

ONTARIO
SUPERIOR COURT OF JUSTICE

B E T W E E N:

THE NEIGHBOURHOOD GROUP COMMUNITY SERVICES, KATHARINE
RESENDES and JEAN-PIERRE AUBRY FORGUES

Applicants

and

HIS MAJESTY THE KING IN RIGHT OF ONTARIO

Respondent

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

APPLICATION RECORD VOLUME 2 OF 2

January 10, 2025

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TAB 10

Court File No. CV-24-00732861

ONTARIO
SUPERIOR COURT OF JUSTICE

B E T W E E N:

(Court Seal)

THE NEIGHBOURHOOD GROUP COMMUNITY SERVICES, JEAN-PIERRE AUBRY
 FORGUES and KATHARINE RESENDES

Applicants

and

HIS MAJESTY THE KING IN RIGHT OF ONTARIO

Respondent

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

AFFIDAVIT OF LAUREN COSTOFF

I, Lauren Costoff, of the Town of New Tecumseth, in the Province of Ontario, **AFFIRM**
AND SAY:

1. I am a legal assistant at Stockwoods LLP, one of the firms that is representing the Applicants, the Neighbourhood Group Community Services, Jean-Pierre Aubry Forgues and Katharine Resendes, and as such, I have personal knowledge of the matters set out in this Affidavit. Where I do not have direct knowledge of a matter, I have stated the source of my information and belief and verily believe that information to be true.

2. The information that I provide in this Affidavit is based on my review of the Hansard records from the Legislature of Ontario and Parliament of Canada and the press release statements or public comments made by the premier of Ontario and the deputy premier and Minister of Health

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and the Parliamentary Assistant to the Ministry of Health. I have attached true copies of the Hansard records and press release statements to this Affidavit, as well as hyperlinks to the videos of the statements made.

3. Attached as **Exhibit “A”** to this Affidavit is a copy of the sections of the Hansard records from the Legislative Assembly of Ontario that relate to the operation of supervised consumption services in Ontario as impacted by *Safer Streets, Stronger Communities Act, 2024*, which enacted the *Community Care and Recovery Act, 2024*, S.O. 2024, c 27, the law which is the basis of this lawsuit.

4. Attached as **Exhibit “B”** is a copy of the *Safer Streets, Stronger Communities Act, 2024*, S.O. 2024, c 27 – Bill 223, (“Bill 233”), which was introduced by the Ontario government on November 18, 2024.

5. Attached as **Exhibit “C”** to this Affidavit is a copy of sections of the Hansard records from the Parliament of Canada that relate to the regulation of supervised consumption services and amendments made to the *Controlled Drugs and Substances Act*, S.C. 1996, c 19 in 2017.

6. Attached as **“Exhibit D”** to this Affidavit is a link to a Cable Public Affairs Channel (CPAC) site containing the video of Ontario’s deputy premier and Minister of Health Sylvia Jones speaking with reporters on August 20, 2024, following her address to the annual general meeting of the Association of Municipalities of Ontario, where she announced new restrictions on supervised drug consumption sites. In the video, health minister Jones states “we are embedding in legislation something that we believe very strongly in, in that there is no safe supply when it

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comes to illicit drug use” (at minute 6) and “I do not call watching someone inject an illicit drug to be healthcare in the province of Ontario” (at minute 10:30).

7. Attached as **Exhibit “E”** to this Affidavit is a copy of the August 21, 2024 Provincial Press Release issued by the Member of Provincial Parliament of Ontario, Deputy House Leader and Parliamentary Assistant at the Ministry of Health, Anthony Leardi, titled “Protecting Communities and Supporting Addiction Recovery”, regarding the restrictions on supervised consumption sites in Ontario.

8. Attached as **“Exhibit F”** to this Affidavit is a link to YouTube containing a Global News video with Ontario premier Doug Ford at a press conference in St Catherines related to Ontario’s investment into the ship building sector on August 21, 2024, the same day that the government announced the restrictions on supervised consumption sites. In the video, premier Ford states while answering media questions: “giving someone, an addict, a place to do their injections, we haven’t seen it get better this was supposed to be the greatest thing since sliced bread it’s the worst thing that could ever happen to a community to have one of these safe injection sites in their neighbourhood. The only problem I have with the federal government, you know, safe supply, they get to go up there and get endless amount of drugs and guess what they do, they go out and they sell it and get other people addicted and then they go and get even stronger drugs. But as far as I am concerned the federal government is the biggest drug dealer in the entire country, it is unacceptable and it needs to stop, We need to get rid of safe supply we need to put money into treatment and detox beds and not continue to give people free drugs” (at minute 0:40).

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9. Attached as **Exhibit “G”** to this Affidavit is a link to a CPAC site containing the video of the News Conference held by Ontario Ministers on November 18, 2024, following the introduction of Bill 223. In the video, Ontario health minister, Sylvia Jones, explains the basis for the introduction of the bill, and says at minute 5:30 “Now imagine taking that child to day care or to school, a process that can be overwhelming, and getting yelled at, harassed, or verbally physically assaulted. Imagine walking that child in the door of their school or daycare and finding someone using drugs, or seeing an individual defecating or urinating in the entrance way. Imagine getting a call that your child has picked up a dirty needle in the day care yard, or a bag of unknown toxic drugs during recess time. For many families living in areas with drug consumption sites these horrific stories are their reality bringing their child for daycare or school fearing the safety of their children and worrying about the long term emotional and mental impact of witnessing open and public drug use, disruptive behaviour, and not feeling safe. Enough is enough. And our government is taking action”. While answering question from the media, health minister Jones goes onto say “as I said, the legislation, if passed, ensures that municipalities and organizations like public health units have to first come to the province because we don’t want them bypassing and getting a federal approval for something we vehemently disagree with” (at minute 21:53), and “I want to be very clear, there will be no further safe injection sites in the province of Ontario under our government” (at minute 22:25).

10. Attached as **Exhibit “H”** to this Affidavit is a copy of the letter sent by premier Doug Ford to 12 mayors across Ontario on December 5, 2024, related to the introduction of new legislation that addresses the use of drugs in public spaces.

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11. Attached as **Exhibit “I”** to this Affidavit is a copy of the December 12, 2024 Provincial News Release issued by the Office of the Premier, news release titled “Ontario Restoring Safety to Parks and Public Spaces” regarding the introduction of the *Restricting Public Consumption of Illegal Substances Act, 2024*.

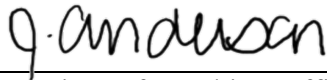
12. I am advised by Carlo Di Carlo, one of the lawyers with carriage on this file, and verily believe that on December 19, 2024, the Toronto Board of Health passed a motion to request the Medical Officer of Health, or Acting Medical Officer of Health as the case may be, to provide evidence in support of the within application brought by the Toronto Neighbourhood Group (among others), if requested by the Applicants (and as determined appropriate by the City Solicitor). Medical Officer of Health oversees Toronto Public Health (“TPH”).

13. On December 20, 2024, Carlo Di Carlo, one of the counsels for the Applicants, wrote to counsel for the City of Toronto’s City Solicitor’s Office. In that letter, Mr. Di Carlo requested that the Medical Officer provide certain evidence to support his clients’ application. Attached as **Exhibit “J”** to this affidavit is a copy of Mr. Di Carlo’s December 20th letter.

14. On December 24, 2024, Fred Fischer, counsel at the City of Toronto’s City Solicitor’s Office, responded to Mr. Di Carlo’s letter to provide him with the requested information. A copy of that letter, together with its hyperlinks and enclosed documents, is attached as **Exhibit “K”** to this affidavit.

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AFFIRMED remotely by videoconference by
Lauren Costoff, who is located in Town of New
Tecumseth, in the Province of Ontario, before
me, Janice Anderson, located in the City of
Barrie, in the Province of Ontario, this 10th day
of January, 2025, in accordance with
O. Reg. 431/20, Administering Oath or
Declaration Remotely.



Commissioner for Taking Affidavits



LAUREN COSTOFF

JANICE ELIZABETH ANDERSON,
a Commissioner, etc., Province of Ontario,
for Stockwoods LLP, Barristers and Solicitors.
Expires October 5, 2027.

This is **Exhibit “A”** to the Affidavit of Lauren Costoff
Affirmed Remotely Before Me in the City of Barrie, Province of Ontario
this 10th day of January, 2025.

A handwritten signature in black ink that reads "J. Anderson". The signature is written in a cursive, flowing style.

A Commissioner for oaths, etc.

JANICE ANDERSON

Legislative
Assembly
of Ontario



Assemblée
législative
de l'Ontario

**Official Report
of Debates
(Hansard)**

No. 181

**Journal
des débats
(Hansard)**

N^o 181

1st Session
43rd Parliament
Monday
18 November 2024

1^{re} session
43^e législature
Lundi
18 novembre 2024

Speaker: Honourable Ted Arnott
Clerk: Trevor Day

Président : L'honorable Ted Arnott
Greffier : Trevor Day

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INTRODUCTION OF GOVERNMENT BILLS

SAFER STREETS, STRONGER COMMUNITIES ACT, 2024

LOI DE 2024 VISANT À ACCROÎTRE LA SÉCURITÉ DANS LES RUES ET À RENFORCER LES COLLECTIVITÉS

Mr. Kerzner moved first reading of the following bill:

Bill 223, An Act to enact two Acts and to amend various Acts with respect to public safety and the justice system / Projet de loi 223, Loi édictant deux lois et modifiant diverses lois relatives à la sécurité publique et au système judiciaire.

The Speaker (Hon. Ted Arnott): Is it the pleasure of the House that the motion carry? Carried.

First reading agreed to.

The Speaker (Hon. Ted Arnott): Would the Solicitor General care to briefly explain his bill?

Hon. Michael S. Kerzner: This bill proposes amendments to the Community Safety and Policing Act, 2019, the Community Care and Recovery Act, 2024, the Highway Traffic Act and various other acts. If passed, this legislation would help protect children and keep communities safe while fighting auto theft and creating a more effective justice system.

MOTIONS

COMMITTEE SITTINGS

Mr. Anthony Leardi: I move that the Standing Committee on Government Agencies shall not meet during its regularly scheduled meeting time on Thursday, November 21, 2024, and instead be authorized to meet on Wednesday, November 20, 2024.

The Speaker (Hon. Ted Arnott): Is it the pleasure of the House that the motion carry? Carried.

Motion agreed to.

PETITIONS

LABOUR LEGISLATION

Mrs. Jennifer (Jennie) Stevens: This petition was presented to myself by Ashley Woolhead from Sudbury. I do agree with what she's agreeing with within this—passing anti-scab labour legislation.

The petition states that we should prohibit employers from using replacement labour—to prohibit employers from using both external and internal replacement workers. She also feels that Ontario workers—and pass anti-scab labour legislation, like the Ontario NDP's bill, Bill 90, the Anti-Scab Labour Act, 2023. The use of replacement workers undermines workers, and scab

labour contributes to higher conflicts on picket lines, which we don't want to see. Strong and fair anti-scab legislation will lead to shorter labour disputes, which will help with safer workplaces.

Speaker, I agree with Ashley Woolhead from Sudbury. I'm going to sign the petition and send it down with page Laura to the table.

FERRY SERVICE

Mr. Ted Hsu: This is a petition from residents of my riding of Kingston and the Islands, Wolfe Island, Simcoe Island, Howe Island, and it's about the Wolfe Island ferry. They are asking the Ministry of Transportation to restore the 60-minute—the hourly schedule for the Wolfe Island ferry; it's currently running at an 80-minute schedule. What has happened with disruption of the ferry service is that the local family medicine clinic was withdrawn—paramedic service was withdrawn in 2022. Contractors are withdrawing their services to the island because of the risk of irregular ferry service. It's affecting tourism. Businesses on Wolfe Island have been affected by disruptions to the ferry service.

So I join my constituents in Kingston and the Islands to call for the government to restore Wolfe Island ferry service at the previous hourly service or better.

SOCIAL ASSISTANCE

MPP Jamie West: This petition is entitled "To Raise Social Assistance Rates." Basically, what the petition says is that the amount of money that you get on Ontario Works or the Ontario Disability Support Program is far below the Market Basket Measure poverty line—OW for an individual would be \$733; ODSP, Ontario Disability Support Program, would be \$1,368.

There was an open letter that went to the Premier and two cabinet ministers, and it was signed by over 230 organizations that recommended that the rates for OW and ODSP be doubled.

They also cite that back during COVID, when the CERB program was—federally, basic income was declared at \$2,000 per month. As you can see, \$733 wouldn't even be half of that.

The petition is asking the Legislative Assembly to double social assistance rates for OW and ODSP.

I support this petition. I think it's a noble cause—to make sure people get out of poverty. I'll affix my signature and provide it to page Alina for the table.

1310

LAND USE PLANNING

Mr. Ted Hsu: I have a petition today called "No Farms, No Food," signed by people from lots of different communities in southwestern Ontario. It is calling on the government to immediately take steps to stop the expropriation of prime agricultural land, and calling on the government to have a transparent and collaborative

conversation with Waterloo region officials and farmers to promote sustainable development in that region of Waterloo.

SEXUAL VIOLENCE AND HARASSMENT

Ms. Sandy Shaw: I have a petition entitled “Justice for Sexual Assault Survivors.” We just heard the Solicitor General table a bill in the House that he proposed will keep Ontarians and children safe. I’m hoping that in that bill, the Solicitor General has taken into account the fact that there are more than 12,000 cases of sexual assault reported in Ontario, but more than 80% of those sexual assault cases go unreported. We know that in 2022 alone, 1,326 cases of sexual assault were withdrawn or stayed before trial. So we have a system that’s allowing sexual assault perpetrators to walk free in this province.

In 2019, the Auditor General put a recommendation forward making strong recommendations to improve this situation that is really difficult. As we continue to see an epidemic of intimate partner violence and femicide in this province, I’m hoping that this bill that we are going to see takes into account the issues I’m putting forward in this petition.

Particularly, I hope that this includes an improvement to the Victim Quick Response Program, and that the recommendations from the Auditor General that want to make the system more responsive and not such a hostile space for survivors, where justice is often delayed—I have hope that this bill will include some of those provisions. We’ll see.

I think that this is a very, very important petition. I’m going to sign it and I’m going to give it to page Ryan to take to the table.

HEALTH CARE

Mr. Terence Kernaghan: The petition that I have to read today is entitled “Health Care: Not for Sale.” When we look at the track record of this government and their profitization of health care, this petition is to stop the privatization, to stop the profitization of our treasured health care system, something that is a Canadian value for all of us, except for those across the floor.

This petition speaks about how privatization will bleed doctors, nurses and PSWs out of public hospitals and will make the health care crisis worse, something we’re seeing in real time. Privatization always ends up with people having to pay more for health care.

It goes on to recommend some very specific measures that this government could undertake today. One of them is to repeal Bill 124, which they wasted thousands of dollars fighting in court—a losing legal battle; to retain, return and respect nurses, doctors and PSWs with better working conditions; to license the internationally trained health care professionals who are ready, willing and able to practise; to include 10 employer-paid sick days, as well as making education free or low cost for nurses, doctors

and other health care professionals; to incentivize health care professionals to work in northern Ontario; and, more than anything else, to fund hospitals to make sure that there are enough nurses on every shift on every ward.

This is something we fully support in the official opposition. I wish the government would think about our public health care system and not about the profit that certain people can make out of health care.

HEALTH CARE FUNDING

Ms. Peggy Sattler: I would like to thank Andy Kroeker, the executive director of West Elgin Community Health Centre, for sharing a petition that is signed by 780 people who live in the West Elgin area in towns from West Lorne, Rodney, Ridgetown, Glencoe, Dutton, Fingal and many more places.

The petition speaks to the financial challenges that are facing the West Elgin Community Health Centre, which is one of 1,800 organizations in community health across Ontario that are all dealing with the fact that there has been a base budget increase of just 7% over the past 16 years, when inflation has shot up about 40% over that same period. This means that the West Elgin Community Health Centre is unable to pay fair salaries to their existing staff.

So the petitioners call on the Legislative Assembly of Ontario to deliver an immediate operational funding increase of 5% to the centre and the other community health organizations across the province, which would support the centre’s ability to care for patients and communities.

I fully support this petition, affix my signature and will send it to the table with page Alina.

SOCIAL ASSISTANCE

MPP Jill Andrew: This petition is entitled “Petition to Raise Social Assistance Rates.” This petition acknowledges that people on ODS poverty and OW are unable to afford the basics, such as a safe place to call home.

This petition recognizes that during the heights of the pandemic, the CERB program provided a “basic income” of \$2,000 per month, which isn’t even a start, quite frankly, to afford a one-bedroom in Toronto—St. Paul’s, and those who have signed this petition know that as well.

So really, this petition is calling for compassion. It’s calling for the recognition of folks who are on ODS poverty and OW that they deserve to have the ability to pay for rent, to pay for food, to afford medicine—the “luxuries” that every MPP in this House has.

I absolutely agree with this petition, and I will affix my signature to this petition and hand it over to Ryan.

TRAITEMENT DU CANCER

M^{me} France Gélinas: J’aimerais remercier Juliette Denis de Hanmer dans mon comté pour ces pétitions. La pétition s’appelle « Prise en charge des médicaments contre le cancer pris à domicile ».

Comme vous savez, monsieur le Président, si on vous donne des médicaments contre le cancer à l'hôpital, tout est gratuit, mais lorsque vous êtes à la maison, vous devez payer pour—le coût des médicaments contre le cancer pris à domicile peut être très élevé. En Colombie-Britannique, en Alberta, en Saskatchewan, au Manitoba et au Québec, ces provinces couvrent le prix des médicaments contre le cancer pris à domicile.

La Société canadienne du cancer demande au gouvernement de l'Ontario de couvrir les médicaments contre le cancer pris à domicile, car les données démontrent clairement que ça va sauver des vies. Donc, les gens qui ont signé la pétition demandent au gouvernement de donner la priorité à l'accès au traitement du cancer en élaborant un programme provincial qui couvre entièrement les médicaments contre le cancer admissibles, qui sont pris à domicile.

J'appuie cette pétition. Je vais la signer et je demande à Macarius to bring it to the Clerk.

SOCIAL ASSISTANCE

MPP Kristyn Wong-Tam: I'm pleased to be standing in this House and to present this petition entitled "Petition to Raise Social Assistance Rates," and it's going to the Legislative Assembly of Ontario. I want to say thank you to Dr. Sally Palmer of Dundas, Ontario, who has been raising this petition in this House for many years.

The petition calls on the government to recognize that the poverty rate in Ontario is not addressed with the OW rate of \$733 a month or \$1,368 a month for the ODSP payment. There has been an open letter to the Premier and two cabinet ministers signed by over 230 different organizations that recommend raising this rate by doubling the rates on Ontario Works and ODSP. They also recognize that during the COVID pandemic, the CERB program gave a basic income to Ontarians of at least \$2,000 a month.

This petition is signed by residents from Hamilton to Caledonia, from Woodstock to Ancaster to Lakefield to Peterborough—and it's more and more. I just want to say thank you, Speaker, for this opportunity, and may the government hear us one more time as we call for justice for those who are living on ODSP and OW.

The Speaker (Hon. Ted Arnott): I'll remind the members to briefly summarize their petitions without getting into additional political commentary on the merits of the petition.

The next petition.

1320

HEALTH CARE

M^{me} France Gélinas: I would like to thank Carole and René Ménard from Hanmer in my riding for these petitions. They're called "Improve Access to Primary Care." Medicare is a program that defines us, Speaker. Care is based on our needs, not on our ability to pay.

Unfortunately, right now in Ontario, 2.3 million Ontarians do not have a family doctor, do not have access to primary care. There are community health centres, Indigenous primary health care, nurse practitioner-led clinics, community-governed family health teams who could all take new patients if only we would fund them.

So the people have signed the petition calling for an immediate increase to funding to community health centres, Indigenous primary health care teams, nurse practitioner-led clinics and community-governed family health teams to give access to primary care to every Ontarian who needs it.

I fully support this petition, will affix my name to it and ask page Ryan to bring it to the Clerk.

HEALTH CARE

Ms. Sandy Shaw: I have a petition entitled "Stop Ford's Health Care Privatization."

As we know, we've been hearing today in the Legislature the questions that our leader, Marit Stiles, the official opposition leader, has been asking about the concerns that we're seeing in our hospitals. We now have deficits all across the province in our hospitals, and there's no clear answer as to how they are going to be addressed.

We're concerned that the privatization that is taking place under this government is bleeding nurses, doctors and PSWs out of our public hospitals, and it's certainly making the health care crisis worse. Certainly, it's making the human resource problem that all of our hospitals are facing—it's become now an absolute crisis.

We know Ontarians have experienced the clear impact of privatization. It always ends up with patients paying a bill. It ends up with long wait-lists. People are not getting the treatment and the procedures that they need. I'm sure all of our constituents are letting you know that they have a year, year-and-a-half, two-year wait-lists to get critical procedures, and so this is a very, very important petition that we hope the government will take to heart and stop underfunding hospitals and make sure that all hospitals have enough staff on every shift in every ward in every province across Ontario, to make sure that we're serving the very basic needs of the people of the province of Ontario.

OPPOSITION DAY

MUNICIPAL FUNDING

Ms. Marit Stiles: I move that, whereas successive Ontario governments have downloaded approximately \$4 billion in annual costs to municipalities for provincial programs; and

Whereas municipalities rely on property taxes to pay for these downloaded costs, which has resulted in property tax increases across the province; and

Whereas, despite these tax increases, many municipalities have had to make significant cuts to essential ser-

Legislative
Assembly
of Ontario



Assemblée
législative
de l'Ontario

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(Hansard)**

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Mardi
19 novembre 2024

Speaker: Honourable Ted Arnott
Clerk: Trevor Day

Président : L'honorable Ted Arnott
Greffier : Trevor Day

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RESOURCE RECOVERY AND
CIRCULAR ECONOMY AMENDMENT
ACT (BEVERAGE CONTAINER
DEPOSIT PROGRAM), 2024

LOI DE 2024 MODIFIANT LA LOI
SUR LA RÉCUPÉRATION
DES RESSOURCES ET L'ÉCONOMIE
CIRCULAIRE (PROGRAMME
DE CONSIGNES APPLICABLES
AUX CONTENANTS DE BOISSONS)

Ms. McMahon moved first reading of the following bill:

Bill 225, An Act to amend the Resource Recovery and Circular Economy Act, 2016 with respect to a beverage container deposit program / Projet de loi 225, Loi modifiant la Loi de 2016 sur la récupération des ressources et l'économie circulaire en ce qui concerne un programme de consignes applicables aux contenants de boissons.

The Speaker (Hon. Ted Arnott): Is it the pleasure of the House that the motion carry? Carried.

First reading agreed to.

The Speaker (Hon. Ted Arnott): Would the member like to briefly explain her bill?

Ms. Mary-Margaret McMahon: I would love to. Thank you.

The bill amends the Resource Recovery and Circular Economy Act, 2016.

Currently, section 107.1 of the act authorizes regulations governing the collection of blue box materials. The amendments expand this regulation-making power by allowing cabinet to establish and govern a beverage container deposit program and require and govern collection depots for blue box materials.

New subsection 107.1(5.1) requires the payment and refund of a specified minimum beverage container deposit in accordance with the regulations.

New subsection 107.1(5.2) requires grocery stores and stores operated by Brewers Retail Inc. to act as collection depots and provide beverage container deposit refunds. It is an offence for Brewers Retail Inc. and grocery store owners to fail to comply with subsection 107.1(5.2).

FIXING TRIBUNALS ONTARIO
BACKLOGS ACT, 2024

LOI DE 2024 SUR LA RÉDUCTION
DE L'ARRIÉRE DES TRIBUNAUX
EN ONTARIO

MPP Wong-Tam moved first reading of the following bill:

Bill 226, An Act to make changes to the appointments process for members of adjudicative tribunals, to establish a panel to provide recommendations to the Attorney General on matters relating to adjudicative tribunals and to provide for the establishment of temporary panels to adjudicate matters before the Human Rights Tribunal and the Landlord and Tenant Board / Projet de loi 226, Loi

visant à modifier le processus de nomination de membres aux tribunaux décisionnels, à créer un comité chargé de présenter au procureur général des recommandations sur les questions ayant trait à ces tribunaux et à prévoir la création de comités temporaires chargés de régler des cas devant le Tribunal des droits de la personne et la Commission de la location immobilière.

The Speaker (Hon. Ted Arnott): Is it the pleasure of the House that the motion carry? Carried.

First reading agreed to.

The Speaker (Hon. Ted Arnott): Would the member like to briefly explain their bill?

MPP Kristyn Wong-Tam: Yes. Thank you, Speaker, for this opportunity.

Fixing Tribunals Ontario Backlogs Act, 2024: This bill makes amendments to the Adjudicative Tribunals Accountability, Governance and Appointments Act, 2019, the Human Rights Code and the Residential Tenancies Act, 2006.

Section 14 of the Adjudicative Tribunals Accountability, Governance and Appointments Act, 2019, is re-enacted to require the Public Appointments Secretariat to compile a publicly available list of appointees and intended appointees to adjudicative tribunals that includes certain information, including information about their attendance before the Standing Committee on Government Agencies and to prohibit the appointment or re-appointment of a person to an adjudicative tribunal without the approval of the chair of the tribunal. A new section, 22.1 of the act provides for the establishment of an access-to-justice panel tasked with making recommendations to the Attorney General with respect to enhancing the independence of adjudicative tribunals and improving access to justice for people appearing before adjudicative tribunals.

The Human Rights Code and the Residential Tenancies Act, 2006, are both amended to provide for backlog reduction panels, those being panels of adjudicators tasked with resolving cases at, respectively, the Human Rights Tribunal and Landlord and Tenant Board. The Standing Committee on Government Agencies is to determine the cases to be resolved by the backlog reduction panels. Each of the backlog reduction panels is to be dissolved once all cases referred to it have been resolved.

1510

PETITIONS

ADDICTION SERVICES

Ms. Chandra Pasma: I'm pleased to rise today to present a petition that calls on this Legislature to continue support and operation of supervised consumption services and associated harm reductions in the province of Ontario. Supervised consumption sites are an evidence-based treatment to the toxic drug supply crisis that we have in the province. It also addresses public health concerns

around use of drugs, reducing the need for hospitalizations and emergency room visits.

The petitioners ask that we not only continue to support, but that we also provide support for voluntary, publicly funded treatment, which is not currently available to everyone who is seeking it in the province of Ontario.

I wholeheartedly endorse this petition. I will sign my name to it and send it to the table with page Alina.

CHILD CARE

MPP Jill Andrew: This petition is titled “Deliver \$10-a-Day Child Care Now.” The people who have signed this petition recognize that \$10-a-day child care is a game-changer. It’s a game-changer for women, for parents who are being bogged down by the affordability crisis here in Ontario. It is one of the most single-handed, foundational pieces that this province can do to ensure that women and people who have children have a successful pathway in their careers. If at home or at work, they don’t have to worry about child care.

This petition is calling for the government of Ontario to deliver \$10-a-day child care and to do that now, since families are drowning in some of the highest child care fees in the country and they simply can’t wait any longer for relief.

I really agree with this petition—I wholeheartedly do—on behalf of women and dads and non-binary families across St. Paul’s who are trying to get an affordability solution, and \$10-a-day child care is an affordability solution.

ADDICTION SERVICES

M^{me} France Gélinas: I would like to thank Paul-André Gauthier, a well-known nurse practitioner from Sudbury, for this petition. It reads, “Petition for Continued Operation of Supervised Consumption Services and Associated Harm Reduction Programs.”

Speaker, every two and a half hours, someone in Ontario dies from the toxic drug supply in Ontario. Supervised consumption and treatment services sites have been instrumental in preventing thousands and thousands of deaths across our province. The closure of consumption and treatment sites will increase the number of preventable deaths, injuries, hospitalizations, emergency visits and incidents of HIV and hepatitis. The sites not only give access to addiction treatment services, but also other health and social services for people who need them.

The provincially commissioned review of the Riverdale consumption site found that it is was desirable to maintain and enhance the funding for consumption and treatment sites, but the closure of the sites will withdraw the health services for people who use drugs and is a denial of their right to access health care. It will also lead to increased drug use in public places. When they are there, they’re part of the continuum of care.

The people who signed the petition are asking the Legislative Assembly of Ontario to reverse the decision to

close the consumption and treatment sites that are already established and fund them adequately.

They would also like to see an increase in the number of consumption and treatment sites available in communities like mine—Sudbury, Timmins, Sault Ste. Marie.

They would like to ensure that publicly funded and not-for-profit, evidence-based treatments are funded in Ontario.

I support this petition. I will affix my name to it and ask Maadhav to bring it to the Clerk.

SOCIAL ASSISTANCE

Ms. Mary-Margaret McMahon: I, too, have a petition. It is a petition to raise social assistance rates.

We know we are all in an affordability crisis in Ontario. People are struggling to make ends meet.

We know that quality of life affects your overall health—physical and mental—and that of your family as well.

Speaker, 230 organizations recommend the doubling of OW and ODSP.

I am very happy to support this. I will affix my name and send it with new page Charlotte.

ADDICTION SERVICES

Ms. Teresa J. Armstrong: It’s very important to all my constituents—especially Alana Pawley from London, who signed this petition. The reason we want to advocate for a continuum of health care is because supervised consumption sites are under threat and they are being closed. We know that people have addictions. It’s a health care issue. In order for them to access health care, they need access to supervised consumption sites.

Every two and a half hours, a person dies of a drug overdose. This is why the supervised consumption services are so important. If we close these sites down, what’s going to happen is, people are going to die. Those things could be prevented, if they were able to access safe supply. When we close these sites, what’s going to happen is the increase to emergency rooms, first responders, incidence of HIV and hepatitis C. Those things will increase.

So the people in London are actually petitioning this government to reverse the decision to close these supervised consumption sites.

Make sure that any community that needs that health care continuum has access to that. Make sure that these sites are not-for-profit and evidence-based, so that anyone who has a disease—an addiction; it’s a health care issue—has access to health care on a continuum, so they can get treatment and actually help themselves and help this province do better when it comes to health care.

I sign the petition, and I will give it to page Laura to deliver to the table.

ONTARIO PLACE

MPP Jill Andrew: This petition is titled “Save Ontario Place,” and it’s signed by members of my community in St. Paul’s and folks across Toronto. It expresses to this Legislature how important Ontario Place is. Speaker, 50 years of public enjoyment, of public space—truly a heritage landmark in our province.

This petition echoes the frustration of Ontarians who are worried about the government’s priority to create a billion-dollar luxury foreign spa, as opposed to investing in repairs to Ontario Place; prioritizing environmental sustainability, accessibility, inclusivity; and, number one, consulting with community—which this petition, signed by hundreds of folks, elaborates that they were not consulted on.

This petition asks this Legislature to halt any further development plans for Ontario Place, to put the people of Ontario over profit, and to invest in the communities and the urgent crisis we have of homelessness, housing insecurity, food insecurity, as opposed to handing over a \$1-billion gift to a foreign Austrian spa company.

1520

I couldn’t agree more. So I’m going to affix my signature and hope that this government will save Ontario Place.

HOUSING

Mr. Anthony Leardi: I have a petition here, and it speaks to the issue of housing in the province of Ontario. It refers to the fact that we’ve experienced remarkable population growth: over three million new individuals in the last three years. It also speaks to the issue of a shortage of housing, and it also speaks to the fact that many families need suitable homes that are safe and that they can afford to purchase.

To summarize, it says that housing costs have increased and that many people find it very difficult either to rent a home or to purchase a home.

At the end, it calls on the Legislative Assembly of the province of Ontario to prioritize policies and programs that accelerate the construction of new homes and rentals.

I certainly support this petition. I’m going to sign it and give it to page Jonah and ask him to bring it to the Clerks’ table.

ADDICTION SERVICES

MPP Jamie West: This petition is titled petition to resume operation of supervised consumption services and associated harm reduction programs. I want to thank the Registered Nurses Association of Ontario for collecting these petitions, and I want to recognize Denise Sandul for all of her work around supervised consumption sites and treatment for people living with addictions.

Basically, what it spells out—and this number is shocking: A person in Ontario dies every 2.5 hours from the toxic drug supply in Ontario. It points out that

supervised consumption sites, or consumption and treatment services sites, have been instrumental in preventing thousands of deaths from the toxic drug supply, and closing these will increase the number of preventable deaths, injuries and hospitalizations. It will also increase emergency room visits and the incidence of HIV and hepatitis.

As well, it points out that SCS or CTS offer access to other health and social services, including addiction treatment, health care and other access like that.

The provincially commissioned review of the South Riverdale CHC found it desirable to maintain and enhance funding for the supervised consumption sites.

It also makes the argument that the closure of a supervised consumption site is the withdrawal of health services and a denial of these people’s right to health care.

It also points out that closing these sites will lead to an increase in drug use in public spaces, and that health care should emphasize prevention as well as treatment in the full continuum of care.

So they’re asking the Legislative Assembly to reverse the decision to close these sites and to ensure that all the established supervised consumption sites remain operational and have adequate funding. They also want to increase funding for the sites so they can help in a more holistic way. And they also want to ensure access to voluntary, publicly funded, not-for-profit, evidence-based treatment.

I support this petition. I’ll affix my signature, and I’ll provide it to page Alina for the table.

TRANSPORTATION INFRASTRUCTURE

Mr. Ric Bresee: I’m pleased to present the petition today. This petition speaks to how quickly the population of Ontario has been growing and the pressures that growth has put on our traffic system, our transportation systems, straining the infrastructure across the province. It speaks to the idea that these are quality-of-life issues, whether that’s talking about the commute and the amount of time it takes for people to get home, for people to access the services across the province. And it speaks to the idea that by expanding our transportation network, by building the roads that are necessary, that will support the community growth in a way that is fair and equitable to everyone.

If I may summarize, Speaker, this petition is asking this government to prioritize highway construction to accommodate population growth and enhance the quality of life for residents all across Ontario.

I very much support this petition. I will sign it and hand it to page Ekam.

CHILD CARE

M^{me} France Gélinas: I would like to thank John Duggan from Val Caron in my riding for these petitions. They’re called “A Future for Child Care in Ontario.”

The petition is quite simple. There are a lot of shortages of child care spaces because of the disparity between the

demand and the availability of child care. We need 65,000 more child care workers to meet the demand for \$10-an-hour child care.

Early childhood educators and workers have been historically undervalued, with low pay, poor working conditions and high turnover.

So they ask the Legislative Assembly to immediately establish an early years and child care workers advisory committee to develop recommendations on how to support the early years and child care workforce and address staffing shortages, including through a salary scale, increased compensation and improved working conditions.

I fully support this petition, will affix my name to it and ask page Ryan to bring it to the Clerk.

The Speaker (Hon. Ted Arnott): That concludes our petitions for this afternoon.

ORDERS OF THE DAY

SAFER STREETS, STRONGER COMMUNITIES ACT, 2024

LOI DE 2024 VISANT À ACCROÎTRE LA SÉCURITÉ DANS LES RUES ET À RENFORCER LES COLLECTIVITÉS

Mr. Kerzner moved second reading of the following bill:

Bill 223, An Act to enact two Acts and to amend various Acts with respect to public safety and the justice system /
Projet de loi 223, Loi édictant deux lois et modifiant diverses lois relatives à la sécurité publique et au système judiciaire.

The Speaker (Hon. Ted Arnott): Would the minister care to lead off the debate?

Hon. Michael S. Kerzner: It's a pleasure to rise today and to speak on our government's bill.

I'll be sharing my time with the Associate Minister of Auto Theft and Bail Reform, the Deputy Premier and Minister of Health, and the parliamentary assistant to the Minister of Transportation, the member from Hastings–Lennox and Addington.

It has been an honour to work with the associate minister, the Attorney General, the Minister of Health and the Minister of Transportation on Bill 223, the government's proposed Safer Streets, Stronger Communities Act, 2024.

Without a doubt, I have never seen a government in my lifetime more preoccupied with the urgency of public safety for every Ontarian, and our preoccupation means that we're not going to stop. People have told us to stop: "Stop. We don't need it. We're going in the wrong direction." And I said, "You're totally wrong. You are absolutely, totally wrong." That's why, day after day, thanks to the leadership of Premier Ford, we have prioritized public safety, with no modern-day precedent of any other government that has taken this so seriously.

It's a top priority for our government. It's not just the slogan, Madam Speaker, and I'll tell you why: We will always put the safety of the people of Ontario first. We will always prioritize the rights of the public over the rights of the criminals, including those convicted of the most serious, egregious and heinous offences. The people of Ontario will always be able to count on us to protect the inherent rights we all have to live safely in our own homes and communities.

It's simple: We all want to have the right to wake up our kids in the morning and see them off to school, to check in on our loved ones and our seniors, to go to work, to come home at the end of the day, to shop, to play in the park and to pray. This inherent right, fundamental to everyone in Ontario—equal—means that we must cherish this, and we must make sure, in every action we take, this inherent right is preserved.

Our commitment to the people of Ontario on public safety started on day one under the government of Premier Ford. After years of neglect, after years of the Liberals in office, who never wanted to talk about it—they never attended a badge ceremony; they never went to a march past at the Ontario Police College so they could see the pride in the people graduating to become police officers. They never invested in the correctional system. They did absolutely nothing. They brought public safety to zero in priority.

1530

That's when Premier Ford stepped in and he said, "We're not going to take that. We're going to say thank you to everyone who keeps us safe. We're going to have their backs and we're going to work hard every day to earn their trust." And that's exactly what we've done.

Ontario, like many jurisdictions across the country and beyond, has seen increases in serious violent crimes. These are alarming trends, and some of this criminal activity is linked to organized crime. We also recognize that there is a growing concern as to whether policing tools such as the 23-year-old Ontario Sex Offender Registry are keeping up with the times.

I just want to give some dimension to the Ontario Sex Offender Registry. It was a prior Progressive Conservative government that led by example. I'll talk more about it later in my remarks, but Premier Mike Harris went forward when others told him also, "Don't do it. Stop." He did and we became the first jurisdiction in Canada, even preceding the federal government, to set up our own Sex Offender Registry in April 2001. That government took a first-in-Canada action with the proclamation of Christopher's Law.

My office is in regular contact with police services that have been calling for new measures to make sure that the Ontario Sex Offender Registry reflects today's realities, to better protect the province's most vulnerable people, particularly our children.

I would say, Madam Speaker, nothing has personally affected me more than meeting the parents of Christopher, together with the member from Haliburton–Kawartha Lakes–Brock and the member from Thornhill and the

Associate Minister of Small Business, who were there with us last week. It was overwhelming for us to begin a conversation, not understanding how we would process the pain that they went through.

A young, beautiful boy, 10 years old, in 1988, was brutally assaulted, taken and killed. They worked for almost 15 years to make sure that somebody heard their plea that we had to move forward with our own Sex Offender Registry, and they did. It was overwhelming, and I know my colleagues will speak about their experience in meeting the family. The family told us that they turned pain into something positive, that they saw this into reality.

I hear the same concerns from parents in my own community of York Centre and in others across the province. I listen very closely. We take all these concerns very seriously. That's why the proposed Safer Streets, Stronger Communities Act, 2024, builds on the previous work of this government, including the Enhancing Access to Justice Act—which we did earlier this year, 2024—and the Strengthening Safety and Modernizing Justice Act, 2023. These acts combined have delivered more support to victims of crime; strengthened bail compliance, one of the greatest challenges confronting this justice system; improved fire safety; and built a more responsive and effective death investigation system. Those were done in the prior bills this government came forward with. At the same time, the proposed amendments to the Community Safety and Policing Act, 2019, contained in this bill today ensure that the groundbreaking policing legislation that came in force on April 1 of this year continues to support police services, police oversight and the people of Ontario.

Madam Speaker, this government has fostered unparalleled relationships with our associations: the Police Association of Ontario, and I had the privilege of being there today and speaking at their conference; the OPPA, the Ontario Provincial Police Association; the Toronto Police Association; the Ontario Association of Chiefs of Police; the Indigenous police chiefs association; and the list goes on. On the fire side, it's the Ontario Association of Fire Chiefs and the Ontario Professional Fire Fighters Association.

Madam Speaker, we worked hard to listen to our stakeholders. The issues that were important for them are important for us. Across the board, it is an honour of a lifetime to call the fire chiefs early in the morning on my way to this beautiful House of democracy, to call the police chiefs so that I can listen to what is happening; I can listen to them. They are incredible people that work hard every day, because they can make a substantial difference in our community's life every day, and that's what we expect that people should do—our firefighters; our police officers; our correctional, probation and parole officers; those amazing 911 call operators; the animal welfare inspectors; the paramedics. Everyone that has a role, they can make a substantial difference in a community's life every day.

Madame la Présidente, la raison pour leur service est de faire une différence dans la vie des gens lorsqu'ils ne s'y

attendent pas—parce que nous croyons en notre province et notre avenir.

It's because we believe in our province. We believe in the power of making a difference, and we'll never stop. We will never stop working to make sure that we have their backs.

Je suis fier de nos policiers, nos pompiers, nos premiers intervenants et de tous ceux qui assurent la sécurité de l'Ontario tous les jours.

Our government is proud to stand by everybody that keeps us safe. The contributions they make are substantial.

It would not be possible to come forward today without the contributions of other ministries as well. The Ministry of Transportation's proposal, as example, to establish a new provincial offence and penalty for vehicle-related fraudulent transactions will, if passed, provide a valuable law enforcement tool. That's important. We've said we will crack down on people that think it's okay to steal a car with VIN fraud. It's not. We will find you, and we will put you where you belong: in jail.

Thanks to Premier Ford, we've established a zero-tolerance policy when it comes to people who want to wreak havoc in our community.

The Associate Minister of Auto Theft and Bail Reform and I travelled to Yellowknife. I told the story here in the Legislature, that we sat at a table with our provincial and territorial colleagues, looking straight in the eye of the Minister of Justice and the Attorney General of Canada and the Minister of Public Safety, and we said, "Your time is up. Do it now. Enact meaningful bail reform so we don't have this vicious cycle that two, three, four times are back on the street." It's completely unacceptable. And we don't have to see people like a beautiful OPP officer, Greg Pierzchala, killed near Cayuga, Ontario, just before New Year's of 2022—so innocent, so wonderful, and he was killed by a violent and repeat offender who was out on bail.

Although the total facts are not known, it was reported by the Toronto Police Association that in my own constituency of York Centre, the accident that took place at Bathurst and Wilson, where a wonderful bus driver was taken to the hospital, together with other people, was because of an auto theft where somebody may have been out on bail.

Enough is enough. Our government will do whatever it takes no matter the cost, no matter the threats, no matter the odds, and we will not be afraid to make sure public safety is our priority morning, noon and night.

I want to talk again about Christopher's Law, because there's nothing more basic than the fundamental community safety, than protecting society's most vulnerable people from sex offenders.

