Guidebook. Government of BC. https://www2.gov.bc.ca/assets/gov/environment/air-land-water/water/waterquality/monitoring-water-quality/small_water_system_guidebook_-january_2017.pdf

[23] Hansman, H (2017). Running water can ease the effects of homelessness. CityLab.com https://www.citylab.com/life/2017/12/running-water-can-ease-the-effects-of-homelessness/547505/

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Mitigation Options

Public Health may recommend:
- That landowner (local government, First Nation, provincial, or private) provide residents access to safe drinking water

If residents do not have access to potable water from an appropriate source, the following tool *TOOL* 2 provides further mitigation strategies for public health staff consideration.

TOOL 2: WATER DISINFECTION TECHNIQUES [24]

Boiling water is the most effective way to disinfect water, particularly if the water may be contaminated with parasites such as Giardia or Cryptosporidium, or if those consuming the water are immune compromised.

The method is as follows:

- Boil water for at least 1 minute. At elevations over 2,000 meters (6,500 feet) boil water for at least 2 minutes
- Store disinfected water in clean, covered, food grade containers

Household bleach can also be used to disinfect water:
-
  Do not use scented bleaches, colour-safe, bleaches with added cleaners or non-chlorine bleach
  Bleach works best when added to warm waterthat is about 20℃ (68℉). Mix 2 drops (0.1 mL) of household bleach (about 5.25% chlorine) with 1 litre (4 cups) of water
- Cover and let stand for 30 minutes before drinking. There should be a slight chlorine smell after the 30 minutes. If not, add another 2 drops. Let the water stand for another 15 minutes
- If the water is cloudy, or colder than 10℃ (50℉), double the amount of bleach added. Cover it and let it stand for 1 to 2 hours before drinking. The longer the treated water stands the better it works to disinfect the water
- To reduce chlorine taste, let the water stand uncovered for a few hours, or pour it back and forth from one clean container to another several times

Note that the above processes will not eliminate risk from chemical contamination of water, if acquired from a non-potable source.

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[24] HealthLinkBC : https://www.healthlinkbc.ca/sites/default/files/documents/healthfiles/hfile49b.pdf

ii.   Food Safety

Based on the task group's experience, if residents are preparing food onsite, it may be helpful to disseminate usual food storage/safety advice to encampment leader or other groups that are providing food to ensure food handling is as safe as possible.

Public/Good Samaritans may provide food to encampments; this food provision may not be regulated by public health depending on the source and/or jurisdictional issues.

Suggested Questions
- Donated food provided? Nature of food donations
- Is any food preparation/cooking taking place?
- Camp stoves used? Camp fires present?
- Any food storage noted onsite?
- How food products are stored (refrigeration/cooler during hot weather)?
- Storage of food so as to not support pest problems?
- Are there water facilities to clean cooking equipment and wash food?

Mitigation Options

Public Health may recommend:
- Occupants be educated or provided resources on food hygiene
- That no person who is sick with vomiting or diarrhea should be permitted into the kitchen/ food area
- Cleaning kitchen area with sanitizer
- That wastewater for dishes should be disposed of in a grey water tank
- Garbage containers are adequate in number,

If significant food handling is noted in the encampment, for the following tools may support occupants in mitigation of potential food handing hazards: *TOOL 3: Guidelines for Cleaning and Disinfecting TOOL 4: Temporary Hand Washing Station Instructions* for more information.

iii.   Sanitation

Based on the task group's experience, the number of toilets and hand-washing stations that are advised to be made available, their location, access and maintenance, as well as where grey water is disposed of, may be considered to maintain sanitation and help prevent disease outbreaks.

Suggested Questions
- Access to toilet facilities on the site? Are toilets available off site?

- Are toilets connected to a sewage system or portable?
- If portable how is it disposed of, what is the frequency, and who is responsible for disposal? *This many depend on the accessibility of resources in the community and location of camp. It may be done by the providers or by a peer program administered by a community non-profit.*
- Is there access to hand washing or bathing facilities?
- Hygiene stations, hand wipes, available adjacent to portable toilets?

Mitigation Options

Public Health may recommend:

- Provision of toilets and hygiene stations. Consideration may include:
  - Number and type of facilities. Encampments will have different needs however, evidence on ratios and accessibility provisions, can be found in the BC Public Health Guidelines: Major Planned Events and the Doctors without Borders Emergency Response Report[25,26]
  - Positioning toilets to allow access to service vehicles and emergency medical services or other aid (as harm reduction measures).[27]
  - Distance recommendations between toilets and food storage/ preparations as reported in the BC Sewerage Systems Regulation[28]
  - That portable toilets and grey water tanks are advised to be serviced regularly (minimum weekly) to prevent overflow

- Hand washing signage may be displayed for encampment residents[29]
- That commonly touched surfaces washrooms, showers, mats and counters are cleaned frequently with an approved sanitizer
- Provision of cleaning solutions, if appropriate. See *TOOL 3: Guidelines for Cleaning and Disinfecting*

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[25] BC Public Health Guidelines: Major Planned Events (2017). https://www2.gov.bc.ca/assets/gov/health/keeping-bc-healthy-safe/major-planned-events/bc-major-planned-events-guidelines_2017_final.pdf

[26] Doctors without Borders (MSF). Refugee Camp Guidelines for Health Professionals. http://refbooks.msf.org/msf_docs/en/refugee_health/rh.pdf

[27] Grauer,P (2018). Harm reduction in housing facilities and public places can save lives, experts say. The Star Newspaper. https://www.thestar.com/vancouver/2018/11/18/harm-reduction-in-housing-facilities-and-public-places-can-save-lives-experts-say.html

[28] BC Government. Sewerage System Standard Practice Manual (2019). https://www2.gov.bc.ca/gov/content/environment/waste-management/sewage/onsite-sewage-systems/sewerage-system-standard-practice-manual

[29] Centre for Disease Control and Prevention (2019). Show me the Science – When & How to Use Hand Sanitizer in Community Settings. USA. https://www.cdc.gov/handwashing/show-me-the-science-hand-sanitizer.html

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- Where there is no access to traditional hand washing for residents, a temporary hand washing station could be employed. See *TOOL 4: Temporary Hand Washing Station Instructions* for more information.

TOOL 3: GUIDELINES FOR CLEANING AND DISINFECTING

Areas within the encampment that are common areas should be considered for routine cleaning and disinfection to prevent the spread of germs. Proper steps for cleaning and disinfecting are important to take into consideration during the flu season and for the prevention of food borne illness or other communicable diseases.[30]

Clean and disinfect correctly
Cleaning involves using a soap or detergent to physically remove dirt from surfaces and does not necessarily kill germs.

Disinfection requires the use of a chemical to kill germs and works best on a clean surface. Disinfectants products usually require a period of time (between 3- 10 minutes) to work. Some disinfectant products also contain a detergent so that they clean and disinfect.

Sanitizing reduces germs. An example of sanitizing would be using a bleach solution, or a disinfectant wipe a table.

