Adam Harr <ash@portlandmaine.gov>

concerned tax payer / life long resident

2 messages

TODD RICH <TRICH@wireless-partnersllc.com> Mon, May 1, 2023 at 10:30 AM
To: "hhsps@portlandmaine.gov" <hhsps@portlandmaine.gov>

Good morning,

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Taxpayer,

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207-332-3243

Kristen Dow <kjd@portlandmaine.gov> Mon, May 1, 2023 at 10:36 AM
To: April Fournier <afournier@portlandmaine.gov>
Cc: Adam Harr <ash@portlandmaine.gov>

Good Morning Councilor,

I am sending along this public comment as it was sent to the HHS&PS committee email address.

Thank you,
Kristen

Kristen Dow
Director of Health & Human Services
City of Portland
39 Forest Avenue
Portland, ME 04101
207-874-8633
Pronouns: she, her, hers

health & human services

Please note that my working hours may be different than yours. Please do not feel obligated to respond outside of your normal work schedule, unless otherwise requested.

[Quoted text hidden]

Adam Harr <ash@portlandmaine.gov>

ConvenientMD - Marginal Way

2 messages

Tim Walton <tim@waltonexternalaffairs.com> Mon, May 1, 2023 at 11:58 AM
To: "HHSPS@portlandmaine.gov" <HHSPS@portlandmaine.gov>
Cc: Celina Frost <CFrost@convenientmd.com>

Good morning Chair Fournier and respective members of the City of Portland's Health & Human Services and Public Safety Committee. My name is Tim C. Walton and I serve as Government Relations Counsel for ConvenientMD.

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Attached, please find an information document outlining our safety concerns as they relate to our Marginal Way clinic. The safety and health situation there with regards to the nearby unhoused encampments has become dire, untenable and out-of-control. Our patients and staff safety, health and well-being is at risk every day as a result of the situation. We believe, after reviewing the document, you will agree that something needs to be done immediately. NOTE: Please note, since this document was prepared, on Friday, the facility experienced an "active shooter" situation, forcing us to close the facility's doors all weekend. The staff is obviously very upset over this and continue to feel unsafe in their workplace.

I, along with Celina Frost, our Director of Compliance and Radiology will be on tomorrow night's zoom meeting.

Tim C. Walton

Walton External Affairs, LLC.

207-557-3049

Portland Maine Security.pdf
2717K

Kristen Dow <kjd@portlandmaine.gov> Mon, May 1, 2023 at 12:22 PM
To: April Fournier <afournier@portlandmaine.gov>
Cc: Adam Harr <ash@portlandmaine.gov>, Heath Gorham <frankg@portlandmaine.gov>

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Here is additional public comment. I have also asked Adam to add you to this email group, so you should be receiving them directly moving forward.

Heath, I am including you as well because the report consistently mentions their work with the PD.

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Adam Harr <ash@portlandmaine.gov>

Encampments and Unsheltered Homelessness in the city

1 message

Kamminga <kamminga.thomas@gmail.com> Tue, May 2, 2023 at 11:49 AM
To: HHSPS@portlandmaine.gov

To City Council,

Thank you for taking the time to read this letter. My name is Kammi Henke and I am the Captain at the Trader Joe's located at 87 Marginal Way. I understand that the encampments are a complicated issue; I would like to highlight some activities that my business experiences.

-multiple overdoses in our public restrooms
-people using our restrooms as a shower on a daily basis
- damage to our property via fencing that repeatedly is cut or torn down and in our public restroom
- increase in people harassing our customers for money in our parking lot
- in the past weeks we have had to have plumber out 2-3 times per week to unclog toilets due to needles and other non sewer materials
-two people have had bags stolen from carts in our parking lot and were later found on people in the encampment by police
- customer complaints and concerns over their safety in our parking lot
- increased trash on our property, including feces and needles along the fence line

Thank you for taking the time to address these concerns and work towards a timely solution that will benefit all involved.

Sincerely,

Kammi Henke
Trader Joe's
207-699-3799

Adam Harr <ash@portlandmaine.gov>

HHS and Public Safety meeting

1 message

Jo Coyne <jocoyne@gwi.net> Mon, May 1, 2023 at 11:37 PM
To: hhsps@portlandmaine.gov

I am forwarding an email I sent two weeks ago to city administrators and councilors. My concerns about Portland's many homeless encampments remain the same. I would love to see a roof over everyone's head but since that's obviously not going to happen anytime soon, I feel strongly that we need to establish a managed camp with security, sanitation and services where occupants register and sign in and out. Communities in other states are using this model successfully. Please see links to two such programs below.

Given the state's current surplus of funds, there is no reason why Portland should not receive state assistance in setting up and funding such a program. With a managed encampment, the city no longer would feel compelled to allow camping in parks and other public spaces. Allowing tents, needles and other drug paraphernalia, weapons, human feces and general trash on public land benefits nobody. Please develop a plan of action before the situation gets any worse. Thank you.

-------- Original Message --------

Subject: HHS and Public Safety meeting (11 April 2023)
Date: 2023-04-16 19:08
From: Jo Coyne <jocoyne@gwi.net>
To: April Fournier <afournier@portlandmaine.gov>
Cc: Danielle West <citymanager@portlandmaine.gov>, Dena Libner <dlibner@portlandmaine.gov>, Ethan Hipple <ehipple@portlandmaine.gov>, Richard Bianculli <richb@portlandmaine.gov>, Victoria Pelletier <vpelletier@portlandmaine.gov>, Anna Trevorrow <atrevorrow@portlandmaine.gov>, Kate Snyder <ksnyder@portlandmaine.gov>, Rosanne Graef <hello@wenamaine.org>, Anne Pringle <oldmayor@maine.rr.com>

Thank you for chairing last week's HHS and Public Safety meeting, April, and for making it available on Zoom. I appreciated the chance to hear so many public officials weigh in on the crisis our city is facing with regard to homeless encampments. However, I admit to feeling discouraged upon hearing of no new plans. Is allowing the unhoused to camp wherever they wish on public lands, including our city parks, without services and sanitation really the best we can do?

I understand the constraints imposed by the Ninth Circuit court case. Other communities, however, have been able to develop programs that provide safe, supportive, temporary housing that preclude tents from being set up all over town. Here are links to two such programs in northern climates that could serve as models for Portland.

https://www.missoulacounty.us/government/administration/commissioners-office/temporary-safe-outdoor-space

https://westernusa.salvationarmy.org/intermountain_us_west/news/safe-outdoor-spaces-more-than-a-bed-in-a-tent-for-denver-areas-unhoused/

I believe there's enough land available adjoining the new shelter on Riverside Drive to accommodate our own version of secure, temporary housing where campers would register and become eligible for appropriate services. Can we afford such a plan? How can we not? Think of the hidden costs involved in what we're doing now, with park personnel spending 40-60% of their time cleaning up campsites and who knows how much time on the part of police officers, public works employees and various outreach workers addressing the problems, with no apparent solutions in sight.

In addition, beyond financial costs, there's the need for dignity, to which you referred at the meeting. I would suggest that need applies not just to the unhoused but to all who are touched by the current crisis...the workers cleaning up human feces, needles and other drug paraphernalia along with general trash; public safety personnel doing their best to keep the peace; public health workers trying to address mental health and medical needs; and, yes, residents like myself who simply would like safe access to city parks and other public spaces. We all deserve to live and work with dignity.

It seems high time for a city-wide conversation about these issues. It would be great if the HHS Committee could partner with, perhaps, the public library and/or neighborhood associations and even state government to organize a symposium that would address not only the problems inherent in the current housing crisis but also possible solutions. Could the HHS Committee help to coordinate such a program? Thank you. Jo Coyne

Jo Coyne
36 Salem Street
Portland ME 04102
207.775.3902
jocoyne@gwi.net

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convenientMD

QA: Portland Landscape
Clinic Concerns

April, 2023

Agenda

1. **Portland Landscape**
   - Increased safety issues
   - Local business response

2. **State Involvement**
   - Local changes

3. **Clinic Perspective**
   - Incident reports
   - Employee testimonials
   - PD logs (TBD)

4. **Exploring Short Term Tactics**
   - Team education
   - Interventions

5. **Exploring Long Term Tactics**
   - Interventions & next steps

5. **Appendix**
   - Incident report detail (blinded)

Portland Landscape

Increased safety issues

Over the past few years, the Portland community has become increasingly more unsafe at times, leading to safety concerns within ConvenientMD. Over the last several months, more discussion has occurred regarding the safety concerns and disruption of the unhoused community near the clinic. The team has dealt with hostile patients, weapons inside, and violence. The team feels unsafe, not sure what additional steps can be taken, and some are looking to leave the Portland clinic.