Again, in 2000, the government moved forward and passed Christopher's Law. It was named after a young boy, as I mentioned, who was the victim of an unspeakable tragedy at the hands of a convicted child molester with a long record of committing heinous crimes. This act established Canada's first sex offenders registry in 2001. Anybody in the province convicted of a prescribed sex offence is automatically added to the registry.

1540

But technology has moved forward in over 20 years. The Internet, social media, email addresses—it has changed a lot. That's why we wanted to come forward in making sure that we update it with the passage of time and the advancements of technology, including social media. We know this is necessary, because the number of sexual assault cases in Ontario has increased significantly in the last 10 years.

Amendments to Christopher's Law contained in this bill, Safer Streets, Stronger Communities Act, will, if passed, equip police services with additional information that can help them prevent, investigate and solve crimes of a sexual nature. It's very important that we take this opportunity and make sure that we do everything we can to keep everybody, the most vulnerable, safe in our province.

I'm really proud that thanks to the wonderful, wonderful efforts of the member from Thornhill and the member of Haliburton-Kawartha Lakes-Brock—for them and for us, it's personal. We're going to continue to make sure that we will send a message out: that those heinous people who think they can get away with it can't.

I also wanted to say there are so many other parts of this bill that deal with, on the public safety side, important things. We want to make sure that at the end of the day, we will continue to move with the times. This will not be our government's last attempt to continue to prioritize public safety, because we do it every day.

I have to tell you something: When you have the privilege like I have to tour the four corners of our province, firstly, you see how big it is; secondly, you see how incredibly fortunate we are to live in a place like this. But the fundamental rights we all have are the same if we're living in the smallest of communities, if we're living in a large urban centre. If we're going through First Nations, Inuit and Métis communities—it's the same. We all have a right to ensure that we can live safely in our communities. That's exactly why, together with my colleagues, we've worked hard, day and night, to transmit a message that is positive, that has resonated with people in Ontario.

I knock on doors in my own community of York Centre. I hear it day after day: "We're scared. It was never like this. What has happened? Why are so many autos being stolen? Why are there so many guns on our streets?" And I say to them, "Our government will not rest." Whether we're coming forward with the \$51-million investment to fight auto theft and fight it hard; whether it's the \$112-million-plus investment with the Bail Compliance and Warrant Apprehension Grant; whether it's putting more boots on the ground, which is undeniable, because they're on our streets—we've taken class sizes that were 40 and 50, only 20 years ago, per class, three classes a year; now we're at 525, times four. The last announcement we made, the last 80 spots of the 2,000-plus—we want to make sure they can go to smaller services and be available for First Nations police services

when that call comes that they have a candidate who wants to serve.

There are so many people in Ontario who have said the same thing. There is no modern-day precedent to the seriousness to which your government, our government led by Premier Ford, has taken public safety. And do you know what, Madam Speaker? We're only getting started.

I believe we're living in unprecedented times. There's a lot we can't control in the geopolitical world we are in. But what we can control here in our Ontario are the legislation; the regulations; the expectation, the tone and the confidence that a government must have to lead and to send a message across Ontario. This will always be our priority.

Madam Speaker, it has been a privilege to speak today on this bill.

The Acting Speaker (M^{me} Lucille Collard): I recognize the Associate Minister of Auto Theft and Bail Reform.

Hon. Graham McGregor: Thank you, colleagues. It's a pleasure to be here in the House this afternoon, speaking to—my notes say "historic," and I'll say "historic," but also just, frankly, a really good, decent, common-sense bill, which is going to keep Ontarians safe all across the province.

We've been crystal clear, as a government, that the safety of the people of Ontario and our communities is a top priority. In fact, if you talk to not only our government, but if you talk to residents out there in the streets, public safety is top of mind for residents, whether it's in my riding of Brampton North or communities across Ontario. I look at the member from Mississauga—and Barrie, and the areas around Barrie, in Scarborough, in Oakville North-Burlington, in Whitby, in Brampton Centre. This is a top priority for the residents we serve. If we can't deliver public safety for our residents, then what are we doing here?

This bill has a lot of measures on how we can deliver concretely on that promise of public safety for our residents.

I'd like to thank everyone involved in making this bill possible: the Solicitor General, the Deputy Premier and Minister of Health, the Attorney General, the Minister of Transportation. All have key items in this bill. I'd like to thank them, their staff in the ministries, as well as the Premier for his leadership. And I'd be remiss if I didn't thank the member for Haliburton-Kawartha Lakes-Brock and the member for Thornhill for their contributions—and, frankly, the contributions of the PC caucus to put this bill together, which I hope that members of this House will support because it will make life a lot better and a lot safer for a lot of people.

First, I'd like to talk about how the measures in this bill, if passed, help combat auto theft and make us all safer.

We are consistently seeing cars being stolen across the province. These thefts are often linked to fraudulent inter-actions and transactions, often including fraudulent vehicle identification numbers. A car and the insurance and everything else that goes along with it is a huge

expense for a family. Make no mistake, this is a crime that takes a real toll on its victims. For many, many Ontarians, a car is the biggest purchase that they're going to make—for the vast majority of Ontarians, it's at least top three. You think about a house and some other purchases and then a vehicle. It disrupts your life when your car is stolen. Even if your car comes back, you feel like you've been violated, your rights have been violated. There's a criminal who was in your car. And our government has, quite frankly, had enough.

I want to dissuade the House of the idea that auto theft is just a property crime. We know, from consulting with law enforcement, that the reason why cars are being stolen is because organized crime can make money off of it. It's very lucrative for organized crime. The funds from stealing and selling cars of Ontarians are used to fund organized crime, human trafficking, drug trafficking and weapons trafficking all across Canada, North America and the world. We're sick and tired of seeing our stolen vehicles being used to fund this organized crime and all the consequences that come with it for our communities.

We can send a simple message for car thieves and organized crime networks today, if we pass this bill as a House. If we were to pass this bill and put it forward, we would be sending a clear message to these organized criminal networks that we are coming after them, because our government and this House should, and always will, put public safety first. That means putting the rights of law-abiding citizens over the rights of criminals. We'll never apologize for that.

The measures in this bill build on what we're already doing. We're investing over \$150 million to help police find and dismantle organized crime networks and put thieves behind bars. This includes a new preventing auto thefts grant that's supporting 21 police projects across the province with \$18 million over three years, beginning in 2023-24, to support new and enhanced crime-fighting measures targeting auto theft.

In addition, we created the provincial auto theft and towing team, led by the OPP, and a new Major Auto Theft Prosecution Response Team.

We're also investing in the GTA-greater Golden Horseshoe investigative fund to stop the illegal export of stolen vehicles and target violent crime linked to criminal organizations. This will provide police with the resources they need, including cutting-edge technology.

And we're investing \$134 million to help police services acquire five new police helicopters for police services in the GTA and Ottawa regions. Equipped with the latest technology, these helicopters will help keep highways safe from violent carjackings, auto theft, street racing and impaired driving.

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Frankly, with the resources we are putting into police hands, auto thieves will simply have nowhere to hide. But there's far more to do to ensure that when we go to bed at night, we know that our cars will still be there in our driveways when we wake up.

That's why our government is proposing changes that would create a new provincial offence under the Highway Traffic Act for knowingly providing a false VIN when applying for a vehicle permit. The penalties, if passed, are stiff and will be a significant deterrent to anyone considering this crime.

I want to be clear. The majority of cars that are stolen in Ontario are for export, and we continue to call on the federal government to do a better job there. We need proper scanning happening at the Brampton and Vaughan rail yards. We need outbound cargo to be properly scanned at the port of Montreal.

But when I say that the majority of cars are exported, that means there is a minority of cars that are staying domestic. A big way that they're staying domestic is through acts of VIN fraud, through ServiceOntario. We're closing those loopholes. We're continuing to work on that to make sure that we're closing the loopholes that we can. But putting this law forward—a penalty of up to \$100,000 for knowingly submitting false information in the process of a VIN and up to six months in jail.

By putting this law forward, this House could send a simple message to auto thieves: If you don't want to spend time in jail, leave other people's vehicles alone.

I'd like to take a moment to talk about what's not in this bill. Combatting crime is a team effort. It requires the hard work of law enforcement, and we can always count on that. It requires the provincial government—and this bill is only the latest example of how this government is doing everything we can to put public safety first. And it requires the federal government, which continues to let us down.

Speaker, what our bill doesn't include are changes to the Criminal Code. That's because the Criminal Code is federal jurisdiction, but it is what tells judges how long they can sentence not only car thieves but also carjackers and other violent criminals. It tells judges the parameters around bail. A properly functioning Criminal Code is absolutely essential to a safe society, but it's increasingly clear we don't have that. Time and time again, we hear of a crime, and the alleged perpetrators are out on bail; or we hear of arrests, thanks to the hard work of law enforcement, and by the time they get to the podium to inform the public, those arrested are already out on bail.

I'll speak about a time in Peel region. Earlier this summer, we were there for the announcement of Project Warlock, which was an initiative funded by this government, led by the Peel police—but partnered with other law enforcement agencies. Eighteen people were arrested, and over 150 Criminal Code charges—these were for things like violent home invasions, carjackings, people walking up and putting a gun to somebody's head, saying, "Give me the keys to your car." By the time we were doing this announcement to celebrate finding these heinous individuals committing these crimes—nine of the 18 individuals were out on bail by the time we were doing the press conference.

I hear some liberal-minded, progressive folks—we put out a letter three weeks ago, prescriptive of what we would like to see in the Criminal Code. We hear progressives and

lawyers losing their minds, saying we're draconian, saying we're unconstitutional—

Mr. Anthony Leardi: So-called progressives.

Hon. Graham McGregor: So-called progressives. That's right.

Madam Speaker, I'm not a lawyer. I'm not a judge. I'm a pretty regular fellow, but I read the Charter of Rights and Freedoms. You can look it up on your cellphone. It's not too hard—maybe for some of the members over on the opposite benches, but pretty easy, I think, for PC members. The Charter of Rights and Freedoms talks about reasonable bail.

The scenario that I just talked about says that everyone has a right to reasonable bail. The scenario I talked about where you had nine of 18 individuals out on bail by the time we were announcing their arrest—where you have a Toronto police officer who was shot at earlier in October, shot at by an individual who was out on bail after over two dozen offences, including multiple breakings and enterings; when you have a scenario like Constable Greg Pierzchala, who was killed by an individual who was out on bail for a gun crime, who had a piece of paper, a gun ban, a piece of paper saying they shouldn't own a firearm. That individual should have been held behind bars.

When you see scenarios like that that we're running into time and time again on bail, how is that reasonable? I'd say that's not reasonable. I think judges, like everybody else, have to realize that they serve the public, not the other way around. And if that makes me draconian, if that makes me hard right, if that makes me out of hand, Madam Speaker, then do you know what? I'm proud of it, because I was sent here by residents to stand up for their public safety, just like every member of this caucus. We will never apologize for demanding law and order in the streets of Canada.

Far too often, we're seeing these individuals out on bail, committing crimes again and again. The landscape in Ontario has changed drastically in the last few years. We're seeing increased instances of violence, violent car thefts and, most concerning, the repeat violent offenders I've talked about who are let out again and again and again and who commit more crime on our streets.

Just yesterday, in the dark, early hours of the morning, in the Solicitor General's riding, there was another horrific incident. Here in Toronto, two vehicles—allegedly stolen—were travelling at a very high speed down Wilson Avenue. One of those vehicles, a BMW, collided with a TTC bus travelling down Bathurst. It struck the bus hard enough to spin the bus into the opposing lanes. Nine people were injured; eight people were taken to hospital, some with life-threatening injuries. Our thoughts go out to them and their families. But it can be no surprise to anyone in this House to learn that there are allegations we've heard that two of the people in the BMW were out on bail—one for a violent robbery. That was just one of the recent ones of these horrible events.

We can't forget about the ones that we talked about before. The incident of the police officer being shot in broad daylight at Yonge and Eglinton by an individual

who was out on bail—over two dozen charges. As I mentioned, when you hear these scenarios, two thoughts cross your mind: one, hopes and prayers that the officer will be okay, and thoughts for their families. And then the second thought—and a thought that we shouldn't be having, but it's a way that we've been trained and conditioned by the scenario and the times that we're living in. The second thought that crossed my mind: Was the alleged shooter out on bail? Fortunately, the answer to question one is that the constable will make a full recovery. But yes, as happens time after time, his alleged assailant was out on bail with a probation order not to possess a firearm.

Ontario's justice system is creaking under the weight of a flawed federal bail system. It makes communities feel unsafe. It makes police officers vulnerable. Our government has had enough. This has to end.

Our government is acting. We're strengthening Christopher's Law. We're tackling VIN fraud. We're doing so much else in this bill, and even more outside it, like hiring new judges and prosecutors to address court backlogs. But these judges must abide by the same broken catch-and-release system. We need the federal government to act, as we have continually called on them to do; as myself and the Solicitor General called on them to do three weeks ago. We repeated that call again yesterday, and we repeat it again today.

We are joined in the tabling of this bill by members of the Police Association of Ontario and the Ontario Association of Chiefs of Police. Both of those organizations acknowledge the good work that the Ontario government is doing. We're throwing everything we can into public safety, to keep residents safe—the God-given right that we all have to be safe in our communities. They acknowledge the provincial leadership but unanimously have all called on the federal government to step up and do their part.

The catch-and-release bail system simply has to end. We want and need meaningful bail reform. It's time for the federal Minister of Justice to—just as we've been doing—work to keep people and communities safe. That's why we've called specifically for the federal government to enact the following: mandatory minimum sentencing for serious crimes to ensure appropriate penalties, like firearms offences—the firearms offences that they repealed in Bill C-5.

If you unload a firearm in Ontario, to spend a minimum of four years in prison—I think that's just common sense. But to some folks out there, the so-called progressives of the world, that's draconian; that's unconstitutional. We saw the Liberals say, "We don't even know if that's going to work."

I'll tell you, Madam Speaker: What's not working is giving a hardened criminal a piece of paper saying, "Don't commit any more crime." That doesn't work. Do you know what does keep them? Putting that individual behind bars. Don't give them the opportunity.

What we've seen time and time again—we have Liberal legislation in front of us, a weak Liberal Criminal Code and we see weak-kneed judges interpreting that. The pendulum has swung so far in the direction of the rights of

criminals and suspected criminals, nowhere near where it needs to be to keep Ontario communities and Ontario families safe. That's why we're saying enough is enough. We need bail reform now.

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Speaker, the measures that we're asking the federal government for:

- mandatory minimums;
- provisions to deny bail for offenders charged with serious offences—murder, terrorism, human trafficking, drug trafficking, carjackings and home invasions;
- requiring ankle monitors as a condition for individuals charged with serious crimes;
- eliminating some of the time credits that defence uses to delay trials, delay proceedings.

This would complement the measures that we're putting forward in the bill. We need the federal government to do their part. We are doing ours.

We are building jails across Ontario to make sure we have the capacity that we need to keep people locked up. We've invested in police. We've got almost 2,100 police constables being graduated across Ontario. That number was 1,400 under the previous government. We have a court system that is bolstered with resources and more resources coming on the way. Last year, the court system actually processed more cases out than we took in for the first time in a decade, under this Attorney General's leadership. We have helicopters on the way. We have automatic licence plate readers for our police services. We have investigative money that they can tap into to work collaboratively, to data-share, to tackle these crimes. Where we are being let down is a weak, ineffective Criminal Code that we need to change.

Now, colleagues in this House can all step up. We've asked the opposition to join our calls for bail reform. They have repeatedly refused to do so. But with this bill, here is another opportunity for the members of the NDP, the members of the Liberals, the Green Party and the independents to stand up and say, "Public safety matters to me and matters to my constituents. I'm going to do the right thing about it." I certainly hope that those members take the opportunity.

The Acting Speaker (M^{me} Lucille Collard): I recognize the Minister of Health.

Hon. Sylvia Jones: It is indeed an honour to rise today to speak on the introduction of the Safer Streets, Stronger Communities Act. I would like to express my appreciation to the member for York Centre, our Solicitor General, for leading the development of this proposed legislation and his strong dedication to community and public safety.

I'd also like to thank the member from Brampton South, the Minister of Transportation, and the member from Barrie–Springwater–Oro–Medonte, our Attorney General, for their important contributions to this legislation and their unwavering advocacy for safer streets and stronger communities.

Some of the most pressing issues facing our communities are mental health and addictions. That's why we created Roadmap to Wellness, our government's plan to

build a world-class mental health and addictions system, through which we're investing \$3.8 billion over 10 years to fill gaps in mental health and addictions care, create new services and expand programs. As part of our 2024 budget, we are investing an additional \$396 million in funding over three years to improve access and expand existing mental health and addiction services and programs alongside supportive housing initiatives.

Through the Roadmap to Wellness and the Addictions Recovery Fund, our government is creating more than 550 addiction recovery beds and new innovative models of treatment, like mobile mental health clinics. But we recognize that more needs to be done to give people their lives back through treatment and recovery.

In the communities where supervised consumption sites have been established, there have been reported concerns expressed about community safety. Our government has heard that the status quo of these sites is not working and, in fact, is having a negative impact on communities. Parents are worried about the discarded needles that their children could pick up. Some parents no longer feel comfortable sending their children to the local elementary school or have pulled them out of their local daycare. Neighbourhood businesses are concerned about the disruptive behaviour and increased crime around drug consumption sites that impact their livelihoods.

Just last year, as an example, compared to the rest of the city, there was a 113% higher increase in reported rates of assault near these sites in Toronto. In Toronto, there have been numerous stories of altercations, stabbings, shootings and unfortunately even a homicide in the vicinity of one of these sites. Residents near Ottawa's sites are concerned about the drug-related crimes in their community. Violent crime was up 146% near Ottawa's Somerset site. Homicide was 450% higher near Hamilton's Urban Core site.

Reports from police services in Ontario and indeed across Canada indicate that hydromorphone distributed at consumption sites is in fact being diverted and trafficked, increasing the supply of dangerous and illegal drugs in communities where these sites operate. We are hearing more and more about the tragic outcomes of an approach that accepts and promotes the use of illegal drugs over treatment and recovery. The parents I talk to are desperate that more needs to be done. Our priority must always be to keep our community safe, especially when it comes to protecting our children. Our government is once again standing up for our communities and our families and taking action to address these problems.

As part of the legislation being introduced today, we are proposing important changes to supervised drug consumption sites, which is a key step in keeping our communities safe while doing more to support the recovery of those who are struggling with addictions. The Safer Streets, Stronger Communities Act would, if passed, establish the Community Care and Recovery Act, which would prohibit the operation of supervised consumption sites within 200 metres of a school or a child care centre. Sites currently located within the 200-metre buffer zone would need to stop providing supervised consumption services no later

than March 31, 2025. The nine remaining provincially funded consumption treatment sites which are located outside of the 200-metre buffer zone will continue to operate, but with enhanced mandatory reporting requirements, transparency and procedures established by the Ministry of Health.

The proposed legislation would also require municipalities and local boards to seek provincial approval prior to making or supporting requests to the federal government for exemptions under federal legislation to stand up new supervised consumption sites, or prior to applying for safe supply service program funding or supporting such applications. It would make it clear that municipalities and local boards do not have the power to apply to the federal Minister of Health for the decriminalization of the personal possession of illegal drugs.

As we move ahead with this proposed legislation, I also note that our government is introducing new measures to enhance public safety for the remaining sites. We are establishing stronger community safety and security plans and policies that aim to discourage loitering and improve community engagement and conflict de-escalation.

Speaker, these measures are just part of the solution. The cycle of addiction is not being broken by supervised consumption sites. For many people, these sites are just a revolving door where people go to consume drugs but never move toward treatment or rehabilitation. We recognize that Ontarians deserve more than a health care system that enables people struggling with addictions to continue to use illegal drugs. We must ensure that those facing addiction challenges receive the support they need, including access to supportive housing, while protecting our communities and maintaining public safety. That is why in August I announced that we are creating up to 19 new homelessness and addiction recovery treatment hubs, or HART hubs, across Ontario, supported by a \$378-million investment.

The HART hubs will build on similar existing hub models that are already in place in some communities in Ontario and successfully providing people with care. They will reflect regional priorities by connecting people with complex service needs to comprehensive treatment and preventative services that can include primary care; mental health services; addiction care and supports; social services and employment supports; shelter and transition beds; supportive housing; and other supplies and services, including naloxone, on-site showers and food. The HART hubs will also add up to 375 highly supportive housing units that will help some of our most vulnerable people in need of transition to more stable long-term help.

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HART hubs are in addition to our investment of nearly \$700 million invested each and every year for supportive housing through the Homelessness Prevention Program and Indigenous Supportive Housing Program. With a focus on treatment and recovery, HART hubs will not offer safe supply, supervised drug consumption or a needle exchange program.

By creating HART hubs, we are supporting the treatment and recovery of individuals with these kinds of complex service needs: those who are homelessness or at risk of homelessness; have substance use and mental health challenges, and social services supports or employment needs. With these types of community-based supports, clients should have a greater ability to function independently and should have stabilized or improved mental health outcomes through treatment and recovery.

Through these hubs, there should be a number of system outcomes, including better integrated service delivery through on-site, connected and co-located services, and pathways to broader community services such as community health centres, youth wellness hubs, hospitals and other services and supports. With enhanced system coordination, there should be increased opportunities for collaboration and to better identify and address the needs of hard-to-reach clients.

The nine provincially funded CTS sites that will need to be closed due to being within the 200-metre buffer zone have been encouraged to submit proposals to transition to HART hubs. These sites could be eligible for up to four times more funding under the HART hub model than they receive currently from the province as a supervised consumption site. The 10 remaining HART hubs will be established through a call-for-proposal process. Two of these will be Indigenous-led hubs. The deadline to submit applications was in mid-October, and decisions about successful applicants are expected to be finalized after careful consideration of the proposals.

Addictions, mental health and homelessness are some of the most pressing and challenging issues in our province. By taking steps to improve community safety and creating new HART hubs, we are taking real action to support our communities and providing comprehensive, accessible and compassionate treatment and care that can give people hope for recovery.

Local leaders have expressed their support for these initiatives. Drew Dilkens, the mayor of Windsor, said that this announcement “is a real game-changer. This major investment will truly support people to get their lives back on track through needed treatment and recovery, while ensuring that neighbourhoods in Windsor and across Ontario remain safe.”

The mayor of Greater Sudbury, Paul Lefebvre, expressed that “collaboration between the province and municipalities is key to addressing community wellness. The HART hubs reflect a focus on treatment and recovery, which mirrors efforts Greater Sudbury and local health providers have been using. I look forward to working with the province on helping people transition to stable, long-term housing.”

From the mayor of Guelph, Cam Guthrie: “I commend the provincial government for moving forward with a detailed plan to save lives, restore families and improve communities struggling with the stranglehold of addictions. I am confident that the new HART hub model, focused on recovery, will show the positive results cities

have been desperately requesting for our most vulnerable citizens, not just in Guelph, but across Ontario.”

A quote from the mayor of Brampton, Patrick Brown: “Grateful for the Ford government’s focus on treatment for addictions and not band-aid solutions.... I share their concern about the proliferation of safe injection sites in areas close to families and children. This needs to stop.”

Barrie’s mayor, Alex Nuttall, stated that, “Today’s announcement by the provincial government will deliver safer streets for the residents of Ontario through increased funding for mental health and addictions support as well as preventing injection sites from being located next to daycare centres and schools. I commend the provincial government for taking these necessary steps to protect our children and our residents.”

Our government recognizes how many of our municipal partners have been strong advocates and supporters for providing better access to mental health, addictions and homelessness services in our communities, and we greatly appreciate all their efforts in helping us build healthier and stronger communities across Ontario. The proposed legislation to support community safety and creating the new homelessness and addiction recovery treatment hubs are bold and innovative actions our government is taking to better connect people with the effective mental health and addictions care they need.

Speaker, I will only add that I hope that, on careful consideration, the members opposite will understand that what we are proposing in this legislation is a move forward to ensure that people have a pathway out of addictions. We have an opportunity here to provide more services, not less, with the implementation of our HART hub model.

The Acting Speaker (M^{me} Lucille Collard): I recognize the member for Hastings–Lennox and Addington.

Mr. Ric Bresee: First, I’d like to thank the Solicitor General, the Minister of Health and the Associate Minister of Auto Theft and Bail Reform for their thoughtful presentations this afternoon and for allowing me to join in in the support for this bill.

Speaker, we all know that auto theft has plagued this province in recent years. That’s why our government is taking decisive action to crack down on car thieves, and we are already seeing the results. Thanks to our efforts and the hard work of our policing partners across the province, we’ve seen a reduction in auto theft in Ontario by 16% this year. But we need to keep up the full-court press, so in May we tabled the Safer Roads and Communities Act, which would establish some of the toughest penalties in Canada for motor vehicle theft. That bill has now passed; we have dealt another blow to car thieves.

Building on our successes, there is always more we can do. This bill, the Safer Streets, Stronger Communities Act, will take those efforts even further. If passed, this legislation would create a new provincial offence for knowingly providing a false vehicle information number, VIN for short, when registering or transferring a car. These registrations typically involve stealing the VIN from a legitimate vehicle and using it to register a stolen vehicle. We are putting an end to this behaviour. With fines as high

as \$75,000 for a first conviction and up to \$100,000 for subsequent convictions, those convicted of knowingly providing a false VIN could face jail times of up to six months and driver’s licence or vehicle permit suspensions for up to a year, because we need to send a clear message that crime never pays.

We’re doing this because we’ve witnessed a troubling increase in the cases of VIN fraud in recent years. Between February 2023 and April 2024, ServiceOntario investigated more than 600 separate cases of fraudulent vehicle registration. To crack down on VIN fraud, we need stronger deterrents. This new provincial offence would tell wannabe car thieves not to waste their time, because our government is responding to their new tactics and equipping our police with the tools that they need.

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The Safer Streets, Stronger Communities Act will ensure that we’re doing everything in our power to stop car thieves in their tracks.

In addition to holding reckless car thieves accountable, our government is also cracking down on careless drivers. Too often, we’ve seen cases of reckless driving in parking lots that are leaving people seriously injured, or worse. In 2023, 14 fatal collisions occurred in parking lots in Ontario, and more than 1,200 collisions resulted in personal injuries. Often, these events in mall parking lots are the precursor to car rallies and drag races, which are even more dangerous.

Currently, careless driving causing bodily harm or death, under the Highway Traffic Act, applies only to those incidents on public roadways, meaning that there has been a loophole in parking lots, where some bad actors have been beyond the reach of the law. This means that too many cases are slipping through the cracks. It also means that police can’t pursue a careless driving charge if someone is injured or even killed in a parking lot. But we have to change that.

If this legislation passes, it would expand the Highway Traffic Act’s application of careless driving and careless driving causing bodily harm or death to parking lots. This would include any parking lot—private lots, commercial lots, industrial parking lots—and any connecting drive-ways and roads. These changes will help local police respond to and prevent unsanctioned events such as car rallies and street racing.

When high-risk driving is leading to serious injuries and deaths in parking lots across Ontario, we need to say enough is enough, and we need to take action.

The Safer Streets, Stronger Communities Act would strengthen our police’s ability to pursue careless driving charges and would serve as a strong deterrent to drivers who continue to put other people’s lives at risk.

Speaker, we all know the consequences of careless driving can be tragic. Our government has absolutely no tolerance for that. Careless drivers need to be held accountable for their actions, and it’s our job to give the police and the courts the tools they need to see that process through.

Our government is determined to give the police the time they need, as well, to thoroughly investigate cases of careless driving so we can hold culprits accountable. Currently, careless driving and careless driving causing bodily harm or death, under the Highway Traffic Act, have a limitation period of six months. This means that the police only have six months to conduct their investigations, collect their evidence and lay charges. Well, Speaker, with the high level of complexity involved in investigations today, sometimes that is simply not enough time—not when police may need to interview the injured and collect detailed and elaborate data from vehicles. It may involve obtaining a warrant. It may even involve having a reconstructionist attend the scene. Depending on the circumstances, an assessment from the Centre of Forensic Sciences may even be required to determine whether charges are warranted. Those assessments can take several months. Needless to say, six months just isn't always enough time.

If the Safer Streets, Stronger Communities Act passes, it would extend the Highway Traffic Act's limitation period for careless driving and careless driving causing bodily harm or death to two years. This would give the police the time they need to investigate cases, to collect evidence and, most importantly, to hold careless drivers accountable.

Speaker, Ontario's roads have ranked among the safest in North America for more than 20 years. This is something that we can all be proud of. We know that commercial vehicle enforcement plays a critical role in that record and in road safety overall.

That's why the Safer Streets, Stronger Communities Act will also help commercial vehicle operators understand what their responsibilities and obligations are, while also helping them to correct issues of non-compliance.

Under the current rules, commercial vehicle operators have the ability to launch an appeal at any time when a decision is taken against their CVOR certificate. This means that years could pass before an appeal is launched.

If the Safer Streets, Stronger Communities Act passes, it would amend the Highway Traffic Act to give CVOR certificate holders a 30-day window to appeal a decision. This will help eliminate lengthy appeal delays and ensure both quicker resolution and quicker accountability. The legislation would also create a framework for an administrative penalty program that would enhance the oversight of commercial vehicles and keep our roads safe.

The current court-based process for CVOR violations is time-consuming and costly, both for the operators and for the enforcement personnel. By introducing administrative penalties, we'll resolve CVOR violations more quickly and help reduce the burden on the operators.

Keeping our roads safe also means acting quickly when violations occur. Currently, the Registrar of Motor Vehicles can place conditions or restrictions on a CVOR certificate only at the time of issuance, suspension or cancellation. Our legislation would give the registrar the authority to place conditions or restrictions on a CVOR

certificate at any time, allowing us to take swift action against commercial vehicle operators who flout the rules.

Speaker, since day one, public safety has always been our number one mission, and it always will be. There has never been a government that has prioritized the safety and the security of Ontarians like this government, under the leadership of Premier Ford.

The Safer Streets, Stronger Communities Act, if passed, will allow us to deliver on each and every one of these objectives, and it will pave the way toward building a stronger, safer Ontario for everyone who calls this great province home.

The Acting Speaker (M^{me} Lucille Collard): We're going to go to questions.

Ms. Jennifer K. French: I would like to address my questions to the Associate Minister of Auto Theft and Bail Reform. I appreciated his remarks, especially as we're talking about countering VIN fraud—I see a small piece in this piece of legislation. There was a lot of fanfare before we actually got to see the legislation.

I know a lot of vehicles are registered every year or put on that provincial vehicle registry. I'm curious to know how many of those are ever investigated, should there appear that there's a questionable VIN or a partial, duplicate, improper or suspicious VIN. I think the answer is, zero of them are investigated or verified. Certainly, I don't think that there's any physical checking happening, which would actually determine the accuracy of the VIN prior to registration.

My question is, why won't this government institute a VIN verification system so that we have a preventive measure to protect Ontarians from VIN fraud? This government is big on after-the-crime measures. Where is the preventive VIN—

The Acting Speaker (M^{me} Lucille Collard): Thank you.

The Associate Minister of Auto Theft and Bail Reform to respond.

Hon. Graham McGregor: I appreciate my colleague for the question.

As my colleague rightly identified, VIN fraud is a growing problem in Ontario. We know the majority of vehicles that are stolen wind up overseas. That means there is a minority of vehicles—a quite large minority, frankly—that are staying here, domestic. The way they are doing that is VIN fraud.

The specifics of the VIN verification services—I think my colleagues met with some of the people I've met. I certainly appreciate their input.

Madam Speaker, we've implemented measures to close some of the loopholes through the ServiceOntario process. That has already happened.

And then, in this bill, by implementing six months in jail time, up to \$100,000 offence—I know my colleague thinks that's minor. I know, in the NDP approach to crime, they would probably blame the cars and cut the criminals some slack.

We're putting in a new offence, where we're going to hold offenders accountable and lock them up. It seems like

the right thing to do, and we certainly hope that our opposition colleagues will support us in this work.

The Acting Speaker (M^{me} Lucille Collard): Next question?

Mr. Lorne Coe: My question is for the Solicitor General.

The safety of people in Ontario is a top priority for all of us here in the Ontario Legislature; it always has been. And every day, I see evidence of how the Solicitor General is working to improve this. In fact, this morning, I saw it at the Ontario police association conference that we attended together, in his interactions not only with the police officers but the general public, when he walked in to where the conference was.

1630

My question is, how does the proposed legislation—beyond the time that he had to speak this morning—ensure that public education on crime prevention and awareness is effectively integrated into our communities within this great province?

Hon. Michael S. Kerzner: Because we're going to have Crime Prevention Month. That's contained in the piece of legislation, as well. Crime Prevention Month is an opportunity to thank the people who are our protectors and pillars of our public safety: our police officers; our firefighters; our correctional, probation and parole officers. We want to acknowledge a month that says thank you.

Why is it that we've never seen, before Premier Ford—in the last 15 years, the government led by the now-independent Liberal Party ever attending a badging ceremony? The Minister of Health was the first person to attend a badging ceremony in 15 years, because she cared, because my predecessor cared. And we care today.

The Acting Speaker (M^{me} Lucille Collard): Next question.

M^{me} France Gélinas: This is what the 50,000 members of the registered nurses' association had to say about section 4 of the bill: It is "a death sentence that will lead to unsafe communities and higher costs."

"Legislation introduced by Premier ... Ford's government is a sweeping attack on harm reduction.... The move will lead to unsafe communities, increased deaths, overwhelmed emergency services, and escalating health care costs. Nurses say the Ontario government will bear responsibility for the avoidable loss of life."

But if you don't trust nurses, maybe you would trust the *Lancet*, the world's leading peer-reviewed medical journal, which says that supervised consumption sites prevent overdose deaths on the site; as well as the overdose mortality rate decreased significantly in their neighbourhoods.

Given the health impact of schedule 4, would you consider removing schedule 4 from this bill?

Hon. Sylvia Jones: No. I think the member opposite is missing the point. We are transitioning consumption sites into full-service sites, HART hubs, where people get service, whether it is for social services, for mental health, for addictions, pathways to recover.

We have to give people more hope because we cannot allow individuals—the only option is to continue to provide them with drug supply. We can do better in Ontario. I know that so many of our clinical health care providers see the value in that full-service model. In fact, the HART hub model—when they are operationalized—can evolve into almost four times the amount of funding that we currently provide for treatment sites. It's a better system because it gives people hope.

At the end of the day, if we're not a government and a health ministry that gives people health, then we're doing the wrong thing.

The Acting Speaker (M^{me} Lucille Collard): The next question.

Hon. Nina Tangri: I joined the Solicitor General and caucus colleagues at the Peel police headquarters last week, where we announced the introduction of this legislation. It was very much welcomed by law enforcement agencies—and then also acknowledging the need for this legislation. Hearing from the Stephensons, the family, of the horrific murder of their young son, who was kidnapped, abused repeatedly, killed, his body left in a field—it made your heart just break.

My question is to the Solicitor General. Can you please explain to this House the need to pass this legislation and why everybody must, must support it?

Hon. Michael S. Kerzner: Well, I want to thank my colleague and friend. She was there. She saw something—by speaking to the family. Just holding their hands reminded us why, when we come home at night, we must hold our kids, our grandkids, our loved ones that much closer.

Times have changed. Nobody envisioned the Internet. Nobody envisioned social media. Nobody envisioned emails. Nobody envisioned the ability to continue on in such an improper way just because.

By the way, we went further, to say, "You can't change your name and get away with it and hide behind a new identity."

There were so many things that we looked at to strengthen Christopher's Law. What Premier Harris and this government did over 20 years ago was amazing, being the first in Canada to move forward with it. We have now taken it to another level to protect our most vulnerable.

The Acting Speaker (M^{me} Lucille Collard): Next question?

Ms. Jennifer K. French: I'm glad to have a second go-around, hopefully again with the Associate Minister of Auto Theft and Bail Reform, who would suggest that I might blame the cars for VIN fraud. There's always the opportunity to be flip, but I would invite him to be effective in this moment.

This is a government that knows that VIN fraud is rampant and is not closing that drive-through lane for criminals. This bill doesn't shut that door.

The associate minister mentioned that they're closing loopholes—not good enough. I want to know why this government is choosing not to institute a VIN verification system. I think they know that there are a whole bunch of

fraudulent VINs sitting on our registry right now and more getting registered every day, and they're not stopping it. I want to know why.

Hon. Graham McGregor: The member knows full well about the anti-VIN-fraud measures that we've put in this bill. I certainly hope the member will vote for that.

But the NDP are missing the point. We could talk about process. We could talk about technology. What we need to do is find the criminals, the scumbags who are stealing cars in our neighbourhoods, and we need to lock those people up. What I haven't heard from the NDP is them to iterate our call on bail reform.

We had a Toronto police officer shot six weeks ago. We didn't hear a word from the Leader of the Opposition, who is a Toronto-area MPP. If you look at her Twitter at that time, you've got four messages about the nomination for the member for Niagara Centre, but not one message about the family, the officer who was shot, or a call for bail reform—

The Acting Speaker (M^{me} Lucille Collard): We're out of time. Thank you.

We're going to go to further debate.

Ms. Jennifer K. French: I'm glad to be able to stand in this House and debate a government piece of legislation. It's an omnibus bill that was introduced in the House yesterday, so here we are the next day. It's a nine-schedule omnibus bill, and it's a bill that rehashes a number of issues that the government has previously gone public with and, in some cases, has already legislated. There's a lot in this bill.

Ms. Teresa J. Armstrong: Are you going to share time?

Ms. Jennifer K. French: Thank you.

Speaker, I've been reminded by everyone—I am sharing my time. So I am looking forward to sharing my time, but not yet, so hold your horses.

This is a significant piece of legislation with a lot in it and a lot to talk about. But I'm standing as the critic for infrastructure, transportation and highways, and I'm going to spend the majority of my time talking about ways that this government could do better to protect Ontarians when it comes to VIN fraud, when it comes to auto theft. There are some solutions I would hope that they would reach for.

A bit of an overview: In schedule 1, the Cannabis Control Act—it prohibits the advertisement or promotion of cannabis sales. Yes, okay—promoting and advertising authorized cannabis should be prohibited, and municipalities should be given more funding to enforce their cannabis bylaws. We don't see that in here.

Schedules 2 and 3: We've heard the government members speak about it, and I know that we will spend the time that it deserves in this House—to talk about Christopher's Law. Christopher's Law from 2000 is the provincial sexual offender registry act that requires those convicted of prescribed sexual offences under the Criminal Code to register their whereabouts upon release. We're seeing changes to Christopher's Law that are long overdue. The changes are welcome, to protect our most innocent in society. We have heard today about Christopher and the work of the Stephenson family to make the world better in

the wake of unspeakable harm and tragedy. So those changes are indeed long overdue.

Schedule 4 of this bill is what they're calling the Community Care and Recovery Act. This schedule proposes a new bill to prohibit new and existing supervised consumption sites. What we need to be seeing are decisions made by government that are evidence-based, with a focus on the continuum of care for all of our neighbours, regardless of where they are on their mental health and addictions journeys. Thousands of lives have been saved because of consumption and treatment sites, and now they're going to be closed. People will die. It is not the only part of mental health and addictions services, but it is an important part. Taking out a part that saves lives every day isn't going to help anything. I don't hear from this government that they believe the lives of people who have addictions have value when this is the tool they are reaching for, shutting down those avenues for help and support.

1640

Speaker, I have heard from community, and I'd like to share a thoughtful letter here from Devon, who writes:

"The Ford government's decision to force the closure of safe consumption sites and prevent future sites is devastating. I am writing to beg you, as the representative from a community that is suffering enormously under multiple governments' cruel public policy, to voice objection as loudly and as frequently as possible.

"We are simply hastening the death of our community members, who are unsheltered, who have substance abuse disorders and severe mental health challenges so we don't have to solve these problems and it is cruel and barbaric. Letting people die so we don't have to help them as an official public policy is unforgivable, and that is exactly what this is.

"Please, please, please do not show a population of desperate people that we would rather have them dead than help them.

"Thank you for taking the time to read this and for doing your best."

That's from Devon in my community.

Speaker, today we heard a number of petitions that have been sent in from across the province specific to this issue, calling on the government to continue to operate supervised consumption services and associated harm reduction programs. Folks have been highlighting that those consumption and treatment services sites have been instrumental in preventing thousands of deaths—deaths from the toxic drug supply. They have highlighted that the closure of supervised consumption services sites will increase the number of preventable deaths, injuries, hospitalizations, emergency room visits, and the incidence of HIV and hepatitis. These sites offer access to other health and social services, including addictions treatment.

The closure of consumption and treatment services sites is a withdrawal of health services for people who use drugs and is, consequently, a denial of their right to health care.

Closing supervised consumption services sites will lead to an increase in drug use in public spaces, the very thing that this government is suggesting that it cares about.

Health care should emphasize prevention, as well as treatment, in a full continuum of care.

People across the province have been sending to all of us petitions calling for the reversal of the decision to close supervised consumption services sites and ensure all sites remain operational and adequately funded. They're calling to increase funding for these sites. Also, they want to ensure access to voluntary, publicly funded and not-for-profit evidence-based treatment. It seems to be too much to ask from this government, and that is a harmful shame. People will die, and that seems to be a calculated risk on the part of this government.

Speaker, I hope the government will reconsider, will listen to Ontarians, will do the right thing by those struggling Ontarians and will remove this schedule from the bill so that we could proceed without it and have these positive conversations with other sections of the bill that could be the focus. Unfortunately, this is a significant piece, and it is a wrong decision by this government.

Schedule 7 is the Courts of Justice Act. It removes the legislated cap on the amount of time a retired provincial judge can serve post-retirement; it's currently 50% of full-time service. It moves it into regulation. This is a good idea. And the province needs to fully fund and staff our courtrooms, reopen shuttered courtrooms and consider creating more courtroom space. This is a government that is shouting from the rooftops that they're building more jails, but they're not looking after our courtroom challenges.

I have something here. This was shared with me by the Durham Regional Police Service Board. They wanted to share information in relation to local Provincial Offences Act cases dropped due to delay. This is a legal opinion they were sharing with me.

"In recent years, with only one to two courtrooms functioning, there has been a growing lack of judicial resources:

"—In 2022, there were 28 presiding days where no justices appeared.

"—In 2023, there were 27 presiding days where no justice appeared for scheduled court."

So far, this year, and this was in March—"There have been 15 presiding days where no justice appeared, and an additional eight days where courts were combined due to one courtroom not having a justice available."

This is in regard to the region of Durham Provincial Offences Court that cannot accommodate the matters before it.

They went on to say, "The regional municipality of Durham is faced with a significant lack of judicial resources due to the province of Ontario not allocating sufficient justices of the peace to adjudicate in this region....

