EXEMPTION REQUEST

Request for exemption to the *Controlled Drugs and Substances Act* to allow for the possession of drugs for personal use in Toronto

Submission to Health Canada

January 4, 2022

TORONTO Public Health

Acknowledgements

We acknowledge that the work we do throughout Toronto takes place on the traditional territory of many nations including the Mississaugas of the Credit, the Anishnabeg, the Chippewa, the Haudenosaunee and the Wendat peoples and is now home to many diverse First Nations, Inuit and Métis peoples. We also acknowledge that Toronto is covered by Treaty 13 with the Mississaugas of the Credit.

The City of Toronto acknowledges all Treaty peoples – including those who came here as settlers – as migrants either in this generation or in generations past – and those of us who came here involuntarily, particularly those brought to these lands as a result of the Trans-Atlantic Slave Trade and Slavery. We pay tribute to those ancestors of African origin and descent.

Toronto Public Health would like to express gratitude for the contributions of the working group members, members of the public, government partners, local organizations, and those who participated in roundtables and interviews who shared their time, experiences, and expertise with us, engaging enthusiastically and in good faith even when perspectives diverged. The recommendations put forth in this submission may not always represent the views of all members.

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A Made-in-Toronto Alternative Approach to Drug Criminalization

The drug poisoning crisis continues to worsen. Recent national data on drug toxicity deaths show that this crisis is Canada-wide. Here in Toronto, deaths involving all substances have increased to record highs and emergency responders continue to respond to an ever-increasing number of fatal suspected overdose calls.

A coordinated public-health focused approach from all levels of government is needed. At the federal level, this includes the Canadian Drugs and Substances Strategy, informed by the work of the Expert Task Force on Substance Use. Provincially, the Roadmap to Wellness envisions an efficient and effective mental health and addictions system, enhanced with investments in services and supports across Ontario. And locally, this includes the Toronto Drug Strategy and Toronto Overdose Action Plan. Combined, these initiatives have the potential to meaningfully change how substance use is addressed and save lives.

There is an urgent need to change drug policy to allow for a public health response to drug use. Decriminalization of the simple possession of all drugs – along with the scale-up of prevention, harm reduction, and treatment services – is an effective way to address the public health and public safety harms associated with substance use. This includes access to a properly regulated safe supply to address the drug poisoning crisis and reduce deaths. These actions to address this crisis, including decriminalization, are critically important as Toronto continues to respond to the homelessness crisis and advance the SafeTO community safety and wellbeing initiative. Substance use needs to be seen as a public health issue and a robust public health response is necessary to effectively combat the drug poisoning crisis.

Criminalization makes it difficult for people who use drugs to access harm reduction services, increasing the risk of injury, disease, and overdose. Even more, criminal records make it hard for people to find a job and a place to live. Canada's current drug laws have resulted in the disproportionate criminalization of Black and Indigenous people. As such, decriminalization is an important and necessary part of a comprehensive approach to the crisis.

This submission contains Toronto Public Health's formal request for an exemption to the *Controlled Drugs and Substances Act* to allow for the possession of drugs for personal use in Toronto. Included in this request for exemption is a Toronto model for an alternative pathway for people who use drugs. Establishing a comprehensive network of health and social supports that are easily accessible, culturally safe, and well-coordinated is an important complement to decriminalization and will meaningfully support the efforts of all levels of government to respond to the crisis.

The Toronto model was informed by a comprehensive consultation process that engaged thousands of Torontonians through interviews, roundtable discussions, and an online questionnaire, as well as an expert working group comprised of people who use drugs, service providers, and other drug policy experts.

Nationally, there is growing support for addressing drug use as a public health issue, including support for decriminalization. Both the Ontario Association of Chiefs of Police and the Canadian Association of Chiefs of Police have called for decriminalization. Canadian municipalities, including Kingston, Montreal, Ottawa, and Vancouver, have indicated support for decriminalization, as has the Government of British Columbia and Ontario's Big City Mayors.

This request adds to this growing support nationally. It reflects a made-in-Toronto approach based on input from a broad range of stakeholders who agree that a different approach is needed given the tragic increase in overdose deaths they have witnessed over the past two years.

In submitting this request, we would like to thank the members of our expert working group and the thousands of Torontonians who participated in our consultation process. We look forward to working collaboratively with Health Canada as we continue to refine an approach to decriminalization that supports access to services for people who use drugs and supports the overall safety and well-being of all Torontonians.

Sincerely,

Dr. Eileen de Villa Medical Officer of Health	Chris Murray City Manager	Chief James Ramer Chief of Police

1. Background and Introduction

The dual public health crises of drug poisonings and the COVID-19 pandemic are having significant and increasingly dire impacts on people who use drugs, their families, and communities.

In Toronto, deaths involving all substances, including opioids, have increased to record highs. Preliminary data from the Office of the Chief Coroner for Ontario show that there were 551 confirmed opioid toxicity deaths among residents of Toronto from July 1, 2020 to June 30, 2021. This represents a 57 per cent increase in confirmed cases compared to the previous 12-month period. These alarming increases are unprecedented.

While some actions have been taken at all levels of government to respond to the drug poisoning crisis, they have not stemmed the tide of the crisis; the situation remains urgent and continues to worsen. There is much more to do to respond effectively to this crisis, including the decriminalization of the possession of all drugs for personal use, scaling up overdose prevention and harm reduction services and supports, and supporting the expansion of safer supply and substance use treatment services.

The current approach to drug criminalization has given rise to serious health and social harms, including social stigma, violence, and structural racism. These harms exist alongside an unregulated market that is increasingly unpredictable in terms of substances and potency. People who use drugs express that they experience stigma and discrimination from health care and service providers, family members, and society at large. Even more, criminal records make it hard for people to find a job and a place to live, both of which are critical social determinants of health.

Many people use drugs without experiencing health-related harms or developing a substance use disorder. However, for those who are most at risk of drug poisoning, substance use disorder, or other health-related harms, the criminalization of drugs discourages people from seeking the support they may need (including harm reduction and treatment) for substance use and reduces the quality of care they receive in the healthcare system.[1,2] Fear of criminal charges may also force people to use substances alone or in unsafe locations or engage in behaviours that place their health or safety at risk, which increases the risk of injury, disease, and overdose.

Criminalization of drugs has not effectively reduced the supply of drugs and the unregulated market is increasingly volatile in terms of potency and composition. The toxicity of the drug supply is reflected in data from Toronto's drug checking service, which continues to identify larger quantities of unexpected substances of concern. Criminalization has also been recognized as having limited effectiveness as a deterrent or public safety measure when taking into consideration the harmful effects of criminal records and short periods of incarceration.

Toronto Public Health's mission is to reduce health inequities and improve the health of the whole population. The decriminalization of drugs as a public health approach to drug

policy was first endorsed by the Toronto Board of Health in 2018. Since then, the Board of Health has adopted recommendations calling on the federal government to decriminalize the possession of all drugs for personal use. In November 2020, the Board of Health reiterated calls to the Federal Minister of Health to decriminalize simple possession of all drugs and scale up prevention, harm reduction, and treatment services.

Decriminalization aligns with City of Toronto objectives for SafeTO, the City of Toronto's Community Safety and Wellbeing Plan, and City Council's and the Board of Health's focus on equity.

Given the worsening drug poisoning crisis and the compounding effects of the COVID-19 pandemic, in December 2021, the Toronto Board of Health directed the Toronto Medical Officer of Health to submit a request to Health Canada by the end of 2021 for an exemption under Section 56(1) of the *Controlled Drugs and Substances Act*, thereby starting a process to decriminalize the personal possession of illicit substances within the City of Toronto's boundaries.

Toronto Public Health is requesting urgent action by the Federal government to provide an exemption under section 56(1) of the *Controlled Drugs and Substances Act* that would decriminalize personal possession of illicit substances within Toronto's boundaries.

This initial submission outlines a proposed exemption model for Toronto that includes alternative pathways to health and social supports for those at risk, support from the community and key stakeholders, and the beginnings of an implementation and evaluation plan to monitor the ongoing impacts of an exemption.

The status quo approach to the drug poisoning crisis is not working. There is an urgent need for a comprehensive public health approach to drug policy that removes structural barriers to healthcare and social services, provides alternatives to the toxic drug supply, and enhances and expands services to improve the health and well-being of Toronto's communities.

2. Local Context

The drug poisoning crisis continues to intensify in Toronto. There is an urgent need to mitigate the harms from the unpredictable unregulated drug supply that are worsening during the COVID-19 pandemic.

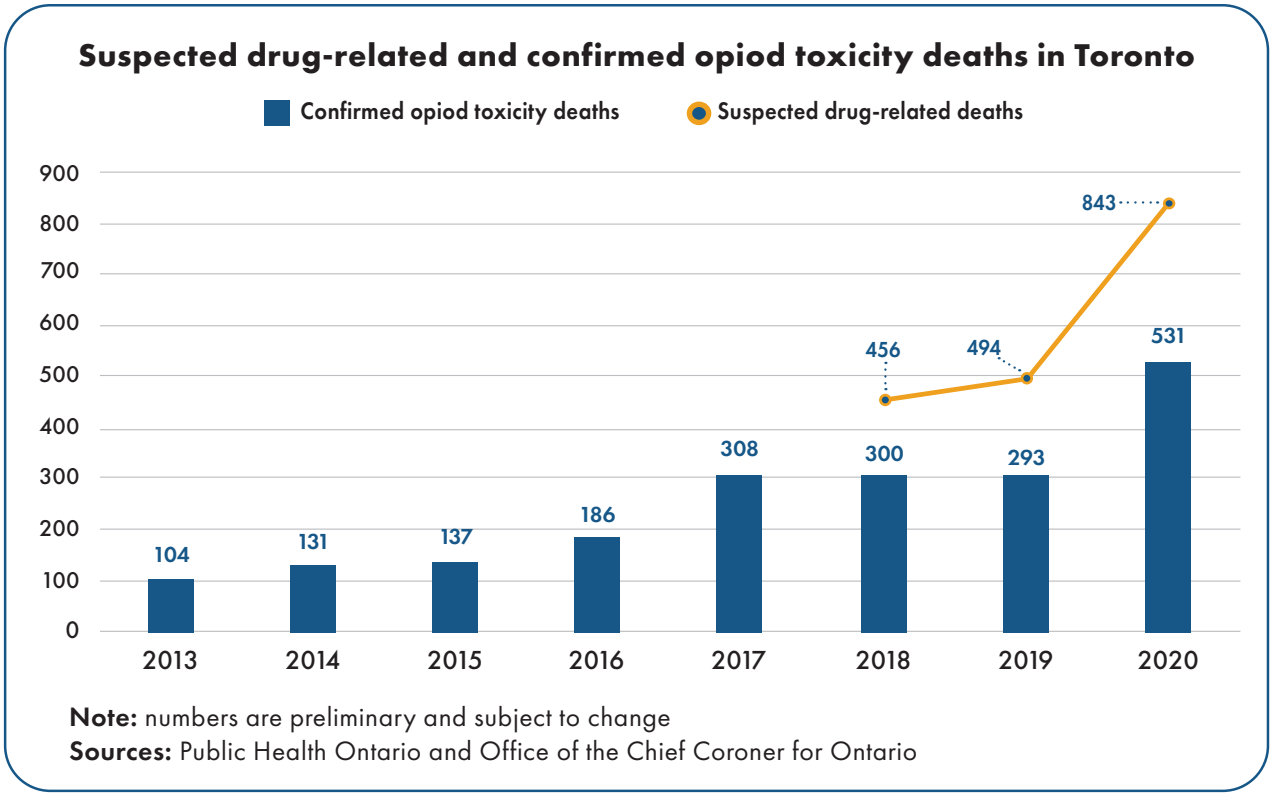
Drug-related deaths

In Toronto, deaths from all substances, including opioids, have increased since the start of the COVID-19 pandemic. Suspected drug-related deaths, not specific to opioids, have been used to track early signals of potential trends. Preliminary data from the Office of the Chief Coroner for Ontario show that from December 1, 2020 to November 30, 2021 there were 869 suspected-drug related deaths in Toronto, which is a 9 per

increase compared to the previous 12-month period. In the rest of Ontario, preliminary data show there were 3,114 suspected-drug related deaths from December 1, 2020 to November 30, 2021, representing an 18 per cent increase compared to the previous 12-month period.

Toronto has also experienced a record high number of opioid toxicity deaths in the last year with 531 confirmed opioid toxicity deaths among residents of Toronto in 2020. This represents an 81 per cent increase in confirmed cases compared to 2019 [3]

Figure 1. Suspect drug-related and confirmed opioid toxicity de ths in Toronto



Demographic data from the Office of the Chief Coroner for Ontario show that in Toronto from April 1, 2020 to March 31, 2021 the majority (96 per cent) of opioid toxicity deaths were accidental. Of the accidental opioid toxicity deaths during this time period:

- 77 per cent occurred among males;
- 46 per cent occurred among individuals aged 25 to 44 years; and
- 29 per cent occurred among individuals experiencing homelessness.[4]

Paramedics calls, emergency visits, and hospitalizations

The increase in opioid toxicity deaths in Toronto is also noted by Toronto Paramedic Services.

From December 1, 2020 to November 30, 2021, Toronto Paramedic Services responded to 6,024 suspected opioid overdose calls, including 354 calls involving

death. This is a 61 per cent increase in the number of suspected opioid overdose calls attended by Toronto Paramedic Services compared to the previous 12 months, and a 44 per cent increase in the number involving a death.

From April 1, 2020 to March 31, 2021, there were 2,630 emergency department visits and 378 hospitalizations due to opioid toxicity; a 17 per cent and 13 per cent increase, respectively, compared to the previous 12 months.

Opioid overdoses among individuals experiencing homelessness

In Toronto's shelter system, there were 1,330 non-fatal calls attended by Toronto Paramedic Services for suspected opioid overdoses and preliminary data from the Office of the Chief Coroner for Ontario show 65 opioid toxicity deaths between October 1, 2020 and September 30, 2021. This is a 110 per cent increase in non-fatal calls and a 117 per cent increase in opioid toxicity deaths compared to the previous 12-month period. Drug toxicity was a major cause of death among people experiencing homelessness in Toronto in 2020. Data collected by Toronto Public Health show that in 2020, 53 per cent of deaths among people experiencing homelessness were due to drug toxicity, an increase from 30 per cent in 2019.[5]

In the first half of 2021, Toronto Public Health received 94 reports of deaths in people experiencing homelessness. Similar to what was observed in 2020, almost half (49 per cent) of the reported deaths in the first half of 2021 were due to drug toxicity.

Substances contributing to drug-related harms

The drug poisoning crisis in Toronto is being driven by an unregulated toxic drug supply, with increasing harms from all substances, including, but not limited to, opioids.

Coroners' investigations revealed that a number of substances, in addition to opioids, contributed to accidental opioid toxicity deaths in Toronto from April 1, 2020 to March 31, 2021[6]:

- Fentanyl and fentanyl analogues contributed to 92 per cent of opioid toxicity deaths.
- Stimulants contributed to 65 per cent of opioid toxicity deaths.[7]
- Benzodiazepines contributed to 14 per cent of opioid toxicity deaths.

There is evidence that the harms from stimulants (such as cocaine and methamphetamine) are increasing,[8,9,10] and these have been noted in cases where stimulants are used on their own, as well as polysubstance use where two or more substances are used. Data from deaths where multiple substances are detected does not allow for a determination about whether polysubstance use was intentional or unintentional. However, the data does confirm that the current drug poisoning crisis is not limited to opioids and includes increasing harms from a range of substances. This is consistent with results from Toronto's Drug Checking Service which show an increase in unexpected, highly-potent drugs in Toronto's unregulated toxic drug

supply.[11] Trends during the COVID-19 pandemic include an increasing per cent of samples expected to contain opioids where benzodiazepines were detected, and more potent forms of opioids, including carfentanil and other synthetic opioids known as 'nitizanes', like isotonitazene and etonitazene.[12]

Regulated opioids, including fentanyl, morphine, oxycodone, hydromorphone, and methadone are medications used to relieve pain; some are also used to treat opioid use disorder.[13] Unregulated opioids can include diverted medications, illicitly manufactured versions of regulated opioids, and other opioids, such as heroin, fentanyl analogues (i.e. carfentanil) and other synthetic opioids (i.e. nitazene opioids). Stimulants are drugs that stimulate, excite or speed up the brain and other parts of the body, including prescription medications, as well as unregulated substances (like cocaine and methamphetamine). Benzodiazepines are depressants that slow down brain activity (and depress the central nervous system), and are sometimes prescribed to treat anxiety, insomnia and alcohol withdrawal. They can be combined with other substances in the unregulated drug supply, and when consumed (intentionally or unintentionally) with opioids, can increase the risk of overdose and death. A growing list of the many drugs identified in Toronto's unregulated drug supply is available from Toronto's Drug Checking Service's Drug Dictionary.[14]

Impact of COVID-19 on people who use drugs

People who use drugs have been impacted negatively by the COVID-19 pandemic in multiple ways. In Canadian qualitative research exploring these impacts, participants reported changes in the unregulated drug supply: decreased accessibility, increased price, reduced quality, and more drugs containing unexpected substances and chemicals.[15] People who use drugs also described an increase in using substances alone for a variety of reasons, including:

- Self-isolation or physical distancing requirements;
- Service reductions at supervised consumption and other harm reduction services;
- Public places and businesses being closed; and
- Not wanting to expose themselves to COVID-19.[16]

The COVID-19 pandemic has also exacerbated the pre-existing need for grief and loss supports for those at the frontline of the drug poisoning crisis facing increased overdose incidents and deaths. Qualitative research recently conducted in Toronto describes the significant toll of responding to overdoses on workers' mental health, including dealing with the impacts of anxiety, anticipatory loss, and burnout. However, adequate workplace responses to support workers have not always been available.[17]

A September 2021 report from the Ontario COVID-19 Science Advisory Table also highlights the impact of the pandemic on increasing rates of opioid-related harms across Ontario.[18] The report recommends strategies to address the crisis which include promoting access to alternative service delivery methods, such as telemedicine

programs when in-person services are not available, as well as ensuring uninterrupted and equitable access to mental health and harm reduction services.

Criminal charges

While Toronto Police Services has deprioritized simple possession charges, some simple possession charges occurred in 2021.

Toronto Police Services data (see Table 1) show that in 2020, 126 people were charged under Section 4(1) of the *Controlled Drugs and Substances* Act (CDSA), the section that regulates possession of a substance. From January to September 13, 2021, 24 people were charged under Section 4(1). These numbers represent charges where simple possession of a substance was the only charge laid.

In 2020, 937 people were charged with at least one charge of possession of a controlled substance as well as other charges under the CDSA or Criminal Code, such as trafficking, production, importation and/or exportation. From January to September 13, 2021, 457 people have been similarly charged.

Table 1. *Controlled Drugs and Substances Act* arrests and charges in Toronto

Category	2019	2020	2021*	Total
Number of arrests with at least one CDSA Section 4(1) charge laid	1,147	937	457	2,541
Number of arrests where only CDSA Section 4(1) charge was laid	**186**	**126**	**24**	**336**

*Note: Data up to and including September 13, 2021
Source: Toronto Police Service

In 2020, the Public Prosecution Service of Canada issued a guideline for federal prosecutors acknowledging that criminal sanctions for the simple possession of drugs have limited effectiveness as both a deterrent and as a way of addressing public safety when considering the harmful impact of incarceration and criminal records. The guideline directs prosecutors to focus on the most serious cases raising public safety concerns for prosecution and to otherwise pursue suitable alternative measures and diversion from the criminal justice system for simple possession cases.

Substance use related stigma and discrimination

Stigma refers to negative attitudes, beliefs or behaviours towards a group of people because of their circumstances and may include discrimination, prejudice, judgement and stereotypes.[19] Stigma and discrimination occur at different levels. One example is structural stigma whereby laws, policies, and institutional practices are based on stigma rather than evidence, and service providers deliver unequal treatment.[20,21] Substance use stigma also intersects with and is compounded by other forms of stigma and discrimination, for example racism and colonialism.[22] In Canada, a significant proportion of the population holds stigmatizing views about people with substance use disorder,[23] including those who work in health care settings or as first responders.[24] This is often

seen in derogatory and stigmatizing language used to refer to people who use substances.[25] Substance use-related stigma can have profound consequences on an individual, especially when it comes from healthcare providers and first responders, and is a barrier to accessing care and treatment.[26] People who use substances can also internalize stigma and experience feelings of shame and embarrassment, which can lead to hiding ones substance use and using drugs alone.[27]

Disproportionate harms of criminalization to populations experiencing structural inequity

Criminalizing drug possession has disproportionate effects on Indigenous and Black people, who are more often targeted for prosecution of drug possession offenses.[28] Incarceration has both indirect and direct negative health impacts such as risk of infection and disease and impacts on family, relationships, and mental health.

> "The legislation criminalizing drug possession is part of historical and ongoing structural racism and continues to have disproportionate effects on Indigenous and Black populations, which are more often targeted for prosecution for simple drug offenses."
>
> - Health Canada's Expert Task Force on Substance Use

Incarceration also tends to have greater negative impacts on people who identify as women and their families than on men. A special report from the British Columbia Office of the Provincial Health Officer found that because the criminal justice system is largely set up to serve male offenders, women who are incarcerated face specific health and safety harms, including Hepatitis C and HIV infections, histories of victimization, and risk of losing their children or miscarrying if they are pregnant.[29] In addition, when released from custody, some women may be isolated from their social safety networks if their parole conditions prohibit them from certain activities (for example, sex work).

3. Toronto Drug Strategy and Indigenous Overdose Strategy

The Toronto Drug Strategy is a comprehensive drug strategy for the City of Toronto, which guides the City of Toronto's policy and programs to respond to substance use and provides recommendations for further action. The Toronto Drug Strategy is based on four integrated parts: prevention, harm reduction, treatment and enforcement and combines the knowledge and expertise of people who use drugs, their families and

Due to the increasing severity of the drug poisoning crisis, the current focus of the Toronto Drug Strategy is the implementation of the Toronto Overdose Action Plan, which provides a comprehensive set of actions to prevent and respond to overdoses. The Toronto Board of Health endorsed the Overdose Action Plan in 2017, and status

reports are provided annually to the Board. In 2019, a comprehensive update was provided with key findings and actions for all levels of government, including:

- The opioid poisoning crisis remains an urgent public health issue, and more action is needed now.
- Alternatives to the toxic illicit drug supply are particularly urgent.
- Decriminalization is critical to reducing stigma, as well as the health and social harms related to drug use.
- There are many underserved groups that are being impacted by this crisis, in particular, Indigenous and racialized communities.
- More harm reduction services and increased capacity are needed across the city in a variety of settings, including housing and shelter programs.

The Toronto Indigenous Overdose Strategy was developed as a companion to the Toronto Overdose Action Plan in winter 2018. The Toronto Indigenous Overdose Strategy has recommended actions that were developed through an Indigenous-led consultation process that gathered advice from Indigenous people who use or have used substances through advice circles and Indigenous and non-Indigenous service providers who serve Indigenous people.

In light of the worsening drug poisoning crisis and this work to pursue an alternative approach to the criminalization of drugs, the Toronto Drug Strategy Secretariat is planning to update the Toronto Drug Strategy and the Toronto Overdose Action Plan in 2022. This will include community consultations with people who use drugs, their families and allies, and service providers.

4. Support for Decriminalization and Toronto's Exemption Request

From May to June 2018, Toronto Public Health engaged the community to complete a community dialogue on what a public health approach to drug policy should look like. The process included four main components:

1. Two community dialogue sessions;
2. 20 interviews with people with lived experience;
3. An online survey sent only to a representative sample of 503 Toronto residents; and
4. An online survey that was open to anyone interested (i.e., open link public engagement survey) with 346 respondents.

Participants noted that drug use needs to be addressed as a public health and social issue, not a criminal issue, and that the decriminalization of the possession of drugs for personal use is a step in the right direction. Sixty-one per cent of those in the representative survey of Torontonians and 91 per cent of those in the engagement survey were supportive of a public health approach which includes increased access to

prevention, harm reduction services, and treatment as well as decriminalization and strict control and regulation of drugs.

There is growing support among law enforcement authorities and civil society for a public health approach to drug policy. In July 2020, the Canadian Association of Chiefs of Police endorsed the decriminalization of personal possession of drugs and urged all police agencies in Canada to recognize substance use as a public health issue. In December 2020, the Ontario Association of Chiefs of Police stated its support for the Canadian Association of Chiefs of Police decriminalization recommendations, as well as its support for safer supply and supervised consumption services.

> "We the Canadian Association of Chiefs of Police agree that evidence suggests, and numerous Canadian health leaders support, decriminalization for simple possession as an effective way to reduce the public health and public safety harms associated with substance use."
>
> – Canadian Association of Chiefs of Police
> Special Purpose Report on Decriminalization of Illicit Drugs

In June 2021, Ontario's Big City Mayors called for the decriminalization of controlled substances. This membership includes 29 single and lower-tier cities with a population of 100,000 or more, who collectively represent nearly 70 per cent of Ontario's population. Also in June 2021, 47 Toronto-based civil society organizations called for decriminalization of simple possession within city limits. A national poll by Angus Reid in February 2021 found overall support (59 per cent nationally and 60 per cent in Ontario) for decriminalization of simple possession of drugs.

> "Now is the time to be bold. Our call for policy change is consistent with OBCM's growing mandate to advocate for the resources our residents and communities need."
>
> – Jeff Lehman, Chair of Ontario's Big City Mayors and Mayor of Barrie.

Health Canada's Expert Task Force on Substance Use recently recommended that substance use should be managed as a health and social priority, and not through criminal or civil sanctions. The Expert Task Force notes that criminalizing simple possession increases the social stigma of people who use drugs, which multiplies the harms they experience and increases the risk of negative outcomes, even for people who use substances occasionally or for the first time.[30] As a result, criminalization leads

to higher drug-related health costs because it keeps people who use drugs away from prevention and early treatment health services due to fear of being arrested, labelled, or outed.[31]

The Expert Task Force recommended that a core priority is to implement a legal regulation framework for substances to minimize the scale of the illegal market, bring stability and predictability to regulated markets for substances, and provide access to safer substances for those at risk of injury or death from toxic illegal substances.

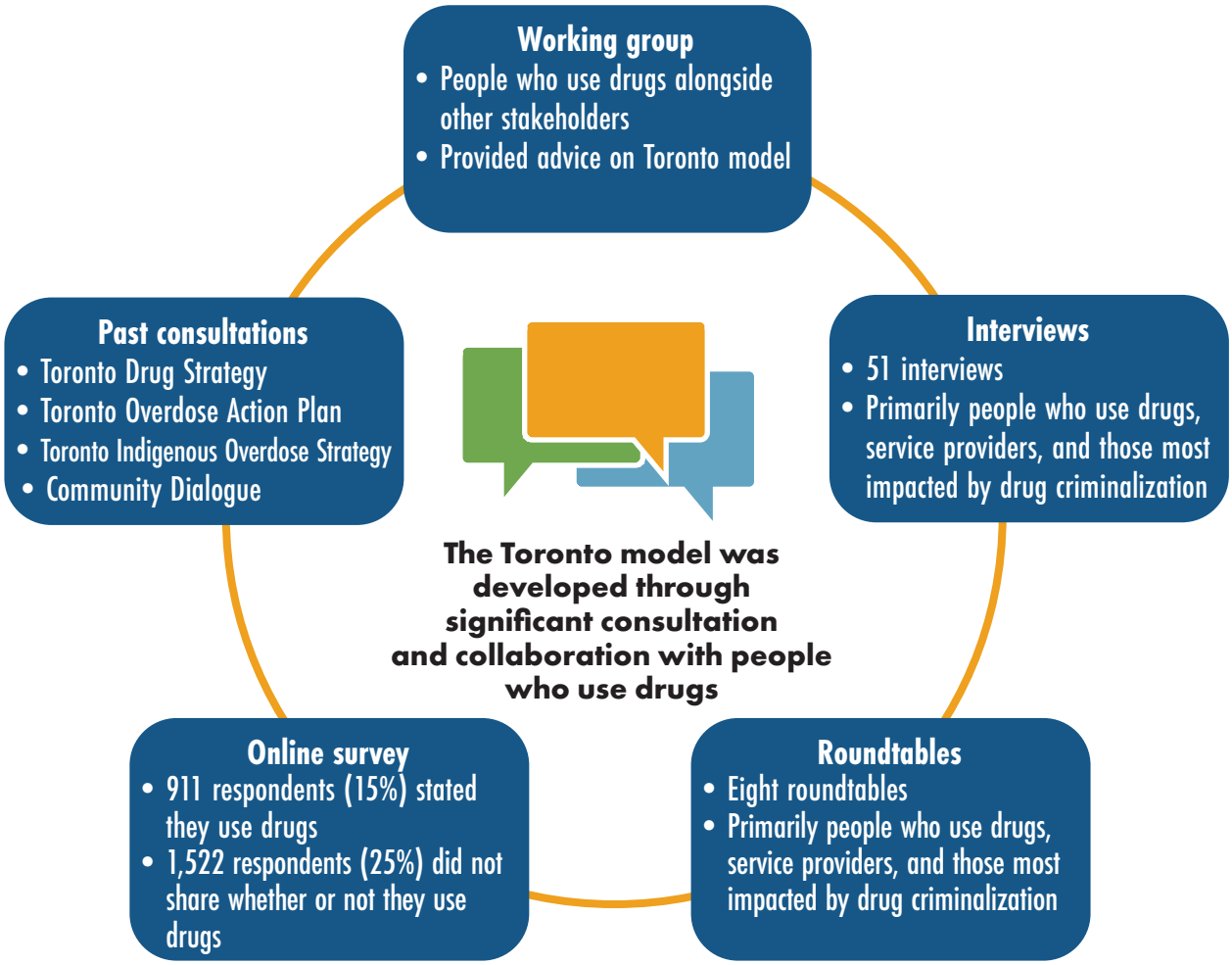
Momentum is building across Canada. On November 1, 2021, the Government of British Columbia became the first province in Canada to seek an exemption from Health Canada under Section 56(1). This follows a similar request from the City of Vancouver, and the endorsement of decriminalization by municipalities, such as Kingston, Montreal, and Ottawa. Based on discussions with other municipalities across the province and other Canadian cities, it is expected that more municipalities will come forward in the near future with similar calls or requests for exemptions.

5. Community Consultation to Inform an Alternative Approach to Criminalization

At its June 14, 2021 meeting, the Toronto Board of Health asked Toronto Public Health staff to convene a multi-sectoral working group to provide advice on developing a health- and social equity-based alternative approach to drug criminalization, as a step towards requesting an exemption under the *Controlled Drugs and Substances Act*. Following this request, Toronto Public Health engaged a consultant to conduct a comprehensive community and stakeholder engagement process in the summer and fall of 2021 to develop the proposed exemption model for Toronto. As shown in Figure 2, the consultation process was centred on people with lived and living experience of drug use and the agencies and service providers that support them through roundtable discussions, interviews, an online questionnaire, and a diverse multi-sectoral working group. In total:

- **27** organizations made up the multi-sectoral working group (for a full list of organizations see Appendix 1).
- **5,995** people completed the online questionnaire, which was open from August 16, 2021 to September 27, 2021.
- More than **166** people/organizations were invited to participate in interviews and roundtables with intentional efforts to engage those most impacted by drug policy such as African, Caribbean, Black, and Indigenous communities and sex workers.
- More than **51** interviews and **11** roundtables were completed.
- General feedback was also received and reviewed throughout the process through the Toronto Public Health consultation e-mail account.

Figure 2. Consultation and collaboration with people who use drugs



The key findings of the public consultation process were:

1. A human rights and public health approach must guide work on decriminalization.
2. There is a need to reduce stigma and increase safety of drug use.
3. Safer supply is critical and immediately needed to reduce overdose injury and fatalities.
4. Harm reduction services are still much too limited.
5. Access to affordable, safe, supportive housing is a major element of this crisis and must be addressed to help stabilize individuals.
6. Community members continue to feel over-policed and subject to coercive and discretionary policing practices.
7. The involvement of people who use drugs must be central to the process and implementation.

Many participants felt the main goal of decriminalization needs to be to reduce interactions with the judicial system and to prevent the further criminalization of people who use drugs. One of the main concerns raised in the consultation was that the

relationship between police and people who use drugs is strained, and that police are not well placed to lead overdose response.

> "If we are using a human rights and a public health approach, this is an opportunity to make things right that we know have been made wrong because of criminalization."
>
> – Working Group Member

More detailed information summarizing the findings of the consultation process are included in Attachment 1.

In addition to the multi-sectoral working group, an Executive Team comprised of Toronto's Medical Officer of Health, Chief of Police, and City Manager was established to provide strategic direction and ensure meaningful consultations, including across City divisions. The Executive Team was supported by two advisors representing Indigenous and African, Caribbean, and Black communities.

Throughout the consultation process, the Medical Officer of Health for Toronto and Toronto Public Health senior management met with intergovernmental partners, other jurisdictions, as well as local organizations. The general perspective was that more action is needed to address the drug poisoning crisis and that decriminalization is one action among many that needs to be taken. In particular, there was general support for areas where the submission aligns with the Provincial Roadmap to Wellness. Other jurisdictions also noted their intention to submit similar requests in the future.

The Toronto Board of Health has called for a national approach to decriminalization. In the absence of a national approach, Toronto Public Health will continue to work with neighbouring jurisdictions as it moves forward to implement decriminalization in Toronto and collaborate to consider a regional approach. See Appendix 2 for a list of local organizations and government partners consulted.

Letters of support for decriminalization received from organizations or individuals are included as Attachment 2.

6. A Strategy to Reduce Harm and Promote Health: Exemption Model for Toronto

Many people who use drugs do so for an actual or perceived benefit and are not at risk of developing a substance use disorder or experiencing other harms from drug use.[32] The proposed Toronto exemption model recognizes the need to move all people who use drugs away from the criminal justice system, enhance health and social supports for those who need them, and decrease the stigma associated with substance use to improve the health outcomes and well-being of people who use drugs and the communities around them.

The Toronto model, as shown in Figure 3, includes two components:

1. The design elements for an exemption from criminal penalties for the personal possession of drugs (i.e., decriminalization); and
2. A health and social equity pathway to help address the needs of people at high risk of harm from the drug poisoning crisis, which builds on existing supports and services.

The Toronto model is a public health response to the drug poisoning crisis that recognizes the importance of human rights, as well as the social determinants of health. The model has been informed by multiple stakeholders, including those who participated in the working group, roundtable discussions, interviews, and an online questionnaire. Detailed consultation results are presented in Attachment 1.

Throughout the consultations, there was widespread agreement on the need to move to an alternative approach and agreement on many of the principles and elements that an alternative model would need to include. However, there were four key components of the model where we heard a range of viewpoints and where additional work will be needed to refine the model. The refinement of the following model elements will occur through detailed discussions in working groups going forward:

1. the definition of "personal possession" under which a person would begin the new decriminalization pathway;
2. the design of an Indigenous-developed and led pathway;
3. components to include in a client-centred network of health and social supports and how individuals would access them; and
4. development of an appropriate and meaningful evaluation framework.

Figure 3. Toronto's proposed exemption model

Toronto Community Anchor Model

The Toronto Community Anchor Model is a public health response to the drug poisoning crisis that recognizes the importance of human rights, as well as the social determinants of health, in reducing the harms associated with drug use and criminalization.