- As of May, 2022, Portland was accommodating 1,500 unhoused individuals in shelters, but that closed down in November, 2022.
- As of January 1st, 2023, 80 asylum seekers arrive every week with no room in local shelters
- As of March 1st, 2023, there were approximately 75 unhoused individuals in the community and approximately 35 encampments within 300 feet of ConvenientMD
- The Portland team has been managing hostile patient situations for the past year, routinely. More information to follow regarding the incident report detail
- As of the end of this month, there is a plan to remove the homeless encampments, but there is not a clear picture of where they will be moved to given the lack of available community shelters
- There is no guarantee that removal of the encampments will “solve” this safety concern as there were safety issues prior to the rise in the unhoused population

Portland landscape

Local business response

- Owner of Dunkin Donuts in the shared building is going to relocate due to the challenges
- Landowner is looking to sell the property
- Four longstanding restaurants have closed their business abruptly
- Portland Gastro leaders sent email to surrounding businesses on Marginal Way to come together and go to the town as one group to try and have bigger impact

Local response

There has been several points of contact with state authorities

- Multiple PD calls over the past couple of years
- Ryan Hansen reached out to the Attorney General's office in February, 2023 with no clear path of resolution
- Jen, Sarah and Celina met with the City Manager, Dena Libner , and Government Relations Counsel Tim Walton in April, 2023. has worked with Senator Duson to keep her apprised of the concern at ConvenientMD
    - This meeting was successful and they laid out a plan to vacate the unhoused by the end of April, 2023. There was no confirmation of where the unhoused population would move to.
    - The City Manager has asked us to keep her updated of every incident report submitted
    - As of April 21, 2023, efforts have been made to start the vacating process in line with the expectation set in the above meeting

The Portland team feels unsafe at work

Below depicts the increase in incident reports for Portland in comparison to a close clinic

Portland Incident Reports:
Jan, 2021- April-2023

93 total incidents

- 34 incidents were hostile, drug or weapon related
- 17 drug, 12 hostile, 5 weapon

Proximity between clinics **(7 miles)**

Westbrook Incident Reports:
Jan, 2021- April-2023

- 33 total incidents
- 4 incidents were hostile, drug or weapon related
- 3 drug, 1 hostile

Refer to appendix for incident report detail

Team testimonials

Nurse

"Portland used to be a city that I felt comfortable working in, but not anymore. I have been working in the city for over 15+ years and what we have seen in the past several years has gotten out of hand.
We never know what is going to happen here on a day-to-day basis.
One day may be fine, but the next, we come in to blood and drug paraphernalia and urine outside our front door.
One person urinated on our lab box outside the front door while patients were in the waiting room.
People are seen shooting-up in car door mirrors in our parking lot.
A co-worker just yesterday was sitting on the sidewalk behind our staff entrance and was approached by an individual asking for money. A patient was punched awhile back refusing to give a panhandler money and sought treatment here. These individuals are mentally unstable and/or on drugs/alcohol, and have been aggressive to us staff members.
There was an unknown "gun threat" that had us call the police took this person under custody at gunpoint in our waiting room. This situation is not normal and should not be normal for anyone to have this happen while at their place of employment!
There are countless times and situations that our safety is in jeopardy. These situations used to be few and far between and were not this prevalent and have only escalated since the unhoused population set up tent city out behind our clinic. I do not even feel comfortable sitting outside for a quick lunch break."

-CMD Nurse

PA-C

"It is a well-known fact that nobody leaves at the end of the night on their own. It is standard for us to wait until everyone has finished their task, no matter how long they take, in order to leave as a group due to the unsafe environment out back of clinic.
The other day we opened the doors at 8am to a puddle of blood and used needles on the doorstep. This was cleaned up very carefully by staff members and minutes later a family walked in the door. That could have been very traumatizing, as well as unsafe if we had not noticed. The week before that, a team member needed to clean urine off of the lab box out front.
I personally had multiple patients suffering from housing struggles and behavioral concerns refuse to leave the clinic even when there is no medical care to be administered. I have been on the phone for hours trying to connect these people with resources regarding housing, things that are not related to medicine.
We have no concerns treating unhoused individuals, as we do any other patient, unless the individual creates an unsafe environment. Which happens all too often, to the point it is expected with each shift and that is concerning. All incidences I have encountered involved individuals who personally state they currently live behind the clinic. It poses a risk to staff as well as all others in the clinic at the time.
This shouldn't be a daily concern."

-CMD Physician Assistant

UCT

"While working here at CMD on Marginal way,
I have been punched in the face.
On a daily basis we have armed unhoused and intoxicated individuals in our facility. I have witnessed individuals injecting drugs in our lobby/ door way and bathroom.
They wash their feet in our drinking fountain,
Steal whatever they can get their hands on in our lobby. Trash our lobby and bathroom.
We fear for our safety and our patient's safety on a daily basis."

-CMD Parametic

MA

"I do have concerns for everyone's safety. My fear is that something tragic may happen before we get help improving the situation out back. Please know that my heart goes out to these homeless people, however I do not feel qualified or equipped to manage their needs/ moods. I am fearful of their unpredictability while at work, and leaving after dark at night. Thanks for letting me share this with you without judgement."

-CMD Medical Assistant

Efforts are underway to obtain the PD logs. Those will be received in the next week

Healthstream Education

On April 12th, 2023, we assigned Course: Anger, Rage, and De-Escalation to the Portland team Members. As of April 21st, 2023, approximately 50% of team members completed the course.

ALICE Training

Marie Hall, certified ALICE trainer met with Jen, Ryan and Celina on 4/20 to plan next steps to Deploy training in the Portland clinic. Next steps are as follows:

1) Training will be completed in person in three sessions (2 hours each) by end of May.
2) Research has been completed to begin the process of securing portable, temporary lock solutions within the clinic exam rooms (bully brakes)

Exploring short term response tactics

Police Department Advisement
The Portland PD were called for consultation about handling weapons in the clinic. The team has been reassured that they will be available for management of weapons in the clinic when called

Operational Changes
Consideration of other workflows to limit access to the building and reduce the safety concerns was discussed. In particular, there was discussion of locking the doors or having everyone stay in their cars. Ultimately, it would be more difficult for Medical Receptionists to open doors and there was concern of patient's ability to contact the clinic

Door Chimes
Door chimes have been installed on the front and back doors to better alert the team of incoming people. This was installed recently.

Patient Bathroom Lock
The door is unlocked by the Medical Receptionists with a release button. This is to control inappropriate use of the bathroom by non-patients. This has been installed for several months. There are still lingering issues.

Plexiglass
More durable protective, fixed glass has been installed in the front desk area. The is better secured and hangs to the floor area

Cameras
There is concern to add in, "fake" cameras due to the liability and cameras that blur out faces also create liability challenges and is costly ($72,000 per year). You cannot record someone's face in a HIPAA compliant environment. This was not going to be an option for resolution

Exploring long term response tactics

There has been extensive follow-through done on pricing out security options.

- Non-contracted hourly rate for security 13 hours per day, 363 days per year is $43.34/hour. You can obtain this service within 10 days, but the guard would need to learn about the building, patients, and general throughput (training)
- Long term security would be a one year contract at $146k per year. This would be for 13 hours per day, 363 days per year

Next steps:

- Better understand local state response to take down encampments to determine next steps
- If concerns still present after encampments move, bring stakeholders together to determine if a T1 security presence request is the next step
- Roll out ALICE training

Lead provider noticed several suspicious people behind the building who appeared to be injecting heroin. Lead provider notified MR who then called the local police department to come assess the situation.

Drug activity in the parking lot was reported by a patient that came into the clinic. She states that 2 vehicles were switching doors, and one was seen apparently stuffing the door with possible drugs. This was also witnessed by myself and xxx, RN through the window of triage 2. xxxx also saw a male subject holding a needle. The patient listed in the incident report, left the clinic and entered the vehicle where this activity was taking place. The police were notified, and their plate # was given to the police. Xxxx called the on-call PM to report the incident.

Person was in the waiting room smoking not wearing a mask and was intoxicated. He was not a patient and was asked to leave. On the way out of the building the person turned and punched me in the head. The police where then called.

Patient came into clinic and was extremely disrespectful to MR and clinical staff. Patient made several derogatory comments to nurse and provider after being brought back into a room. Patient was refusing to communicate appropriately with provider. Patient made demands from provider without allowing her to perform an exam. Patient began to yell and provider left the room and requested patient to leave. Patient came into hallway yelling at provider, demanding that she come back into the exam room. PM requested patient to leave as he was acting inappropriately and making employees feel unsafe. Patient demanded corporate phone number and card was given. Patient made several inappropriate comments to patients in the waiting room as he left.

when patient arrived, she was very confrontational with staff. She accused staff of yelling at her and of rolling their eyes at her. Patient presented distraught and with signs of delusion. She threw her id at staff. Patient mentioned that she had recently purchased a gun. As clinical staff came out onto the floor to assess her needs and introduce themselves, she was very rude to clinical staff. After provider introduced themselves, she was yelling at this clinical member and then said, "because the penis didn't make it in my vagina you wont see me?" Clinical staff then disengaged. Patient then said, "Thanks for embarrassing me" and then left. She then returned about twenty minutes later and asked why she could not be seen. She was told that she could not be seen because she was being confrontational. She then accused staff of not seeing her because she had been sexually assaulted. PM called police at this point as she refused to leave. After going outside, this patient slammed her head on the window of her vehicle very hard multiple times. She then drove off before the police arrived.

pt came into the clinic and was incredibly rude to both myself and the MR. When asked to come in to the clinic for his swab he responded that he would at his own leisure. He raised his hand at me when i went to swab him and I asked him to put his hand down. His response was "I'm not going to hurt you". He appeared inebriated at time of visit. I handed him his results instruction paper and asked him if he had questions. He then said he could not find his results paper after I witnessed him put the paper into his back pack. He then pulled out a crumpled paper and I told him he has his paper and he can leave. He then went to the front desk and asked for the instructions sheet. My manager xxxx then asked him to leave.
Staff found needles on the ground next to her car. I tried to enter staff members name above, but it didn't recognize her as an employee.

We called Portland PD this evening at the Portland clinic due to a patient under the influence having a knife on him. He was with two other individuals who were under the influence of drugs as well. All three were asked to leave but were lingering. Police issued a no trespassing order to all three individuals and staff was advised if they show up on site again to hit panic alarm and they will be arrested. Patient with weapon is xxxxx. The other two individuals were never registered. Just a side note, we really should have camera?s outside out building. I will send a follow up email to facilities to request that. This is a major safety concern due to our specific location in the city.