"It is with regret that I inform Durham Regional Police Service that of the 11,000 charges being withdrawn on

Monday, approximately 35% to 45% of those were laid by DRPS.

"We will continue to prioritize our most serious cases involving high public interest."

Things aren't good anywhere, eh?

So this change is allowing retired justices to work more in their retirement. That's a stopgap measure. Coming from education and knowing that retired teachers are in high demand right now, I understand the need to be creative, but how is this the permanent solution? It isn't.

I'd like to talk about schedule 8. Schedule 8 is changes under the Highway Traffic Act to create an "offence to knowingly submit, display, present or surrender a false vehicle identification number for a motor vehicle in certain documents." So this bill creates a new provincial offence of using a false vehicle identification number, or VIN.

Fun fact: Tampering with a VIN is already a crime under section 353.1 of the federal Criminal Code, carrying a prison term of up to five years, and this bill would make this a provincial offence as well, like a speeding ticket. I guess it's supportable, but it seems like a half measure. If someone isn't deterred by the fact that it's already a crime under the federal Criminal Code, then a provincial offence may or not be the significant deterrent that this government and this minister are making it out to be. Again, this is an after-the-crime measure and arguably not preventive.

We've talked a lot about car theft in this room. Here, from the Toronto Star: "Car Thieves Could Lose Driver's Licence for Life, Ford Government Says." This is actually regarding another bill that's before this House right now.

"Under the proposed new law, anyone convicted of motor vehicle theft would automatically lose their licence for 10 years. A second conviction would mean 15 years' suspension; three convictions and the suspension is for life.

"Critics, however, said the new penalties will have little effect...

"Adam Weisberg, managing partner at Weisberg Law Criminal Lawyers LLP, called the proposed law 'misguided' and 'completely ineffective.'

"The perpetrators of these crimes are already not deterred by the prison sentences they face.

"There is little that the provincial government can do to combat auto theft, other than direct police resources at investigations into these auto-theft rings ... it's just a frustrated attempt from our province to signal that frustration to the public"....

Yes, and we're seeing that again in this bill. This government has been talking about cracking down on VINs, and I was expecting them to crack down on VINs, but that's not what's happening. We're tinkering around the edges.

Earlier this month, the Toronto police made 59 arrests and filed 302 charges after uncovering a scheme involving the registration of phony VINs by employees of a ServiceOntario location.

Basically, re-VINing has been happening right under this government's nose, and it's hard to see how making

this federal crime a provincial offence, like a speeding ticket, is going to deter that fraud.

The NDP and I have called for preventive measures to stop the fraudulent use of VINs before the fraud occurs, including creating a system to verify suspicious VINs, which exists in some other provinces.

1650

Speaker, front-line workers at ServiceOntario, we've seen in this case, some are—well, I suppose anyone is susceptible to corruption by organized crime, and I think that's what we have seen here. But we also know that other ServiceOntario workers came forward and do their job as well as they can with an A-to-Z menu of services that they offer at ServiceOntario. So those front-line workers are tasked with, I guess, crossing their fingers when they're registering VINs and making sure that they are indeed authentic, because in order to ensure that VINs are the real deal, they would physically have to inspect—to suggest otherwise is verifying paperwork, not verifying the vehicle, and that's an important thing to understand. There is no digital fix for this.

I'm going to read from this article: "Other Provinces Inspect Vehicles with Problematic VINs, Why Not Ontario?" This was from March 2024.

"After a 32-year career as a theft investigator with the Ontario Provincial Police, John Tod started working for a business that helps provincial governments sniff out phony vehicle registrations as a way to curb vehicle theft....

"The 17-digit VIN is a vehicle's serial number, intended to help governments, police and insurers link a vehicle to its owner to prevent all manner of auto theft and fraud.

"In Alberta and Saskatchewan, in cases where a clerk in the vehicle registration office or insurance company finds an issue with the VIN of a vehicle being registered, the vehicle is flagged for inspection....

"However, those inspections do not happen in Ontario, which makes it easy for thieves to sell stolen vehicles in Canada's largest province with little fear someone will ever check on the vehicle's history, Tod said....

"He said the lack of an inspection program in Ontario is actually making the province a destination for thieves to register vehicles stolen in other jurisdictions.

"I've been warning the Ontario government about this for four years,' he said....

"Police are starting to raise the issue."

There was a national summit a little while ago, and we saw OPP Commissioner Thomas Carrique speak in his role as the head of the Canadian Association of Chiefs of Police. He told a House of Commons committee during that time that mandatory inspections of vehicles with problematic VINs should be mandatory. He also called for a national system of vehicle registrations. Right now, each province manages its own system.

Fun fact: We live in a province that doesn't manage its own system. Prove me wrong.

Here's an article, Speaker: "Just Bought a Used Car? There's a Chance It's Stolen, as Thieves Exploit Weakness in Vehicle Registrations

"Nearly 1/3 of stolen vehicles may now have been title 'washed' and resold"

This is from a CBC news piece in April.

"Derek Crocker bought a used Ford F-150 pickup truck from a dealership in Toronto in 2022....

"After Crocker entered what should have been the truck's unique VIN in Ford's app, the function to remotely start the vehicle never worked....

"But it wasn't until his F-150 was in an accident and required bodywork that the problem with the VIN was revealed." So he Googled the VIN number that was on his truck and found a truck for sale in Utah.

This story is worth a read, for the folks at home.

"Crocker's own insurance would not cover his loss because he'd—albeit unknowingly—purchased a stolen vehicle. After a long discussion with the dealership that sold him the stolen truck, his money was returned....

"How could two cars with the same VIN be registered?

"Provincial centres that administer vehicle registration, such as ServiceOntario, do not have a system that checks if VINs already exist in other jurisdictions." They don't even check if it exists elsewhere in our own jurisdiction. It's wild.

I've had local media ask if I'm sure that the government could actually crack down on this and could verify problematic VINs. Why aren't they? And the answer to them, and the answer to you, and the answer to the folks at home is, I don't know. How many vehicles are registered every year? That's a real question. I don't know. Half a million? A million? I have no idea.

But of those vehicles that are registered, how many of them have problematic, missing, partial, duplicate, improper or suspicious VINs? And of those that might—I don't know how they're flagged, but if they were flagged—how many are physically examined to determine if those VINs are legit? The answer to that, unless they prove otherwise, unless they tell me otherwise, I'm going to say, is zero, none. So if none of them are ever checked, how many duplicates, how many problematic VINs are on our registry right now? There is no wonder that criminals are literally coming to Ontario to do this, to launder VINs, to commit VIN fraud.

Here we have a bill in front of us that says we're going to create a provincial offence if you knowingly tamper with a VIN. Okay, but it's already a federal crime. How does this—tantamount to a speeding ticket—serve as a deterrent? It does not protect Ontarians.

I've already talked about Project Thoroughbred. The results of the investigation known as Project Thoroughbred were that the Toronto police recovered 363 stolen vehicles, valued at approximately \$14 million—they laid 302 charges at the time of this writing. It says, "According to police, ServiceOntario employees knowingly used false documents provided by car thieves to portray fake VINs as valid. The fraudulent VINs were then used to register for real Ontario licence plates for the stolen vehicles that were sold to unknowing buyers at a significant discount."

They also discovered chop shops throughout the city. Taverner said, "As you can imagine, this is a very lucrative

market for these stolen vehicles and parts, they offer high rewards financially with minimal risk.”

The Ontario government announced new legislation that would introduce a provincial offence for fraudulent vehicle registrations and re-VINing. That’s what we’re debating today.

The article goes on to say, “The offence would come with fines up to \$100,000, up to six months in jail, and driver’s licence or vehicle permit suspensions, according to the announcement made by” the transportation minister.

“Toronto police urges customers to be extra careful when purchasing a used vehicle, and to make sure they obtain vehicle history reports prior to making a purchase.” That’s what we’re supposed to do if we’re buying used vehicles: crawl under a car and check it ourselves, I guess—rely on the Carfax report. Tighten this up.

Interestingly, the province, this government, the Ontario Regulatory Registry posted—this was dated June 24, 2021, under the previous Minister of Transportation. There was a summary of the proposal; they explain about VINs and what they’re for. It says, “Sometimes bad actors attempt to fraudulently apply for an assigned VIN. They may do this to clone a VIN of another vehicle, or to mask a stolen vehicle. Sometimes they try to replace a VIN to trick buyers into thinking that an irreparably damaged vehicle that is only usable for parts is fit for on-road use.” This is the MTO, this government’s MTO. This is from their summary of proposal.

“Currently Alberta and Saskatchewan use a third-party company to properly identify vehicles and issue VINs to motor vehicles and trailers.... The company completes a detailed inspection of the vehicle, and investigation of the history of the vehicle before a VIN can be assigned. After introducing third-party investigations into their assigned VIN programs, Alberta and Saskatchewan reported significant improvements to the integrity of their assigned VIN programs, including the recovery of stolen vehicles.”

1700

This was related to the MOMS Act, which was the Moving Ontarians More Safely Act, 2021. The Ministry of Transportation put out this summary of proposal and said that “the ministry committed to explore options on how to improve the integrity of Ontario’s Assigned VIN Program. The objective is to reduce fraud and help recover stolen vehicles by preventing bad actors from fraudulently applying for an assigned VIN.

“That is why the MTO is seeking feedback on how to improve the assigned VIN program.

“One question that we are looking to include is whether the public would support requiring an investigation by a third-party company before assigning a VIN?” And it goes on: “We invite you to review the details of this proposal and submit comments for MTO consideration. Please let us know about your ideas, potential benefits, or concerns that you have as well as any recommendations to improve the integrity of Ontario’s assigned VIN program.”

That’s from the MTO. That’s from June 24, 2021. What is today? November something?

Ms. Teresa J. Armstrong: November 19.

Ms. Jennifer K. French: November 19, 2024. What did you do with the input? What did this ministry do with everything that they heard and learned? Sweet nothing, it would seem. What did you hear from folks? Are people interested in having the VIN registry protected and having a VIN verification system? Is that what you heard? Is that not what you heard? Where is the leadership?

I’ll tell you where there’s some leadership. There was some leadership at the Standing Committee on Public Safety and National Security, on February 29, 2024. The Commissioner of the Ontario Provincial Police, Commissioner Thomas Carrique—these are from his remarks; I’ve already referenced this before: “Today organized crime has a strong hold on the illicit transnational auto theft market. It’s estimated that 80% of passenger vehicles are exported, and 10% of these vehicles are re-VINed and sold domestically, with the remaining 10% being chopped down and sold for parts. The lucrative international market of stolen Canadian vehicles has surged, as many of the desirable vehicles are readily available in Canada and are either very costly internationally or simply not available for purchase in those countries they’re being exported to.”

He goes on to specifically say, “In response to this public and officer safety concern, and to disrupt the illicit transnational market being controlled by organized criminal networks, the profits of which often finance other criminal activities ranging from drug trafficking and arms dealing to human smuggling and even international terrorism, Canadian police leaders are calling for a strengthening of port security and monitoring mechanisms, including inspections and the use of technology, to disrupt the illegal export of stolen vehicles....

“We’re calling for verification of third-party vehicle registration, the physical inspection of problematic VINs during the registration process, and the creation of a national system for vehicle registrations.”

It was a much longer submission, but I’m highlighting the provincial pieces. Nobody is denying that there is a federal component to this, but there is an opportunity for the province to show leadership. You’re being told by insurance companies, you’re being told by police and former police—wilfully ignoring, by your own words of the summary proposal that you were seeking input to make the world a better place when it comes to re-VINing, and yet here we are.

Side note: The feds also want Ontario to do more on the auto theft push. They are interested in having provincial partners across the country. We need to make sure that our registry holds water, not just problematic VINs.

Continuing on schedule 8: Currently the registrar of commercial vehicle operators has a limited range of remedies for non-compliant truck operators, such as the cancellation of the commercial vehicle operator’s registration, or CVOR, certificate. You know, the changes proposed in this bill seem reasonable. The bill was tabled yesterday; I’d be interested in hearing from the trucking industry and road safety stakeholders to properly understand all of the impacts. But it doesn’t do anything

to address the trucking challenges that we know to be rampant in this province.

The Ontario Trucking Association says it believes “a lot of change is necessary to make the roads a safer place for truck drivers ... A recent survey by the Ontario Trucking Association shows that the top three concerns for truckers on northern highways are unsafe passing by other vehicles, the lack of truck rest areas and trained truck drivers.”

The well-trained truck drivers piece is really, really challenging for folks right now. I think everybody in this House watched the CBC Marketplace episode “Hidden Camera, Internal Memo Reveal How Unqualified Truck Drivers Are Getting onto Canada’s Roads.” It was shocking, and we don’t see measures in this bill reflecting what we learned.

It was shared by Marketplace. A “DriveTest examiner responsible for testing people who want to obtain their commercial trucking licence” had said, “In our company, there are times where we feel that someone shouldn’t be passing and we have to pass them ... Our hands are tied.” It was someone who highlighted that there are people who “took bribes” and “gave licences.”

Behind the scenes, with hidden cameras: “Ontario’s Minister of Transportation ... declined an interview request with Marketplace multiple times” on this issue. A spokesperson from the ministry sent an email that said, “If Serco is unable to control fraud in the programs it administers, we will re-evaluate the contract with them.”

“However, the ministry was made aware of the memo from Serco multiples times, including months in advance of publication.”

Talk is cheap, guys. It’s very concerning that we have real information about how dangerous things are right now, and we don’t see the leadership. We don’t see it in this bill that the government is actually making changes.

The MPP for Thunder Bay–Superior North has asked this Premier about the blatant fraud and bribery that was illustrated in that Marketplace segment.

Truckers For Safer Highways’ Travis McDougall wrote a very thoughtful series of letters to the minister, to the Premier, and said, “It is evident that the Ministry of Transportation has failed to adequately ensure that all new drivers are properly trained and licensed. As a result, there are drivers on our highways who should not be behind the wheel of heavy trucks. This presents a serious safety risk to all road users....

“We are calling on your government to take immediate and decisive action to demonstrate that safety on Ontario’s highways is a top priority, not merely a talking point. With the winter season upon us, the dangers posed by the current situation are even more pressing, and we fear that without urgent action, we may witness further tragedies on our roads.”

Speaker, I’ll end with the government talking about careless driving as a penalty, talking about laying the hammer down with the one hand, but with the other hand, they still have policies on the books to let people plead down. That careless charge, if police officers actually lay that charge, is not leading to conviction. It’s not leading to

those penalties. People are pleading down, if they even get their day in court.

So if the government isn’t willing to fix the backlog and the court problem, they can build all of the jails that they want. They can say that they’re going to fill them, but not if people don’t go through the court system. So we have layers and layers of challenges and we don’t see this government rising to those challenges in this bill.

And with that, I will share my time. Thank you.

The Acting Speaker (M^{me} Lucille Collard): I recognize the member from Nickel Belt.

M^{me} France Gélinas: I would like to start my comments with schedule 6. Schedule 6, section 3 is amended to give the minister the power to issue awards related to policing.

Let me say a few words about a good friend of mine, Dan Lee. Dan Lee is a career police officer with the Ontario Provincial Police and retired as a sergeant after 31 years of service. He loved police work and his fellow police officers. His postings led him from Geraldton to Japan to Upsala and to, finally, Sudbury. He continued to work in various part-time capacities following his retirement.

Dan was the recipient of the OPP Commissioner’s Citation in 1994 and received awards from the Ontario Law Enforcement Torch Run for Special Olympics. The city of Greater Sudbury presented him with an award of distinction and a civic award, and the YMCA honoured him in 2006 and awarded him the YMCA Canada Peace Medal. The Salvation Army presented him with awards in 2023, and he was inducted into the Sudbury hall of fame in 2019 for his long-time commitment to Sudbury sports.

1710

Dan loved people and was heavily involved in community life in Sudbury. Some of his activities included the following: past director of the Sudbury community services board; member of the Salvation Army advisory board; president of the Sudbury sports council; co-founder of Operation Red Nose; co-founder of the Bridge of Nations; co-chair of the 2010 Ontario Summer Games; co-chair of the Special Olympics national summer games, with a long-time commitment to the Law Enforcement Torch Run. He was the founder of the OPP Strike Force group, involving at its peak four sports and 34 teams for youngsters and adolescents; and past president and committee member for the Holy Redeemer Church.

Dan was also actively involved and vice-chair with the OPP Veterans’ Association, and maintained a continued interest in Sudbury activities all along.

Talking about the Bridge of Nations, it is an absolutely amazing project that was envisioned by Ursula Sauve and Dan. Dan joined Ursula as a founding committee member to help bring the Bridge of Nations to life. That happened in 2007. He helped create a colourful and powerful symbolic celebration of all the people and cultures that make Sudbury a multicultural melting pot, a place where we celebrate our diverse heritage and live peacefully together.

I’d like to end by saying Dan Lee’s words of wisdom about volunteering. Here’s what he said, “You don’t need

special expertise to volunteer. You just need the will to engage. It's always a learning curve. Volunteering is a rewarding experience where you can enjoy accomplishing a goal in the company of the nicest possible people. You come away with strong friendships that last a lifetime and have the pleasure and privilege of meeting people from all walks of life and from all around the world. You meet the best people because the best people volunteer."

Dan passed away last Tuesday, and I wanted him to—rest in peace, Sergeant Lee.

All this to say that I support schedule 6. I support all of the schedules in this bill, except for having an issue with schedule 4. When schedule 4 came out, which was yesterday, my inbox started to get flooded instantly. So far, I have received—as of 3 o'clock when I came into this room because I stopped counting—3,088 emails regarding schedule 4 of the bill. I will read a few of them into the record.

"Nurses Warn the Ontario Government Will Bear Responsibility for Preventable Deaths that Will Ensurue from Withdrawing Essential Life-Saving Health Services." They wrote that yesterday.

"Legislation introduced by Premier Doug Ford's government is a sweeping attack on harm reduction and supervised consumption services ... across Ontario, effectively blocking municipalities from addressing the toxic drug crisis, warns the Registered Nurses' Association of Ontario.... The move will lead to unsafe communities, increased deaths, overwhelmed emergency services, and escalating health-care costs. Nurses say the Ontario government will bear responsibility for the avoidable loss of life.

"On Monday, the government tabled a bill to close SCS sites located within 200 metres of a school or child care centre by March 31, 2025. This directive affects nine provincially funded sites in Ottawa, Guelph, Hamilton, Thunder Bay, Kitchener, and Toronto, as well as one privately funded site in Toronto. Since 2017, these 10 sites have prevented approximately 8,500 overdose-related deaths. By choosing to close rather than relocate these services, the government is knowingly increasing their risk of preventable deaths and health care costs, as highlighted by its own internal assessments.

"The legislation further restricts municipalities from renewing applications to the federal government for supervised consumption "sites, effectively eliminating harm reduction services in Ontario. This comes amid a devastating crisis that claimed 3,800 lives last year and over 22,000 since 2018, when Premier Ford's government first took office. The bill also prohibits municipal advocacy for decriminalizing personal drug use, disregarding evidence-based harm reduction strategies and undermining democratic processes.

"The scope of the crisis is dire, with an average of 10 people dying daily from tainted drugs" here in Ontario. "We will witness more preventable deaths because the government is sending a clear message: People who use substances are disposable," says RNAO president and nurse practitioner "Lhamo Dolkar. "Supervised consump-

tion sites save lives by providing critical mental health and health care support. You cannot help someone after they are dead," she emphasizes.

"Dr. Doris Grinspun, RNAO's CEO, criticizes the government's focus on crime reporting near remaining" supervised consumption "sites while ignoring evidence provided by the police that shows there is less crime in communities with SCS than in those without these health and social services. The Premier and his team are also aware of the proven benefits of SCS services in reducing death, illness, and health care costs. 'This is an ideologically driven policy that will cost more lives. Our health system treats those with cancer and chronic illnesses with compassion and with comprehensive services; we must extend the same care to persons dealing with substance use,' Grinspun urges. She warns of increased deaths, more discarded needles, and rising infections such as HIV and hepatitis C. 'The result will be more parents burying their children and longer wait times for ambulances. Just one HIV case can cost taxpayers half a million dollars. Premier Ford, our communities need more health care, not more ideology.'

"While RNAO acknowledges the government's August announcement of \$378 million for 19 new homelessness and addiction recovery treatment (HART) hubs, it criticizes the exclusion of harm reduction services like supervised consumptions, "safer supply programs, and needle exchanges. 'HART hubs should offer comprehensive, wraparound care, but this plan falls short and contradicts the stated aim of keeping communities safe,' says Grinspun.

"Dolkar points to a lack of genuine engagement with local communities: 'Mayors across Ontario have called for more support for mental health, substance use, and homelessness. Despite promises to listen, this legislation silences their voices and undermines their ability to advocate for public health.' The legislation also bans municipalities from seeking exemptions to operate supervised consumption "sites, pushing more people towards emergency rooms or worse, dying on the streets. Data indicates that closing these sites will increase substance use and the presence of discarded needles, contrary to the government's assertions.

"By cutting these services, Premier Ford is creating barriers to health care for those who need it most," says Dolkar. The government's own documents highlight the disproportionate impact on Indigenous, Black, and low-income individuals who already face significant barriers. 'Harm reduction programs help build trust with care providers, opening pathways to primary care and support. This legislation will only make it harder for vulnerable groups to access essential services,' Dolkar adds.

"When elected to office, Premier Ford committed to 21 supervised consumption "sites. Seventeen were delivered and then the government stopped assessing applications for additional sites forcing Windsor, Sudbury, and Timmins to close, and Barrie to withdraw their application. With 10 sites now being closed, only eight will remain. Monday's decision is a nail in the coffin for"

supervised consumption sites “and the Ontarians that they serve. ‘RNAO calls on Premier Ford and his government to immediately reverse its decision to close SCS sites and instead adopt an integrated care model that supports both harm reduction and treatment services. The government can still change course, but once these closures lead to the first death, it will be too late,’ Dolkar concludes.”

1720

This comes from the executive director and the president of the board of the registered nurses’ association, which represents over 64,000 people.

The registered nurses are not the only ones who have talked about this. I would like to quote, actually, a physician from Sudbury. Her name is Dr. Emily Groot. Dr. Groot wrote to Honourable Sylvia Jones and Honourable Michael Tibollo, and here’s what she had to say:

“I am the medical director of Réseau Access Network’s supervised consumption site”—called Minoogawbi, La Place, The Spot. “I am a public health and preventive medicine specialist in good standing with the College of Physicians and Surgeons in Ontario. I completed undergraduate studies and medical school at McMaster University, a master of public health at the University of Toronto, and residency training at Queen’s University.

“When I finished medical school in 2010, I swore to uphold the Hippocratic oath, which includes the phrase, ‘I will prevent disease whenever I can, for prevention is preferable to cure.’ This has shaped my career: first, as associate medical officer of health for the Thunder Bay District Health Unit, then as regional supervising coroner for the north region Sudbury office.”

She went on to say: “I accepted my role with Réseau Access Network to provide high-quality care to people who use drugs, but as a public health physician, I would also like to highlight the benefits of The Spot”—La Place, Minoogawbi—“to the general public.”

“(1) Reduced transmission of HIV and hepatitis C (HCV): Supervised consumption sites are an important tool to reduce blood-borne disease transmission. This is particularly true in Sudbury: From 2012 to 2021, the rate of new HCV infections diagnosed in the Sudbury region ranged from 50.8 to 78.7 new cases per 100,000 persons per year, which is significantly higher than the rate in Ontario,” which is 31.7 to 37.4 per 100,000.

“(2) Reduced health care system costs.” She gives the example: “The average total health care costs per 30 days for Canadians with decompensated cirrhosis”—which is caused by hepatitis C—“is \$8,753. As a result of the reduction in disease transmission and improvements in health outcomes associated with supervised consumption,” sites are actually saving money.

“(3) Increased public safety: Although there is negligible risk associated with public drug use and discarded needles, these can lead to public safety concerns: supervised consumption sites reduce both. Further, supervised consumption sites either decrease or have no impact on crime or public nuisance calls.”

That comes from Dr. Emily Groot, who is the medical director of consumption services at Réseau Access Network.

But if this is not enough, I would like to quote from the Lancet. The Lancet is one of the world’s leading peer-reviewed medical journals. It was established more than 200 years ago, in 1823, and they rank among the top medical journals globally.

Here’s what they had to say: “Supervised consumption sites (SCS) prevent overdose deaths on-site....

“The overdose mortality rate decreased significantly in neighbourhoods that implemented” supervised consumption sites. So they looked at not only the prevention of death that happens in the site, but they went a kilometre around, four kilometres around, and for up to five kilometres around, they saw an eight-to-10-deaths decrease by 100,000 people.

I must say that these particular overdose mortality incidents and supervised consumption sites services were done in Toronto, and the results are Toronto-specific. They studied from after 2017, when the sites were established. They saw a significant decrease in the overdose mortality events in Toronto from May 1, 2017, to December 31, 2019, but they did not see a parallel decrease in other neighbourhoods.

They basically estimated that approximately two overdose fatalities per 100,000 people were averted in the square miles surrounding the supervised consumption sites in 2019: “Policy-makers should consider implementing and sustaining” supervised consumption sites “across neighbourhoods where overdose mortality is high.”

This comes from the Lancet, and it was published in February 2024.

To put the research a bit in context:

“Evidence before this study

“The influence of supervised consumption services ... on client outcomes is well known. However, the evidence base regarding how” supervised consumption sites “influence population-level public health outcomes is small, particularly with respect to overdose....” So this is why they started this study, which was peer-reviewed and published. It has to do specifically with three supervised consumption sites here in Toronto.

The next thing I want to read is a letter that has been sent to myself, to Doug Ford, to Michael Tibollo and to Sylvia Jones. I am copied on this—and I am receiving those letters, hundreds of them, every 10 minutes. They read as follows:

“Premier, your plan to gut and prohibit harm reduction programming in Ontario—including the closure of 10 supervised consumption sites (SCS) and no needle exchange—is a triumph of ideology over health care. People will die preventable deaths from your plan to withdraw these critical health care services.

“The scale of Ontario’s toxic drug crisis is staggering. Across Ontario, an average of 10 people per day are dying from tainted drugs. In 2023 alone, over 3,800 people across Ontario died from the unregulated drug supply.”

Harm reduction programs such as” supervised consumption sites “and safer supply save lives and open the door to treatment and recovery.

They welcome “your investment in 19 homelessness and addiction recovery treatment (HART) hubs. The investment, however, fails to recognize the scale of Ontario’s toxic drug crisis. Greater investments in housing, treatment and other services are required. Further, your ideological response to this crisis excludes important evidence-based health care services required to lead people to recovery. The 19 new HART hubs must all offer harm reduction services, including supervised consumption, needle exchange and safer supply.

They end by saying, “Harm reduction is health care.

“Sincerely,”—this one was from Claudia Winkelmann, but as I said, as of 3 o’clock when I came up, I had received 3,088 similar letters. I am not the only one; Doug Ford, Michael Tibollo and Sylvia Jones were all on that email, and this only started 24 hours ago, when the bill was tabled.

I still have a lot: “SCS closures: A death sentence that will lead to unsafe communities and higher costs...

“Premier Doug Ford and his government’s misguided measures will endanger the lives of thousands of Ontarians struggling with substance use, say members of the ... RNAO. The announced steps mean unsafe communities, more deaths, overwhelmed emergency services and spiking health care costs, and leave nurses wondering who the government is trying to serve.”

1730

I also would like to read a list of people from Toronto who—same thing—signed this statement. On the list of people who signed the statement, there is:

—Alan Broadbent, a Toronto businessman and social advocate;

—Philip Berger, a long-time downtown Toronto medical physician;

—Joanne Campbell, retired vice-president of community relations at CAMH;

—Gordon Cressy, former chair of the Toronto Board of Education;

—David Crombie, former mayor of Toronto;

—Dr. Cheri DiNovo, Trinity-St. Paul’s Centre for Faith, Justice and the Arts;

—Paul Garfinkel, inaugural CEO of CAMH and professor emeritus in psychiatry at the University of Toronto;

—Dr. Doris Grinspun from RNAO;

—Sahil Gupta, emergency physician at St. Michael’s Hospital;

—Barbara Hall, former mayor of Toronto;

—Bruce Kidd, Olympian and professor emeritus of sport and public policy at the University of Toronto;

—Dr. Vincent Lam, addiction medicine specialist and medical director of Coderix Medical Clinic;

—Steve Lin, interim chief, department of emergency medicine at St. Michael’s Hospital;

—Heather McGregor, chief executive director at the YWCA Toronto;

—David Miller, former mayor of Toronto;

—Michael Rachlis, physician and adjunct professor at Dalla Lana School of Public Health;

—Ben McNally;

—John Sewell, also a former mayor of Toronto;

—Ed Waitzer, a lawyer;

—Dr. Daniel Werb from St. Michael’s Hospital;

—Kathleen Wynne, former Premier of Ontario—and the list goes on.

Basically, they’re “a group of Torontonians united in opposition to Premier Doug Ford’s decision to close 10 ... supervised consumption sites. As individuals who have played a strong role in various aspects of public policy and public discourse, we believe this decision is misguided and represents failed policy. We urge the government to reverse this course of action and instead strengthen, not eliminate, this crucial harm reduction service, which is a key part of a comprehensive response to substance use and the overdose crisis.”

Let’s be clear: Everybody supports the HART hubs. Treatment and recovery is a path, but if you cannot keep people alive, then there is no path.

There are lots of people in my riding who have died. I’ve shared this with this House already. Every single day, a first responder will have at least seven calls for overdoses—and that’s every single day. It goes up and down, but there’s a minimum. On average, two people per week in Sudbury will die of an overdose. If you don’t keep those people alive—many, many of them want to go into treatment, want to go into recovery, but there’s an 18-month wait-list for children and over a two-year wait-list for adults to get into treatment and recovery. How do you keep those people alive, who wait on wait-lists that are so long? You do this through a supervised consumption site, and consumption and treatment services keep people alive.

We support the HART hubs. There will be 10 of them aside from the sites that are being closed. There are hundreds of municipalities that have asked for a HART hub; 10 lucky ones will be chosen. What happens to every other municipality that needs one—that wants recovery, that wants treatment, that are dealing with people with substance use and have no access and are faced, like us in the north, with an 18-month wait-list for children and a 24-month wait-list for adults? This is not acceptable. We have to provide a continuity of care so that they get better.

The last thing I wanted to talk about was schedule 1. Schedule 1 amends the Cannabis Control Act—the advertisement and promotion of cannabis that is sold unlawfully. There’s already a law for this, but I want to talk about Atikameksheng Anishnawbek that has written to the Ministry of the Attorney General to operate a retail cannabis store in Atikameksheng Anishnawbek:

“Please accept this letter as our formal request to enter into negotiations regarding the operation of a retail cannabis store in Atikameksheng Anishnawbek.

“As a First Nation, it is important to us that we regulate and control businesses that operate on Atikameksheng lands. To that end, we would always reserve the right to

control and administratively run those businesses to protect the interests of members of our community.

“It is necessary to point out that we reserve the right to license, as a governing body, those who wish to conduct all businesses, including distribution of cannabis.

“As such, formal approval from the provincial government is not a requirement for us to proceed with this process. Having said that, it is in everyone’s interest that we strive to harmonize rules and regulations between Atikameksheng, its citizens, and the policies and procedures set out by the provincial government.

“It would only be in matters where our interests may diverge that Atikameksheng would seek an independent path. At this stage, we do not foresee such a divergence.

“It is important for us to move forward expeditiously as we wish to ensure that the sale and distribution of cannabis within Atikameksheng lands is properly regulated so as to prevent third-party black market enterprises from establishment in our community.

“As we move forward, we are open to discussions with you to harmonize our processes and policies with those of the provincial government.

“We welcome your suggestions as to how we might best achieve the intended harmonization.”

They copied Minister Vic Fedeli, Minister Greg Rickford, myself, the MP etc.—

The Acting Speaker (M^{me} Lucille Collard): Sorry, I’m just going to interrupt for a second.

We seem to have forgotten the long-standing rule to name people by their riding or their title and not their name. We’re seeing a lot of that on both sides, so this is just a general reminder.

I’ll go back to the member.

M^{me} France Gélinas: No problem, Speaker. Merci.

When you look at schedule 1, if this has to do with First Nations—I can tell you that Atikameksheng Anishnawbek has written to the Ministry of the Attorney General and they have yet to receive an answer, and that was a long time ago that they started this. So if schedule 1 is made to go after First Nations, then I would say to do your homework. When a First Nation takes the time—and this is signed by the chief, and copied to me and to everybody else—please make sure that you treat them with respect and that you answer their letter, so that they can be partners with the provincial government and not have the Cannabis Control Act and schedule 1 go after First Nations communities.

The Acting Speaker (M^{me} Lucille Collard): We’re going to go to questions.

Hon. Michael S. Kerzner: I want to ask the member from Nickel Belt—in her very eloquent remarks, there wasn’t one comment made to echo the urgency on having the federal government move forward with meaningful bail reform. There wasn’t one comment acknowledging that our police services should be thanked for the incredible work they do. There wasn’t one comment to make sure that the violent and repeat offenders are no longer on our streets.

So my question to her is: Why is her party so silent on public safety?

M^{me} France Gélinas: I don’t blame you for not listening to every word that I say, but I started with an eight-minute dissertation on Dan Lee. Dan Lee was an OPP officer, and all of the good that he had done for our community—because we have a very active OPP retired group, as well as a very active OPP volunteers’ group, who do wonderful work throughout our community.

And I thank you for including schedule 6, which I read into the record: “Section 3 is amended to give the minister the power to issue awards related to policing.” I would support this 100%. We have a lot of police sergeants, police officers, who are very deserving of an award. The hard work that they do is not always recognized the way that it should be, and I fully support—I started by saying that I support all of the schedules in this bill. You’re going in the right direction—

The Acting Speaker (M^{me} Lucille Collard): Thank you. We need to go to the next question.

Ms. Chandra Pasma: Thank you to my colleagues from Nickel Belt and Oshawa for their very thoughtful comments on this bill and making sure that the concerns of many people across the province are expressed in this House.

My question is for the member for Oshawa. We know that a former, retired OPP officer, John Tod, who had a 32-year career in the force in the theft division has said that the government really needs to introduce a VIN verification system, that the only way that we’re really going to prevent auto theft is if we have a system to verify vehicle serial numbers before the vehicle is sold. Ontario doesn’t have a system like that right now. I don’t see it anywhere in the bill.

1740

I know that the member has spent time working on this file. Could the member please explain to us what a vehicle identification number verification program would actually do to stop theft in the province and why we should be listening to former OPP officers when they ask for something?

Ms. Jennifer K. French: It’s a layered question, but I think it’s simple: We need to have a preventive VIN verification system. Right now, we have the front lines of ServiceOntario that deal with a whole whack of services, including dealing with VINs and getting them registered. They don’t go out to the parking lot and check physically whether that VIN is legit, and that is what would be required if there were a flag about duplications or partials or questionable VINs.

As it stands now, if they were to have any question—and I don’t even know how that would get flagged—there is no system. There is nothing. There is no investigation. There is no verification.

In other provinces, they have something: this third-party thing. I don’t know if that’s the right fit for here or if it could be in-house. But certainly, listening to law enforcement, former law enforcement, the insurance industry—this government even acknowledges that that’s a

good idea. The former Minister of Transportation did a summary of proposals and a call for feedback, and that was years ago. As far as we can tell, they've done nothing with it, so there's no prevention in this bill.

The Acting Speaker (M^{me} Lucille Collard): I'm going to go to the next question.

Ms. Donna Skelly: Madam Speaker, through you to either of the members from the opposition, I know it is important to challenge government on bills that are brought forward, and I know that the member from Oshawa is concerned about something she perceives in this legislation, which is an inability to flag fraudulent VIN numbers.

But there are a lot of amazing things in this bill that I'm hoping that she would agree she would want to see passed in legislation in Ontario, for example:

- making persons with active reporting requirements ineligible from legally changing their names through the Change of Name Act—I'm assuming that the members would want to support something like that;

- giving police services more tools to monitor sex offenders and investigate sex crimes through Christopher's Law;

- to support terrorism victims by amending the Limitations Act, removing the limitation period;

- protecting children and families by prohibiting the operation of supervised consumption sites within 200 metres of a school, or licensed child care centre or early Ontario family centre; and

- requiring municipalities and local boards to seek provincial approval prior to making or supporting requests for new supervised consumption sites.

My question—

The Acting Speaker (M^{me} Lucille Collard): I'll go to the member for Oshawa to respond.

Ms. Jennifer K. French: I appreciate the question because, to this member's point, this is a bill that has a whole whack of stuff in it. There are nine schedules that deal with very significant issues, or some tinker around the edges, with the exception—and she and I can agree to disagree on schedule 4. I would politely request that this government could remove that schedule so that we could support all of the other schedules.

But how we see the ending of supervised consumption, or consumption and treatment sites—we can disagree on that. Certainly, I think that we have seen thousands of lives that have been saved because of consumption and treatment sites. We are asking that the government take a more compassionate approach, evidence-based, and look at that continuum of care.

The other issues that the member has raised—absolutely, they require attention, and we're supportive and have said that.

The Acting Speaker (M^{me} Lucille Collard): Next question.

Mr. Tom Rakovec: The government talks about listening to police. One of the things that I've talked to government members about and something that the police have talked to me about when it comes to auto theft is

talking to auto manufacturers about things like key fobs and the technology that goes into building these cars and how much more work could be done to make them harder to steal. A lot of the reports—what I hear, when a car is stolen, it's a person who's just sending a signal, someone is picking it up, and it makes the car so much easier.

I think that in a market as big as Ontario, where we purchase new cars all the time—and manufacturers should listen if they want to do business here—it's within this purview of this government to actually reach out to them and talk about the standards we should set to having our cars protected. Do you agree with that?

Ms. Jennifer K. French: I think anything that we can do to protect Ontarians from car theft, from auto theft, is important. I know it's a cat-and-mouse game, that we're dealing with organized crime and that we could come up with a solution today that is already obsolete tomorrow. But if we are not listening to the authorities, if we are not listening and acting as quickly as we can and being involved, then we're missing opportunities.

Establishing a VIN verification system is one piece. The transportation enforcement officers have talked about how many stolen vehicles they have recovered just in Gananoque. There are things going on, and we do have to be flexible and nimble. When it comes to the manufacturers, we should be partnering with everyone who can help us with this problem.

This government always points to the feds, but there are provincial measures that we could put in place today or tomorrow to help curb auto theft.

M. Anthony Leardi: J'aimerais poser une question à la députée de Nickel Belt. Annexe numéro 1 du projet de loi propose d'ajouter une nouvelle interdiction concernant la publicité du cannabis. En bref, ça veut dire que ça va être interdit d'avoir une pub de vente de cannabis si on n'est pas autorisé.

J'invite la députée d'offrir son opinion.

M^{me} France Gélinas: Je suis 100 % d'accord—100 % d'accord. Si vous me demandez, moi, je dirais que je n'en veux pas de promotion de cannabis du tout, du tout. Donc, te dire qu'on n'aurait plus de promotion de cannabis qui est vendu illégalement, absolument, et je vous encourage à aller encore plus loin que ça. Toute la publicité qui est faite avec les enfants, la publicité—la plupart du cannabis est consommé en fumée, qui n'est pas bon pour la santé, qui n'est pas bon pour les poumons. Donc, on veut arrêter la promotion du cannabis. Envoyez fort, vous avez 100 % mon—

La Présidente suppléante (M^{me} Lucille Collard): Merci. Further debate?

Hon. Doug Downey: I'm pleased to rise today also to join the conversation around the Safer Streets, Stronger Communities Act. I'll be sharing my time with the Associate Minister of Small business.

If the bill passes, it will help protect our communities. It will keep the streets safer. It will be a continuation of the important work that we have been doing to achieve those two goals.

Now, Speaker, before I get going, I want to acknowledge the great work of my friend and colleague the Honourable Minister Kerzner, the Solicitor General, along with his staff, who have done tremendous work getting us to this point and leading the charge on the bill. I also want to thank the Minister of Health and her wonderful team, the Minister of Transportation, my seatmate, and of course, the others who—

The Acting Speaker (M^{me} Lucille Collard): I apologize to the Attorney General.

Just a couple minutes ago, I made a warning to use titles or riding names to identify members. I would appreciate if both sides of the House would respect that rule. Thank you very much.

Hon. Doug Downey: Absolutely, Speaker. I've developed some bad habits over my time here. My colleague across the way, the member from Oshawa, has encouraged me to say "Speaker" instead of "Madam" or "Mr. Speaker." I'm trying to—old dog, new tricks.

Now, Speaker, I do want to thank my colleagues, the Solicitor General, the Minister of Health, the Minister of Transportation and others who have helped put this bill together. There are so many good things happening in here. But on top of that are the stakeholders, whether it be our justice partners—in my case, the practising lawyers, the paralegals, the legal professionals and others who have provided very important recommendations. It's all working together that moves us forward, that puts us in a safer Ontario. And that's why the Safer Streets, Stronger Communities Act is such a necessary step to move forward.

One of the items I want to highlight are the Limitations Act changes. It's really important for keeping our communities safe and increasing access to justice for victims of crime to have a vital priority.

1750

Now, Speaker, it has been the focus of many to focus on the rights of criminals. We also think that there is a responsibility side to that. We want to focus on the victims, and we want to focus on the needs of the victims and those in our community who are, if not directly victimized, certainly affected.

The justice system needs to be accessible and responsive to all Ontarians, especially those that need us the most. It is why we are proposing to amend Ontario's Limitations Act to remove the time limits for starting civil actions under the federal Justice for Victims of Terrorism Act. By doing this, victims of terrorism would be able to launch civil lawsuits against terrorists at any time and not feel pressure to do so within a certain time frame.

Before I go any further, I want to explain that under the federal Justice for Victims of Terrorism Act, victims of terrorism can start a lawsuit against the terrorists and their supporters. Under the current law, limitation periods are already suspended if the person starting the lawsuit can't do so within the normal period of time because of a physical, mental or psychological condition. But by making these changes to Ontario's Limitations Act, Ontar-

ians would not have to prove physical or mental hardships in order to delay starting a civil suit.

We can't even imagine, some of us as individuals, the devastating impact it has on both the individual and their communities. By proposing these amendments to the Limitations Act, we are telling victims of terrorism that we are listening to them and we're making the necessary changes that would increase their access to justice. This would also send a clear signal that our government recognizes the serious nature of these crimes and we are doing something about it.

The next piece I want to touch on is protecting Ontarians through combatting the illegal cannabis market. Now, when the federal government began, six years ago, telling us that we would have a cannabis market, it was up to this government to figure out how to manage that. We had three primary principles. The first principle was going after the black market, the second principle was protecting our communities and the third principle was protecting our children. Everything that we have done around the cannabis market touches on those three primary principles.