The model recognizes that racialized and indigenous individuals are disproportionately impacted by the harms associated with drug use and criminalization, and works to ensure access to culturally appropriate, trauma-informed services by health workers and peers.

THE MODEL IS INTENDED TO:

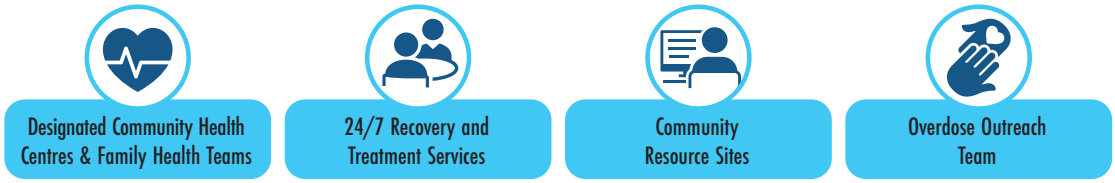
Operate city-wide	**Determine limits based on community use**	**Reduce demand on police and court services**
Apply to all drugs	**Ensure timely access to voluntary services**	**Eliminate fines or other penalties**

THE MODEL FEATURES:

Open access to people who use drugs as well as voluntary referral by first responders and a dedicated outreach team to the Toronto Community Anchor Drug Use Network

New investments, as well as improved access and linkages to existing health services and social supports, that meet the needs of people who use drugs, particularly African, Caribbean, Black, women, 2SLGBTQ+ residents, and includes a dedicated indigenous-developed and Indigenous-led pathway.

Toronto Community Anchor Drug Use Network (in development)



Health Maximization Social & health supports to stabilize & foster health & well-being, e.g:	**Harm Reduction** Supports to reduce harms associated with drug use, e.g:	**Substance Use Treatment** Expanded access to low barrier evidence-based options, e.g:	**Mental Health Services** Access to voluntary services, e.g:	**Safer Supply** Low barrier expanded prescription access, e.g:
✓ Improved, equitable access to health care	✓ Overdose prevention	✓ Day and residential treatment	✓ Trauma counselling	✓ Injectable Opiod Agonist Treatment (IOAT)
✓ Food and nutrition	✓ Collaborative health referral	✓ Rapid Access Addiction Medicine (RAAM) in hospital & select CHC + FHT	✓ Substance use counselling	✓ Expanded formulary alternatives
✓ Housing	✓ Drug checking		✓ Mental health treatment	
✓ Income support enrollment				

Part One: Decriminalization

The proposed exemption model from criminal penalties has the following design elements based on consultation and research to date:

- **Operate city-wide:** The exemption from criminal penalties should apply to the entire City of Toronto rather than just certain areas or neighbourhoods (e.g., areas with high rates of overdose or higher rates of police interaction). Applying an exemption to the whole city prevents substance use from concentrating in just one area, and treats all residents equally.

- **Apply to all drugs:** Consideration was given to whether an exemption should apply to all illicit drugs listed in the CDSA or only some (e.g., those that are most frequently identified in overdose). The clear consensus from the working group and consultation was that an exemption from criminal penalties should include all drugs listed in the CDSA without restrictions. Participants expressed that there is no way to know which drugs may cause the most harm in the future, in addition to the fact that many harms come from polysubstance use (i.e., where two or more substances are used). Toronto Public Health also heard that different groups of people use different types of drugs, thus decriminalizing only some drugs could lead to continued inequity in criminalization of some members of the community.

- **Eliminate fines or other penalties:** Consideration was given to models in other jurisdictions that have implemented fines for possession of drugs for personal use rather than charges, or other types of systems where individuals can waive fines if they attend treatment. Consensus from both the working group and other consultation methods was that the model should not include fines or administrative penalties as an alternative to charges and the majority of participants expressed that police should not confiscate drugs that meet the threshold for personal possession. Toronto Public Health heard that fines will disproportionately fall on those who are low-income, and nonpayment of fines could lead to continued criminalization of vulnerable or marginalized groups.

- **Determine the definition of "personal use" based on community input**: Further work is required to determine how individuals will begin using the alternative pathway. This work will include working closely with people who use drugs to refine our thinking on the quantity of drugs that a person may carry under the Toronto model. Toronto Public Health heard repeatedly that any decision for this part of the model needs to be informed by people who use drugs. In addition, we heard that it would be useful if established quantities were consistent nationally and informed by Health Canada. In the absence of a national framework, a panel with drug researchers, people who use drugs, harm reduction workers, and police is proposed to determine the appropriate quantity for personal possession, meeting on an annual basis to review quantities as necessary. Any consideration for how much a person may carry needs to

consider more than personal use, and should also take into consideration purchasing, sharing, and using patterns, which may differ from person to person.

- **Ensure timely access to services and supports:** The consultation process revealed multiple views on whether referral to treatment or other services is more effective if it is voluntary or mandatory. We also heard differing opinions about who should make referrals, with some emphasizing that peers and outreach teams would be best placed to do so as referrals from police could be seen as coercive. How the offer of treatment or referral to services will be implemented requires further refinement. In addition, we heard that there is a general need for support services that are accessible, culturally safe, destigmatized and trauma informed.

  While the majority of respondents opposed mandated treatment, a few saw value in a model of involuntary options that could be leveraged under specific circumstances, such as when a person who uses drugs may have multiple symptoms from prolonged drug use which may hinder their ability to get accurate medical diagnoses or make their own decisions regarding care. Many interviewees emphasized that treatment should be centred on human rights, bodily autonomy, and seek to meet the individual where they are, without coercive approaches.

  It is important to note that voluntary service access does not preclude obligations under the *Mental Health Act, 1990*, or the *Health Care Consent Act, 1996*, which govern health care decision making, consent, and the power of certain individuals to make orders regarding patient admission, treatment, and care. These laws are in place to ensure that an individual does not pose a harm to themselves or others when choosing not to receive treatment.

It is important to note that the design elements above reflect the important perspectives gathered through consultation and research completed by Toronto Public Health to date. More detailed information summarizing the findings of the consultation process are included in Attachment 1.

Further consultation with Health Canada and other partners is needed to refine some of the essential model components and the details of each. The model will be further developed through working groups with people who use drugs and other stakeholders to achieve a decriminalization model that can be implemented, reviewed and further refined to meet the shared goal of all stakeholders to realize an alternative approach to criminalization.

Part Two: Health and social equity pathway

The exemption model developed for Toronto seeks to reduce harm for all people who use drugs, including those who do not require further health supports or referrals. However, for those who are most at risk of harm from drug poisoning or experiencing other harms from substance use, or for those who wish to access support for other

social determinants of health, such as housing, there is a clear need for improved access and navigation to existing supports.

Coupling decriminalization with harm reduction, treatment and other social and health supports can help to bring people who use drugs into an environment where they feel acknowledged and safe, removing the burden of having to hide drug use or use drugs alone. Harm reduction workers, first responders, health care workers, or peers are then able to more effectively build trust with people who use drugs and provide access or referrals to safer supply programs, treatment options, primary care, mental health care, and broader social services like housing, where appropriate.

> "People who use drugs said that they knew how to access harm reduction and safe supply, but cannot access trauma counselling and supports around trauma, housing, income stability, and other basic social determinants of health that have become inaccessible."
>
> – Working Group Member

Additional work will be needed to fully develop the comprehensive network of health and social supports envisioned as part of this model. However, an initial frame for this network is show in Figure 4. Under a system of decriminalization, first responders would no longer press charges when they come into contact with a person possessing drugs for personal use. Instead, individuals would be referred to a network of services by first responders or other outreach workers. During consultation, there were varying viewpoints on how these referrals could best be provided. Emergency medical services would continue to provide assessment and intervention, if needed, and transport individuals needing care to a hospital setting. This network would bring together supports and services that already exist in the city and include new services and supports to fill existing gaps. Additional investment from all levels of government will be needed to enhance, expand and integrate services in the city.

Figure 4. Comprehensive network of health and social supports

The new model involves providing people who use drugs with options and low barrier access to services. A person who uses drugs may choose to access primary health care or other health supports, access a treatment bed, go to a community resource site or "chill out space" where they can safely recover, or be referred to the overdose outreach team for harm reduction information, supplies, and resources. Overdose outreach team members may also continue to check-in or follow-up to see if a person needs additional support or referrals.

> The pathway is developed to include a continuum of health and social services that people can opt in to or select from at any time, including in some way, at all hours of the day.

Additional consultation will be needed with people who use drugs, service providers, and other stakeholders to further develop the exact components of this network and ensure it is accessible, culturally safe, destigmatized and trauma informed.

The network would build on existing health and social services, including community health centres and family health teams in Toronto with expertise in harm reduction and substance use disorder treatment, outreach workers, and treatment centres and services. These community resources have experience supporting people who use drugs to connect to health and social supports. The network is intended to work collaboratively, and may either provide these services directly or act as an access point to other services in the city. The services that could be expanded and enhanced as part of this network are outlined in Figure 5.

Figure 5. Services and supports for people who use drugs

Health maximization Social and health supports to stabilize and foster health and well-being	**Harm Reduction** Supports to reduce harms associated with drug use	**Substance Use Treatment** Expanded access to low barrier evidence-based options	**Mental Health Services** Access to voluntary services	**Safer supply** Low barrier expanded prescription access
Improved, equitable access to health care	Overdose prevention	Day and residential treatment	Trauma counselling	Injectable Opiod Agonist Treatment (iOAT)
Food and nutrition	Collaborative health referral	Rapid Access Addiction Medicine (RAAM) in hospital & select CHC + FHT	Substance use counselling	Expanded formulary alternatives
Housing	Drug checking		Mental health treatment	
Income support enrollment				

Referrals or connections by the network may be made to services or supports in the following areas:

- **Health Maximization:** social and health supports including access to health care, housing, or income support.
- **Harm Reduction:** supports to reduce harm associated with drug use, including supervised consumption and drug checking services.
- **Substance Use Treatment:** access to evidence-based treatment, including Opioid Agonist Therapy (OAT).
- **Mental Health Services:** voluntary mental health or substance use care and counselling.
- **Safer Supply:** access to pharmaceutical-grade alternatives to the unregulated drug supply, including injectable opioid agonist treatment (iOAT).

Many of the health and social supports for people who use drugs outlined above currently exist in Toronto. However, in some cases program funding is time-limited and in other cases there is not sufficient capacity to meet the needs of the communit . These services include a network of drop-ins, harm reduction organizations offering outreach and supply distribution, and nine publicly accessible supervised consumption services. Low barrier health centres and community health centres serve those who have been under-served by traditional health care. Street outreach and harm reduction programs and community health centres also work to connect clients to additional health and mental health services, as well as income and housing supports. There is new and limited access to safer supply programs, and a network of providers offering opioid agonist therapy, including through rapid access addiction medicine clinics, that provide alternative to the unregulated drug supply. There is limited access to medical withdrawal management through one program, as well as three other withdrawal management services. Day and residential treatment is available through five organizations. For crisis situations, 24/7 telephone and mobile crisis response is available, and the City of Toronto will be launching four community-led crisis response pilots in 2022 with the goal of providing an appropriate response to non-emergency calls

that would have previously been directed to the police. A list of existing health and social support services are described in more detail in Appendix 3. The model proposes formally designating existing services as part of the network and enhancing the pathway through additional coordination and service funding.

Using a human rights approach means that everyone should have access to the health services they need, when and where they need them. Starting by viewing someone who uses drugs as a whole person with needs across a continuum of services is an important first step in this process, and can lead to broader improvements in population health.

> "When people are marginalized or face stigma or discrimination, their physical and mental health suffers. Discrimination in health care is unacceptable and is a major barrier to development. But when people are given the opportunity to be active participants in their own care, instead of passive recipients, their human rights respected, the outcomes are better and health systems become more efficient."
>
> – Dr. Tedros Adhanom Ghebreyesus, Director-General, World Health Organization

The effectiveness of the pathway is significantly determined by the availability of culturally safe services and supports that respect the autonomy and dignity of people who use drugs. Consultation efforts and research have identified that people who use drugs are not always accessing currently available resources for a variety of reasons. Training and continuous improvement in culturally safe care is an important component for all health care workers and peers.

The Toronto model also recognizes the importance of having an Indigenous-led and Indigenous-developed pathway to culturally safe services for Indigenous people who use substances. More information about this pathway can be found in the next section.

Successful implementation of the Toronto model will require more work, including identifying members of the network, building out a governance structure, and increasing resources for those doing work on the ground. There is an opportunity to enhance, expand and better integrate a range of supports and services to address the needs of people who use substances.

Recognizing that decriminalization is a new approach, Toronto Public Health is committed to continuing to work with all partners to continue to refine the model, in consultation with Health Canada. Further consultation and collaboration with people who use drugs and community and service providers will be critical to move forward on (1) the definition of "personal use" under which a person would begin the new decriminalization pathway; (2) the design of an Indigenous-developed and led pathway; (3) components to include in a client-centred network of health and social supports and

how individuals would access them; and (4) development of an appropriate and meaningful evaluation framework.

Indigenous-developed and Indigenous-led health and social referral pathway

Culture-based care is key to building a solid foundation for programs or services to aid in the overall healing journey as experienced by Indigenous people of this land.[33] Given the destructive history of failed assimilation, it is past time to celebrate and bring forth hope and the best possible care for Indigenous communities.[34] After years of Indigenous advocacy for their community, Indigenous people's right to design, lead and manage their own health care services is finally being recognized and actioned, and this is crucial to closing the gaps in care.[35] Self-determination for this decriminalization referral pathway is fundamental to ensuring the needs of Indigenous people are being met in care.

It is clear that there are still many barriers within care as experienced by the Indigenous community. Ongoing systemic racism, including in the Canadian justice system, has far-reaching negative health impacts on Indigenous communities.[36] The Truth and Reconciliation Commission Calls to Action ask all levels of government in Canada to acknowledge the current state of Indigenous health in Canada and to recognize and implement the health care rights of Indigenous people as well as to recognize the value of Indigenous healing practices.[37] More Indigenous people live in Ontario than in any other province or territory in Canada, and there are more Indigenous people living in Toronto than in any other city or reserve in Ontario.

An Indigenous-led health care pathway will build on existing Indigenous-led health and social services using the following key principles from the Toronto Indigenous Health Strategy:

1. Health plans are developed with Indigenous Peoples as full partners.

2. Wherever Indigenous Peoples go to access programs and services, they receive culturally appropriate, safe and proficient care, and all barriers to optimal care have been removed.

3. Care is planned to be responsive to community needs and is appropriate, efficient, effective and high quality at both systems and interpersonal levels.

4. Dedicated resources and funding for Indigenous health programs and services will support a coordinated and collaborative system.

5. Leverage and build the capacity of Indigenous leadership and Indigenous communities to care for themselves.

Indigenous leaders have suggested convening an Indigenous-led work group as a good way to develop this pathway, with the ability to use the key findings of the Toronto

Indigenous Overdose Strategy as a guide. Indigenous leaders have been engaged to guide the design of a working group.

7. Expansion of Existing Health and Social Services

While decriminalization is an important step towards removing stigma and reducing barriers, decriminalization alone will not solve the drug poisoning crisis. For those most at risk of drug-related harms or drug poisoning, existing services available to support people who use drugs, including opioid agonist treatment programs, safer supply programs, and drug checking services have limited funding or limited capacity to serve residents. It is crucial that these programs have the infrastructure and capacity to provide people, if desired, with access to the supports they need, when and where they need it. Expanding to other sites and scaling up so that services can serve more people and respond to inequities in the current system will be necessary to effectively contribute to the response to the drug poisoning crisis in Toronto.

> "Decriminalization is the right thing to do for a number of reasons but let's be careful about framing it as the answer to the crisis and not to promise that this will lead to fewer deaths or solve the crisis."
>
> – Working Group Member

Government of Ontario

Building a comprehensive and connected network of health and social supports aligns with the Government of Ontario's Roadmap to Wellness, a plan to build a modern, connected, and high-quality mental health and substance use treatment system in Ontario centred on the needs of individuals and their families. The Roadmap to Wellness has the following four pillars:

1. Improving quality: enhancing services across Ontario
2. Expanding existing services: investing in priority areas
3. Implementing innovative solutions: filling gaps in care
4. Improving access: a new provincial program and approach to navigation.

The Roadmap to Wellness recognizes a number of challenges with the current system including long wait times, barriers to access, poor coordination, lack of funding, and lack of quality data. Toronto Public Health's calls for the expansion of existing programs to serve more people and respond to gaps in the current system aligns with the four pillars of the Roadmap to Wellness.

Prior to the COVID-19 pandemic, the Toronto Academic Health Science Network (a network of academic health organizations that is comprised of the University of Toronto and 12 affiliated hospitals), Toronto Public Health, and several community organizations partnered to create the Toronto Academic Health Science Network/Toronto Public

Health Opioid Task Force. This group, now called the Toronto Opioid Overdose Action Network, also includes South Riverdale Community Health Centre, Parkdale Queen West Community Health Centre, Anishnawbe Health, and people with lived experience of drug use. Recognizing that the COVID-19 pandemic intensified the drug poisoning crisis, the Toronto Opioid Overdose Action Network sent a proposal to Ontario Health in the fall of 2020 proposing the creation of integrated services between hospitals, community health centres, and community service providers to ensure continuous care for people who use drugs as they move through different parts of the health care system.

The Toronto Opioid Overdose Action Network requested $0.6 million in 2020-2021 funding and $5.3 million in annualized funding for harm reduction teams, safer opioid supply, injectable opioid agonist therapy, and addiction consultation services. One-time funding of $601,800 was received from Ontario Health in early 2021 to be used in fiscal year 2021-2022. This funding was used for:

- Harm reduction teams;
- Safer opioid supply;
- Injection opioid agonist treatment (iOAT);
- Rapid access addition medicine (RAAM) clinics; and
- Addiction consultation services.

As part of the Roadmap to Wellness, there will be increased annual financial support ($2.25 million), beginning in late 2021, that will expand some services for people who use drugs in Toronto. Funding will be provided through Ontario Health to various organizations (including Toronto hospitals and community agencies) that are part of the Toronto Opioid Overdose Action Network. The services that will be expanded include harm reduction services in high risk community settings, substance use treatment access through rapid access addiction medicine clinics, and hospital-based addiction consultation services to improve the care for people who use drugs while they are in acute care settings.[38]

Government of Canada

Toronto has also received funding for safer supply programs through the Federal Substance Use and Addictions Program. In April 2021, the Federal government announced $7.7 million in additional time-limited funding for three safer supply programs in Toronto, including:

- $2.3 million over two years for iOAT at the Works;
- $2.15 million for two years for Safer Opioid Supply Program in Parkdale Queen West; and
- $3.28 million for Safer Opioid Supply Program in Downtown East.

Equity lens: health and social equity pathway

Qualitative data and community information shows that existing services do not yet meet the needs of all those who use drugs. More can be done to provide support to distinct communities including:

- Culturally safe, trauma-informed training for all providing health and social services.
- Organizations that provide harm reduction services to address the needs of specific groups, such as African, Caribbean, Black communities, Indigenous people, and Two-Spirit, Lesbian, Gay, Bisexual, Transgender, Queer or Questioning communities (2SLGBTQ+) need support to expand their harm reduction programming, and potentially offer supervised consumption services.
- People who are pregnant or parenting often face barriers accessing essential services due to the risk of being separated from their children. Evidence-based harm reduction, treatment, and social support services that meet the needs of women, gender-diverse people, and parents who use substances are needed.
- Supervised consumption sites are currently located across downtown neighbourhoods, for limited hours of the day. However, overdoses occur across Toronto, and at all hours and more City-wide services are needed.
- There is increasing evidence that overdose deaths are occurring among people who inhale drugs, and the need for tailored harm reduction services for this group includes supervised inhalation and smoking services.

Budget proposals to address the drug poisoning crisis

On December 6, 2021, the Toronto Board of Health requested the Medical Officer of Health to advocate to Health Canada and the Ontario Ministry of Health to fund:

- enhanced resources for the Toronto Drug Strategy Secretariat;
- enhanced programming for The Works;
- an expanded Overdose Outreach Team;
- expanded injectable Opioid Agonist Treatment (iOAT);
- enhanced data and improved data sharing; and
- mobile consumption services.

These services are urgently needed to enhance and expand harm reduction and clinical services, as well as provide more services outside the downtown core.

In addition, on December 6, 2021, the Toronto Board of Health requested the Medical Officer of Health to include funding to support the Toronto Drug Strategy Secretariat and the enhanced use of an overdose alert app in the Toronto Public Health 2022 Operating Budget Submission for consideration in the 2022 Budget process.

Significant change on an issue as complex as substance use will take time and a dedicated commitment from multiple levels of government. The need for expansion of treatment options in Toronto has been included in multiple Toronto Drug Strategy

Secretariat reports and plans including the 2005 Toronto Drug Strategy, the 2017 Toronto Overdose Action Plan, the 2019 Toronto Overdose Action Plan Update, and the 2021 Toronto Overdose Action Plan Update. The Board of Health has also advocated for more affordable, supportive and harm reduction housing. More work is also needed to ensure better coordination and continuity of service, and to assist individuals with navigation supports.

The City of Toronto will continue to work with the Government of Ontario and the Government of Canada on funding opportunities for these critical services applying an equity lens to any such request.

8. Implementation Considerations

If Toronto's exemption request is granted, a detailed implementation plan would be developed, including mapping the steps within the alternative pathway, a final evaluation plan, a communication plan, a risk registry and risk mitigation strategies, as well as policy and training. For the purpose of this initial request, high-level implementation considerations have been included below.

Communications

As part of the community dialogue undertaken in 2018, Toronto Public Health consulted the community on a public health approach to drugs. Education to better understand the complexity of drug use particularly of currently illicit substances was identified as an important issue.

Through this extensive consultation process, many respondents shared that they did not have a high level of knowledge or understanding of the health and social harms caused by current drug policies. In addition, individuals with greater knowledge or experience in this area, including individuals with lived experience and front line workers, were more likely to support policy change.

It is therefore necessary to increase public knowledge about the current drug poisoning crisis and build public confidence in policy change throughout the decriminalization exemption process. As part of this approach, Toronto Public Health would develop communication strategies and plans to proactively communicate to:

- The general public to increase public knowledge about the drug poisoning crisis, public health regulation, public health approaches to drug use, and the need for new policy and programs to support and promote the health of the entire population including people who use drugs;
- People who use drugs to ensure transparency about the process to seek exemption and what it means for them;
- Service providers and those who work in health and social services to increase resources and awareness for individuals who are seeking treatment and support;

- Key stakeholders including members of Toronto City Council, the Board of Health, local law enforcement, neighbouring municipalities, and the provincial and federal governments.

Toronto Public Health will continue to provide up to date information and impacts of policy changes and decision as related to the development of an alternative approach to the criminalization of drug use that builds public confidence and trust. Working closely with people who use drugs, communications resources within Toronto Public Health and the City of Toronto will be key to the development of the communication plan.

Risks and Risk Mitigation

Toronto Public Health has carefully considered the potential risks related to decriminalization and how to mitigate them. Risks below are considered a sample of what will become a more detailed risk registry, which will need to be updated and maintained as implementation proceeds, along with a detailed evaluation process. Potential risks include:

Determining the supply for personal possession

- A baseline for personal possession that is set below typical drug use patterns could leave those with the most serious substance use challenges subject to drug seizure.
- If the amount a person can legally carry is set too low, it may influence the composition of the drug supply and lead to increasing potency.
- Inequitable enforcement of personal possession limits could perpetuate existing systemic discrimination against people who are racialized and other marginalized populations.

To mitigate any risks associated with possession amounts, work to determine the definition of personal possession will be informed by people who use drugs, including consideration of purchasing, sharing, and using patterns, which may differ from person to person. Any quantity limits will continue to be monitored, evaluated and refined as decriminalization is implemented.

Other risks

- Poor uptake of referrals could limit harm reduction opportunities.

Building trust with people who use drugs and who have faced fear of criminalization, stigma, and discrimination will take time and intentional efforts. A comprehensive communication strategy will accompany decriminalization and one of the focuses will be reaching people who use drugs. The evaluation of the model will also monitor implementation and provide the opportunity to use findings to continuously improve the model.

- Referrals could overstretch the capacity of existing services (for example, a lack of sufficient capacity and infrastructure in health and social services).

Alongside decriminalization, Toronto Public Health will work with provincial and federal partners on investment for necessary enhancements to health and social services to address the drug poisoning crisis. One of the goals of decriminalization is to remove barriers to accessing supports and services for people who use drugs. The evaluation of the model will monitor the extent to which decriminalization achieves the goal and refinements to the model will be made as necessary.

- Decriminalization could change drug use patterns or increase public consumption.

A recent systematic review of evaluations of decriminalization in other jurisdictions found that in the majority of jurisdictions that have implemented decriminalization, drug use trends did not change and drug use did not increase following decriminalization.[39] Decriminalization reduces the barriers to accessing health and social services for people who use drugs, which offers the opportunity to mitigate any potential changes in drug consumption through health promotion and connection to services. The ongoing monitoring and evaluation will assess any changes in drug use patterns and based on findings, additional communication and health promotion strategies will be developed, if necessary.

- People who use drugs could relocate to Toronto to avoid criminal prosecution in other cities.

The Toronto Board of Health has called for a national approach to decriminalization. However, in the absence of that, Toronto Public Health will continue to work with our regional partners and outline funding requirements to build a comprehensive network of services to meet the needs of people who use drugs.

- Law enforcement would need to consider how to enforce different laws across bordering municipalities.

The implementation of decriminalization at municipal borders, in the absence of a national approach to decriminalization, will be advanced in partnership with neighboring municipalities.

9. Expected Impacts and Outcomes

Toronto Public Health engaged The Centre on Drug Policy Evaluation (CDPE) to develop an initial evaluation framework for the proposed Toronto exemption model. Outcomes, as well as process, will be monitored and evaluated. The proposed evaluative approach will involve several phases and will be continually reviewed and refined throughout the submission process with Health Canada, and during implementation.

The evaluation framework development was grounded in the lived experience of people who use/have used drugs and their input will be centred as the evaluation is refined. In addition, data collection among people who use drugs and who experience

marginalization and structural inequity will be prioritized. Further consultation with people who use drugs, service providers and other stakeholders will be needed to ensure we have a meaningful and appropriate evaluation framework. However, an initial approach is outlined below.

The first phase of the evaluation would focus on the immediate implementation of the change in legal status of drug possession for personal use within Toronto's boundaries. The objective of this initial phase would be to evaluate the impact of the decriminalization of possession of drugs for personal use on law enforcement and criminal justice engagement. See Table 2 below for a logic model that could underlie this initial evaluation approach.

Future evaluation phases will need to be further refined with stakeholders, but could focus on changes in access to services; outcomes such as service usage (and resulting changes in health and or/social indicators); and stigma indicators.

Table 2. Logic model for evaluation of change in legal status of drug possession for personal use

Inputs	• Decriminalizing personal possession of illegal substances within Toronto's boundaries
Activities	• Ending of arrests and charges associated with personal possession of illegal drugs
Affected Populations	• All residents of Toronto • People in Toronto who experience criminalization related to drug use; disproportionately racialized and Indigenous people, unhoused, marginalized, and poor people who use drugs (i.e., those experiencing structural inequity)
Outputs	• # of arrests for personal possession of illegal drugs in Toronto • # of charges for personal possession of illegal drugs in Toronto • # of arrests of people from populations that experience disproportionate criminalization related to drug possession • # of charges of people from populations that experience disproportionate criminalization related to drug possession
Short-Term Outcomes	• Overall reduction in # of arrests for personal possession of illegal drugs in Toronto • Overall reduction in # of charges for personal possession of illegal drugs in Toronto • Overall reduction in police encounters among populations in Toronto experiencing disproportionate criminalization related to drug possession • Overall reduction in engagement of populations experiencing disproportionate criminalization related to drug possession in the criminal justice system
Long-Term Outcomes	• Reduction in # of people incarcerated for charges including personal possession of illegal drugs • Reduction in anticipated stigma by people criminalized for their drug possession from affected populations

10. Conclusion

In response to direction from the Toronto Board of Health, Toronto Public Health is requesting the federal government take urgent action and provide an exemption under 56(1) of the *Controlled Drugs and Substances Act* that would decriminalize personal possession of illicit substances within Toronto's boundaries.

Like many other jurisdictions, the drug poisoning crisis in Toronto continues to worsen, compounded by the effects of the COVID-19 pandemic and an unregulated toxic drug supply. Toronto Public Health is committed to taking action to address the drug poisoning crisis. Decriminalization is an important component of this and has the potential to benefit all people who use drugs as well as those who are disproportionately impacted by the harms of criminal justice based drug policy.

Decriminalization can help remove the burden, stigma, or perception that someone using drugs is acting outside the law or a criminal. While the number of arrests or charges and prosecutions in Toronto may be declining, decriminalization would send a clear message to the public and people who use drugs that substance use is a health issue, not a criminal issue.

This initial submission, informed by the perspectives of people who use drugs, summarizes the local context, the need for urgent action, the proposed alternative model, and support from key stakeholders. Once feedback is received from Health Canada, Toronto anticipates taking steps to establish a quantities panel, initiate an indigenous-led working group, and refine the alternative pathway model with the community and people who use drugs.

We look forward to working with Health Canada to advance this initial submission.

Attachment 1: Summary of Public Consultations on Drug Decriminalization
Attachment 2: Letters of Support for Decriminalization

Appendix 1: Toronto's submission to Health Canada Working Group members

The working group was chaired by Dr. Eileen de Villa, the Medical Officer of Health for Toronto. Organizations represented include:

- Black CAP
- Canadian Association of People Who Use Drugs
- Canadian Institute for Substance Use Research
- Centre for Addiction and Mental Health
- Centre for Drug Policy Evaluation
- Community Action for Families
- Families for Addiction Recovery
- Family Service Toronto
- Gerstein Centre
- HIV Legal Network
- John Howard Society – Toronto
- Ontario Harm Reduction Network
- Parkdale Queen West Community Health Centre
- Shelter, Support, and Housing Administration, City of Toronto
- Social Development, Finance, and Administration, City of Toronto
- South Riverdale Community Health Centre
- St. Michael's Hospital, Li Ka Shing Knowledge Institute
- St. Michael's Homes
- St. Michael's Hospital
- The Works, Toronto Public Health
- Toronto Aboriginal Support Services Council
- Toronto Drug Users Union
- Toronto Harm Reduction Alliance
- Toronto Paramedic Services
- Toronto Police Service
- University of Toronto
- Wellesley Institute

Appendix 2: Consultation with local organizations and government

Regional Government
Durham Region Assistant Medical Officer of Health
Halton Region Medical Officer of Health
Peel Region Medical Officer of Health
York Region Acting Medical Officer of Health

Government of Ontario
Ministry of Health • OHIP and Drug & Devices • Public Health • Mental Health and Addictions • Indigenous, French Language and Priority Populations • Provincial Programs Branch
Ontario Health • Vice President • Director, Provincial Programs Branch
Public Health Ontario
Solicitor General Chief Coroner for Ontario

Government of Canada
Health Canada Director General, Controlled Substances Directorate

Other Jurisdictions Outside of Ontario
Calgary – Alberta Health Services Medical Officers of Health
Montreal Public Health Director
Vancouver Coastal Health Director, Strategic Initiatives and Public Health Planning

Other Organizations
Addictions and Mental Health Ontario Chief Executive Officer (Interim) and Director of Public Affairs

Other Organizations
Centre for Addictions and Mental Health Various
Doctors for Decriminalization Steering Committee Member

Appendix 3: Health and Social Supports in Toronto

Note: this is not an exhaustive list of all programs and organizations in Toronto offering harm reduction or treatment services.

Health Maximization – Social and health supports to stabilize and foster health and well being

Many people use drugs without experiencing health-related harms or having a substance use disorder. For those who do experience health-related harms or have a substance use disorder, there are often underlying contributing factors, including limited access to the social determinants of health, and trauma. Criminalization means that these underlying conditions often go unaddressed, because people who use drugs are fearful of seeking help and being reported by healthcare and other service professionals.[40]

City of Toronto Initiatives

The City of Toronto has a range of programs and initiatives that can support individuals to access health and social supports, including Toronto Employment and Social Services, Streets to Homes Street Outreach and Support, the Housing TO Action Plan, the Downtown East Action Plan, the Poverty Reduction Strategy, and SafeTO.

For more information about City of Toronto's strategies that support or intersect with this exemption request, see Appendix 4.

Toronto Drop-Ins

Individuals who have lost their housing and are experiencing homelessness are at an increased risk for overdose and other health harms. Drop-ins provide a welcoming space where participants experiencing homelessness or precarious housing can feel safer and can meet their own basic physical, social, personal, and mental health needs. There are over 50 drop-in centres across Toronto. Drop-ins are unique in that they go beyond providing emergency needs (for example, a bed) and provide basic needs such as showers, laundry access, food, clothing, harm reduction supplies, clothing, and hygiene products.

Harm Reduction Services

Overdose Prevention and Harm Reduction Outreach

There are over sixty organizations in Toronto providing overdose prevention and/or harm reduction outreach services.

For example, The Works, run through Toronto Public Health, provides a range of harm reduction outreach services in Toronto's downtown east and throughout the city, including distributing naloxone and other harm reduction supplies; retrieving discarded harm reduction equipment; providing a number of referrals including to shelters, housing, primary care and mental health services; and education about safer drug use and safer disposal. At shelter hotel sites, harm reduction workers also conduct harm

reduction and overdose preparedness assessments, and provide other harm reduction services to both staff and residents of the shelter sites.

The Works supports over 60 agencies across Toronto to offer harm reduction supplies and services at over 100 locations and access points.

The Works offers supervised consumption services at one downtown location (277 Victoria Street), and within three Urgent Public Health Needs Sites (UPHNS) at shelter hotel sites.

Supervised Consumption Services

Supervised consumption services (SCS) are offered in several locations in Toronto. There are seven sites that offer consumption and treatment services funded by the Government of Ontario, and two overdose prevention sites at community-based organizations that no longer receive funding from the Government of Ontario. The City of Toronto has been advocating for an expansion of SCS in Toronto through the Board of Health and Municipal Drug Strategy Coordinating Network of Ontario (MDSCNO). In March 2021, the MDSCNO requested that the Government of Ontario remove the current cap of 21 Consumption and Treatment Services and create and fund an UPHNS program to save lives and improve the health, safety and well-being of people who use drugs in Ontario.

Urgent Public Health Needs Sites (UPHNS)

Urgent Public Health Needs Sites (UPHNS) are embedded into selected shelters across Toronto, allowing residents at the location to consume drugs under trained supervision, reducing the risk of overdose fatalities. There are currently four sites across Toronto. Additional sites will be confirmed as needs and resources are established.

Integrated Prevention and Harm Reduction Initiative (iPHARE)

The Integrated Prevention and Harm Reduction (iPHARE) initiative is a multi-pronged effort by the City of Toronto and community agencies to address opioid-related deaths in Toronto's shelter system. Increased harm reduction outreach and opening UPHNS in the shelter system are part of this initiative.

Drug Checking

Since 2019, free and anonymous drug checking has been available in Toronto, provideing people who use drugs with the opportunity to make informed decisions based on knowledge about the contents of their drugs.

Virtual Overdose Response Services

In addition to the services above, 24 hour virtual supervised consumption by peers and connection to overdose response when needed is available in Toronto.

Substance Use Treatment

Expanding access to pharmaceutical alternatives to the unregulated drug supply has been recognized as a life-saving and critical part of a comprehensive approach to the drug poisoning crisis.