Using bleach
Bleach solution on its own does not do a good job of cleaning. For bleach to be effective it is helpful for the surface to be previously cleaned with soap and water. Mixing bleach correctly is important. Read the label on the bleach bottle to determine the type of bleach and follow the instructions below.

Area to be cleaned	Bleach amount (5.25%)	Water amount	Cleaning steps
Food surfaces	15 ml	3.8 L	1. Wash with soap and hot, clean water. 2. Rinse with clean water. 3. Sanitize in a solution of 1 tablespoon of household chlorine bleach in 1 gallon of clean water. 4. Allow to air dry
Non-food contact surfaces that do not soak up water	48 ml	3.8 L	1. Clean surface with soap and warm, clean water. 2. Rinse with clean water.

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[30] Seattle & King County Public Health (2018). Sanctioned Homeless Encampments: Initial Planning and Management Checklists. Environmental Health Services; Health Care for the Homeless. https://www.rtfhsd.org/wp-content/uploads/sanctioned-homeless-encampments-checklists.pdf

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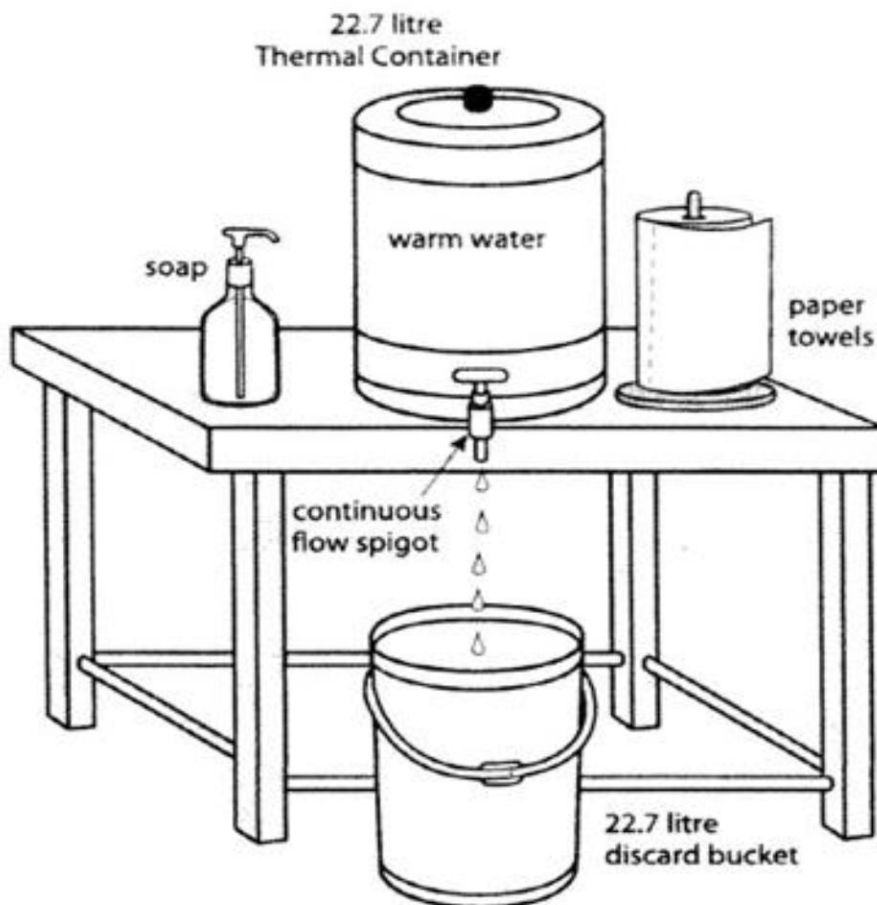|			
			3. Sanitize using a mixture of 1 cup (240 mL) of bleach to 5 gallons of water. 4. Allow to air dry.
Heavy Soiling (Feces and other fluids)	240 ml	3.8 L	1. Clean surface with soap and warm, clean water. 2. Rinse with clean water. 3. Disinfect, allow to soak for 10 minutes 4. Allow to air dry.

Source: https://www.cdc.gov/disasters/bleach.html

TOOL 4: TEMPORARY HAND WASHING STATION INSTRUCTIONS

A temporary hand washing station can be set up anywhere it is needed.[31] It is recommended to place one in the kitchen tent for use by anyone handling food or for individuals to wash hands before eating. Additionally, a temporary hand washing station can supplement rented equipment and provide back up for failure of rented hand washing equipment.

Supplies needed:
- 5 gallon (22.7L) or larger gravity flow, insulated container
- Warm water
- Bucket for catching wastewater (dispose as grey water)
- Soap
- Paper towels
- Hand Sanitizer

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[31] Image Credit: Interior Health, https://www.interiorhealth.ca/sites/default/files/PDFS/temporary-food-service-guidelines.pdf

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22.7 litre
Thermal Container

warm water

soap

paper
towels

continuous
flow spigot

22.7 litre
discard bucket

iv. Waste Management

Lack of proper waste containers and clearance strategy, including organic waste and standing or grey water, may result in accumulation of waste, attracting rodents or other pests, which may increase the chances of vector-borne disease.[32],[33]

Suggested Questions
- How is solid waste (garbage) collected on site?
- How is it disposed of, how frequently and by whom?
- Are sharps containers provided? How many and where are they located?

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[32] McVea, DC, et al. (2018). Exposure to Rats and Rat-Associated Leptospira and Bartonella Species Among People Who Use Drugs in an Impoverished, Inner-City Neighborhood of Vancouver, Canada. Vector Borne Zoonotic Disease; 18 (2) https://www.ncbi.nlm.nih.gov/pubmed/29298408

[33]World Health Organization (2006). Overview of greywater management: Health Considerations. http://applications.emro.who.int/dsaf/dsa1203.pdf

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- Are arrangements made for emptying/replacement of sharps containers on a regular basis?
- Are there tents with evidence of hoarding habits[34]? How is this managed while maintaining resident autonomy, understanding that some residents may have all their possessions or store recycling as a means of income in a tent and that this may not be problematic unless it poses a fire or sanitation risk?
- If there are any signs of pest infestation? What type of vector (rats, mice, other)?
- If there are pallets used to keep structures dry in extreme weather, are they kept clear of debris that may attract pests?

Mitigation Options

Public Health may recommend:
- Waste containers be emptied regularly (weekly or more frequently if needed).
- Providing designated flammable and hazardous waste disposal (batteries, light bulbs, fuels, motor oils, etc.)
- Clearly posting garbage collection and handling suggestions.
    - Suggestions that no garbage be kept in sleeping structures, for insect/rodent control
    - Providing animal waste bags so waste can be picked up immediately.
- Providing grey water holding tank if sewer is not accessible (this may require permitting)
    - Instructions for dirty water not to be dumped on the surface of the ground or into storm drains

If waste disposal seems to pose a risk at a particular encampment, it may be helpful to post signage.

v. Extremes of Temperature (Heat/Cold)

Though BC is generally thought of as a temperate climate, this varies between geographic regions and seasons; furthermore, climate change promises to bring hot stretches for longer periods of time, as well as more severe precipitation events [35].