Now, Speaker, we are providing another tool for police to go after those who are online, marketing and advertising illegal cannabis. I did listen to my colleague from Nickel Belt and concerns around First Nations. This is not a tool focused on First Nations. This is a tool focused on the bad actors in the online space, because it is a little bit of Whac-A-Mole, where they sometimes put up a site and then switch over to another site, and the public is not protected in that unregulated market. So this is a tool for the police to go after them with provincial measures, in addition to the existing tools that are there federally, the Criminal Code and otherwise. We want to go after the advertising and promotion of the sale of illegal cannabis as part of our plan to go after the black market, protecting our communities and looking after our children.

I don't think anybody thinks that we should be ignoring the illegal cannabis market and the bad actors behind it, and I would look forward to my colleagues across the way supporting us on this piece and others.

Now, one more piece in the act has to do with having part-time judges being able to lend their expertise, to use their expertise to help us as we move through the justice system. In a simplistic way, it is like supply teachers, who can come back and supply in the classroom, but only to a certain amount. This allows retired judges to come back and help us, up to a certain amount. As the context changes and as the need changes, this act will allow us to be more flexible to maximize the contribution of very experienced judges who can help with the caseload that we have, the criminal backlog that had developed. And I can tell you, Speaker, that it is an interesting update that we have tackled a great amount of the COVID backlog in criminal cases—nearly 50%, we have tackled, but that's a whole other speech.

I'm watching the clock, Speaker, and I'm going to sit down and let my colleague the Associate Minister of Small Business talk about more parts of this act.

The Acting Speaker (M^{me} Lucille Collard): The Associate Minister of Small Business.

Hon. Nina Tangri: It truly is an honour and a privilege to rise today in support of the Safer Streets, Stronger Communities Act. This proposed legislation represents a significant milestone in our government's ongoing efforts to ensure that everyone in our province feels secure in their community, their workplace and their home.

Safety is the bedrock of prosperity. Without it, our families cannot thrive, our communities cannot grow and our economy cannot flourish. The Safer Streets, Stronger Communities Act addresses pressing safety challenges, empowering law enforcement, protecting our most vulnerable and ensuring that our justice system is effective.

But today, I just really want to start with recognizing and thanking my colleagues in the Ministries of the Solicitor General, Health, Transportation, Public and Business Service Delivery and Procurement, the Attorney General and everyone for their outstanding work. Their dedication to this legislation underscores the importance of the multi-ministry approach to achieving a safer Ontario.

As the Associate Minister of Small Business, I'm especially focused on how this legislation will benefit not just individuals and families but also the backbone of our communities: Ontario's small businesses.

In Ontario, 98% of all companies are small businesses, with fewer than 100 employees. The small business community is over 400,000 strong and employs well over two million people. These enterprises are vital to our province's success, and they deserve a safe environment in which to operate, innovate and contribute to their communities.

The Safer Streets, Stronger Communities Act is a comprehensive and forward-thinking piece of legislation, built around three key pillars:

- (1) Safer streets: introducing targeted measures to enhance highway safety and combat auto theft.
- (2) Safer communities: providing law enforcement with robust tools to monitor offenders and strengthen protections for vulnerable populations.
- (3) A stronger enforcement: streamlining processes within our justice system to ensure accountability and deter criminal activity.

These pillars reflect our government's unwavering commitment to addressing the safety concerns that touch every corner of Ontario. From urban cities like Toronto and Ottawa to smaller towns and rural areas like Mono or Kenora, this legislation will help foster the kind of safe and vibrant communities we all want to see.

At its core, this act achieves several critical outcomes. It strengthens our ability to tackle auto theft and highway safety concerns, which directly impacts businesses that rely on transportation and logistics. Secondly, it enhances the tools available to law enforcement, ensuring they can effectively monitor offenders and prevent future crimes. Finally, it modernizes and streamlines aspects of our justice system, enabling a more efficient response to the complex challenges of today's criminal landscapes.

For small business owners, these changes are not just theoretical; they have concrete, real-world implications. Crime and safety concerns directly affect local economies, influencing everything from consumer confidence and foot traffic to insurance premiums and operational costs.

In closing, before we end this evening, by addressing these issues head-on, we're creating an environment where businesses can focus on what they do best: serving their customers, innovating and growing without the constant threat of crime disrupting their operations.

In my community in Mississauga, we have plazas where we don't want to go in the evening because there's stunt driving taking place, careless driving. This gives the tools to our law enforcement to be able to tackle that head-on, helping those businesses to succeed and thrive. Because quite frankly, when we're not going to visit our small businesses, how can they succeed? It's so important that we collectively help support all of our business communities, our vulnerable citizens, to make sure that we are all there for them. This is what this act is there for. Thank you for your time. Thank you to everyone—

The Acting Speaker (M^{me} Lucille Collard): Thank you to the member for understanding. It is 6 o'clock now and we have to move to private members' public business.

Report continues in volume B.

Legislative
Assembly
of Ontario



Assemblée
législative
de l'Ontario

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Mercredi
20 novembre 2024

Speaker: Honourable Ted Arnott
Clerk: Trevor Day

Président : L'honorable Ted Arnott
Greffier : Trevor Day

REPORTS BY COMMITTEES

STANDING COMMITTEE ON GOVERNMENT AGENCIES

The Speaker (Hon. Ted Arnott): I beg to inform the House that today the Clerk received the report on intended appointments dated November 20, 2024, of the Standing Committee on Government Agencies. Pursuant to standing order 110(f)(9), the report is deemed to be adopted by the House.

Report deemed adopted.

INTRODUCTION OF GOVERNMENT BILLS

CUTTING RED TAPE, BUILDING ONTARIO ACT, 2024 LOI DE 2024 VISANT À RÉDUIRE LES FORMALITÉS ADMINISTRATIVES ET À FAVORISER L'ESSOR DE L'ONTARIO

Mr. Harris moved first reading of the following bill:
Bill 227, An Act to amend various Acts / Projet de loi 227, Loi modifiant diverses lois.

The Speaker (Hon. Ted Arnott): Is it the pleasure of the House that the motion carry? Carried.

First reading agreed to.

The Speaker (Hon. Ted Arnott): Would the minister like to briefly explain his bill?

Hon. Mike Harris: I'll try to be as brief as I can, Mr. Speaker, but I did want to say thank you. The proposed Cutting Red Tape, Building Ontario Act, 2024, part of our broader fall 2024 red tape reduction package, contains proposals from 14 ministries, and it includes 27 schedules. This legislation, if passed, will establish measures to help build a stronger economy, save time, keep costs down and improve service delivery for businesses and the people of Ontario.

If you'll indulge me for a second, as it is my first government bill, being able to introduce that here today, I did want say a huge thank you to my team at the Ministry of Red Tape Reduction in my office and also in our officials' office as well for all the hard work that they've done to put this together. Fourteen different ministries, Speaker—it is not easy, but we are getting it done for the people of Ontario.

PETITIONS

ENVIRONMENTAL PROTECTION

Ms. Sandy Shaw: I have a petition here entitled "Stand Up for Local Conservation Authorities." I would say, just like all our communities across Ontario, people are very concerned about wetlands, and they're concerned about

their natural spaces, and the fact that we are allowing developers to dig, build and excavate without oversight from conservation authorities is a particular concern for people.

I would say now that the very fact that the Royal Botanical Gardens, the RBG, has been forced to lay off 15 employees and the RBG is responsible for such beautiful natural areas that run along Cootes Paradise—it's a protected area, it's a beautiful area, and the fact that now we are losing staff that will help to preserve this, not just for us but for future generations.

So I really think that this is an important petition. We see a government that has made reckless and harmful changes to conservation authorities. We also see this government that has let wetlands move out of protection, has watered down environmental protections and doesn't seem to be concerned, as most people are, with the preservation of our natural green heritage.

I will add my name to this petition, Mr. Speaker, and I'll be happy to pass it to Charlotte to take to the table.

ORDERS OF THE DAY

SAFER STREETS, STRONGER COMMUNITIES ACT, 2024

LOI DE 2024 VISANT À ACCROÎTRE LA SÉCURITÉ DANS LES RUES ET À RENFORCER LES COLLECTIVITÉS

Resuming the debate adjourned on November 20, 2024, on the motion for second reading of the following bill:

Bill 223, An Act to enact two Acts and to amend various Acts with respect to public safety and the justice system / Projet de loi 223, Loi édictant deux lois et modifiant diverses lois relatives à la sécurité publique et au système judiciaire.

The Speaker (Hon. Ted Arnott): Further debate? I recognize the member for Kiiwetinoong.

Mr. Sol Mamakwa: Meegwetch, Speaker.

Remarks in Anishininiimowin.

It's always an honour to be able to stand up for the people of Kiiwetinoong. Kiiwetinoong is a very unique riding. Kiiwetinoong is 294,000 square kilometres, with 31 First Nations and four municipalities. And out of those 31 First Nations, 24 are fly-in First Nations.

I know this government has named this bill the Safer Streets, Stronger Communities Act. I'm not sure how this bill will make the First Nations, will make the communities in the north stronger or safer. Because one of the things that it does is that it ignores the truth. It ignores the evidence—the evidence provided from within the government itself. An example could be safe consumption sites. But also, it disregards the solutions put forward by communities themselves.

There's so much to talk about. We all know this is a wedge bill, and I'm going to talk about that a little bit.

Yesterday, I had leaders, community members, leadership from Netmizaaggamig Nishnaabeg, also known as Pic Mobert First Nation. I want to acknowledge my colleague the Solicitor General, who put the bill forward. When the chief and council—they were right up there; they were in my office—of Netmizaaggamig Nishnaabeg were here at Queen's Park, just yesterday, they declared a state of emergency in their community because of the crisis in public safety, because of the crisis in policing. Mr. Speaker, the situation in their community is dire.

One of the things that happened yesterday too is the Solicitor General, along with the Associate Minister of Mental Health and Addictions, cancelled a meeting with the chief and council—very last minute. And it was unable to be rescheduled for later on yesterday, while the chief and council were still here in Toronto. Just imagine the cost to come to Queen's Park, to come to Toronto, to try to come up with a solution, to work together. And yet we are here today talking about safer and stronger communities.

The leadership of Netmizaaggamig Nishnaabeg pointed out in their press conference that the unsafe situation on the First Nation, on the reserve, would not be accepted or tolerated anywhere off-reserve in Ontario. Anywhere else in the province, the government would already have ensured the community is adequately resourced with police officers to bring the violence and the criminal activities under control.

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Speaker, as First Nations, as reserves, we live under a system of oppression. We live under the systems of colonialism and racism, and what's going on here right today is exactly what's going on.

The leadership is already on their way back to their community.

Again, I say it's not under control in this community, in this reserve, in this First Nation, Netmizaaggamig, where for years they have been experiencing drug trafficking by gangs from Toronto, addictions and mental health struggles, sex trafficking. But the police presence is still almost non-existent. For example, a young man was beaten and held at gunpoint. A call to emergency responders for help was not responded to for four hours—four hours.

Netmizaaggamig Nishnaabeg knows the solutions to the public safety crisis in their own community, in their own reserve, in their own First Nation, but they need more resources if they're going to implement these solutions themselves. What they are asking for is accountability in policing, in justice and for local laws to be enforced quickly and consistently to curb the intense organized crime and violence. One of the things that they're asking for is they're asking for improved funding for mental health services in the community. For example, they need to see greater investment in local detox, treatment and aftercare.

All in all, all they're asking for is to be treated equitably. This government of Ontario needs to stop having different standards for safety. Pic Mobert First Nation—Netmizaaggamig Nishnaabeg—and all First

Nations, for that matter—that they have other parts in Ontario.

You have to remember, as well, this Bill 223 makes amendments to the Community Safety and Policing Act. This is the same Community Safety and Policing Act that the Chiefs of Ontario are bringing the government to court over because the act says, "Adequate and effective policing does not include,

"(a) the enforcement of municipal or First Nation bylaws, other than prescribed bylaws."

The Canadian Human Rights Commission has described discrimination as "an action or a decision that treats a person or a group unfairly or negatively for reasons such as their race, age or disability."

There's no question about this. The deliberate and the explicit exclusion of First Nation laws from being enforced under the Community Safety and Policing Act is discriminatory and needs to be changed to ensure that First Nations laws are respected and acknowledged—not only that, that they are enforced.

I want to jump onto something else. The Minister of Health stated, very clearly, "There will be no further safe injection sites in the province of Ontario under our government."

Speaker, Ms. Mskwaasin Agnew is a member of Toronto Indigenous Harm Reduction who told CBC News, "Harm reduction is sacred and it is an integral part of the health and well-being of many Indigenous people's lives." Regarding the closures of supervised consumption spaces, Ms. Agnew said, "We will see an overrepresentation of Indigenous people paying the price."

Speaker, one of the 10 safe drug consumption sites that this province is forcing to close is in Thunder Bay. It is called Path 525, and it's operated by the NorWest Community Health Centres. Path 525 is only the safe consumption site in Thunder Bay. There will be no alternative space when it's forced to close. That's probably the only one in northwestern Ontario.

Vanessa Tookenay, a member of the Fort William First Nation who is now in recovery, told CBC's Sarah Law that, in the past, she overdosed a couple of times at Path 525, and then this is what she said: "Had I not been there, I wouldn't be alive." These are her words.

Speaker, an internal document from this very government's staff flags that limiting access to harm reduction and overdose prevention services has a high risk of having a high number of negative impacts, including death.

I want to talk about where the bill talks about the Sex Offender Registry. I want to talk about some of the issues that we face in northwestern Ontario. Every now and then, I'll bring up a former OPP officer, a former Anglican minister and a former Boy Scout leader who is living today. His name is Ralph Rowe. He is one of the most prolific pedophiles in Canada. Where I come from, he abused over 500 boys—where I come from. I know this bill, but he's still out walking. He's still living. He hasn't changed his name. It talks about addressing the Sex Offender Registry, and it has an impact. One of the biggest

causes in Kiiwetinoong of mental health struggles and intergenerational trauma is because of this man. I know this government likes to talk big about being tough on crime, but still, one of the biggest criminals in Ontario is still walking freely.

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I want to know, why is Ralph Rowe still free? Why doesn't Canada, why doesn't Ontario know about Ralph Rowe and the crimes he committed against young First Nations men, children in the north as young as five years old? At that time—in the 1970s, in the 1980s—Ralph Rowe was a trusted person. As I said before, he had positions of authority with the Boy Scouts, the Anglican church, OPP. And he had a float plane, a ski plane. He had full access. All these institutions were complicit in what happened in northern Ontario.

In 1994, Ralph Rowe struck a plea agreement with the crown in that there are certain crimes that the crown can be prevented from seeking additional imprisonment for if they occurred in the 1970s and 1980s. Some crimes were even more serious than the ones from the plea agreement. He was sentenced to three years in 2007, and subsequently to a concurrent year in 2009. In 2012, he served a two-year conditional sentence under house arrest after making a guilty plea. In October 2023, the court approved a \$13-million settlement in a class action lawsuit against Scouts Canada, the Anglican Diocese of Kiiwetinoong and Ralph Rowe.

I'm going to quote this gentleman: "My heart and soul screamed out in agony, crying, so lonely, scared, sick, trembling in pain." These are the words of John Fox, one of the survivors of Ralph Rowe. When I went to see him last month, he talked about the terrible impacts of Ralph Rowe's abuse on his life, on his mental health and the choices that he made.

For a time, John sold drugs, alcohol, weed—whatever he can do. That's what he told me. And this is what he said to me: "I was just thinking, well," eff "you God, you want to do this? Then fine. And I wanted to hurt God. So how do you hurt God? You hurt his people." And that's why he sold drugs for 20 years, sold booze. But today, John is in a good place. He's doing much better.

Ralph Rowe took so much from so many people with his crimes. One of the things John Fox said is, "I have seen so many poor"—where is the justice for the survivors of Ralph Rowe, for their families? This is all I have to say about 223 today. Meegwetch.

The Acting Speaker (Mr. Tom Rakocvic): Questions?

Mrs. Robin Martin: Thank you to the member for his comments. Certainly, we all are concerned about how to deal with these very, very challenging issues that are everywhere in society and how to help people best.

I think the difference is, we have maybe different views of what the priority should be. Having seen what happened at the South Riverdale Community Health Centre, Peter Tabuns said the shooting there caused people to question the presence of the site for drug users, and many people fear that the presence of the site attracts drug dealers. This

was before the arrest of an employee at that site for their alleged involvement with drug dealing.

My question is: Do you understand the concerns that your colleague Peter Tabuns has for his constituents and the concerns that people have for children and ordinary people just walking by a site?

Mr. Sol Mamakwa: When we talk about Ontario, Ontario is a very big place. The only time I come to Toronto is—I go to my apartment, I go to Queen's Park and that's it. I don't spend much time with what's going on here.

But there's a lot of stuff happening in northern Ontario, in the riding of Kiiwetinoong. As I mentioned, I represent four municipalities. I represent 31 First Nations. Out of those 31 First Nations, 24 of those First Nations are fly-in First Nations. The amount of drugs, the amount of suicides that I see—I think the youngest funeral of a girl that died by suicide was 11 years old. That's the reality in the north; that's the reality in Kiiwetinoong. I think sometimes the people who make the decisions here do not understand who we are in the north. Meegwetch.

The Acting Speaker (Mr. Tom Rakocvic): The member for Hamilton West—Ancaster—Dundas.

Ms. Sandy Shaw: I want to thank the member from Kiiwetinoong. Time and time again, we have all sat here and watched as he brings truth to this House, and time and time again, we have seen the government make the choice to ignore these difficult truths.

He is representing his people, who only want what we would all want, which is fair, equitable and just treatment. The fact that there was leadership here from the Anishinabek, and the minister of mental health and addictions and the Solicitor General chose to snub them and to turn their backs, is shameful.

Now that this member has shared with all of us the horrific crimes of Ralph Rowe, I want to know, through the member: What is this government going to do to set these intergenerational harms and traumas right?

Mr. Sol Mamakwa: Meegwetch to the member, my colleague, for the question. I think in one of their statements specifically for Pic Mobert First Nation, they had specific requests. I think the policing approach would not work. They have a different-tier approach to policing, and that's what they're asking for. They're asking for mental health services.

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Again, I've been here about six and a half years or so, and I bring the stories of what's going on in Kiiwetinoong. I bring the truth of what's going on in Kiiwetinoong. There are just far too many needless deaths and unnecessary suffering that is happening. We need to come together. At least hear us, at least hear the people who are crying for help in the north, not just the people that are your people, not just the ridings that are blue. We are people too.

The Deputy Speaker (Ms. Donna Skelly): Further questions?

Mr. Andrew Dowie: I want to thank the member opposite for his comments on the bill and the consequences of such. I had in my region, as well, a

consumption treatment site that closed. Even though I did have a chance to speak to so many involved, I'm trying to reconcile how the cycle of addiction is broken by the supply of drug paraphernalia and a location in which to consume. How do you separate the drug from the user so they can pursue a path to recovery? I'm hoping the member opposite might be able to share how that's achieved through this consumption treatment site.

Mr. Sol Mamakwa: Meegwetch to the member opposite for the question. Sometimes we try to deal with issues downstream. Sometimes it's so much better to address things in an upstream way, like why are people doing drugs. In our community, there is so much intergenerational trauma. I just spoke about the Ralph Rowe intergenerational trauma, where this Anglican minister, this supposed Cub leader, this former OPP officer—who was a white man who had a float plane or a ski plane to access all these First Nations in northern Ontario, who abused over 500 boys in the north. We lost a lot of them and we still continue to live that from the intergenerational trauma. What it leads to is the addictions, the mental health. I think, again, we need to go back to upstream solutions.

The Deputy Speaker (Ms. Donna Skelly): Questions?

Mr. Joel Harden: I want to thank the member from Kiiwetinoong as well. I agree with what the member from Hamilton West—Ancaster—Dundas said. There is profound truth you always bring.

But something I feel that many people don't recognize in respect to you, which I do and I know members of our caucus do, is that you were a professional health promoter before you came here. I'm thinking about victims' services and I'm thinking of the lack of support in this particular bill to offer resources to the north, to Indigenous communities. I'm thinking about the children who are brought to my city, dislocated from their communities, who suffer and, in the most tragic instances, decide to take their own lives.

I'm wondering if you have advice for the government about how the bill could be amended so those upstream resources could be invested in Kiiwetinoong, so youth and their families could have hope?

Mr. Sol Mamakwa: Before I became an MPP, I did a lot of health policy work with the Nishnawbe Aski Nation, which represents the 49 First Nations in northern Ontario. When we talk about safety, when we talk about adding what needs to be able to say—I think health transformation in northern Ontario needs to happen. Before the arrival of the settlers, as First Nations people, as the first peoples of these lands, we always had our health system. We never had hospitals. I think that's one of the things: We need to be able to bring services closer to home, whether it's health care—when we talk about these health services, when we talk about mental health.

One of my goals when I was a health adviser, I wanted to eliminate suicide in Nishnawbe Aski Nation territory. I didn't want to just cut 20%. I wanted to eliminate suicide in NAN territory, even if it took 50 years, if it took 100 years. But that was always the goal. Meegwetch.

The Deputy Speaker (Ms. Donna Skelly): We don't have time for further questions.

We'll now move on to further debate.

Ms. Aislinn Clancy: I'm happy to be here today to speak to you a bit about my thoughts about the current bill. I will focus on the CTS part of the legislation.

A CTS site exists in my riding. The community came together—city, health care providers, community—to put that in place with support of the daycare centre across the street.

I'm here to share with you today that my community resoundingly continues to support the CTS being there. The city of Kitchener passed two motions, with regional council, labour organizations, health care, medical staff, the child care centre across the way, faith communities, citizens, neighbours, students from university all coming together with unanimous support for the CTS site in my community.

Yes, we need these HART hubs. I appreciate the additional funding. I think we can all agree, across all parties, that addiction treatment funding and mental health treatment funding is needed. We need that more than ever. But not at the expense of harm reduction, which is statistically and evidence-based shown to save lives.

Some 22,000 people have died from an opioid or drug overdose since this government came into office. One death in every two and a half days takes place in my community. It is not because of this drug policy. At our CTS site, zero deaths have taken place. So I ask this government if they could please start by following the advice of, "Not about us without us."

In this document, I don't see evidence—and I don't see the voices of the people working on the front lines. Just the other day, the Working Centre had me over. They had outreach workers around the table. They were sobbing, they were broken. These are front-line workers who are burnt out. They are falling apart. They remember the times during COVID when people were dying at record pace from overdoses and they say, "I can't go back there."

I had a young woman—she's in her twenties, she had her shirt on saying, "November comes at the same time every year," because that's about it being cold and not having enough shelter beds. She said, "I can't go back there. I can't go back there where more and more of my clients die."

Imagine you all as nurses, business owners, see all your customers die. So imagine as a family member, we see people—maybe those in our family have gotten a diagnosis. Maybe they got a cancer diagnosis that says, "You're stage 4; you have a few months to live." Imagine our own government giving thousands of people that news, that on March 31, you will die.

Unfortunately, folks who use drugs come forward and say, "Aislinn, I will be dead on April 1." How do I sit with someone in my constituency office with that news, that they face death because this is life-saving health care that is being removed from them?

This, we know, is kind of a bit of smoke and mirrors for the fact that we are failing on housing. We know that

housing is health care. More and more, when I dig into why we're facing this opioid crisis—we know there has been a massive amount of evidence that talks about the pharmaceutical companies that are enriching themselves for decades now, benefiting and profiteering off of these addictions that have been created from well-meaning, working Ontarians.

We need to start pointing the finger in the right direction. We need to be providing the supports like housing, which we know is health care. If you spend one week without shelter, we know that your well-being goes into the garbage. Quickly, your mental health deteriorates and you run the risk of exacerbating your addictions or having addictions. So it's important that we recognize the need for housing.

Even at the University Health Network they saw this: 55 of their patients were responsible for 4,000 hospital visits. Think of that—it's staggering. Now, they see that they provide supportive housing to those 55 individuals to alleviate the pressure on our health care system. I think we need to heed the warnings that we run the high risk—by reducing access to harm reduction and overdose support, it will result in increased emergency department visits, health impacts, overdose and death.

We know Indigenous, Black and low-income individuals may be more adversely impacted as they face higher barriers to health care, and for Indigenous populations, disproportionately higher rates of opioid-related deaths.

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So we need to look at health care being for every individual, and if folks aren't getting the health care they need, we need to ask why. Instead of kicking out the rungs on the ladder that lead people to thrive, we need to be building more rungs on the ladder to ensure every single person has access to a better life in Ontario.

The Deputy Speaker (Ms. Donna Skelly): It's now time for questions.

Ms. Laura Smith: I listened to the member opposite talking about different steps. One of the things that this bill recognizes, that these offenders under Christopher's Law—these heinous individuals who commit crimes against children so terrible that I can't repeat them—they also go on to make application to change their name and hide their identity and go back into the communities.

I was just wondering if the member thinks that this legislation is positive, given these are positive steps to stop these offenders from making application to change their name.

Ms. Aislinn Clancy: Thank you for the question. Of course, this is an important step, but I will remind the government that prevention is better. We want to prevent someone from being sexually abused as a child.

In Ontario, I know of—this is just what I know of—three federal programs and one provincial program that are funded to reduce people's recidivism. They're data-proven programs like circles of support that ensure that offenders don't reoffend. They have no funding. They no longer exist. If we truly want to protect the vulnerable from being offended sexually, from being abused sexually,

we need to ensure that all four of these programs are funded again and we ensure that every—whether they're young, adult, convicted or not—get the help they need to ensure they no longer are at risk of offending and abusing a young child sexually.

The Deputy Speaker (Ms. Donna Skelly): Further questions?

Ms. Sandy Shaw: To the MPP for Kitchener Centre: I want to share that we on this side of the House—that bill—protecting children from sexual predators, it makes sense. So much of this, almost all of this bill, makes sense, but why have they put in this bill schedule 4, which essentially withdraws any kind of treatment for people? My sense is that this government doesn't understand that these people seeking treatment, they're professionals, they're our mothers, they're brothers, like the member Windsor West talked about, who are suffering from pain from an accident.

So we feel that this bill is supportable but that they should withdraw schedule 4 and have a whole rethink on this, because the harm that they are doing, the deaths that we are going to see—I don't think they understand the damage that they're causing by withdrawing any kind of treatment for people.

Ms. Aislinn Clancy: I think it's unfortunately a political strategy. I hate that we politicize people's lives. I want to work across party lines with every party in this House. I believe that there are good people all across, and I know that this is hard to hear, because I know that maybe many in the government don't want to see people die. I know they don't want to see people come into harm's way. I think you're caring individuals that care for people's families, care for good health care. I believe in you, and I'm hoping you'll stand up for that, because I don't like to feel so divided, and I don't like creating a bill that puts us in a place that says we support something that encourages sex abuse. That's just an awful thing to say about anyone in this House.

So I don't like these things being put together. I think it was a tactic, and I don't think we should be playing politics with people's lives.

The Deputy Speaker (Ms. Donna Skelly): Further questions?

Mrs. Robin Martin: Thank you to the member for her comment. I can say that I'm pretty certain that everyone in this House cares about the lives of Ontarians and Ontarians who are struggling, and wants to find the best solutions.

In my former role as parliamentary assistant to the Minister of Health, we had started with a new kind of consumption treatment site focused on treatment, and the issue, I was told by the experts, was that you have to come to a consumption site every time—that's the only way you get saved there—and that the average patient needs to use it four or six times a day and only comes to the consumption site once. So how is that protecting people?

Ms. Aislinn Clancy: Because I have talked to the people who work there and I've talked to the people who use the sites—they tell me that this saves their lives, and the data says that. I live in this neighbourhood. These are

my neighbours. Before the site came into place, I found needles on my street. Since then, the peer support workers, because they respect their neighbours, scour throughout the community. I'm worried that that daycare centre across the street is going to find dead bodies and needles. Those don't happen right now.

So, with all due respect, I agree we need more investment in addictions and mental health supports, wholeheartedly, but I think the data and the people I spoke to that use these sites—

The Deputy Speaker (Ms. Donna Skelly): It's now time for further debate.

Mr. Steve Pinsonneault: It is a privilege to rise today as a member of provincial Parliament for Lambton–Kent–Middlesex, representing a vibrant and resilient rural community. In my capacity as parliamentary assistant to the Minister of Rural Affairs, I have the honour of bringing forward the concerns, values and priorities of rural Ontario to this esteemed chamber.

Today, I'm here to speak about the Safer Streets, Stronger Communities Act. This legislation amplifies the principles that guide our government: the pursuit of safer communities, robust economic systems and an enhanced quality of life for every resident in Ontario. This bill is comprehensive in its scope and bold in its vision. It addresses critical issues, including auto theft, reckless driving, fraud prevention and regulation of commercial vehicles, all while ensuring that Ontario's rural and urban residents alike benefit from the result of improvements in public safety.

Public safety is not a luxury; it is a necessity. It is the bedrock upon which communities, whether urban or rural, thrive. For more rural communities like those in Lambton–Kent–Middlesex, safety takes on a special significance. In these communities, where distances between neighbours can be measured in kilometres and access to emergency services can take longer than in urban areas, safety measures must be both proactive and practical.

The Safer Streets, Stronger Communities Act recognizes these unique needs and ensures that rural Ontario is not just included in the conversation but is at the forefront of it. This bill is not merely about enforcing laws. It is about creating an environment where families feel secure, where businesses can operate without fear and where communities can grow stronger.

One of the most pressing issues this legislation tackles is auto theft, a crime that is not only disruptive but deeply personal. For rural Ontarians, a vehicle is often much more than a mode of transportation. It is a vital tool for daily life. It is commuting to work, taking a loved one to a medical appointment, transporting goods or tending to farm duties. Losing a vehicle could mean losing one's livelihood, an impact far beyond the individual.

Auto theft has become increasingly sophisticated, often tied to organized crime networks that exploit loopholes in existing systems. One prevalent method is VIN fraud, where criminals steal the vehicle identification numbers from legitimate vehicles and use them to disguise stolen ones. This not only deceives buyers but undermines the integrity of our entire vehicle registration system.

To combat this, the Safer Streets, Stronger Communities Act introduces a new provincial offence for knowingly providing a false VIN during a transaction with the Ministry of Transportation. The penalties for this offence are intentionally severe, ranging from \$50,000 to \$75,000 for a first conviction and escalating to \$100,000 for repeat offenders. These fines are complemented by potential jail time of up to six months and the suspension of driving privileges for up to a year.

For rural residents, these measures are a welcome assurance that their vehicles and, by extension, their livelihoods are being protected. It is a decisive step towards restoring public confidence in our system, ensuring that criminals are held accountable for their actions.

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While penalties are important, prevention is equally as critical. Our government is investing in advanced technologies and operational safeguards to close the gaps that criminals exploit. The Ministry of Transportation has implemented VIN verification software, a tool that automatically cross-references vehicle information against secure databases to detect irregularities. This technology ensures that fraudulent transactions are identified and stopped before they can cause harm.

ServiceOntario has also enhanced its fraud prevention protocols. Identity verification processes have been strengthened, and transaction data is now monitored more rigorously to flag abnormalities. These measures are especially significant for rural residents who rely on ServiceOntario for essential services. By ensuring that these services are secure, we are protecting individuals and communities from the far-reaching impacts of fraud.

These are excellent and welcome additions by the Minister of Transportation, Prab Sarkaria, and Minister of Public and Business Service Delivery and Procurement, Todd McCarthy. Thank you for these important changes.

Madam Speaker, auto theft is rarely an isolated incident. It is often part of a larger web of organized crime that includes drug trafficking, gun violence and human exploitation. Recognizing this, our government has adopted a holistic approach to dismantling these networks.

Through the Guns, Gangs and Violence Reduction Strategy, we have allocated over \$358 million to combat organized crime. A portion of these funds is directed specifically towards tackling auto theft, with \$51 million dedicated to initiatives like the OPP provincial auto theft and towing team, or PATT, for short. This specialized unit collaborates with municipal police forces to target and dismantle organized crime networks responsible for auto thefts.

In addition, Ontario's major-auto-theft prosecution response team provides law enforcement with the resources needed to build strong cases against offenders. By ensuring that these cases are prepared and prosecuted effectively, we are not just addressing symptoms but attacking the root causes of crime. For rural communities, where law enforcement resources are often stretched thin, these initiatives provide critical support. They ensure that rural residents are not left vulnerable to the ripple effects of organized crime.

Another cornerstone of the Safer Streets, Stronger Communities Act is focusing on reckless and careless driving. Preliminary data from 2023 highlights a concerning trend: 14 fatalities and over 1,200 personal injury collisions occurred in parking lots across Ontario. These spaces, often considered low-risk, have become hotbeds for dangerous behaviours like street racing and unsanctioned car rallies.

The legislation expands the scope of careless driving laws to include private parking lots. This change empowers police to address reckless driving behaviour in these areas, protecting not only drivers but also pedestrians and other road users. For rural communities, where parking lots often double as social and commercial hubs, this change is particularly impactful.

Additionally, this bill extends the limitation period for laying charges in cases of careless driving from six months to two years. This allows law enforcement more time to conduct thorough investigations, gather evidence and ensure that justice is served.

Safeguarding our families—responsible zoning for supervised consumption sites: The safety and well-being of children and families remain a top priority for this government. The Safer Streets, Stronger Communities Act introduces zoning restrictions that prevent supervised consumption sites from operating within 200 metres of schools, child care centres and family hubs. This policy responds to the concerns of parents and communities, while maintaining a commitment to addressing addiction through evidence-based solutions.

I know myself, as a father, it would have brought me great concern if I took my children to a school where there were supervised consumption sites next door. Existing sites within these zones can be transitioned into HART hubs, which provide comprehensive care and treatment. This balanced approach ensures community safety and public health are both prioritized.

For rural families, these measures provide a sense of security, knowing that their children's environments remain safe and focused on their well-being. Those that need care will be able to access services they need, and the community will feel safer at the same time.

Rural Ontario depends on heavy commercial vehicles. From transporting agricultural products to delivering goods, trucking is a lifeline for rural communities. However, the increase in commercial vehicle traffic brings with it significant safety challenges. The Safer Streets, Stronger Communities Act strengthens the oversight of the commercial vehicle operator's registration, or CVOR, program. It gives the Ministry of Transportation more authority to intervene early when the operators demonstrate unsafe behaviour. Introducing administrative penalties and legislation ensures that violations are addressed swiftly, reducing the burden on the court system. These measures not only enhance road safety but also support the long-term sustainability of rural economies by ensuring that commercial operators meet high safety standards.

We are investing in driver training and testing. Proper training is the foundation of road safety. Ontario was the

first jurisdiction in North America to implement mandatory entry-level training for commercial drivers. This program sets high standards for driver education, ensuring that individuals have the skill and knowledge they need to operate large vehicles safely. Our government is now working with the industry stakeholders to update these training requirements, reflecting the evolving needs of the trucking sector. These updates will further enhance safety standards while supporting the economic vitality of rural Ontario, where trucking is a key industry.

Empowering communities through collaboration: Madam Speaker, legislation alone cannot solve all the problems. Effective implementation requires collaboration among government, law enforcement and the communities. The Safer Streets, Stronger Communities Act reflects this by understanding and including provisions that empower local police, improve inter-agency coordination and engage residents in safety initiatives.

For rural Ontario, this collaborative approach is especially meaningful. I heard in our rural consultations the importance of sharing best practices and working together. It ensures that residents have a voice in shaping safety measures and that local concerns are addressed. By working together, we can build communities where everyone feels safe and secure.

In closing, the Safer Streets, Stronger Communities Act represents a bold step forward in our government's commitment to public safety. It is a comprehensive and thoughtful response to the challenges facing our province, from auto theft and careless driving to fraud prevention and commercial oversight.

For rural Ontario, this legislation is a positive step forward. It addresses unique challenges faced by rural residents, protects their livelihoods, and ensures that their communities remain safe and vibrant.

I want to thank again the ministers involved in this legislation for taking the multi-sector approach to these pressing issues. As a representative for Lambton-Kent-Middlesex, I am proud to support this bill and the vision it represents. Together, let's build a safer, stronger Ontario, one where every resident, regardless of where they live, can thrive.

1400

The Deputy Speaker (Ms. Donna Skelly): It is now time for questions.

Ms. Laura Smith: Thanks to the member for his really quite elaborate conversation on all of these topics, because there's so much to hit on with this bill being so encompassing.

He talked about being a father and the benefits that this legislation, if passed, will have on families and particularly schools, and he talked about the 200-metre buffer zone on consumption sites. Could the member opposite please talk about how this will make things a little safer around schools and daycare centres for those locations that do have these sites?

Mr. Steve Pinsonneault: Thank you to the member. Honestly, as a father, I would have serious concerns of a young child going to a site that's next to the school. I have

spoken to a lot of families in my riding; they share the same concern. There's a time and a place for everything. This is not the place.

I just think, if this bill passes, you're going to see a sense of relief where parents, myself included, can feel safer about their child going to school. They're not going to worry about what happens in these sites. I think this bill is going to make my riding and myself personally and the parents I represent feel safer.

The Deputy Speaker (Ms. Donna Skelly): Questions?

Mr. Jeff Burch: I thank my friend from Lambton–Kent–Middlesex for his comments. Look, our health care system is in crisis. We have millions of people without family doctors. We have emergency rooms, like in my community, that are closing. I understand the argument about proximity to daycares and schools, but here we have legislation that takes away yet another health care service, one that a lot of people are dependent on for their lives, but it replaces it with nothing. Bringing forward a piece of legislation like this, don't you think it's the government's responsibility to replace it with something since you're taking yet another health care service away from people who desperately need it?

Mr. Steve Pinsonneault: What we are doing is creating a safer place for our daycares; a safer place for our schools. These existing sites are going to be transitioned into the HART hubs. This bill is dealing with safety. We will be transitioning these into the HART hubs, and that should suffice for that.

The Deputy Speaker (Ms. Donna Skelly): Further questions?

Mr. Robert Bailey: I'd like to ask the honourable member from Lambton–Kent–Middlesex, my neighbour, in addition to what is proposed in this legislation, what else is the government doing to continue to prevent auto car theft?

Mr. Steve Pinsonneault: We have taken auto theft seriously. I don't care where you go in Ontario; it affects everybody. The government is increasing the offences. They're making the fines higher. They're adding in jail time. We're investing \$51 million just into auto theft, realizing that we do have a problem there. We're organizing crime networks to put thieves behind bars: the creation of the Ontario theft and towing team by the Ontario Provincial Police and a new community safety grant that targets this exact problem.

We're going to work on preventing auto theft. This bill pushes towards that.

The Deputy Speaker (Ms. Donna Skelly): Further questions?

Ms. Sandy Shaw: I'm glad we're talking about auto thefts, because no one wants to see auto thefts in the province. I had my Crown Vic stolen. It's a cop car, so it's surprising to me that it would be stolen, but it was.

But what you're doing here is after the fact. These are provisions that are after a crime has occurred. We've had the member from Oshawa, Jennifer French, say time and time again that VIN fraud is occurring all across the province. In fact, 59 arrests and 302 charges were laid after

phony VINs were being issued by employees at Service-Ontario. So why has this bill completely ignored the preventive measure to make sure VIN fraud does not occur, so that stolen vehicles can't be re-VINed?

Mr. Steve Pinsonneault: By putting stiffer penalties in place, that is going to deter auto theft. Honestly, we are spending money into this. We understand a lot of it is organized. We understand that it is an issue right across the province. We are investing 51 million bucks into it to recognize that it is a problem.

But this bill will deter auto theft. This bill will make it so that people, when they do six months behind bars, will think the next time about whether they want to steal a car or not. The auto rings are the ones that we're going after, and this will have a ripple effect. This bill will be effective.

The Deputy Speaker (Ms. Donna Skelly): Further questions?

Mrs. Robin Martin: Thank you to my colleague the member from Lambton–Kent–Middlesex for your comments. This bill is really about public safety. We had the Police Association of Ontario here today, so I'm just wondering if you've had any discussions with police officers or the Police Association of Ontario and if you have any thoughts on what the police think of the changes proposed in this bill.

Mr. Steve Pinsonneault: Thank you. My partner's brother is an OPP officer, and he does think these are positive changes. We are making it easier for them to do their job. They are able to enforce what is going on.

Let's face it: It's been a wild ride to this point with auto theft and it has been getting worse. We are putting the right tools in place. We are giving authority to the right people, and at the end of the day, we are going to fix this problem.

The Deputy Speaker (Ms. Donna Skelly): Further questions?

Mr. Joel Harden: To my friend from Lambton–Kent–Middlesex: Thank you for your comments. I want to provide a thought on a pilot in our community and get your reaction to the thought. The Ottawa police have been working with community health centres and with small businesses. Particularly it started in the market in the downtown area, if you're familiar with that: the ByWard Market.

What they have been trying to do is identify leaders who are in the drug-user community to help restore a kind of social order and social compact with small businesses. As those neighbours—and they are neighbours; they live in my city too—are struggling with their addiction issues, they actually can respect someone from within their community. And the police officers are saying to the small business owners, to the elected officials like me, “We have to find a way to reach people to persuade them to take a path of wellness.”

This is one measure, a pilot measure. It's called the Block Leaders program, where these folks from within the drug-user community—folks who use drugs—are tapped as leaders and empowered to try to help people not cause disturbances, to engage in social behaviour. I'm wondering what you think about that, as a pilot idea.

Mr. Steve Pinsonneault: Honestly, I'm not familiar with that particular pilot project you're talking about. I do know in several communities within my riding they have the community watch program, which is in itself quite effective.

To answer your question, I'm not familiar with that and I'd honestly have to do some research before I could really give you an opinion.

The Deputy Speaker (Ms. Donna Skelly): That's all the time we have for questions and answers. We're going to move on to further debate.

Miss Monique Taylor: I'm always honoured to take my space, to stand in this Legislature, to be able to add voice and hopefully some reason to bills that come before us. Today is the Safer Streets, Stronger Community Act that is before us. There are several schedules within this bill that talk about public safety, that talk about policing. There's some good stuff in there, stuff that we would improve for sure, as you've heard. Our critic for transportation, the member for Oshawa, has put forward several thoughts and ideas that could have improved this bill. Unfortunately, the government didn't see it necessary to act on that.

1410

But the part that I am going to focus on today is schedule 4, talking about safe consumption sites, the removal of them from our community, Speaker—as you are from Hamilton also, as well as the member from Hamilton West—Ancaster—Dundas—and what that does to our communities. Because, let's face it, people who use drugs in our communities are people too. They are our parents; they are our brothers and sisters, our cousins, our neighbours. There are probably not many people who can actually say that they don't know somebody who has used drugs or has become an addict and fallen to the awful addictions that we see in our community.