Access to Injectable Opioid Agonist Treatment

Expansion of injectable opioid agonist treatment (iOAT) as a treatment option for substance use disorder has been recognized and recommended by a number of groups, including Addiction and Mental Health Ontario.

The Works, supported by Health Canada's Substance Use and Addictions Program (SUAP), has expanded medication options available for people with opioid use disorder and is now offering injectable hydromorphone to those who do not respond to currently available services and/or who remain at high risk of overdose.

The funding from Health Canada for iOAT represents a positive step towards supporting this critical and life-saving services; however, funding is limited to two years, and supports a relatively small clinic that will serve approximately 35 people at high risk of overdose, at a fixed site in downtown Toronto. Expansion to other sites, and scaling up so that services can serve more people will be necessary for iOAT to effectively contribute to the response to the drug poisoning crisis in Toronto.

Opioid Agonist Therapy (OAT)

Opioid Agonist Therapy (OAT) is available through low-barrier, walk-in clinics that patients can attend to get help for substance use disorder without an appointment or formal referral. These clinics also provide time-limited medical addiction care (including pharmacotherapy, brief counselling, and referrals to community services). OAT is also available through a number of other physicians in Toronto.

Day and Residential Treatment and Withdrawal Management

Publicly funded residential treatment programs are offered by five organizations in Toronto. Three organizations offer withdrawal management services at five locations across Toronto that are also publicly funded.

Safer Supply Programs in Toronto

There are limited Safer Opioid Supply Programs available in Toronto. These projects are currently funded by the Government of Canada for two years and help people with opioid use disorder access pharmaceutical alternatives and increase engagement with healthcare and social services to foster better health outcomes.

Appendix 4: City of Toronto Initiatives

Toronto Drug Strategy and Toronto Overdose Action Plan

The Toronto Drug Strategy is a comprehensive drug strategy for the City of Toronto, which guides the City of Toronto's policy and programs to respond to substance use and provides recommendations for further action.[41] The current focus of the Toronto Drug Strategy is the implementation of the Toronto Overdose Action Plan, which provides a comprehensive set of actions to prevent and respond to overdoses.[42]

Toronto Indigenous Overdose Strategy

The Toronto Indigenous Overdose Strategy was developed as a companion document to the Toronto Overdose Action Plan. The Toronto Indigenous Overdose Strategy has recommended actions that were developed through an Indigenous-led consultation process that gathered advice from Indigenous people who use or have used substances through advice circles and Indigenous and non-Indigenous service providers who serve Indigenous people.

SafeTO Community Safety and Well-being

Under the *Ontario Police Services Act*, all municipalities are mandated to prepare and adopt a Community Safety and Well-Being Plan. SafeTO is a comprehensive Ten-Year Community Safety and Well-Being Plan that reimagines core elements of community safety and well-being. Its goal is to shift away from addressing community safety issues through a lens of law enforcement and crime, which increase barriers and risks for Torontonians, particularly those from Indigenous, Black, 2SLGBTQ+ and equity-deserving communities as a result of systemic racism embedded within the Canadian justice system. SafeTO also seeks to move from a reliance on reactive emergency response to a culture of proactive prevention. SafeTO focuses on strengthening the social determinants of health and reducing health inequities to effectively prevent community violence, vulnerability and the risk factors that negatively impact communities. SafeTO promotes and celebrates the well-being and resilience of all residents through multi-sectoral action toward seven strategic goals: Reduce Vulnerability; Reduce Violence; Advance Truth and Reconciliation; Promote Healing and Justice; Invest in People; Invest in Neighbourhoods; and Drive Collaboration and Accountability.[43]

Community Crisis Response Pilot

With under investment in the mental health system and substance use services in Ontario, police play a default role in responding to persons in crisis. However, this police-led response creates service barriers and risks for many Torontonians, particularly for Indigenous, Black, and equity-deserving communities. The Community Crisis Response Pilot provides four community crisis support service in Toronto for some non-emergency 911 calls for service. Mobile crisis support teams comprising of a multidisciplinary team of crisis workers with crisis intervention and de-escalation training are dispatched to respond to non-emergency crisis calls involving person in crisis, wellness checks and other calls as appropriate. Community health service partners are anchor partners to ensure that adaptive and service-user centred care continues after the initial crisis intervention.[44]

Community Justice Centres
The Ontario Ministry of the Attorney General is partnering with the City of Toronto to develop two Justice Centre pilots. The Downtown East Justice Centre pilot will address the cycle of offending for chronic offenders affected by mental health and substance use issues, concurrent disorders, poverty and homelessness. The Justice Centre moves justice out of the traditional courtroom and into a community setting. It brings together justice, health, employment, education and social services to collectively address the root causes of crime, break the cycle of offending and improve public safety and community well-being. The City of Toronto's support for Justice Centres is based on the need to provide enhanced local access to service for those engaged in the justice system.[45]

HousingTO 2020 - 2030 Action Plan
The HousingTO 2020-2030 Action Plan recognizes that affordable, good quality, and stable housing is a key social determinant of health.[46] City Council, as part of the HousingTO Plan, has established a target of approving 40,000 affordable homes by 2030, including 18,000 supportive homes for people experiencing homelessness or those who are at risk of homelessness. A minimum of 5,000 affordable and supportive homes will be dedicated to Indigenous communities.

Supportive housing provides permanent rental homes with support services to help residents achieve housing stability and prevent them from a return to homelessness. Since December 2020, the City of Toronto has made over 500 supportive homes available for occupancy through leveraging units within Toronto Community Housing Corporation portfolio, modular construction, and acquisition and renovation of properties. Non-profit operators provide 24/7 on-site staffing and a variety of supports for tenants, including harm reduction, relapse prevention and recovery-related programs, connections to primary health care, income assistance and eviction prevention programs.

It is anticipated that by the end of 2021 an additional 749 homes will be made available including 210 homes within TCHC portfolio, 308 homes through acquisition and 231 through modular construction. An additional 170 homes created through modular construction are expected to be completed in spring 2022.

Downtown East Action Plan
Toronto's Downtown East has long been home to diverse populations who live, work, and play in the area, with strong representation from Indigenous people, 2SLGBTQ+, racialized people, newcomers, and people on low incomes. The area is also home to high numbers of marginalized people at risk because of a lack of affordable and supportive housing, access to safe drug supply, or adequate mental health services/supports. In addition, they experience social stigma and discrimination which further excludes them from society. The Downtown East Action Plan was developed to address the complex challenges in this area of the city related to poverty, homelessness, housing, community safety, mental health and substance use, particularly opioid-related overdoses. The four central outcomes for the plan are: Safe,

Inclusive Communities; Cross Sectoral Trust and Collaboration; Stability for Marginalized People; and Model for a City Response to Complex Issue.[47]

Poverty Reduction Strategy

Toronto is increasingly unaffordable for many residents. There are much higher levels of poverty and a much greater risk of poverty among specific population groups and neighbourhoods. In Toronto, poverty is gendered, racialized, and geographically concentrated. The Toronto Poverty Reduction Strategy is the City of Toronto's long-term strategy to address immediate needs, create pathways to prosperity, and drive systemic change for those living in poverty in Toronto. The strategy focuses on housing stability, services access, transit equity, food access, the quality of jobs and incomes, and systemic change.[48]

Toronto Action Plan to Confront Anti-Black Racism

The City of Toronto acknowledges that anti-Black racism persists in the city, affecting the life chances of more than 200,000 people of African descent or origin who call Toronto home. Anti-Black racism has had detrimental impacts on the life and work of Black people in our city. The City of Toronto recognizes its responsibility to create a city that works for all residents. Confronting and removing barriers caused by anti-Black racism benefits all Torontonians, especially other Toronto communities experiencing racism and marginalization. To begin confronting anti-Black racism in Toronto, the City in collaboration with Torontonians of African descent created Toronto's Action Plan to Confront Anti-Black Racism, which outlines action and economic investment to address anti-Black racism in the city. [49]

References

[1] Health Canada. No date. Stigma around Substance Use. Available at https://www.canada.ca/en/health-canada/services/substance-use/problematic-prescription-drug-use/opioids/stigma.html.
[2] Toronto Public Health. 2018. Discussion Paper: A Public Health Approach to Drugs. Available at https://www.canada.ca/en/health-canada/services/substance-use/problematic-prescription-drug-use/opioids/stigma.html.
[3] Coroner's Opioid Investigative Aid, Office of the Chief Coroner for Ontario, November 15, 2021.
[4] Coroner's Opioid Investigative Aid, May 2017 to March 2021, Office of the Chief Coroner for Ontario, extracted July 18, 2021.
[5] Toronto Public Health. Deaths of People Experiencing Homelessness: January 1, 2017 to June 30, 2021. Available at: https://www.toronto.ca/community-people/health-wellness-care/health-inspections-monitoring/monitoring-deaths-of-homeless-people.
[6] Coroner's Opioid Investigative Aid. April 1 2020 to March 2021, Office of the Chief Coroner for Ontario. Available at: https://www.toronto.ca/wp-content/uploads/2020/12/8d4b-TOIS-Coroner-Data_Final.pdf
[7] Stimulant Harms Snapshot | Public Health Ontario.
[8] Special Advisory Committee on the Epidemic of Opioid Overdoses. 2021. Opioids and Stimulant-Related Harms in Canada. Available at: https://health-infobase.canada.ca/substance-related-harms/opioids-stimulants/.
[9] Ontario Agency for Health Protection and Promotion (Public Health Ontario). No date. Stimulant Harms Snapshot, 2018-2020. Available at: https://www.publichealthontario.ca/en/data-and-analysis/substance-use/stimulant-harms.
[10] Ontario Drug Policy Research Network, et al. 2020. Preliminary Patterns in Circumstances Surrounding Opioid-Related Deaths in Ontario during the COVID-19 Pandemic. Available at: https://odprn.ca/research/publications/preliminary-patterns-in-circumstances-surrounding-opioid-related-deaths-in-ontario-during-the-covid-19-pandemic/.
[11] Toronto's Drug Checking Service. No date. What's in Toronto's Drug Supply. Available at: https://drugchecking.cdpe.org/.
[12] Toronto's Drug Checking Service. No date. Alerts. Available at: https://drugchecking.cdpe.org/alerts/.
[13] Government of Canada. No date. Opioids. Available at: https://www.canada.ca/en/health-canada/services/opioids.html.
[14] Toronto's Drug Checking Service. No date. Drug Dictionary. Available at: https://drugchecking.cdpe.org/drug-dictionary/.
[15] Ali, F., et al. 2020. Identifying the Needs and Challenges of People Who Use Drugs (PWUD) During the COVID-19 Global Pandemic: A National Qualitative Assessment. Available at: https://campusmentalhealth.ca/resource/identifying-the-needs-and-challenges-of-people-who-use-drugs-pwud-during-the-covid-19-pandemic/.
[16] Ibid.
[17] Khorasheh, T., et al. 2021. Impacts of Overdose on Front-Line Harm Reduction Workers in the City of Toronto. Available at: https://maphealth.ca/wp-content/uploads/Bayoumi_HRW_BriefReport.pdf.
[18] Ontario COVID-19 Science Advisory Table. 2021. The Impact of the COVID-19 Pandemic on Opioid-Related Harm in Ontario. Available at: https://doi.org/10.47326/ocsat.2021.02.42.1.0.
[19] Government of Canada. No date. Stigma around Substance Use. Available at: https://www.canada.ca/en/health-canada/services/opioids/stigma.html.
[20] Bennet, D and D Larkin. 2018. Project Inclusion: Confronting Anti-Homeless and Anti-Substance User Stigma in British Columbia. Pivot Legal Society. Available at: http://www.pivotlegal.org/full_report_project_inclusion_b.
[21] Public Health Agency of Canada. 2019. Addressing Stigma: Towards a More Inclusive Health System. The Chief Public Health Officer's Report on the State of Public Health in Canada 2019. Available at: https://www.canada.ca/content/dam/phac-aspc/documents/corporate/publications/chief-public-health-officer-reports-state-public-health-canada/addressing-stigma-what-we-heard/stigma-eng.pdf.
[22] Ibid.
[23] Health Canada. 2019. Follow-up Survey and Qualitative Research on Opioid Awareness, Knowledge and Behaviours for Public Education Final Report. Available at: http://epe.lac-bac.gc.ca/100/200/301/pwgsc-tpsgc/por-ef/health/2019/137-18-e/report.pdf.

[24] Knaak, S, S. Mercer, R. Christie and H. Stuart. 2019. Stigma and the Opioid Crisis: Final Report. Mental Health Commission of Canada. Available at: https://mentalhealthcommission.ca/wp-content/uploads/2021/09/Opioid_Report_mar_2020_eng.pdf.
[25] Government of Canada. no date Stigma around Substance Use. Available at: https://www.canada.ca/en/health-canada/services/opioids/stigma.html.
[26] Public Health Agency of Canada. 2019. Addressing Stigma: Towards a More Inclusive Health System. The Chief Public Health Officer's Report on the State of Public Health in Canada 2019. Available at: https://www.canada.ca/content/dam/phac-aspc/documents/corporate/publications/chief-public-health-officer-reports-state-public-health-canada/addressing-stigma-what-we-heard/stigma-eng.pdf.
[27] Bennet, D and D Larkin. 2018. Project Inclusion: Confronting Anti-Homeless and Anti-Substance User Stigma in British Columbia. Pivot Legal Society. Available at: http://www.pivotlegal.org/full_report_project_inclusion_b.
[28] Health Canada Expert Task Force on Substance Use. 2021. Report 1: Recommendations on Alternatives to Criminal Penalties for Simple Possession of Controlled Substances. Available at: https://www.canada.ca/content/dam/hc-sc/documents/corporate/about-health-canada/public-engagement/external-advisory-bodies/reports/report-1-2021/report-1-HC-expert-task-force-on-substance-use-final-en.pdf.
[29] BC Office of the Provincial Health Officer. 2019 Stopping the Harm: Decriminalization of People Who Use Drugs in BC, Provincial Health Officer's Special Report. Available at: https://www2.gov.bc.ca/assets/gov/health/about-bc-s-health-care-system/office-of-the-provincial-health-officer/reports-publications/special-reports/stopping-the-harm-report.pdf.
[30] Health Canada Expert Task Force on Substance Use. 2021. Report 1: Recommendations on Alternatives to Criminal Penalties for Simple Possession of Controlled Substances. Available at: https://www.canada.ca/content/dam/hc-sc/documents/corporate/about-health-canada/public-engagement/external-advisory-bodies/reports/report-1-2021/report-1-HC-expert-task-force-on-substance-use-final-en.pdf.
[31] Ibid.
[32] Ibid.
[33] Rowan et al. Cultural interventions to treat addictions in Indigenous populations: findings from a scoping study. Substance Abuse Treatment, Prevention, and Policy. 2014: 9:34. Available at: http://www.substanceabusepolicy.com/content/9/1/34.
[34] Ibid.
[35] Halseth, R. & L. Murdock. 2020. Supporting Indigenous Self-Determination: Lessons Learned from a Review of Best Practices in Health Governance in Canada and Internationally. Prince George, BC: National Collaborating Centre for Indigenous Health Available at: https://www.nccih.ca/495/Supporting_Indigenous_self-determination_in_health___Lessons_learned_from_a_review_of_best_practices_in_health_governance_in_Canada_and_Internationally.nccih?id=317.
[36] Davinder, F., S. Prowse and M. Anderson.. Over incarceration of Indigenous people: a health crisis. 2019. CMAJ 2019 May 6;191:E487-8. Available at: https://www.cmaj.ca/content/191/18/E487
[37] Truth and Reconciliation Commission of Canada, 2015. Truth and Reconciliation Commission of Canada: Calls to Action. Calls to Action. Available at: https://ehprnh2mwo3.exactdn.com/wp-content/uploads/2021/01/Calls_to_Action_English2.pdf.
[38] Government of Ontario. 2017. News Release: Ontario Expanding Support for Addictions Treatment Throughout the Province. Available at: https://news.ontario.ca/en/release/1000477/ontario-expanding-support-for-addictions-treatment-throughout-the-province.
[39] Scheim, A.I., Maghsoudi, N., Marhsall,Z., Churchill, S., Ziegler, C., and Werb, D. Impact evaluations of drug decriminalisation and legal regulation on drug use, health and social harms: a systematic review. British Medical Journal Open 2020;10:e03514. Available at: https://bmjopen.bmj.com/content/bmjopen/10/9/e035148.full.pdf.
[40] Health Canada Expert Task Force on Substance Use. 2021. Report 1: Recommendations on Alternatives to Criminal Penalties for Simple Possession of Controlled Substances. Available at: https://www.canada.ca/content/dam/hc-sc/documents/corporate/about-health-canada/public-engagement/external-advisory-bodies/reports/report-1-2021/report-1-HC-expert-task-force-on-substance-use-final-en.pdf.

[41] City of Toronto. Toronto Drug Strategy. 2005. Available at: https://www.toronto.ca/wp-content/uploads/2017/11/9767-torontodrugstrategy-rep-appendix-a-d-2005-aoda.pdf.
[42] Toronto Public Health. Toronto Overdose Action Plan. 2017. Available at: https://www.toronto.ca/wp-content/uploads/2018/01/9483-Toronto-OD-Action-Plan.pdf.
[43] City of Toronto. SafeTO: Toronto's Ten-Year Community Safety and Well-Being Plan. 2021. Available at: https://www.toronto.ca/legdocs/mmis/2021/ex/bgrd/backgroundfile-168550.pdf.
[44] City of Toronto. Community Crisis Support Service Pilot. 2021. Available at: https://www.toronto.ca/legdocs/mmis/2021/ex/bgrd/backgroundfile-160016.pdf.
[45] City of Toronto. Report Back on Accessing Justice – New Toronto Courthouses. 2021. Available at: https://www.toronto.ca/legdocs/mmis/2021/ex/bgrd/backgroundfile-166988.pdf.
[46] City of Toronto. HousingTO: 2020 - 2030 Action Plan. Available at: https://www.toronto.ca/wp-content/uploads/2020/04/94f0-housing-to-2020-2030-action-plan-housing-secretariat.pdf.
[47] City of Toronto. Downtown East 2023 Five Year Action Plan. 2019. Available at: https://www.toronto.ca/legdocs/mmis/2019/ec/bgrd/backgroundfile-134601.pdf.
[48] City of Toronto. TOProsperity: Toronto Poverty Reduction Strategy. 2015. Available at: https://www.toronto.ca/legdocs/mmis/2015/ex/bgrd/backgroundfile-84626.pdf.
[49] City of Toronto. Toronto Action Plan to Confront Anti-Black Racism. 2017. Available at: https://www.toronto.ca/legdocs/mmis/2017/ex/bgrd/backgroundfile-109127.pdf.

ATTACHMENT 1

Summary of Public Consultations on Drug Decriminalization

Prepared by MASS LBP for Toronto Public Health

November 15, 2021

Toronto Public Health

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Executive Summary

On 14 June, 2021, the Board of Health instructed Toronto Public Health (TPH) to facilitate a multi-sector working group and public consultation to provide guidance on shaping an alternative approach to drug criminalization. TPH hired MASS LBP to facilitate the working group and conduct a consultation process that engaged stakeholders and the broader public. These consultations particularly centred the perspectives of people who use drugs (PWUD) from a range of backgrounds, whose lived experience ensure diverse perspectives were considered. The findings in this summary report reflect what was heard in the stakeholder and public consultations.

Consultation participants generally agreed there would be many benefits if the exemption request to decriminalize the possession of drugs was approved by Health Canada. Participants felt that, at the very least, an exemption would reduce all police interactions with people who use drugs (PWUD). Many participants felt that criminalization and incarceration are not evidence-based pathways to treatment, and have often resulted in the harmful oppression of those who use drugs. Consultation participants pointed to the need for decriminalization to focus, instead, on improving the quality of life of PWUD by accounting for the social determinants of health, and removing morality and criminality as values that underpin how society treats PWUD. The development of new drug policy should centre PWUD, engage and empower them at every step of the process.

Consultation participants highlighted many flaws and systemic inequities that plague current drug policy and resources. Much of the discussion was devoted to the everyday difficulties experienced by PWUD as they try to navigate a system that denies them their humanity. These issues are further magnified by the unique intersecting identities of most PWUD, such as sex workers, Indigenous peoples, those who identify as LGBTQ2SIA+, and those from African, Caribbean, and Black (ACB) communities. An unregulated market flooded with toxic drug supply, discriminatory policing, stigma in health care, and challenges navigating the opioid crisis were just some of the realities participants described throughout the consultation.

Participants were aligned on many elements of an alternative approach, agreeing that the model should be: city-wide, cover all drugs, apply to all ages, and have no associated fines or penalties. However, the exact nature of the shape, structure and scope of an exemption request to Health Canada was contested. Some participants felt the success of the decriminalization model would hinge upon an expansion of harm reduction services, increased funding from government bodies, and systemic change within the city's institutions. Others

believed that systemic change, while admirable, was beyond the scope of the exemption request, advocating for a submission to Health Canada that focuses primarily on removing the threat of criminalization from the lives of PWUD. Participants also shared nuanced perspectives on the role of police, the efficacy of mandated treatment, and whether there should be a threshold for the quantity of drugs permitted for personal possession. Key themes and considerations from this public consultation include:

1. **Centering lived experience**
   Participants consistently highlighted how intersecting identities inform the unique and diverse experiences of PWUD. In particular, they highlighted the disproportionate impact that the criminalization of drugs and over-policing have had on African, Caribbean, Black (ACB), and Indigenous communities. Respondents shared how these yokes of oppression have played out throughout their lives and underscored the importance of centering their perspectives in the development of the City's drug policy. Specific considerations for and the needs of ACB, Indigenous peoples, women and women-identifying individuals, raised by participants, are embedded throughout the report.

2. **Improving access to services**
   Many participants believed decriminalization would need to be associated with the expansion of resources to address some of the issues that impact the community. The few harm reduction services available in the city currently face a number of challenges, resulting in barriers to access for PWUD. Inadequate funding, service concentration in the downtown core, and long wait times are some of the obstacles to be addressed for decriminalization to truly have an impact on the lives of PWUD.

3. **Reducing stigma**
   Removing criminal penalties will only go so far in addressing the barriers faced by PWUD. Participants described pervasive stigma in health care, policing, and society at large that robs PWUD of access to employment, adequate health care, and basic human rights on multiple levels. Even if the exemption request was successful, participants emphasized the need to challenge and mitigate the stigma against PWUD through systemic cultural change.

4. **Options for mandated treatment**
   Participants unanimously agreed that voluntary pathways to treatment should be included in any City of Toronto decriminalization model. However, there was some

disagreement on the inclusion of involuntary treatment as a feature of the model. Many participants viewed mandatory treatment as ineffective and worried it would strip away PWUD's agency over their own bodies. However, some respondents advocated for the use of mandated treatment in a narrow set of circumstances, such as when an individual is deemed incapable of making sound decisions for their health.

5. **A different role for police**

   Participants generally agreed that police should have a minimal role in drug-related 9-1-1 calls within the decriminalization model. Many participants felt the role for police should be limited to incidents that involved violence. The historical injustices carried out by police towards PWUD and other marginalized communities have resulted in a strained relationship characterized by trauma and mistrust. If the police were to be involved in 9-1-1 calls, participants felt a significant cultural shift would be needed, enabled by extensive training in harm reduction practices and a shift to a more support-focused role when interacting with PWUD.

6. **Drug supply concerns**

   One of the pressing issues surfaced during the consultations was the dangers posed by toxic supply in an unregulated market. All consultation participants pointed to the desperate need to expand safe supply services in order to adequately respond to the opioid epidemic killing PWUD. Participants also outlined the limitations of current safe supply programs, naming issues that ranged from low potency to the exclusion of those who use non-injectable drugs.

7. **Determining the threshold for possession**

   Opinions were relatively divided on the exact quantity or threshold for possession of a controlled substance. However, participants generally agreed that multiple factors needed to be taken into account when establishing a threshold. Many cautioned against repeating the past mistakes of other jurisdictions, and emphasized variability when it comes to individual drug use and tolerance. Others were opposed to the idea of a threshold in general because it could allow room for police discretion and therefore police bias. Also, many practices taught by harm reduction workers to promote safe use could be mistaken by police as indications of trafficking.

Purpose and Context

On 14 June, 2021, the Board of Health instructed Toronto Public Health (TPH) to facilitate a multi-sector working group and public consultation to provide guidance on shaping an alternative approach to drug criminalization. TPH hired MASS LBP to facilitate the working group and conduct a consultation process that engaged stakeholders and the broader public.

The findings in this summary report reflect what was heard through the stakeholder and public consultations. These consultations centered the perspectives of people who use drugs (PWUD) from a range of backgrounds, whose lived experience would strengthen the submission and ensure diverse perspectives were considered. Years of ineffective criminal drug policy that either moralizes or punishes people for doing drugs have demonstrated the importance of having those with lived experience engaged to avoid perpetuating existing inequities. Though people from all demographic and socio-economic groups are affected by these policies, the harms disproportionately impact Black and Indigenous peoples, those with mental illness, and other marginalized groups. By focusing on what PWUD hope to see from decriminalization, the City can create policy that is safe and meets the needs of those most impacted.

The opioid epidemic in the city (and beyond) is the impetus for the push to decriminalize the simple possession of drugs, and it underpins the consultation process and the request for decriminalization as a whole. High levels of toxicity in an unregulated market have contributed to thousands of overdose deaths in Toronto and across the country. Criminalization of possession of drugs only exacerbates the dangers posed by this tainted supply because fear of legal recourse forces PWUD to manage their use in secrecy, resulting in unsafe practices and a reluctance to seek help when needed. A toxic supply, underfunded harm reduction services, and few available pathways for treatment are resulting in high mortality rates.

The consultations by Toronto Public Health were conducted amidst a surge in COVID-19 cases that affected outreach efforts to vulnerable PWUD, particularly those who are street-involved or unhoused. COVID-19 has exposed existing gaps in health, social service, and illustrated how they fail to serve those who need them most. These stresses have been exacerbated by the continued criminalization of those who use controlled substances. Vulnerable PWUD continue to be disproportionately impacted by the pandemic, further underscoring the importance of centering their perspectives in any decriminalization model.

The consultation process captured and documented the views and perspectives of PWUD and those who work in harm reduction services. Participants were asked their views on the benefits and challenges of decriminalization, role of police, and other important elements of the model. While doing so, they were also given space to illustrate the need for decriminalization by pointing to the flaws and gaps within the City's current drug policy. Their feedback will inform the Working Group, elements of the model, and strengthen the submission to Health Canada for the exemption request.

Key Findings

The consultation process surfaced themes and considerations that are organized into seven buckets:

1. Centering lived experience
2. Improving access to services
3. Reducing stigma
4. Options for mandated treatment
5. A different role for police
6. Drug supply concerns
7. Determining the threshold for possession

1. Centering lived experience

A consistent theme over the course of the consultation process was the importance of acknowledging intersectional identities and how these shape the lived experiences of PWUD. By extension, participants emphasized the need for those with lived experience to not only be consulted but to also be involved in leading the process through every phase of the submission to Health Canada. This will not only strengthen the submission by providing agency to PWUD to shape their own futures, but it also highlights the reality that not all PWUD are criminalized in the same manner: their various other identities impact their lived experience as drug users.

Demographic groups such as sex workers, those belonging to African, Caribbean, and Black (ACB) communities, and Indigenous peoples have been historically excluded from decision-making circles and there was a perception among consultation participants that these same groups are overrepresented in drug incarcerations. Centering their perspectives in the submission process could ensure that the decriminalization model incorporates their needs and does not perpetuate existing inequities. It is important to examine and incorporate the cultural aspects of how different communities navigate their drug use, and the historical and present-

day impact criminalization has had on their lived experience throughout the submission process for decriminalization to be effective.

Where consultation participants raised considerations and needs specific to a particular demographic, we included this in the relevant section. The legacy of oppression and its ongoing exclusionary effects, however, warrant a broader naming and acknowledgement as well.

2. Improving access to services

Many respondents hoped that decriminalization would lead to greater uptake in support services because the fear of criminalization would be reduced. Respondents felt that greater resource allocation would be needed to facilitate enhanced access to harm reduction services. Across the board, respondents cited access to harm reduction services and treatment resources as a barrier to changing their drug use. Even PWUD who are able to access these supports pointed to other flaws, including a rigid structure and gaps in the system, also symptomatic of a lack of funding. By increasing access to harm reduction and social support services, decriminalization can help address larger systemic challenges that disproportionately affect PWUD.

Barriers to service are broken out along a number of key themes: a lack of infrastructure and capacity, geographic barriers, and a lack of affordable housing.

Lack of infrastructure and capacity

Participants agreed that an insufficient infrastructure of harm reduction services is a major barrier to access. While all those interviewed favoured decriminalization, many pointed to existing capacity issues that would not be adequately addressed through exemption alone. They felt that currently available harm reduction and health services would be unable to keep up with increased demand that would result should the exemption request succeed. As an example, participants highlighted difficulties with continuity of care, explaining that it can take days for opioid agonist therapy (OAT) prescriptions to be continued.

The process of establishing supervised consumption services in the city is long and arduous which makes it difficult to quickly expand locations and services. The ever-changing list of requirements, from multiple levels of government, needed to establish a site leads to two years of work before it can actually open. Furthermore, when new services and resources are able to overcome bureaucratic red tape, their funding is often subject to government oversight and political whims — as illustrated by Ontario Premier Doug Ford's decision to freeze the opening

of all new supervised consumption sites. Interviewees described this as an undesirable shift from "advancement" of harm reduction resources to "containment." In its current state, services in the city would be inadequate to support PWUD in a decriminalized model.

For those who decide to seek treatment for drug use, admission to a treatment centre is a massive challenge; wait-times for enrolment range from four to twelve months. During this time, PWUD can often return to drug use due to lack of timely intervention. The exception to this trend are those who have the resources to pay for private treatment which can cost upwards of $30,000. Respondents identified the need for more Ministry-funded beds within rehab services, along with greater integration of peer support workers and health systems, for decriminalization to succeed in uplifting the lives of PWUD.

Geographical barriers

PWUD also face geographical barriers when they try to access services. Supervised Consumption Services (SCS) and Opioid Agonist Treatment (OAT) facilities are concentrated in the downtown core. This geographical concentration creates an additional barrier for individuals in the inner suburbs like Scarborough and Etobicoke. PWUD are located in every corner of the city, and those who do not live in the downtown core or those who lack the means to make the commute are trapped without support. The few services available outside the core are inadequate, with one respondent stating, "The OAT clinics I've seen in Scarborough are mostly private and [of] really poor quality." Even if a PWUD has the means to travel to the available resources, many SCSs are not open on weekends, another barrier for those working 9-to-5 jobs. Participants were optimistic that approval of the exemption request and subsequent decriminalization accompanied by greater resources would result in the much-needed expansion of services beyond the city's core.

Lack of affordable housing

A lack of capacity affects harm reduction resources as well as other social determinants of health, such as housing. Participants felt that a lack of affordable housing further criminalized PWUD by making them more vulnerable because they lack the security of stable shelter. As one respondent indicated, some PWUD who experience homelessness actively choose to commit crimes so they can go to jail to get off the streets. This suggests that street-involved PWUD often seek the structure, consistent meals, and warm shelter that jails provide. This is indicative of the need to address larger social barriers outside of health and law enforcement.

Considerations

While participants agreed that access to and delivery of services for PWUD are limited, some respondents felt that improving service access was beyond the scope of the request for decriminalization. They cautioned that tying service expansion to the success of the exemption request was risky, and emphasized the need to focus on the immediate goal of removing the threat of criminalization from the lives of people who use drugs. The issue of stigma within health and treatment services was also identified. For services to be effective, harm reduction supports would need to undergo a lengthy cultural transformation in addition to increased resource allocation. For some respondents, the extended timeline required to transform harm reduction services increased its vulnerability to changing government priorities and they worried the decriminalization request would be jeopardized if it were tied to service expansion.

3. Reducing stigma

To achieve decriminalization's goal of improving the lives of PWUD, all respondents agreed that broad social stigma and perceptions of drug use must be addressed. Interviewees felt that the exemption request, if approved, would help shift mindsets and decrease stigma.

Decriminalization could catalyze more open conversations among the public, as well as new training for police, health care workers, and other institutional players. Participants felt that the public, generally, continues to view PWUD through a moralized lens and fails to grasp the importance and impact of harm reduction services. This also extends to public services whose drug policies are contingent on the will of the political party in power. For decriminalization to have a tangible impact on the lives of people who use drugs, it needs to address the stigma that negatively affects their everyday lives.

Stigma from police interventions

Police interventions in the lives of PWUD exacerbate the stigma they face. As one respondent observed, "Drug users can be very well known to the police. We end up not being treated well and [are] barred from accessing public spaces and amenities because they know us and assume we're up to something." Participants expressed that the negative perceptions held by police can follow PWUD for years, with law enforcement viewing their presence alone as a guilty act. This is further exacerbated by the social and professional toll of having previous drug offenses tied to one's record. Many PWUD spoke of the difficulties in gaining employment, housing, and other services due to previous possession charges on their record — even if they have since

ceased their drug use. This, according to participants, suggests that decriminalization should be accompanied by the expunging of past possession convictions from the records of PWUD.

Social stigma

Another factor frequently highlighted by respondents is a broad-based social stigma against drugs, which often prevents PWUD from following recommended harm reduction practices. This stigma often pushes PWUD to use in "hiding holes" — that is, to hide their drug habits and use in secrecy — which has contributed to a multitude of overdose deaths in the city. Tackling societal preconceptions about drug use could allow PWUD to communicate openly about their struggles and to establish supportive relationships even if they're using.

The effect of social stigma was particularly highlighted in the lived experiences of women and women-identifying individuals who use drugs during the consultation process. Drug use is still highly stigmatized within the Children's' Aid Society (CAS), and how CAS would interact with the exemption request was seen as an important factor to be addressed to avoid further marginalizing women who use drugs. Many participants described how even people who smoke cannabis are marginalized within the system despite its legalization, and how others are afraid to make use of safe supply services due to fear of what will happen to their children. This includes determining if there would still be a "duty to report" to CAS, in addition to ushering in large-scale cultural change within the organization.

Indigenous participants spoke of the difficulty of assessing culturally-relevant supports due to the social stigma associated with drug use. Abstinence is often required by Elders before individuals can participate in cultural practices such as Ceremony. This becomes a barrier to treatment for those who decide to pursue it, as it leaves many Indigenous PWUD without a bridge to culturally-appropriate support. Participants described how stigma has pushed many Indigenous PWUD out of their community and isolated them from their culture. While some elders have moved away from requiring abstinence in order to participate in Ceremony, many participants felt that stigma was an ongoing presence in their communities.

Stigma in healthcare

Another major area where stigma negatively impacts the lives of PWUD is health services. Respondents pointed to gaps in healthcare services and treatment options that must be addressed for decriminalization to be successful. A majority of the respondents highlighted the need to reframe drug use in medical care as nurses often do not feel comfortable administering drugs within certain schedules. It is incredibly difficult for PWUD to access medications while in the hospital. Some interviewees reported negative experiences faced by PWUD in receiving

proper medication when their drug use is noted on their medical file; some PWUD have been refused basic painkillers on occasion. As one participant framed it, “You need to train medical and nursing staff so that they are not gatekeeping substances from the people who need it.” To make things worse, some PWUD report being ill-treated by medical professionals. Some participants pointed to a lack of safe sites in hospitals that are sensitive to the needs of PWUD, with many respondents sharing stories of individuals leaving hospitals during life-threatening crises when they were not able to access substances.