Patient arrived at Portland clinic. Checked in and brought to exam room immediately where she had a black eye, face all scratched up, and she was not very aware of what was going on. Clinical staff triaged her and came to the conclusion she was under the influence of Heroin and Meth. When patient came to, she openly admitted she had just used. We stated due to her condition we were going to call 911. Patient jumped off table and said F* this and left clinic. Staff was unable to have her sign AMA paperwork. Patient left and came back into the clinic multiple times to sit down and nod off, then would get back up and leave. After speaking to my DO and asking her multiple times to leave, we decided to call Portland PD to have her removed. Staff advised to hit panic button if patient enters clinic again.

PT is not allowed on property. PT came in without a mask. MR's let them know there was nothing we could do to assist them today. On PT's way out they were swearing talking about how MMC abuses her and other random things. PT left property.

Per email from xxxx ack of incidents in and around the clinic. We just had a guy who appears to be homeless and clearly on opiates. He was frozen in place bent over in half right in front of our doors. I went out and asked if he was okay and he moved on a little to the side of the building. The husband of a pt. who was waiting in the car actually, went out and screamed at the guy to "get the F*** outta here." The person finally kept moving further down the road. It's been an exciting day watching the locals outside the clinic." My email to xxxx on "Hi xxxxi! I don?t think xxxxi filled out an incident report for this, so I wanted to pass it along. We are being overrun by the homeless population here. Unfortunately we had to call again this morning because a woman was having intercourse on the lawn across the street and then went #2 on the lawn after. I also picked up 25 needles off the lawn out back last week. Thank you for keeping a pulse on all the fun things that happen here. I hope you had a nice weekend!

patient was dropped off by 2 adults at registration and was given wheelchair. Patient C/O having the same symptoms as she had 5 days ago and needing to be seen. Patient asked to speak to a nurse. I () met with patient who stated she was in really bad pain xxxx needed to be seen soon. I advised her she would be seen shortly. When I returned to waiting room about 15 min. later the patient was sitting in lobby booth with wheelchair in front of her. Her head was down (chin touching chest) and she did not respond to verbal stimulus initially but did on second attempt although her eyes opened only briefly and she did not respond verbally other than with unintelligible speech. I Asked co-worker xxxx for help getting patient into wheelchair and we placed her in exam room 9. I did rapid assessment on patient and notified xxxx of the patient assessment and advised him that i believed patient was a possible overdose patient and that I believed we should check the patients blood sugar and start an Iv and he agreed. xxxx assessed the patient and stated he concurred that patient was a likely overdose and needed transport via ambulance to hospital. I notified the front desk to call 911 and finished placing IV and Medcu ambulance arrived and patient received 2 mg Narcan prior to the ambulance taking patient to MMC. Patient did become somewhat verbal and more responsive post Narcan and was able to keep eyes open and independently move extremities.

I hope you had a fabulous weekend. Because you are working on the bathroom lockdown situation it was brought to my attention that I should let you know about the situation yesterday which may or may not help you get it faster. lol While I was checking in patients a homeless man wiggled into the bathroom. When I had a moment of down time I noticed him leaving so I went to clean the bathroom. A sink covered in blood and blunt were left. While I was cleaning the sink, I didn't think that I needed to lock the door but he came back in the bathroom abruptly while I was in their, apologized and quickly grabbed the blunt and ran out the door. I am fine but was told you should know about it.

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It appears a domestic violence situation outside spilled into the clinic. An intoxicated man and a woman came into the clinic shoving and fighting. Another patient thought she heard something about a gun and asked registration staff for paper. She wrote "possible gun threat not sure" registration passed the note to us and said call 911. We pushed the panic button and we called 911 to provide a description of the man who was reported to have a gun and give updates as to what was happening. We cleared the waiting room of patients and registration staff, we sheltered in place patients already here. We provided water to the people sheltering in P2 and tried to provide updates. We didn't want to evacuate them as their cars were parked right outside of the lobby and we were concerned that they could be injured if shooting occurred. I went outside to the front doors to try and prevent more people from coming in as we cleared the waiting room and while moving patients more came in. As I approached the front door Portland PD arrived and came in with their assault rifles shouting put your hands up and get down. Once the person was in custody we provided PPD with the witnesses and people involved in the incident. The woman involved was in the bathroom flushing multiple times, I think she was trying to get rid of drugs or something. The police department was here for about 2 hours after the incident interviewing the woman involved. The man in custody was removed by Portland PD .

Pt. was using heroin outside the clinic and had an OD. Her friend gave her 8 mg of narcan and when she woke up she stumbled into the clinic and stated she just OD'd and was given narcan outside. Pt. was brought to room 9 where we started caring for her. I asked her where her dirty needles were so we didn't get stuck and she stated in her backpack. As she was moving around on the stretcher I saw the handle of the knife and grabbed it off her person. It was a 12 inch kitchen knife, she states she carries it because she is homeless and she has been beaten and raped living on the streets. I want to make sure everyone understands she did not threaten us, in fact she was cooperative, honest and compliant with our requests. I just wanted it noted that there was a unhoused person using heroin outside our clinic who then brought a 12 inch knife into our treatment room.

A patient came in the clinic on Sunday and told the MRs that someone was unconscious under their car and they asked us to call the cops. I went out to the parking lot and found the man laying under her car. He was not unconscious, but he was clearly on some drugs. I asked him what he was doing and he said "this is my moms car" - I replied it was not his moms car, it was this patients and she needed to leave. He got up and left no problem. A few minutes later we saw the man in front of the clinic about to get hit by a car because he was stumbling in the middle of Marginal Way. We called the cops to have them check on him, when he saw them coming he ran.

Woman entered the clinic very obviously altered by Heroin. Asked to use the bathroom, when request was denied she demanded tissues. Staff gave her a few tissues, she took them and went into the vestibule. She got down on her knees and started to empty her backpack out on the floor. Peter and I walked out to ask her to please leave. Her needles and heroin bags dumped out on the floor. She was planning to inject. We told her she needed to leave immediately. She gathered her things back in her hands and stumbled out the door. Clinic was disinfected.

Someone walked by the clinic and urinated on the outside PCR lab box. Several patients in the waiting room witnessed it. After it happened and the person walked away. I heard about it later so I notified xxxx who advised we fill out the incident report.

Went to leave to go home for the day. Left building and saw a homeless man leaning on my car using my passenger side mirror to inject drugs into his neck.

Unknown gentleman, appeared homeless due to appearance, came in with no mask and another person. Ran over to the waiting room bathroom began pulling on the door. As they were pulling on the door they began to yell at reception "I need to use the bathroom, it is an emergency, I need to take a shit". Receptionist was with a patient, registering them, and asked the gentleman if they were planning on being seen. They stated that they were, but needed the bathroom first. Reception stated that we would have to let them in after registration is complete but that they need to wait until they were finished with the person that came in first. Xxxx and xxxx I team member came around as the gentleman continued to yell saying they need to use the bathroom immediately and that they would check in after. Staff told gentleman that we do not have a public bathroom therefore we need to complete registration then have them use the restroom out back. The gentleman was continuing to increase volume and was not easily redirected with the answers provided by staff. Staff had suggested that gentleman try Dunkin as they usually do have a public restroom. The gentleman stated they would not let them use it either, and continued to try and have us let him in. The gentleman ended up giving up and left the building and walked over to Dunkin.

Patient came in to have her hand looked at. Patient seemed "normal" and asked if she could use the restroom. We said we didn't have a public bathroom and she said "so because you have a virtual provider and can't see me here, you won't let me use the bathroom." I made the call to open the bathroom and let her use it. After 27 minutes of trying to get her out of the bathroom, I was finally able to get her to come out. She set her things down in the corner of the waiting room over by the bathroom and started to eat her snack and do her makeup in her mirror. She was rummaging through her things in her bag and mumbling to herself. I asked her twice if there was someone I could call for her to have her brought to another urgent care or MMC to be seen for her hands. She said no. I then asked her two times to please pack her things and move along, she couldn't hang out in the waiting room. She took her time, but packed things up. Upon doing that she pulled a 3 plus foot metal fire poker out of her PANTS and started swinging it around. She kept saying "this will do the trick." Side note- I had my back turned to this woman while she was packing her things up because she kept yelling "can you please turn around and give me some privacy," so I did. While my back was turned she could have killed me in 2 seconds with that fire poker. Direct strike to my head while my back was turned. She then started to leave the clinic, as she was leaving she stole our hand sanitizer bottle, I was not going to chase her for that. Directly after that, I came across the 'group' out back here took an ax, and chopped the lock off the fence around our dumpster and there was about 12 plus of them digging through the dumpster and throwing trash everywhere. There were two of them even having intercourse inside the fence area. PD was called to address both issues. Woman with the fire poker living out back in the third tent in from the left. When I left the clinic for the evening- she was doing martial arts in the field with it.

convenientMD

QA: Portland Landscape
Clinic Concerns

April, 2023

Agenda

1. **Portland Landscape**
   - Increased safety issues
   - Local business response

2. **State Involvement**
   - Local changes

3. **Clinic Perspective**
   - Incident reports
   - Employee testimonials
   - PD logs (TBD)

4. **Exploring Short Term Tactics**
   - Team education
   - Interventions

5. **Exploring Long Term Tactics**
   - Interventions & next steps

5. **Appendix**
   - Incident report detail (blinded)

Portland Landscape

Increased safety issues

Over the past few years, the Portland community has become increasingly more unsafe at times, leading to safety concerns within ConvenientMD. Over the last several months, more discussion has occurred regarding the safety concerns and disruption of the unhoused community near the clinic. The team has dealt with hostile patients, weapons inside, and violence. The team feels unsafe, not sure what additional steps can be taken, and some are looking to leave the Portland clinic.