People living in tents or under tarps may be more at risk of heat related illness[36].

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[34] International OCD Foundation (2009). Hoarding Fact Sheet. https://iocdf.org/wp-content/uploads/2014/10/Hoarding-Fact-Sheet.pdf

[35] cleanBC: Climate Preparedness and Adaptation Strategy – Actions for 2022-2025 p17-20. https://www2.gov.bc.ca/assets/gov/environment/climate-change/adaptation/cpas.pdf

[36] https://www.vch.ca/sites/default/files/import/documents/VCH_Climate_Change_Poster_Heat.pdf

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Image source:
https://www.vch.ca/sites/default/files/import/documents/VCH_Climate_Change_Poster_Heat.pdf

In Montreal, strategies such as hot day checks on the socially isolated, or homeless, and water distribution by various groups including local government staff or nongovernmental organizations have been part of extreme heat strategies that effectively decrease the number of heat-related deaths [37].

Cold weather poses challenges as well. Where some residents may seek refuge in shelter, many camp members may stay in their tents without proper supplies against the cold or the rain due to overcrowding at shelters, real or perceived lack of safety in shelters, fear of losing their belongings, and/or inability to use harm reduction supplies[38].

Suggested Questions
- What type of shelters are in use/ the number of shelters?
- What form of heating is in use (during cold weather)?
- Are areas of shade available?
- Is water available?
- Is cooling station on site or in proximity?

Mitigation Options

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[37]Centre for Climate and Energy Solutions (2017). Resilience Strategies for Extreme Heat.
https://www.c2es.org/site/assets/uploads/2017/11/resilience-strategies-for-extreme-heat.pdf
[38] Thomson, M (2015). Vancouver Homeless Count Report 2015. https://vancouver.ca/files/cov/vancouver-homeless-count-2015.pdf

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During very cold and wet times, recommendations would be for encampment residents to have alternative shelter or housing arrangements. In absence of such solutions, for cold weather response, including extreme rain, public health may recommend:

- Providing a warming tent to decrease risk of heating in individual tents
- Providing pallets or cinderblocks for residents to raise tents off the ground to protect against precipitation
- Conducting site visits after extreme weather events.

Some warming options could be a fire hazard. Partners may work with Fire Safety to mitigate risk. This may be considered on a case by case basis.

For hot weather response, public health may recommend [39],[40]:

- Educating camp residents of potential heat amplifying effects of tents and relative protection of some tarps to provide up to 10C heat relief (fire resistant tarps are required to address safety).
- Promoting access to shade spots/ cooling spaces for residents.
- Promoting access to adequate drinking water/hydration
- Working with other health allies to alerting residents that some medications may make the effects of heat worse or worsen pre-existing conditions.
    - Advise residents to check on each other for heat illness related symptoms including high body temperature, confusion, hallucinations, and lack of coordination, seizures, or a loss of consciousness and to go for help if they observe these.
    - Advise residents that those who are taking medications, particularly for mental health issues, may be most at risk. Emphasize that people should not stop taking medication but increase their water intake and seek refuge from the heat.
        - As extremely hot weather can provoke suicidal ideation in some people, alerting residents, particularly leaders depending on the camp governance style, to check on those who might be at risk.

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[39] Lubik, A, Kosatsky, T (2018). Developing a Municipal Heat response Plan: A Guide for Small and Medium-sized Municipalities. BC Centre for Disease Control. http://www.bccdc.ca/resource-gallery/Documents/Guidelines%20and%20Forms/Guidelines%20and%20Manuals/Health-Environment/Developing%20a%20municipal%20heat%20response%20plan.pdf

[40]Samra, S (2010). Beating the Heat on the Street. Canadian Observatory on Homelessness. https://www.homelesshub.ca/resource/beating-heat-street

vi. Infection Prevention and Control /Outbreak Management

Difficulties with water, food, sanitation, waste management and overcrowding all create a cumulative risk for the development of disease and the potential for outbreaks of gastrointestinal (GI) or respiratory diseases at the camp. **In the event of documented or suspected disease transmission in the encampment,** public health action to identify and mitigate the source according to the principles outlines above should be taken.

Suggested Questions
- What are the symptoms? <u>Onset date of illness?</u> How many affected? Duration of illness?
- Have immunizations been provided on site?
- Is there access to hand washing facilities? Is hand sanitizer supplied?
- Is it likely that encampment residents have access to protection against sexually transmitted infections (condoms, substance testing/ treatment and/or PrEP)?

Mitigation Options
Public health may recommend:
- Immunization
- Cleaning/disinfection
- Mitigation of identified source
- Access to condoms or other sexual health promotion measures
- TB Screening
- Connecting any person identified with a communicable illness to a healthcare provider
- Education of camp leadership on the potential for lice or scabies, and potential remediation/ prevention

vii. Harm Reduction

The term "harm reduction" focuses on minimizing death, disease and injury associated with higher risk behaviour, while recognizing that the behaviour may continue despite the risks[41]. Harm reduction involves a range of supports to empower and support people to be safer and healthier. Studies have shown that harm reduction activities do not encourage substance use; contrarily, harm reduction activities are likely to support people into treatment.[42]

Harm reduction is a public health approach that saves lives by minimizing harm and potential danger. A harm reduction approach meets people where they are at with open arms, acceptance, and compassion – not judgment or shame. A harm reduction approach recognizes that every life is valuable, and that substance use and addiction are complex and challenging.[43]

Suggested Questions

- Are there sharps containers on site?
- Are there adequate harm reduction supplies available on site?
- Is there safer use information available on site? Is there a mechanism for sharing drug safety alerts with the site?
- Is there naloxone on site?
- What mental health and substance use services are available to campers on site?

Mitigation Options
Public Health may recommend
- Providing harm reduction supplies, including training and provision of naloxone, on site
- Providing needle disposal
- Offering drug checking services on site
- Connecting encampment residents to peer support networks and peer navigators

For more information and resources, refer to the BC Overdose Prevention Services Guide[44]

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[41]Harm Reduction International (2019). What is Harm Reduction? https://www.hri.global/what-is-harm-reduction
[42] BCCDC Harm Reduction Services (2019). Reducing Harms Resources. https://towardtheheart.com/about
[43] First Nations Health Authority (2020). Harm Reduction. https://www.fnha.ca/what-we-do/mental-wellness-and-substance-use/overdose-information/harm-reduction
[44] BC Centre for Disease Control (2019). BC Overdose Prevention Services Guide. http://www.bccdc.ca/resource-

viii. Public Health Support to Decampment

Decampment occurs when authorities make the decision that residents need to leave the encampment area and dismantle the structures to move elsewhere. Based on local experience in Surrey, this may occur with agreement of residents to move to supportive housing. From a public health standpoint, decampment should not occur without redirecting camp residents into stable or temporary housing. However, public health has little jurisdiction over whether or not a camp is moved and under what conditions.