The stigma of drug use also interferes with the efficacy and safety of the treatments administered to PWUD. The current practice of moralizing drug treatment, which stems from stigma, can actually drive PWUD towards higher drug dependency. Some respondents pointed out the pressing need to better educate health care professionals on the balance between drugs, and how the tolerance of an individual must be considered when prescribing medication to PWUD. For example, individuals being treated with hydromorphone are often instructed to quit cold turkey after being discharged, which can worsen their drug use. This moralizing of treatment and forced abstinence has compelled individuals to return to the street because they were not offered support to ease their use.

Indigenous participants highlighted the importance of “weaving culture into healing” in health and harm-reduction services. Punitive measures rooted in stigma against drugs can re-perpetuate the harm brought about from Residential Schools by cutting off PWUD from culture and family. Participants pointed to trauma-informed practices and restorative justice measures as appropriate alternatives to stigma-based treatment. They felt this would provide safe pathways to treatment for Indigenous PWUDs seeking treatment.

Considerations

Many participants suggested that the role of peer support workers be expanded, and that dedicated outreach teams and people with lived experience join first response teams to help combat stigma. By having peer support workers embedded in hospitals and across the system, like in Community Health Centres (CHC), PWUD would have support from individuals who could relate to their experiences and advocate for a harm reduction approach to care. However, many respondents observed that peer support workers in health care spaces are often treated dismissively by hospital staff and are hindered from actively doing their work. One support worker explained, “We need to be more accepted, and the importance of our role be acknowledged. Peers know how to treat others who use drugs as humans, and we

also give them hope." The institutionalization of peer support workers can supplement decriminalization and service expansion, and help improve the lives of PWUD.

4. Options for mandated treatment

The inclusion of mandated treatment in the exemption model received a lot of attention throughout the consultation. Respondents were unanimous in stressing the need for voluntary treatment pathways but the issue of involuntary, mandated treatment, was contentious.

Reasons for

While the majority of respondents opposed mandated treatment, a few saw value in a model of involuntary options that could be leveraged under specific circumstances. When discussing the Drug Dissuasion Committee in the Portugal Model, some peer support workers expressed support for a similar mechanism. Some members of the roundtables felt mandated treatment could benefit PWUD by allowing an individual to "get a taste" of not using drugs and to make an informed decision on whether they were ready to stop. The same group also highlighted the benefit of mandated treatment for medical diagnoses, citing the long-term effect drug use can have on the mental state and physical tolerance of some PWUD. Effects of long-term drug use on the body often makes it difficult for doctors to provide accurate diagnoses because PWUD can present dual symptoms. In such cases, involuntary treatment can impose abstinence and reduce drug use effects, empowering the PWUD to make their own decisions and facilitating proper diagnosis and care from healthcare professionals.

Mental health considerations were another lens for mandated treatment. A roundtable of family members of PWUD was largely supportive of voluntary services but cited gaps within the *Mental Health Act* as a scenario where mandated treatment might be appropriate. The *Mental Health Act* does not allow for any type of mandated treatment if the individual in question is deemed to "have the capacity" — that is, they are not an imminent danger to themselves or others. Family members of PWUD who wish to help treat their substance use disorder are powerless to do anything as long as the PWUD does not want to seek treatment. As a result, families are often left to watch as their loved ones deteriorate with no timely interventions to help them. Involuntary treatment could provide a family with the option to intervene in their loved one's drug use before they hurt themselves or others (often the family members themselves), are criminalized, or die.

Reasons against

Consultation participants shared the perspective that substance use does not necessarily equate a substance use disorder. Just because someone uses drugs does not mean they are addicted or see a problem with their drug use. As such, mandating treatment does not make a lot of sense for most PWUD, and recovery looks different from person to person. Nearly all participants emphasized that treatment options (that range from abstinence to safe supply programs) should be tailored to individual circumstances and take a soft approach. Some PWUD might be able to functionally manage their own recovery without a program while still using, "Just because you're using [substances] doesn't mean that you aren't in recovery, just in another type of recovery." Incorporating mandated or coerced recovery in a decriminalization model risks further marginalizing PWUD.

Many participants felt that 12-step programs, like Alcoholics Anonymous (AA), are problematic and ineffective due to strict and oppressive rules, lengthy wait times, and stringent referral policies. These programs often penalize people or kick them out for relapsing. One participant likened them to zero-tolerance policies that result in people skipping meetings if they have even just one drink. There is often a coercive and religious element to these programs which poses an additional barrier.

Many interviewees emphasized that treatment should be centred on human rights, body autonomy, and seek to meet the individual where they are, without coercive approaches. Someone who is using safely under supervision should not be forced to undergo treatment. One roundtable participant suggested "dual diagnosis" approaches as a possible solution. Such programs take into account a variety of factors and offer a wide spectrum of treatment pathways to best fit individual needs.

5. A different role for police

There was strong agreement that Toronto Police Services (TPS) should have a minimal role in drug-related calls. Many participants felt the main goal of decriminalization is to reduce interactions with the judicial system and to prevent the further criminalization of PWUD. Many participants articulated that a role for police, in an alternate model, would be counterproductive and serve to perpetuate opportunities for problematic police behaviours with PWUD.

Issues with police involvement

One of the main concerns raised in the consultation was that police are neither medical professionals nor social service providers, and therefore are not well placed to be leading overdose response or "gate-keeping" any of those services. Many believe that TPS offers rudimentary training in overdose response, which can make the situation worse. PWUD who were interviewed recounted various negative behaviours exhibited by police during calls, described by some as "fishing trips." These included scenarios of police interfering with medical care, entering homes when they weren't supposed to, and targeting PWUD outside of harm reduction sites. As a result, many PWUD expressed that they have little to no trust in the Toronto Police and feel traumatized in their presence.

This strained relationship between police and drug-using communities makes individuals reluctant to call the police in times of crisis. Due to negative practices and gaps in laws such as the Good Samaritan Drug Overdose Act, PWUD often do not feel comfortable reaching out to police in acute crisis situations. Many respondents shared painful stories of abandoning a friend who was actively overdosing instead of contacting emergency services because they were afraid of being criminalized if they were discovered. While the Good Samaritan Act should theoretically protect them from criminalization, it fails to do so if the individual has concurrent warrants on their record. This puts people in a position where they either have to watch their friend die or risk being incarcerated.

Police presence around harm reduction services has also created a barrier for PWUD seeking services. One group of peer workers at a harm reduction clinic explained that police, while not allowed within the site, often stand across the street. Because the police are required to arrest people with warrants, their presence deters PWUD with warrants from entering the site or seeking help.

Members of ACB communities highlighted the current and historical oppression they've faced by the police and the additional risk this poses for the PWUD. Black interviewees shared stories of how they are over-surveilled, over-targeted, and how they feel overrepresented in arrests and convictions. One ACB respondent stated that simple decriminalization would fail to make much of a difference on its own, as it does not address police culture. Many participants believe that the police will continue to find a way to criminalize PWUD regardless of the legality of simple possession. These participants believed that only decriminalization accompanied by police accountability would help in making a tangible difference in the lives of PWUD who are overly targeted by the police.

Shifts in police culture

While there was consensus on minimal police presence in drug-related calls, some participants suggested that the police could play a small, supportive role in calls where violence is a factor or when requested by a PWUD. However, mandatory training would be critical to ensure better outcomes for PWUD. Curriculum should include learning on trauma-informed practices and how to operate within a harm-reduction framework, as well as a new understanding of the limits of police power, especially within a decriminalization model.

Roundtable participants also felt that police could support PWUD to access support and services with rides to a hospital or treatment centre if requested or by referring them to harm reduction services in the city.

Participants agreed that a meaningful police presence in drug-related calls will only be possible if deliberate efforts are made to change the present police culture that drives an abuse of power and the marginalization of PWUD. “There needs to be folks who are having very assertive conversations with the police and what they can and can’t do,” said one respondent. Participants strongly felt that a lot of time and work will be needed for PWUD to feel comfortable with the police. If the exemption request is successful, the police would need to focus on being trauma-informed and on re-investing in their relationships within the community.

6. Drug supply concerns

While most consultation participants favoured decriminalization, they recognized it would do little to address the root cause of the overdose crisis in Toronto: the toxicity of the drugs being supplied in an unregulated market. Every participant pointed to the urgent need to expand safe supply programs to increase the quality of life of PWUD and prevent needless deaths.

Challenges in measuring doses

Currently, unregulated drug supply is so toxic that people often cannot trust the concentration of opioid in the drug they purchased. Criminalization makes it harder for PWUD to follow important harm reduction practices such as measuring out doses with a scale or avoiding use in isolation. The unregulated market will continue to thrive in secrecy and with non-regulated supply.

Some participants discussed the unique harms the unregulated market has on women. Due to the toxicity of supply, PWUD who identify as women often only buy off someone they know is safe, and generally buy higher quantities as a result. Many interviewees described these as abusive relationships, where transactional sex is a large component. This is further complicated with women sex workers, dependent on pimps who often control their drugs. Interviewees described situations where sex workers are not allowed to hold their own drugs, and receive injectable drugs only after the man has used, resulting in them not using sterile syringes. They are also often used as a scapegoat if the pimps get caught by the police. Respondents believed that decriminalizing drug possession and increasing access to safe supply programs could help curtail the unregulated market and predatory dealers, while also encouraging PWUD not to use in secrecy.

Inadequacies of safe supply programs

Many participants highlighted the gaps that exist within safe supply programs in the city. Not only are safe supply programs difficult to establish, once established they often struggle to adequately meet the needs of PWUD. Many participants explained that drugs available at safe supply sites fail to satiate those who have become used to the high potency levels in the unregulated market supply. This increased tolerance means the dosage of safe supply does little to help those who use these services to prevent withdrawal.

Participants also spoke about the limited drug diversity in current safe supply programs: safe supply programs primarily stock injectable drugs. This excludes stimulants and drugs that are smoked (such as crack-cocaine), which are often represented in the drug use patterns in ACB and other racialized communities. PWUD in ACB and other communities who smoke their drugs are thus pushed into the underground market, where they are at risk of toxic supply and as a result, overdoses. PWUD of these communities aren't offered the same protections that are afforded by supervised consumption services and are pushed to use in secrecy.

Harm reduction workers acknowledged these gaps, stating, "Even what we can provide is non-ideal because of access and funding structures." While safe supply programs have saved countless lives in the opioid epidemic, roundtable participants highlighted the need for safe supply programs to address these inadequacies with additional pharmaceuticals, as well as supervised inhalation space that would provide a safe space for people who smoke drugs.

Some participants recommended that the City of Toronto lobby the provincial government to add diacetylmorphine to the formulary of the Ontario Drug Benefit program. This advocacy has begun however, so it seems that this news has not reached some front line workers or PWUD.

Considerations

A few individuals consulted felt that conversations around safe supply were out of the scope of decriminalization. One participant articulated her apprehension, "You're creating a system that will rely on a [health] system that isn't meant to support them." Expanding the availability of safe supply programs does not eliminate the uphill battle of stigma that comes from doctors, many of whom either don't feel comfortable prescribing drugs for safe supply or are opposed to decriminalization and drug use, in general. Other participants echoed this sentiment, stating that even if doctors were brought on board, the system would still rely on limited resources or support.

7. Determining the threshold for possession

Determining the threshold quantities for personal possession proved to be one of the more contentious topics during consultations.

Factors for determining threshold

The majority of participants recommended that thresholds be set in full consultation with PWUD, prioritizing their voice over that of police or health professionals. Participants cautioned that any preconceived notions of health officials or law enforcement about appropriate quantities would fail to acknowledge the lived realities of PWUD compelled to navigate an unregulated market. To avoid the mistakes of other jurisdictions, the City must engage with people who use all types of drugs and not just injectables, in order to figure out what is safe, practical, and accounts for the diverse needs of PWUD. One group felt that any discussion of thresholds for personal possession would need to recognize and mitigate the power imbalance between PWUD and the police that could lead to PWUD removing themselves from the exemption request process.

Participants listed many considerations for determining thresholds, including the type of drug (i.e., crystal meth vs. fentanyl), duration of the effect, and the wide range of personal tolerances. They believed it would be difficult to determine a blanket quantity because drug use patterns and tolerance vary from person to person. An example stated by one participant highlighted the fact that pregnant women metabolize drugs differently, something that must be considered in determining both safe supply and the quantity of possession.

Those interviewed noted the importance of considering harm reduction practices in PWUD's buying habits. A common example was the act of carrying a scale — a tactic commonly advocated for by harm reduction workers in order to measure out doses and avoid overdosing on a toxic supply. However, under current laws, carrying a scale is one of the factors police officers consider to determine if an individual is a drug dealer. The same applies to the presence of small baggies, which people who are purchasing for other individuals often carry. Respondents emphasized the need to take these considerations into account when determining threshold in order to avoid criminalizing people who are simply splitting and sharing.

While a majority of those consulted spoke about the challenges of setting a quantity for possession, one group of peer support workers had a succinct response: a half ball (1.7 g). They explained that 1.7 g is a large enough quantity for a multi-day supply for the average PWUD, but it is not so low that one would lose the price advantage of buying in bulk. This quantity could be applied to any drug, including methamphetamine and cocaine that can be measured as a "ball."

Drawbacks of setting a threshold

Though many emphasized the wide range of factors that should be considered in setting a threshold for possession, a few participants were opposed to the idea of thresholds as a whole. One roundtable group stated, "Thresholds aren't necessary unless they're trying to appease the police." A general concern was that setting a threshold would still allow room for police discretion, giving them space to continue to harass and target PWUD. These participants believed that the larger issue of "arrest quotas" and a police culture that stigmatizes PWUD and marginalized groups would remain unaddressed, allowing bias to come into play. Thresholds also fail to take into account the financial constraints of most PWUD, who often don't have expendable income and buy in large quantities to take advantage of volume discounts. Some respondents also believed that thresholds can only work properly in a regulated market. Given the toxicity of the supply in the unregulated market and the lack of safe alternatives, many PWUD do not know how much of their drug of choice is actually present in what they are consuming. Any threshold set in an unregulated market would therefore need to specify whether quantities apply to the specific drug or include filler substances.

Considerations

A small group of respondents opined that grappling with the issue of setting a threshold for possession was out of the scope of the conversation altogether. Given that the goal of the

submission is decriminalization, they feared that any additional considerations such as thresholds would only dilute and possibly hurt the request.

Consistent with the push to include PWUD at all levels of the process, some respondents recommended that Health Canada include PWUD in conversations about establishing a threshold. This would allow those working on this issue to take their time and weigh all considerations to arrive at a quantity that would appease the police without inadvertently criminalizing PWUD.

Methods

Toronto Public Health contracted MASS LBP to conduct the public consultation and facilitate a working group. The consultation consisted of surveys, roundtable focus groups and interviews with key constituencies identified by Toronto Public Health.

Key constituencies for this consultation included:

- People Who Use Drugs (PWUD)
- Harm reduction workers
- African, Caribbean, and Black communities
- Indigenous communities
- Sex workers
- Families of PWUD

Survey responses include a demographic breakdown of the survey respondents (See Appendix A: Summary of Survey Responses). Participants in the roundtables and interviews were offered a small honorarium for their time and given the option to remain anonymous. Due to the nature of the roundtables (a group setting) and the sensitive nature of the topic, demographic information was not asked for, nor was any captured.

Survey questions

The survey was available online, through CheckMarket, and hard copy through service providers. See Appendix A for a summary of the survey findings, including a demographic breakdown of the respondents.

1. Do you wish to proceed to the survey?
2. What should be the objectives of drug policy in Toronto?
3. Decriminalization refers to the removal of criminal penalties for the personal use and possession of drugs. The production and sale of drugs is still against the law. What benefits or challenges do you expect if personal possession of controlled drugs is decriminalized?
4. What role, if any, should the police have in responding to drug related 911 calls?
5. What services would help people who use drugs reduce the possibility of harm for their use?
6. What barriers do you see that make it difficult for people who use drugs to access these or other services?
7. Personal possession refers to the concept that an individual could be carrying drugs for personal use (sometimes a defined amount). Currently, personal use, possession, production and sale of drugs in Canada is illegal. What should be considered when determining the quantity of drugs an individual can have for personal possession?
8. What role should community members, including people who use drugs, have in developing and evaluating this new policy?
9. What other measures should Toronto consider to reduce substance use harms, including non-fatal and fatal overdoses, associated with drug use?
10. Do you have stable housing?
11. If yes, please provide the first three letters and numbers of your postal code (e.g., M5G):
12. Are you someone who currently uses unregulated drugs (these are also sometimes called 'drugs', 'street drugs' or 'illegal drugs')?
13. Have police stopped you, talked to you, ticketed you, arrested you or charged you because of your drug use?
14. What is your age?
15. People often describe themselves by their race or racial background. For example, some people consider themselves "Black", "White" or "East Asian".

Organizations contacted for interviews and roundtable focus groups

- 2-Spirited People of the 1st Nations
- ACT
- Agincourt Community Services
- AIDS Committee of Durham Region (ACDR)
- All Saints Drop in
- Association of Midwives
- Black Coalition For AIDS Prevention (Black CAP)
- Black Creek Community Health Centre
- Breakaway Community Services
- CAMH
- Canadian HIV/ AIDS Legal Network

- CAPUD
- Dixon Hall
- Families for Addiction Recovery
- Fred Victor
- Gilbert Centre for Social and Support Services
- Harm Reduction Hangouts Project at Lumens
- Homes First
- John Howard Society of Durham Region
- KAPOW
- LAMP
- Lumenus Community Services
- Maggie's Toronto Sex Workers Action Project
- TCHC
- MAP centre at St. Mike's
- MAPS Canada
- Moss Park OPS
- Moyo Health and Community Services
- Native Child and Family Services
- Native Women's Resource Centre
- Ontario Aboriginal HIV/AIDS Strategy (OAHAS)
- Parkdale Queen West Community Health Centre
- Parkdale SCS
- Pieces to Pathways, Breakaway
- Prisoners with HIV/AIDS Support Action Network (PASAN)
- Regent Park CHC
- Regent Park SCS
- Shelter, Support and Housing, City of Toronto
- Sherbourne Health Centre (SHC)
- Simon Fraser University
- South Riverdale Community Health Centre (SRCHC)
- South Riverdale Community Health Centre, Women's Harm Reduction Program
- Street Health OPS
- Syme-Woolner Neighbourhood and Family Centre (SWNFC)
- Toronto Drug Users Union (TDUU)
- The 519
- The AIDS Network
- The Indigenous Network
- The Neighbourhood Group, St. Stephen's Community House
- The Works, City of Toronto Public Health
- Toronto Harm Reduction Alliance
- Toronto Indigenous Health Advisory Circle, Youth Council
- TRIP! Project
- Unison Health and Community Services
- Unity Health
- Warden Woods Community Centre
- Wayside House of Hamilton
- Wellfort Community Health Services: Bloom Clinic
- YMCA house drop-in program
- YSAP

Roundtables conducted: 76 participants

The roundtables were conducted online via Zoom, with the option to meet in-person if desired. Participants were recruited and coordinated by stakeholder organizations. Interested participants were provided with questions prior to the roundtable and offered an honorarium. This summary report reflects what participants shared during these focus groups.

Organizations participated:

- Safer Opioid Supply (staff + clients)
- Canadian Association of People Who Use Drugs
- Shelter Hotel Overdose Prevention Project
- Families for Addiction Recovery
- Parkdale-Queen West Harm Reduction Team
- The Works, City of Toronto Public Health
- Breakaway Community Services
- Regent Park CHC (staff + clients)

Key Questions:

1. What should be the objectives of the City of Toronto's Drug Policy?
2. What benefits do you expect if personal possession of controlled drugs is decriminalized? (*Decriminalization refers to the removal of criminal penalties for the personal use and possession of drugs. The production and sale of drugs are still against the law.)
3. What challenges do you expect if personal possession of controlled drugs is decriminalized?
4. What role, if any, should the police have in responding to drug-related 911 calls?
5. What service(s) would help people who use drugs reduce the possibility of harm or seek support for their substance use (if they've identified it as an issue)?
6. What barriers do you see that make it difficult for people who use drugs to access these or other services?
7. What should be considered when determining the quantity of drugs an individual can have for personal possession?
8. What role should community members, including people who use drugs, have in both developing and evaluating the city of Toronto's Drug Policy?
9. What other measures should Toronto consider to reduce substance use harms, including non-fatal and fatal overdoses, associated with drug use?

Number of interview participants: 51

Interviews were conducted online via Zoom, or over the phone. Those who chose to participate were provided the questions prior to the interview and were offered an honorarium. The interviews were not recorded and participants were invited to share as much or as little as they felt comfortable. This summary reflects what participants shared during these interviews.

Key Questions:

1. What should be the objectives of the City of Toronto's Drug Policy?
2. What benefits do you expect if personal possession of controlled drugs is decriminalized?
   *Decriminalization refers to the removal of criminal penalties for the personal use and possession of drugs. The production and sale of drugs is still against the law.
3. What challenges do you expect if personal possession of controlled drugs is decriminalized?
4. What role, if any, should police have in responding to drug related 911 calls?
5. What service(s) would help people who use drugs reduce the possibility of harm or seek support for their substance use (if they've identified it as an issue)?
6. What barriers do you see that make it difficult for people who use drugs to access these or other services?
7. What should be considered when determining the quantity of drugs an individual can have for personal possession?
   *Personal possession refers to the concept that an individual could be carrying drugs for personal use (sometimes a defined amount). Currently, personal use, possession, production and sale of drugs in Canada is illegal.
8. What role should community members, including people who use drugs, have in both developing and evaluating the city of Toronto's Drug Policy?
9. What other measures should Toronto consider to reduce substance use harms, including non-fatal and fatal overdoses, associated with drug use?

Working Group

Dr. Eileen de Villa, Medical Officer of Health for the City of Toronto, chaired a working group to provide input into an alternative model to criminalization in Toronto. This group met five times:

- **Meeting 1:** The meeting oriented members to the working group. They were introduced to the purpose of the group, the Terms of Reference, and were given space to introduce themselves and discuss their views on the development of the model.

- **Meeting 2:** The meeting began with an update on the public consultation and the exemption process. The bulk of the meeting was dedicated to discussing success factors for the exemption request submission to Health Canada, as well as potential design elements of the model.

- **Meeting 3:** The chair began by presenting the preliminary consultation findings to the Working Group, discussing their strengths and receiving feedback from members on the need to prioritize certain demographics. The group also discussed the evaluation framework and the emerging community anchor model.

- **Meeting 4:** The working group was presented with an update on possible funding opportunities, Board of Health timelines, and the evaluation framework. Members were then invited to provide feedback on the updated model for the submission.

- **Meeting 5:** Members were presented with the final conclusions from the public consultations and provided input on the findings. Toronto Public Health walked the working group through the components of the submission, including the elements of the model and its framing. Members were invited to provide commentary. Next steps in the submission process were shared, and members were encouraged to write letters of support to Health Canada on behalf of their organizations.

Membership of the Working Group included representatives from:

- Black Coalition for AIDS Prevention (Black CAP)
- Canadian Association of People Who Use Drugs
- Canadian Institute for Substance Use Research
- Centre for Addiction and Mental Health
- Centre for Drug Policy Evaluation
- Community Action for Families
- Families for Addiction Recovery
- Family Service Toronto
- Gerstein Centre
- HIV Legal Network
- John Howard Society – Toronto
- Ontario Harm Reduction Network
- Parkdale Queen West Community Health Centre
- Shelter, Support, and Housing Administration, City of Toronto
- Social Development, Finance, and Administration, City of Toronto
- South Riverdale Community Health Centre
- St. Michael's Hospital, Li Ka Shing Knowledge Institute
- St. Michael's Homes
- St. Michael's Hospital
- The Works, Toronto Public Health

- Toronto Aboriginal Support Services Council
- Toronto Drug Users Union
- Toronto Harm Reduction Alliance
- Toronto Paramedic Services
- Toronto Police Service
- University of Toronto
- Wellesley Institute

About MASS LBP

MASS is an independent advisory firm that works with forward-thinking governments and not-for-profits to help them make better decisions by deepening and improving their efforts to engage and consult with citizens. Fundamentally, we believe in people. Given the opportunity to participate in a thorough, fair, and inclusive process, citizens are ready to provide constructive advice, offering officials the intelligence, perspective, and sensitivity that difficult public issues require.

Since 2007, MASS LBP has led some of Canada's most original and ambitious efforts to engage citizens in tackling tough policy options while pioneering the use of Civic Lotteries and Citizens' Reference Panels on behalf of a wide array of clients such as: Vancouver Coastal Health, Centre for Addiction and Mental Health, Supervised Injection Services, and the Canadian Drugs Futures Forum.

Appendix A: Summary of Survey Results

Appendix A: Summary of Survey Results

TORONTO PUBLIC HEALTH COMMUNITY ATTITUDES SURVEY ON DECRIMINALIZATION 2021

Original Sequences of Questions

1. Do you wish to proceed to the survey?

2.What should be the objectives of drug policy in Toronto?

3. Decriminalization refers to the removal of criminal penalties for the personal use and possession of drugs. The production and sale of drugs is still against the law.What benefits or challenges do you expect if personal possession of controlled drugs is decriminalized?

4. What role, if any, should the police have in responding to drug related 911 calls?

5. What services would help people who use drugs reduce the possibility of harm for their substance use or seek support for their substance use?

6. What barriers do you see that make it difficult for people who use drugs to access these or other services?

7. Personal possession refers to the concept that an individual could be carrying drugs for personal use (sometimes a defined amount). Currently, personal use, possession, production and sale of drugs in Canada is illegal.

What should be considered when determining the quantity of drugs an individual can have for personal possession?

8. What role should community members, including people who use drugs, have in developing and evaluating this new policy?

9. What other measures should Toronto consider to reduce substance use harms, including non-fatal and fatal overdoses, associated with drug use?

10. Do you have stable housing?

11. If yes, please provide the first three letters and numbers of your postal code (e.g., M5G):

12. Are you someone who currently uses unregulated drugs (these are also sometimes called 'drugs', 'street drugs' or 'illegal drugs')?

13. Have police stopped you, talked to you, ticketed you, arrested you or charged you because of your drug use?

14. What is your age?

15. People often describe themselves by their race or racial background. For example, some people consider themselves "Black", "White" or "East Asian".

Sequence as Presented in this Report

Respondent information presented first.

10. Do you have stable housing?

11. If yes, please provide the first three letters and numbers of your postal code (e.g., M5G):

12. Are you someone who currently uses unregulated drugs (these are also sometimes called 'drugs', 'street drugs' or 'illegal drugs')?

13. Have police stopped you, talked to you, ticketed you, arrested you or charged you because of your drug use?

14. What is your age?

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What should be considered when determining the quantity of drugs an individual can have for personal possession?

8. What role should community members, including people who use drugs, have in developing and evaluating this new policy?

9. What other measures should Toronto consider to reduce substance use harms, including non-fatal and fatal overdoses, associated with drug use?

Responses Representation

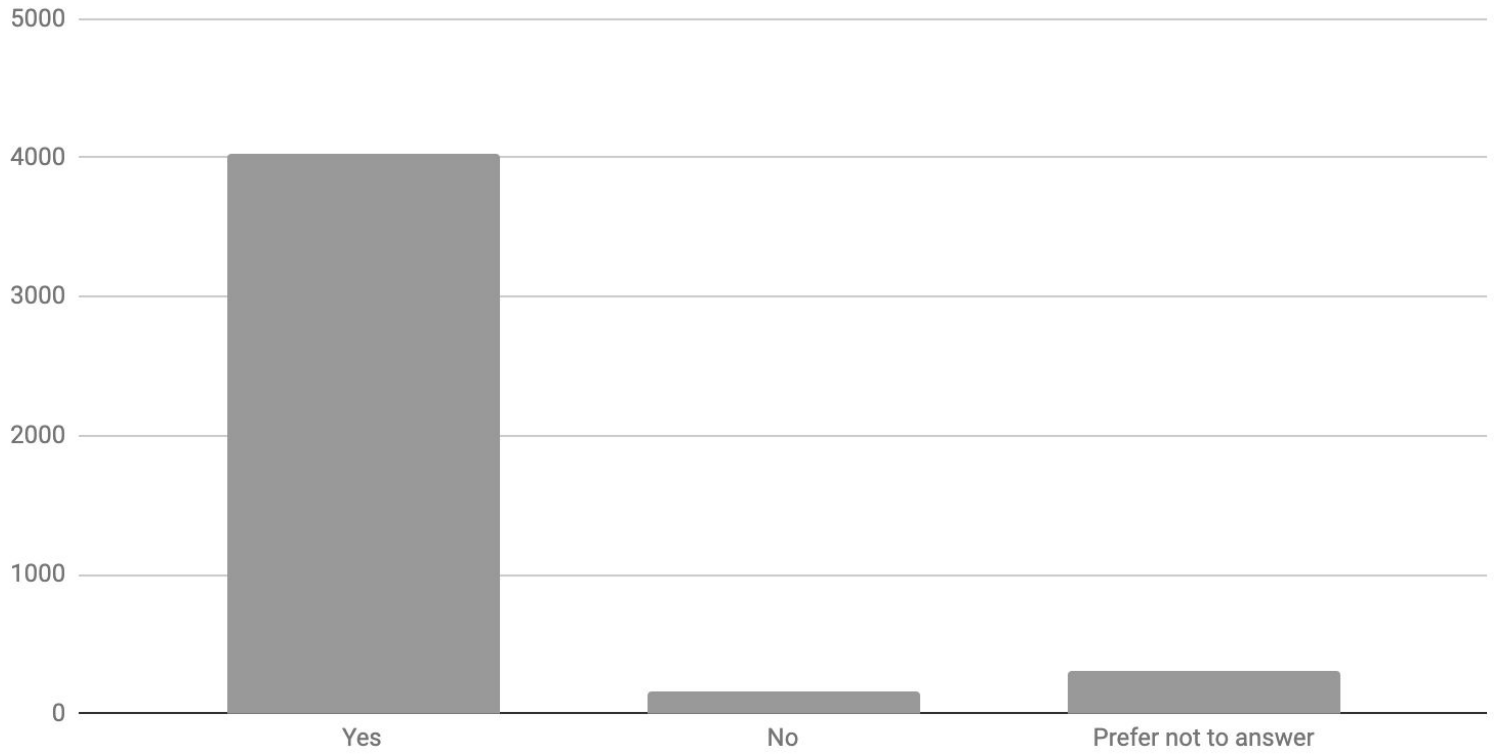
1. 6,340 Survey Records
2. 23 No (removed)
3. 6,317 Yes (kept)
4. 322 Didn't complete any Q2.X (removed)
5. **5,995 responses left to analyze**

Question 10:

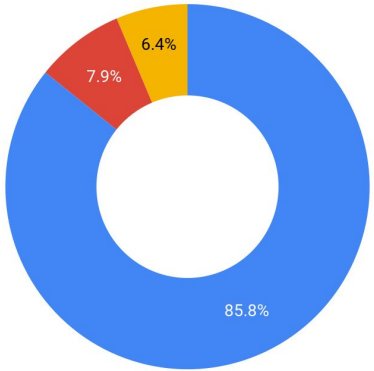
Do you have stable housing?

Multiple choice
4,481 Responses, 1,514 No response

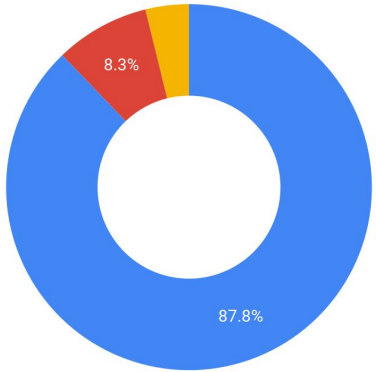
10. Do you have stable housing? *(4,481 Responses)*



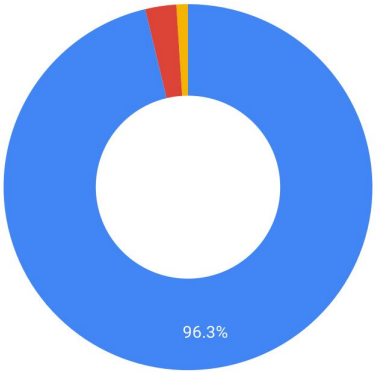
10. Do you have stable housing?