- As of May, 2022, Portland was accommodating 1,500 unhoused individuals in shelters, but that closed down in November, 2022.
- As of January 1st, 2023, 80 asylum seekers arrive every week with no room in local shelters
- As of March 1st, 2023, there were approximately 75 unhoused individuals in the community and approximately 35 encampments within 300 feet of ConvenientMD
- The Portland team has been managing hostile patient situations for the past year, routinely. More information to follow regarding the incident report detail
- As of the end of this month, there is a plan to remove the homeless encampments, but there is not a clear picture of where they will be moved to given the lack of available community shelters
- There is no guarantee that removal of the encampments will “solve” this safety concern as there were safety issues prior to the rise in the unhoused population

Portland landscape

Local business response

- Owner of Dunkin Donuts in the shared building is going to relocate due to the challenges
- Landowner is looking to sell the property
- Four longstanding restaurants have closed their business abruptly
- Portland Gastro leaders sent email to surrounding businesses on Marginal Way to come together and go to the town as one group to try and have bigger impact

Local response

There has been several points of contact with state authorities

- Multiple PD calls over the past couple of years
- Ryan Hansen reached out to the Attorney General's office in February, 2023 with no clear path of resolution
- Jen, Sarah and Celina met with the City Manager, Dena Libner, and Government Relations Counsel Tim Walton in April, 2023. has worked with Senator Duson to keep her apprised of the concern at ConvenientMD
    - This meeting was successful and they laid out a plan to vacate the unhoused by the end of April, 2023. There was no confirmation of where the unhoused population would move to.
    - The City Manager has asked us to keep her updated of every incident report submitted
    - As of April 21, 2023, efforts have been made to start the vacating process in line with the expectation set in the above meeting

The Portland team feels unsafe at work

Below depicts the increase in incident reports for Portland in comparison to a close clinic

Portland Incident Reports:
Jan, 2021- April-2023

93 total incidents

- 34 incidents were hostile, drug or weapon related
- 17 drug, 12 hostile, 5 weapon

***Proximity between clinics* (7 miles)**

Westbrook Incident Reports:
Jan, 2021- April-2023

- 33 total incidents
- 4 incidents were hostile, drug or weapon related
- 3 drug, 1 hostile

Refer to appendix for incident report detail

Team testimonials

Nurse

"Portland used to be a city that I felt comfortable working in, but not anymore. I have been working in the city for over 15+ years and what we have seen in the past several years has gotten out of hand.
We never know what is going to happen here on a day-to-day basis.
One day may be fine, but the next, we come in to blood and drug paraphernalia and urine outside our front door.
One person urinated on our lab box outside the front door while patients were in the waiting room.
People are seen shooting-up in car door mirrors in our parking lot.
A co-worker just yesterday was sitting on the sidewalk behind our staff entrance and was approached by an individual asking for money. A patient was punched awhile back refusing to give a panhandler money and sought treatment here. These individuals are mentally unstable and/or on drugs/alcohol, and have been aggressive to us staff members.
There was an unknown "gun threat" that had us call the police took this person under custody at gunpoint in our waiting room. This situation is not normal and should not be normal for anyone to have this happen while at their place of employment!
There are countless times and situations that our safety is in jeopardy. These situations used to be few and far between and were not this prevalent and have only escalated since the unhoused population set up tent city out behind our clinic. I do not even feel comfortable sitting outside for a quick lunch break."

-CMD Nurse

PA-C

"It is a well-known fact that nobody leaves at the end of the night on their own. It is standard for us to wait until everyone has finished their task, no matter how long they take, in order to leave as a group due to the unsafe environment out back of clinic.
The other day we opened the doors at 8am to a puddle of blood and used needles on the doorstep. This was cleaned up very carefully by staff members and minutes later a family walked in the door. That could have been very traumatizing, as well as unsafe if we had not noticed. The week before that, a team member needed to clean urine off of the lab box out front.
I personally had multiple patients suffering from housing struggles and behavioral concerns refuse to leave the clinic even when there is no medical care to be administered. I have been on the phone for hours trying to connect these people with resources regarding housing, things that are not related to medicine.
We have no concerns treating unhoused individuals, as we do any other patient, unless the individual creates an unsafe environment. Which happens all too often, to the point it is expected with each shift and that is concerning.
All incidences I have encountered involved individuals who personally state they currently live behind the clinic.
It poses a risk to staff as well as all others in the clinic at the time.
This shouldn't be a daily concern."

-CMD Physician Assistant

UCT

"While working here at CMD on Marginal way,
I have been punched in the face.
On a daily basis we have armed unhoused and intoxicated individuals in our facility. I have witnessed individuals injecting drugs in our lobby/ door way and bathroom.
They wash their feet in our drinking fountain,
Steal whatever they can get their hands on in our lobby. Trash our lobby and bathroom.
We fear for our safety and our patient's safety on a daily basis."

-CMD Parametic

MA

"I do have concerns for everyone's safety. My fear is that something tragic may happen before we get help improving the situation out back. Please know that my heart goes out to these homeless people, however I do not feel qualified or equipped to manage their needs/ moods. I am fearful of their unpredictability while at work, and leaving after dark at night. Thanks for letting me share this with you without judgement."

-CMD Medical Assistant

Efforts are underway to obtain the PD logs. Those will be received in the next week

Healthstream Education

On April 12th, 2023, we assigned Course: Anger, Rage, and De-Escalation to the Portland team Members. As of April 21st, 2023, approximately 50% of team members completed the course.

ALICE Training

Marie Hall, certified ALICE trainer met with Jen, Ryan and Celina on 4/20 to plan next steps to Deploy training in the Portland clinic. Next steps are as follows:

1) Training will be completed in person in three sessions (2 hours each) by end of May.
2) Research has been completed to begin the process of securing portable, temporary lock solutions within the clinic exam rooms (bully brakes)

Exploring short term response tactics

Police Department Advisement
The Portland PD were called for consultation about handling weapons in the clinic. The team has been reassured that they will be available for management of weapons in the clinic when called

Operational Changes
Consideration of other workflows to limit access to the building and reduce the safety concerns was discussed. In particular, there was discussion of locking the doors or having everyone stay in their cars. Ultimately, it would be more difficult for Medical Receptionists to open doors and there was concern of patient's ability to contact the clinic

Door Chimes
Door chimes have been installed on the front and back doors to better alert the team of incoming people. This was installed recently.

Patient Bathroom Lock
The door is unlocked by the Medical Receptionists with a release button. This is to control inappropriate use of the bathroom by non-patients. This has been installed for several months. There are still lingering issues.

Plexiglass
More durable protective, fixed glass has been installed in the front desk area. The is better secured and hangs to the floor area

Cameras
There is concern to add in, "fake" cameras due to the liability and cameras that blur out faces also create liability challenges and is costly ($72,000 per year). You cannot record someone's face in a HIPAA compliant environment. This was not going to be an option for resolution

Exploring long term response tactics

There has been extensive follow-through done on pricing out security options.

- Non-contracted hourly rate for security 13 hours per day, 363 days per year is $43.34/hour. You can obtain this service within 10 days, but the guard would need to learn about the building, patients, and general throughput (training)
- Long term security would be a one year contract at $146k per year. This would be for 13 hours per day, 363 days per year

Next steps:

- Better understand local state response to take down encampments to determine next steps
- If concerns still present after encampments move, bring stakeholders together to determine if a T1 security presence request is the next step
- Roll out ALICE training

Lead provider noticed several suspicious people behind the building who appeared to be injecting heroin. Lead provider notified MR who then called the local police department to come assess the situation.

Drug activity in the parking lot was reported by a patient that came into the clinic. She states that 2 vehicles were switching doors, and one was seen apparently stuffing the door with possible drugs. This was also witnessed by myself and xxx, RN through the window of triage 2. xxxx also saw a male subject holding a needle. The patient listed in the incident report, left the clinic and entered the vehicle where this activity was taking place. The police were notified, and their plate # was given to the police. Xxxx called the on-call PM to report the incident.

Person was in the waiting room smoking not wearing a mask and was intoxicated. He was not a patient and was asked to leave. On the way out of the building the person turned and punched me in the head. The police where then called.

Patient came into clinic and was extremely disrespectful to MR and clinical staff. Patient made several derogatory comments to nurse and provider after being brought back into a room. Patient was refusing to communicate appropriately with provider. Patient made demands from provider without allowing her to perform an exam. Patient began to yell and provider left the room and requested patient to leave. Patient came into hallway yelling at provider, demanding that she come back into the exam room. PM requested patient to leave as he was acting inappropriately and making employees feel unsafe. Patient demanded corporate phone number and card was given. Patient made several inappropriate comments to patients in the waiting room as he left.

when patient arrived, she was very confrontational with staff. She accused staff of yelling at her and of rolling their eyes at her. Patient presented distraught and with signs of delusion. She threw her id at staff. Patient mentioned that she had recently purchased a gun. As clinical staff came out onto the floor to assess her needs and introduce themselves, she was very rude to clinical staff. After provider introduced themselves, she was yelling at this clinical member and then said, "because the penis didn't make it in my vagina you wont see me?" Clinical staff then disengaged. Patient then said, "Thanks for embarrassing me" and then left. She then returned about twenty minutes later and asked why she could not be seen. She was told that she could not be seen because she was being confrontational. She then accused staff of not seeing her because she had been sexually assaulted. PM called police at this point as she refused to leave. After going outside, this patient slammed her head on the window of her vehicle very hard multiple times. She then drove off before the police arrived.

pt came into the clinic and was incredibly rude to both myself and the MR. When asked to come in to the clinic for his swab he responded that he would at his own leisure. He raised his hand at me when i went to swab him and I asked him to put his hand down. His response was "I'm not going to hurt you". He appeared inebriated at time of visit. I handed him his results instruction paper and asked him if he had questions. He then said he could not find his results paper after I witnessed him put the paper into his back pack. He then pulled out a crumpled paper and I told him he has his paper and he can leave. He then went to the front desk and asked for the instructions sheet. My manager xxxx then asked him to leave.
Staff found needles on the ground next to her car. I tried to enter staff members name above, but it didn't recognize her as an employee.