In addition, the Surrey experience demonstrated that decampment can be a difficult transition for some residents; therefore, public health supports, sometimes through Mental Health and Substance Use services and outreach partners, is advised to be made available where possible. Further, for Indigenous encampments members, it would be important to remember multi-generational trauma that informs perceptions of authority figures which may be reminiscent of past trauma, such as residential schools. Relationship building and culturally appropriate supports may be needed for these encampment members.

If decampment is not resulting in relocation to housing:
- Are there people with mental health and substance use disorders in the camp?
  - Are there ways to connect them with their case managers, or alert case management teams that a camp is being decommissioned so if they have clients residing there, they can offer support?
  - Do residents/former residents know where the nearest safe injection/ disposal unit is and/or do they have access to naloxone?
  - Are supports, including peer supports available through partners and/or the health authority?

If going into temporary housing:
- Can screening for active TB (i.e. symptom screen most typically) occur before moving into modular housing? Can screening for latent TB occur soon following a move?
  - Has housing/shelter staff and other residents been educated about TB risk, protective factors and stigma reduction?
  - Transition to supportive housing should not be dependent on TST status.
- Have relationships between support agencies and camp residents been solidified?

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gallery/Documents/Guidelines%20and%20Forms/Guidelines%20and%20Manuals/Epid/Other/BC%20Overdose%20Prevention%20Services%20Guide_Jan2019_.pdf

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Mitigation Options

- Public health may provide cards with relevant health information/ resources
- Public health may engage peer supports if available
- Public health may assist service provider organizations with appropriate harm reduction supports
- Public health may coordinate culturally relevant support for Indigenous residents
- Public health may organize screenings for TB if needed and resources are available

C. Resources

Resource 1: Description of Potential Roles of Partners for Health and Safety at Encampments

A.   Occupants

Occupants and/or leaders in an encampment community can be valuable and active partners, as a source of information about the culture of the encampment and can help outreach teams connect with members and better understand the needs and goals of individuals. All government actors and health care providers should recognize the specific and necessary expertise of people with lived experience, particularly in regard to peer-run and peer-delivered services[45]. It should be understood, however, that not every encampment has an organizational structure or leaders.

B.   Landowner

In general, the landowner is the entity to which correspondence, advice, recommendations, and, if needed, public health orders are addressed. Encampments may involve municipal property, provincially owned lands, First Nations Lands, and/or private property. Landowners may find themselves in conflict between ensuring basic needs for persons in the encampment, addressing perceptions and public safety needs within the community, resolving legal issues, and protecting their own assets.   Municipalities can have dual roles of direct ownership, as well as providing permits for land uses. Landowners may:
- Provide leadership in response to encampment and coordination of services or engage in supportive working groups
- Engage in Bylaw enforcement, parking and/or transportation

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[45] Bennett,D, and Larkin, DJ (2016). Report: Project Inclusion Pivot Legal Society.
http://www.pivotlegal.org/project_inclusion_full

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- Working with BC Housing to assure land availability and provide permits for temporary or permanent supportive housing
- Offer hygiene options, sanitation, waste removal and security, including
    - Providing access to safe drinking water
    - Providing garbage cans, dumpsters, washroom facilities or portable toilets and waste removal, solid and liquid
    - Working with regional health authorities to provide sharps disposal to be placed in accessible locations with pickup programs in place
    - Working with environmental health officers to solve concerns

C   BC Housing

In response to homelessness, BC Housing's most important functions are 1) development and operation of shelter services with very specific operating minimums and requirements 2) development and operation of supportive housing with specific requirements 3) street outreach staff, and 4) coordination with health and other partners.

BC Housing may:

- Provide water and temporary bathrooms in the absence of municipal or provincial capacity
- Provide some food to residents
- Facilitate pest control
- Provide and distribute flame-retardant tarps and tents when necessary
- Interact with encampment residents to connect them with available services where appropriate
- Fund new temporary or supportive housing sites

D.   First Responders (Police, Fire, Ambulance)

Efforts in some BC settings have demonstrated that close communication and coordination between public health teams and first responders is an important component of encampment response. Public health may support first responders in reducing the health risks to staff and of persons experiencing homelessness, including risk of injury from violence or fire.

In order to reduce injury risk and support health and safety of encampment occupants, first responders may:
- Offer expertise on public safety and the protection of vulnerable individuals
- Participate as core members of the outreach teams
- Provide requested assistance from outreach teams when they encounter people who are experiencing homelessness that are at-risk of arrest
- Request fire mitigation measures, including spacing and clear walkways between tents; request and/or support evacuation plans

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- Ensure fire extinguishing options are available on site
- Provide information for mitigating risks for carbon monoxide poisoning
- Work with the encampment residents to reduce fire related risks in encampments for smoking, cooking, and warming fires
  - It should be acknowledged that there are circumstances where burning may be for ceremonial purposes; however, how and when such fires may be permitted is a decision of the fire chief.
- Suggest safe placement for combustibles if on site
- Conduct regular site visits to review issues affecting fire and life safety and issue orders to landowner related to fire prevention
- May attend medical emergencies
- May provide assistance for overdose, assaults, infections and other conditions in real time
- May provide community paramedic services on site to augment primary care services

E   Ministry of Children and Family Development

The Ministry of Children and Family Development (MCFD) and Delegated Aboriginal Agencies are mandated under the *Child, Family and Community Service Act* to ensure the safety and wellbeing of children (age under 19).   Encampments pose significant risks to children; therefore, any child frequenting or living in one must be reported to MCFD.   If a child protection report is made child protection, social workers may share information and collaborate with the community agencies involved in the encampment to:

- Investigate the child's circumstances;
- Consider legal interventions to protect the child;
- Work with the child, family and community to support the child. and in best cases their parent(s)/ guardian. to move to safe and appropriate accommodation; and,
- If the child refuses to leave the encampment, monitor the child's circumstances through regular visits and provide support services to mitigate the risk of harm.

In some circumstances, there may be strong and systemic mistrust of MCFD among First Nations people, who are overrepresented in encampments.   Special consideration should be given to MCFD role and the risks and challenges therein.

F   Indigenous Agencies (Indigenous Nations, Friendship Centres, First Nations Health Authority, Urban Indigenous Centre and Others)

Due to ongoing systemic power imbalances and a lack of cultural safety, and humility, many Indigenous Peoples have had personal experiences with harmful colonial policies and

systems, institutions, and individuals. There is often a mistrust in Canadian institutions and agencies due to historical and ongoing colonial abuses including Indian Residential Schools, Indian Hospitals, Sixties Scoop policies, the child welfare system, the justice system, and violence against Indigenous women and girls. Real and perceived racism and prejudice also contributes to a sense of mistrust and anxiety when dealing with officials. Where possible and appropriate, to support the well-being of Indigenous camp members, public health should reach out to local Friendship Centres, Métis Associations, or other outreach centres to facilitate the connection to cultural and spiritual supports. While various agencies many be able to provide different services, Indigenous Agencies[46] may:

- Help encampment residents access health services that they need to improve or maintain their health
- Advocate on an encampment resident's behalf within the health system, including the mental health system
- Provide assistance accessing First Nations Health Authority benefits and funding for services
- Provide education on health issues and concerns
- Connect residents with community resources and benefits
- Provide homelessness prevention and/ or outreach programs

G   Other Community Agencies

These organizations may be valuable resources when responding to encampments and could be embedded within any collaborative response planning.