RACIALIZED RESPONDENTS



RESPONDENTS WHO USE DRUGS



NON-RACIALIZED RESPONDENTS; NO REPORTED DRUG USE

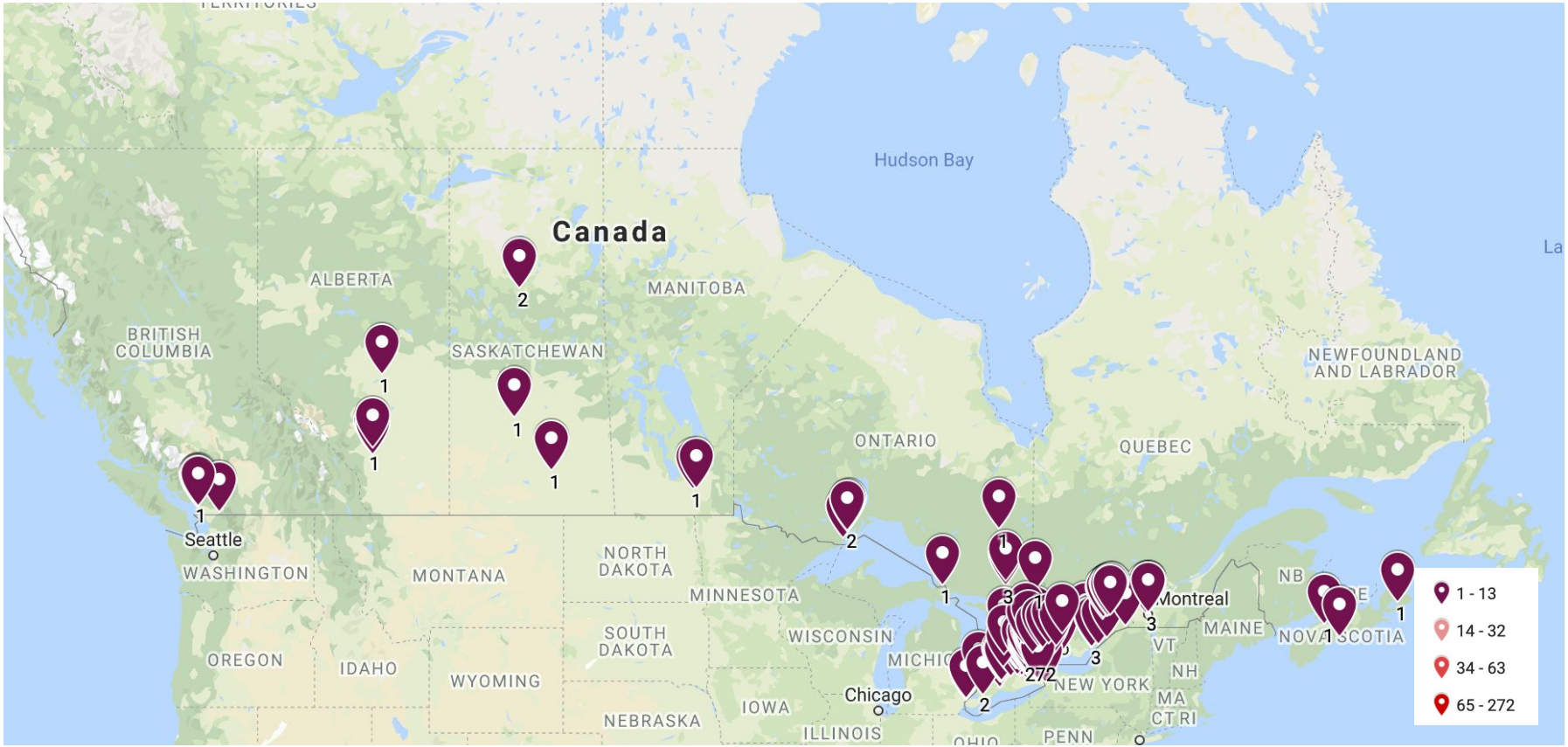
Yes No Prefer not to answer

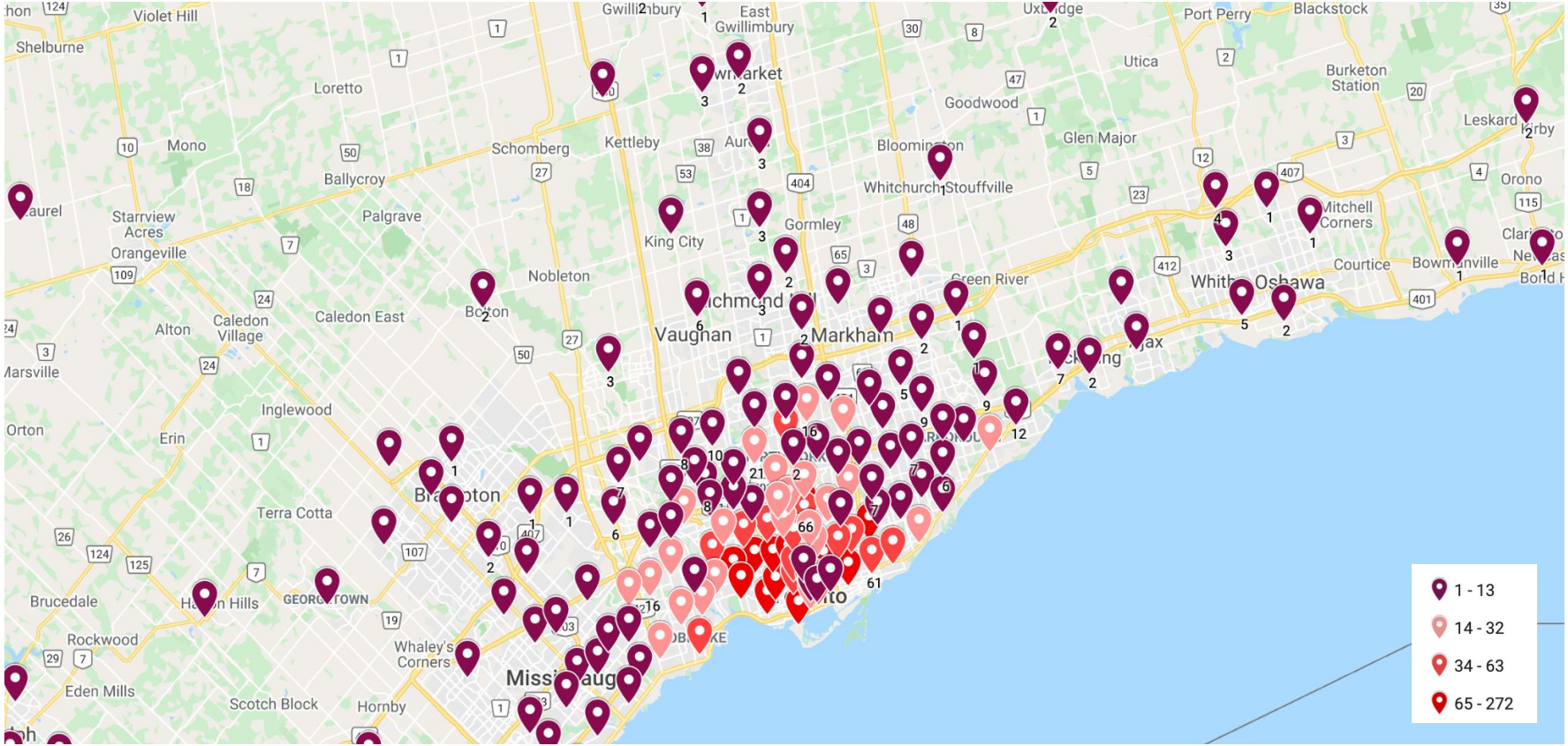
Question 11:

If yes, please provide the first three letters and numbers of your postal code (e.g., M5G)?

3,688 Responses in the valid format, 2,285 No response

3,352 from Toronto (M FSAs)


Hudson Bay
Canada
ALBERTA
MANITOBA
BRITISH COLUMBIA
SASKATCHEWAN
ONTARIO
QUEBEC
NEWFOUNDLAND AND LABRADOR
Seattle
WASHINGTON
MONTANA
NORTH DAKOTA
MINNESOTA
SOUTH DAKOTA
WISCONSIN
OREGON
IDAHO
WYOMING
NEBRASKA
IOWA
ILLINOIS
Chicago
Montreal
MAINE
NEW YORK
NB
VT
NH
MA
CT RI
PENN
1 - 13
14 - 32
34 - 63
65 - 272

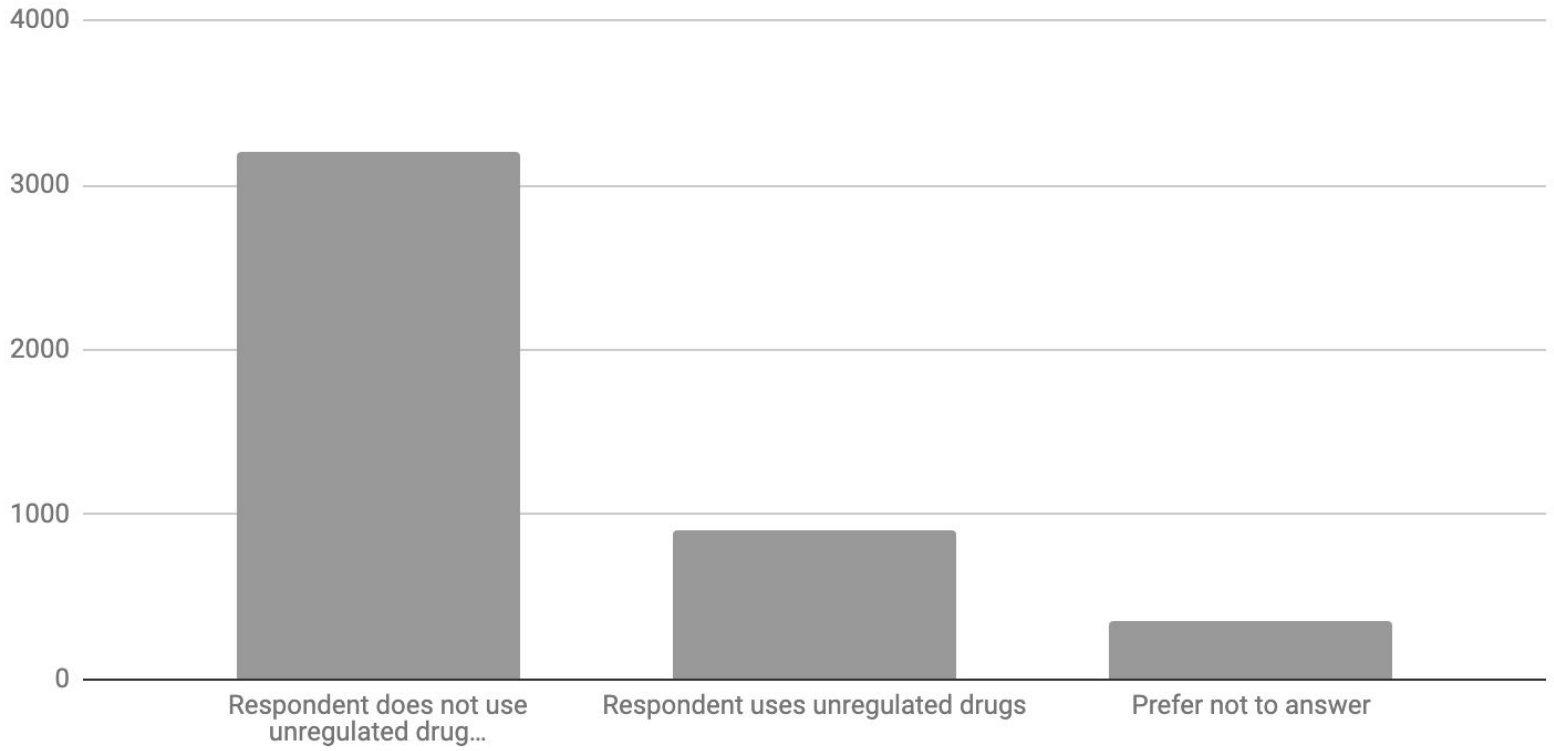

Violet Hill
Shelburne
Loretto
Mono
Ballycroy
Schomberg
Kettleby
East Gwillimbury
Newmarket
Goodwood
Uxbridge
Port Perry
Blackstock
Utica
Burketon Station
Leskard
Orono
Starrview Acres
Orangeville
Palgrave
King City
Gormley
Bloomington
Whitchurch-Stouffville
Glen Major
Mitchell Corners
Courtice
Bowmanville
Nobleton
Bolton
Caledon East
Caledon Village
Alton
Vaughan
Markham
Green River
Whitby
Oshawa
Ajax
Inglewood
Erin
Orton
Terra Cotta
Brampton
Brucedale
Georgetown
Rockwood
Whaley's Corners
Mississauga
Eden Mills
Scotch Block
Hornby
1 - 13
14 - 32
34 - 63
65 - 272

Question 12:

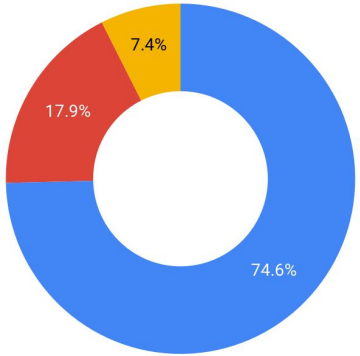
Are you someone who currently uses unregulated drugs (these are also sometimes called "drugs", "street drugs" or "illegal drugs")

Single choice
4,473 Responses, 1,522 No response

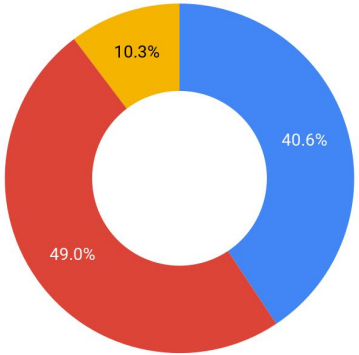
12. Are you someone who currently uses unregulated drugs (these are also sometimes called "drugs", "street drugs" or "illegal drugs") *(4,473 Responses)*



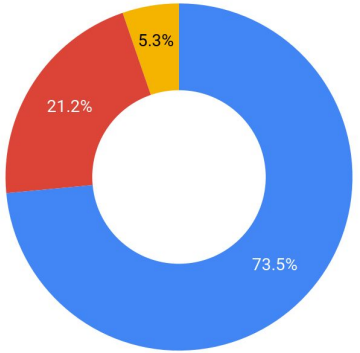
12. Are you someone who currently uses unregulated drugs (these are also sometimes called "drugs", "street drugs" or "illegal drugs")



RACIALIZED RESPONDENTS



UNDERHOUSED RESPONDENTS



NON-RACIALIZED RESPONDENTS; HOUSED

Respondent does not use unregulated drug...
Respondent uses unregulated drugs
Prefer not to answer

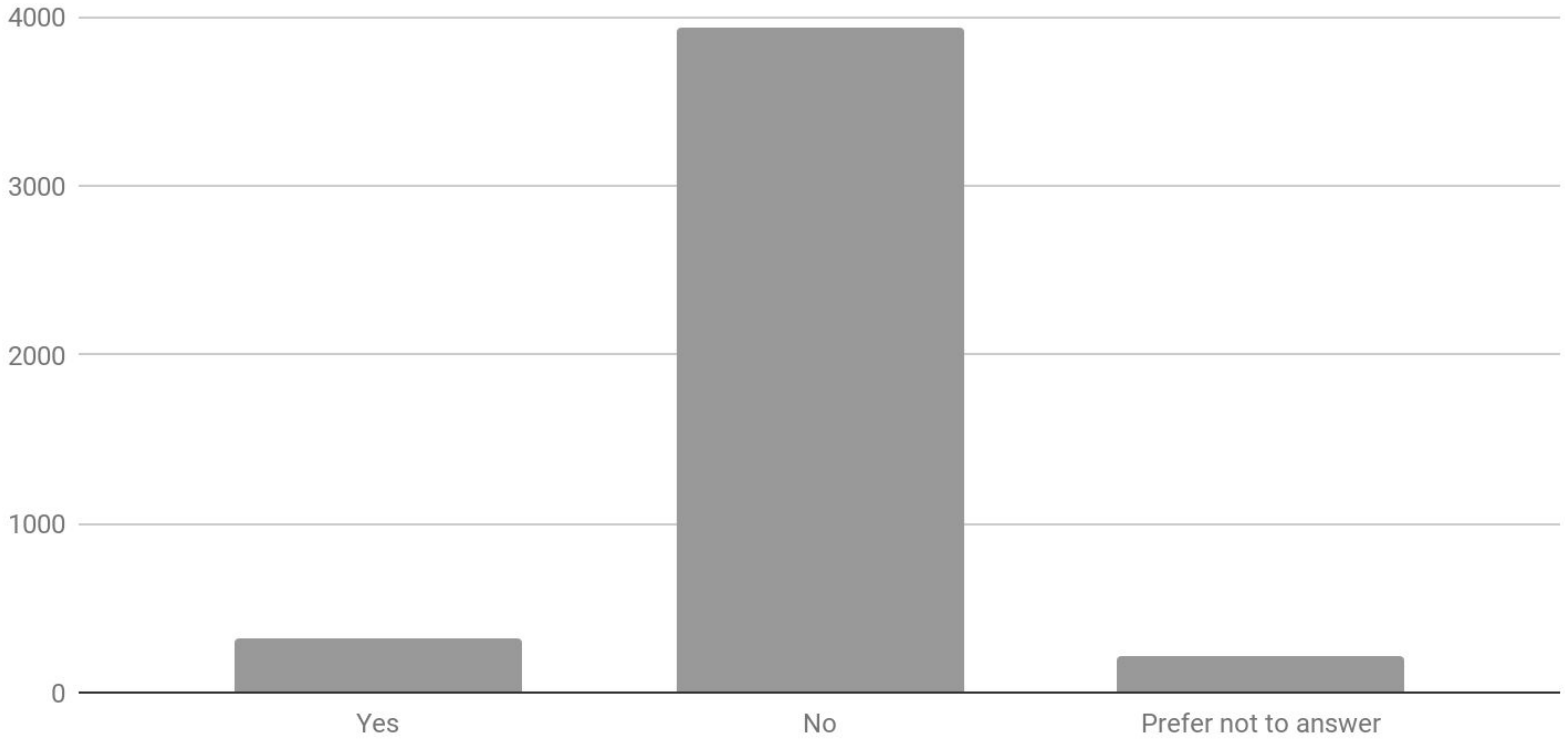
Question 13:

Have police stopped you, talked to you, ticketed you, arrested you or charged you because of your drug use?

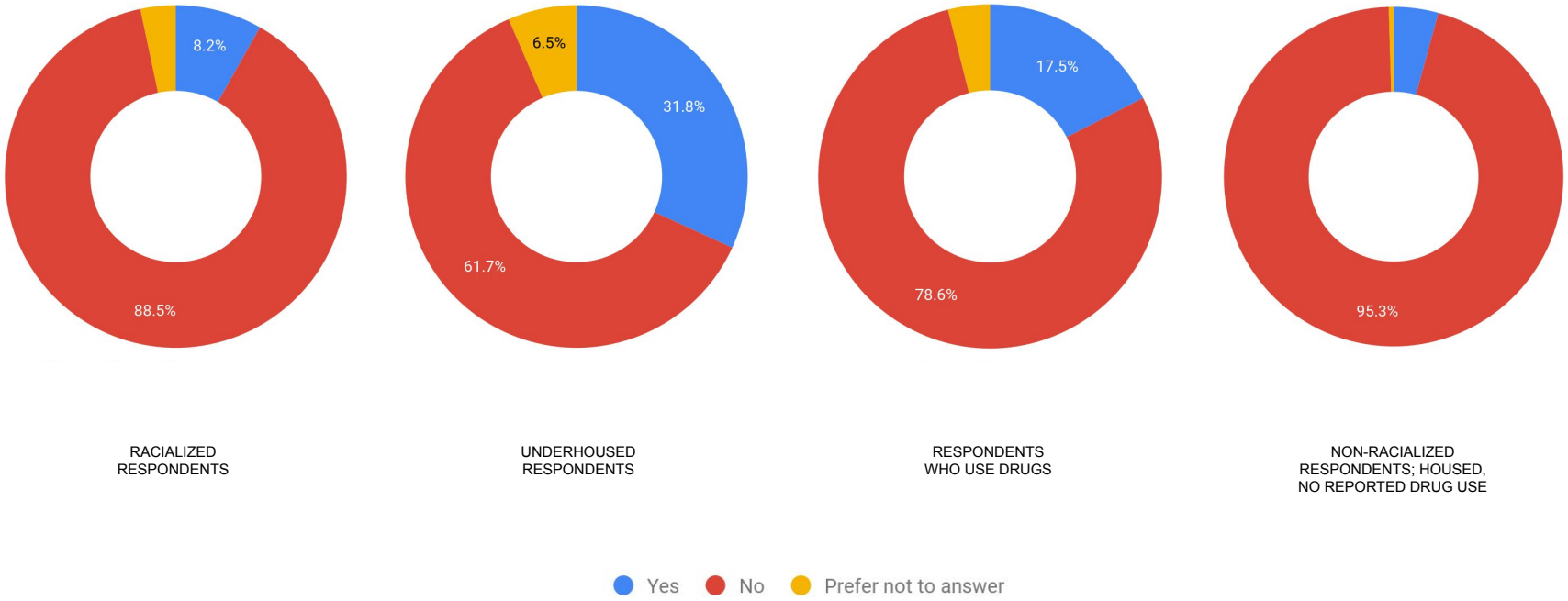
Single choice
4,467 Responses, 1,528 No response

13. Have police stopped you, talked to you, ticketed you, arrested you or charged you because of your drug use?

(4,467 Responses)



13. Have police stopped you, talked to you, ticketed you, arrested you or charged you because of your drug use?



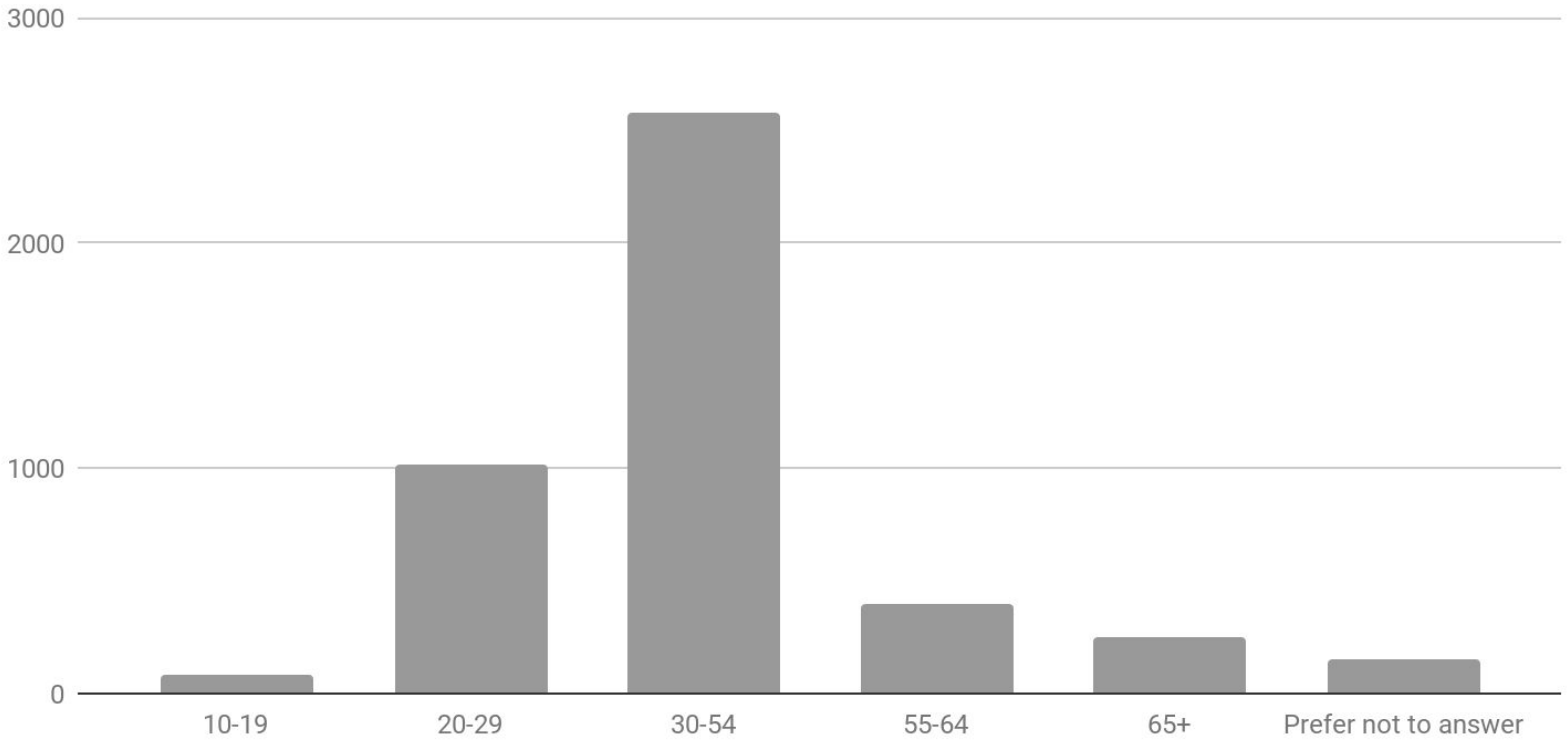
Question 14:

What is your age?

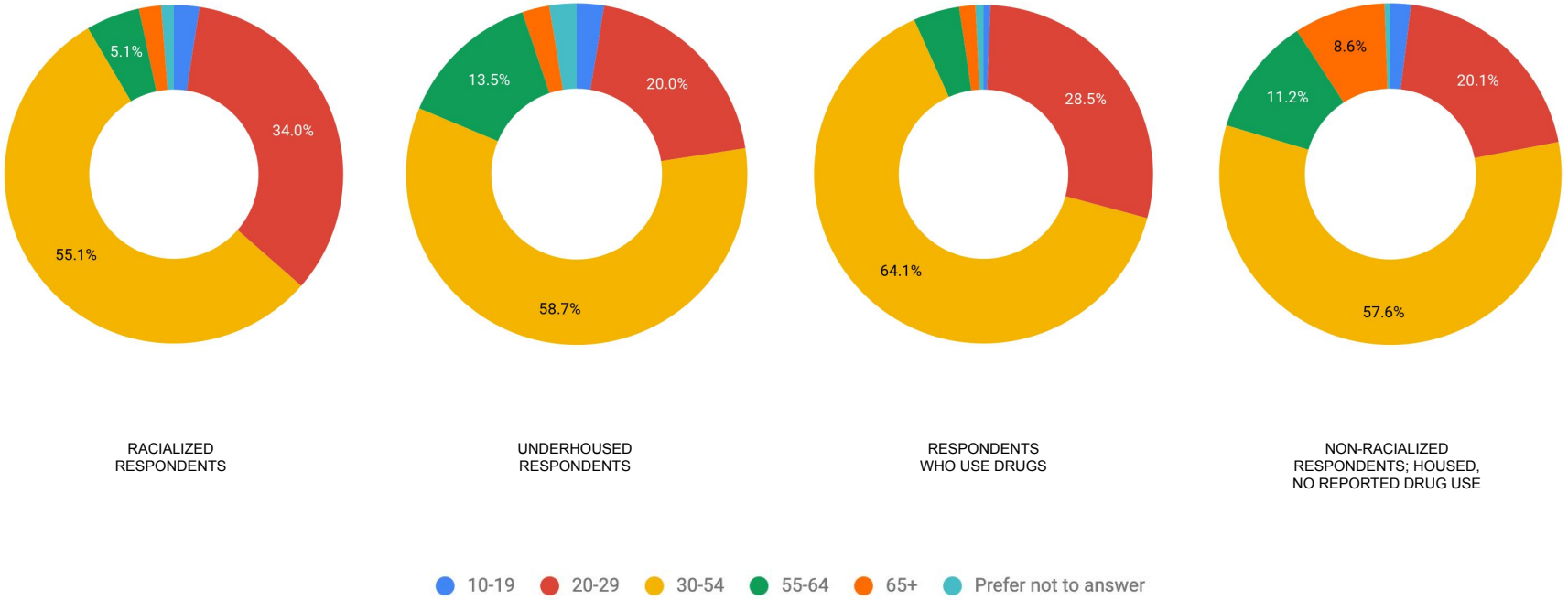
Single choice
2,184 Responses, 3 No response

14. What is your age?

(2,187 Responses)



14. What is your age?

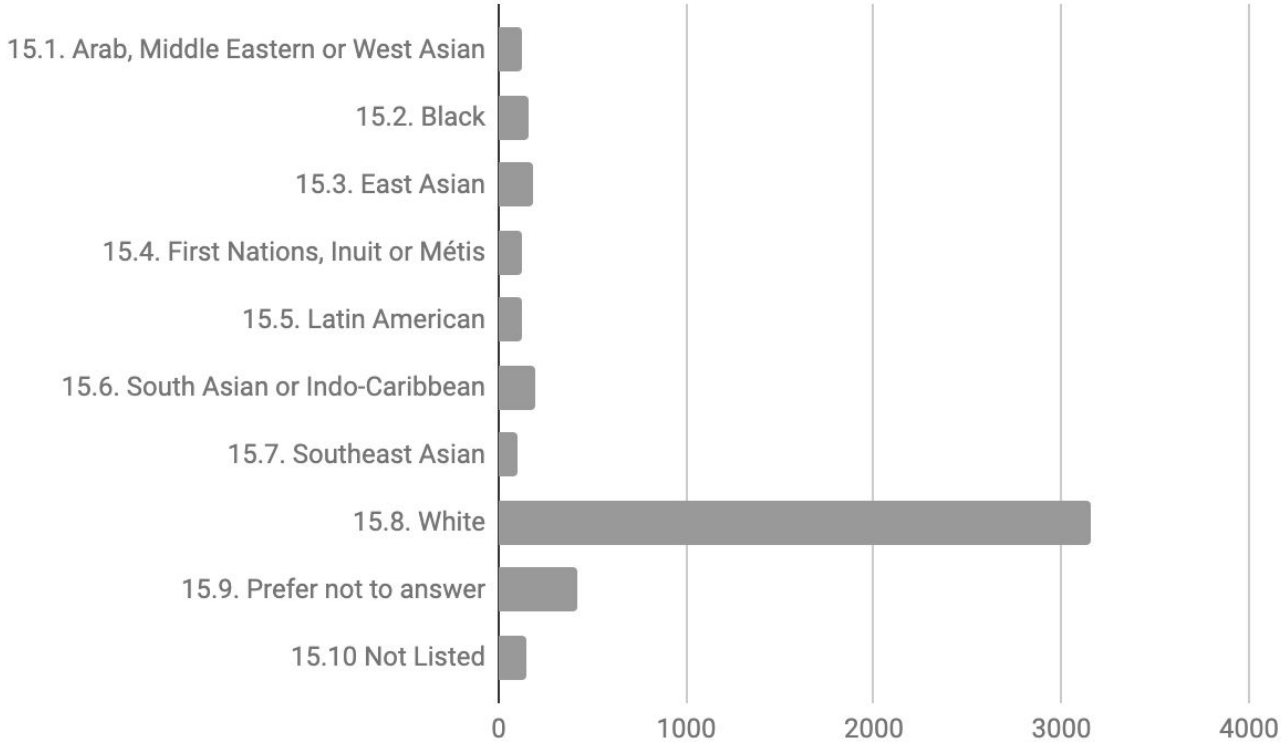


Question 15:

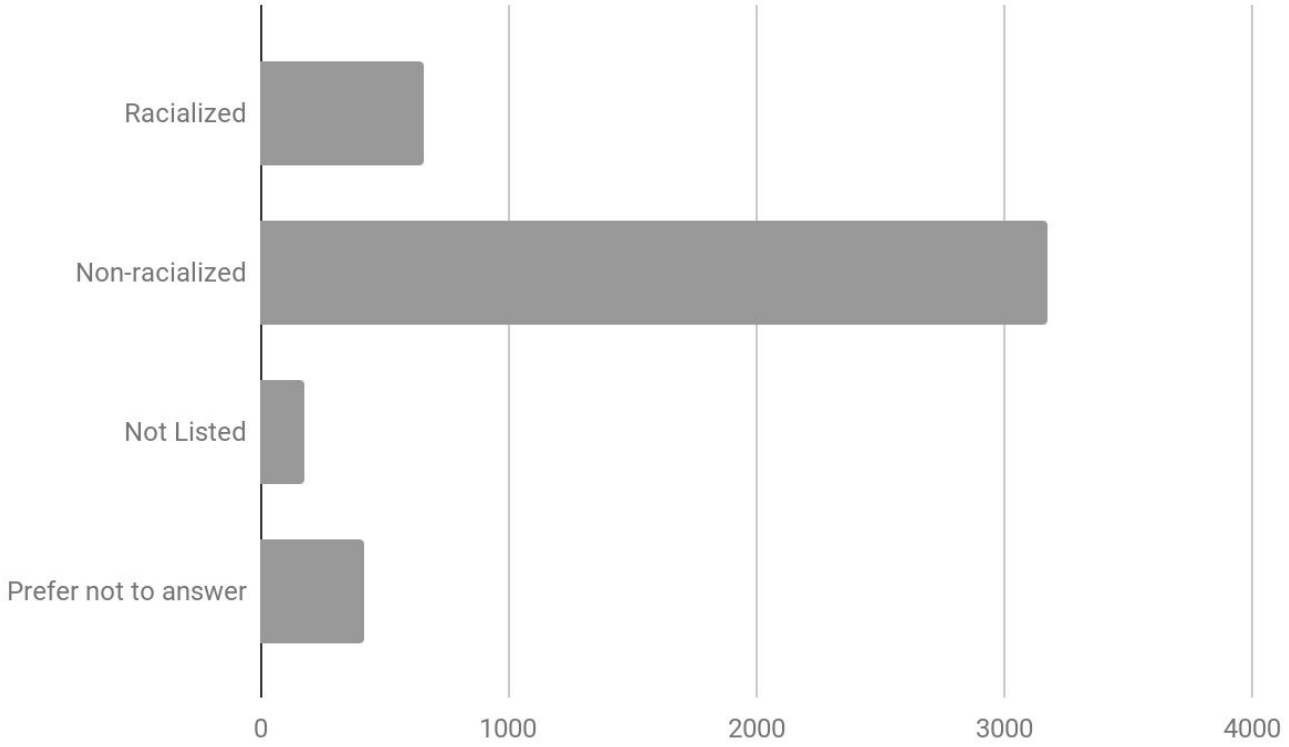
People often describe themselves by their race or racial background. For example, some people consider themselves "Black", "White" or "East Asian".

Check all that apply
4,436 Responses (with multi-answers), 1,559 No response

15. People often describe themselves by their race or racial background. For example, some people consider themselves "Black", "White" or "East Asian". *(2,187 Responses)*



15. Categorized Responses



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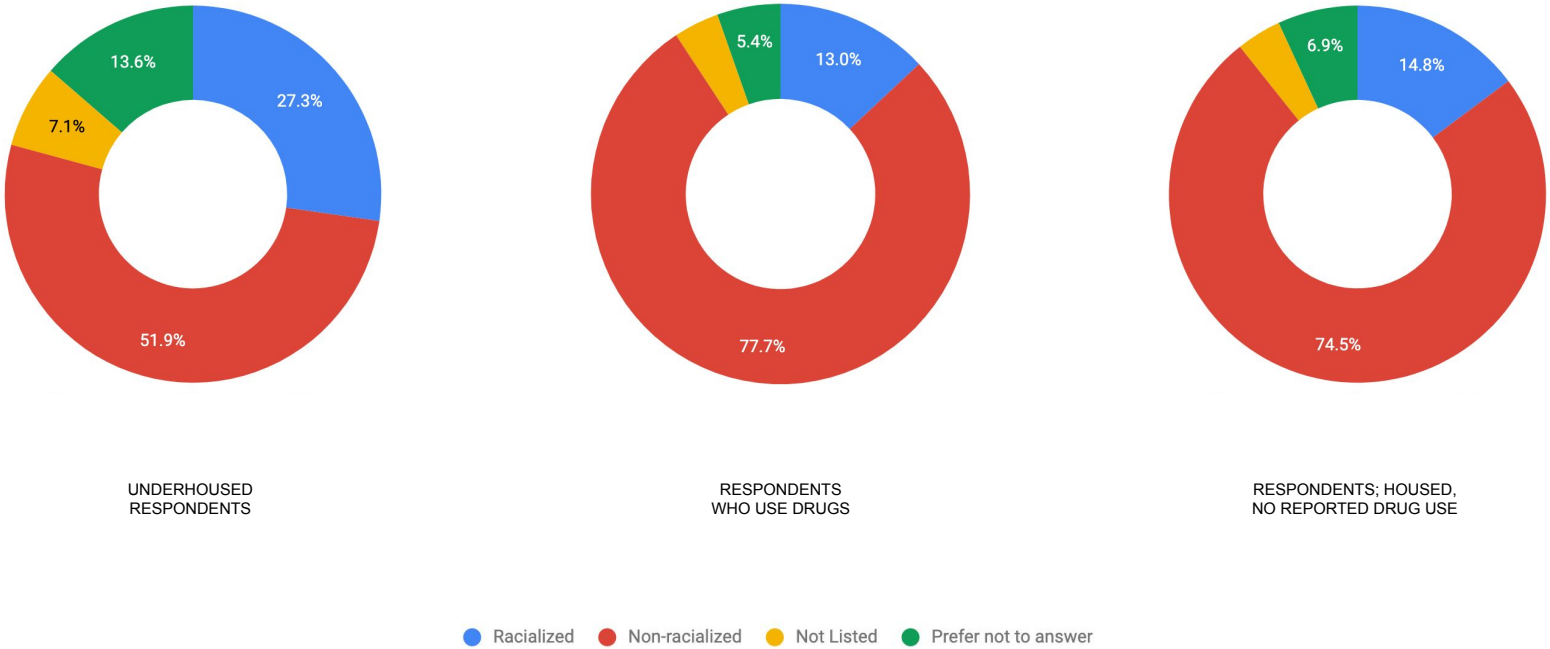
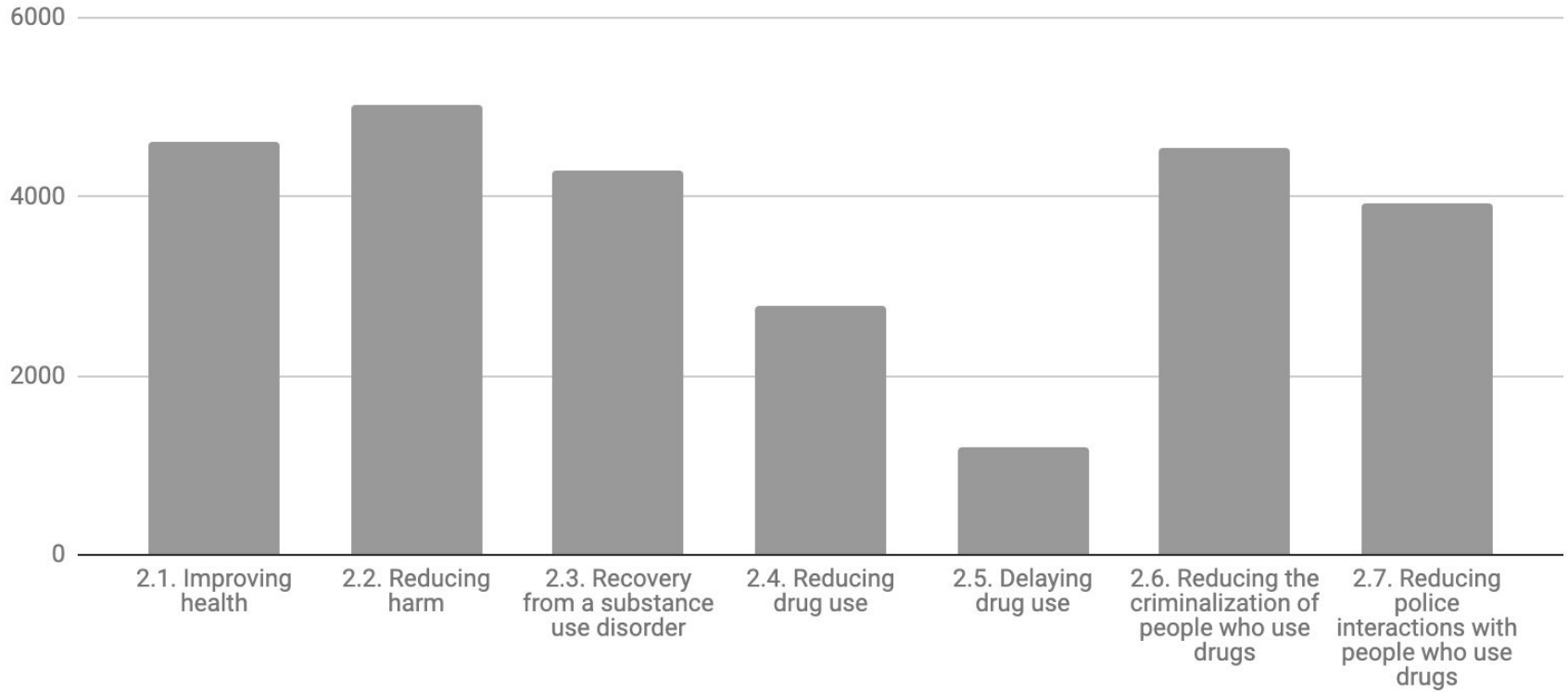


Question 2:

What should be the objectives of drug policy in Toronto?