We called Portland PD this evening at the Portland clinic due to a patient under the influence having a knife on him. He was with two other individuals who were under the influence of drugs as well. All three were asked to leave but were lingering. Police issued a no trespassing order to all three individuals and staff was advised if they show up on site again to hit panic alarm and they will be arrested. Patient with weapon is xxxxx. The other two individuals were never registered. Just a side note, we really should have camera?s outside out building. I will send a follow up email to facilities to request that. This is a major safety concern due to our specific location in the city.

Patient arrived at Portland clinic. Checked in and brought to exam room immediately where she had a black eye, face all scratched up, and she was not very aware of what was going on. Clinical staff triaged her and came to the conclusion she was under the influence of Heroin and Meth. When patient came to, she openly admitted she had just used. We stated due to her condition we were going to call 911. Patient jumped off table and said F* this and left clinic. Staff was unable to have her sign AMA paperwork. Patient left and came back into the clinic multiple times to sit down and nod off, then would get back up and leave. After speaking to my DO and asking her multiple times to leave, we decided to call Portland PD to have her removed. Staff advised to hit panic button if patient enters clinic again.

PT is not allowed on property. PT came in without a mask. MR's let them know there was nothing we could do to assist them today. On PT's way out they were swearing talking about how MMC abuses her and other random things. PT left property.

Per email from xxxx ack of incidents in and around the clinic. We just had a guy who appears to be homeless and clearly on opiates. He was frozen in place bent over in half right in front of our doors. I went out and asked if he was okay and he moved on a little to the side of the building. The husband of a pt. who was waiting in the car actually, went out and screamed at the guy to "get the F*** outta here." The person finally kept moving further down the road. It's been an exciting day watching the locals outside the clinic." My email to xxxx on "Hi xxxxi! I don?t think xxxxi filled out an incident report for this, so I wanted to pass it along. We are being overrun by the homeless population here. Unfortunately we had to call again this morning because a woman was having intercourse on the lawn across the street and then went #2 on the lawn after. I also picked up 25 needles off the lawn out back last week. Thank you for keeping a pulse on all the fun things that happen here. I hope you had a nice weekend!

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Someone pulled backdoor open to breakroom and said his friend OD'd in parking lot. Registration called 911 right away and xxxx and I went outside with OD kit and emergency bag. The car was turned off and we pulled an unresponsive male slumped over with agonal respirations 2-4 breaths a minute out of the car. We put him on the ground and gave him 2 mg of nasal Narcan and used BVM with O2 at 15 lpm a minute for rescue breathing. NPA 34 Fr. was placed in his left nare and we then gave a second dose of nasal Narcan 2 mg. His friend stated his name is xxx and he uses "benzos and fentanyl". Track marks of various stages noted to his left AC, no needles or drugs seen by CMD staff. Portland PD arrives and pt. starts to wake up, he sits up and is reassured he is okay. PFD arrives and report given and care transferred. Pt. ambulates to ambulance on his own.-

A man who was walking in the parking lot (not a patient) stopped in and dropped off items he said were sitting in the parking lot. One was a (presumably) used needle in a paper towel, a large ziploc bag filled with lots of empty plastic bags, and a small black purse filled with unused needs and a tourniquet. I told clinical - and Linda came to the front with gloves on. She disposed of the needle and then opened the bag to see its contents.

It appears a domestic violence situation outside spilled into the clinic. An intoxicated man and a woman came into the clinic shoving and fighting. Another patient thought she heard something about a gun and asked registration staff for paper. She wrote "possible gun threat not sure" registration passed the note to us and said call 911. We pushed the panic button and we called 911 to provide a description of the man who was reported to have a gun and give updates as to what was happening. We cleared the waiting room of patients and registration staff, we sheltered in place patients already here. We provided water to the people sheltering in P2 and tried to provide updates. We didn't want to evacuate them as their cars were parked right outside of the lobby and we were concerned that they could be injured if shooting occurred. I went outside to the front doors to try and prevent more people from coming in as we cleared the waiting room and while moving patients more came in. As I approached the front door Portland PD arrived and came in with their assault rifles shouting put your hands up and get down. Once the person was in custody we provided PPD with the witnesses and people involved in the incident. The woman involved was in the bathroom flushing multiple times, I think she was trying to get rid of drugs or something. The police department was here for about 2 hours after the incident interviewing the woman involved. The man in custody was removed by Portland PD .

Pt. was using heroin outside the clinic and had an OD. Her friend gave her 8 mg of narcan and when she woke up she stumbled into the clinic and stated she just OD'd and was given narcan outside. Pt. was brought to room 9 where we started caring for her. I asked her where her dirty needles were so we didn't get stuck and she stated in her backpack. As she was moving around on the stretcher I saw the handle of the knife and grabbed it off her person. It was a 12 inch kitchen knife, she states she carries it because she is homeless and she has been beaten and raped living on the streets. I want to make sure everyone understands she did not threaten us, in fact she was cooperative, honest and compliant with our requests. I just wanted it noted that there was a unhoused person using heroin outside our clinic who then brought a 12 inch knife into our treatment room.

A patient came in the clinic on Sunday and told the MRs that someone was unconscious under their car and they asked us to call the cops. I went out to the parking lot and found the man laying under her car. He was not unconscious, but he was clearly on some drugs. I asked him what he was doing and he said "this is my moms car" - I replied it was not his moms car, it was this patients and she needed to leave. He got up and left no problem. A few minutes later we saw the man in front of the clinic about to get hit by a car because he was stumbling in the middle of Marginal Way. We called the cops to have them check on him, when he saw them coming he ran.

Woman entered the clinic very obviously altered by Heroin. Asked to use the bathroom, when request was denied she demanded tissues. Staff gave her a few tissues, she took them and went into the vestibule. She got down on her knees and started to empty her backpack out on the floor. Peter and I walked out to ask her to please leave. Her needles and heroin bags dumped out on the floor. She was planning to inject. We told her she needed to leave immediately. She gathered her things back in her hands and stumbled out the door. Clinic was disinfected.

Someone walked by the clinic and urinated on the outside PCR lab box. Several patients in the waiting room witnessed it. After it happened and the person walked away. I heard about it later so I notified xxxx who advised we fill out the incident report.

Went to leave to go home for the day. Left building and saw a homeless man leaning on my car using my passenger side mirror to inject drugs into his neck.

Unknown gentleman, appeared homeless due to appearance, came in with no mask and another person. Ran over to the waiting room bathroom began pulling on the door. As they were pulling on the door they began to yell at reception "I need to use the bathroom, it is an emergency, I need to take a shit". Receptionist was with a patient, registering them, and asked the gentleman if they were planning on being seen. They stated that they were, but needed the bathroom first. Reception stated that we would have to let them in after registration is complete but that they need to wait until they were finished with the person that came in first. Xxxx and xxxx I team member came around as the gentleman continued to yell saying they need to use the bathroom immediately and that they would check in after. Staff told gentleman that we do not have a public bathroom therefore we need to complete registration then have them use the restroom out back. The gentleman was continuing to increase volume and was not easily redirected with the answers provided by staff. Staff had suggested that gentleman try Dunkin as they usually do have a public restroom. The gentleman stated they would not let them use it either, and continued to try and have us let him in. The gentleman ended up giving up and left the building and walked over to Dunkin.

Patient came in to have her hand looked at. Patient seemed "normal" and asked if she could use the restroom. We said we didn't have a public bathroom and she said "so because you have a virtual provider and can't see me here, you won't let me use the bathroom." I made the call to open the bathroom and let her use it. After 27 minutes of trying to get her out of the bathroom, I was finally able to get her to come out. She set her things down in the corner of the waiting room over by the bathroom and started to eat her snack and do her makeup in her mirror. She was rummaging through her things in her bag and mumbling to herself. I asked her twice if there was someone I could call for her to have her brought to another urgent care or MMC to be seen for her hands. She said no. I then asked her two times to please pack her things and move along, she couldn't hang out in the waiting room. She took her time, but packed things up. Upon doing that she pulled a 3 plus foot metal fire poker out of her PANTS and started swinging it around. She kept saying "this will do the trick." Side note- I had my back turned to this woman while she was packing her things up because she kept yelling "can you please turn around and give me some privacy," so I did. While my back was turned she could have killed me in 2 seconds with that fire poker. Direct strike to my head while my back was turned. She then started to leave the clinic, as she was leaving she stole our hand sanitizer bottle, I was not going to chase her for that. Directly after that, I came across the 'group' out back here took an ax, and chopped the lock off the fence around our dumpster and there was about 12 plus of them digging through the dumpster and throwing trash everywhere. There were two of them even having intercourse inside the fence area. PD was called to address both issues. Woman with the fire poker living out back in the third tent in from the left. When I left the clinic for the evening- she was doing martial arts in the field with it.

May 2018

Caution is Needed When Considering "Sanctioned Encampments" or "Safe Zones"

In their 2017 Point-in-Time counts, some communities reported significant increases in the number of people experiencing homelessness. These increases were driven primarily by increases in the number of individuals (people in households without children) who are unsheltered—living and sleeping outside, in tents, in parks, in cars or RVs, in encampments, or in other places not meant for human habitation. These increases were seen largely in communities facing significant challenges within their rental markets—rapidly increasing rents, competition for units, and a limited supply of housing that people can afford.

Addressing the needs of people experiencing unsheltered homelessness is an issue that often generates contentious, emotional debates across communities. It requires urgent action. Understandably, leaders and housing and services providers within such communities want to find ways to address both the immediate safety and living conditions of the people who are unsheltered and the concerns of other community members.

As we respond to the crisis of unsheltered homelessness, we must not repeat past mistakes of focusing only on where people will be tonight. We must simultaneously be focused on where people can succeed in the long term—and we know that is permanent housing.