We don't have to go far in our community to see people suffering from addictions on our streets. And, unfortunately, we are seeing our streets be more unsafe. We see our neighbours scared to go to some parts of our communities and our neighbourhoods. We see needles in our parks. We see a community that we just don't recognize any longer. But the portion, schedule 4, that is within this bill that will remove all consumption sites from our city—we only have one. We had another one in—the Minister of Sport is here, also another member from Hamilton.

This move is not going to help solve the problem, unfortunately. I wish there would be a day in our community where we wouldn't need these sites, but we do need sites. We do need the opportunity to save people who want to be saved while they're using drugs that they're addicted to. Nobody grows up as a child and says, "I want to be an addict." It's something that happens through prescription medications. It's something that, possibly, many homeless people are facing in our community. They possibly may not have been drug-addicted before they were homeless, but they find themselves using narcotics and using drugs to either stay awake and not fall asleep for their own safety, or they're taking drugs on the opposite

end of the spectrum: to sleep through this time in their life. And it becomes a terrible situation.

My heart breaks when I see people on our streets who you can clearly tell are under the influence. I spend many a time on the street with our Social Navigator Program, talking to people, building relationships with people, trying to understand how they got to that position. And none of it is pretty. None of it comes from a good-news story. They have fallen through the cracks somewhere at some point of their lives, to have found their way to a narcotic, and that narcotic has taken over their lives.

So, as a government, as legislators, as leaders in our communities, we should be finding every possible solution to help that person through that scenario. Not everybody is ready for recovery. Not everybody recognizes the fact that they need recovery. But when we don't have the available option when that person is ready for recovery, then we are failing way before any of this schedule could help or not help.

People need access to detox and to rehabs, first and foremost. People need access to safe, affordable homes. People need access to family doctors. People need access to mental health care. All of these things, and lack thereof, lead people to a place where they don't want to be. Let's face it. And are there folks out there who found their way to drugs through a party? Sure. Absolutely that's happened. But at that party, they probably weren't expecting the fact that they would be next on the street, barely being able to keep their clothes on or barely being able to stand up straight and not being able to walk a line and finding themselves using these awful narcotics. Their parents can't do anything about it while they're watching their loved ones on the street or finding themselves in jails because they're stealing or they're doing criminal offences to find that next drug. This is the reality of what real people in our community are facing.

To take away a place of safety that someone has made a conscious decision to enter—they're not in the park leaving their needles and pipes; they're in a safe place with health care officials who will ensure that they're not going to die. This is what is being removed with this schedule.

This is not a way forward. This does not fix the addictions in our community. Not one stitch of this will fix it; it will actually make our communities less safe. We're going to find more paraphernalia in parks. We're going to find more paraphernalia in the bus stops. We are going to find more people overdosing literally on our sidewalks.

Our paramedics are already busy, our police are already busy—and they're here today. They're going to be running, trying to save that person's life. Are they going to make it on time? Where are our health care systems going to be?

What is this lack of good judgment, I have to say, going to do for the finances that the Conservatives seem to think about instead of worrying about the health and the true life of our constituents? That is the concern, and that is why this schedule should be removed from this bill.

This bill is about safer streets, stronger communities. Safer streets and stronger communities are not going to

happen when we remove safe consumption sites in our community. It's not going to happen; it's going to make it worse. If you don't believe that it's actually going to make it worse, then you're not paying attention.

More people will die. More people will be in ambulances. More police will have to attend the site. More families will be at gravesites saying goodbye to their loved ones that they desperately wanted to help and didn't have the tools to do so.

That is not the direction that I'm sure anyone in this Legislature wants. That cannot be the direction that anyone in this Legislature wants for their community or for their own family members, because I'm sure there has got to be a family member somewhere on the government side who is affected by drugs.

Let's talk about a mom who goes to work every day. She's functioning. Many people who have drug addictions are functionable. They're not all on the streets. They're not all presenting in that sort yet, possibly—and hopefully never are.

She's coming home from work or he's coming home from work—mom or dad. Kids are at home. Before they get there, they want to make sure that they're taking what they need because their body is addicted to these drugs, so they're going to the safe consumption site to use. They're not hiding in their bathroom. They're not hiding in their car. They're in a safe environment where, if something goes wrong, there is somebody there immediately to fix them and to help them through that so that they can get home to their kids safely. That's what a safe consumption site does.

Are there problems in the community around safe consumption sites? Sure. Do you know why that is? Because those same sites don't have the resources to be able to manage what's happening on the streets around them. There are actual studies. It's proven. It is very proven, and it was the Lancet that did a peer medical review that safe consumption sites save lives in and around the site. That's actual fact.

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But due to public pressure, I guess, that the Premier was getting, due to the scene that people are seeing on their streets and in their neighbourhoods and in their parks—this is a knee-jerk reaction. This is not the solution. Like I said, if people are not using in a safe consumption site, they are going to be in the parks, they are going to be in their cars, they are going to be at bus stops, they're going to be wherever they can find space to use. And when nobody is there with that Narcan to give them that instant injection, they're going to die.

The number of overdoses: If I can—I haven't even looked at my papers yet. The number of overdoses that we have seen in our community is quite large.

Ms. Sandy Shaw: It's 22,000 deaths in Ontario.

Miss Monique Taylor: It's 22,000 deaths in Ontario.

Let's look at this: Hamilton Urban Core Community Health Centre had 61,667 total visits. That was 6,122 unique clients, 400 non-fatal overdoses—non-fatal because somebody was there to protect that person. That's a

big number. When I've met with urban core, they've told me they have not had one death, not one. How many deaths are we going to see if we don't have these sites available to us? That's not okay.

RNAO: They've spoken out very clearly, stating the need for safe consumption sites for the ability to save lives. These are our nurses. These are our health care workers. These are the same people who are going to either be trying to help people once they've overdosed and been taken to an emergency room or the same people who are going to put the toe tag on the people who didn't make it. These are our health care workers. These are the people whose voices we should be listening to when we're dealing with situations like this.

Now, the minister has talked about the HART hubs. The minister has said that the HART hub is the model that will be in place to replace the safe consumption sites. The HART hub will reflect community needs. That's great. Safe consumption sites are doing that now; they're building relationships. They're providing all the supports that they have the ability to. They could offer shelter beds. They could offer addiction care. They could offer primary care. They could offer supportive housing. They could offer employment support. That's a lot of "coulds".

What the minister said the HART hubs won't offer: They won't offer supervised consumption sites, they won't offer safer drug supplies and they won't offer needle exchange programs.

Let's talk about those needle exchange programs for a moment—and it's not just needles; it's also the glass pipes that are used. If they're sharing those tools, we are going to see an increase in HIV and in hepatitis. It's inevitable. It's absolutely inevitable. People have worked years to be able to get to the point where we are. They have worked off their feet while we see the explosion of drug use in our communities.

I would like to know what the government is doing to help the crisis and the epidemic that we're seeing on our streets when it comes to drug use. You're not doing anything. You're not doing anything to ensure that people have a way out, and that's what we need.

We need immediate detox. If someone says, "I want help," we should be able to take them by their hand and walk them right there, right then, no questions asked, immediately. Telling them, "Come back in 48 hours and we might be able to find you a bed," that's not going to work, and that's just for detox. And then, once we get them detoxed, which is an awful, painful, terrible thing to have to go through and that is done under supervised health care because people could die from detox, we have nowhere to send them. We have nowhere to help them, to give them the rehabilitation, to help them rehabilitate back into community, into a healthy life, drug-free.

You are offering none of those programs. They are wait-listed, and people are dying. People's kids are dying on the street daily. Absolutely daily, people are dying on our streets. It's an epidemic.

By removing a safe consumption site that somebody has made a conscious decision to enter, where they are

getting some of those supports, where they are making relationships, where they do have the hope of possibly getting into a detox and a rehab centre, you're taking it away. You're taking it away for the Premier to be able to say, "I'm cracking down and making our communities safer." No, Premier, you are not. You are not making our communities safer. You are actually making it worse.

We talk about moving the safe consumption site away from schools. Okay, I get it. Move them. Do what you need to do. But let's not forget that some of those children in those schools have parents who have addiction issues, who need sites like this so that they're not overdosing in the bathroom at home in front of their children. This is the reality. What you've put forward in front of us today is so anti-reality and is so blindsided by public appeal or policy that you think you know about. You are so wrong. You are so wrong.

I'm literally begging the government to remove this schedule. Remove this schedule. Let's put together a study. Let's work together for the betterment of our communities, to try and address the crisis that we see in our communities, to stop the overdoses, to stop the deaths. But we need to make sure that we have housing available, that we have shelter spaces available, that we have detox available, that we have rehab programs available, that we have health care available, that people can have a family doctor, that people have a roof over their heads, that people have access to employment and hope at the end of the day.

Because if you have a drug addiction and you're literally living on the street—maybe you don't even have a tent because somebody stole it or your encampment has been cleared out—what hope do you have? What hope do you have? Why would you want to get clean at that point? I might as well just stay drug-addicted and not have to pay attention to it. These are the things that our communities need. We're desperate. People are desperate.

Please, let's not forget. We cannot keep looking away. There is nowhere else to look. It's in every direction. People are people, regardless of their addiction, regardless of who they are. Something needs to be done. We need to start today by removing this schedule, by ensuring that people have actual, real services that will save lives in our communities.

Thank you.

The Deputy Speaker (Ms. Donna Skelly): Questions?

Mr. John Jordan: I want to start by saying that nobody is arguing that people who suffer from addictions aren't people, so I take exception to that implication. When you talk about taking away all your injection sites, I think the proper wording would be that injection sites that are close to our schools and our daycares—we're taking those away.

1430

This bill is not about abandoning people. That's why we have the homeless, addiction and recovery centres. It's about helping people to get better. So my question to the member opposite: Is the member opposed to saying that safe injection sites should not be near our schools and our

children? And is the member opposite in favour of homelessness, addiction and recovery centres?

Miss Monique Taylor: I am not opposed to any service that will save lives in our community. But I'm not going to turn my head and pretend that these services aren't part of a necessary plan to ensure that we do take care of people in our communities.

As I said in my remarks, I don't want kids exposed to this—absolutely not—but nobody can look away. You can't look away without seeing somebody in your community. This is not going to stop that. It's actually going to push more people into the community.

We only had one in Hamilton. We're losing it and there is no hope of getting another. All of the ones we are losing are not able to be replaced, and the ones that aren't being removed are not getting any more funding. So you're really actually taking them all away.

The Deputy Speaker (Ms. Donna Skelly): Questions?

Ms. Sandy Shaw: I want to thank the member for Hamilton Mountain for explaining and describing this crisis, this epidemic, that is in all of our communities. I know you know Hamilton so well. We met with the police from our community this morning. They talked about having to deploy Narcan two, three, four times a day. They said, "This is not our job," but they are doing it.

I know that you've gone on with the Social Navigator Program, that what you're talking about, you have seen with your own eyes. I think this idea that this government's saying, "We're closing these sites near schools"—sure; nobody wants to put our kids at risk. But you're closing all the sites. Hamilton has a population of 500,000-plus. We had one, and it's being closed. Can you describe what you have seen when you work with the Hamilton police and our social navigator program?

Miss Monique Taylor: Thank you to the member from Hamilton West–Ancaster–Dundas. I want to be really clear, and I said it through my remarks: We have kids who live and go to those same schools whose parents use those safe consumption sites, because they're in their neighbourhood and that's where they live. So those kids are not able to get away from it regardless.

That's where it comes to the government further investing in sites to ensure that community safety around it is there, and that there's relationships built. Just because you have an addiction doesn't make you a bad person. People do have their issues; there is no doubt. I can't sugar-coat any of that. Boy, I would love to, but I cannot.

We need community services, wrap-around services that look like all different types of things to ensure that our kids are safe and that we're not leading them to a life of addiction and to a life that nobody chooses for their kids.

The Deputy Speaker (Ms. Donna Skelly): Further questions?

Mr. Billy Pang: Question to the member opposite: I have friends, first-hand, who were drug addicts. Now they have quit. I can tell you none of them—zero, none—support this type of injection site.

Across Ontario, addiction treatment centres, that the HART hubs are modelled on, refuse to allow drugs to be

consumed on the premises where recovery and treatment is offered. The key is that recovery and treatment is offered. We applaud the hard work and dedication of the places. The staff, the team, day in and day out, are helping those recovering from addiction without enabling drug habits.

So are you saying that these fine health workers are wasting their time? Or do you recognize that there is more than one way to keep addicts safe?

Miss Monique Taylor: His last line meant everything: There is more than one way to keep addicts safe—yes, there is, and this is one of them.

Do his friends disagree with this? Possibly. That's okay. Not everybody is going to agree on everything, but your friends had the ability to get rehab, to be able to get clean. Maybe they were able to pay for it. We don't have these resources in our community to be able to do this, and let's not forget the fact that detox is a severe thing. People die from not having drugs, the drugs that they need—people die from that.

So we need to ensure we have proper detox facilities, proper rehab facilities and that we do have a mix of things. But taking away a safe consumption site and forcing people back on the street or into dark hallways where they could die and overdose is not the solution to help people get the recovery that they need, it's just not.

The Deputy Speaker (Ms. Donna Skelly): Further questions?

Mr. Joel Harden: Thanks to the member from Hamilton Mountain for your comments. There has always been something I've found confusing about this particular debate and the way it is framed; it is almost as if we have to choose, like we have to choose between housing, treatment, employment options or safe places for people to not die because we have a poisonous illicit drug supply out there—it is like folks are playing Russian roulette with their lives often out there.

When I look at the evidence, when I talk to people at home, they say we need both. I want to say to the government, in all honesty, if the government had approached the community health centre in my riding that is slated to close the consumption treatment services on March 31 and said, "We want these services to be more of the focus than the CTS. We want us to work together," they would have, with open arms, said: "We have been waiting for these resources for 15, 20 years. This is great." That would have been the response. Instead, it was a press announcement at AMO in the summer that no one had any notice of, and you're dealing with centres that are helping people in extreme trauma.

I guess I'm asking the member from Hamilton Mountain, can't we have both? Can't we have a more collaborative way to doing community health and safety?

Miss Monique Taylor: Thank you to the member from Ottawa Centre. Yes, absolutely, we have an epidemic on our hands. It is an extreme crisis that, as you heard, people know of people—from the other side, from the government side—so we need all hands on deck and that means all services on deck: safe affordable housing, proper detox,

proper rehab—on time, not rehab in two months because God love them if they even make it that far, or if they still want it at that point of that day.

We need all resources available to someone when they need it—immediately—and that's investment, I get that, but it's investment in our communities, it's investment in our kids, it's investment in our communities—it is the safety that our community members are asking for.

This is not going to solve the problem because what are you going to cut next when things are only worse after these are closed?

The Deputy Speaker (Ms. Donna Skelly): We have time for one final question.

Ms. Laura Smith: I want to thank the member opposite. We talked about different sites, and I'm going to refer to them simply as sites. Sometimes these sites often see less than 100 clients a month, these CTS sites.

Could you clarify how many duplicate or repeat overdoses are being prevented on the same persons over and over again? Instead of helping them recover, I think we have to look at this in a quality way and I'm just wondering if she has any comments on that.

Miss Monique Taylor: I would love for people to have more services and better access. While they're in those facilities, they are getting supports but those same people are handcuffed about what supports they can offer to the people who are using.

It's a whole thing; it's not something that you can just use one piece of the puzzle and think you're fixing something because you're not—you're actually making the problem worse by what you are doing.

By providing more supports in our community, by ensuring that we are offering all of those things, those sites would love to have those options and services available to—

The Deputy Speaker (Ms. Donna Skelly): It is time for further debate.

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Ms. Patrice Barnes: My thanks to the Solicitor General and the Associate Minister of Bail Reform for their amazing work, and to all my colleagues who contributed to this bill.

It is an honour and responsibility to stand up before you as the voice of the community and the region of Durham. Today, I want to talk a bit about the shared commitment that lies at the very core of what we do as public servants, parents and community members. It is about ensuring the safety of our streets and the strength of our communities.

As we look at the challenges that confront our province, one thing is clear: Public safety must be a priority and cannot be an afterthought. That is why I'm proud to stand behind the Safer Streets, Stronger Communities Act, 2024, which is not just a collection of laws but a powerful road map for creating safer neighbourhoods, supporting victims and holding those who break the law accountable.

This bill also provides the Solicitor General with the ability to create long-service and good-conduct medals for the municipal emergency workers, and I just want to thank the Solicitor General for that as I had the privilege to

introduce that private member's bill just a couple of weeks ago. This is an important step towards honouring their service, celebrating their sacrifices and showing them that Ontario stands behind them, now and always.

In Ajax and across the Durham region, we're incredibly fortunate to live in one of the most dynamic and diverse communities. Ajax is a place where families work hard, where businesses thrive and where we constantly build towards a greater future. As our community grows, so do the challenges that we face. Whether it's the troubling rise in auto thefts, the dangers of reckless driving or concerns around the safety of our children in public spaces, these issues remind us of the need for bold and decisive action.

The Safer Streets, Stronger Communities Act is not just about addressing crime; it's about addressing the concerns of families like yours and mine. It's about ensuring that every child can walk to school without fear, that every parent can drive to work without worry and that our neighbourhoods continue to feel like home.

Let us talk about the rising impact of auto theft. In Toronto, a car is stolen every 40 minutes. In my community, residents have experienced this first-hand. Vehicles are stolen from driveways, shopping centres and public spaces. Sometimes the same person might have lost their car twice, to be victimized more than once. These aren't just statistics; they are stories of disruptions, of families left stranded and of hard-working people burdened by costs they should never have to bear.

This legislation takes action against auto theft. It creates new provincial offences for the fraudulent use of VIN numbers and enhances penalties for those who participate in this growing crime. It also supports police services, including in my community of Durham, with targeted funding for dismantling organized crime networks behind these thefts. Because it is not just about the stealing of the car; it is all the other pieces that are connected.

We do recognize that organized crime is a big part of this. And what comes out of organized crime? We have money laundering. We have human trafficking. We have sex exploitation. For a community like Ajax, where many families rely on their vehicles to commute, run errands and care for loved ones, the measures that we are putting in place are most urgent.

As a mother, one of the important aspects of this legislation to me is the protection it offers to children and families. Many parents have shared their concerns about supervised consumption sites that are located too close to schools, child care centres and family hubs. I recognize that this is a polarizing discussion. We have support on both sides. I have spoken to families who do not support safe consumption sites, families who have said that if their family member was able to really hit bottom, they probably would still be here alive.

Our government is continuing to look at the ways that we can help and support people who are suffering from addictions. We do not say that it is the wrong pathway to take. We say and we have continued to hear that we need more wraparound offerings to be able to do this. That is why in our government's Roadmap to Wellness, our

government has taken action to build a modern mental health and addictions support system that is focused on providing people with the right care in the right places.

While we must be compassionate for individuals struggling with addiction, we cannot ignore the impact on our communities, especially our most vulnerable. We should have an expectation of people recovering. We should have an expectation of people being able to recover and live full lives.

The members across talk about a parent that has an addiction that a child has to deal with. These are long-lasting impacts on not only those children, but on those families as well, and so we really should be talking about what we are talking about now: the supports that we want to put in place, wraparound supports that help people to get past addiction. It is not easy; we do not say it is. We do not say that it will happen overnight. But we do think that we should expect better for people who are in addiction; that we should not continue to perpetrate and keep them in a state where their quality of life is so diminished.

The act abolishes sites from being within 200 metres of schools and child care centres, while providing a pathway for these sites to transition into homelessness and addiction recovery hubs. These hubs will be a game-changer. They focus on treatment and recovery, while offering critical supports like mental health services, addiction care and housing. These ensure we are addressing addiction compassionately, while prioritizing the safety of our children and the integrity of our communities.

We are offering people who are struggling with addiction the opportunity to get help and wraparound support, bringing dignity back to those who are suffering from addictions. The fallout from being in the throes of addiction is long-lasting, and we know it leads to many more things. People who are in the state of addiction are in an altered state where the most important thing for them is their next shot. We have seen this, and this is why our government is committing to building these HART hubs, to have a crossover that will give people who are suffering from addictions additional supports.

The next thing that we are tackling within this bill is dangerous driving and recklessness. We have seen the devastating impact of dangerous driving, whether it's collisions in parking lots or the chaos of illegal street racing. These actions endanger everyone. This legislation strengthens penalties for careless driving, extends the time police have to lay charges and, for the first time, applies these laws to private spaces like parking lots. This means reckless drivers will face consequences whether they endanger lives on a highway or in a local mall. For families in Ajax, where shopping centres, community hubs, are vital to daily life, this sends a powerful message: Safety comes first and reckless behaviours are not tolerated.

Durham region is fortunate to have dedicated law enforcement officers who work tirelessly to protect our communities. This act gives them the tools they need to monitor sex offenders, prevent name changes for individuals on the Sex Offender Registry and investigate sex crimes more effectively.

Additionally, this legislation removes the limitation periods for victims of terrorism to pursue justice, ensuring that no one is denied their day in court simply because too much time has passed. These measures reflect our government's unwavering commitment to supporting victims and standing with those who serve and protect. It is important.

We are extending the drug treatment centres that are connected to courts. These are drug treatment courts that combine judicial supervision with structural substance programs. This is what we're talking about when we're talking about looking at holistic ways of helping people who are suffering from addictions: giving them options, giving them the opportunity to regain their lives and to regain dignity. Through these programs, it provides alternatives to incarceration for individuals facing charges related to non-violent criminal activities and associated with substance disorders. They provide intensive case management, frequent court appearances and random drug testing. Successful completion of these programs can result in a non-custodial sentence, and it is a collaborative approach, and we've talked so much about that and the import of these wraparound services. It's a collaboration between a judge, the prosecutor, counsel and treatment providers to help these individuals to choose a different path from the continual cycle of addiction.

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We are also talking about some of the things that we have invested within our government. We have heard through our colleague on the other side about this government really not doing anything to help people that are suffering, and I disagree with that. Our government has continued to invest in mental health and addictions. We have created the Roadmap to Wellness, where we have invested \$525 million since 2019, and that has covered a range of addiction treatments and supports, including the rapid access addiction medicine clinics, which provide quick access to addiction services without the need of a referral. We have expanded our youth hubs. Our youth wellness hubs offer evidence-based mental care, substance use and primary care to youth 12 to 25 years. Since 2020, our government has opened 23 new youth hubs, including in northwestern Ontario. We have launched virtual intensive treatment programs which are six-week intensive programs for moderate to severe substance use that people from across Ontario can access across the Internet. We have structured psychotherapy programs, offering convenient, free cognitive behavioural therapy to Ontarians across the province. So this that we're talking about are just some of the things that we are investing in that offer support around mental health and addictions.

We have also, within this bill—we have talked a little bit more about the long service and good-conduct medals for emergency workers.

Actually, before I go to that, I'm just going to pull this up: When we talk about the hubs—the integrated treatment court hubs that offer drug treatment—I want to talk about that a little bit more.

We talk about the judicial supervision, which is integrated treatment. The courts are involved, and regular

judicial oversight, with judges playing an active role in monitoring progress with participants. These provide a really non-adversarial approach. These courts use a collaborative, non-adversarial model, including judges and prosecutors. And that's what we're talking about: really having different options for people that are suffering from addiction. The comprehensive integrated support that these court services offer provides access to a range of services, including substance abuse treatment, mental health support, social services, and tailored to individual needs. These programs have a great success rate. That is why we are continuing to support programs like those that help people to recover and to get back to living—because a drug addiction is not living; it is really living in a heightened state of emergency at all times.

And I know families that have accessed this. I have been in close contact with people that have been addicted to drugs as well. They wanted somebody to lift them out. They wanted somebody to help them. Our colleague across the way is right: Sometimes you're not ready, and you have to make that decision. But how do we do that? How do we help them to make that decision if we continue to keep them in this altered mental state where they cannot make rational decisions?

So this is—I really disagree; we are being painted with a brush of “people that don't care.” I know we have gotten it in our constitutions: “There's blood on your hands. There will be blood on your heads.” But I also attended a high school recently, and it was the ACT program that was teaching high school kids first aid, and they had taught quite a lot of kids across Ontario first aid. And now in that first aid treatment they're now training them how to administer naloxone kits. That is where we are in our province, where we are training in so many different areas. Our kids are being trained on that, as well. That is important because when there is somebody in crisis, you want to have somebody that can help you.

We'll move on, and I'll talk a little bit about the long-service and good conduct medal. In addition to our law enforcement officers, it's important that we recognize the municipal emergency workers, recognizing that they face similar dangers and challenges as their counterparts. In Ontario, we are proud to have a diverse range of front-line emergency workers, from urban communities, such as Toronto, to smaller communities, such as Thunder Bay and Cornwall.

Within this bill, it now gives the Solicitor General the opportunity to explore how to put in place a long-service medal for those that have served for a long period of time. I don't want to say how many years because I'm not sure what he is going to come up with as of yet. I think this is so important, and even as many of us have met with police officers within our communities today, that we recognize. We recognize that policing has changed. Policing has become the catch-all for so many of our social services and it does take a toll on them, as well. We're seeing officers that are not staying as long as they used to stay. You know, of the officers that I met, one of the officers today was actually retiring after 33 years of service; I don't know

how many of the young officers will stay that long anymore.

It is so important that we recognize their work and the work that they do. I can say that every organization has their challenges, and the police do, as well, because policing has changed. As an organization, they need to look at how they change, how they talk about and deal with the challenges that they are facing today. How do they do that when training is the same? We need to talk about what our communities look like now.

What makes the Safer Streets, Stronger Communities Act so important is that it doesn't react to crime; it works to prevent it. By proclaiming November as a community safety and crime prevention month, we're fostering a culture of awareness and action. That also goes to the point where we need to acknowledge and appreciate our front-line workers, because the work they do is so essential. The act also expands justice centres that we've set, which is also an amazing piece in crime prevention.

These initiatives are about breaking the cycles of harm and ensuring that people receive the help they need before they reach a breaking point. When I look at Ajax, I see a community filled with potential, as do many of us across the province. I see young people walking to school with big dreams, families building their futures and seniors enjoying the peace that they have worked so hard to gain. The Safer Streets, Stronger Communities Act is about preserving that potential and protecting the quality of life we all cherish.

This legislation ensures that no family has to live in fear and children can walk to school and experience their playgrounds in a safe space. No one is left without support. It's creating a province where every Ontarian feels like they belong and feels like they are safe. The road to safer streets and stronger communities starts with us. It starts with full action, with listening to the voices of our residents, and with a government willing to put people first.

The Safer Streets, Stronger Communities Act is a testament to what we can achieve if we work together, and it is my commitment—and I thank you for your partnership, your dedication, and your belief in the power of community. Together we can and will make Ontario a safer and stronger place that is more united.

The Deputy Speaker (Ms. Donna Skelly): It's now time for questions.

Mr. Tom Rakocevic: I want to thank the member for her very thoughtful speech today. She mentioned auto theft, and it's something that we are all very concerned with. Certainly, in the time that the government has been in office, it has been a growing problem. In fact, auto thefts in the province of Ontario are up by more than 100% in the six years since the government has held power. I know during that period of time, the government has met with different industries and different businesses. We hear about it all the time.

One of the industries and one of the places that they have not invested their time is talking to auto manufacturers who want to sell cars in Ontario and what they

can do about making these cars safer. This is something that law enforcement and police have talked to us about, how easy it is, when you have those remote key fobs and other things, to be able to break into these cars.

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Will the member commit to talking to her colleagues and ministers about how important it is to speak to these manufacturers to ensure that cars that are sold in the province of Ontario have the highest standards of protection? I think this is something you can do, and I hope you'll do it in a very public way, if you do so.

Ms. Patrice Barnes: Thank you to the member for that question. Of course, we continue to explore every option that we can to make Ontario safer for Ontarians. We talk about technology and the reality of government is, technology moves ahead so much faster than we do with legislation, so much faster than we do, and we're often behind the eight ball when it comes to regulating technology. I think this is what we are seeing with car theft.

It's easier for us to be able to press a button and get into our cars. I went into my friend's car the other day, because they lent it to me, and I kept looking for the key to put it in the hole, and now it's just a push button. It is something that—old school, I don't how to say it, but definitely the conversation continues to figure out how we can do better.

The Deputy Speaker (Ms. Donna Skelly): Questions?

Mr. Sheref Sabawy: Thank you for the really informative speech from my colleague. I would like to ask her and also tell the opposition, we hear from our Associate Minister for Auto Theft and Bail Reform how much is needed to change to require keeping criminals where they belong, behind bars. We hear many stories about cars thefts and break-ins, where people can take the keys and flee with the cars; many cars get into accidents and we discover that they are stolen. Stories about thieves who actually go to court and then the same day they get bailed out and they do another incident to collect money for the lawyers.

What is the government doing to aid the collection of these bail statistics to support the recent calls for Criminal Code reform?

Ms. Patrice Barnes: Thank you for that question. We recognize that car theft is a crime of opportunity. Before you had one or two cars that were stolen across the province. It wasn't that lucrative. Now it is. It's a part of organized crime. It funds so many other things. We can't just think about this as just a car going missing. There's so much more, the implications. We continue to work with our federal counterparts in regard to how to stop this crime and break down this crime. Because we can be concerned about what's coming in, but we now need to really look at what's going out. Part of that is the amount of cars that are flowing out of our country and into other countries are really creating a cash system.

The ministry is collecting bail data on behalf of the Ontario Court of Justice and we'll continue to look at that and analyze those—

The Deputy Speaker (Ms. Donna Skelly): Further questions?

Mr. Terence Kernaghan: I'd like to thank the member for her comments and debate today. I think people across Ontario are growing very tired of political games. Of all the schedules in Bill 223, we support them all, with the exception of schedule 4. This government seems ideologically opposed to not only providing supports for people who are struggling with addiction and mental health, but also providing affordable housing for anyone who needs it.

I'd like to ask the member: We see the proliferation of Doug Ford's encampments across the province. Does the member not agree that it is cheaper and more humane to house people with supports than it is to leave them languishing on the streets?

Ms. Patrice Barnes: Again, I take exception to the statement that says that we are playing games. You don't play games with peoples' lives. That is why we are invested in our Homelessness Prevention Program, and we've rolled that out to municipalities across the province. We have invested \$700 million into that program. That is a substantial investment. That is just one program out of the many that we have put in place as a government to support people that are suffering from homelessness, addictions and mental health.

We continue to ask the opposition to continue to support these programs. We know they are concerned about it. They can vote and can support the rolling out of funding for these programs.

The Deputy Speaker (Ms. Donna Skelly): Further questions?

Mr. David Smith: I want to thank my colleague from Ajax.

We heard from the Associate Minister of Auto Theft and Bail Reform that change is required to keep criminals where they belong, behind bars. What is the government doing to aid the collection of bail statistics to support the recent call for criminal change reforms?

Ms. Patrice Barnes: Thank you, sir. I'm extremely proud of this program because we had out in Durham region—when I was on the police board, they had come up with this bail tracking dashboard. I remember when they showed it to us on the police board, and it was such a great thing to be able to look in real time about people that are out on bail and where they were stationed. It really gave the police officers in Durham at the time the ability to be able to locate perpetrators that were out on bail. We have since rolled that out province-wide, which is a fantastic opportunity for officers to be able to—what we say, “Tools to do their jobs.”

I had mentioned before that the OCJ reports on their website, and they collect and analyze and report reliable data on bail, which is crucial to supporting the proper administration of the bail system and addressing concerns about public safety. So we're really starting to look at that data, really digging down into that, and continue to work to keep people in jail.

The Deputy Speaker (Ms. Donna Skelly): Further questions?

Ms. Sandy Shaw: I wanted to, on behalf of the member from Oshawa—who has been bringing up time and time again the fact that this government is not cracking down on VIN fraud. You had a perfect opportunity in this bill to include that. We know that earlier this month, Toronto police made 59 arrests and filed 302 charges after they uncovered a scheme involving the phony registration of VINs, vehicle identification numbers, by employees of a ServiceOntario location.

We've been calling time and time again for preventative measures to stop the fraudulent use of VINs, which is a clearly important component to vehicle theft. Vehicles are stolen, they're re-VINed, they might be sold unwillingly to people in the communities, or they might be shipped off, but this is a huge piece of your attempt to stop auto theft. It's a huge, huge component that you've completely overlooked. Why is that?

Ms. Patrice Barnes: I say to my colleague across the way, we continue to look at ways to be effective. This legislation is the first step towards that. Of course, we have never said or ruled out the possibility of implementing technology that can actually track and do what you're talking about in regard to tracking VIN registration.

The proposal in this bill is to actually create an offence for re-VINing vehicles because we don't have that now. The proposed legislation would create a new provincial offence under the Highway Traffic Act for providing a false VIN number when applying for a vehicle permit. Penalties would range from \$50,000 to \$75,000 for the first conviction and \$75,000 to \$100,000 for subsequent convictions, with the possibility of up to six months in jail. So I think we're making the—

The Deputy Speaker (Ms. Donna Skelly): It is now time for further debate.

Ms. Jessica Bell: I'm pleased to be here in the Legislature today to speak to the Safer Streets, Stronger Communities Act, Bill 223. What a bill—wow. What a divisive bill we have here.

A few days ago, I was sent a photo of a man called Jonah by his mother, Katherine McCloskey. Jonah is holding his two-year-old son, Hendrix, on a TTC train because Hendrix loves trains. Jonah died of an overdose on June 2, 2024. Hendrix lost his dad at a time in his life where he will probably never hold memories of him, and Katherine McCloskey lost her son.

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Jonah's mother, Katherine, spoke about her son at a press conference we hosted at Queen's Park in September of this year. I cannot believe she came. Her son had just died. She says, “I could not protect my adult son Jonah from being killed by Toronto's toxic drug supply, but the Conservative government can choose to protect some of this province's most vulnerable sons and daughters.”

The Conservatives are not listening to Katherine's plea. This bill is a bill that will close 10 consumption and treatment sites by March 2025, and ban new sites from opening up anywhere in Ontario. Those sites include the consumption site in Kensington on Augusta Avenue.

Let's be clear about what consumption and treatment sites are. They are essentially a room where people go and inject their own drugs under the watchful eye of a nurse or a health care worker who can revive them if they overdose. That's essentially what it is. These sites can also help people access health care and other services, such as getting a doctor's appointment with a family doctor or getting on a wait-list for supportive housing, because often that health care worker in that room is that person's only point of contact for services—their only point of contact for services.

The statistics are horrific. They are horrific. According to Public Health Ontario, in 2022, 2,531 people died of an overdose. That's a lot. There were also 2,044 hospitalizations and 12,144 emergency room visits—to our overcrowded, overburdened hospitals. I had someone come up to me and say, "You know, when someone goes to the hospital with an overdose, it's not like they just come in and walk out." Some of them do, but some of them don't, because when people overdose, oxygen to the brain is reduced, which can lead to permanent brain damage. So we are having situations where often young people, under 40, are in a situation where they are experiencing permanent brain damage because we do not have an easy and safe place for them to use and survive an overdose addiction. It is an absolute shame. It means people will die, people like Jonah: sons, daughters, fathers, mothers.

I also want to be clear. When consumption and treatment sites close, the problem of addiction does not go away. People take drugs elsewhere. Instead of using them at the site, they will use them in nearby washrooms. They will use them outside businesses, which they currently do in Kensington. They will use them in schoolyards. The entire neighbourhood becomes a consumption site if we don't provide a safe, secure location with health care workers present for people to use and survive if they overdose. That's the facts. That is the facts.

Now, the Conservatives say they'll set up 10 abstinence treatment centres to help some people struggling with addiction. I'd like to know when. It would be good to know when. But, quite frankly, an abstinence-only approach is as dangerous as instructing a drowning person on how to swim instead of throwing them a life jacket.

The Minister of Health was asked by a reporter from the Trillium, Jack Hauen, if research had been done about how many people will die as a result of this decision to close consumption sites. And her answer is astonishing. Her answer is, "Jack"—that was the reporter's name—"people are not going to die. They're going to get access to service." Do you really believe that? Do you honestly really believe that?

I really question why the Conservatives are taking such a dangerous approach to addressing addiction. I question it. And I fear, I fear it is because an election is coming up and the Conservatives want to play a divisive game of securing votes by choosing wedge issues and targeting vulnerable people instead of showing leadership and addressing the crisis of addiction.

Municipalities, hospitals, nurses, public health experts and even two provincial government-commissioned reports recommend keeping consumption sites open. There is sometimes an issue of crime, no question. And consumption sites have approached this government and said, "Why don't you help us with that issue by providing us with additional social workers and security so we can tackle that specific issue?" The government chose to ignore that recommendation.

The truth is the Ontario government can and must meet people where they're at by keeping them alive and preventing them from having an overdose by keeping consumption sites open. The truth is the government can and must provide more treatment, health care, counselling and housing to help people recover and rebuild their lives. And the truth is—and I never hear the government talk about this; I never hear them talk about this—the government can do more to help people from becoming addicted in the first place by tackling root cause issues like poverty, a lack of housing and abuse. Where is your plan to stop addiction from happening in the first place? Because I don't see it.

We recently organized a rally in our neighbourhood of Kensington. We did outreach to the businesses, we went one-on-one. We know there are challenges with the consumption site. We're not going to pretend that there isn't. So we went one-on-one to the businesses, we went one-on-one to residents in the area, we gave out flyers, we worked with the local neighbourhood group that runs the consumption site to hold a rally. To say this community understands that this consumption site is valuable to our community because it saves lives, and it contains the issue of drug use within a specific area instead of having it go everywhere. And we had many people come out, and I want to read some of their quotes.

One of them is from Patricia Au. She's a local parent at Kensington Community School—within a 200-metre radius. Kensington actually supports the consumption site because before the consumption site existed, people were using in the schoolyard. They were using in the schoolyard, because that's the reality of Kensington.

The Kensington Community School, the principal, supported the consumption site being established, and Patricia, who is a local parent and a member of the parent council, also supports it. And her quote is: "Closing the site undermines our community's efforts to create a safe environment for the most vulnerable members and to offer them the support they need to manage their addictions. As a parent in this neighbourhood, with children who attend the local elementary school, we have taught our kids the values of compassion and humanity towards those in need. Safe injection sites play a crucial role in breaking the cycle of addiction. If school-age children can grasp this concept, the government should step up and understand this too."

Here's another quote. This comes from an individual who uses the consumption site in Kensington. They've chosen to remain anonymous, so we're going to call them a client. This is their quote: As a client of the Kensington site, "I have to say it is my extended family, without them

I would be using alone in laneways and alleyways. I don't know if I would be alive. I am scared if the OPS"—overdose prevention site—"closes what will happen to me and my friends? The staff" at the site "show us love, support and understanding. We are not judged or stigmatized in any way. Why would anyone want to take that away from us? I don't understand. The announcement made me cry. I don't want to lose any more friends." This site "is the only family I have and we're losing too many people to overdose." This site "saves lives every day. They saved two more people yesterday.

"Why doesn't this government want us to be safe? Don't we matter.... Please reconsider the announcement. You are killing us if" this site "closes.... We want" the site "to stay."

I want to read some other quotes from people who attended the community rally at Kensington. It was a diverse group of people. Over 200 people came.

This is a quote from local resident Robyn Armstrong, who attended the rally, and she said that the site is extremely important for her community. She said that "the site doesn't make her concerned for her son's safety." She said she is a parent and she "welcomes the site as important health care.

"Safe sites reduce public drug use and save the lives of vulnerable people." She gets it, and when people live in Kensington—the vast majority of people get it, because they know people are not going to go away if the site closes.

This is another quote. This comes from Joanne, who manages a bar in the area. She said she "has befriended some people who regularly visit the consumption site.... Sometimes, it's hard." It is hard. The consumption site is not an easy place to visit. "Some people can't even work here because you see people overdosing across the street. She says "the site should stay open as people using drugs won't leave the area even if it closes. 'They're still going to be here. They might as well have services, food and a place to shower.'" That is the reality of it. It's called harm reduction for a reason. It's hard to see this government making decisions that put politics ahead of saving people's lives. It is very hard.

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I want to talk a little about some other aspects of the bill in the time I have remaining, and the aspects of the bill that I would like to talk about is the decision by the government to move ahead with better regulating the VIN process. What we see with the issue of VINs with this new bill is that the government is going to create a new provincial offence of using a false vehicle identification number, and the fine associated with using a false VIN is up to \$100,000, imprisonment of up to six months and a possible suspension of a driver's licence. This is a good step in the right direction, and we want more steps taken in order to ensure the province is doing everything it can to clamp down on the market for stolen vehicles, and this is an issue in my riding. This is an issue in my riding.

Earlier this year, I attended and was a speaker at an event on safety at the Rosedale United Church in my

riding. The event was organized by numerous residents' associations—the North Rosedale, South Rosedale, Moore Park, Summerhill, Governors Bridge and Bennington Heights residents' associations—and the main topic of this town hall was the sharp rise in auto theft. I've reached out to the ministers responsible for this topic to raise the concerns that I heard at this event.

Residents spoke of having their homes broken into, of having their car keys stolen while they were sleeping in the home. Many residents spoke up again and again about how angry, betrayed, scared and worried they were for their safety, both inside and outside the home.

The police were there—it's Toronto police 53 division—to give a summary of the extent of the rise of auto theft, not just in this particular area but across Ontario, and the statistics are sobering. There has been a 524% increase in auto theft claims costs from 2018 to 2023. It is shocking. People have the right to feel safe. That's what I expect in Ontario; I think that's what everyone expects.

We also know that solving the issue of auto theft is going to require a coordinated effort from all three levels of government. Now, at that town hall—and also we're hearing the government on the other side do this as well—there was a lot of focus on what the federal government can do. I agree. The federal government should be doing more to ensure that stolen vehicles are not quickly and easily shipped out of our ports to other countries and sold.

But what I also think is important is for us to focus on what the provincial government can do to address the issue of auto theft, and what I see in this bill is a move to clamp down on the very real issue of a vehicle being stolen and then being re-registered through ServiceOntario, through the use of a false vehicle identification number, and there is some effort here to address that problem.

My request, and I think our party's request, is that you need to go further. Other provinces have moved forward with having a proactive response to investigating vehicle identification numbers to ensure that no vehicle that is stolen is permitted to be re-registered under the ServiceOntario process and get a new VIN. It shouldn't happen, and the measures that I'm seeing in this bill, what I'm hearing from stakeholders already, is that it doesn't go far enough. If we want to stop the resale of stolen vehicles in Ontario, you need to do more. The Conservatives need to do more.