Check all that apply
5,995 Responses (with multi-answers), 322 No response (removed from survey)

2. What should be the objectives of drug policy in Toronto? *(5,995 Responses)*



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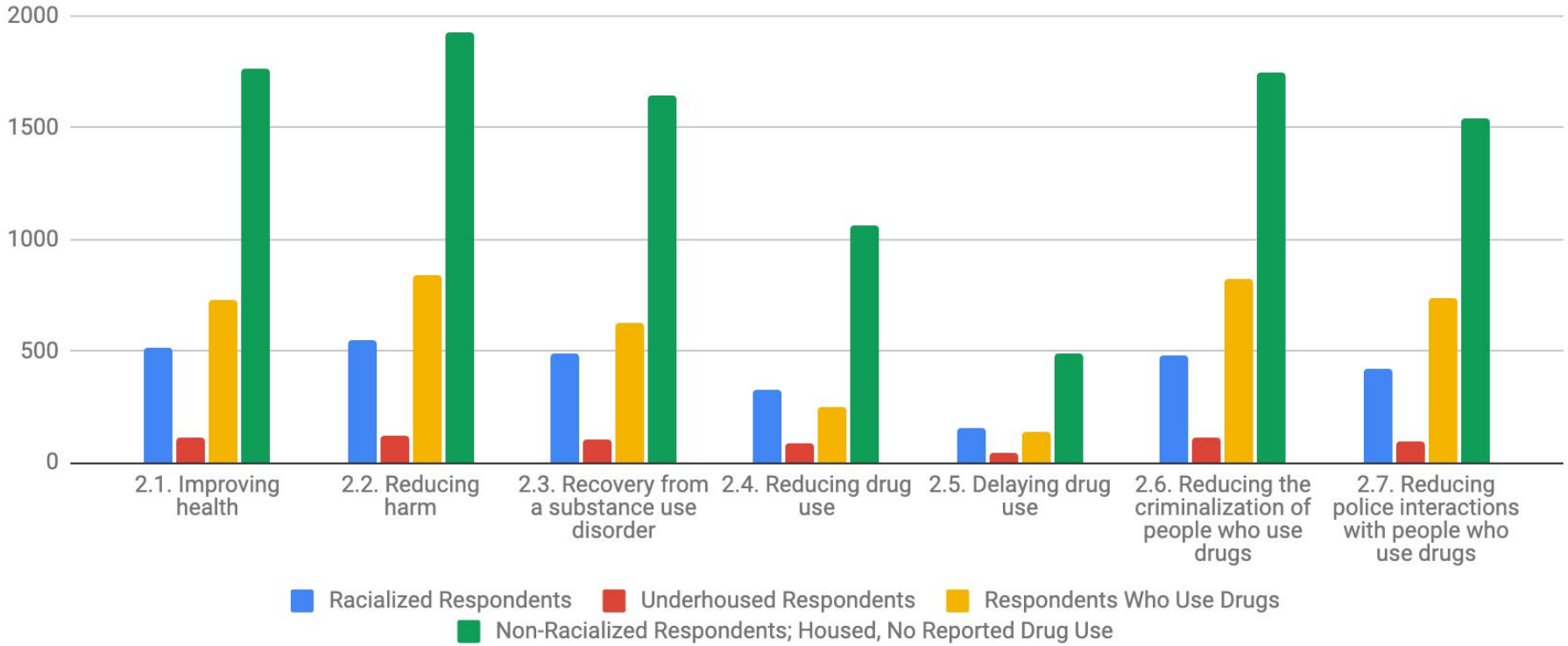
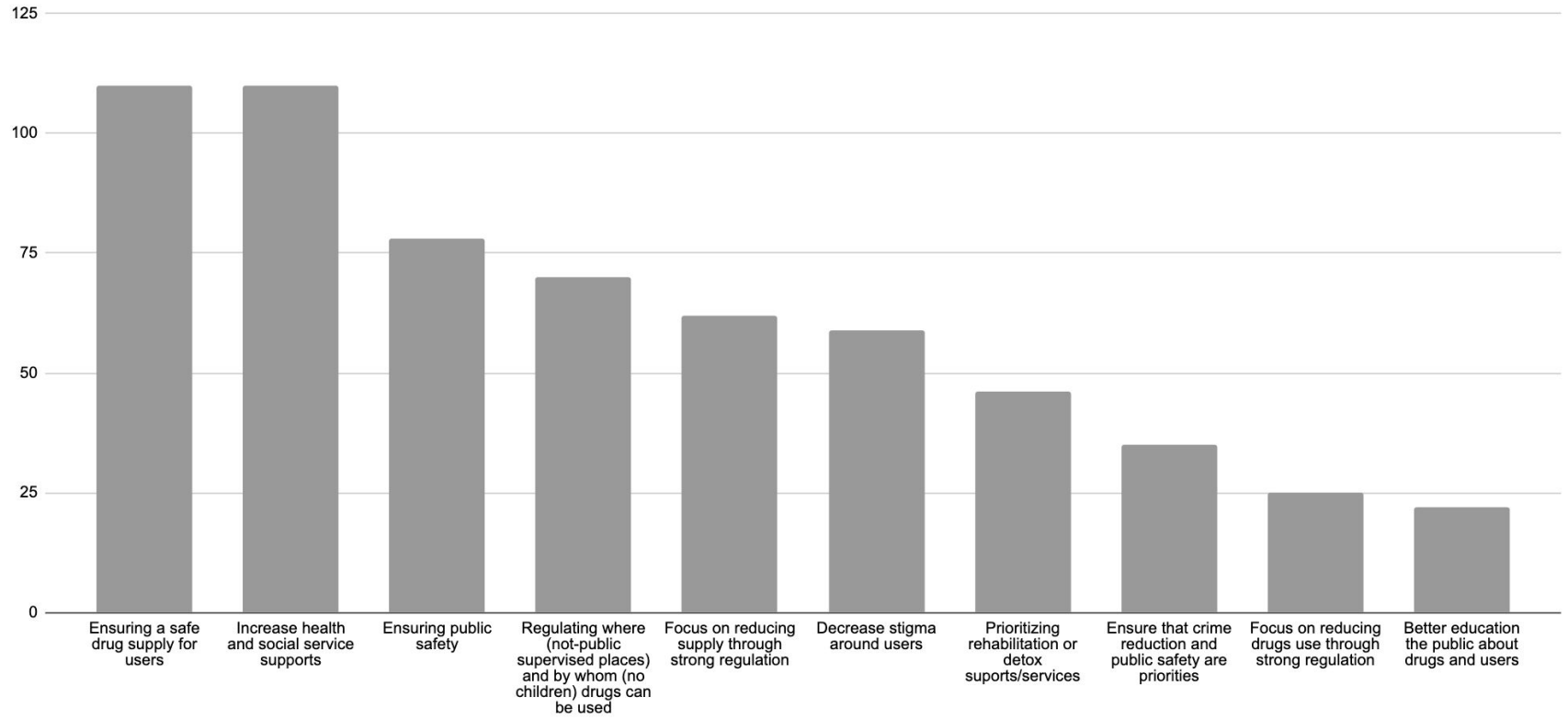


2.8 What should be the objectives of drug policy in Toronto — Other? (755 Responses, 499 Classified using mult-tag category AI analysis)



Question 3:

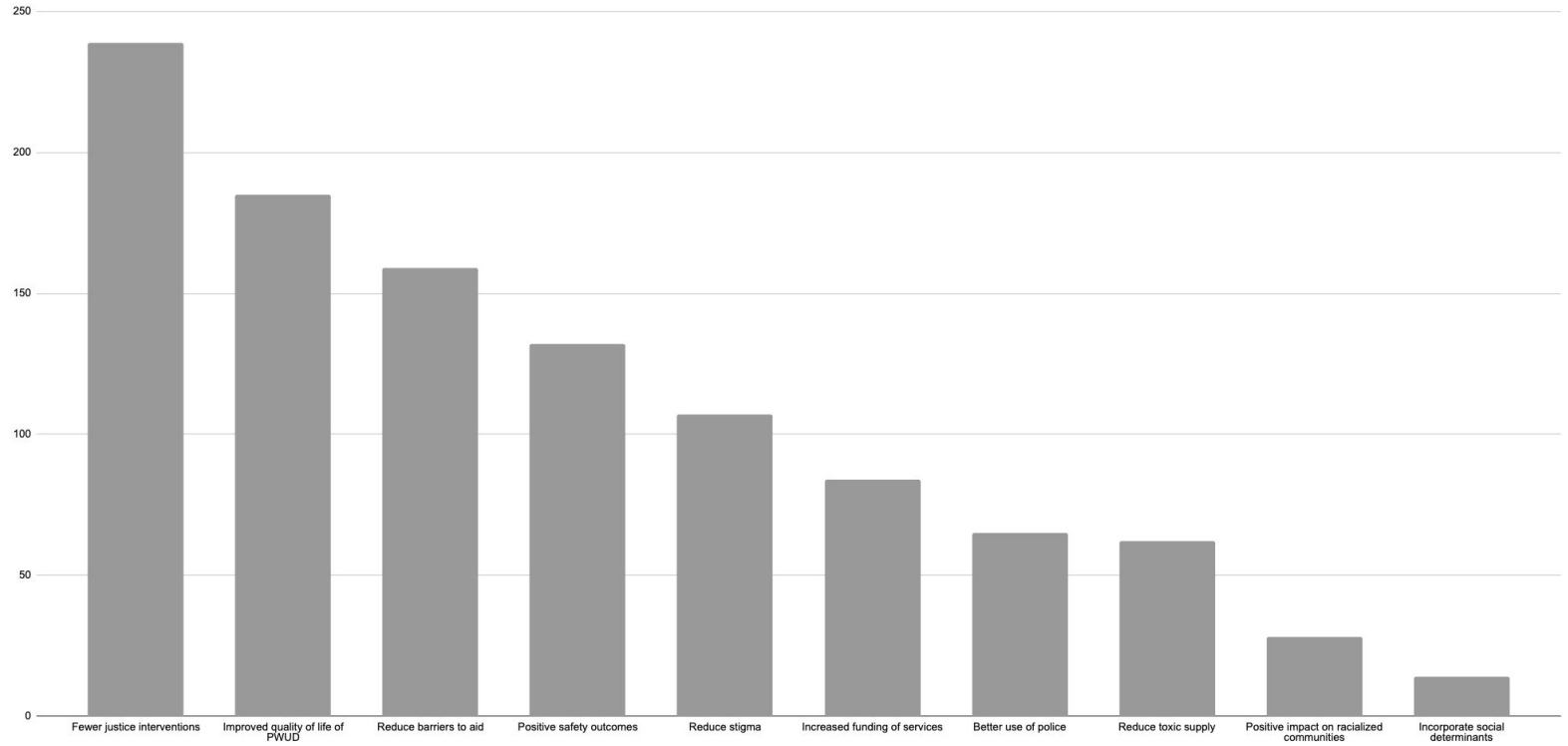
What benefits or challenges do you expect if personal possession of controlled drugs is decriminalized?

Open Text
4,308 Responses 1,687 No response

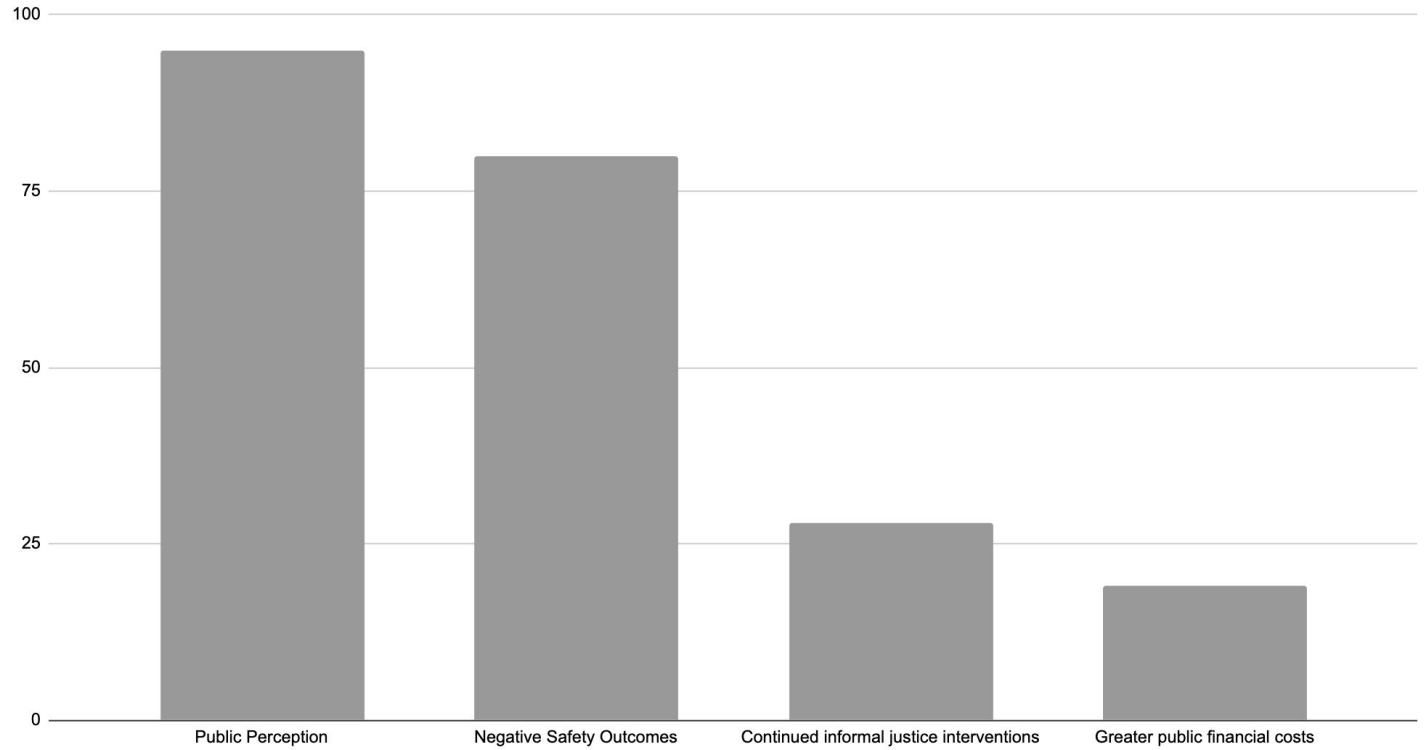
375 were randomly sampled and collated into benefits and challenges and then manually catagorized

1,092 benefits and 257 challenges were identified

3. What <u>benefits</u> or challenges do you expect if personal possession of controlled drugs is decriminalized? *(Sample of 375 responses)*



3. What benefits or challenges do you expect if personal possession of controlled drugs is decriminalized? *(Sample of 375 responses)*



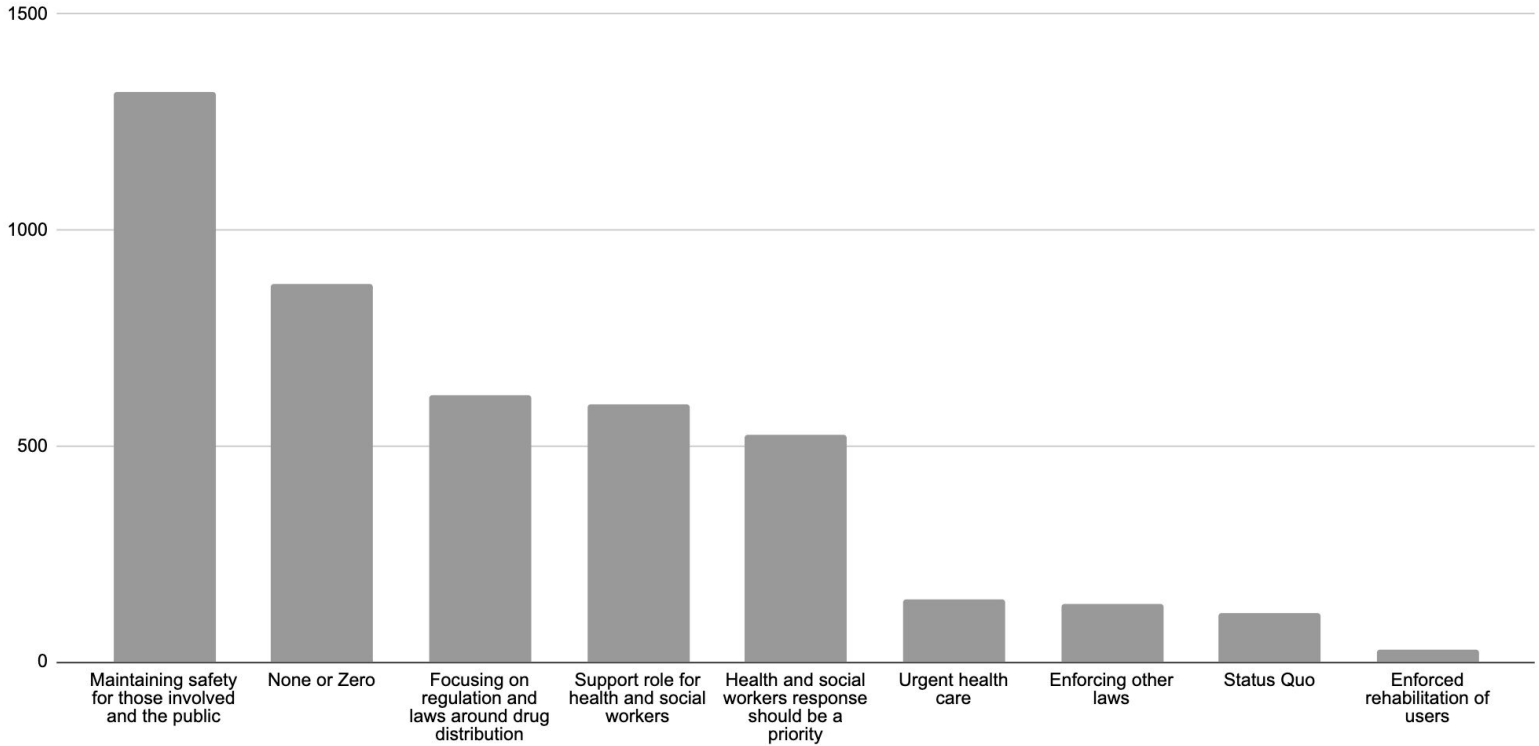
Question 4:

What role, if any, should the police have in responding to drug related 911 calls?

Open Text
4,451 Responses 1,544 No response

3,591 Classified using mult-tag category AI analysis

4. What role, if any, should the police have in responding to drug related 911 calls? *(3,591 Classified)*

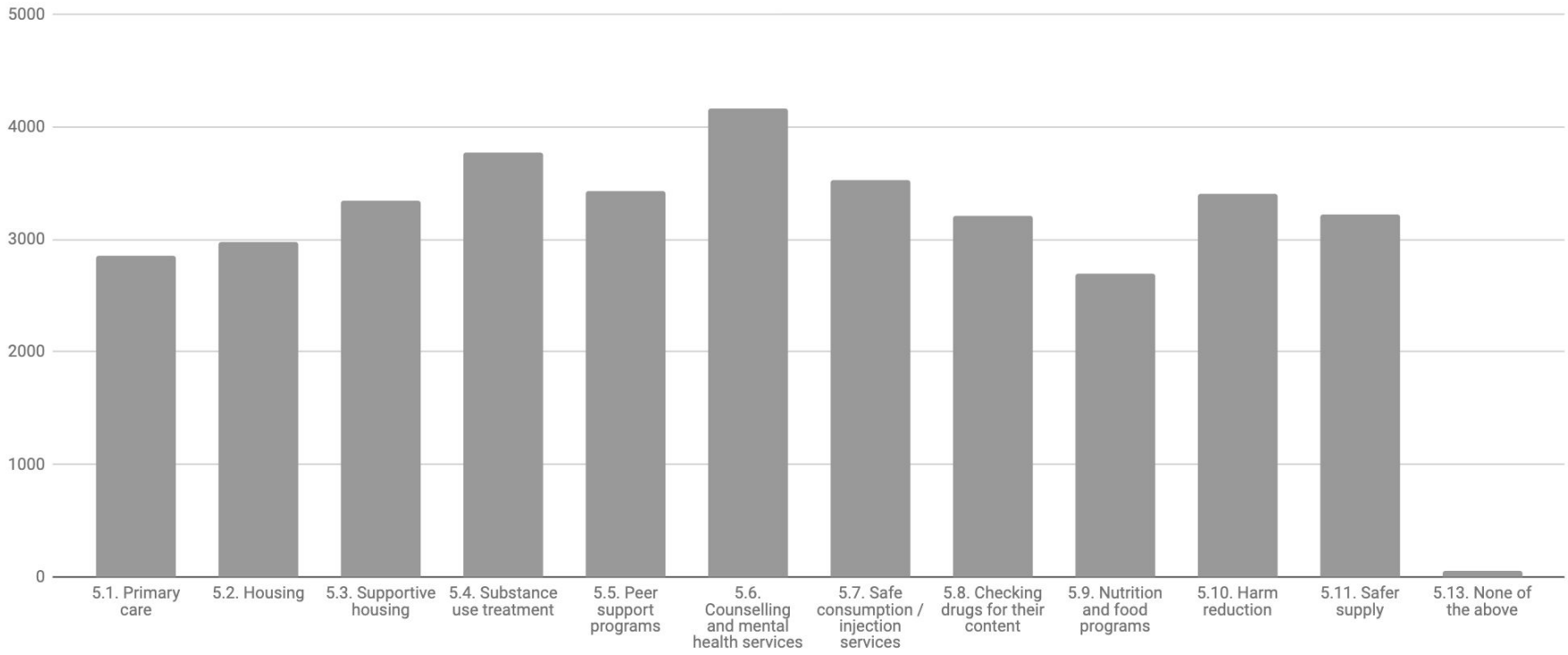


Question 5:

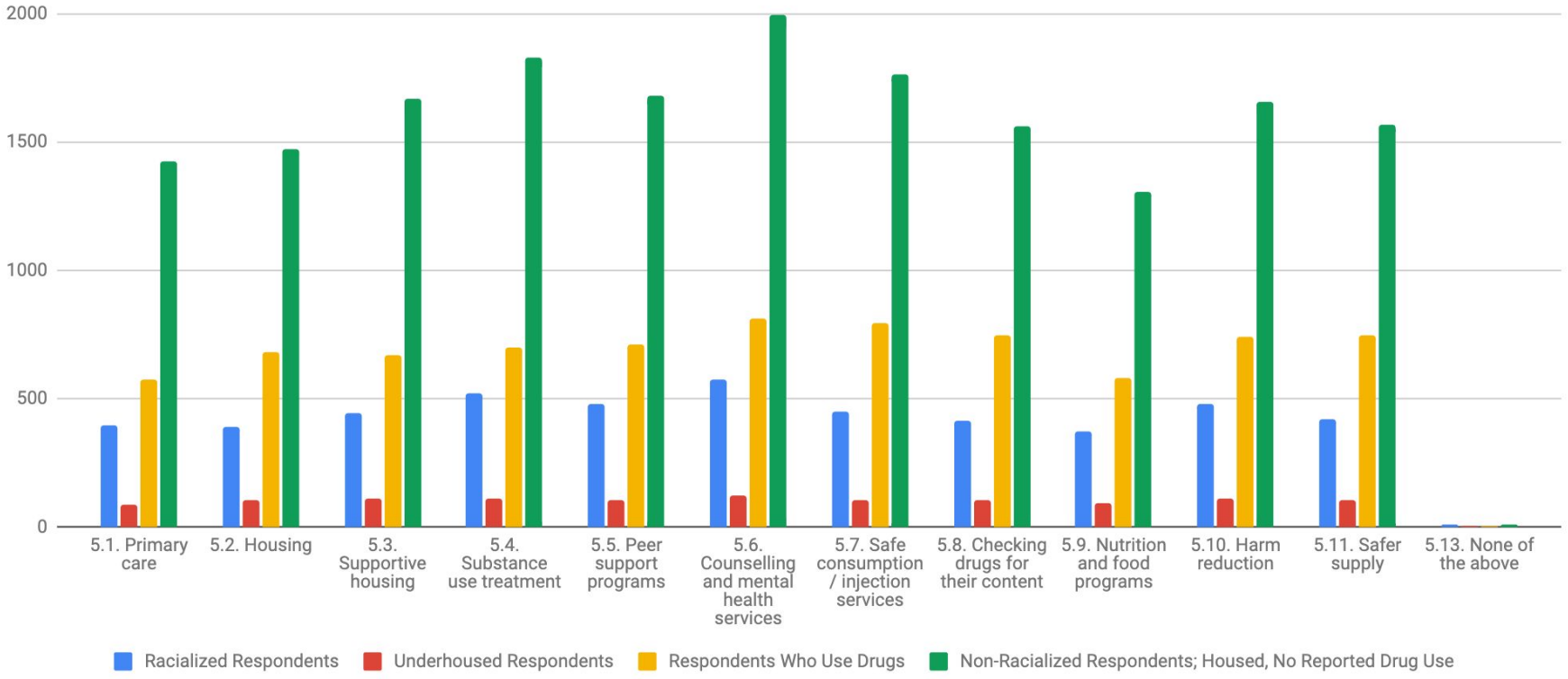
What services would help people who use drugs reduce the possibility of harm for their substance use or seek support for their substance use?

Check all that apply
4,615 Responses (with multi-answers), 1,380 No response

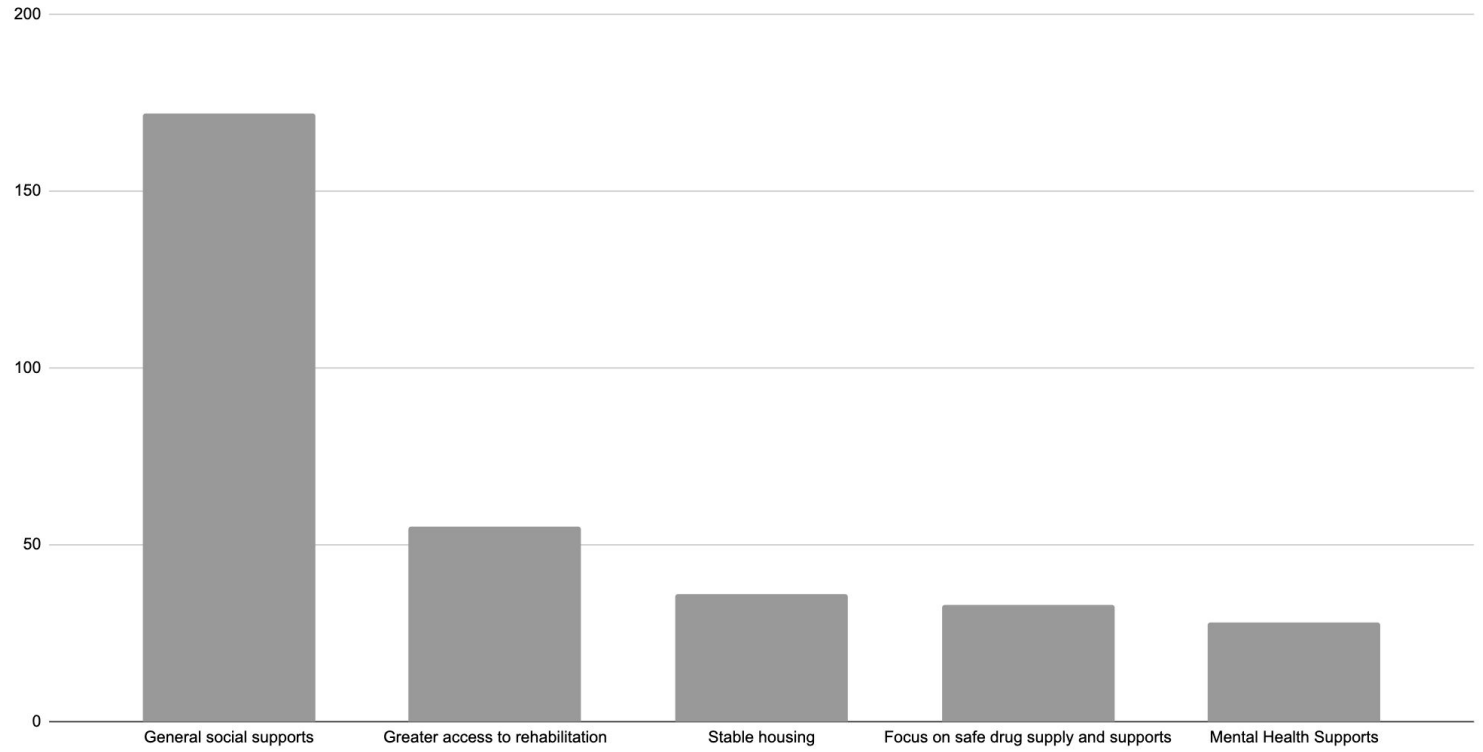
5. What services would help people who use drugs reduce the possibility of harm for their substance use or seek support for their substance use? *(4,615 Responses)*



5. What services would help people who use drugs reduce the possibility of harm for their substance use or seek support for their substance use? *(4,615 Responses)*



5.12 What services would help people who use drugs reduce the possibility of harm for their substance use or seek support for their substance use — Other? (607 Responses, 311 Classified using mult-tag category AI analysis)



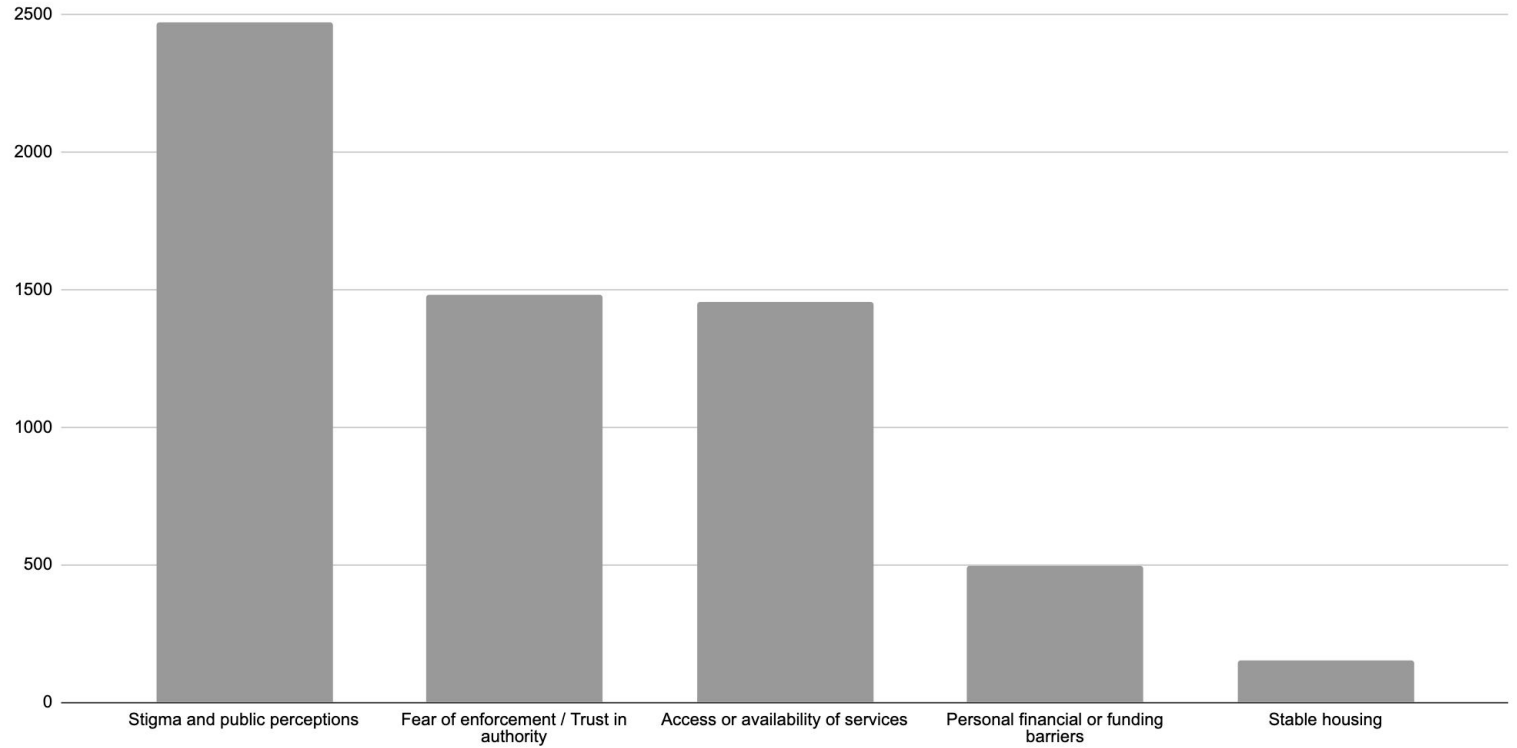
Question 6:

What barriers do you see that make it difficult for people who use drugs to access these or other services?