Executive Director Matthew Doherty
Housing First Partners Conference
April 10, 2018

In response, some communities have created, or are considering creating "sanctioned encampments," "safe zones," or other similar settings with a goal of helping people stay in a safer and more sanitary environment, without the risk of being arrested or cited. Sometimes these settings feature sheds or other structures, or provide areas for people to stay in their cars or RVs. Others simply provide places for people to sleep in their own tents or on mats. Some communities have created these environments as a voluntary option for people living in unsafe situations. In other cases, people living outside may be compelled to move to the designated locations through the threat of citation or arrest. Before communities make the decision to create such environments, it is important to weigh the costs and consequences of that action, and the impact on the community's systemic efforts to end homelessness.

If your community is exploring this step, here are a few cautions we think you should consider and discuss:

- **Creating these environments may make it look and feel like the community is taking action to end homelessness on the surface—but, by themselves, they have little impact on reducing homelessness.** Ultimately, access to stable housing that people can afford, with the right level of services to help them succeed, is what ends homelessness. People staying within such settings are still unsheltered, still living

outside, and remain homelessness – and oftentimes, these settings are not providing them with a truly safe, healthy, and secure environment. It is also important to note that the intended target population may not decide to enter these settings. Additionally, if there is not adequate planning and resources devoted to help people exit these settings on a path out of homelessness, creating these settings alone does not reduce homelessness in communities.

Ultimately, access to stable housing that people can afford—with the right level of services to help them succeed—is what ends homelessness.

- **Creating these environments can be costly in money, staff time, and effort.** Creating and then operating such settings typically requires significant funding, energy, and staff time from both public and private agencies devoted to locating and arranging for the use of sites, educating and engaging neighbors, addressing any permitting requirements, providing a secure and hygienic environment, setting up and maintaining any structures, providing adequate services and supports, and many other planning and operational details. It is critically important to discuss the opportunity costs of pursuing these efforts, and whether critical resources would be better focused on other strategic activities—or used directly for permanent housing and services interventions—that could have a greater impact on ending people's homelessness.

- **These environments can prove difficult to manage and maintain.** For example, communities often find that temporary sheds (which are sometimes referred to as "tiny homes") or other structures that may have been put up in these settings do not hold up over time and require significant upgrades and/or repairs. Maintaining a hygienic environment can prove challenging if there are not adequate sanitation facilities at the sites. And there often need to be significant investments into security to be able to ensure the safety and well-being of people staying in these settings, as many people may be vulnerable to victimization and such communities can become targets for illegal activities, such as drug sales and human trafficking.

- **Although often proposed as "temporary" approaches, these programs prove difficult to close once they open.** While a community may intend for these settings to be a temporary part of its response to homelessness, they can prove difficult to close, especially if there are not adequate plans and resources dedicated to helping people exit these settings and end their homelessness.

If your community does decide to proceed despite these cautions, we'd suggest you also discuss the following:

- **Are we doing all we can within our existing emergency shelter programs, and can we also create more effective indoor shelter or crisis housing options, if needed?** These outdoor environments should not take the place of suitable indoor emergency shelter and other crisis housing options, which can be provided in a variety of settings, from designated facilities, to hotels and motels, to new and existing housing units, and many others. Many communities are transforming their current shelter systems or creating additional safer, low-barrier indoor shelter spaces where people can come inside "as they are" and access services.

  Communities have removed barriers to entry, including by accepting diverse household compositions, staying open 24/7 or for extended hours, welcoming people with behavioral health care needs, providing for secure storage of belongings, and allowing for pets. In addition, communities are focused on increasing their capacity

to directly link individuals in emergency shelter or other crisis housing options to resources and services that help them to move out of homelessness.

For most communities, improving the existing shelter system can address the needs of people sleeping unsheltered and in encampments. Similarly, providing more housing options for people in shelters can help people exit more quickly and expand the number of people a shelter can serve over time. When creating new shelter and crisis housing capacity, communities are also purposefully using sites that can be used in the future for other purposes, such as conversion to permanent housing.

- **Are we planning and budgeting for how people staying in these settings will be able to exit homelessness and access permanent housing?** The creation of these environments is often pursued with urgency, but the planning is sometimes too rushed and the alignment of the services and housing solutions that will be necessary to help people exit is often thought of as something that can be addressed later. If these settings are to play any meaningful role in ending people's homelessness, it is vitally important to ensure that people staying in them will have ready access to the services necessary to address their needs and to exit homelessness. Planning and adequately budgeting for people's permanent housing outcomes should be central from the very first conversations and at every stage of the planning processes. That budgeting should include costs aligned with the number of successful exits being pursued. For example, if every "slot" or "space" is intended to turn over through successful exits every 60 days, has planning and budgeting addressed how 6 such successful exits per "slot" or "space" will be achieved?

- **Are we aiming as high as we can in providing a high-quality environment within these temporary settings?** Families and individuals experiencing the crisis of unsheltered homelessness deserve access to decent, high-quality places to stay as they create their paths out of homelessness. The creation of poor quality environments can reinforce negative perceptions about what people experiencing homelessness need or deserve as living environments. In many cases, the planning for these settings in communities does not seem to have been thoughtful enough about the quality of the environment they are providing; sometimes even basic safety or health issues, such as ventilation or heat, have not been planned for. There should be close consultation with public health officials to be sure land being used is not contaminated, that essential health, hygiene, and safety needs are being met, and that further public health problems are not being created. It is also essential to discuss whether the settings being planned will provide an environment for the target population—which sometimes includes pregnant women and children—that is aligned with your community's values and expectations. *For example:* Within your community's systemic response to homelessness, is it acceptable for infants and small children to be sleeping in tents or in sheds tonight?

Families and individuals experiencing the crisis of unsheltered homelessness deserve access to decent, high-quality places to stay as they create their paths out of homelessness.

- **Are we assessing the outcomes, impact, and cost-effectiveness of these efforts?** Programs being operated in such settings should be integrated into the community's existing Homeless Management Information System

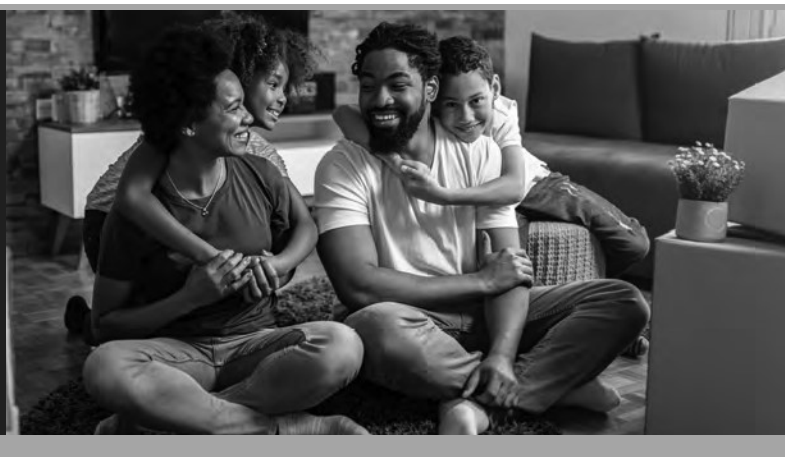
and performance measurement processes. The outcomes being achieved—including a primary emphasis on the outcome of exits from homelessness—should be carefully measured and monitored. The community should assess whether the investment of costs—including all planning, capital, operations, services, and housing placement assistance costs—is proving to be a cost-effective investment in comparison with other actual or potential strategies and programs.

At USICH, and with our federal and national partners, we will continue to work with communities that are grappling with these challenges and connect them to peers in other communities to learn from each other. We will also continue to develop and provide more guidance regarding effective responses to these challenges. Contact your USICH Regional Coordinator if you need help thinking through these issues.

As you consider these cautions and concerns and engage in discussions, here are some USICH resources that may be helpful:

- Ten Strategies to End Chronic Homelessness
- Ending Homelessness for People Living in Encampments
- Case Studies on: Ending Homelessness for People Living in Encampments
- The Role of Outreach and Engagement in Ending Homelessness
- Key Considerations for Implementing Emergency Shelter Within an Effective Crisis Response System
- Asking the Right Questions about Tiny Houses
- Strategies to Address the Intersection Between the Opioid Crisis and Homelessness
- Resources for Building an Effective Crisis Response System
- The Housing First Checklist: Assessing Projects and Systems for Housing First Orientation

Executive Summary



After steady declines from 2010 to 2016, **homelessness in America has been rising**, and more individuals are experiencing it in unsheltered settings, such as encampments. This increase stems from decades of growing economic inequality exacerbated by a global pandemic, soaring housing costs, and housing supply shortfalls. It is further exacerbated by inequitable access to health care, including mental health and/or substance use disorder treatment; discrimination and exclusion of people of color, LGBTQI+ people, people with disabilities and older adults; as well as the consequences of mass incarceration. As our nation faces the growing threats of climate change, more Americans are being displaced from their homes and people experiencing unsheltered homelessness face even greater risk to their health and safety as a result of climate-related crises like wildfires, floods, and hurricanes. Even as homelessness response systems are helping more people than ever exit homelessness, more people are entering or reentering homelessness.

Homelessness has no place in America. *All In: The Federal Strategic Plan to Prevent and End Homelessness* (herein referred to as *All In)* is a multi-year, interagency blueprint for **a future where no one experiences homelessness, and everyone has a safe, stable, accessible, and affordable home.** It serves as a roadmap for federal action to ensure state and local communities have sufficient resources and guidance to build the effective, lasting systems required to end homelessness. While it is a federal plan, local communities can use it to collaboratively develop local and systems-level plans for preventing and ending homelessness. To reach the Biden-Harris Administration's vision, the plan sets an **ambitious interim goal to reduce homelessness by 25% by January 2025** and sets us on a path to end homelessness for all Americans.