- **Outreach teams, case managers, and peer specialists** often have relationships with people in encampments, and can connect them to needed services, housing, income, and other supports through knowledge and experience with effective outreach and engagement strategies.
- **Affordable housing providers, food programs, and harm reduction services** may serve people who are experiencing homelessness and are also important partners that can offer access to data, resources, and expertise.
- **Other non-governmental organizations** often are interested in improving the lives of people experiencing homelessness and may be able to provide volunteer and financial support to assist the community response.
- **Local businesses** may be impacted by encampments, which can motivate them to support effective solutions. Business leaders can leverage their professional affiliations and relationships with the local Chamber of Commerce and other business associations to generate public support and provide resources for programs that create lasting solutions[47].
- **Local media** (See *Resource 2*)

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[46] BC Housing Homeless Outreach Program. Find a homeless outreach worker.
https://www.bchousing.org/housing-assistance/homelessness-services/find-homeless-outreach-worker
[47] Matsqui-Abbotsford Impact Society. Business Engagement Ambassador Project
http://www.impactabby.com/street-community/

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H   Clinical Health Services

Given associations between homelessness and poor health, clinical staff may provide information to encampments residents on where to access appropriate, culturally competent, trauma-informed health care services at encampment sites or in community service locations. Knowledge of encampment residency may be incorporated into treatment plans, discharge planning, referrals to community agencies.
Coordination of clinical health services with outreach services may also occur in the context of an encampment situation.

Public health may be involved in mobilizing services to assist encampment occupants, including, but not limited to primary health, mental health and substance use, and home health as follows:

- Primary care services in the encampment, notably wound care.
- Sexual and reproductive health services
- Support for management of chronic diseases such as diabetes, COPD, HIV/AIDS, and cardiac illnesses
- Linkage to other primary and specialized care services, including Indigenous Primary Care clinics or Traditional Healers
- Access to mental health clinical assessments and outreach services, including assertive community treatment and intensive case management, as well as connections to FNHA mental health benefits or other appropriate benefits
- Connection to harm reduction services (e.g., drug checking services, overdose prevention and supervised consumption services, OAT services, and overdose recognition and response training) and the provision of harm reduction supplies
- Mobility assistance, daily function support, chronic disease management, and assistance in complex medication management

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Resource 2: Trauma Informed Health Services 101 and Resources

<u>Trauma Informed Care 101</u>

<u>(Excerpt from the Canadian Observatory on Homelessness with additional content</u>[48]<u>)</u>

Some people experience very few traumatic events in their lives. For others, experiences of traumatic stress are chronic. Research and experience tell us that for people experiencing homelessness, rates of trauma are extraordinarily high. Many who enter the homeless service system have experienced violence, loss, and disruptions to important relationships from an early age.

Additionally, people who are homeless experience the loss of place, safety, stability, and community. These losses are also traumatic. They have a major impact on how people understand themselves, the world, and others. People who have experienced multiple traumas do not relate to the world in the same way as those who have not. They require services and responses that are uniquely sensitive to their needs.

What makes an experience traumatic?

- The experience involves a threat to one's physical or emotional well-being.
- It is overwhelming.
- It results in intense feelings of fear and lack of control.
- It leaves people feeling helpless.
- It changes the way a person understands themselves, the world and others.

Becoming Trauma-Informed
We know people can and do recover from trauma, and we want to provide services and environments that support healing. To be a "trauma-informed" provider is to root your care in an understanding of the impact of trauma and the specific needs of trauma survivors. We want to avoid causing additional harm to those we serve.

What does this mean in practical terms? How is this different than business as usual? Here are some concrete practices of trauma-informed care.

Understanding Trauma and its Impact
Educating providers on traumatic stress and its impact is essential. Trauma survivors, particularly those who have experienced multiple traumas, have developed a set of survival skills that helped them to manage past trauma. These survival strategies (like substance abuse, withdrawal, aggression, self-harm, etc.) make sense given what people have

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[48] Guarino, K (2009). Trauma-Informed Care 101. Canadian Observatory on Homelessness. https://www.homelesshub.ca/resource/trauma-informed-care-101

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experienced. But they can be confusing and frustrating to others and often get in the way of current goals.

Without an understanding of trauma, providers may view those they serve in negative ways. Providers might describe behaviors as "manipulative," "oppositional," or "lazy." Yet these behaviors may be better understood as strategies to manage overwhelming feelings and situations. Trauma-informed training can help providers understand these responses and offer trauma-sensitive care.

Promoting Physical and Emotional Safety
Traumatic experiences often leave people feeling unsafe and distrustful of others. Creating a sense of physical and emotional safety is an essential first step to building effective helping relationships.

Safe physical environments may include:

- Well-lit spaces
- Security systems
- The ability to lock doors
- Visible posting of consumer rights
- Culturally familiar decorations
- Child-friendly spaces

Practices that help to create a safe emotional environment include:

- Providing consistent, predictable, and respectful responses to consumers across an agency
- Asking consumers what does and does not work for them; providing choice and agency and meaningfully seeking informed consent.
- Being clear about how consumer information is used
- Providing opportunities for consumers to engage in their own cultural and spiritual rituals

Supporting Control and Choice Situations that leave people feeling helpless, fearful, or out of control remind them of their past traumatic experiences and leave them feeling re-traumatized. Ways to help consumers regain a sense of control over their daily lives include:
- Keeping consumers well informed about all aspects of their care
- Providing opportunities for consumers to give input into decisions about how a program is run
- Allowing for consumer control over their own spaces and physical belongings
- Having clear boundaries around and giving advanced notice for room or apartment checks
- Ensuring that consumers have input into their service goals

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- Using interventions respectful of and specific to cultural backgrounds
- Maintaining an overall awareness of and respect for basic human rights and freedoms regardless of housing status.

Integrating Care across Service Systems

Becoming trauma-informed means adopting a holistic view of care and recognizing the connections between housing, employment, mental and physical health, substance abuse, and trauma histories. Providing trauma-informed care means working with community partners in housing, education, child welfare, early intervention, and mental health. Partnerships enhance communication among providers and help minimize consumers' experiences of conflicting goals and requirements, duplicated efforts, and or of feeling overwhelmed by systems of care. It helps build relationships and resources to provide the best quality of care possible.

Who Experiences Trauma?