Open text
4,051 Responses, 1,944 No response

2,434 Classified using mult-tag category AI analysis

6. What barriers do you see that make it difficult for people who use drugs to access these or other services? *(2,434 Responses)*



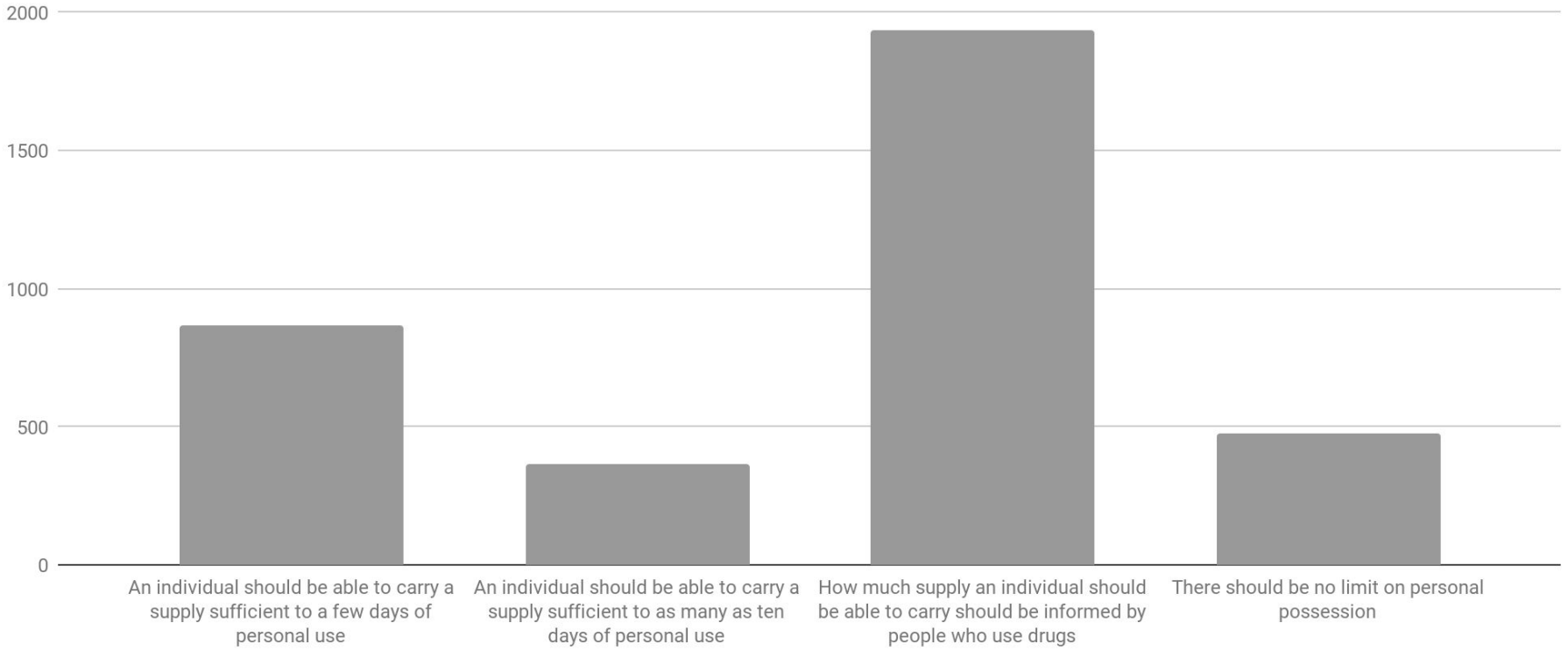
Question 7:

What should be considered when determining the quantity of drugs an individual can have for personal possession?

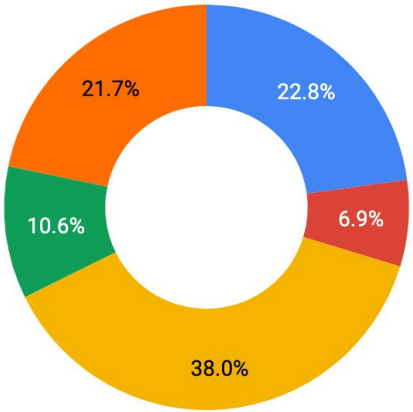
Single choice
4,599 Responses, 1,396 No response

7. What should be considered when determining the quantity of drugs an individual can have for personal possession?

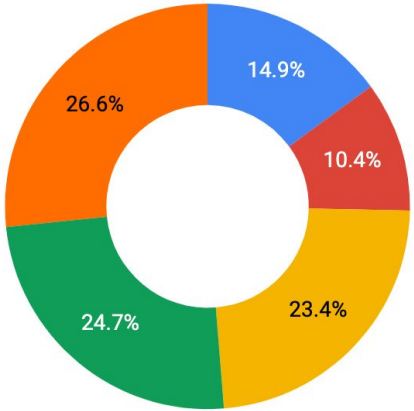
(4,599 Responses)



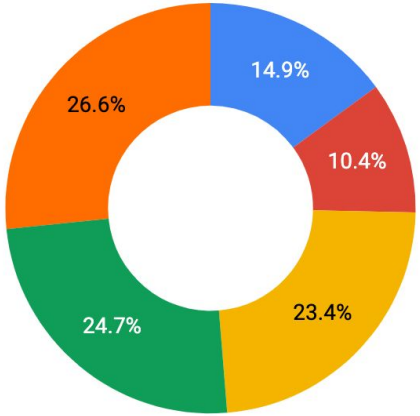
7. What should be considered when determining the quantity of drugs an individual can have for personal possession?



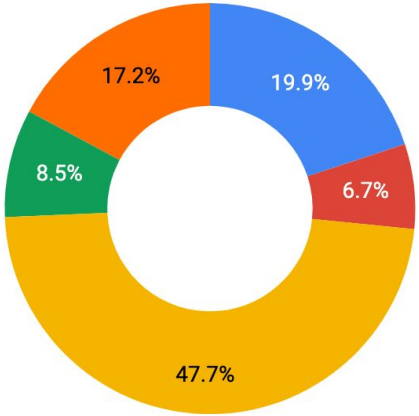
RACIALIZED RESPONDENTS



UNDERHOUSED RESPONDENTS



RESPONDENTS WHO USE DRUGS



NON-RACIALIZED RESPONDENTS; HOUSED, NO REPORTED DRUG USE

An individual should be able to carry a supply sufficient to a few days of personal use
An individual should be able to carry a supply sufficient to as many as ten days of personal use
How much supply an individual should be able to carry should be informed by people who use drugs
There should be no limit on personal possession
Other, please specify

Question 8:

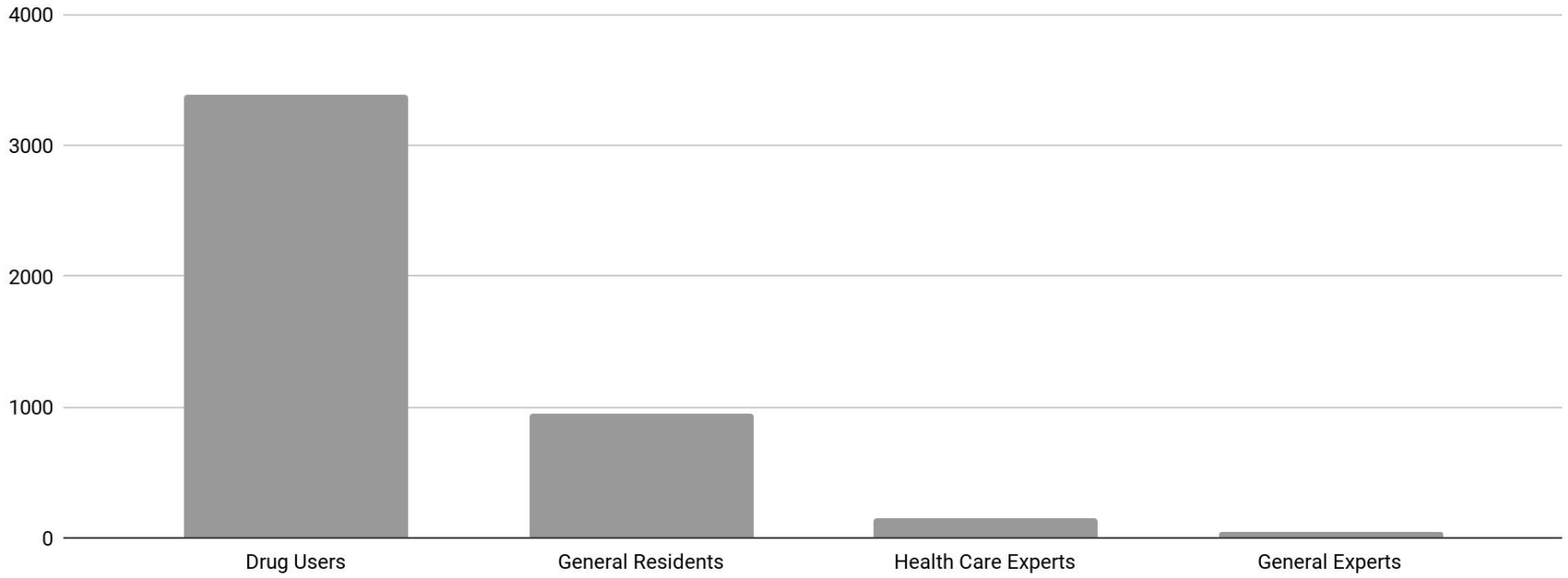
What role should community members, including people who use drugs, have in developing and evaluating this new policy?

Open Text
3,925 Responses 2,071 No response

3,636 Classified using mult-tag category AI analysis

8. What role should community members, including people who use drugs, have in developing and evaluating this new policy?

(3,636 Responses)



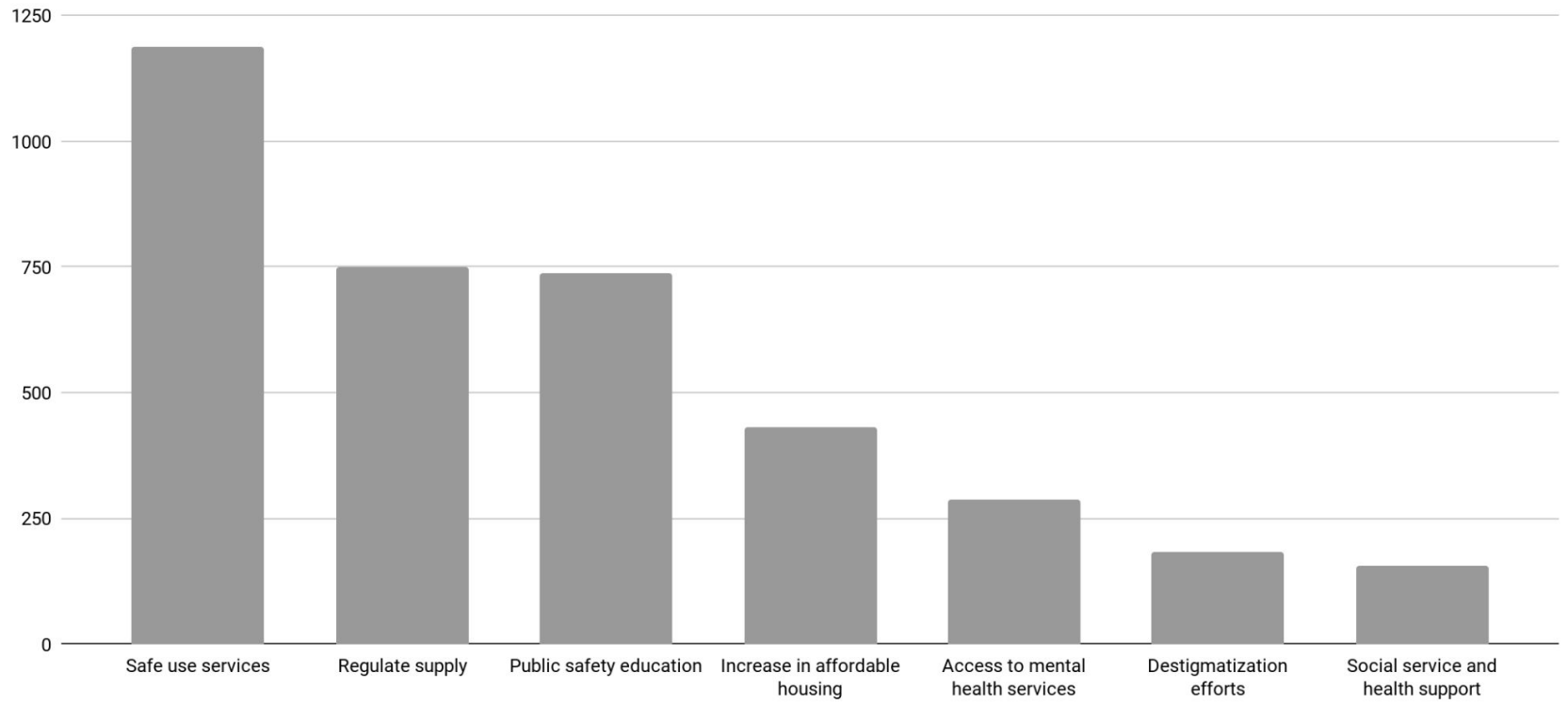
Question 9:

What other measures should Toronto consider to reduce substance use harms, including non-fatal and fatal overdoses, associated with drug use?

Open Text
3,443 Responses 2,552 No response

2,434 Classified using mult-tag category AI analysis

9. What other measures should Toronto consider to reduce substance use harms, including non-fatal and fatal overdoses, associated with drug use? *(2,434 Classified)*



ATTACHMENT 2

Letters of Support for Decriminalization

Attachment 2

Letters of Support for Decriminalization

This attachment contains letters of support for decriminalization submitted through Toronto Public Health's consultation process or the Toronto Board of Health. Letters are presented in the order in which they were received.

No.	Individual/Organization
1.	Gord Tanner, Acting General Manager, Shelter, Support and Housing Administration, City of Toronto
2.	Robin Griller, Executive Director, St. Michael's Homes
3.	James Ramer, Chief of Police, Toronto Police Service
4.	Susan Davis, Executive Director Gerstein Crisis Centre
5.	Dr. Alexander Caudarella
6.	Chris Brillinger, Executive Director, Family Service Toronto
7.	Angela Robertson, Executive Director, Parkdale Queen West Community Health Centre
8.	Jason Altenberg, Chief Executive Officer, South Riverdale Community Health Centre
9.	Sandra Ka Hon Chu, Co-Executive Director, HIV Legal Network
10.	Angie Hamilton, Executive Director, Families for Addiction Recovery
11.	Toronto Harm Reduction Alliance
12.	Scott Bernstein, Executive Director, Multidisciplinary Association for Psychedelic Studies Canada (MAPS Canada)
13.	Queer Ontario Steering Committee
14.	Maura Lawless, Executive Director, The 519
15.	Dr. Leslie Buckley, Chief, Addictions Division, Centre for Addiction and Mental Health
16.	Nick Boyce, Director, Ontario Harm Reduction Network

Shelter, Support & Housing Administration
Mary-Anne Bédard, General Manager

Metro Hall, 6th Floor
55 John Street
Toronto, Ontario M5V 3C6

Tel: 416-392-7885
Fax: 416-392-0548
Mary-Anne.Bedard@toronto.ca
www.toronto.ca

November 8, 2021

Re: City of Toronto's application for exemption to decriminalize simple drug possession

Attn: Health Canada Exemptions Section

This letter confirms that the City of Toronto's Shelter Support and Housing Administration (SSHA) division strongly supports the application for an exemption to decriminalize simple drug possession in the City of Toronto. This support echoes increasing calls for decriminalization of drug possession in Canada from various health and public policy professionals, nursing associations, and public health bodies.

Criminalization has created an illegal drug market that produces stronger drugs and an increasingly toxic and lethal drug supply. It forces people to use drugs in unsafe spaces and contributes to higher rates of non-fatal and fatal overdose. It results in the stigmatization of people who use drugs and criminal records that make it harder for people to secure employment and housing.

People experiencing homelessness are among those most impacted by drug laws that criminalize possession and use of drugs. In April 2021, SSHA conducted its fifth Street Needs Assessment (SNA), a city-wide point-in-time count and survey of people experiencing homelessness in Toronto. The SNA found that 42% of respondents reported having a substance use issue, with people staying outdoors being significantly more likely (65%) to report a substance use issue than those staying in shelters (41%). In the midst of the drug poisoning emergency in Toronto and the compounding impact of the COVID-19 pandemic, rates of non-fatal and fatal opioid poisoning are increasing across the city, and particularly within the shelter system. Non-fatal overdoses in the shelter system increased from an average of 26 per month in 2018 to an average of 67 per month in 2020, and the number of fatal overdoses at sheltering sites has spiked from an average of about one per month in 2018 to four per month in 2020.

Decriminalization on its own is not enough. It must be part of a broader alternative approach that includes increased investment in deeply affordable and supportive housing and an alternative model that connects those who are ready with enhanced wrap-around supports and services. This includes access to treatment, for which we know there is unmet demand. For example, only 16% of the respondents in the 2021 Street Needs Assessment who reported having a substance use issue had used a treatment facility in the past year, while 33% of respondents who were not currently in treatment for a substance use issue were interested in accessing treatment. This was higher among

families in City-administered shelter sites, with 42% of respondents being interested in accessing treatment.

Although this application is focused on decriminalization within the City of Toronto, it must be stressed that decriminalization should be implemented Canada-wide, through legislative change that includes expungement of criminal records from previous offenses related to simple possession. This would serve to ensure maximum impact on the health, safety and well-being of people who use drugs and are experiencing homelessness. Such prior offenses can present a barrier to securing housing, even for those who are managing their use or no longer using. To ensure broad and equitable application, previous offenses should be completely and automatically deleted, at no cost to the individual.

Once again, SSHA submits its full interest and support for the application being put forward for an exemption to decriminalize simple drug possession in the City of Toronto. This represents a critical step for the City in advancing efforts to reduce harms associated with drug use, save lives, and support the complex health and harm reduction needs of those who use drugs and are experiencing homelessness.

Sincerely,

Gord Tanner

Acting General Manager
Shelter, Support and Housing Administration

St. Michael's
HOMES

November 15, 2021

Dr. Eileen De Villa
Chief Medical Officer of Health, Toronto

Dear Dr. de Villa,

RE: Toronto Community Anchor Model Proposal for submission to Health Canada

I am writing in support of the submission under consideration at the Toronto Board of Health this month aimed at implementing public health and human rights based approaches to responding to substance use challenges in the City of Toronto through an application to Health Canada.

As a member of the Working Group on Toronto's Submission to Health Canada for an Exemption to the Controlled Drugs and Substances Act (WGTS), I participated in the development of the proposal before the Board of Health this month. A broad range of community-based substance use providers, people with lived experience, and public health officials have together developed a strong proposal to reduce the criminal justice-related harms of substance use, while improving voluntary access to supports for recovery from substance use disorders.

As an organization providing services to people in early recovery from substance use challenges, we find that one of the barriers our participants face in having healthy and safe lives, is their history of involvement with the criminal justice system. This proposed model can help to reduce that barrier to building better lives for people who use drugs in the City of Toronto.

Thus, I am writing to ask the Board of Health to support approval of the submission to Health Canada.

Yours,

Robin Griller
Executive Director
St. Michael's Homes

Toronto Police Service

40 College Street, Toronto, Ontario, Canada. M5G 2J3
(416) 808-2222 FAX (416) 808-8202
Website: www.TorontoPolice.on.ca

Office of the Chief of Police

File Number: ----------

Sent via e-mail

November 23, 2021

Dr. Eileen de Villa
Medical Officer of Health
277 Victoria Street, 5th Floor
Toronto, ON M5B 1W2

Dear Dr. de Villa:

Re: Letter of Support – Alternative Approach to Drug Criminalization in Toronto

Thank you for providing the Toronto Police Service with the opportunity to participate in Toronto Public Health's ongoing efforts to develop an alternative approach to drug criminalization in Toronto.

We agree that the current approach to managing drug use does not support safe communities or advance the health of people who use drugs. Decriminalization of the simple possession of all drugs – combined with the scale-up of prevention, harm reduction, and treatment services – is a more effective way to address the public health and public safety harms associated with substance use.

Decriminalization has been supported by both the Canadian Association of Chiefs of Police (CACP) nationally, and the Ontario Association of Chiefs of Police (OACP) provincially. As highlighted by the OACP, we agree that:

- Substance Use Disorder is a public health issue and requires a coordinated and collaborative approach.

- There are benefits to addressing the simple possession of drugs through health channels rather than a criminal justice response.

- Decriminalization of simple possession of drugs must be preceded by a framework of diversion program options, including voluntary and involuntary options, to provide frontline police with established referral pathways to health, rehabilitation, and recovery support.

Like the provincial and national associations of chiefs of police, we endorse the decriminalization of personal possession of illicit drugs. **We support a Toronto Public Health request to Health Canada for an exemption to the *Controlled Drugs and Substances Act* and we support a proposed Toronto model as a comprehensive approach to establish an effective network of health and social supports for people who use drugs, provided that:**

- The model for decriminalization of simple possession of drugs in Toronto is developed in conjunction with, and preceded by, an adequately funded framework that will provide for on-demand, wrap around, health and social supports.

- The model for decriminalization of simple drug possession in Toronto must include the establishment of a regulated safe supply of drugs, sanctioned by Health Canada and/or the Ministry of Health, as part of the effort to keep those who use drugs safe, while we attempt to connect them with important health and social services.

- Toronto emergency responders, including Toronto Police Service members, are involved in the diversion process of referral pathways to services.

- The model for decriminalization of simple possession of drugs in Toronto must strike a balance between public health and public safety.

- The Toronto Police Service will remain an active participant and be involved in all future discussions on decriminalization.

We welcome the opportunity to continue this work with Toronto Public Health, people who use drugs, and health and social service providers to support access to services for people who use drugs, as well as to enhance the overall safety and well-being of all Torontonians.

I have consulted with the Toronto Police Service Board on my letter to you today. They have expressed their support for the position I have outlined herein.

Sincerely,

James Ramer, M.O.M.
Chief of Police

cc. Chris Murray, City Manager, City of Toronto

Gerstein Crisis Centre

Board of Directors

Ms. Lisa Manuel
(Vice-chair)

Mr. Arnab Basu
Ms. Lucia Costa
Ms. Marcy Gerstein
Ms. Stephanie Gloyn
Mr. Desmond Rowley
Ms. Adiba Jafar
Ms. Lubna Khalid
Mr. Jaipreet Kohli
Ms. Kathryn Mettler
Ms. Marina Morrow
Ms. Hricha Rakshit
Mr. Adam Wheeler

Executive Director

Ms. Susan Davis

November 25, 2021

Re: Support for Toronto's Submission to Health Canada for an Exemption to the Controlled Drugs and Substances Act (WGTS)

Dear Health Canada,

Established in Toronto in 1989, Gerstein Crisis Centre provides a range of 24-hour crisis response and intervention services to people across the City of Toronto who are living with mental health and addiction issues. As an accessible source of support and recovery for individuals experiencing a mental health crisis, we work collaboratively to improve timely and equitable access to services that are guided by the voices of those with lived experience, to promote wellness, recovery, and strong consumer survivor networks. Gerstein Centre's spectrum of crisis services include 24/7 telephone support, an in-person mobile crisis team, community support referrals, substance use crisis management, follow-up, Mental Health and Justice supports and access to short term crisis beds.

We see in our work everyday vulnerable and marginalized people who use drugs are often the most likely to suffer the consequences associated with drug use stigma and to have interactions with police that result in charges. This stigma and involvement with the criminal justice system often impedes their ability to reduce the harms associated with drug use or to seek social supports, stable housing or health services including treatment. An exemption from the CDSA would begin to reduce this stigma and the barriers to safer use and care that could save lives.

Our communities are facing complex issues and solutions will require innovative models that work collaboratively and cross over jurisdictional lines and government ministries. Support from all three levels of government – municipal, provincial, and federal – is needed to begin to address the inequities that people living with mental health and addiction issues face and to improve the overall wellbeing and health of our communities. Significant resources and policy change are required to reduce harms and improve health, and this includes decriminalization of substance use.
We whole heartedly support Toronto's Submission to Health Canada for an Exemption to the Controlled Drugs and Substances Act (WGTS) which includes the expansion of pathways and supports available to those most at risk from an increasingly toxic drug supply. Too many lives have been lost, the time for action is now.

Sincerely,

Susan Davis
Executive Director
Gerstein Crisis Centre

100 Charles Street East Toronto, ON M4Y 1V3
416-929-0149
www.gersteincentre.org

UNITY HEALTH TORONTO
Caring hearts. Leading minds.

November 26th 2021

Letter of support for Toronto Public Health submission to Health Canada

As an acute care physician and director of substance use services I write this letter of support for Toronto public health's decision to submit a drug possession decriminalization exemption to Health Canada.

In the context of our current public health crisis of unprecedented overdose deaths implementation of decriminalization should be seen as having minimal risk, significant support within the medical community and potential to save young lives.

Regularly I meet clients in hospital who are hesitant to disclose substance use. They fear that if they acknowledge illicit drug use they will somehow be punished or the police will become involved. People who use drugs have early discharge (against medical advice) from hospital at rates that are significantly higher than the general population. Leaving hospital with untreated conditions increases the risk of complications and death. This lack of trust has significant and damaging effects; it can result in a failure to appropriately treat and support these individuals. Decriminalization is required for people to feel comfortable sharing, discussing and seeking help for their use of illicit drugs when they are admitted to institutions such as hospitals.
Furthermore, I have heard again and again from my patients that fear of criminalization has caused delays in seeking out treatment for their substance use issues or hesitancy to call emergency services when they witness an overdose.
It is true that in past years, Toronto police service and crown attorneys have been less likely to place or pursue charges for simple possession. However, as it remains an illegal act, I have seen repeatedly as a physician that the fear my patients have has not reduced.

Toronto public health's initial submission takes into account not only the immediate benefit decriminalization could have but also offers a multitude of appropriate and robust alternatives to policing for simple drug possession. This broad and well consulted plan can help drastically improve the lives and well-being of people who use drugs.

It has been an honour to be part of this process as a member of the working group developing and advising on the submission.

Dr. Alexander Caudarella MDCM CCFP ABAM (d)
Alexander.caudarella@mail.uToronto.ca
778 872 3486

For People For Change
FAMILY SERVICE TORONTO

November 26, 2021

Dear Members of the Toronto Board of Health:

Family Service Toronto provides a range of services to individuals, groups, and government, including: clinical counselling services, community development, gender based violence support and prevention, peer support, case management for people with developmental disabilities, financial services (PassportONE), community service space, public policy, and research. Family Service Toronto provided service to over 80,000 people in 2020/21 having successfully moved full virtual service provision in April 2020.

Family Service Toronto is pleased to endorse the Toronto Medical Officer of Health's recommendations for a public health response to the drug crisis that recognizes the importance of human rights as well as the social determinants of health in reducing the harms associated with drug use and criminalization. It is clear to us that problematic or destructive drug use is a health issue, not a criminal justice issue. The report before you constitutes an important step in moving our societal view of how to respond to problematic or destructive drug use from a punitive, de-humanizing, and ineffective response, to a humane, supportive, and effective response. This is a hugely complex problem with no easy, one-step solution. The step you are considering today is a leap forward in providing a comprehensive vision of how society can change its perception and response to problematic drug use, a pre-requisite to facilitate individual drug users to make their own leap forward.

Family Service Toronto was privileged to serve on the working group struck by the Medical Officer of Health to assist in preparing the submission to Health Canada. The effort to make the working group process as accessible and broad based as possible was evident throughout the process. The debate at the working group was spirited, reflecting the complexity and urgency of the issue. The result is the best thinking of people who use drugs, the institutions who interact with them, and the services and agencies who strive to support them. Family Service Toronto urges Members of the Board of Health to endorse the submission to Health Canada.

Sincerely,

Chris Brillinger
Executive Director

November 26, 2021

PARKDALE QUEEN WEST Community Health Centre
www.pqwchc.org

Board of Health
10th floor, West Tower, City Hall
100 Queen Street West
Toronto, ON M5H 2N2

email: boh@toronto.ca

Meeting No. 32 - Agenda Item on Decriminalization

To the Members of the Board of Health:

Parkdale Queen West Community Health Centre strongly supports the need to end the war on drugs and supports decriminalization. Daily through our harm reduction programs, supervised consumption services, primary care and safer opioid supply programs witness and respond to the tragic and preventable impacts of criminalization.

We know that decriminalization is a necessary component of ending stigma and discrimination and we also see the disproportionate harms that criminalization has on black and Indigenous communities; as such we see decriminalization as necessary to address systemic racism and colonization. Hence, while outside the scope of authority of the Board of Health, we strongly believe that the Board must be in alliance with the calls for expungement of records for those who were impacted by criminalization for simple possession as the harms of those records continues to reverberate for many community members.

We support a vision of decriminalization that is built on the needs and voices of people who use drugs, and that simultaneously attempts to address the need for a regulated and safer supply of drugs to support the end of the overdose crisis. We look forward to seeing the full details of the Toronto plan; and a commitment that people who use drugs are central to policy making, implementation and evaluation of a Decriminalization Strategy, thus ensuring that our implementation efforts do not create additional or unintended harms to the community.

Sincerely,

Angela Robertson
Executive Director

South Riverdale COMMUNITY HEALTH CENTRE
955 Queen Street East | Toronto, Ontario | M4M 3P3
main tel: 416.461.1925 medical tel: 416.461.2493
main fax: 416.469.3442 medical fax: 416.461.8245
srchc.ca

November 26, 2021 SENT VIA EMAIL: boh@toronto.ca

Toronto Board of Health
c/o City Clerk's Office
Toronto City Hall
10th fl. W., 100 Queen St. W.
Toronto ON M5H 2N2
Toronto Board of Health

Dear members of the Toronto Board of Health:

South Riverdale Community Health Centre strongly supports the need to end the war on drugs and supports decriminalization. On a daily basis through our harm reduction programs, supervised consumption services, primary care and safer opioid supply programs, we witness and respond to the tragic and preventable impacts of criminalization. We know that decriminalization is a necessary component of ending stigma and discrimination and we also see the disproportionate harms that criminalization has on black and indigenous communities; as such we see decriminalization as necessary to address systemic racism and colonization.

We support a vision of decriminalization that is built on the needs and voices of people who use drugs and that simultaneously attempts to address the need for a regulated and safer supply of drugs to support the end of the overdose crisis. We look forward to seeing the full details of the Toronto plan and encourage us all to ensure that our efforts do not create additional harms to the community.

Sincerely,

Jason Altenberg
Chief Executive Officer

c.c. Councillor Joe Cressy – Chair, Board of Health, City of Toronto - councillor_cressy@toronto.ca
Dr. Eileen de Villa – Medical Officer of Health, City of Toronto - eileen.devilla@toronto.ca
Alicia Neufeld - Associate Director, Toronto Drug Strategy Secretariat - alicia.neufeld@toronto.ca

Ontario's Community Health Centres

Empowered, healthy and thriving communities where everyone belongs.

November 29, 2021

BY EMAIL: TPHconsult@toronto.ca

To Dr. Eileen de Villa, Medical Officer of Health, Toronto Public Health:

Re: Toronto's submission to Health Canada for a section 56 exemption to the *Controlled Drugs and Substances Act*

For almost three decades, the HIV Legal Network has worked to uphold the human rights of people living with and affected by HIV and advocated for the removal of punitive drug laws and policies that have fueled deadly stigma and epidemics of preventable illness and death. **As such, the HIV Legal Network supports the long-overdue decriminalization of personal drug possession as well as necessity trafficking, and looks forward to reviewing the full details of Toronto's "alternative approach" to drug decriminalization**.

As you know, pursuant to section 56(1) of the *Controlled Drugs and Substances Act* (CDSA), the federal Health Minister may, "on any terms and conditions that the Minister considers necessary, exempt from the application of all or any of the provisions of this Act or the regulations any person or class of persons or any controlled substance or precursor or any class of either of them if, in the opinion of the Minister, the exemption is necessary for a medical or scientific purpose *or is otherwise in the public interest*." [emphasis added] **We urge Toronto Public Health to situate its exemption request squarely "in the public interest" (rather than for a "medical purpose"), as drug decriminalization should be rooted in human rights and social justice**, and not unnecessarily tied to health outcomes. As we detail further below, tethering drug decriminalization to health outcomes may result in inadvertent and further harms to people who use drugs.

While we welcome Toronto Public Health's efforts to convene a working group to develop a section 56(1) exemption, going forward, we implore Toronto Public Health to center the people most directly affected by criminalization at all stages of the exemption process: people who are most often profiled, harassed, arrested, and charged for their drug use. As the working group has repeatedly underscored, drug prohibition perpetuates grave harms on Indigenous, Black, other racialized, marginalized, and low-income communities who are disproportionately arrested and incarcerated for drug offences and disproportionately subjected to child apprehension orders. **The meaningful and equitable input of people who use drugs, particularly those from Indigenous and Black communities, must be**

1240 rue Bay Street, Suite/bureau 600, Toronto, Ontario, Canada M5R 2A7
Telephone/Téléphone: +1 416 595-1666 Fax/Télécopieur: +1 416 595-0094
info@HIVLegalNetwork.ca www.HIVLegalNetwork.ca
Charitable Registration/Numéro d'organisme de charité #141110155 RR0001

prioritized in the proposed "Quantities Panel" and the Evaluation team, and their participation should be adequately compensated. People who use drugs, and particularly those who have been most harmed by punitive drug laws, are best equipped to determine the appropriate quantities and thresholds reflecting real-world drug use practices and to develop an evaluation plan for an exemption that is intended to benefit them. Without the expertise and leadership of people who use drugs, there is a real danger of "net widening" and further criminalization.

We support an exemption that applies city-wide to all drugs and to all residents of Toronto, including youth. The exclusion of youth from the section 56(1) exemption submissions of Vancouver and B.C. is discriminatory and troubling, since the prohibition on drug possession does harm to those criminalized, regardless of their age. We urge Toronto Public Health not to repeat this mistake and ensure youth are included in its application.

We also support an exemption that makes clear that it **does not replace criminalization with any fines or penalties** such as geographic, drug use, or personal contact restrictions or curfews, referrals to drug treatment courts, other involuntary treatment, or other health interventions. Coercive health interventions are not only ineffective, but they violate the rights to liberty and autonomy of people who use drugs. Additionally, **there should be clear rules prohibiting police from confiscating people's substances, paraphernalia, or medical supplies, and strict limitations relating to when police can stop, search, and investigate a person for drug possession**.