To develop this plan, USICH undertook a **comprehensive and inclusive process** to gather input from a broad range of perspectives. Through more than 80 listening sessions and 1,500 public comments, USICH received feedback

Within this plan, USICH is using the term "people of color" to be inclusive[4] of all racial groups other than non-Hispanic white, including Black/African American; American Indian/Alaska Native; Asian/Asian American; Latino/a; and; Native Hawaiian or Pacific Islander. USICH acknowledges that the experiences of each of these groups is not the same and that the needs of each group must be uniquely considered and addressed upon implementation. For more information on terms used in this plan, see the Appendix C on Pages 88-95.

from organizations and people—including **more than 500 who have experienced homelessness—** who represent **nearly 650 communities** across nearly every state as well as tribes and territories. All of this input directly influenced *All In,* which was **created by USICH with collective thinking** of the 19 federal agencies that make up the council.

Although *All In* builds off former federal strategic plans to prevent and end homelessness, it is reflective of the Biden-Harris Administration's priorities. It goes further than any prior USICH federal strategic plan to **comprehensively advance equity and to address systemic racism** and the ways in which federal policies and practices have resulted in severe racial and other disparities in homelessness. While other plans have mentioned homelessness prevention, this plan includes specific strategies focused on **upstream prevention**. And *All In* aligns with the administration's existing work to transform social service systems—including the National Mental Health[5] and National Drug Control[6] strategies. This plan also builds upon the national Housing Supply Action Plan[7] that seeks to close the housing supply gap in the next five years.

How *All In: The Federal Strategic Plan* (FSP) Aligns With Other Biden-Harris Administration Work

Housing Supply Action Plan Legislative and administrative actions to close the housing supply shortfall	**National Mental Health Strategy** A vision to transform how mental health is understood and treated	**National Drug Control Strategy** A whole-of-government call to action to combat overdose epidemic
FSP identifies ways to reform zoning and land-use policies and to reduce regulatory barriers. **See Housing & Supports Strategy 2:** Expand engagement, resources, and incentives for the creation of new supportive and affordable housing.	FSP pilots new approaches, expands pipeline of providers, and invests in peer support models. **See Housing & Supports Strategy 6:** Strengthen system capacity to address and meet the needs of people with chronic health conditions, including mental health conditions and/or substance use disorders.	FSP focuses on high-impact harm-reduction interventions. **See Housing & Supports Strategies 6 and 7:** Maximize current resources that can provide voluntary and trauma-informed supportive services and income supports to people experiencing or at risk of homelessness.

Ending homelessness requires an **all-hands-on-deck response** grounded in authentic collaboration. Upon release of this plan, USICH will immediately begin working with federal partners as well as local and state entities in the public and private sectors to **develop implementation plans** that will identify key activities, milestones, and metrics for making, tracking, and publicizing progress. USICH will regularly measure progress and update the implementation plans. The plan itself, *All In,* will be annually updated to reflect evolving evidence, input, and lessons.

This plan is built around three foundational pillars—**equity, data, and collaboration**—and three solution pillars—**housing and supports, homelessness response, and prevention**. Each pillar includes strategies the federal government will pursue to facilitate increased availability of and access to housing, economic security, health care, and stability for all Americans.

Summary of *All In: The Federal Strategic Plan to Prevent and End Homelessness*

FOUNDATION PILLARS

Lead With Equity

Strategies to address racial and other disparities among people experiencing homelessness:

1. Ensure federal efforts to prevent and end homelessness promote equity and equitable outcomes.
2. Promote inclusive decision-making and authentic collaboration.
3. Increase access to federal housing and homelessness funding for American Indian and Alaska Native communities living on and off tribal lands.
4. Examine and modify federal policies and practices that may have created and perpetuated racial and other disparities among people at risk of or experiencing homelessness.

Use Data and Evidence to Make Decisions

Strategies to ground action in research, quantitative and qualitative data, and the perspectives of people who have experienced homelessness:

1. Strengthen the federal government's capacity to use data and evidence to inform federal policy and funding.
2. Strengthen the capacity of state and local governments, territories, tribes, Native-serving organizations operating off tribal lands, and nonprofits to collect, report, and use data.
3. Create opportunities for innovation and research to build and disseminate evidence for what works.

Collaborate at All Levels

Strategies to break down silos between federal, state, local, tribal, and territorial governments and organizations; public, private, and philanthropic sectors; and people who have experienced homelessness:

1. Promote collaborative leadership at all levels of government and across sectors.
2. Improve information-sharing with public and private organizations at the federal, state, and local level.

SOLUTION PILLARS

Scale Housing and Supports That Meet Demand

Strategies to increase supply of and access to safe, affordable, and accessible housing and tailored supports for people at risk of or experiencing homelessness:

1. Maximize the use of existing federal housing assistance.
2. Expand engagement, resources, and incentives for the creation of new safe, affordable, and accessible housing.
3. Increase the supply and impact of permanent supportive housing for individuals and families with complex service needs—including unaccompanied, pregnant, and parenting youth and young adults.
4. Improve effectiveness of rapid rehousing for individuals and families—including unaccompanied, pregnant, and parenting youth and young adults.
5. Support enforcement of fair housing and combat other forms of housing discrimination that perpetuate disparities in homelessness.
6. Strengthen system capacity to address the needs of people with disabilities and chronic health conditions, including mental health conditions and/or substance use disorders.
7. Maximize current resources that can provide voluntary and trauma-informed supportive services and income supports to people experiencing or at risk of homelessness.
8. Increase the use of practices grounded in evidence in service delivery across all program types.

Improve Effectiveness of Homelessness Response Systems

Strategies to help response systems meet the urgent crisis of homelessness, especially unsheltered homelessness:

1. Spearhead an all-of-government effort to end unsheltered homelessness.
2. Evaluate coordinated entry and provide tools and guidance on effective assessment processes that center equity, remove barriers, streamline access, and divert people from homelessness.
3. Increase availability of and access to emergency shelter—especially non-congregate shelter—and other temporary accommodations.
4. Solidify the relationship between CoCs, public health agencies, and emergency management agencies to improve coordination when future public health emergencies and natural disasters arise.
5. Expand the use of "housing problem-solving" approaches for diversion and rapid exit.
6. Remove and reduce programmatic, regulatory, and other barriers that systematically delay or deny access to housing for households with the highest needs.

Prevent Homelessness

Strategies to reduce the risk of housing instability for households most likely to experience homelessness:

1. Reduce housing instability for households most at risk of experiencing homelessness by increasing availability of and access to meaningful and sustainable employment, education, and other mainstream supportive services, opportunities, and resources.
2. Reduce housing instability for families, youth, and single adults with former involvement with or who are directly exiting from publicly funded institutional systems.
3. Reduce housing instability among older adults and people with disabilities—including people with mental health conditions and/or with substance use disorders—by increasing access to home and community-based services and housing that is affordable, accessible, and integrated.
4. Reduce housing instability for veterans and service members transitioning from military to civilian life.
5. Reduce housing instability for American Indian and Alaska Native communities living on and off tribal lands.
6. Reduce housing instability among youth and young adults.
7. Reduce housing instability among survivors of human trafficking, sexual assault, stalking, and domestic violence, including family and intimate partner violence

U.S. Interagency Council on Homelessness

7 Principles for Addressing Encampments

Purpose

This document provides a set of principles to help communities as they develop and implement their response to encampments.

Background

Communities across the United States face a crisis of unsheltered homelessness and encampments. 2020 marked the first time that more individuals experiencing homelessness were unsheltered than sheltered. The COVID-19 public health crisis has only exacerbated this ongoing emergency, with unsheltered people confronted by a global pandemic on top of daily threats to health and safety. These daily threats take the lives of thousands of people experiencing homelessness each year.

Local decision-makers are caught between demands for swift action and the reality that permanent, sustainable solutions—housing with voluntary supportive services—take time and investment to bring to scale. With rising housing costs and limited resources, elected officials, nonprofit providers, businesses, the faith community, advocates, and people with lived experience often struggle to find common ground and effective solutions. Some communities turn to strategies that use aggressive law enforcement approaches that criminalize homelessness, or they close encampments without offering shelter or housing options. These approaches result in adverse health outcomes, exacerbate racial disparities, and create traumatic stress, loss of identification and belongings, and disconnection from much-needed services. While these efforts may have the short-term effect of clearing an encampment from public view, without connection to adequate shelter, housing, and supportive services, they will not succeed. When people's housing and service needs are left unaddressed, encampments may appear again in another neighborhood or even in the same place they had previously been.

Homelessness is a complex social problem with roots in racial inequities. As communities continue to build political and public will and mobilize the resources necessary to provide housing and services to end homelessness, we must acknowledge that homelessness is a failure of systems, not individuals and that we all have a constructive role to play in addressing it. Addressing encampments and ending unsheltered homelessness will require a system-wide, coordinated effort to promote healthy and safe communities where all can live in dignity.

We know that each community is different, and no one-size-fits-all solution exists. We are, however, beginning to see effective practices emerge from communities that successfully address unsheltered homelessness and move people from encampments into housing and support. Based on these efforts, the principles outlined here are intended to help communities as they develop and implement their responses to encampments. As we come together to create comprehensive, community-wide solutions to encampments, our communities will become safer and more welcoming for all.