(Except from the BC Trauma-Informed Practice Guide[49])

Among all Canadians:
• 76% of Canadian adults report some form of trauma exposure in their lifetime, 9.2% meet the criteria for PTSD
• An estimated 50% of all Canadian women and 33% of Canadian men have survived at least one incidence of sexual or physical violence

Among people experiencing homelessness in BC:
• 51% of homeless people from three BC communities interviewed reported childhood sexual abuse, 55% reported physical abuse, 60% reported neglect, 58% reported emotional abuse; and 57% met the criteria for current PTSD

Among people in BC seeking/needing help with substance use and mental health concerns:
• 63% of women entering treatment for substance use problems at the Aurora Centre indicated that they had experienced physical violence, and 41% had experienced sexual violence
• 44.6% of participants in the North American Opiate Medication Initiative (NAOMI) in Vancouver reported a history of physical or sexual abuse, and 62.5% reported emotional abuse
• Very high rates of trauma and PTSD have been found in people with serious mental illnesses. 58% of women at Riverview Psychiatric Hospital had been sexually abused as children

Among BC youth with substance use and related risks:

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[49] Urquhart, C, Jasiura, F and the Trauma-Informed Practice Working Group (2013). Trauma-Informed Practice Guide. http://bccewh.bc.ca/wp-content/uploads/2012/05/2013_TIP-Guide.pdf

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• According to Vancouver Island Health Authority data as many as 25% of youth engaging in addictions services reported a history of trauma

Among Canadians with mental health and substance use concerns beyond BC:
• 90% of women in treatment for alcohol problems at 5 Canadian treatment centres indicated abuse-related trauma as a child or adult; 60% indicated other forms of trauma
• 90% of females and 62% of males youths in co-occurring disorders treatment at CAMH endorsed concerns with traumatic distress

Resources for Trauma Informed Practice

Trauma Informed Practice Guide (2013)
Created by Provincial Mental Health and Substance Use Planning Council, this resource to translate trauma informed principles into practice based on research and best practices by those already employing trauma informed practices in their work. It includes information on understand trauma, trauma-informed approaches, implementing trauma-informed approaches, and a number of resources including:
Info Sheet on Self-Care for Practitioners
Trauma-Informed Practice Organizational Checklist
Info Sheet on Trauma-Informed Engagement Skills
Info Sheet on Asking About Trauma and Responding to Disclosure
Info Sheet on Strategies for Sharing Information About Trauma
Info Sheet on Grounding Skills and Self-Care Strategies
Trauma-Informed Practice Related Resources
http://bccewh.bc.ca/wp-content/uploads/2012/05/2013_TIP-Guide.pdf

PHSA BC: Indigenous Cultural Competency Training Program
This website includes information about the Indigenous Cultural Competency (ICC) Online Training Program delivered by the Provincial Health Services Authority of British Columbia (PHSA
BC). Information for registering for core training is provided and, once completed, there is access
to supplementary training, resources, and on-going support.
http://www.culturalcompetency.ca

BC Patient Safety & Quality Council: Cultural Safety and Humility Action Series

This webinar program deals with 11 sub-topics beginning with Leading a Framework for Cultural Safety & Humility with FNHA CEO Joe Gallagher, through to cultural Humility in nursing in BC, and responding to anti-Indigenous racism in the health care system.

https://bcpsqc.ca/resources/program/sub-topics/cultural-safety-humility-action-series/

Trauma-Informed Organizational Toolkit for Homeless Services

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Created by the National Center on Family Homelessness, the *Trauma-Informed Organizational Toolkit* is intended to provide programs with a roadmap for becoming trauma-informed. The *Toolkit* offers homeless service providers with concrete guidelines for how to modify their practices and policies to ensure that they are responding appropriately to the needs of families who have experienced traumatic stress.

https://www.air.org/sites/default/files/downloads/report/Trauma-Informed_Organizational_Toolkit_0.pdf

Resource 3: Working with the Media/ Communications: How to Frame Homelessness in a way that will not exacerbate stigma

Media coverage is essential for people to understand what is happening in their neighbourhoods, but without thoughtful messaging it can increase fear and stigma towards those experiencing homelessness. Research from the Frameworks Institute (2018) showed that experts view the problems of people experiencing homelessness quite differently than the public:

Experts understand that homelessness is the result of deficiencies in the social structure, such as a lack of affordable housing, wage stagnation, discrimination and cuts to social welfare programmes. The economic insecurity caused by these various systemic factors can push people into a variety of insecure housing situations. In addition, structural violence, such as the racism, social exclusion and discrimination experienced by Indigenous peoples stemming from colonization, and systemic gaps that leave individuals without continuity of services, support or opportunity, including for those exiting corrections, mental health, addictions and child welfare systems are recognized as fundamental drivers.

Unsurprisingly, however, the public tends to assign blame for homelessness to individual actors: people whose personal failings, poor mental health or calculated decisions led them to rough sleeping. Both the third sector's and the media's stories about homelessness rarely take the time to explain its structural causes. Instead, the public is more commonly exposed to illustrative stories that focus on the circumstances of a particular individual – especially those who are rough sleeping, the type of homelessness that is both the most extreme and the most familiar to the public. Though this framing strategy may be intended to generate sympathy and concern, such stories inadvertently feed people's stereotyped expectations about who is homeless and why.[50]

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[50] Nichols, J, Volmer, A, Busso, D, Pineau, MG, O'Neil, M, Kendall-Taylor, N (2018). Reframing Homelessness in the United Kingdom. The Framework Institute, UK. https://www.frameworksinstitute.org/publication/reframing-homelessness-in-the-united-kingdom/

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The media can help frame homelessness as the public health crisis that it is by redirecting to a common theme framework of four key issues:

• Best practices in public health can help to prevent illness and promote the health and wellbeing of people experiencing homelessness. People living in homelessness are at increased risk for many acute and chronic health issues, related to the conditions of homelessness as well as other social determinants of health.[51]

• People's fundamental commonality. Homeless people are, like all of us, human beings and members of society. The right values, metaphor and stories can orient people to what we all share.

• The lived experience of homelessness. Metaphor and stories about various types of housing insecurity, when told in the right ways, can help people understand what it feels like to be homeless.

• The role of systems. The values, metaphor and solutions that help to make up the frame encourage systemic thinking about how homelessness happens and cultivate support for systems level policy change to bring about solutions.

Myth vs Facts on People Experiencing Homelessness

(Excerpt from the Canadian Observatory on Homelessness[52])

Myth: People who are homeless people come from other provinces/ areas.

Fact: it's a homegrown homeless challenge and many people who have been dealing with homelessness for years.

Myth: People choose to be homeless.
Fact: A variety of different factors can contribute to an individual's experience of homelessness. Often, people experience homelessness when all other options have been exhausted, and/or they are dealing with circumstances that make it difficult to maintain housing. Despite rhetoric to the contrary, the majority of people who are homeless were originally living in the communities in which they experience homelessness. Some of the obstacles that may lead people to their experiences of homelessness include the affordable housing crisis, eviction/ renoviction/ demoviction, mental health and/or addictions problems. Additionally, 70% of youth aging out of care are not accessing services and therefore vulnerable.