The other piece that I believe the MPP for Toronto Centre raises regularly is that if we want to address the issue of auto theft, we need an appropriate policing response and we also need an appropriate legal response. What we're seeing in the court system today is astronomically long delays in people getting access to justice, and that is overwhelmingly because there are significant staffing shortages and judges in the provincial court system—overwhelmingly. And this doesn't just concern the issue of auto theft. It also concerns issues of people who are survivors of assault, of sexual assault. They're having their cases thrown out in court because the timeline for them to get a hearing and a trial is so long that the case is thrown out. That should not be happening in Ontario

today, and it does. That is a shame, and I urge this government to fix it.

We recently had a fall economic statement that was just announced, and what shocked me is that instead of bolstering support for our justice system, this government has made a decision to cut funding to the justice system, which will only make the issues that we are seeing in our legal system worse. That is the wrong direction to take.

I want to conclude by talking a little bit about what I've seen this government do over the last few months since we've returned to the Legislature. What I see is this government is engaging in politics of division.

We are seeing them blaming the Liberal carbon tax for the affordability crisis even though affordability is a measure that this government can address.

We're seeing this government blame bike lanes—three bike lanes approximately three feet wide—for the entire congestion crisis that we have across the GTHA. That doesn't even make sense. Toronto has been on record of having the worst commute times for decades, and yet somehow, mysteriously, there are these three bike lanes in downtown Toronto that are the reason why people are having congestion issues on the 401. No reasonable person believes that, yet you're doing that. You're saying, "Oh, it's bike lanes. They're the reason that we have a congestion crisis," instead of dealing with the issue at hand, which is investing in transit.

We see this government blaming the poor for living in encampments, which I find awful because there are reasons why people live in encampments. They're struggling, they're vulnerable, they're poor.

I would like to see this government move forward with vacancy control and real rent control so rent can be affordable again. I would like to see this government build affordable housing instead of turning their back on it. I would like to see this government increase social assistance rates so people can afford to live in our cities and towns. That is a very effective way to deal with the encampment crisis, but I don't see this government doing that. Instead, they're playing the game of blaming people for problems that this government has a responsibility to address.

When I go door to door, the issues that I hear about are issues that I would like this government to address and what we are advocating for, and those issues include ensuring that housing is affordable—that it is possible for an individual or family to buy a home; that it is possible for an individual to move into Toronto, get a job and afford the rent. That's not a lot to ask for. That's what people want.

When I go door to door, I hear people talk about their lack of access to family doctors. They want a family doctor or a nurse practitioner who can see them if they have a problem. That's what they want, but instead, we're seeing this government move ahead with privatization and not move forward with meaningful steps to ensure everyone in Ontario has a doctor.

When I go door to door, I hear people talk about how they want municipalities that work. They want potholes to

be filled; they want the transit to turn up on time; they want to pay a reasonable fare; they want the libraries to be open; they want daycares; and they want our parks to be free from garbage. In order for that to happen, the Conservatives need to properly fund services at the municipal level so that our cities and towns can work. That's what people want, but instead, what we're getting from this government is the game of diversion. I think that's a shame because people will die as a result of that and people will suffer. I think that you should take a different approach.

That's all I have to say today. What a terrible bill. Aspects of this—it's just an outright terrible bill. People in my riding will die when this consumption and treatment site closes, and I think that is a shame. Thank you.

The Acting Speaker (Ms. Patrice Barnes): Questions?

Ms. Laura Smith: I listened respectfully to the member opposite, and our government is taking a balanced approach. I used to work under the child protection act, and this bill introduces measures to address the root cause of crime, including expanding justice centres and integrated treatment courts. I've spoken to parents who live near sites, and they're not lying when they talk about stepping over needles and being afraid to be near consumption sites with their children.

I'm just wondering what the opposition's comments are on a balanced approach that focuses on both crime prevention and rehabilitation when these programs are often proven effective and reduce reoffending and improve public safety.

1530

Ms. Jessica Bell: Thank you very much for that question. I think there's this assumption that if you move a consumption and treatment site, suddenly people who are using drugs are just going to magically disappear. That's, quite frankly, not true. What we have seen is that if a consumption and treatment site is moved, people continue to use; it's just more likely they're going to use in the street, they're going to use in the schoolyard, they're going to use in front of a business. Containing the problem actually results in increased safety.

If this government was serious about addressing the addiction issue and keeping people alive using a harm reduction approach, they would allow other consumption and treatment sites to be opened that are 200 metres or further away from schools and daycares, but this government is choosing not to do that. I think that is a shame.

The Acting Speaker (Ms. Patrice Barnes): Further questions?

Ms. Catherine Fife: What an impassioned speech—informed, researched, evidence-based commentary on safe consumption sites. One of the shocking numbers that the member mentioned was the over 2,600 people who died of drug-related toxicity in Ontario last year. Just to give you some context: A Boeing 747 holds 366 passengers, so seven planes crashed in this province last year, and the government's response is to shut down, basically, the safety and health and well-being of those individuals. It's really quite something.

“Researchers have studied safe consumption sites for efficacy in three primary areas ... reducing individuals’ physical harms associated with drug use”—which she covered—“such as the spread of HIV and hepatitis C, infections, and overdose” and reducing social harms.

To my colleague: What do you really think is going on with this bill that has a poison pill, ironically, in removing safe consumption sites?

Ms. Jessica Bell: Thank you to the member for Waterloo. Yes, this bill does have a poison pill in it. There are measures in this bill that are absolutely supportable, but then there’s this terrible aspect of the bill where there is a move to close down consumption and treatment sites.

I would like this government to take a comprehensive approach to dealing with the issue of addiction, where we meet people where they’re at and keep them alive, and we provide comprehensive holistic services, from mental health care to support to affordable housing to addiction treatment. We can do both. It’s not one or the other.

The Deputy Speaker (Ms. Donna Skelly): Further questions?

Mrs. Robin Martin: I listened intently to my friend from University–Rosedale. We have consumption sites now and people are still overdosing outside of them. In fact, I was told that people come near the site but won’t go in, so they are on the streets sometimes—often—and needles are on the streets and drugs are on the streets and other things are on the streets.

How do you answer the family of Karolina Huebner-Makurat, 44, who was killed because these sites become a magnet for crime? Statistics have painted a grim picture. It’s out of control around consumption sites. Crime data shows 113% higher reports of assault, 76% higher reports of break-and-enter, 40% higher reports of shootings, 96% higher reports of robbery and 44% higher reports of homicide. People are being killed because these places are magnets for crime.

Ms. Jessica Bell: This is a genuine question back to the member opposite: What do you think is going to happen when these consumption and treatment sites close? Where do you think people are going to go? In that situation where an individual was shot, the consumption and treatment site and the social service agency asked for additional support and additional funding to provide for security in the area, like many of the consumption and treatment sites have. Did the government provide it? No.

Where is this government’s plan to address some of the root-cause issues that lead people to use in the first place? Where is the increase in social assistance rates? Where is the plan to provide affordable housing and supportive housing that matches the need? Where is the commitment to provide serious mental health and addiction services that match the urgency of the problem? I don’t see it.

The Deputy Speaker (Ms. Donna Skelly): Further questions?

Mr. Terence Kernaghan: I would like to thank my friend from University–Rosedale for a very informative and important speech. I just wish that the government had

been listening about what root causes are and how to address them.

My question, though: the member’s comments about thieves and criminals using ServiceOntario locations to register stolen vehicles, and the fact that there is no system in place in Ontario to verify VINs—this has made Ontario not only a hot spot for theft, but a hot spot to move stolen property.

Are the punishments that are set out in Bill 223 an effective deterrent to crime, and do punishments actually solve the root cause of the problem?

Ms. Jessica Bell: Thank you to the member for that question. What we are hearing is that, in this bill, there is a move to crack down on the use of taking a stolen vehicle and getting it licensed again, giving it a VIN number through the ServiceOntario process.

The problem we see is that experts are telling us that it doesn’t go far enough, and that one measure that the Ontario government could do is to look at what other provinces are doing and to move ahead with a system in place that would investigate and verify VIN numbers in a more proactive fashion. My hope is that, when we go to the amendments process, there is a move to take this measure to crack down on VIN abuse one step further so we can stop the sale of stolen vehicles in Ontario.

The Deputy Speaker (Ms. Donna Skelly): Further questions?

Ms. Patrice Barnes: I was listening intently to my colleague on the other side. She brought up the Kensington safe consumption site. I just want to say, let’s look at some of the things that we’ve seen through their Instagram account. We have a post that went on their Instagram account that says, “This is a beautiful chunk of fentanyl used today by one of our clients. We thank them for letting us snap a” quick “pic and share.” Or they’re crafty when they posted, “Making them pre-made crack pipes.”

Can you not see why a community would be concerned about consumption sites? What do you think about this kind of posting that seems to be creating an atmosphere where it’s okay?

Ms. Jessica Bell: Thank you are very much for that. We did extensive outreach in the community to talk about the consumption and treatment site. We went to all the retail businesses in that area. We visited the local schools. We’ve gone door-to-door in the neighbourhood, and we work regularly with the Neighbourhood Group, which is the organization that runs that consumption and treatment site.

The Neighbourhood Group is one of the most well-established and well-liked social service agencies in the area. They provide daycare services. They provide employment counselling. They hire people. They provide a drop-in service. They run some supportive housing. I cannot speak to that specific Instagram post, but I would urge you to take another look at the Neighbourhood Group, because we have a lot of respect for what they do, and many people do.

The Deputy Speaker (Ms. Donna Skelly): That’s all the time we have for questions. We’re going to move on to further debate.

Mr. Steve Clark: I appreciate the opportunity to have a few minutes to talk about this very important debate on Bill 223—very important.

I had the minister in the riding last week during break week. I really appreciated Minister Kerzner's time. It's not the first time he's been in my riding, but we talked about very important issues around law and order. One of the big things we did last week on break week was, when the minister was in the riding, he announced a major investment: some \$21.8 million for the municipality of North Grenville to expand their waste water plant. Why is that important?

Interjections.

Mr. Steve Clark: Yes, you can applaud, for sure. Yes, it's great.

Why is that important? It's important because, as part of our correctional expansion, we need to build capacity. I think we all agree on the government side of the House that, for too long, these facilities weren't invested in.

The Brockville Jail, the oldest operational jail in Ontario, first opened in 1842—182 years, the jail has operated in the city of Brockville. What is our government doing to that jail? On August 27, 2020, Premier Ford was in the riding; he announced that the Brockville Jail would expand from 54 beds, up 12, to 66. Not a big announcement, but an important announcement given that 182-year asset. As well, at the time—same date, August 27, 2020—the Premier announced a new Eastern Ontario Correctional Complex in the municipality of North Grenville.

1540 Why was Minister Kerzner's announcement so important in North Grenville? Because the plant is going to—basically, the waste water plant, 30 years old—triple the cost. So we are paying our fair share; we are paying over a third of the cost of the upgrade to this facility because of the Eastern Ontario Correctional Complex.

Why is that important for debate today? Because I made the promise to our community a couple of years ago during an election that I would make sure that the government paid their way in all those associated costs. If you're going to put a law-and-order agenda forward as a government, you're going to have to make these investments—you need to pay your way. I want to thank Minister Kerzner for coming to the riding, for recognizing that.

What has happened since then? Since the Premier made the announcement in 2020—in fact, because of our capacity, the fact that we need more capacity in our correctional complex—he has announced another 184 beds to Brockville. So it's no longer going to be the 54 beds plus 12; it's going to be now another 184 beds, up to 250—in fact, larger than the facility in North Grenville, the Eastern Ontario Correctional Complex there. As well as the St. Lawrence Valley treatment centre, 100 beds, which is now going to go to 125 beds—those extra 25 beds are for females which is very important because it's not just a correctional complex, it also provides those wraparound mental health services.

But, in fact, that facility—because my predecessor Bob Runciman announced the St. Lawrence Valley treatment

centre when he was the Solicitor General—was actually going to be a 200-bed facility. During the 2003 election, the then Liberal candidate Dalton McGuinty announced that if he became Premier, they were going to honour that expansion—they were going to expand it to 200 beds—which, immediately upon becoming the Premier, Dalton McGuinty cancelled that project.

We are now building capacity back in Brockville that was taken away by the left-wing agenda of Ontario. They are in favour of law and order on PAO Day when all the police are here, but then in the chamber, they revert back to their normal mantra.

So just to show that we had a plan to build that capacity in the 1990s, and the second that the Liberal-NDP agenda took over in 2003 for 15 years, that was one of literally the first cuts—regardless of what was said on the campaign trail—the decision was made to stop that, and we're now just building that old capacity back.

Thanks to Minister Kerzner for the announcement and thank you for providing the municipality the certainty that they need around that plant.

Mrs. Robin Martin: We're investing in justice.

Mr. Steve Clark: We are investing in justice; it's very important. That is part of this bill.

I'm going to talk about the HART hubs, the homelessness and addiction recovery treatment hubs. A lot of conversation about it here today from the opposition. I've got a community that can't wait. They applied. The one thing that this program did in August at AMO when Minister Jones announced it, all of my municipal officials—all on board with it. We had a situation where, just before the last election, I announced six treatment beds and six withdrawal management beds—

Interjections.

Mr. Steve Clark: I know, it was great. I applaud it. I talked about it in the election. What happened was the agency gave the beds back. The member for Peterborough—Kawartha was actually very happy because those beds were transferred.

So now, finally, we have the mental health and addiction agency that covers both my riding and the member for Lanark—Frontenac—Kingston's riding. We're now working together, we've got all the mayors, all the municipal officials, all the stakeholders—we are now working together, and now we've got this wonderful homelessness and addiction recovery treatment hub—the HART hub—application that covers not just the member for Lanark—Frontenac—Kingston's riding, but my riding as well.

It is part of what Minister Tibollo talks about over and over again, it's the hub-and-spoke model, it's the continuum of care, where you've got everybody working together to make sure that we get the outcomes we want.

Unlike some of the members across, who are dealing with an announcement that Minister Jones made at AMO, it was really appreciated by AMO, by local mayors. And it didn't matter whether you were a big-city mayor or whether you were a small township mayor. People appreciated the significant investment that our government

was making and the fact that it aligned so very well with Minister Tibollo's continuum of care. I had him in the riding for one of his famous round tables. The guy literally is the most travelled minister in the government. It's that old "I've been everywhere, man." He's been everywhere. He's been everywhere in this province.

The one thing that I want to give him credit for—he really unified all those people. I'm not going to speak for MPP Jordan, but we've had a lot of fractious discussions amongst mental health and addiction providers. There's been periodically a divergence of opinion on how to handle things. But now, because of Minister Jones and the ministry with these HART hubs, we now have everybody on the same page that this is the way to move forward.

I'm very, very pleased, Speaker, that we're having this conversation, because in ridings like mine, where we need to build capacity in our correction facilities, where we don't have those treatment beds and those withdrawal-management beds, we need to have that coordinated opportunity so that mayors and agencies who want to provide supportive housing—I'm going to pick on MPP Jordan, because we do share so many resources in Lanark and Leeds-Grenville, that it finally gets people on the same page. It finally has people working. We've got about over 100 on our by-name list in Leeds-Grenville, and I've got the mayors talking about building a supportive housing project that's 150 units. It would effectively wipe out the by-name list in the riding. It would be unbelievable if we were able to do that.

We now have mayors and agencies and non-profits, people like the John Howard Society, folks that come out of church basements. There's a great hub that is operating in the riding that provides overnight accommodation and other groups like Indwell.

I'm looking at the Minister of Sport. I toured a facility in his riding, or in Hamilton: top-notch organization that wants to work and be a partner with the government, that wants to make sure that they take those housing dollars and leverage them with the mental health dollars.

Again, I want to give credit to Minister Jones and Minister Tibollo for being able to do that work, provide that opportunity. I know in my community we can't wait—

The Deputy Speaker (Ms. Donna Skelly): I apologize to the government House leader. However, pursuant to standing order 50(c), I am now required to interrupt the proceedings and announce that there have been six and a half hours of debate on the motion for second reading of this bill. This debate will therefore be deemed adjourned unless the government House leader directs the debate to continue.

Mr. Steve Clark: Speaker, please adjourn the debate.
Second reading debate deemed adjourned.

The Deputy Speaker (Ms. Donna Skelly): The government House leader is seeking unanimous consent to adjourn. No? To see the clock? Hang on a second.

Orders of the day. I apologize.

Mr. Steve Clark: Madam Speaker, if you seek it, you will find unanimous consent to see the clock at 6.

The Deputy Speaker (Ms. Donna Skelly): Now the government House leader is seeking unanimous consent to see the clock at 6. Agreed? Agreed.

PRIVATE MEMBERS' PUBLIC BUSINESS

COMMUNITY SAFETY

Mr. Billy Pang: Speaker, I move that, in the opinion of this House, November should be proclaimed as Community Safety Month in Ontario.

The Deputy Speaker (Ms. Donna Skelly): Pursuant to standing order 100, you have 12 minutes for your presentation.

Mr. Billy Pang: I'm grateful for the opportunity to rise in this Legislature today to present my motion that, in the opinion of this House, November should be proclaimed as Community Safety Month in Ontario. This motion addresses a critical issue affecting Ontarians across the province: the increasing prevalence of crime and the urgent need to enhance community safety and crime prevention efforts.

Crime is no longer just a distant headline. For many, it has become a harsh and personal reality. From break-ins and car thefts to violent home invasions, these incidents disrupt the lives of our family, friends and neighbours. They rob us of peace of mind and undermine the sense of security we deserve. It is deeply concerning that many Ontarians now feel unsafe in their own homes, places meant to provide comfort and sanctuary. Parents worry for their children. Seniors, who deserve to enjoy their retirement years in peace, feel vulnerable.

1550

This is not the Ontario we strive to build. This is why I have tabled this motion to establish November as Community Safety Month.

Before discussing the broader impact of this motion, I want to acknowledge the leadership of the Honourable Michael Kerzner, our Solicitor General, and his dedicated team. Their work on the Safer Streets, Stronger Communities Act, 2024, demonstrates their unwavering commitment to addressing public safety concerns.

This important legislation enacts two acts and amends various others to strengthen public safety and the justice system, helping to address the pressing issues facing our communities. I am proud to announce that, echoing to my motion, the schedule of this act enacts the Community Safety and Crime Prevention Month Act, 2024, proclaiming the month of November each year as Community Safety and Crime Prevention Month.

Speaker, this initiative stems from a clear recognition: Safety is a shared responsibility. Our goal is to bring together residents, law enforcement and local organizations to promote crime prevention strategies that reduce crime rates, increase public awareness and foster a stronger sense of vigilance and community engagement. It

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Clerk: Trevor Day

Président : L'honorable Ted Arnott
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While I salute the compassion the minister has proposed in this debate with this HART hub model, with the idea of counselling and employment services and housing and food support—that is all great, but we have to make sure people don't die from the poisoned supply that we have in our streets. It was confirmed to me recently by members of the Ottawa police force, who are seeing this every single day when they walk around our communities: people who are literally overdosing because of the criminal element in our city that is selling a substance to someone they know to be lethal.

So that's what I want to say, Speaker. I want to say, from the bottom of my heart, thank you to the Registered Nurses' Association of Ontario. These folks are on the front line, many of whom work in our CTS site in Ottawa Centre. They know, as do our first responders. So it's a plea to the government, through this petition, that they listen to the signees of this petition, make sure we maintain our CTS treatment services and offer a full spectrum of care and support to people who we want to save. We don't want them to leave this Earth; we want them to wake up tomorrow and know they're loved, and get them to seek support and treatment.

Thank you. I'll send it to the Clerks' table with Maadhav.

HOUSE SITTINGS

The Acting Speaker (Ms. Bhutla Karpoche): I beg to inform the House that, pursuant to standing order 9(g), the Clerk has received written notice from the government House leader indicating that a temporary change in the weekly meeting schedule of the House is required, and therefore the afternoon routine on Wednesday, December 4, 2024, shall commence at 1 p.m.

ORDERS OF THE DAY

SAFER STREETS, STRONGER COMMUNITIES ACT, 2024

LOI DE 2024 VISANT À ACCROÎTRE LA SÉCURITÉ DANS LES RUES ET À RENFORCER LES COLLECTIVITÉS

Mr. Kerzner moved third reading of the following bill:

Bill 223, An Act to enact two Acts and to amend various Acts with respect to public safety and the justice system / Projet de loi 223, Loi édictant deux lois et modifiant diverses lois relatives à la sécurité publique et au système judiciaire.

The Acting Speaker (Ms. Bhutla Karpoche): I turn back to the minister to begin debate.

Hon. Michael S. Kerzner: It's an honour to rise on third reading, and final reading, of Bill 223, the government's proposed Safer Streets, Stronger Communities Act, 2024.

I've said this many times: There is no greater inherent right that we all have across Ontario, regardless of where

we live, than that inherent right to live safely in our homes and communities: that right we all have to make sure that when we wake up our kids in the morning, they will go to school safely; that we will be able to go to work; that we will be able to come home at the end of the day, to shop and to play with our kids and check in on our seniors and loved ones, and have a place to pray safely.

It has been a privilege of a lifetime to stand alongside our Premier, Premier Doug Ford, prioritizing our public safety morning, noon and night. And our government will not stop. When others told us to give it up, find another priority, go in another direction, we said no. We said we will fight auto theft and we will fight it hard. We will fight to make sure that the federal government knows how serious—they need to change the bail laws. We don't want violent and repeat offenders on our streets. When they told us to stop and not invest more money at the Ontario Police College so that we could graduate more constables to keep us safe, we kept going. When they told us to sit down, we stood up. When they told us to be quiet, we made sure our voices were heard.

Ontarians trust our government, under Premier Ford, to keep them safe.

Madam Speaker, there are a number of important things in Bill 223 that are important—and I want to thank my colleagues and the other ministers, the member from Thornhill, the member from Haliburton, and others who contributed to this bill.

There's something that became very personal to me. It's when I got to meet the Stephenson family—the parents of the late Christopher Stephenson, who was taken on Father's Day a long time ago, in 1988, and was brutally murdered. It was Premier Mike Harris who came forward over 20 years ago with Christopher's Law (Sex Offender Registry). The bill was named in memory of Christopher Stephenson, an 11-year-old boy who was the victim of an unspeakable tragedy. We go through times in our lives when we can't actually believe they're happening. There's a surrealness when we are elected to this amazing House of democracy, but when we have moments that become personal and real—when I met the Stephensons, it was overwhelming.

This change that we're making in Bill 223, amongst other things, closes the loop on one's ability to change their name, to hide—to think it was okay with what they did, and they can re-create themselves under another identity. I'm so glad that under our changes, under Bill 223, we're closing that.

Bill 223, with regard to the changes in Christopher's Law, also goes back to the fact that police services need to have additional tools, because we've come of age—we have Internet. We have social media. Police services must have the sophistication they need at all times to keep Ontario safe.

Madam Speaker, I'll end my remarks where I started. It is a privilege to be the Solicitor General for Ontario and to stand with Premier Ford morning, noon and night, to do everything we can to be that trusted voice for Ontarians—that our government will not stop, we will not rest, we will

not be silent in our quest for public safety for everyone. This is our inherent right. Our government will do everything to make sure that right is fulfilled.

The Acting Speaker (Ms. Bhutla Karpoche): Further debate?

Mr. John Fraser: It's a pleasure to speak to Bill 223. Public safety is important to Ontarians, important to Ontario families, and there are measures in this bill that are going to help in that regard. I do agree with some of the things around bail reform. But one of the things I have the most concern about in this bill is that while the government is pointing the finger towards Ottawa, it's doing nothing about court delays—nothing. We know that court delays force judges to do things like worry about the constitutionality of whether someone gets a fair trial. We know it's a problem. So I would take what the government is doing more to heart—and I'm going to support the bill—if they actually were doing something on court delays. Everybody can shrug it off and say, "It's not our fault." Well, it is. It's that simple. Fix court delays.

1330

I know the government is planning to build more jails. The important thing is that jails are safe places for the people who are there, the people who work in there, the correctional officers, the nurses, the administrators. They need to be safe places, and when they're not safe places, then what happens is, we get somebody either getting a reduced sentence or not being sent there.

I know about jails because my dad used to work in the corrections system for a long time. The most important thing is calm and order. I know the Solicitor General knows that, and I'm sure that's what he's aspiring to achieve in each and every correctional institution. They have to be safe places. I want to reiterate that.

Now, the thing that I have the most concern about in this bill—and I voted for it—is what's happening with safe consumption sites. I agree: They shouldn't be that close to schools. I think we all agree on that. Safe consumption sites are there to save lives. You can't treat somebody if they're dead. It's that simple. So while I'm supporting this bill, it's incumbent upon the government to ensure that there is not a large gap in service.

I know the government has got RFPs out, and they're looking for people for the new program, which includes addictions treatment and counselling, but if there's a big gap, if people can't go to a place where it's safe for them, we're not going to be able to treat them, because they're not going to be alive. That's the biggest concern I have with the bill.

I know the members on the other side were a bit excited that I voted with them a couple of times this morning, but make no mistake about it: I know what the game at hand is here, but we've got to make sure that those people who are suffering from addictions, who are at risk of dying—they're people's sons and daughters and mothers and fathers. We've got to make sure that as of March 31 this year, we don't have a gigantic gap in service that's going to result in more people dying and not being able to get addictions treatment: those sons and daughters, those

mothers and fathers, those aunts and uncles, those friends and neighbours.

The Acting Speaker (Ms. Bhutla Karpoche): Further debate?

Ms. Laura Smith: It's an honour for me to be here and speak to this bill, the Safer Streets, Stronger Communities Act. This significant bill includes a multi-level approach in assisting our police to better track offenders, including measures and amendments that will seek to enhance Christopher's Law, which is the basis for Ontario's Sex Offender Registry. This is, quite simply, positive news for Ontarians, especially our most vulnerable: our children. It provides for better monitoring of those who have committed offences, giving our police partners stronger capabilities to track offenders, including those who have committed heinous crimes against our children.

For the purposes of my remarks today, I'm going to focus on the portion of the bill that falls under Christopher's Law. In my previous life, just a few short years ago, I dealt with matters under the child protection act. Sadly, I really saw the underbelly of a system that dealt with the most heinous of offenders. When I had the opportunity to bring real action as a representative of the community and support our most vulnerable, I worked alongside my colleague the member from Haliburton—Kawartha Lakes—Brock on a private member's bill, Bill 138, the Change of Name Amendment Act. This bill narrows in on those offenders who have committed crimes and then attempt to hide from their victims and the communities by making application to legally change their name.

Speaker, name changes are relatively common in Ontario and often include a positive transition in life. I used to deal with them quite commonly. It could be a new beginning for an adopted child or perhaps a way for an individual to capture a part of their family lineage. But sadly, there are so many bad actors who use this application to hide their identity for the wrong reasons. These convicted offenders could take advantage of this opportunity of a legal name change to distance themselves from crimes so very heinous, providing them with a new life and a fresh start. This is something that their victims will never have.

The right to change one's name should not be abused. As a community of people who sit within this House, I believe we have a moral obligation to put the rights of the victims first. I'm proud and honoured that my work around Christopher's Law is being absorbed into the Safer Streets, Stronger Communities Act, but let me give you a bit of background on this area of the bill.

In 1988, when Christopher Stephenson was just 11 years old, he was kidnapped at knifepoint at a Brampton mall. After hours of abuse, the abuser killed Christopher and left his body in a field. It was determined through investigation that the person responsible for the attack was a repeat sexual offender.

I want to thank the Stephenson family for their determination and courage. When I saw them last week—and I spoke to Mr. Stephenson just a few days ago—they

reminded me that Christopher would have been 48 years old on November 9. His father shared with me that Christopher loved hockey and baseball. He was extremely well liked, and he excelled at school. In the fifth grade, Christopher wrote a beautiful poem about The Fire. This seems fitting as it was from the ashes of this horrific experience that Christopher's parents rallied to create Christopher's Law, also known as the Ontario Sex Offender Registry, which came into effect in 2001.

The work is quite simple: to empower police and effectively track sex offenders that fall into this registry by banning them from making application for a legal name change. Speaker, let me be clear: Ontario currently has strong laws and Ontarians seeking a legal name change must undergo a criminal record check. But under most circumstances, those who change their name must register these details with the Ontario Gazette, where name changes are published. Yet truthfully, Speaker, most Ontarians do not read the Gazette, let alone know of its existence. While safeguards do exist, they still do not prevent convicted sex offenders from making application to change their names here in Ontario. I think of Kevin Daniel Hudec, who was charged with possessing and making child pornography in Saskatchewan, who legally changed his name to Gabriel Michael Fisher. And I, like most, certainly think of Karla Homolka, who is now living under the name of Leanne Teale in Quebec. My understanding is that Ms. Homolka—or should I say Ms. Teale—was at one point volunteering at a school.

As a mother, this is especially problematic. It hits home for me; it really does. We have to work to protect Ontario's children, our most vulnerable citizens, with robust legislation. Closing this loophole will strengthen our government's zero tolerance against sexual offenders. And our position with survivors and their families—putting them first and not the thousands of offenders who have committed the most heinous and reprehensible crimes against our most precious citizens. This bill, if passed, will stop the Karla Homolkas of the world from becoming Leanne Teale.

I want to extend my thanks to the Premier for his support, and I also want to thank the gracious Stephenson family for their steadfast dedication to this cause. I hope everyone will support the Safer Streets, Stronger Communities Act for the sake of our communities, our children and our children's children.

The Acting Speaker (Ms. Bhutla Karpoche): Further debate?

Mr. Joel Harden: I'm happy to rise in a debate about public safety. I want to begin the debate by acknowledging events that are currently happening right now outside this chamber with direct relevance, I think, to the Solicitor General's bill. The Solicitor General has taken an interest—and I'm thankful for it—in the safety of transit in our city and the new deal for Ottawa. This is a major issue and I'm happy to work with him and his government on this, but it's going to be a lot easier working for transit policy in the province of Ontario now that, as I understand

it from revelations online, Metrolinx CEO Phil Verster has resigned today—resigned.

What that shows is that the precious funds that the taxpayers of Ontario share with this House so we can distribute them to services are going to, we hope, go directly to services like safety on transit in downtown Ottawa, and for goodness' sake, Speaker, in this city of Toronto, the LRT systems that are constantly delayed, constantly over budget, the hundreds of small businesses that have had to close because of the incompetence of Mr. Verster and his army of—wait for it—82 executive vice-presidents, up from 27 under the Liberals in 2018.

I am so thankful, as the province's transit critic, today to talk about the fact that as the minister has talked about prioritizing security on transit, we have an opportunity to do that in the greater Toronto area now that Mr. Verster is gone. I hope the Premier encouraged that action. We certainly encouraged that action on this side of the House. This is something that is an opportunity for us now that I know the government has heard the opposition because we have been calling for Mr. Verster's ouster for the better part of a year.

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It's now time for us to take those precious taxpayer funds and not distribute them to a one-million-dollar-paid individual—which, as revelations lead me to believe today, Speaker, Mr. Verster was earning a \$12,000-a-year vehicle allowance and—wait for it—he didn't even own a vehicle.

Now we have an opportunity to turn the page, to put the precious funds of the province back where they belong, to make our communities safe.

I'm thankful to pass to other colleagues, like the member from Nickel Belt, for further comment on this bill.

The Acting Speaker (Ms. Bhutla Karpoche): Further debate?

Ms. Laurie Scott: I'm pleased to be here to speak to Bill 223, the Safer Streets, Stronger Communities Act, third reading.

More than two decades ago, with the support of victims' groups and law enforcement organizations, Ontario passed Christopher's Law, creating a provincial sex offender registry. Christopher's Law was sparked by the tragic murder of 11-year-old Christopher Stephenson by a convicted pedophile. After years of dedicated advocacy by Christopher's shattered parents, Jim and Anna, a victory for survivors of sexual predators was achieved in 2001 with the proclamation of Christopher's Law.

Ontario's provincial Sex Offender Registry was the first of its kind in Canada. Before its passage, there was no way of tracking the movements of sex offenders or ensuring they could not hide their past atrocities. It was an essential tool in protecting Ontario's most vulnerable, but also, it gives police services a critical tool to prevent, investigate and solve crimes of a sexual nature and to manage sex offenders within their local communities.

We know there is growing concern, however, especially among law enforcement, that the Ontario Sex

Offender Registry needs to be updated to respond to advancements in technology, including social media, which has become the recruitment tool of choice for human traffickers. We have heard these concerns from the Police Association of Ontario, the Ontario Association of Chiefs of Police as well as numerous individuals in policing and victim support working to support victims and prevent sexual assaults.

The Peel Regional Police chief, Nish Duraipapp, spoke about how strengthening Christopher's Law will tighten protections for children and families by implementing stricter conditions for sex offenders and enhancing police enforcement abilities. The Solicitor General and the member for Thornhill were there the day that we had a press conference about this very topic, and the police chief mentioned to me that he is the same age that Christopher would have been had he been alive.

That's why our government introduced the legislation we are debating today, to sharpen Christopher's law and ensure the Ontario Sex Offender Registry continues to be an effective tool at protecting Ontario's most vulnerable.

Predators go where children go, and today, that is predominantly online. It's very sad that social media and online media has exploded in prevalence since Christopher's Law was first implemented and has become a favourite tool of predators to lure vulnerable children and others into threatening and exploitive situations.

Requiring sex offenders to report when they are starting to use or make changes to email addresses, social media, usernames and other digital identifiers would make it easier for police to more efficiently investigate criminal activities and monitor offenders on the Sex Offender Registry. The legislation would also add new strict travel notification requirements.

Our government is also proposing to amend the Change of Name Act, which would prohibit sex offenders from changing their names while they have reporting obligations to the Ontario Sex Offender Registry. This proposed change would make it easier for police to monitor sex offenders and prevent them from using a new identity to commit crimes.

As mentioned by my colleague from Thornhill, she and I tabled a joint private member's bill, an act to amend the name change act, with the goal of stopping convicted offenders under Christopher's Law from legally changing their name in Ontario.

I thank my colleague for her work before she became a member of provincial Parliament in working with child protective services, and we believe this is one measure that sends a message that predators will be held accountable for their crimes that have devastated lives.

We are grateful for the proposal and the unanimous support it received here in the Legislature. We thank the Premier, the Solicitor General and the Minister of Public and Business Service Delivery and Procurement for their responsive and decisive action. This is a sign of the zero-tolerance approach to sexual assault that our government has made.

Sexual offenders who have committed horrific crimes should not be allowed to change their names and hide their identities, and that's why we're closing the loophole already addressed in other provinces that provides sex offenders anonymity and an opportunity to escape accountability.

I just want to lend my voice to the support of this bill. Thank you very much, Madam Speaker, for the time.

The Acting Speaker (Ms. Bhutla Karpoche): Further debate? I recognize the member from Nickel Belt.

M^{me} France Gélinas: Thank you, Speaker—

Interjection.

M^{me} France Gélinas: And thank you, Jamie.

It's a pleasure to say a few words about this bill. I will go through the different schedules of the bill, starting with schedule 1. The first schedule of the bill is basically to limit advertising and promotion of cannabis that is sold unlawfully. I can tell you that, from this side of the House, you have 100% of our support. Most of the cannabis is smoked. Smoking, as we all know, produces dangers to your health. The less we promote, the less we advertise smoking of any products, the healthier the people of Ontario will be. So a step in the right direction with schedule 1—after I had already checked that it was not about cannabis on First Nations, which the minister reassured me that this was not what this was all about.

Second, schedule 2, the Change of Name Act: A lot has been said already, in the few minutes that we've taken to talk about third reading of this bill, about how wrong that is. We all remember Paul Bernardo. We all remember Karla Homolka. We all remember the awful crimes that they have committed, the young people that have died. Not being allowed to change their name, again, is a step in the right direction. They did awful crimes. They will pay for their crimes and live with the consequences of them. So, to change the Sex Offender Registry to make sure that they don't go under a different name is something that, on this side of the House, we fully support.

Same thing with schedule 3, Christopher's Law—I know that it was brought as a private member's bill. It is something that we have voted in favour of and that we supported in the past and that we continue to support.

I will skip schedule 4, but I just want to notice that, although quite a few members—including ministers and others—have talked about the bill, none of them have spoken about schedule 4. But I won't be one of them. I will speak about schedule 4; I'm just skipping it for now.

Schedule 5, the Community Safety and Crime Prevention Month Act: that in November of each year, the Community Safety and Crime Prevention Month—the more we can talk about safety, the more we can talk about prevention, to learn and share best practice, the better off our communities are going to be. Do we support schedule 5? Absolutely. We believe in health promotion, disease prevention. We believe in prevention. When people know the risk, when people know how things happen in our community that make us feel unsafe, that are unsafe, then as a community we can change things. I believe in the

power of people: The more of us know, then the better the chances that we will live in safe communities.

The next one, schedule 6, the Community Safety and Policing Act, the power to issue awards related to policing: I want to take a few minutes to talk about my good friend Sergeant Dan Lee. Sergeant Lee worked in and around Sudbury for the OPP for over three decades. He was involved in so, so many community groups in our community, helping everyone from women victims of violence to children living in poverty, to building what is called in our community the Bridge of Nations. It is just beautiful. It's a bridge right downtown that you can see from downtown everywhere, and it has the flags of all of the countries of origin of everybody who lives in Sudbury. There are 50, 60 flags? Maybe more—80.

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MPP Jamie West: Close to 80.

M^{me} France Gélinas: Yes. There are close to 80 flags on this, and it represents the diversity of Sudbury. People come from all over the world, and we live together and we live in harmony, and we like to learn from each other. I can tell you that I especially like some of the food I get to discover—because I'm a big foodie—from people coming from all over the world who come to Sudbury. And Dan Lee was instrumental—he was one of the people.

I had the privilege of attending his funeral last Friday. I can tell you, Speaker, the church was packed with community leaders from every organization in Sudbury and many, many people who Dan Lee, the OPP officer, helped through his career. Kids who were no longer kids, who he had taken under his wing—he started a sports club for children coming from poor neighbourhoods or at risk of getting in trouble with the law, and he would take them under his wing and make sure they made the right decisions. I'm really sorry that Dan is no longer with us. But I certainly like schedule 6. I know that there are other outstanding police officers who do so much. Sure, they respond to the call of duty when they're on duty, but they also do so much off duty to keep our communities safe, to keep our communities healthy—and creating links. He retired and was very involved with the OPP retirees who do all sorts of beautiful work in our community. So schedule 6, to issue awards related to policing—100%, you get our support for that. We have some really outstanding members of the different police services throughout our province. They certainly answer the call of duty; many of them go way beyond that, to make our communities safe, and I would love to be able to give those good men and women and LGBTQ an opportunity to be awarded.

Next is schedule 7. Schedule 7 is sort of technical in nature, giving former provincial judges who have retired the chance to work more than 50% full-time in a calendar year. There were many victims of crime who came to Queen's Park two weeks ago because they never had a chance to have their day in court. Many of them were women victims of violence who—the time had ticked, and they never got their day in court. Do we need to bolster our court system so that everybody has access to justice in a

timely way? Absolutely. Will schedule 7 fix all the problems? No. But it is certainly a small step that can be done in the short term so that former provincial judges who have retired, who choose to come and help, would have an opportunity to continue to work if they so choose.

Then there's schedule 8, the Highway Traffic Act. Again, the member from Oshawa has spoken at length about some steps that could be taken in the short term regarding the VIN numbers on vehicles—vehicle thefts continue to be rampant—and all of the problems that come with that. There are a few good steps in schedule 8. Had we had an opportunity to have hearings and have debates, I can guarantee you that a lot of people would have come to tell the government there is an easy step that you can take right here, right now, that other provinces in our country have taken to make sure that we do everything we can to decrease auto theft. Unfortunately, they are not in schedule 8, but a few other small steps are being taken.

In schedule 9, the Limitations Act—“not subject to a limitation period and to specify related transitional rules” for the Justice for Victims of Terrorism Act. This idea that the victim of a terrorist attack had a very small amount of time to bring their case to the justice system—I don't know too many victims of terrorist acts, but I can just imagine the post-traumatic stress disorder that comes with having lived through this. Giving them time for them to get the strength to be able to go through a court proceeding I think is something very humane to do. I think it's something that will help people who are victims of terrorist acts—which I hope there are as few of them as possible. I don't like crime, but we all know that it does happen.

So there's a lot of good steps in the bill. There's lots of steps that go into the right direction. We've made suggestions to go further in the same direction that you are pointing but never really had an opportunity.

I see people in the gallery. Usually, a bill goes through first and second reading. After second reading, we give everyone in Ontario an opportunity to be heard. If this bill is going to affect you, affect your community, your family, somebody you know, you have an opportunity to come to Queen's Park—or through Zoom if you, like me, live up north and don't like to travel through a snowstorm—and be heard and be questioned. After we listen to what people have to say, then we make changes to the bill. Often the changes that I have seen done are really, “This is what we wanted to do but we realized that, oh, we never realized it would have had an impact on people of the north. Oh, we never realized it would have a negative impact for another group. Let's make sure that the aim that we wanted, the objective that the bill was supposed to do, actually does that.” But the government negated, cancelled all of this.

We voted on this bill in second reading less than two hours ago—an hour and 50 minutes ago, to be specific—and here we are in third reading. We never gave the people of Ontario an opportunity to be heard. We never gave the people of Ontario an opportunity to make the bill even stronger by making sure that if you support the direction, maybe rather than taking one tiny step, maybe we will take

one big step in that direction and go even further with ideas that come from all over our great province. This did not happen.

I do want to speak about schedule 4. Schedule 4 has not been spoken about by any of the members of the Conservative Party, but we in the NDP have to talk about schedule 4. Schedule 4 talks about consumption and treatment sites. Consumption and treatment sites are sites that we consider harm reduction. For people that have a mental illness and addiction, the stigma that exists in our community often makes it really hard for them to seek help. They often get ostracized, they get discriminated against, they get isolated, and it becomes really hard for them to gain access to care. Through the consumption and treatment sites—basically it is a place where they feel like they belong. It's a place where they feel safe, and with the highly toxic drug supply circulating through our province right now, it's a place where people who use drugs can do this. It's never safe to use drugs, but they can do this under supervision.

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The nice thing about consumption and treatment sites is that it's a safe place for a person who deals with an addiction to establish a link with a health care provider. As I say, they go to the emergency department, it is really tough. The people in the waiting room will discriminate against them. Often, even the people who work in the ER will discriminate against people that deal with mental issues or addiction issues, but not in a consumption and treatment site. There, they will be treated with respect. They will be helped. They will be kept alive.

What happens is that once the health care providers who work at the consumption and treatment sites establish a trusting relationship, this is the first step towards the path to recovery. This is Ontario. This is 2024. We know how to treat mental illness. We know how to treat addiction. There is treatment out there that exists. You will be healthy again, but you have to get to those treatment sites, you have to gain access to those treatments.