Principle 1: Establish a Cross-Agency, Multi-Sector Response to Encampments

Engaging people in encampments requires cross-departmental and community-wide collaboration and coordination. Effective coordination includes all relevant partners and may vary depending on the size of the community:

- City and County officials, including the Mayor, City/County Manager, and other public officials
- The homelessness response system including:
    - Continuum of Care
    - Coordinated Entry
    - Homeless Management Information System (HMIS)
    - Homeless outreach providers, including peer specialists
    - Emergency shelter providers
    - Transitional housing providers
    - Permanent housing providers
- Encampment residents
- Public housing authorities
- Behavioral health departments and community providers
- Public health departments
- Hospital systems
- Health Care for the Homeless projects, federally qualified health centers, and rural health centers
- Parks departments
- Departments of public works
- Departments of transportation
- Emergency management agencies
- School districts and McKinney-Vento liaisons
- Advocacy groups, especially those led by people with lived experience of homelessness
- Neighborhood volunteers and mutual aid groups
- Faith community
- Business community
- Landlords and housing developers

Such collaboration facilitates communication to account for the needs of encampment residents as well as the neighborhood. To this end, some communities have found it helpful to utilize a "command center" approach by establishing daily coordination meetings among all providers, volunteers, and city/county agencies involved with encampment planning and response. This command center approach involves daily updates and "huddles" to ensure continued communication and coordination.

While law enforcement may need to play a role in decommissioning an encampment, law enforcement should not drive the process, but instead, serve as one of many collaborative partners in designing and implementing effective strategies.

Resources:

- Ending Homelessness for People Living in Encampments: Advancing the Dialogue (USICH)
- Effective Police-Mental Health Collaboration Responses to People Experiencing Homelessness (Department of Justice's Bureau of Justice Assistance)

- Sharing the Solutions: Police Partnerships, Homelessness, and Public Health (Department of Justice's Office of Community Oriented Policing Services and The Center for Court Innovation)

Principle 2: Engage Encampment Residents to Develop Solutions

Successful strategies rely on connecting early and often with encampment residents and centering their identified needs. Like with all aspects of an effective homelessness response, engaging with encampments should prominently and meaningfully include elevating the lived expertise of people experiencing unsheltered homelessness. To the extent possible, encampment residents should take part in discussions and decisions related to their living environments.

Encampment residents may choose to identify an encampment spokesperson or liaison to speak on behalf of the group. When an encampment is going to be closed, ample, visible public notice must be given. Encampment closures should occur only after outreach teams have had time to engage with residents to find alternative shelter, housing, and service options.

Resources:

- Engaging Individuals With Lived Expertise (HUD)

Principle 3: Conduct Comprehensive and Coordinated Outreach

The most effective outreach responses connect people directly to shelter and housing, mental health and treatment services, and health care. They are part of an overall coordinated homeless response system, linked by sharing data and information, using a coordinated map to identify coverage and or gaps in outreach across the city/county.

Ideally, outreach is not solely focused on encampment removals but occurs regularly and consistently well before an encampment closure. Multidisciplinary outreach teams can help meet many of the immediate needs of encampment residents while providing connections and resources to support successful transitions into housing. These efforts should coordinate with a broader network of programs, services, or staff who are likely to encounter individuals experiencing unsheltered homelessness. These teams might include peer outreach workers, law enforcement, and other first responders, hospitals, health and behavioral healthcare providers, child welfare agencies, homeless education liaisons, workforce systems, faith-based organizations, and other community-based providers. Approaches that center public health, including deploying alternate response teams, such as mobile crisis teams, Assertive Community Treatment (ACT) teams, or Homeless Outreach Teams (HOT teams), are proven outreach models that help build trust and save lives.

Resources such as street medicine and harm reduction strategies can help meet the health needs of people experiencing unsheltered homelessness, especially those with mental illness and/or substance abuse disorders. Outreach and services should be person-centered, trauma-informed, low-barrier, and voluntary.

Additionally, a coordinated neighborhood-by-neighborhood outreach approach in which teams have ample time to build trusting relationships in specific geographic areas can result in higher acceptance rates for housing, shelter, and services and stronger communication and support from neighbors and businesses.

Resources:

- Core Elements of Effective Street Outreach to People Experiencing Homelessness (USICH)

Principle 4: Address Basic Needs and Provide Storage

Thoughtful, effective strategies to address encampments can take time to implement. While people are still living in encampments, we encourage public restrooms, parks, and other community spaces to remain open and for cities to continue public services such as garbage collection, provision of sharps containers, facility maintenance, and regular cleaning. The COVID-19 pandemic reinforced the urgency of promoting public health for both sheltered and unsheltered individuals and ensuring that all residents have safe and sanitary places to wash their hands and use the restroom.

Providing access to storage for people experiencing unsheltered homelessness is also important. Communities should take special care to avoid destroying personal belongings when an encampment closes and provide storage for an adequate period to allow a person the opportunity to collect their belongings. Fear of losing belongings can be a determining factor in whether a person chooses to move into a shelter or not. When an encampment is closing, or a person chooses to go into a shelter or treatment program that cannot accommodate all of their belongings, providing secure, accessible storage options can ensure that they do not lose personal items, including clothing and identification.

Resources:

- Interim Guidance on People Experiencing Unsheltered Homelessness (Centers for Disease Control and Prevention)
- Protecting Health and Well-being of People in Encampments During an Infectious Disease Outbreak (HUD)
- Infectious Disease Toolkit for Continuums of Care: Preventing & Managing the Spread of Infectious Disease within Encampments (HUD)

Principle 5: Ensure Access to Shelter or Housing Options

Encampments should not be closed unless there is access to low-barrier shelter or housing. Moving encampment residents around without a place to go to will only cause further instability and trauma. The urgency to end homelessness is often stymied by significant barriers to locate or construct permanent affordable housing. Emergency shelters are often full. Community responses to the COVID-19 pandemic tested new models of non-congregate shelter in hotels and motels with success when congregate shelters had to reduce capacity by half. However, in some cases, this was not enough. Communities had to turn to alternative sheltering options, such as “tiny houses,” safe parking lots, and sanctioned encampments or safe sleeping sites. When communities need to deploy these alternative shelter options, they should ensure that they account for personal choice, that they are voluntary, sanitary, safe, and connect people to services and housing. It is important to offer a range of shelter and housing options that meet the needs of an individual or family unit. Across each encampment engagement strategy, planning and budgeting should ultimately focus on the primary goal, which is how people can exit homelessness and move as quickly as possible into permanent housing.

Communities may need to deploy many of these interim solutions as they work to create more permanent affordable housing options. Interim shelter solutions should ensure voluntary, sanitary, and safe shelter with few programmatic requirements to serve all those in need. Interim solutions should include a range of person-centered options, with as

much individual choice as possible, including trauma-informed services and other models based on principles of harm reduction, which keep people alive and create pathways to mental health care, substance use treatment, and housing.

Providing interim solutions should not come at the expense of a community's commitment to developing permanent housing and service solutions but should instead be viewed as a necessary emergency response to the crisis of encampments.

Resources:

- Caution is Needed When Considering "Sanctioned Encampments" or "Safe Zones" (USICH)
- Model Transitions from Non-Congregate Shelter: Joint Recommendations for Assisting People Experiencing Homelessness (FEMA and HUD)
- Exploring Homelessness Among People Living in Encampments and Associated Cost: City Approaches to Encampments and What They Cost (HUD and HHS)

Principle 6: Develop Pathways to Permanent Housing and Supports

To end homelessness for everyone, we must link people experiencing unsheltered homelessness with permanent housing opportunities with the right level of services to ensure that those housing opportunities are stable and successful. When adequate housing options and voluntary wraparound supports are readily available, Housing First strategies have been shown to be effective in ending homelessness for people with complex medical, mental health, and substance use issues. However, the challenge remains that many communities do not have access to enough units or supportive services to scale up this approach. Cities, counties, and states must coordinate their efforts to mobilize available resources—including significant funding from the American Rescue Plan—to move people as quickly as possible from homelessness into housing. Close coordination with their local CoC's Coordinated Entry System (CES) is also important to determine how people in encampments will be prioritized for housing and services.
Whether directly from unsheltered homelessness into permanent housing with supports or through the interim step of dignified shelter, our efforts to address encampments must be focused on providing access to both housing and services to help people stabilize and reconnect with friends and family, and the community.

Resources:

- Case Studies: Ending Homelessness for People Living in Encampments (USICH)
- Planning a Housing Surge to Accelerate Rehousing Efforts in Response to COVID-19 (HUD)
- Housing Surges—Special Considerations for Targeting People Experiencing Unsheltered Homelessness (HUD)

Principle 7: Create a Plan for What Will Happen to Encampment Sites After Closure

Some encampments are in places that are not safe. Encampments located in medians near highways and in spaces that have been identified as hazardous waste sites are not safe, and communities should take measures to secure those locations to keep encampments from returning.

For encampments in public spaces like parks, communities should engage neighborhoods, the faith, business communities, and formerly homeless individuals to reimagine and invest in these public spaces so that all residents can

benefit from their use. Plans for former encampment sites should emphasize safety, accessibility, and inclusivity. Communities can invest in infrastructure improvements in former encampment sites. Examples include curb cuts to increase mobility access and enhanced lighting to encourage safety.

Additionally, communities can facilitate local coordination among public works, service providers, and volunteer organizations to establish coordinated strategies to serve people experiencing homelessness who may continue to use the public space after the encampment is gone.

Resources:

- Crime Prevention through Environmental Design: It's More than Just Lighting (2016 Choice Neighborhoods Conference)
- The Curb-Cut Effect (Stanford Social Innovation Review)
- Coexistence in Public Space: Engagement tools for creating shared spaces in places with homelessness (SPUR and Gehl)

For more guidance:

- Read "Responding to the Growing Crisis of Unsheltered Homelessness and Encampments," a blog by USICH Regional Coordinator Katy Miller.
- Read "What Other Cities Can Learn From Boston's Public Health Approach to Encampments," a blog by HUD Senior Advisor of Housing and Services Richard Cho.
- Subscribe to the USICH newsletter to receive future guidance and resources.
- Contact the USICH regional coordinator for your state.