Myth: All people who experience homelessness are addicts.
Fact: Many people who experience homelessness do not struggle with substance use problems or addictions. Just like in the general population, only a percentage of those who

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[51] Public Health Ontario (2019). Evidence Brief: Homelessness and health Outcomes: What are the Associations? https://www.publichealthontario.ca/-/media/documents/eb-homelessness-health.pdf?la=en
[52] Canadian Observatory on Homelessness (2019). Myths and Questions about Homelessness. https://www.homelesshub.ca/about-homelessness/homelessness-101

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are experiencing homelessness deal with addictions. People experiencing homelessness may deal with other issues related to their experiences of homelessness, including trauma and mental illness, for example. It should be emphasized that those use substances deserve and should have access to the same level of care.

Myth: There are plenty of adequate services and supports to help those experiencing homelessness.

Fact: Many of the solutions and supports for homelessness have focused on emergency services, such as shelters and food banks. For individuals who are trying to escape a cycle of poverty and homelessness, emergency services alone are not adequate. There is a need to focus on the larger systemic factors, including the lack of affordable housing and the criminalization of homelessness that prevent people from obtaining permanent and suitable shelter. Further, people are often eligible for Income Assistance but haven't been able to access to adequately navigate the system to apply.

Myth: Property values will go down if we let homeless shelters into our neighbourhoods.

Fact: Downtown Toronto, Canada is a concentrated area with supports and services for people experiencing homelessness. Despite the large numbers of people who go into the downtown core to access these services, housing prices remain high and there is no evidence to support this myth. This common misperception and attitude is referred to as "Not in My Backyard" (NIMBY) and can have detrimental effects for people who need to access services in different neighborhoods.

Myth: Crime increases around homeless encampments.

Fact: Though there is often concern and stereotypes about increased crime around encampments, the media should be aware that in studies from the US, when properly supported, there is evidence no link between crime rates and encampments.[53]

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[53] Schmid, T (2018). No link between homeless villages and crime rates, Guardian review suggests. The Guardian Newspaper. https://www.theguardian.com/us-news/2018/may/23/homeless-villages-crime-rate-seattle-portland

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Resource 4: Annotated Bibliography

Public Health Ontario: Homelessness and Health Outcomes: What are the associations?
The purpose of this evidence brief is to provide an overview of the associations between homelessness and health from review-level evidence. This is a bi-directional problem, and evidence shows that not only does homelessness predispose people to poor health outcomes, but that poor health status can contribute to homelessness. It also identifies specific illnesses that people experiencing homelessness may face and that the multidimensionality of this issue is likely underrepresented in literature. The purpose is to identify specific health outcomes associated with homelessness to inform planning and priority-setting by Ontario public health practitioners.
https://www.publichealthontario.ca/-/media/documents/eb-homelessness-health.pdf?la=en

The Homeless Hub
This resource centre website was created by the Canadian Observatory on Homelessness (COH).The COH is a research and policy partnership between academics, policy and decision makers, service providers and people with lived experience of homelessness. It is intended to bridge the gap between research, policy, and practice. One of the key objectives of the COH is to build a collective and consistent understanding of homelessness in Canada, as well as to mobilize knowledge. The COH collects and produces tools, reports, and resources to support communities across Canada to understand and develop innovative solutions to homelessness.
http://homelesshub.ca/sites/default/files/COHhomelessdefinition.pdf

Alternatives to Unsanctioned Homeless Encampments
This review of alternatives to unsanctioned homeless camps was commissioned by the City of Oakland in order to understand the health hazards association with unsanctioned camps, but also to look at responses that may produce positive results, as sweeping camps away is ineffective and does nothing to address root causes. The authors did a needs assessment of the camp residents and city stakeholders and analyzed best practice case studies for both housing first options and sanctioned encampments. The report concludes with recommendations.
https://gspp.berkeley.edu/assets/uploads/page/15-13160_-_Goldman_Student_Report_-_Final_Draft_-_May_11_2015_reduced_size.pdf.pdf

Seattle & King County Public Health (2018). Sanctioned Homeless Encampments: Initial Planning and Management Checklists. Environmental Health Services; Health Care for the Homeless.
The checklists contained in this document should be used in the initial planning and ongoing management of sanctioned homeless encampment sites. The initial planning and set-up checklist includes items and design features that will be necessary for sanctioned encampments to have and use in their planning phase. The ongoing management checklists

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identify the major risks and challenges associated with homeless encampments and therefore address minimum standards that sanctioned homeless encampments should provide. The management checklists are separated by the major risk topic areas.
Some of the checklists may not be relevant to an encampment site depending on the layout and needs of the residents. For example, if a sanctioned encampment site does not have any residents with pets then the checklist for pet management may be disregarded.
https://www.rtfhsd.org/wp-content/uploads/sanctioned-homeless-encampments-checklists.pdf

Tent City USA: The Growth of America's Homeless Encampments and How Communities are Responding

This report was created by the National Law Centre on Homelessness & Poverty. It documents the apparent rapid growth of encampments of people experiencing homelessness or "tent cities" across the United States and the legal and policy responses to that growth. Learnings from the report include: law enforcement threats do not decrease the number of people on the streets, encampment evictions are not the best way to protect health & safety, case studies of non-enforcement approaches show promising lessons, examples of cities end homelessness through housing, and successful approaches to encampments all follow certain principles.
https://homelesslaw.org/wp-content/uploads/2018/10/Tent_City_USA_2017.pdf

Doctors without Borders (MSF): Refugee Camp Guidelines for Health Professionals.

This book is a collective accomplishment of the different sections of Médecins Sans Frontières (MSF), and has been written to consolidate the broad experience of MSF in refugee programmes. It deals with refugees and internally displaced persons, and what a health agency can do to relieve their plight. It focuses on policies rather than on practical aspects and is meant to act as a guide to decision-makers. Some of the contents may be applicable to guide health practitioners in supporting local encampments.
http://refbooks.msf.org/msf_docs/en/refugee_health/rh.pdf

Homelessness and Global Climate Change in the Waterloo Region: Are we Ready?