I can speak for my community. I come from northeastern Ontario. For the families that I serve that have a child under the age of 18 that deal with mental health or an addiction issue, there is an 18-month wait-list in order for them to gain access to treatment. During those 18 months, lots of awful things can and do happen. We need to work at many, many levels to make access to mental health and addiction accessible to all, to make it so that it responds to people's need. Right now, we are not there, but the consumption and treatment sites establish this respectful relationship, put them on a path to recovery, make sure that if they continue to use drugs that they do it in a place where if they do overdose, they're not going to die from it.

In my community, it is a minimum of two people every single week that die of overdose. I was at the Ontario Professional Fire Fighters Association Christmas dinner this weekend, and on every shift, they say that it's eight, 10, 12 overdose calls that they get on every single shift in my community.

We had a consumption and treatment site in Sudbury for about a year. It was paid for by the municipal government because they knew that the need was there while they waited for funding from the provincial government. The funding from the provincial government never came and then people donated to keep the site open. Because it doesn't matter where you live in Sudbury, there's a good chance you know somebody who has died of an overdose.

Me, personally, my nephew and two of my close friends have died of a drug overdose. The poisoning of the drugs throughout Ontario is just a killer. The consumption and treatment sites test the drugs, they help people if they overdose, they establish that trusting relationship so that you keep them ready while they're on the wait-list, waiting and waiting and waiting for their turn to come to finally gain access to treatment. You keep them alive. You keep them on a good path. But all of this disappeared. The consumption and treatment site in Sudbury closed. We are now at four times the death rates compared to the other parts of the province.

The community next to us, in Sault Ste. Marie, is at six times the death rate from drug overdose from what it is throughout Ontario. It's the same thing for Timmins. In northern Ontario, we only have one consumption and treatment site. It's located in Thunder Bay, and it is scheduled to close like eight others. I want people to realize that we have the body of evidence that supports that consumption and treatment sites save lives.

I want to quote from The Lancet. The Lancet is a medical journal that has existed since 1923. It is peer-reviewed. They did a study of consumption and treatment sites right here in Toronto. They looked at the death rate in the neighbourhood before the site opened and after the site opened. I encourage all of you to read this.

The body of evidence is very strong that everywhere consumption and treatment sites existed, they saved dozens of lives every month. The statistics were there. They went from 70 deaths per 100,000 people to two deaths per 100,000 people from May 1 to July 31. They go area by area in seven sites in Toronto and show the positive effect they have had in keeping people alive until their name finally comes to gain access to treatment.

I know that the government has announced other treatment sites, hubs that will open. We know when the nine consumption and treatment sites will close; it is on March 31, 2025. We know exactly when they close. We know that the new services that the government has promised to put into place won't come into place till December 2025, a full nine months. You cannot take away a service that saves lives with a promise of something that will come nine months later. How many people will die during those nine months? I'm ready to guess it will be thousands of lives. If the statistics continue the way they are, 60% of them will be young men between the age of 20 and 35. This makes no sense. Let's keep them alive.

Had we had an opportunity to have clause-by-clause consideration of your bill, we would have asked to withdraw schedule 4. I've already talked about schedules 1, 2, 3, 5, 6, 7, 8 and 9. They're all steps in the right

direction; they're all things that the NDP is pleased to support. But schedule 4, the closing of consumption and treatment sites: If you find that they're too close to a school, move them away. Don't close them. If you feel that there's a better neighbourhood, sure, do this. But don't just take away preventive health care services that keep people alive, because they will die. Rather than having one nephew and two of my friends dead, I will be standing here with many more deaths. That makes no sense.

Those are all preventable deaths. It is on our shoulders to do the right thing. Put the consumption and treatment sites in a safe place away from schools—yes, absolutely. But don't just close them before new services are available. You are giving a death sentence to people.

The Acting Speaker (Ms. Bhutla Karpoche): Further debate?

Ms. Aislinn Clancy: I appreciate the opportunity to speak about this. I live a few blocks, actually, from a CTS site. I walk past it on my way to work every day. Before it came about—actually, when it first started—I walked along my street. I have young kids. I walked along my street and I did find a needle. I had a phone number, and I reported it and it was disposed of.

Since that time, our program has learned and grown to be a model across the province. They kept it quiet. If you walked past the clinic, you wouldn't even know that you were walking past a consumption and treatment site. It's kind of nestled into our community. It just looks like a regular office building.

A lot of the narratives I hear, I'm not sure where they're coming from. It's not the reality I've lived for the five years or six years that I've lived in my community, walking past our consumption and treatment site every day. People know they can go inside. They don't need to be out front using drugs, because they're welcome inside. Our consumption and treatment site—if you think of mental health, one of the number one ways we combat mental health concerns is by getting rid of the stigma. If you go to a consumption and treatment site—I've toured ours. You can see that it is the most stigma-free health care provider I've ever witnessed in my life.

1410

I am very grateful to this government. The investment in the HART hubs is a real, important step. It's a great investment, and my community is really celebrating the investment in addiction and mental health treatment. We know that the concerns young people face especially are off the charts. But like the member from Kitchener-Conestoga will know, the number of people experiencing homelessness in our community has doubled in the past two years.

There is a book out there where someone wanted to know how it was to be homeless, and so they decided to live as someone who is unsheltered. They found that after one week, only one week, their mental health had gone into the garbage. So people do need a way to cope. If you had to live in a tent right now, you would want to find a way to cope. Unfortunately, without alternatives, drugs are

a way to cope. They're not a healthy way to cope, but they are that.

So we have 2,300 people in our region—I know the member from Cambridge is in my region as well—double the amount of people living unsheltered this November. Every year in November, it gets cold, and every year, we don't have enough shelter beds in our region to support people living unsheltered. This is one of the refuges in that storm. Our consumption and treatment offered by Sanguen is a refuge in the storm.

This weekend, I was joined by a panel of experts. We had our child care centre that is down the street, across the street from the CTS. They support the continuation of this important health care provider. We had a woman who is not only a peer support worker but also has used the services herself. She said when her mom died, she went and got drugs again and used meth again because she was grieving. But she brought it in there, she checked that it was safe. She was supported by her neighbours and the health care providers. She said because she did face this day in dignity, with people who cared about her—she said, "It is because of that that I didn't continue to use and relapse." So she didn't relapse because she could go there and get support.

I talked to front-line workers. They're sobbing. During the pandemic, they saw too many dead bodies and they were breaking down in front of me, worried that they would experience this trauma again. I think it's a courtesy to our front-line workers to listen to them and not cause them undue stress.

Clean needles: We're seeing that clean needles will no longer be provided. This is the undoing of 40 years of good harm reduction treatment. So while we'll take a dirty needle, we won't give someone a clean needle? Well, people don't come in to just give you their dirty needle. They come in to give you the dirty needle because they can get a clean one. Just last summer in London, we saw an AIDS outbreak. Imagine that: an outbreak of AIDS in London, Ontario, this past year. Our public health is worried about that. That is a cost on our health care system that is unnecessary.

So not only do we need this to prevent added stress and strain and cost on our health care system; we need to keep these sites to prevent the trauma of our front-line workers and further burnout of underpaid health care providers. We need it to support the folks living unsheltered because we don't have enough beds or supportive housing, and because of that, they fall into addictions and mental health problems. So this government has given them a death sentence.

I hope none of us have to have a family member who receives a diagnosis saying you have—how many months is it now? December, January, February, March: four months—so we've just said to thousands of our neighbours in Ontario, "You have four months to live." That's not right. Your government shouldn't be giving you a diagnosis that means you will have an end of life.

And then I do applaud the barriers for sex offenders to change their names, but I call on the minister from York

Centre. In York Centre, four programs in Ontario—three of federal funding, one of provincial funding—were closed, and they are programs that prevent sexual offenders from offending again. Four programs that are supported in data to prevent sex offenders from offending again were closed in this province in a matter of a few months.

I appreciate that we want to make it harder for sexual perpetrators to hide themselves, but we should ensure the mental health care that they need to not reoffend exists. These are closed programs, they're good bang for your buck, and prevention is the way we should be going in this matter.

The Acting Speaker (Ms. Bhutla Karpoche): Further debate?

Hon. Todd J. McCarthy: I proudly join third reading debate this afternoon on a matter of the utmost importance to the safety and the well-being of all of our communities. That is Bill 223, the Safer Streets, Stronger Communities Act. This legislation is a testament to our unwavering commitment to protect our most vulnerable citizens and to ensure that justice is served.

Two and a half decades ago, Ontario led the way with Canada's first sex offender registry, and today we are making it stronger. The proposed enhancements to Christopher's Law (Sex Offender Registry), 2000, will provide our police services with the necessary tools to better monitor and supervise registered sex offenders. These changes are not just administrative; they are essential steps to prevent, investigate and solve egregious sex crimes, particularly those that target our children.

The amendments we are introducing will require sex offenders to report to a police service within a prescribed period of time after being ordered to serve a conditional sentence or receiving a passport or driver's licence. They will also mandate offenders to report any changes to their digital identifiers, such as email addresses and social media usernames. Additionally, new, strict travel notification requirements will ensure that registered sex offenders provide advanced notice of their travel plans, enhancing our ability to monitor their movements and prevent potential harm.

Furthermore, our government is proposing critical changes to the Change of Name Act. These amendments will prohibit sex offenders with active reporting obligations from legally changing their names. This measure will close a loophole that has allowed offenders to evade detection and to avoid accountability, thereby enhancing public safety and ensuring that these individuals cannot hide their identities to commit new crime.

These legislative changes are not just about tightening regulations. They're about protecting our citizens and residents and supporting victims and their families. The tragic case of Christopher Stephenson, whose murder led to the creation of Ontario's Sex Offender Registry, reminds us all of the devastating impact that these crimes have on families in our province. We owe it to Christopher's memory and to countless other victims to ensure that our laws are strong and effective.

Our government's commitment to public safety is unwavering and the people of this province trust our government and our Premier, the Honourable Doug Ford, with safety and security measures such as contained in this bill. By strengthening Christopher's Law and the Change of Name Act, we are providing law enforcement with the tools they need to keep our community safe. These measures will help maintain Ontario's high compliance rate for registered sex offenders and ensure that those who pose a risk are closely monitored.

I want to take a moment to acknowledge the tireless advocacy of the Stephenson family, victims' groups and law enforcement organizations. Their efforts have been instrumental in shaping these legislative changes that we are proposing. We also recognize the support of the Police Association of Ontario and the Ontario Association of Chiefs of Police, who have wholeheartedly endorsed these enhancements as vital tools for preventing and solving crime.

In closing, I urge all members of this House to support Bill 223, the Safer Streets, Stronger Communities Act. It is a crucial step toward a safer Ontario where our children and communities are protected from those who seek to do harm. Let us stand together in support of these measures and reaffirm our commitment to justice and public safety.

The Acting Speaker (Ms. Bhutla Karpoche): Further debate?

Mr. Billy Pang: I'm pleased to join today's debate and speak in support of Bill 223. One of our most fundamental responsibilities as elected representatives is to uphold the safety of our communities. The Safer Streets, Stronger Communities Act, 2024, introduced by the Solicitor General, is a vital step in ensuring just that.

This bill will create a safer Ontario by addressing pressing concerns such as auto theft, fraud, illegal cannabis sales and sex offender monitoring, while providing stronger tools to law enforcement and, overall, protecting all Ontarians. As I've mentioned in my earlier motion to designate November as Community Safety Month, we must acknowledge the real and growing fear many Ontarians are experiencing right now as crime rates surge, concerns expressed by families, friends and neighbours all across Ontario.

In November, I had the privilege of participating in an important community meeting hosted by the Markham Community Alliance. Over 200 residents joined York Regional Police and community leaders to address the growing crime wave in Markham-Unionville. At that meeting, I heard first-hand from community members about their vehicles being stolen, homes that got broken into and people getting robbed. These stories reveal not just the statistics behind crime, but the fear and vulnerability people feel in their own homes, for their own lives.

The meeting also showcased our community's strong voice through a petition titled "Stop Crime, Safer Communities," which gathered over 5,300 signatures. This initiative highlights our community's urgent call for stronger action against crime and for measures that priori-

tize safety and justice, not just in Markham–Unionville but all across the province of Ontario.

The Safer Streets, Stronger Communities Act is a significant step in strengthening our commitment to community safety and addressing the urgent concerns of Ontarians. While this act aims to enhance the tools and the resources available to protect our communities, it also calls attention to the need for urgent reforms in the bail system. But the federal government's lenient bail policies continue to undermine the efforts to keep Ontarians safe.

Our government has invested in programs and initiatives to prevent youth from engaging in criminal activities. Our government has been fighting hard against auto theft, investing in new helicopters, expanding the joint air support unit and putting more boots on the ground. But the question we kept asking the federal government remains the same: How many more Ontarians have to suffer because of weak bail laws that allow violent and repeat offenders to return to our streets?

Every time a dangerous offender is granted bail, it puts our neighbours, families and communities at risk. This leniency is allowing criminals to target innocent people again and again, while those who break the law continue to roam free, causing harm to others.

Although we have yet to receive answers from the federal government about why they continue to allow weak bail laws that put Ontarians at risk, Bill 223 takes direct action against rising crime rates by providing law enforcement with the tools they need to effectively fight crime and protect our communities.

This bill strengthens laws such as Christopher's Law, enhancing the Ontario Sex Offender Registry, and proposes changes that will make it harder for offenders to hide their identities or continue their crimes undetected.

The efforts of the Solicitor General reflect our government's commitment to build a safer Ontario, addressing immediate safety concerns while laying the groundwork for long-term change.

In closing, the Safer Streets, Stronger Communities Act is more than just legislation; it's a promise to our communities, a promise to ensure every resident can live and thrive without fear. Let's work together to pass this bill to create a safer future for Ontarians.

The Acting Speaker (Ms. Bhutla Karpoche): The time for debate on Bill 223 is concluded.

I beg to inform the House that the Clerk has received a submission related to Bill Pr55, An Act respecting Mount Pleasant Group of Cemeteries. Pursuant to standing order 93(a), the submission stands referred to the Standing Committee on Procedure and House Affairs.

Mr. Kerzner has moved third reading of Bill 223, An Act to enact two Acts and to amend various Acts with respect to public safety and the justice system. Is it the pleasure of the House that the motion carry?

All those in favour of the motion will please say "aye."

All those opposed to the motion will please say "nay."

In my opinion, the ayes have it.

I declare the motion carried.

Interjection: On division.

The Acting Speaker (Ms. Bhutla Karpoche): On division.

Be it resolved that the bill do now pass and be entitled as in the motion.

Third reading agreed to.

Mr. Steve Clark: Point of order, Speaker.

The Acting Speaker (Ms. Bhutla Karpoche): The government House leader on a point of order.

Mr. Steve Clark: Thank you, Speaker. I just want to announce to the House that the night sitting scheduled for this evening has been cancelled.

The Acting Speaker (Ms. Bhutla Karpoche): Orders of the day?

CUTTING RED TAPE, BUILDING ONTARIO ACT, 2024

LOI DE 2024 VISANT À RÉDUIRE LES FORMALITÉS ADMINISTRATIVES ET À FAVORISER L'ESSOR DE L'ONTARIO

Mr. Harris moved third reading of the following bill:

Bill 227, An Act to amend various Acts / Projet de loi 227, Loi modifiant diverses lois.

The Acting Speaker (Ms. Bhutla Karpoche): I return to the minister.

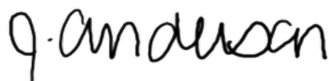
Hon. Mike Harris: Thank you very much, Madam Speaker. Everybody buckle up; another riveting 25 minutes here in the Ontario Legislature.

I will say, I am very honoured to lead off third reading debate of the Cutting Red Tape, Building Ontario Act, 2024. This package is more than just a piece of legislation. It is a crucial part of our government's ongoing commitment to cutting red tape and is the next step forward in our ongoing action to make life easier and more affordable by reducing unnecessary red tape. It also continues to build on the foundation necessary to ensure Ontario remains a leader in innovation and economic growth. It builds on the significant progress we have made since we formed government in 2018. This bill represents our dedication to reducing needless regulations while safeguarding what matters most: public health, safety and the environment.

If passed, this bill would mark another major step in reducing red tape barriers, creating more opportunities for businesses, families and individuals. Because, Speaker, red tape is not just an inconvenience; it's a barrier. It raises costs, blocks productivity and limits opportunity. Red tape challenges innovation and slows down our economic growth. For businesses, excessive regulation discourages investment and reduces Ontario's competitive advantage. For families, it drives up costs and adds frustration. Unnecessary and overregulation are a roadblock to success.

Before we formed government in 2018, Ontario was known as the red tape capital of Canada. Under the previous Liberal government, our province was burdened with over 386,000 regulations—double that of any other province. These policies weighed heavily on businesses, with compliance costs averaging \$33,000 a year. That's year over year for businesses. But, Speaker, let's be clear:

This is **Exhibit “B”** to the Affidavit of Lauren Costoff
Affirmed Remotely Before Me in the City of Barrie, Province of Ontario
this 10th day of January, 2025.

A handwritten signature in black ink, appearing to read "J. Anderson", written over a horizontal line.

A Commissioner for oaths, etc.

JANICE ANDERSON

CHAPTER 27

An Act to enact two Acts and to amend various Acts with respect to public safety and the justice system

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or read on for print version

Assented to December 4, 2024

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Preamble

The Government of Ontario:

Believes in keeping Ontario communities safe through supported and accountable policing and an efficient and effective justice system.

Is taking action to protect children, families and people struggling with addiction by restricting supervised consumption sites, in line with its belief that addictions treatment is the best way to achieve lasting recovery.

Is committed to fighting auto theft and careless driving in Ontario with enhanced oversight of commercial motor vehicles and stronger penalties.

Is working to give police the tools that will assist them in keeping our communities safe from sex offenders.

Therefore, His Majesty, by and with the advice and consent of the Legislative Assembly of the Province of Ontario, enacts as follows:

Contents of this Act

1 This Act consists of this section, sections 2 and 3 and the Schedules to this Act.

Commencement

2 (1) Except as otherwise provided in this section, this Act comes into force on the day it receives Royal Assent.

(2) The Schedules to this Act come into force as provided in each Schedule.

(3) If a Schedule to this Act provides that any provisions are to come into force on a day to be named by proclamation of the Lieutenant Governor, a proclamation may apply to one or more of those provisions, and proclamations may be issued at different times with respect to any of those provisions.

Short title

3 The short title of this Act is the *Safer Streets, Stronger Communities Act, 2024*.

SCHEDULE 1

CANNABIS CONTROL ACT, 2017

1 The *Cannabis Control Act, 2017* is amended by adding the following section:

Advertising or promotion of unlawful sale of cannabis

8.2 No person shall knowingly advertise or promote the sale of cannabis by a person or entity that is not authorized to produce, sell or distribute cannabis under this Act or the *Cannabis Act* (Canada).

2 Subsections 23 (2) and (3) of the Act are amended by striking out “section 6 or 13” wherever it appears and substituting in each case “section 6, 8.2 or 13”.

Commencement

3 This Schedule comes into force on the day the *Safer Streets, Stronger Communities Act, 2024* receives Royal Assent.

SCHEDULE 2

CHANGE OF NAME ACT

1 The *Change of Name Act* is amended by adding the following section:

SEX OFFENDERS, ETC.

Ineligibility

5.1 (1) The following persons are ineligible to have a change of name under any provision of this Act, except if an exception set out in the regulations applies:

1. A person required under section 7 of *Christopher's Law (Sex Offender Registry), 2000* to comply with section 3 of that Act.
2. A person who would be required under section 7 of *Christopher's Law (Sex Offender Registry), 2000* to comply with section 3 of that Act but for the application of subsection 7 (2) or (3) of that Act.
3. A person who has been,
 - i. found guilty of a prescribed criminal offence, or
 - ii. found not criminally responsible of a prescribed criminal offence on account of mental disorder.

Exception

(2) Subsection (1) does not apply in respect of,

- (a) a change of name that has been certified as described in subsection 8 (2) by the Attorney General or a person authorized by the Attorney General; or
- (b) a revocation under section 10 of a change of name that has been obtained by fraud or misrepresentation or for an improper purpose.

Notice

(3) The Registrar General shall inform a person who seeks a change of name but is ineligible under this section of their ineligibility and the reason for their ineligibility or, if the

change of name was applied for under subsection 5 (1), the Registrar General shall inform the applicant.

Transition

(4) This Act, as it read immediately before the day section 1 of Schedule 2 to the *Safer Streets, Stronger Communities Act, 2024* came into force, continues to apply with respect to an election or application submitted to the Registrar General before that day.

Repeal

(5) Subsection (4) and this subsection are repealed six months after the day section 1 of Schedule 2 to the *Safer Streets, Stronger Communities Act, 2024* came into force.

2 Subsection 7.1 (1) of the Act is amended by adding “and whether the person is a person described in subsection 5.1 (1)” after “subsection 6 (10)”.

3 Section 13 of the Act is amended by adding the following subsection:

Same

(2) The Lieutenant Governor in Council may make regulations providing for exceptions from this Act or any provision of this Act, and making such exceptions subject to any conditions provided for in the regulations.

Christopher's Law (Sex Offender Registry), 2000

4 *Christopher's Law (Sex Offender Registry), 2000* is amended by adding the following section:

Disclosure exception, *Change of Name Act*

10.1 (1) An employee of or person authorized by the ministry for the purposes of this section shall have access to the sex offender registry at any time and may collect, retain and use information obtained from the sex offender registry for the purposes of section 7.1 of the *Change of Name Act*.

Same

(2) An employee of or person authorized by the ministry for the purposes of this section may disclose information contained in the sex offender registry to the Registrar General, as defined in section 1 of the *Change of Name Act*, for the purposes of section 7.1 of that Act,

and the Registrar General may collect, retain and use the information for the purposes of that Act.

Same

(3) Any disclosure of personal information made under subsection (1) or (2) shall be deemed to be in compliance with clauses 42 (1) (e) of the *Freedom of Information and Protection of Privacy Act* and 32 (e) of the *Municipal Freedom of Information and Protection of Privacy Act*.

Commencement

5 This Schedule comes into force on a day to be named by proclamation of the Lieutenant Governor.

SCHEDULE 3

CHRISTOPHER'S LAW (SEX OFFENDER REGISTRY), 2000

1 The English version of *Christopher's Law (Sex Offender Registry), 2000* is amended by striking out "his or her" wherever it appears and substituting in each case "their".

2 (1) Subsection 1 (1) of the Act is amended by adding the following definition:

"Minister" means the Solicitor General or such other member of the Executive Council as may be assigned the administration of this Act under the *Executive Council Act*; ("ministre")

(2) The definition of "ministry" in subsection 1 (1) of the Act is repealed and the following substituted:

"ministry" means the Ministry of the Minister; ("ministère")

(3) Clause (b.1) of the definition of "sex offence" in subsection 1 (1) of the Act is repealed and the following substituted:

(b.1) an offence referred to in paragraph (b) or (f) of the definition of "designated offence" in subsection 490.011 (1) of the *Criminal Code* (Canada), as it read on October 25, 2023, in respect of which an order in Form 52 was made under subsection 490.012 (2) of that Act as it read on that date,

(b.1.1) an offence referred to in the definition of “secondary offence” in subsection 490.011 (1) of the *Criminal Code* (Canada) for which an order has been made under section 490.012 of that Act,

(4) Subsection 1 (1) of the Act is amended by adding the following definition:

“sex offence against a child” means,

(a) a sex offence that is committed against a person who is under 18 years of age and as a result of which the offender is required to comply with the *Sex Offender Information Registration Act* (Canada), or

(b) an offence that is committed outside Canada against a person who is under 18 years of age and as a result of which the offender is required to comply with the *Sex Offender Information Registration Act* (Canada); (“infraction sexuelle visant un enfant”)

(5) Section 1 of the Act is amended by adding the following subsection:

Same

(4) For the purposes of this Act, if an offender is released from custody as a result of being credited with remission within the meaning of the *Ministry of Correctional Services Act*, the custodial portion of the sentence ends as of the day of the offender’s release as a result of the remission.

3 (1) Subsection 3 (1) of the Act is amended by striking out the portion before clause (a) and substituting the following:

(1) Every offender who is resident in Ontario shall appear in person at a designated bureau, police station or detachment of the police service that provides policing where the offender resides or at another place in the area where the police service provides policing designated by that police service,

(2) The English version of subsection 3 (1) of the Act is amended by striking out “he or she” wherever it appears and substituting in each case “the offender”.

(3) Subsection 3 (1) of the Act is amended by adding the following clauses:

(a.2.1) within the prescribed period after the offender is ordered to serve a conditional sentence;

.....

(c.2) within the prescribed period after the offender receives a driver's licence;

(c.3) within the prescribed period after the offender receives a passport;

(c.4) within the prescribed period after the offender starts using a new email address or a new user name associated with a social media account or makes a change with respect to such an email address or user name;

(c.5) within the prescribed period after the offender starts using a new prescribed digital identifier for the purpose of communicating through the internet or makes a change with respect to such a digital identifier;

.....

(e.3) subject to clause (e.4), at least 14 days before departing for travel if the offender expects not to be at their main residence or any of their secondary residences for a period of seven or more consecutive days;

(e.4) in the case of an offender who is convicted of a sexual offence against a child, at least 14 days before departing for travel to a location outside Canada, regardless of the expected duration of their absence;

(e.5) subject to clause (e.6), within seven days after departing for travel if the offender decides after departing to not be at their main residence or any of their secondary residences for a period of seven or more consecutive days or if the offender has not appeared in person as required under clause (e.3);

(e.6) in the case of an offender who is convicted of a sexual offence against a child, without delay after departing for travel to a location outside of Canada if the offender

decides after departing to extend their stay beyond the date of return that was indicated when appearing in person under clause (e.4) or if the offender did not appear in person as required under clause (e.4);

(e.7) before departing for travel if there is a change in any information provided under clause (e.3) or (e.4) that occurs before departing;

(e.8) if there is a change in any information provided under clause (e.3), (e.4), (e.5) or (e.6) after departing for travel,

(i) within seven days after the date on which the change occurs, or

(ii) in the case of an offender to whom clause (e.4) or (e.6) applies, without delay after the date on which the change occurs;

(4) Clauses 3 (1) (f) and (g) of the Act are amended by striking out “presented himself or herself to a police service” wherever it appears and substituting in each case “appeared in person at a police service”.
(5) Section 3 of the Act is amended by adding the following subsections:

Exception

(1.0.1) Despite a requirement under subsection (1) for an offender to appear in person at a location, an offender is not required to appear in person at a location if the following criteria are satisfied:

1. The clause of subsection (1) in respect of which the requirement applies to the offender is a prescribed provision in a regulation made under clause 14 (h.2).
2. The offender complies with the requirement prescribed in a regulation made under clause 14 (h.3) in respect of the prescribed provision.

Interpretation

(1.0.2) In circumstances in which a clause of subsection (1) is a prescribed provision as described in paragraph 1 of subsection (1.0.1), any reference to appearing in person at a

location shall be read to include complying with the applicable requirement prescribed as described in paragraph 2 of subsection (1.0.1).

.....

Same

(1.3) Clauses (1) (a.2.1), (c.2) and (c.3) apply only if the event referred to in them occurs on or after the day this subsection came into force.

Exception

(1.4) If a member of a police service is satisfied that there was a reasonable excuse for an offender failing to comply with clause (1) (e.3) or (e.4), the offender is exempt from the requirement to comply within 14 days with the applicable clause and the offender shall instead comply as soon as feasible before departing for travel.

(6) Subsection 3 (2) of the Act is amended by striking out “Upon presenting himself or herself” at the beginning and substituting “Upon appearing in person”.

(7) Subsection 3 (3) of the Act is amended by,

(a) striking out “subsection (1), subsection 7 (2) and subsection 9 (1)” and substituting “subsections (1), 7 (2), 9 (1) and 9.0.1 (1)”; and

(b) striking out “present themselves” wherever it appears and substituting in each case “appear in person”.

(8) The English version of subsection 3 (4) of the Act is amended by striking out “he or she” and substituting “the person”.

4 Subsection 4 (2) of the Act is repealed and the following substituted:

Verification of address

(2) Subject to the regulations, the police service shall make reasonable efforts to verify an offender’s address, as provided to the police service by the offender, at least once after the offender last appeared in person at the police service under subsection 3 (1).

5 (1) The English version of subsection 6 (1) of the Act is amended by striking out “him or her” and substituting “the offender”.

(2) The English version of subsection 6 (3) of the Act is amended by striking out “If the offender believes any information about him or her in the sex offender registry is incorrect, he or she shall” and substituting “If the offender believes that any information about the offender in the sex offender registry is incorrect, the offender shall”.

6 (1) The English version of section 7 of the Act is amended by striking out “he or she” wherever it appears and substituting in each case “the offender”.

(2) Subsection 7 (2) of the Act is amended by,

(a) adding “Subject to any regulations made under clause 14 (h.4)” at the beginning; and

(b) striking out “present himself or herself” and substituting “appear in person”.

(3) Section 7 of the Act is amended by adding the following subsections:

Exception

(2.0.1) Despite the requirement under subsection (2) for an offender to appear in person at a location, an offender is not required to appear in person at a location if the following criteria are satisfied:

1. Subsection (2) is a prescribed provision in a regulation made under clause 14 (h.2).
2. The offender complies with the requirement prescribed in a regulation made under clause 14 (h.3) in respect of subsection (2).

Interpretation

(2.0.2) In circumstances in which subsection (2) is a prescribed provision as described in paragraph 1 of subsection (2.0.1), the reference in subsection (2) to appearing in person at a location shall be read to include complying with the applicable requirement prescribed as described in paragraph 2 of subsection (2.0.1).

(4) Subsection 7 (4) of the Act is repealed and the following substituted:

Reporting requirement ceases to apply

(4) An offender is no longer required to comply with section 3 in relation to a sex offence for which this Act would be made applicable to the offender under section 8 if one of the following circumstances applies:

1. The offender provides, in accordance with section 9, proof of a pardon in respect of the offence.
2. The offender provides, in accordance with section 9.0.1, proof of one of the following being overturned, as the case may be:
 - i. The conviction in respect of the offence.
 - ii. The finding of not criminally responsible on account of mental disorder in respect of the offence.

7 (1) The English version of section 8 of the Act is amended by striking out “he or she” wherever it appears and substituting in each case “the offender”.

(2) Section 8 of the Act is amended by adding the following subsections:

Same

(1.3.1) Despite subsection (1), clauses 3 (1) (a.2.1), (c.2) and (c.3) apply to every offender anywhere in Canada who, on or after the day subsection 7 (2) of Schedule 3 to the *Safer Streets, Stronger Communities Act, 2024* comes into force,

- (a) received a conditional sentence order for a sex offence, in the case of clause 3 (1) (a.2.1);
- (b) received a driver’s licence, in the case of clause 3 (1) (c.2); or
- (c) received a passport, in the case of clause 3 (1) (c.3).

Same

(1.3.2) Despite subsection (1), clauses 3 (1) (c.4) and (c.5) apply in accordance with the regulations.

Same

(1.3.3) Despite subsection (1), clauses 3 (1) (e.3) to (e.8) apply to every offender anywhere in Canada who, on or after the fourteenth day after subsection 7 (2) of Schedule 3 to the *Safer Streets, Stronger Communities Act, 2024* comes into force, departs for travel.

(3) Subsection 8 (1.4) of the Act is repealed and the following substituted:**Same**

(1.4) Despite subsection (1) and section 7, and subject to any other reporting requirement under this Act, this Act applies to an offender anywhere in Canada who, on or after May 12, 2008, becomes subject to an order in Form 52 made under subsection 490.012 (2) of the *Criminal Code* (Canada), as it read on or before October 25, 2023, for as long as the order is in force.

(4) Section 8 of the Act is amended by adding the following subsection:**Same**

(1.7) Despite subsection (1) and section 7, and subject to any other reporting requirement under this Act, this Act applies to an offender anywhere in Canada who, on or after the day subsection 7 (4) of Schedule 3 to the *Safer Streets, Stronger Communities Act, 2024* comes into force, becomes subject to an order made under section 490.012 of the *Criminal Code* (Canada) in respect of an offence referred to in the definition of “secondary offence” in subsection 490.011 (1) of that Act for as long as the order is in force.

8 Subsection 9 (1) of the Act is repealed and the following substituted:**Proof of pardon**

(1) An offender who receives a pardon for a sex offence may provide proof of the pardon to a police service by,

- (a) appearing in person at a designated bureau, police station or detachment of the police service that provides policing where the offender resides or at another place in the area where the police service provides policing designated by that police service; or
- (b) taking such other steps as may be prescribed by the regulations.

9 The Act is amended by adding the following section:

Conviction or finding overturned

9.0.1 (1) This section applies in respect of an offender if the offender's conviction or the offender's finding of not criminally responsible on account of mental disorder in respect of a sex offence is overturned.

Proof

(2) An offender to whom this section applies may provide proof of the conviction or finding being overturned to a police service by,

- (a) appearing in person at a designated bureau, police station or detachment of the police service that provides policing where the offender resides or at another place in the area where the police service provides policing designated by that police service; or
- (b) taking such other steps as may be prescribed by the regulations.

Information submitted to ministry

(3) If the person authorized by the police service to receive the proof mentioned in subsection (2) is satisfied that the conviction or finding, as the case may be, was overturned, the police service shall advise the ministry accordingly.

10 Section 9.1 of the Act is repealed and the following substituted:

Offender deleted from registry

Pardon

9.1 (1) If an offender receives a pardon of the type described in clause (a) or (b) of the definition of "pardon" in subsection 1 (1) in respect of a sex offence for which this Act is made applicable to the offender, the ministry shall delete every reference to and record of the offender from the sex offender registry in respect of that sex offence.

Conviction or finding overturned

(2) If an offender's conviction or finding in respect of a sex offence for which this Act is made applicable to the offender is overturned, the ministry shall delete every reference to and record of the offender from the sex offender registry in respect of that sex offence.

Time limit

(3) The ministry shall, 50 years after the death of an offender, delete every reference to and record of the offender from the sex offender registry.

11 (1) Subsection 10 (1) of the Act is amended by striking out "subsections (2) and (3)" and substituting "subsections (2), (3) and (3.1)".

(2) Section 10 of the Act is amended by adding the following subsections:

Same, research

(3.1) The Minister may authorize a person to consult information contained in the sex offender registry, compare the information with other information or, by electronic means, combine the information with, or link it to, any other information contained in a computer system for research or statistical purposes.

Conditions

(3.2) The Minister shall not provide the authorization under subsection (3.1) unless the Minister,

- (a) is satisfied that the research or statistical purposes cannot reasonably be accomplished without consulting the information or without comparing or combining the information with, or linking it to, the other information, as the case may be; and
- (b) obtains from the person a written undertaking that no subsequent disclosure of the information or of any information resulting from the comparison or combination of the information with, or the linking of the information to, other information will be made, or be allowed to be made, in a form that could reasonably be expected to identify any individual to whom it relates.

(3) Subsection 10 (4) of the Act is amended by striking out “subsection (2) or (3)” and substituting “subsection (2), (3) or (3.1)”.

12 The English version of section 11 of the Act is amended by striking out “he or she” wherever it appears and substituting in each case “the offender”.

13 Subsection 12 (1) of the Act is amended by striking out “the Minister of Community Safety and Correctional Services” and substituting “any current or former member of the Executive Council”.

14 Section 14 of the Act is amended by adding the following clauses:

(c.1) prescribing what constitutes a change in address for the purposes of clause 3 (1) (c);

(c.2) for the purposes of clauses 3 (1) (c.4) and (c.5), governing the types of changes in respect of which those clauses apply;

(c.3) prescribing digital identifiers for the purposes of clause 3 (1) (c.5);

(c.4) governing the verification of addresses under subsection 4 (2);

.....

(h.1) prescribing circumstances in which an offender is not required to comply with section 3, either on a temporary or permanent basis, due to their physical or mental capacity;

(h.2) prescribing provisions of this Act for the purposes of paragraph 1 of subsection 3 (1.0.1) and paragraph 1 of subsection 7 (2.0.1);

(h.3) prescribing requirements in respect of prescribed provisions of this Act for the purposes of paragraph 2 of subsections 3 (1.0.1) and 7 (2.0.1);

(h.4) with respect to an offender who is serving the custodial portion of a sentence intermittently in respect of an offence other than a sex offence,

(i) providing that subsection 7 (2) does not apply,

(ii) governing timing of compliance with subsection 3 (1), which may include requiring the offender to comply with subsection 3 (1) within a prescribed period instead of the applicable period prescribed under subsection 3 (1);

(h.5) for the purposes of subsection 8 (1.3.2), governing the application of clauses 3 (1) (c.4) and (c.5);

(h.6) prescribing steps for the purposes of clauses 9 (1) (b) and 9.0.1 (1) (b);

Commencement

15 (1) Except as otherwise provided in this section, this Schedule comes into force on the day the *Safer Streets, Stronger Communities Act, 2024* receives Royal Assent.

(2) Sections 1 to 10 and 12 to 14 come into force on a day to be named by proclamation of the Lieutenant Governor.

SCHEDULE 4

COMMUNITY CARE AND RECOVERY ACT, 2024

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Definitions

1 In this Act,

“child care centre” means a child care centre within the meaning of the *Child Care and Early Years Act, 2014*; (“centre de garde”)

“controlled substance” means a controlled substance within the meaning of the *Controlled Drugs and Substances Act* (Canada); (“substance désignée”)

“designated premises” means,

- (a) a school, other than a school at which the only programs provided are adult education programs,
- (b) a private school, other than,
 - (i) a private school located on a reserve, or
 - (ii) a private school that only offers classes through the internet,
- (c) a child care centre, other than a child care centre located on a reserve,
- (d) an EarlyON child and family centre, other than an EarlyON child and family centre located on a reserve, or
- (e) a prescribed premises; (“lieu désigné”)

“EarlyON child and family centre” means a centre of that name, administered by a service system manager within the meaning of the *Child Care and Early Years Act, 2014*, offering programs for families and children; (“centre pour l’enfant et la famille ON y va”)

“Health Canada” means the federal Minister of Health and the Department over which that Minister presides; (“Santé Canada”)

“local board” means a local board within the meaning of section 1 of the *Municipal Affairs Act*; (“conseil local”)

“Minister” means the Minister of Health or any other member of the Executive Council to whom responsibility for the administration of this Act is assigned or transferred under the *Executive Council Act*; (“ministre”)

“precursor” means a precursor within the meaning of the *Controlled Drugs and Substances Act* (Canada); (“précurseur”)

“prescribed” means prescribed by the regulations; (“prescrit”)

“private school” means a private school within the meaning of the *Education Act*; (“école privée”)

“regulations” means the regulations made under this Act; (“règlements”)

“reserve” means a reserve as defined in subsection 2 (1) of the *Indian Act* (Canada) or an Indian settlement located on Crown land, the Indian inhabitants of which are treated by Indigenous and Northern Affairs Canada in the same manner as Indians residing on a reserve; (“réserve”)

“safer supply services” means the prescribing of medications by a legally qualified medical practitioner as an alternative to a controlled substance or precursor; (“services d’approvisionnement plus sécuritaire”)

“school” means a school within the meaning of the *Education Act*; (“école”)

“supervised consumption site” means a site in respect of which the federal Minister of Health has granted an exemption to allow activities at the site in relation to a controlled substance or precursor that is obtained in a manner not authorized under the *Controlled Drugs and Substances Act* (Canada),

(a) under section 56.1 of the *Controlled Drugs and Substances Act* (Canada), in circumstances where the federal Minister of Health is of the opinion that the exemption is necessary for a medical purpose, or

(b) under subsection 56 (1) of the *Controlled Drugs and Substances Act* (Canada), in circumstances where the federal Minister of Health is of the opinion that the exemption is necessary for a scientific purpose or is otherwise in the public interest. (“site de consommation supervisée”)

Prohibition re location of supervised consumption site

2 (1) Subject to subsection (4), no person shall establish or operate a supervised consumption site at a location that is less than 200 metres, measured in accordance with subsection (2), from a designated premises.

Measurement

(2) Subject to the regulations, the distance mentioned in subsection (1) shall be measured in accordance with the following rules:

1. The distance shall be measured from the geometric centre of the building in which a supervised consumption site is located.
2. In the case of a school, the distance shall be measured to the door primarily used by the public to enter the building in which the school is located for the purpose of accessing the area where the school operates.
3. In the case of a private school, the distance shall be measured from,
 - i. the centre of the building in which the school is located, as determined by the private school and made available on a Government of Ontario website, or
 - ii. if the private school is located only in a portion of a building, the centre of the portion of the building in which the school is located, as determined by the private school and made available on a Government of Ontario website.
4. In the case of a child care centre or EarlyON child and family centre, the distance shall be measured to the geographic coordinates of the street address of the child care centre or EarlyON child and family centre, determined through the use of software or a web service that implements an address geocoding process.
5. In the case of a premises prescribed for the purposes of clause (e) of the definition of “designated premises” in section 1, the distance shall be measured to the point specified in the regulations.
6. If the measurement results in a number of metres that is not a whole number, the number shall be rounded up to the nearest whole number.

Geocoding

(3) If the regulations provide for a specific software or web service for the purposes of paragraph 4 of subsection (2), the distance to a child care centre or EarlyON child and family centre shall be measured using the prescribed software or web service.

Exception

(4) If a private school began providing instruction or a child care centre began operating after the day the *Safer Streets, Stronger Communities Act, 2024* received Royal Assent,

subsection (1) does not apply to a supervised consumption site with respect to the private school or child care centre, as the case may be, until the day that is 30 days after the day the private school began providing instruction or the child care centre began operating.

Same

(5) Despite subsection (4), if the Minister specifies a day on which subsection (1) applies to a supervised consumption site, subsection (1) applies to the supervised consumption site as of that day.

Limit on power of municipalities, local boards

Application for exemption to decriminalize

3 (1) Subject to such exceptions as may be prescribed, despite sections 7 and 8 of the *City of Toronto Act, 2006* and sections 9, 10 and 11 of the *Municipal Act, 2001*, a municipality or local board does not have the power to apply to Health Canada for an exemption under subsection 56 (1) of the *Controlled Drugs and Substances Act* (Canada) from any provision of that Act for the purpose of decriminalizing the personal possession of a controlled substance or precursor.

Applications related to supervised consumption sites, safer supply services

(2) Subject to such exceptions as may be prescribed, despite sections 7 and 8 of the *City of Toronto Act, 2006* and sections 9, 10 and 11 of the *Municipal Act, 2001*, a municipality or local board does not have the power, without the approval of the Minister, to do any of the following:

1. Apply to Health Canada for an exemption or a renewal of an exemption to the *Controlled Drugs and Substances Act* (Canada) for the purpose of operating a supervised consumption site.
2. Apply to Health Canada for funding under Health Canada's Substance Use and Addictions Program or any other Health Canada program in respect of safer supply services, or enter into an agreement with the Government of Canada with respect to funding under such a program in respect of safer supply services.