As many members of the working group have also emphasized, **police should not be tasked with referring people to services**, as such an encounter would still be experienced as coercive by people who use drugs. It is imperative that the proposed "dedicated outreach team" that is responsible for making referrals to the community anchors includes people who use drugs and other skilled and trained frontline workers. Any savings realized through de-tasking police, prosecutors, and prisons systems from the enforcement of drug offences should be reinvested in low-threshold harm reduction, health, and social services.

We also have concerns with the limitations of decriminalizing a multi-day supply that does not permit the sharing and selling of drugs for subsistence, to support personal drug use costs, and to provide a safe supply (i.e. "necessity trafficking"). It is common for people to sell limited quantities of drugs to others in their network as a means of livelihood, to support their own independent use, or to provide a safe supply and it is a poor use of public resources to criminalize selling or sharing in these circumstances. Decriminalizing necessity trafficking is in line with a human rights–based approach to drug policy.

As noted above, **Toronto's exemption and corresponding evaluation should not be tied to health outcomes, including the current overdose crisis**. The criminalization of drug possession has perpetuated numerous harms and human rights violations against people

who use drugs (including *Charter* rights to life, liberty, and security of the person) and there is no justification for continuing to do so. The removal of the constant threat of criminalization is itself a positive outcome, irrespective of impacts on health. While the expansion of health and harm reduction services for people who use drugs is a laudable objective, and we strongly urge the city to invest in sustained funding for low-threshold harm reduction, health, and social services, including gender-responsive services for women and trans people, this exemption request alone will not lead to the significant expansion of health services. Even in the absence of new services, it is beneficial to remove criminalization and its attendant stigma and other harms from the lives of people who use drugs.

As such, **an evaluation of this exemption, and indicators of success, cannot hinge on health outcomes**. Rather, an assessment should be based on fair and appropriate measures based on the objectives of decriminalization (i.e. a reduction in the number of charges laid for simple possession and of people being charged, as well as some demographic analysis to address potential continued bias in the application of the law). Other outcomes, including the anticipated benefits for health and well-being of persons previously criminalized, are important. However, these are secondary and not essential to judging the success of decriminalization efforts, the goal of which is to reduce the inherent harm of being criminalized and of the policing that accompanies it.

The work of undoing the harmful legacy of drug criminalization is only beginning, and we conclude by recommending that **Toronto Public Health supports a longer-term working group comprising people who use drugs and civil society organizations who can provide input and oversight to the exemption process**, including during negotiations between Toronto Public Health and Health Canada. This would facilitate ongoing transparency and accountability to the communities most directly affected by the proposed exemption.

Sincerely,

Sandra Ka Hon Chu, Co-Executive Director
HIV Legal Network

Families for
Addiction Recovery

Suite 200, 100 Consilium Place
Scarborough, ON Canada
M1H 3E3

Tel 1.855.377.6677
Email info@farcanada.org
Web www.farcanada.org

Dr. Eileen de Villa
Medical Officer of Health
Toronto Public Health
277 Victoria Street
5th Floor
Toronto, ON, M5B 1W2

Dear Dr. de Villa:

Letter of Support – Alternative Approach to Drug Criminalization in Toronto

Thank-you for inviting Families for Addiction Recovery (FAR) to be a member of the Working Group on an alternative approach to drug criminalization in Toronto. FAR endorses your recommendations for an alternative approach to the criminalization of drugs and, in particular, that:

1. The Board of Health reiterate its call requesting the Federal Minister of Health to use their authority under the Controlled Drugs and Substances Act to:

    a. Develop a national framework to permit the simple possession of all drugs for personal use; and
    b. Support the immediate scale-up of prevention, harm reduction, and treatment services.

2. The Board of Health direct the Medical Officer of Health to submit a request to Health Canada by the end of 2021 for an exemption under Section 56(1) of the Controlled Drugs and Substances Act, thereby starting a process to decriminalize the personal possession of illicit substances within the City of Toronto's boundaries.

We will reserve comment on details of the particular model being developed until it has been finalized and made public.

One final comment. It is difficult to understand why the Working Group has been tasked with developing pathways to treatment and services. Many people use illegal drugs non-problematically and many who use legal substances do so problematically. In fact, alcohol is the substance with the greatest cost to the criminal justice system. It would make more sense to examine alternative pathways to treatment and services in the context of all substances.

Angie Hamilton
Executive Director
Families for Addiction Recovery
angie@farcanada.org

Toronto Harm Reduction Alliance (THRA)

November 30, 2021

Dr. Eileen de Villa
Medical Officer of Health
Toronto Public Health
277 Victoria Street, 5th Fl
Toronto, ON M5B 1W2

Re: City of Toronto's Submission for the Decriminalization of Substances

The Toronto Harm Reduction Alliance (THRA) is a grassroots organization composed of people who use drugs (PWUD), frontline workers, students, researchers, and allies. We would like to thank the Toronto City Council, Toronto Public Health, and Dr. de Villa for convening this working group and placing the city on a path towards a more equitable and just drug policy that decriminalizes the possession of all drugs as part of a larger holistic model.

We are glad to see that the City is recognizing and admitting that drug prohibition and criminalization is rooted in racist, colonial, and classist ideas and stereotypes that are destructive to communities and counterproductive to keeping people and communities safe.

While THRA supports many aspects of the proposed framework, we have serious concerns in regards to its implementation. Additionally, the members of the Working Group were provided with insufficient time to review the final proposal in detail and discuss the proposal with their members. Here we will briefly outline some key measures of the proposal that we support and those that we oppose in regards to drug decriminalization.

We support drug policy based on an anti-racist, anti-oppression, harm reduction, human rights framework that is grounded in de-colonization approaches and policies. We believe that drug decriminalization will reduce stigma, reduce the costs associated with the legal system and incarceration, and improve the lives of PWUD and their families. By decriminalizing drugs, you decriminalize people.

Toronto Harm Reduction Alliance believes that there should be no weight or amount thresholds for any drug. People purchase drugs in different amounts for different reasons. Although THRA opposes the implementation of threshold amounts, if one is to be imposed, we request that the majority of the panel be composed of people who currently use drugs and that the panel reflect the broad range of PWUD. Additionally, we strongly oppose police veto power on said panel.

One of our greatest concerns is in regards to the new directive governing Toronto Police Service (TPS) officers and their rules of engagement for interacting with PWUD. The current TPS model has created strained relationships with PWUD—especially within the Indigenous, African, Caribbean, Black, and 2SLGBTIQ+ communities—which underlines the need for explicit rules of engagement.

We also believe that public drug use should not be considered just cause for approaching PWUD as this stipulation can act as a loophole that can be readily abused by TPS to continue to approach and harass PWUD and diminish the benefits of decriminalization.

Toronto Harm Reduction Alliance also opposes the use of involuntary referrals by TPS. Toronto Police Service officers are not health professionals and therefore unable to adequately evaluate a person's needs. Additionally, involuntary treatment for people who are not interested takes beds away from people actively seeking treatment which we believe is unjust and counterproductive.

We also request that the City create a robust system to evaluate the effects of drug decriminalization. Metrics should include the number of all police interactions and arrests—particularly those related to drugs, drug use, and public disorder—and referrals to support services. Additionally, we do not believe that overdoses are an appropriate metric for evaluating this policy.

In conclusion, THRA supports the City of Toronto's effort to decriminalize the possession of all drugs in principle but the City's actual directives, implementation, and enforcement of the policy will ultimately determine our level of future support.

Sincerely,

Toronto Harm Reduction Alliance

December 6, 2021

The Honourable Jean-Yves Duclos
Minister of Health
jean-yves.duclos@parl.gc.ca

VIA EMAIL

Dear Minister of Health,

As the Executive Director of The Multidisciplinary Association for Psychedelic Studies Canada (MAPS Canada), I would like to express my organization's support for British Columbia's and Toronto's initiatives to decriminalize personal possession of all illegal drugs, including psychedelics. MAPS Canada is committed to conducting and publishing scientific research supporting the beneficial uses of psychedelic medicines in the treatment of mental health conditions.

We strongly believe decriminalization will be beneficial for people who use drugss, practitioners, and will help end the stigma around drug-use that has persisted for too long. People who use drugs in isolation under fear of arrest, from opioids to psychedelics, are at higher risk of harm.

MAPS Canada is currently supporting the final phase of clinical trials for 3,4-methylenedioxymethamphetamine (MDMA)-assisted psychotherapy for the treatment of post-traumatic stress disorder (PTSD). We are also in the initial implementation stage of an MDMA-assisted psychotherapy trial for eating disorders and have a number of other studies in the beginning stages.

We are very encouraged that the province of British Columbia and the City of Toronto are piloting this project and basing their decisions on solid public health advice that is based in evidence from around the world and in Canada. We urge you to strongly consider granting their *Controlled Drugs and Substances Act* section 56 exemption requests. We believe the science speaks for itself and I encourage you to refer to the Literature Review in the attached Appendix for a summary of significant positive results showing the benefits of psychedelics for treatment of PTSD and other mental health conditions.

Warm regards,

Scott Bernstein
Executive Director

c.c:

The Right Honourable Justin Trudeau
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The Honourable Carolyn Bennett
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Appendix

The use of psychedelics is not a new phenomenon. For millennia, cultures world-wide have respected the function of psychedelic plants and fungi to provide healing, knowledge, creativity, and spiritual connection [1-11].

Lysergic acid diethylamide (LSD) and psilocybin were two of the first psychedelic substances to show therapeutic potential in the 1960s [21]. Recent scientific studies are demonstrating how psychedelics can be beneficial for treating conditions such as end-of-life anxiety [12], substance use disorders [13-15], cluster-headaches [16], post-traumatic stress disorder (PTSD) [17-19], anxiety [13], alleviating obsessive-compulsive disorder (OCD) [20], treatment resistant depression [13], and decreasing chronic pain [22]. Studies observing use of psychedelics in the community, outside of carefully controlled lab environments, also show positive outcomes, such as reducing rates of intimate partner violence [23], reducing recidivism [24], reducing suicidality [25, 26], improving mood and improving social connectedness [27, 28] and improving the ability to relate to nature [29]. Meta-analyses of the academic literature consistently report optimism regarding the significant potential health, social and spiritual benefits of psychedelics [15, 30-37].

The U.S. Food and Drug Administration (FDA) assessed the data and subsequently granted Breakthrough Therapy designation for two studies investigating psilocybin therapy for treatment-resistant depression and for MDMA assisted therapy for PTSD. Breakthrough designation allows the FDA to grant priority review to drug candidates if preliminary clinical trials indicate that the therapy offers substantial treatment advantages over existing options for patients with serious or life-threatening diseases.

In addition to treating a variety of conditions, psychedelics can also be valuable for personal and spiritual growth. Specifically, a Johns Hopkins study on “healthy normals” found that over 75% of the respondents considered their psilocybin experience to be one of the top five most meaningful or spiritual experiences of their lives [38, 39].

The risk of harm from psychedelics is extremely low. In 2000, a risk assessment on mushrooms containing psilocybin was conducted by the Netherlands-based Coordination Centre for the Assessment and Monitoring of new drugs and concluded that the health risk to the individuals, the public, and threats to public order was low. This has been confirmed by many researchers [40-43] and the European Monitoring Centre for Drugs and Drug Addiction [44]. David Nutt’s analysis of drug harms is of specific interest, as his detailed assessment includes an exhaustive list of harms to both self and others and concludes that mushrooms, LSD and ecstasy (MDMA) are three of the least harmful in a long list of both legal and illegal drugs [42].

It is notable that the Canadian Medical Association Journal chose to put an exploration of the psychedelic renaissance on the front cover of its journal which is sent to all Canadian physicians [45].

REFERENCES

1. Andritzky, W., *Sociopsychotherapeutic functions of ayahuasca healing in Amazonia.* Journal of Psychoactive Drugs, 1989. **21**(1): p. 77-89.
2. McKenna, D.J., *Ayahuasca: An ethnopharmacologic history*, in *Ayahuasca: Hallucinogens, consciousness, and the spirit of nature*, R. Metzner, Editor. 1999, Thunder's Mouth Press: New York. p. 187-213.
3. Labate, B.C., I.S.d. Rose, and R.G.d. Santos, eds. *Ayahuasca Religions: A Comprehensive Bibliography and Critical Essays*. 2008, MAPS: Santa Cruz, CA.
4. Heaven, R. and H.G. Charing, *Plant Spirit Shamanism*. 2006, Rochester, Vermont: Destiny. 5. Stewart, O., C, *Peyote Religion*. 1987, Norman: University of Oklahoma Press.
6. Smith, H. and R. Snake, eds. *One nation under god: The triumph of the Native American church*. 1996, Clear Light Publishers: Santa Fe, NM.
7. Labate, B.C. and C. Cavnar, *Peyote: History, Tradition, Politics and Conservation*. 2016, Santa Barbara, CA: Praeger.
8. Fernandez, J.W. and R.L. Fernandez, *Returning to the path: The use of ibogaine in a equatorial African Ritual Context and the binding of time, space and social relationships*, in *The Alkaloids,*. 2001, Academic Press, Department of Anthropology the University of Chicago: Chicago. p. 235-247.
9. Dobkin de Rios, M., *The wilderness of mind: Sacred plants in cross-cultural perspective*. Sage research papers in the social sciences (Cross-cultural studies series, No. 90-027). 1976, London: Sage Publications.
10. Dobkin de Rios, M., *Visonary Vine, Hallucinogenic healing in the Peruvian Amazon*. 1972, Long Grove: Waveland Press.
11. Dobkin de Rios, M., *Hallucinogens: Cross-cultural perspectives*. 1984, Albequerque, NM: University of New Mexico Press.
12. Griffiths, R.R., et al., *Psilocybin produces substantial and sustained decreases in depression and anxiety in patients with life-threatening cancer: A randomized double-blind trial.* Journal of Psychopharmacology, 2016. **30**(12): p. 1181- 1197.
13. Dos Santos, R.G., et al., *Antidepressive, anxiolytic, and antiaddictive effects of ayahuasca, psilocybin and lysergic acid diethylamide (LSD): a systematic review of clinical trials published in the last 25 years.* Therapeutic Advances in Psychopharmacology, 2016. **6**(3): p. 193-213.
14. Johnson, M.W., et al., *Pilot study of the 5-HT2AR agonist psilocybin in the treatment of tobacco addiction.* Journal of Psychopharmacology, 2014. **28**(11): p. 983-992.
15. Krebs, T.S. and P.O. Johansen, *Lysergic acid diethylamide (LSD) for alcoholism: meta-analysis of randomized controlled trials.* Journal of Psychopharmacology., 2012. **26**(7): p. 994-1002.
16. Sewell, R.A., J.H. Halpern, and H.G. Pope, Jr., *Response of cluster headache to psilocybin and LSD.* Neurology, 2006. **66**(12): p. 1920-1922.
17. Mithoefer, M.C., et al., *3,4-methylenedioxymethamphetamine (MDMA)-assisted psychotherapy for post-traumatic stress disorder in military veterans, firefighters, and police officers: a randomised, double-blind, dose-response, phase 2 clinical trial.* Lancet Psychiatry, 2018. **5**(6): p. 486-497.
18. Mithoefer, M.C., et al., *The safety and efficacy of {+/-}3,4-methylenedioxymethamphetamine-assisted psychotherapy in subjects with chronic, treatment-resistant posttraumatic stress disorder: the first randomized controlled pilot study.* Journal of Psychopharmacology., 2010. **25**(4): p. 439-52.
19. Mithoefer, M.C., et al., *Durability of improvement in post-traumatic stress disorder symptoms and absence of harmful effects or drug dependency after 3,4-methylenedioxymethamphetamine-assisted psychotherapy: a prospective long term follow-up study.* Journal of Psychopharmacology, 2013. **27**(1): p. 28-39.
20. Moreno, F.A., et al., *Safety, tolerability, and efficacy of psilocybin in 9 patients with obsessive-compulsive disorder.* Journal of Clinical Psychiatry, 2006. **67**(11): p. 1735-1740.
21. Dyck, E., *Psychedelic psychiatry: LSD from clinic to campus*. 2008, Baltimore, MD: Johns Hopkins University Press. 22. Whelan, A. and M.I. Johnson, *Lysergic acid diethylamide and psilocybin for the management of patients with persistent pain: a potential role?* Pain Manag, 2018. **8**(3): p. 217-229.
23. Walsh, Z., et al., *Hallucinogen use and intimate partner violence: Prospective evidence consistent with protective effects among men with histories of problematic substance use.* J Psychopharmacol, 2016. **30**(7): p. 601-607.
24. Hendricks, P.S., et al., *Hallucinogen use predicts reduced recidivism among substance-involved offenders under community corrections supervision.* Journal of Psychopharmacology, 2014. **28**(1): p. 62-66.
25. Hendricks, P.S., et al., *Classic psychedelic use is associated with reduced psychological distress and suicidality in the United States adult population.* Journal of Psychopharmacology, 2015. **29**(3): p. 280-

288.
26. Argento, E., et al., *The moderating effect of psychedelics on the prospective relationship between prescription opioid use and suicide risk among marginalized women.* J Psychopharmacol, 2018. **32**(12): p. 1385-1391.
27. Forstmann, M., et al., *Transformative experience and social connectedness mediate the mood-enhancing effects of psychedelic use in naturalistic settings.* Proc Natl Acad Sci U S A, 2020. **117**(5): p. 2338-2346.
28. Carhart-Harris, R.L., et al., *Psychedelics and connectedness.* Psychopharmacology (Berl), 2018. **235**(2): p. 547-550. 29. Kettner, H., et al., *From Egoism to Ecoism: Psychedelics Increase Nature Relatedness in a State-Mediated and Context-Dependent Manner.* Int J Environ Res Public Health, 2019. **16**(24).
30. Amoroso, T. and M. Workman, *Treating posttraumatic stress disorder with MDMA-assisted psychotherapy: A preliminary meta-analysis and comparison to prolonged exposure therapy.* J Psychopharmacol, 2016. **30**(7): p. 595- 600.
31. Dos Santos, R.G., et al., *Classical hallucinogens and neuroimaging: A systematic review of human studies: Hallucinogens and neuroimaging.* Neurosci Biobehav Rev, 2016. **71**: p. 715-728.
32. Passie, T., et al., *The pharmacology of lysergic acid diethylamide: a review.* CNS Neurosci Ther, 2008. **14**(4): p. 295- 314.
33. Dos Santos, R.G., et al., *The current state of research on ayahuasca: A systematic review of human studies assessing psychiatric symptoms, neuropsychological functioning, and neuroimaging.* J Psychopharmacol, 2016.
34. Dos Santos, R.G., et al., *Efficacy, tolerability, and safety of serotonergic psychedelics for the management of mood, anxiety, and substance-use disorders: a systematic review of systematic reviews.* Expert Review of Clinical Pharmacology, 2018.
35. Nunes, A.A., et al., *Effects of Ayahuasca and its Alkaloids on Drug Dependence: A Systematic Literature Review of Quantitative Studies in Animals and Humans.* J Psychoactive Drugs, 2016. **48**(3): p. 195-205.
36. Mangini, M., *Treatment of alcoholism using psychedelic drugs: a review of the program of research.* J Psychoactive Drugs, 1998. **30**(4): p. 381-418.
37. Dos Santos, R.G. and J.E.C. Hallak, *Therapeutic use of serotoninergic hallucinogens: A review of the evidence and of the biological and psychological mechanisms.* Neurosci Biobehav Rev, 2019. **108**: p. 423-434.
38. Griffiths, R.R., et al., *Psilocybin can occasion mystical-type experiences having substantial and sustained personal meaning and spiritual significance.* Psychopharmacology (Berl), 2006. **187**(3): p. 268-283; discussion 284-292.
39. Griffiths, R.R., et al., *Psilocybin occasioned mystical-type experiences: immediate and persisting dose-related effects.* Psychopharmacology (Berl), 2011. **218**(4): p. 649-65.
40. Johnson, M.W., et al., *The abuse potential of medical psilocybin according to the 8 factors of the Controlled Substances Act.* Neuropharmacology, 2018. **142**: p. 143-166.
41. Nutt, D., et al., *Development of a rational scale to assess the harm of drugs of potential misuse.* Lancet, 2007. **369**(9566): p. 1047-53.
42. Nutt, D.J., et al., *Drug harms in the UK: a multicriteria decision analysis.* Lancet, 2010. **376**(9752): p. 1558-1565. 43. van Amsterdam, J., A. Opperhuizen, and W. van den Brink, *Harm potential of magic mushroom use: a review.* Regul Toxicol Pharmacol, 2011. **59**(3): p. 423-9.
44. EMCDDA -European Monitoring Centre for Drugs and Drug Addiction, *Hallucinogenic mushrooms: An emerging trend case study*. 2006.
45. Tupper, K.W., et al., *Psychedelic medicine: a re-emerging therapeutic paradigm.* Canadian Medical Association Journal, 2015. **187**(14): p. 1054-1059.

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December 6, 2021

Queer Ontario welcomes the opportunity to share our perspective on the issue of the decriminalization of drugs that are currently illegal under the *Controlled Drugs and Substances Act*.

Many individuals who take a public role within Canadian queer communities have advocated for a human rights and public health approach to substance use and dependency. Substance use in the form of alcohol and drugs was reported by roughly 29% of 2SLGBTQ+ individuals in the last 12 months, which is almost triple the rate for those who identify as heterosexual (Haig, 2020). These disparities in health outcomes are one compelling reason to advocate for the decriminalization of all drug use and to move toward a human rights and health care model for drug consumption and dependency.

Therefore, we at Queer Ontario support the efforts of Toronto Public Health and other agencies for the full decriminalization of all drugs for personal use and possession advanced under the mantle of public health care principles as well as being informed by a human-rights based approach.

References

Haig, T. (2020). “Shocking statistics released about assaults against LGBTQ people in Canada.” RCI: Radio Canada International. https://www.rcinet.ca/en/2020/09/10/shocking- statistics-released-about-assaults-against-lgbtq-people-in-canada/

Sincerely,

Queer Ontario Steering Committee
c/o 519 Church Street Community Centre
519 Church St.
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Queer Ontario is a provincial network of gender and sexually diverse individuals — and their allies — who are committed to questioning, challenging, and reforming the laws, institutional practices, and social norms that regulate queer people.

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December 7th, 2021

Re: QS4.4: Actions to Respond to the Drug Poisoning Crisis in Toronto

As a City Agency committed to the health, happiness, and full participation of 2SLGBTQ and Downtown East communities, The 519 works with some of Toronto's most marginalized community members. We strive to make a real difference in people's lives, while working to promote equity and justice. Through our work, we are acutely aware of the harmful effects that the criminalization of drug use has on 2SLGBTQ community members, especially those experiencing homelessness. We stand in full support of the Toronto Board of Health's recent request to decriminalize the personal possession of illicit substances within the City of Toronto's boundaries and provide the following comments in an effort to ensure that the lived experience and needs of drug-using 2SLGBTQ community members are reflected within this much-needed policy change.

For several years, The Yonge-Church Corridor has had the highest level of overdose calls and one of the highest levels of drug poisoning rates in Toronto. Home to 1.1% of Toronto's population, in 2020, 8% of all overdose calls came from the area which includes the Church-Wellesley Village. Through working closely with drug-using community members and 2SLGBTQ community members experiencing homelessness, we see the impact that the criminalization of drug use has on our community members, and the barriers that it creates with regards to queer, trans, and 2-spirit individuals being able to access the supports that they need to get on to the path of wellness.

Too often, these barriers result in death. As we read aloud the record number of names of community members lost at the 2021 Trans Day of Remembrance, many were community members experiencing homelessness and substance use issues. These names included those we worked with tirelessly to get access to hotel and shelter beds, only to see them die by drug poisoning.

The community anchor model and evolving Toronto model that Toronto Public Health has described are essential to the safety and wellbeing of 2SLGBTQ communities. All too often, we hear from community members after an overdose that they did not call 911 because they were scared they would be arrested. Every day, we have community members turn to our organization to find them much needed supports because they do not have anywhere to go. Sadly, those supports often simply don't exist.

A dedicated focus by the City of Toronto on investing in and advocating for alternatives to criminalization for drug users, including treatment options, expanded harm reduction services are essential to the health and wellbeing of vulnerable 2SLGBTQ communities.

Decriminalization cannot happen in a vacuum. The success of this approach is predicated on a holistic and intersectional understanding of what is required for equity deserving community members to move towards wellness. As well as a fundamental acknowledgement of the trauma caused by systemic discrimination as root causes of substance use.

It is not uncommon for the people that we work with to find themselves unable to access substance use or mental health services that are affirming of their gender expression or sexual orientation. It is all too common for community members to access supports, only to find themselves in situations that are hostile and discriminatory.

As The City of Toronto continues to move towards a harm reduction and health-focused lens in relation to drug use, an equity-based understanding of the broader social determinants of health are essential to ensuring positive outcomes for 2SLGBTQ community members. Queer, trans and two-spirit folks who use drugs will not be able to move towards wellness and stability without a seismic shift in the way support systems provide appropriate and affirming supports. Additionally, mental health and substance use treatment can only useful if they are accessible and affirming for people living in poverty. An understanding of the stigma of drug use needs to understand the specific ways in which the stigma that many 2SLGBTQ community members face is deeply intertwined with their drug use and experiences of transphobia and homophobia.

The 519 staff have been on the frontline of responding to the opioid drug poisoning crisis. Our staff regularly provide life-saving interventions for people who are overdosing. This work is unfunded, but we do it because we must. We also grieve with our communities, our staff and community partners for the lives lost.

At the same time, we are very aware of the negative personal and community impacts that methamphetamine use also creates within 2SLGBTQ communities. Through our Toronto Public Health funded Breaking the Ice outreach program and our longstanding drop-in programming, we see the harmful effects that methamphetamine use has on a wide range of our community members, as well as how the broader social service, substance use treatment, and mental health service sectors while many well intended are ill-equipped and not sufficiently resourced to deal with this crisis. We urge this committee and Toronto Public Health to ensure that any move towards the decriminalization of drugs and enhanced supports for people who use drugs includes the specific needs of 2SLGBTQ people who use methamphetamine.

The 519 is eager and willing to work with Toronto Public Health, the 2SLGBTQ Advisory Committee, the communities we work with, and our community partners to ensure that the proposed decriminalization of personal possession is embedded within deep

consultation of 2SLGBTQ communities to ensure that their unique experiences, needs, and hopes to build the necessary affirming approaches, strategies and interventions will be successful. We strongly encourage the 2SLGBTQ Advisory Committee to call on City Council and all levels of government to invest in the development of these essential programs and services that will respond to this crisis and save the lives of so many people in our community.

Sincerely,

Maura Lawless

camh

December 10, 2021

To whom it may concern:

On behalf of the Centre for Addiction and Mental Health (CAMH), I am pleased to submit this letter in support of the request by Toronto's Medical Officer of Health for an exemption under Section 56(1) of the *Controlled Drugs and Substances Act*. This exemption would decriminalize the personal possession of illicit substances within the City of Toronto's boundaries.

Over 75,000 deaths per year in Canada are attributable to substance use.[1] Fatal opioid poisonings in particular have greatly increased during the pandemic,[2] lending additional urgency to this issue. The criminalization of substance use has not proven to be effective in dissuading it. In fact, rather than reducing substance-related harms, enforcement-based strategies exacerbate them.[3 4 5 6]

- Criminalization discourages people who use drugs from seeking health services, which has adverse public health consequences such as accelerating the spread of HIV and hepatitis C, and increasing overdose deaths.
- It produces an environment in which people may be exposed to criminality and violence.
- It stigmatizes people with substance use disorders.
- Racialized communities, notably Black and Indigenous, disproportionately experience these harms, worsening already existing health inequities.

The public consultations conducted by Toronto Public Health earlier this year support these conclusions.[7] For all these reasons, people who use drugs would be better served by a system in which the primary focus is on their health and its social determinants.

We support the request by Toronto's Medical Officer of Health for an exemption under Section 56(1) of the *Controlled Drugs and Substances Act*, but we encourage the federal government to adopt a model of decriminalization that applies across the country and to all currently illicit drugs. We also agree that criminal sanctions should not be replaced with administrative ones such as fines.

As stated by the Medical Officer of Health, decriminalization alone will not end the opioid poisoning crisis. Earlier this year, CAMH called for the decriminalization of substance use and a suite of measures to support a public health approach.[8] In that statement we urged Health Canada to work with provinces and territories to ramp up treatment and harm reduction services. For example, for people seeking treatment for opioid use disorder, medication-assisted therapies (e.g. opioid agonist treatment [OAT], including injectable [iOAT]) and psychosocial treatment should be readily available.[9 10] iOAT with hydromorphone or diacetylmorphine are difficult to offer and access due to complex regulatory requirements as well as a lack of coverage on provincial formularies. We hope Health Canada will work with provinces to make these evidence-based interventions more accessible to people who would benefit from them. In response to data suggesting

increases in substance use during the pandemic,[11] [12] we also suggest that Health Canada facilitate the development and implementation of primary prevention and health promotion measures.

As recommended by the federal task force earlier this year, Canada needs a national drug strategy that addresses the use of all psychoactive substances as a public health issue.[13] We echo that call. Ending the criminalization of people who use drugs is a necessary step in that direction.

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The Centre for Addiction and Mental Health (CAMH) is Canada's largest mental health and addiction teaching hospital and one of the world's leading research centres in this field. CAMH is committed to playing a leading role in transforming society's understanding of mental illness and substance use and building a better health care system. To help achieve these goals, CAMH communicates evidence-informed policy advice to stakeholders and policymakers.

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[1] CSUCH Working Group (2020). *Canadian substance use costs and harms 2015–2017*. Ottawa, ON: CCSA.

[2] Government of Canada (2021). Opioid- and stimulant-related harms in Canada. https://health-infobase.canada.ca/substance-related-harms/opioids-stimulants/

[3] Anderson et al. (2017). *The new governance of addictive substances and behaviours*. Oxford University Press.

[4] Csete et al. (2016). Public health and international drug policy. *The Lancet*, *387*(10026), 1427–1480.

[5] Drucker (1999). Drug prohibition and public health: 25 years of evidence. *Public Health Reports*, *114*(1), 14–29.

[6] Reuter & Pollack (2006). How much can treatment reduce national drug problems? *Addiction*, *101*(3), 341–347.

[7] Toronto Public Health / MASS LBP (2021). Summary of public consultations on drug decriminalization. https://www.toronto.ca/legdocs/mmis/2021/hl/bgrd/backgroundfile-173569.pdf

[8] Centre for Addiction and Mental Health (2021). Statement on the decriminalization of substance use. https://www.camh.ca/-/media/files/pdfs---public-policy-submissions/camh-statement-on-decriminalization-sep2021-pdf.pdf

[9] Centre for Addiction and Mental Health (2021). *Opioid agonist therapy: A synthesis of Canadian guidelines for treating opioid use disorder*. https://www.camh.ca/-/media/files/professionals/canadian-opioid-use-disorder-guideline2021-pdf.pdf

[10] Canadian Research Initiative in Substance Misuse (2021). National injectable opioid agonist treatment guideline. https://crism.ca/about-crism/

[11] Centre for Addiction and Mental Health (2021). COVID-19 national survey dashboard. https://www.camh.ca/en/health-info/mental-health-and-covid-19/covid-19-national-survey

[12] Canadian Centre on Substance Use and Addiction (2021). Mental health and substance use during COVID-19. https://www.ccsa.ca/mental-health-and-substance-use-during-covid-19

[13] Health Canada Expert Task Force on Substance Use. (2021). Report #1: Recommendations on alternatives to criminal penalties for simple possession of controlled substances. https://www.canada.ca/content/dam/hc-sc/documents/corporate/about-health-canada/public-engagement/external-advisory-bodies/reports/report-1-2021/report-1-HC-expert-task-force-on-substance-use-final-en.pdf

December 17, 2021

By email: boh@toronto.ca

To: Toronto Board of Health

Re: The City of Toronto's submission to Health Canada for an exemption to the Controlled Drugs and Substances Act under Section 56(1)

The Ontario Harm Reduction Network (OHRN) supports harm reduction efforts in Ontario by offering knowledge exchange and networking opportunities to service providers and agencies and responding to their information requests. We bring together harm reduction workers from across the province through The Outreach Network – a network of 120 frontline service providers at 45 community-based agencies in Ontario. OHRN works at reducing individual, organizational and structural stigma and barriers to care.

Drug-related stigma is created by drug laws based on colonial, racist, and classist social ideas and policy – drug prohibition and criminalization were never rooted in evidence. These laws are disproportionately applied to, and disproportionately affect, Black, Indigenous, low-income, and other marginalized peoples and communities. OHRN recognizes the need for fundamental systems and policy changes related to our drug laws. We cannot adapt, or build, programs and services in a system that continues to criminalize people for using drugs, that continues to allocate resources in problematic and ineffective ways, that drives a deadly illicit supply, and continues to perpetuate colonial, racist, and classist policy.

Decriminalizing drug use and creating a regulated drug supply could shift public thinking and reduce stigma, could reallocate resources to programs and services that address social determinants of health (e.g., low-threshold harm reduction programs, housing, mental health), could reduce crime, and people will not die from toxic illegal drugs.

What the model for decriminalization and regulation will look like is not yet clear, but OHRN cannot comment on specific recommendations in the Toronto Public Health (TPH) model as we have yet to see the full proposal. OHRN appreciated TPH's invitation to participate in the working group, but we have been concerned with the process, specifically the hurried nature of the discussions and, most importantly, that it has not centered people most directly affected by criminalization and prohibition.

The meaningful and equitable involvement of people who use drugs, particularly those from Black, Indigenous, and criminalized communities, has not been prioritized. OHRN would like a commitment that further work on the model will involve these perspectives and experiences, and that these voices will be included in ideas and decision making. Without the expertise of people who use drugs, there is a significant danger of unintended consequences of poorly considered decriminalization such as: broadened criminalization (trafficking over possession charges); fines, coercive, or forced treatment and other health services, as a substitute to criminal charges; and the wrong measures of success being tracked, which could undermine decriminalization efforts.

OHRN has concerns about models for decriminalization that medicalize drug use, or are too focused on health outcomes. Drug decriminalization needs to be rooted in human rights and social justice, not simply linked to health outcomes. In earlier drafts of the TPH model, we were concerned about this.

We were worried about elements of the evaluation framework and what outcomes were, or were not, to be measured. Interactions with law enforcement and charges laid, for example, would be meaningful measures of decriminalization, but were not part of initial evaluation discussions. We were also concerned that using overdose data as a measure of success could be hurtful to efforts, as decriminalization on its own will not have a significant impact on overdose numbers, without providing a regulated supply of non-toxic drugs.

The prohibition of drugs has created an increasingly volatile and toxic illicit drug supply which has killed thousands, increased people's tolerances (making withdrawal and treatment even harder), leads to people's involvement in survival-criminal-behaviour to afford their drugs (e.g., shoplifting; sex work), and increases gang and gun violence as criminal organizations control the illegal drug trade. We encourage TPH to think beyond decriminalization, to work with people who used drugs to conceptualize what a legal and regulated supply of drugs could look like, and to call on all levels of government to work on this.

We also are not clear what policies the police will have to follow (e.g., when police can stop, search, and investigate a person; confiscating people's drug use equipment; whether they attend overdose calls; what role they will play in making referrals).

We are also questioning how the model will be supported - scaling up of social and health supports will not happen without significant investments or reallocations of resources.

There is still much to consider to develop a realistic, effective and positively impactful model for decriminalization and regulation. We, once again, strongly urge Toronto Public Health to support a working group that centres diverse voices of people most impacted by criminalized drug use, and the organizations who work with them, to develop further iterations of any model.

Sincerely,

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