This report from the University of waterloo was developed to explore both, exposure-sensitivity and adaptive capacity of people experiencing absolute homelessness. It seeks to understand how this specific group of people experience the exposure to extreme weather situations and how they manage those situations. It sought to assess vulnerabilities currently, and how those vulnerabilities and coping mechanism may work under changing conditions, as well as the effectiveness of knowledge translation and community engagement with groups with lived experience.
https://www.researchgate.net/publication/269689517_A_Report_from_the_Study_on_the_Vulnerability_to_Global_Climate_Change_of_People_Experiencing_Homelessness_in_Waterloo_Region

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Indigenous Engagement and Cultural Safety Guidebook: A Resource for Primary Care Networks

This resource from the BC First Nations Health Authority is designed for those who are planning and implementing Primary Care Networks; however, it may be useful in the context of encampments, as the overall objective of enabling communities to build meaningful relationships and trust with Indigenous communities. To support the provision of culturally safe care, informed by the practice of cultural humility, the guidebook focuses around four critical components: how to engage and form partnership with Indigenous communities & health service organizations, how policies and mechanisms influence culturally safe care, how incorporate education, training and performance review, and how to obtain feedback on individual experiences of receiving care.

https://bcrhn.files.wordpress.com/2019/11/guidebook-indigenous-engagement-and-cultural-safety-v1.0.pdf

Report: Project Inclusion

This report from Pivot Legal Society is a comprehensive study into the ways in which specific laws and policies in policing, health care, and the court system directly undermine the health and safety of people who are homeless and living with substance use issues by trapping them in a cycle of criminalization. It includes experiences directly from those affected and has gathered insight into how local laws and practices create harm by shaping lived experience. It also illustrates the role stigma plays in worsening systemic barriers. *Project Inclusion* also proposes innovative solutions, informed by those affected, as answers to these problems and a means to protect the health and human rights of people across the province.

http://www.pivotlegal.org/project_inclusion_full

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VII. Appendices

APPENDIX A- Methods

This best practice document was developed based on literature review, environmental scan, and expert opinion.

Literature review
A literature review was conducted in October 2018 in Pubmed using search terms related to encampments, homelessness, and public health. There was no peer reviewed literature found.

Environmental scan
Environmental scan using Google was conducted in October 2018 and repeated in April 2019. Relevant documents from several jurisdictions were identified and are listed in the resources sections. The environmental scans were supplemented by resources and internal HA documents identified by working group members and external contributors.

Expert Opinion
Every effort was made to get a broad range of expert opinion from those who have been actively managing PH issues in encampments, providing other services in encampments or are otherwise working with homeless populations. Invitations to comment were extended to ten local governments and municipal partners (i.e. Fire Departments and the Union of BC Municipalities) with whom Working Group members have been managing encampments; thirteen non- PPH regional health authority staff from across the province; seven Ministries and eleven ministry staff. Those providing input are listed in Section II and acknowledged with Gratitude

Background materials, research, evidence, tools, and resources were identified, gathered and reviewed by Working Group members. Key roles and responsibilities for community and public health practitioners as well as likely scenarios for situational assessments and responses were compiled and reviewed by Working Group members. Efforts were made to ensure key external stakeholders gave feedback and had their roles properly represented, including BC Government Ministries, Indigenous partner organizations, and local governments located in each Health Authority. If, after multiple attempts were made to engage with a stakeholder, no feedback was received, acceptance of Homeless Encampment Best Practices for Public Health Practitioners Document was presumed.

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APPENDIX B- Working Group Terms of Reference

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Public Health Guidance for (Homeless) Encampments (GHE) Working Group
TERMS OF REFERENCE –JANUARY 2019

1.0   BACKGROUND

In April 2018 a group on interested public health (PH) practitioners was convened at the request of the Provincial Health Officer to develop a Public Health Guidance for (Homeless) Encampments for BC Practitioners (i.e. "Guidance Document"). Such guidance would draw on existing materials already developed by health authorities and would provide consistent advice to PH practitioners. Such guidance will include the breadth of public health services, including environmental health, harm reduction, communicable disease control and other as needed.

The development of the Guidance Document is endorsed by Public Health Executive Committee and referred to the EHPAC and Public Health Guidance for (Homeless) Encampments Working Group.

2.0   WORKING GROUP MANDATE

1) Develop Public Health Guidance for (Homeless) Encampments for BC Practitioners.
2) Determine appropriate scope and content of guidance document, including environmental health, harm reduction and communicable disease control
   a. Possible scope: to identify public health issues and give recommendations
   b. To give guidance on how to relate to other sectors
   c. To give recommendations explicitly to public health but make recommendations about how to incorporate other aspects
3) Provide expert advice on key issues included in guidance document
4) Coordinate development of guidance document among appropriate members of the Ministry, BCCDC and health authorities.
5) Coordinate feedback on guidance document among appropriate members of the Ministry, BCCDC, health authorities, EHPAC and PHEC.
6) Liaise with relevant public sector groups as needed.
7) Assist and advise on dissemination and implementation of final product.

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3.0   WORKING GROUP STRUCTURE

3.1   Reporting and decision-making roles

The Public Health Best Practices for (Homeless) Encampments (GHE) Working Group (GHE-WG) reports to the EHPAC and through EHPAC to the Public Health Executive Committee (PHEC).

Decisions will be made by consensus, if possible, and each member commits to making every effort to find a consensus solution. The working group is accountable to EHPAC and to PHEC, which has ultimate authority over decisions affecting provincial recommendations and services provided. If consensus or a majority of at least 80 percent cannot be reached by Working Group members, the co-chairs will determine an appropriate process or outcome, including taking the issue to PHEC for decision.

When required for decision, quorum shall consist of 50 percent of the membership, ensuring representation from each participating health authority, and ministry is present.

3.2   Membership

The working group is chaired by a Health Authority representative. Secretariat support is provided by administrative assistants.

Membership will include representation from each of the following organizations (members may send a delegate when unavailable for a meeting):

1. BC Centre for Disease Control
2. First Nations Health Authority
3. Fraser Health Authority
4. Harm Reduction
5. Interior Health Authority
6. Ministry of Health
7. Northern Health Authority
8. Vancouver Coastal Health Authority
9. Vancouver Island Health Authority

We also

Additional members are included to ensure membership reflects a balance of environmental health, communicable disease and harm reduction expertise, as well as front-line, leadership and strategic perspectives.

Guests may be invited as needed to attend, at the chair's discretion.

3.4   Working Group Principles

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- Apply a population and public health focus to all policy discussions and recommendations as well as a service quality lens

- Demonstrate partnership and collaboration

- Appropriately and respectfully accommodate local circumstances within an established framework

- Transparent decision making

- Cultural safety

- Information-sharing culture, supported by technology

- Expectation of confidentiality

3.5   Frequency and Focus of Meetings

GHE-WG will meet as needed to fulfill its mandate, usually by video or teleconference. Frequency and duration of meetings will vary depending on stage of the working group's progress. As of January 2019, the frequency was decided at every six weeks for 1.5hrs. Members are expected to review documentation and provide feedback in between meeting times.
GHE-WG is a time limited working group for the duration needed to fulfill its mandate.
Funding is not provided for face to face meetings.

3.6   Secretariat role

Secretariat support to the committee, including Best Practice Document development, is provided health authority administrative assistants.
Efforts will be made to provide agendas and supporting materials in timely manner to allow review of materials in advance of meeting. The secretariat will circulate record of decisions within one week of each meeting.

3.6   Conflict of interest
Members are expected to be aware of, declare and abide by their own organization's conflict of interest policy.

3.7   Miscellaneous
Members must seek prior approval of the co-chairs to invite non-members to meetings to assist with specific issues or as observers.

Last Updated: January 2018