3. Support, including by passing a by-law or making a resolution, an application made to Health Canada by any other person in respect of any matter described in paragraph 1 or 2.

Regulations

4 The Lieutenant Governor in Council may make regulations,

(a) prescribing anything that is referred to in this Act as prescribed or as otherwise dealt with in the regulations;

(b) defining or clarifying the meaning of any word or expression used in this Act that is not otherwise defined in this Act.

Amendment to this Act

5 Section 4 of the Act is amended by adding the following clause:

(c) varying, for specified circumstances, how the distance mentioned in subsection 2 (1) shall be measured under subsection 2 (2).

Commencement

6 (1) Except as otherwise provided in this section, the Act set out in this Schedule comes into force on the day the *Safer Streets, Stronger Communities Act, 2024* receives Royal Assent.

(2) Sections 2 and 5 come into force on the later of April 1, 2025 and the day the *Safer Streets, Stronger Communities Act, 2024* receives Royal Assent.

Short title

7 The short title of the Act set out in this Schedule is the *Community Care and Recovery Act, 2024*.

SCHEDULE 5

COMMUNITY SAFETY AND CRIME PREVENTION MONTH ACT, 2024

Preamble

By proclaiming the month of November as Community Safety and Crime Prevention Month, the Province of Ontario recognizes the critical importance of raising awareness about community safety and preventing crime. With this step, the Province of Ontario joins other jurisdictions as well as groups across Canada that mark November as Community Safety and Crime Prevention Month.

The Province of Ontario also recognizes the importance of advancing community safety and tackling crime. Proclaiming November as Community Safety and Crime Prevention Month creates the opportunity for Ontarians to come together to appreciate the people working on the frontlines to improve community safety and prevent crime, raise awareness about community safety and recognize the important local partnerships and action that keep our communities safe.

Community Safety and Crime Prevention Month

1 The month of November in each year is proclaimed as Community Safety and Crime Prevention Month.

Commencement

2 The Act set out in this Schedule comes into force on the day the *Safer Streets, Stronger Communities Act, 2024* receives Royal Assent.

Short title

3 The short title of the Act set out in this Schedule is the *Community Safety and Crime Prevention Month Act, 2024*.

SCHEDULE 6

COMMUNITY SAFETY AND POLICING ACT, 2019

1 (1) The definition of “Minister” in subsection 2 (1) of the *Community Safety and Policing Act, 2019* is amended by striking out “Minister of Community Safety and Correctional Services” and substituting “Solicitor General”.

(2) Subsection 2 (1) of the Act is amended by adding the following definition:

“prescribed entity” means an entity that is prescribed to provide a policing function in an area in accordance with section 14; (“entité prescrite”)

2 Section 3 of the Act is amended by adding the following subsection:

Power to issue awards

(4) The Minister may issue awards related to policing, including awards for long service.

3 Subsection 10 (2) of the Act is amended by adding “Subject to the regulations” at the beginning.

4 (1) Subsections 19 (1) to (6) of the Act are repealed and the following substituted:

Request for temporary assistance

(1) A chief of police may request temporary assistance in providing adequate and effective policing from another chief of police or an entity that employs First Nation Officers.

Temporary assistance notice

(2) If a chief of police makes a request for temporary assistance under this section, the chief of police shall provide notice of the request as soon as possible to,

(a) the Inspector General; and

(b) the police service board of the chief of police or, in the case of a request made by the Commissioner, the Minister.

Content of notice

(3) The notice provided under subsection (2) shall include,

(a) a description of the circumstances surrounding the temporary assistance request;

(b) the policing functions that are requested;

- (c) the timeframe for the provision of the assistance;
- (d) the extent of the assistance required;
- (e) whether the chief of police or entity that employs First Nation Officers that is receiving the request has agreed to provide the assistance, in whole or in part;
- (f) the anticipated financial implications as a result of obtaining the assistance; and
- (g) any other prescribed matters.

Notice of change

(4) If a change occurs in any of the matters listed under subsection (3) after the notice of request for temporary assistance has been provided, the chief of police shall provide notice of the change as soon as possible to,

- (a) the Inspector General; and
- (b) the police service board of the chief of police or, in the case of a request made by the Commissioner, the Minister.

Assessment upon receiving notice

(5) Upon receiving a notice of request for temporary assistance under subsection (2) or a notice of change under subsection (4), the police service board of the chief of police or the Minister, as the case may be, shall determine,

- (a) whether the ability to request temporary assistance is used or is anticipated to be used on a recurring basis to ensure adequate and effective policing is provided; and
- (b) whether the policing functions for which temporary assistance is requested to be provided may need to be the subject of an agreement under subsection 14 (1) or (2) in order to ensure adequate and effective policing is provided and that section 13 is complied with.

Rules re providing temporary assistance

(6) The following rules apply to requests for temporary assistance made under this section:

1. If the request is made to the Commissioner, the Commissioner shall provide such temporary assistance as the Commissioner considers necessary and shall stop providing the assistance when the Commissioner considers it is appropriate to do so.
2. If the request is made to a chief of police other than the Commissioner or to an entity that employs First Nation Officers, the chief or entity may,
 - i. decline to provide assistance, or
 - ii. provide such temporary assistance as the chief or entity considers necessary and stop providing the assistance when the chief or entity considers it is appropriate to do so.

Notice after assistance by chief of police has stopped

(6.1) A chief of police who provided temporary assistance shall, after the assistance has stopped, provide notice to the Inspector General and the chief's police service board or, if the chief is the Commissioner, to the Minister, with the following information:

1. The chief of police's decision to provide temporary assistance.
2. Whether the request for temporary assistance was fulfilled in whole or in part.
3. The financial implications of providing assistance.
4. Any other prescribed matters.

Notice after assistance by entity that employs First Nation Officers has stopped

(6.2) If the temporary assistance was provided by an entity that employs First Nation Officers, the chief of police who requested the assistance shall, after the assistance has stopped, provide notice to the Inspector General with the following information:

1. Whether the request for temporary assistance was fulfilled in whole or in part by the entity.
2. The financial implications of providing assistance for the entity, if known.

3. Any other prescribed matters.

(2) Subsection 19 (7) of the Act is amended by striking out “or emergency”.

(3) Subsection 19 (8) of the Act is repealed and the following substituted:

Cost, police service board or entity

(8) If no agreement has been entered into with respect to the cost of the temporary assistance provided under this section, the police service board of the chief of police, or entity that employs First Nation Officers, that provided the assistance may certify the cost of the assistance provided, and the cost shall be paid by the police service board of the chief of police who requested the assistance or, in the case of a request made by the Commissioner, by the Minister.

(4) Subsection 19 (9) of the Act is amended by striking out “or emergency”.

(5) Subsection 19 (11) of the Act is amended by striking out “or emergency”.

(6) Subsection 19 (12) of the Act is repealed.

5 Subsection 35 (1) of the Act is amended by striking out “at the time of his or her appointment as a member of the board” and substituting “before exercising the powers or performing the duties of a member of the board”.

6 Subsection 83 (4) of the Act is repealed and the following substituted:

Certificate of appointment

(4) The police service board or the Commissioner shall issue a certificate of appointment to a person after his or her appointment as a police officer but before the day the person begins to exercise the powers or perform the duties of a police officer.

7 Subsection 85 (1) of the Act is amended by striking out “at the time of his or her appointment” and substituting “before exercising the

powers or performing the duties of a police officer”.

8 Subsection 91 (8) of the Act is amended by striking out “at the time of his or her appointment” and substituting “before exercising the powers or performing the duties of an auxiliary member”.

9 Subsection 92 (6) of the Act is repealed and the following substituted:

Certificate of appointment

(6) The police service board or the Commissioner shall issue a certificate of appointment to the person after his or her appointment as a special constable but before the day the person begins to exercise the powers and perform the duties of a special constable.

10 Subsection 95 (4) of the Act is amended by striking out “at the time of his or her appointment” and substituting “before exercising the powers or performing the duties of a special constable”.

11 Subsection 101 (7) of the Act is amended by striking out “at the time of his or her appointment” and substituting “before exercising the powers or performing the duties of a First Nation Officer”.

12 Subsection 107 (10) of the Act is amended by striking out “to investigate the matter, or to investigate it further” and substituting “to investigate the matter further”.

13 (1) Subsection 261 (1) of the Act is amended by adding the following paragraphs:

5.1 for the purposes of subsection 10 (2), determining an area for which a municipal board has policing responsibility in a manner other than in accordance with Part IV;

.....

19.1 governing payments for policing provided by a municipal board or the Commissioner under a regulation made under paragraph 5.1, including the cost of any necessary equipment and facilities, and,

i. identifying the persons who are required to pay, in whole or in part, for the costs of those services,

- ii. governing the determination of the amounts payable for those services, which may be based on financial capacity,
- iii. governing the payment of those amounts, including providing for the calculation and payment of interest and penalties,
- iv. governing the collection of those amounts, including providing for payment credits and refunds for overpayments, and
- v. for the purposes described in subparagraphs i, ii, iii and iv, establishing different requirements for different classes of territories;

(2) Section 261 of the Act is amended by adding the following subsection:

No payment owed

(1.1) For greater certainty, a regulation made under paragraph 18, 19 or 19.1 of subsection (1) may provide that no payments for policing provided to a municipality or a territory without municipal organization are owed.

Commencement

14 This Schedule comes into force on the day the *Safer Streets, Stronger Communities Act, 2024* receives Royal Assent.

SCHEDULE 7

COURTS OF JUSTICE ACT

1 Subsection 44 (2) of the *Courts of Justice Act* is amended by striking out “50 per cent of full-time service in a calendar year” at the end and substituting “the limits specified by the regulations made under this Act”.

2 Subsection 53 (1) of the Act is amended by adding the following clause:

- (h) providing for the limits to which service as a provincial judge on a part-time basis is subject for the purposes of subsection 44 (2);

Commencement

3 This Schedule comes into force on a day to be named by proclamation of the Lieutenant Governor.

SCHEDULE 8

HIGHWAY TRAFFIC ACT

1 Clause 5 (1) (i) of the *Highway Traffic Act* is amended by striking out “permit” and substituting “permit, CVOR certificate”.

2 The Act is amended by adding the following section:

False vehicle identification number

9.1 (1) Every person who knowingly, in or with any application, declaration, affidavit or document that is required under this Act or by the Ministry, submits, displays, presents or surrenders a vehicle identification number that is false, is guilty of an offence and on conviction, in addition to any other penalty or punishment to which the person may be liable, is liable to any of the following or any combination of the following:

1. A fine of,
 - i. not less than \$50,000 and not more than \$75,000, for a first conviction, and
 - ii. not less than \$75,000 and not more than \$100,000, for each subsequent conviction.
2. Imprisonment for a term of not more than six months.
3. Suspension of the person’s driver’s licence for a period of not more than one year.
4. Suspension of the person’s vehicle permit for a period of not more than one year.

Limitation

(2) No proceeding for an offence under this section shall be instituted more than six years after the facts on which the proceeding is based are alleged to have occurred.

3 Subsection 17 (1.1) of the Act is repealed and the following substituted:

Terms and conditions

(1.1) The Registrar may issue a CVOR certificate subject to any terms and conditions that the Registrar considers appropriate, including terms or conditions requiring the holder of the CVOR certificate,

- (a) to develop and implement safety practices or a remedial program;
- (b) to pay for and successfully complete educational courses or require the certificate holder's drivers, employees, shareholders, officers or agents to take and successfully complete educational courses, including educational courses provided by or on behalf of the Ministry;
- (c) to pay for and arrange for an assessment of the certificate holder's safety performance and practices by a person approved by the Registrar or to perform a self-assessment; or
- (d) to provide the Registrar with information and documentation to determine whether terms and conditions have been complied with and to assess the impacts of the terms and conditions.

4 Subsection 17.0.2 (2) of the Act is repealed and the following substituted:

Invalid for more than 12 months

(2) The Registrar shall refuse to renew a CVOR certificate that has been invalid for more than 12 months before the application for renewal is received by the Registrar.

5 The Act is amended by adding the following section:

Amendments to CVOR certificate, terms and conditions

18 (1) The Registrar may, at any time as the Registrar considers appropriate, amend a CVOR certificate by varying, attaching or removing terms or conditions, including by attaching terms or conditions requiring the holder of the CVOR certificate,

- (a) to develop and implement safety practices or a remedial program;

(b) to pay for and successfully complete educational courses or require the certificate holder's drivers, employees, shareholders, officers or agents to take and successfully complete educational courses, including educational courses provided by or on behalf of the Ministry;

(c) to pay for and arrange for an assessment of the certificate holder's safety performance and practices by a person approved by the Registrar or to perform a self-assessment; or

(d) to provide the Registrar with information and documentation to determine whether terms and conditions have been complied with and to assess the impacts of the terms and conditions.

Information

(2) The Registrar may require the holder of a CVOR certificate to provide the Registrar with information and documentation that the Registrar considers necessary to determine whether to amend the certificate as described in subsection (1), and the certificate holder shall comply promptly with such a requirement.

Notice of term or condition

(3) Where the Registrar, in amending a CVOR certificate, attaches a new term or condition to it or varies a term or condition, the Registrar shall notify the holder of the CVOR certificate, in writing, of the amendment together with the effective date and a summary of reasons.

Effective date of term or condition

(4) An amendment described in subsection (3) takes effect starting on the effective date specified in the notice.

Written submissions

(5) Within 30 days after being notified of an amendment described in subsection (3), the holder of the CVOR certificate may make written submissions respecting the amendment.

Decision

(6) The Registrar shall review and consider any information submitted under subsection (5) and shall notify the holder of the CVOR certificate, in writing, of the decision.

No right to appeal

(7) There is no right to appeal a decision of the Registrar under this section.

6 Subsection 20 (2) of the Act is amended by striking out the portion before clause (a) and substituting the following:

Where contravention of s. 16 (2) or 47 (8) or a term or condition

(2) A police officer who has reason to believe that a commercial motor vehicle is being operated in contravention of subsection 16 (2) or 47 (8) or a term or condition of the CVOR certificate may,

.....

7 (1) Section 21.1 of the Act is amended by adding the following subsection:

Administrative penalty for inadequate safety rating

(2.1) If a prescribed authorized person is satisfied that a person is or was the holder of a CVOR certificate at the time that a prescribed safety rating is or was assigned by the Registrar under subsection 17.1 (1) to the person, the prescribed authorized person may, by order, impose an administrative penalty on the person in accordance with this section and the regulations.

(2) Subsection 21.1 (7) of the Act is repealed and the following substituted:

Appeal

(7) A person who is subject to an order imposing an administrative penalty may, in accordance with the regulations, appeal the order to a person prescribed for the purpose of this subsection and the prescribed person may, in accordance with the regulations, confirm, vary or set aside the order.

(3) Subsection 21.1 (10) of the Act is amended by striking out “\$20,000” and substituting “\$50,000”.

(4) Subsection 21.1 (14) of the Act is amended by adding the following clause:

(c.1) prescribing safety ratings that may lead to the imposition of an administrative penalty under subsection (2.1);

(5) Clause 21.1 (14) (l) of the Act is repealed and the following substituted:

(l) prescribing and governing procedures for making and serving an order under this section, including prescribing rules for service, prescribing the day on which an order is deemed to have been received, providing that service of an order on one person may be effective as service on another person and providing for service on persons outside Ontario;

(6) Subclause 21.1 (14) (m) (v) of the Act is repealed and the following substituted:

(v) governing when a person prescribed under clause (d) may confirm, vary or set aside an order, including establishing any criteria to be considered or not to be considered by the person, and limiting the extent to which an order may be varied;

8 Subsection 47 (1) of the Act is amended by striking out “or” at the end of clause (f) and by adding the following clause:

(f.1) failure to comply with a term or condition of the CVOR certificate; or

9 Subsection 47.1 (1.1) of the Act is repealed and the following substituted:

Notice of safety record concerns

(1.1) The Registrar may also notify an operator at any time if,

(a) the Registrar has reason to believe that the operator may not operate a commercial motor vehicle safely or in accordance with this Act, the regulations or other laws relating to highway safety; or

(b) the operator has failed to comply with a term or condition of the CVOR certificate.

10 Subsections 50 (1), (1.1) and (2) of the Act are repealed and the following substituted:

Appeal

(1) Every person aggrieved by a decision of the Minister made under subsection 32 (5) for which there is a right of appeal, pursuant to a regulation made under clause 32 (14) (n) or an order of the Registrar under clause 47 (1) (b), may appeal the decision or order to the Tribunal.

Same

(1.0.1) Every person aggrieved by a decision or order of the Registrar under section 17 or clause 47 (1) (a) or (c) may appeal the decision or order to the Tribunal within 30 days after the day the decision or order takes effect.

Immediate suspension, cancellation of CVOR certificate not stayed

(1.1) Despite the *Statutory Powers Procedure Act*, the filing of an appeal under subsection (1.0.1) in respect of an order immediately suspending or cancelling a CVOR certificate pursuant to subsection 47 (2.2) does not stay the order, unless the Tribunal orders otherwise.

Powers of Tribunal

(2) The Tribunal may confirm, modify or set aside the decision or order of the Minister or Registrar under subsection (1) or (1.0.1).

11 (1) Subsection 130 (1) of the Act is repealed and the following substituted:

Careless driving

(1) Every person is guilty of the offence of driving carelessly who drives a vehicle or street car on a highway or in a specified place without due care and attention or without reasonable consideration for other persons using the highway or specified place.

(2) Subsection 130 (3) of the Act is repealed and the following substituted:

Careless driving causing bodily harm or death

(3) Every person is guilty of the offence of driving carelessly who drives a vehicle or street car on a highway or in a specified place without due care and attention or without reasonable consideration for other persons using the highway or specified place and who thereby causes bodily harm or death to any person.

(3) Subsection 130 (5) of the Act is repealed and the following substituted:

Deemed lack of reasonable consideration

(5) For the purposes of subsections (1) and (3), and without limiting the generality of subsections (1) and (3), a person is deemed to drive without reasonable consideration for other persons using the highway or specified place if he or she drives in a manner that may limit his or her ability to prudently adjust to changing circumstances on the highway or in the specified place.

(4) Subsection 130 (6) of the Act is amended by adding “or in the specified place” at the end.

(5) Section 130 of the Act is amended by adding the following subsection:

Limitation

(7) No proceeding for an offence under this section shall be instituted more than two years after the facts on which the proceeding is based are alleged to have occurred.

(6) Section 130 of the Act is amended by adding the following subsection:

Definitions

(8) In this section,

“driver” means a person driving or having care, charge or control of a vehicle, whether or not the vehicle is on a highway or in a specified place, and “drive” has a corresponding meaning; (“conducteur”)

“specified place” means,

- (a) any parking lot, structure or garage, whether public or private, paved or unpaved, flat or multilevel, above or below grade, including any driveway or road that connects the parking lot to a highway,
- (b) any parking lot into which drivers are expressly or impliedly invited or permitted to enter, with or without payment, and no matter whether payment was made or whether the driver entered with or without permission; and
- (c) any private, commercial or industrial parking lot from which the public would ordinarily be excluded. (“endroit précisé”)

12 (1) Subsection 214.1 (2) of the Act is amended by striking out “The Minister of Community Safety and Correctional Services” at the beginning and substituting “The Solicitor General”.

(2) Subsection 214.1 (4) of the Act is amended by striking out “the Minister of Community Safety and Correctional Services” and substituting “the Solicitor General”.

Commencement

13 (1) Except as otherwise provided in this section, this Schedule comes into force on the day the *Safer Streets, Stronger Communities Act, 2024* receives Royal Assent.

(2) Sections 2, 3, 4, 5, 8 and 9 come into force on a day to be named by proclamation of the Lieutenant Governor.

SCHEDULE 9

LIMITATIONS ACT, 2002

1 (1) Subsection 16 (1) of the *Limitations Act, 2002* is amended by striking out “or” at the end of clause (j), by adding “or” at the end of clause (k) and by adding the following clause:

- (l) a proceeding under subsection 4 (1) of the *Justice for Victims of Terrorism Act* (Canada).

(2) Subsections 16 (1.1) and (1.2) of the Act are repealed and the following substituted:

Same

(1.1) Clauses (1) (h), (h.1), (h.2) and (l) apply to a proceeding whenever the act on which the claim is based occurred or the proceeding was commenced, and regardless of the expiry of any previously applicable limitation period.

Same

(1.2) Subsection (1.1) does not apply in the case of a proceeding that,

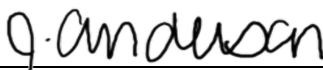
(a) has been dismissed by a court and no further appeal is available; or

(b) has been settled by the parties and the settlement is legally binding.

Commencement

2 This Schedule comes into force on the day the *Safer Streets, Stronger Communities Act, 2024* receives Royal Assent.

This is **Exhibit “C”** to the Affidavit of Lauren Costoff
Affirmed Remotely Before Me in the City of Barrie, Province of Ontario
this 10th day of January, 2025.

A handwritten signature in black ink, appearing to read "J. Anderson", is positioned above a horizontal line.

A Commissioner for oaths, etc.

JANICE ANDERSON



HOUSE OF COMMONS
CHAMBRE DES COMMUNES
CANADA

House of Commons Debates

VOLUME 148 • NUMBER 130 • 1st SESSION • 42nd PARLIAMENT

OFFICIAL REPORT
(HANSARD)

Tuesday, January 31, 2017

—

Speaker: The Honourable Geoff Regan

CONTENTS

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Government Orders

Citing two rulings by Speaker Fraser on November 24, 1986, and April 14, 1987, she asked the Chair to intervene to find the motion out of order until such time as the government could demonstrate that unreasonable obstruction by the opposition necessitated its use.

[Translation]

In response, the hon. parliamentary secretary countered that the motion to proceed to orders of the day was, in fact, in order and consistent with the rules of the House. The motion, “That the House do now proceed to the Orders of the Day”, is what is defined as, quote, “A superseding motion designed to dispose of the original question before the House, either for the time being or permanently.”

Such motions have been moved in recent years with some frequency by both the government and the opposition. In fact, as was the case on November 30, examples can be found of such motions being moved during routine proceedings and on a Wednesday, as well as prior to the moving of a motion for time allocation or the consideration of a bill subject to time allocation.

[English]

The issue then is whether its use on November 30 was procedurally appropriate; that is, was it used within the strict confines of the rules and practices of the House. The opposition House leader suggested that it was not. She cited rulings by Speaker Fraser from 1986 and 1987 in support of her contention.

While all Speaker's rulings constitute an important point of reference in the adjudication of matters before the House, they must always be examined in the context of their era. Routine proceedings in 1986 and 1987 was conducted in a completely different order of rubrics and the circumstances of the time were vastly different. Even so, it is notable that a motion moved on November 24, 1986 to proceed to the orders of the day during routine proceedings was found to be in order by the Chair.

[Translation]

As House of Commons Procedure and Practice, Second Edition, states on page 541:

The motion “That the House do now proceed to the Orders of the Day” may be moved by any Member prior to the calling of Orders of the Day.... The Chair has ruled that a motion to proceed to the Orders of the Day is in order during Routine Proceedings which, in recent practice, is the only time that it has been proposed.

● (1015)

[English]

I have also considered whether, as the opposition House leader contends, such situations require the intervention of the Speaker to determine if a bill or motion has received sufficient debate. My predecessor clearly indicated in a ruling on November 26, 2014, at page 9830 of *Debates* that “it is not for the Speaker to judge whether an issue has been sufficiently debated”. I share that view. It is not within the purview of the Speaker to express a view on whether the duration of debate has been appropriate on a measure before the House. Accordingly, it is clear to the Chair that the procedural exigencies were met when the government moved a motion to proceed to the orders of the day during routine proceedings. I can therefore confirm that the motion was in order.

[Translation]

I thank all members for their attention.

GOVERNMENT ORDERS

[English]

CONTROLLED DRUGS AND SUBSTANCES ACT

Hon. Jane Philpott (Minister of Health, Lib.) moved that Bill C-37, An Act to amend the Controlled Drugs and Substances Act and to make related amendments to other Acts, be read the second time and referred to a committee.

She said: Mr. Speaker, I am pleased to begin debate today on Bill C-37 to address a serious and pressing public health matter, to improve public safety, and to protect the health of Canadians.

[Translation]

I am eager to work with all the MPs to help advance this important bill, in particular with my new parliamentary secretary, the hon. member for Louis-Hébert.

[English]

This legislation is introduced in the context where Canada is facing a national public health crisis related to opioids, characterized by ever-increasing rates of harm, overdose, and death.

The opioid crisis raises many concerns, and the one we hear about perhaps most often is the rapid rise in the numbers of deaths from accidental overdose. Last year, in British Columbia alone, more than 900 people died from overdose. That is an 80% increase from 2015. The majority were linked to the swift spread of powerful drugs like fentanyl. Alas, the situation is getting worse. Last week it was reported that there were 20,000 overdoses in British Columbia alone. At a national level, deaths from overdoses are now more numerous than deaths caused by motor vehicle accidents.

[Translation]

Before I continue, I would like to extend my condolences to the families and friends who have lost a loved one. We share their grief. We are aware of the pressing need to turn the tide of this crisis as quickly as possible.

[English]

I would also comment at the outset that while the focus of the legislation is on immediate action to address the opioid crisis, we must bear in mind that lasting solutions require an understanding of the roots of the opioid crisis, which are messy, but not mysterious. It should be acknowledged, for example, that pain is a central theme at the heart of the drug crisis. Sometimes, problematic drug use begins with physical pain, but we must also admit that emotional pain is a factor in substance use. To fully resolve the opioid crisis we must address the multiple social drivers, including poverty, social isolation, childhood trauma, sexual abuse, and mental illness.

Government Orders

Addressing the roots of the crisis demands a whole of society response. It means calling out stigma and discrimination as barriers to accessing care. It means building a society where children receive tender attention and adults are not isolated and lonely. It means an international search for effective answers and being willing to discuss bold policy alternatives and the evidence associated with them. We must deal with this crisis comprehensively, collaboratively, and compassionately. We must assess what works and what does not work, and then we must do what works.

The crisis is moving eastward in Canada, with more drug seizures of fentanyl and carfentanyl.

[Translation]

Canadians are increasingly aware that problematic substance abuse spares no one—people of all ages and from all socio-economic groups—and that it has devastating consequences on individuals, families, and communities.

• (1020)

[English]

In the past year, I have met with bereaved parents, people who use drugs, first responders, addiction specialists, mental health experts, indigenous leaders, health educators, and others to learn their perspective on the challenges we face. A complex, multi-dimensional social challenge of this nature demands timely, coordinated, and effective action.

Before I discuss the details of this proposed legislation, I would like to thank many members of this House who have been outspoken on the urgent need to respond together. I thank the member for Vancouver Kingsway for his support and advocacy on the issue, and especially for his calls to pass this legislation by unanimous consent.

[Translation]

I would also like to thank the Standing Committee on Health. Its members are actively working on this issue, and they made a series of recommendations that we reviewed carefully. We have acted on that. I look forward to responding formally to the committee report in due course.

[English]

There are many important components of this proposed legislation that would support communities and enhance public health and public safety when it comes to the use of drugs and substances. Bill C-37 would save lives. It needs to be passed without delay.

At this point, please permit me to outline some of the federal actions to date on the matter.

Early last year we made naloxone, the antidote to overdose, available without prescription. We arranged an expedited review of naloxone nasal spray and ensured an emergency supply for Canadians.

We granted an exemption to the Dr. Peter Centre in Vancouver to operate Canada's second supervised consumption site, along with an unprecedented four-year renewal of the exemption for Insite in Vancouver.

Last summer, we announced Health Canada's opioid action plan to improve education for the public and prescribers, to expand access to treatment, and to build the database.

In September, we overturned a ban on the use of prescription heroin, so that it is available to treat the most severe cases of addiction.

Our government has supported the good Samaritan overdose act to remove the fear of drug possession charges for individuals who call 911 when they witness an overdose.

We added regulations to schedule fentanyl precursors as controlled substances, making it harder for illicit substances to be manufactured in Canada.

[Translation]

In November, along with the Ontario Minister of Health, Eric Hoskins, I hosted a national conference and summit on opioids, which led to a joint statement of action to address the opioid crisis. That statement includes 128 separate commitments made by Health Canada, nine provincial or territorial health departments, and over 30 other organizations. In February we will provide Canadians with an update on the progress made so far regarding those commitments.

[English]

In work led by the Minister of Public Safety and Emergency Preparedness, the RCMP now has an agreement with China to combat the flow of illicit fentanyl.

Because this is a national crisis, we activated additional supports. In collaboration with the provinces and territories, we have established a special advisory committee on illicit opioids that includes the Council of Chief Medical Officers of Health to advance information among jurisdictions related to the opioid crisis.

We have built a task force within the federal health portfolio to work with other federal departments in a comprehensive response to the crisis. We funded McMaster University to produce new evidence-based guidelines for prescribing opioids for chronic pain. They are now available for consultation.

We funded the Canadian research initiative in substance misuse to provide evidence-based guidelines for medication-assisted treatment; and with the support of the Prime Minister, we identified new federal funding of \$5 billion over the next 10 years to address mental health and addictions. We know that untreated mental illness is a common cause of addiction, and early intervention is key.

We introduced the new Canadian drugs and substances strategy, to reinstate harm reduction as a pillar in Canadian drug policy and return the lead for drug policy to the Minister of Health.

In December, I introduced Bill C-37, which proposes to amend the Controlled Drugs and Substances Act and other acts. This legislative framework is an important part of our comprehensive approach to drug policy. It aims to accomplish three important goals: one, to provide support for harm reduction, in particular the establishment of supervised consumption sites; two, to reduce the supply of illicit substances; and three, to reduce the risk of diversion of other legitimate controlled substances.

Evidence shows that, when properly established and maintained, supervised consumption sites in communities that want and need them will save lives and improve health without increasing drug use or crime rates.

Last year, I visited Insite in Vancouver to witness the important work it does to help vulnerable people and communities. I was moved by what I saw. Facilities like Insite promote health-seeking behaviour by introducing people who use drugs to the health system in a non-judgmental and non-stigmatizing manner. They have hygienic facilities and sterile equipment, and are supervised by qualified health professionals who provide advice on harm reduction and treatment options as well as prevention of overdose.

Under the Controlled Drugs and Substances Act, the Minister of Health has the ability to provide exemptions to allow supervised consumption sites, but the Respect for Communities Act from the previous government introduced unnecessarily onerous requirements that must be met by communities before the Minister of Health could even respond to the request for an exemption.

We have heard desperate cries for help from communities most affected by the opioid crisis. They have indicated that the current requirements are burdensome and hinder their ability to offer services needed to reduce harm and to save lives. Currently there are applications being reviewed by Health Canada from across the country from communities such as Vancouver, Toronto, and Montreal.

Proposed legislation would simplify and streamline the application process for communities that want and need to establish supervised consumption sites. It would replace the current 26 application criteria with the five factors outlined in the Supreme Court of Canada 2011 decision regarding Insite. In fact, the criteria in the proposed legislation are exactly those written in paragraph 153 of the Supreme Court decision.

A vital criterion that Bill C-37 retains is the requirement for community consultation. It would improve transparency by adding a requirement for decisions on applications to be made public, including reasons for denial.

To support these proposed changes, Health Canada would post new information online about what is required in applications, how to process works, and the status of applications.

●(1025)

[Translation]

To help keep opioids and other illicit substances off the street in Canada, we need to make sure that they are not easy to produce. To that end, the bill proposes to prohibit the unregistered importation of pill presses and encapsulators. This measure has been included in

part because certain jurisdictions, such as British Columbia, have asked for it. While it is true that those devices do have legitimate uses, they can also be used to manufacture counterfeit drugs that contain dangerous substances, including fentanyl.

[English]

This legislation would also give Canada Border Services officers greater flexibility to inspect suspicious mail, no matter the size, that may contain goods that are prohibited, controlled, or regulated. Protecting the privacy of Canadians is of the utmost importance. The measure would only be for incoming international mail where the prevalence of illicit drugs is greater. In fact, just one standard size mail envelope can contain 30 grams of fentanyl, enough to cause 15,000 overdoses.

[Translation]

Lastly, the bill updates a number of provisions regarding compliance and enforcement of the Controlled Drugs and Substances Act in order to modernize that piece of legislation. These legislative measures allow over 600 licensed dealers to manufacture, purchase, sell, distribute, import, export, and transport controlled substances for legitimate purposes.

The proposed amendments will allow Health Canada inspectors to conduct inspections in a variety of situations, especially in any location where it is suspected that any activities involving controlled substances are taking place. These amendments will help prevent the diversion of controlled substances to the illegal market.

●(1030)

[English]

Bill C-37 supports our government's new Canadian drugs and substances strategy, which the Minister of Public Safety and Emergency Preparedness and I announced on December 12. In the past, federal drug strategies aimed to balance public health and public safety objectives through key pillars of prevention, treatment, enforcement, and at times, harm reduction; but in 2006, under the national anti-drug strategy of the previous government, the harm reduction pillar was removed. Our government will pursue an evidence-based approach to drug policy. Accordingly, this new strategy would formally reinstate harm reduction as a key pillar, in addition to prevention, treatment, and enforcement.

It should be noted that the reintroduction of harm reduction does not diminish the importance of the other pillars. In particular, we must not let up on our efforts for prevention and treatment. I will continue to encourage the expansion of access to a broad range of treatment options, which are essential to reducing the number of overdose deaths. In reframing problematic substance use as the public health issue that it is, it returns the lead to the Minister of Health from the Minister of Justice.

Government Orders

In conclusion, the opioid crisis has taken a toll on many communities across Canada. It requires swift action, as well as a more balanced approach to deal with problematic substance use. Our renewed evidence-based approach would allow the government to better protect Canadians, save lives, and address the root causes of this crisis. Canada needs this action now.

While our focus must be on the current crisis, we must also pursue a balanced approach over the long term to address the upstream causes of problematic substance use.

[Translation]

We will continue to work with our partners, including the provinces, territories, municipalities, and indigenous communities.

[English]

While we cannot end this crisis immediately, we can markedly reduce its impact and set ourselves on a path to health for all. Measures proposed in Bill C-37 aim to take swift action to address the opioid crisis. I call on hon. members of the House to support the passage of Bill C-37 without delay.

Mr. Colin Carrie (Oshawa, CPC): Madam Speaker, I would like to ask the minister about the current injection site application requirements versus the proposed requirements. For example, the current requirements explicitly state, as far as consultation is concerned, that there needs to be the provincial health minister's opinion, the provincial public safety minister's opinion, the local government's opinion, letters from the head of the police force in the area, letters from health professionals in relation to public health, and consultations with professional licensing authorities for physicians and nurses.

In addition, they require that the public have 90 days after the day on which notice is given to provide the minister with comments. The current bill states that there is only a need to have an expression of community support or opposition, and that is about it.

It further states that the minister may give notice, and it indicates a period of time not to exceed 90 days in which members of the public may provide the minister with comments. Therefore, under the new regulations, theoretically, a one-day consultation would suffice, and as long as one advocacy group was in favour, the minister would approve the site.

I am wondering if the minister could clarify what she means by community and community consultation.

Hon. Jane Philpott: Madam Speaker, I thank the hon. member for his question and for his acknowledgement of the seriousness of this crisis.

When it comes to making decisions about supervised consumption sites, consultation with communities is absolutely essential. I hear from communities almost every day, people who are living in places like the Downtown Eastside in Vancouver and communities like Victoria. The member for Victoria is here today.

If members speak to people who go into these communities and speak to business owners, first responders, and law enforcement officials, they will hear their cries of desperation. These communities are saying that people are dying in their streets and that they need to find a way to save people's lives.

Of course the community has to be consulted. There will always be questions, and they are absolutely legitimate. What Bill C-37 allows is for the Minister of Health to be able to make a reasonable decision and to make sure that all the appropriate people are consulted. Communities are desperately crying out for these kinds of facilities to be available. We have deep, abundant scientific evidence that they save lives, and we have seen that in communities where they have been introduced, the public has in fact come to see that they are highly effective in allowing public safety and making sure that people are safely introduced to the public health system.

• (1035)

Mr. Don Davies (Vancouver Kingsway, NDP): Madam Speaker, I am glad to hear the minister acknowledge the comprehensive roots and causes of substance use disorders. I agree with her, very much, that addiction is a complex psychosocial disease. I think we all agree in this House that addiction is, first and foremost, a health issue.

Taking all of these facts together, it is clear that we need to provide Canadians with a full range of treatment options if we are really to help people recover, if we are really going to stop overdoses, and if we are really going to reduce the deaths being caused in cities across this country.

However, it is also a fact, and I think the minister knows this, that there is a shocking lack of detox and treatment facilities in this country that are publicly available, affordable, and free. A lot of families want to get help for a family member. It costs \$10,000 or \$20,000 a month to access treatment. It takes an average of eight days in British Columbia to access detox. We all know that with addiction, if someone does not get into treatment today, they may not be ready tomorrow.

Will the minister assure this House that in the upcoming budget, there will be significant new federal funding to help create detox and treatment facilities for Canadians across this country, which is the only real way to actually deal with this health issue?

Hon. Jane Philpott: Madam Speaker, I am so pleased that the member for Vancouver Kingsway has raised this matter. He is absolutely right that harm reduction alone will not solve the opioid crisis. It requires a range of pillars, and that includes access to treatment.

I would absolutely agree with the member that there is a tragic shortage of treatment facilities in this country. When I speak to mayors of big cities, people who work in emergency departments, and people who are first responders, they decry the fact that people can have their lives saved, but then they go back out onto the streets. They need treatment.

When those people need treatment and are ready for treatment, they should have access to treatment. That is why I am very pleased that we were able to offer to the provinces and territories \$5 billion in new money for mental health and addictions. I certainly hope that my colleagues, the ministers of health, particularly in the provinces where this is the greatest challenge, will use some of those resources to expand access to treatment facilities so that people will be able to get, possibly, opioid substitution therapy, for example, and will be able to have their social issues addressed and live healthy lives.

Ms. Dianne L. Watts (South Surrey—White Rock, CPC): Madam Speaker, I thank my colleague for looking at this issue and understanding the complexities of it.

I have some questions. If we go back to 1996, the treatment for opioid dependency was the methadone program. As the years have gone by, and you have not mentioned that program—

The Assistant Deputy Speaker (Mrs. Carol Hughes): I would remind the member to address the chair and not the individual member.

Ms. Dianne L. Watts: Madam Speaker, today we see the abuse that program has undergone. We can look at the sale of prescriptions for methadone. We can look at the people using methadone, along with other drugs.

I am just wondering if the minister can speak to the review of that program and the costs it has borne over the years to end up with the results we see today.

Hon. Jane Philpott: Madam Speaker, I am pleased to answer this question, which raises again the issue of treatment, which is clearly an important part of the response to the opioid crisis. The member raises the issue of medication-assisted therapy, and that includes opioid substitution therapy, products like methadone and another product called buprenorphine/naloxone, which is also known as Suboxone. These are absolutely essential parts of the solution to the opioid crisis. People who have been identified as having a severe addiction are in many cases, unfortunately, accessing drugs that are laced with much more powerful drugs, like fentanyl, and that is causing many of the overdose deaths.

We are looking to work with provinces, territories, and communities including indigenous communities, to make sure that treatment options are available. There are challenges in accessing some of these opioid substitution therapies across the country. There are challenges with cost. There are challenges with making sure that prescribers can use them in a proper way. However, we know, and I know from having talked to the parents of people who are suffering with problematic substance use, that they want their children to be able to access these kinds of treatments and to find good health.

• (1040)

Mr. Chris Bittle (St. Catharines, Lib.): Madam Speaker, during the break I had an opportunity to meet with a friend of mine who is a firefighter in Niagara. I asked him how work was going, and he said that it was terrible. He was going from call to call with the opioid crisis and overdoses.

We hear a lot about the opioid crisis related to British Columbia, but my question for the hon. Minister of Health is how the government is going to address this issue from coast to coast to coast.

Hon. Jane Philpott: Madam Speaker, I am very grateful for this question. It does emphasize the tremendous toll this places on first responders in many of the cities across the country, and even in rural areas. It is heartbreaking for them to see people die of overdoses and to have to try to get to them to respond.

The member also raises the matter that there is a shortage of good data, and that is one of the things I am very concerned about. In fact, it has been raised by the health committee and others.

Government Orders

We have tasked the chief public health officer of this country to work with the medical officers of health across the country, with Stats Canada, and with the Canadian Institute for Health Information to find a way, and I will continue to push on this, to get access to good, rapid, up-to-date data across the country so that we can recognize where there are pockets of substance use challenges that are not adequately being addressed.

Mr. Colin Carrie (Oshawa, CPC): Madam Speaker, I am happy to finally get the opportunity to rise in the House to debate bill C-37, an act to amend the Controlled Drugs and Substances Act and to make related amendments to other acts.

I think all members of the House and all Canadians would agree that the ongoing opioid crisis is absolutely tragic. I know that the Premier of British Columbia and a few of our colleagues from B.C. have asked the minister to issue a national public health emergency as the overdose numbers continue to rise in the province.

This is a very complex issue. There is not just one solution.

I was fortunate to have been part of the opioid study recently conducted at the health committee. It allowed me, and I think all my colleagues on the committee, to truly learn and empathize with struggling addicts, communities, first nation health professions, and families that have had to endure an opioid-related death.

We had the opportunity to hear many first-hand stories, something that I am so grateful to have had the opportunity to be part of. We heard from parents who lost their children. We heard from recovered drug addicts, government officials, and the first responders who are reviving these people hourly. We sometimes seem so focused on those battling drug addictions that we forget about the first responders who are working so hard to ensure that our streets and our citizens are safe.

I would like to personally thank everyone who appeared as a witness. I truly believe that their testimony has played a huge role in encouraging all levels of government and Canadians to work together, and of course, to take action.

With that, I would now like to get to the bill itself.

The bill aims to achieve five main things. First, it would grant increased powers to the Canada Border Services Agency. Second, it would regulate the importation of unregistered devices, such as pill presses. Third, it would increase prohibitions against certain actions related to controlled substances. Fourth, it would give the minister authority to temporarily schedule and control new dangerous substances. Fifth, it would streamline the application process for approving and opening supervised injection sites.

We know that there are many factors that have contributed to the opioid crisis. While one cause of the crisis results from illegal substances and organized crime, many are battling addiction because of the over-prescribing of painkillers.

Government Orders

This bill seeks to address one aspect of the crisis: illegal activities and organized crime. I look forward to seeing what measures will be taken to address prescription drugs and over-prescribing, as I think we must acknowledge that it is a key contributor as well.

We know that China has been a primary source of fentanyl, carfentanil, and other dangerous opioids. It has been reported over the last year, and by the CBSA itself, how easy it is to import illicit substances into Canada with the current regulations.

My Conservative colleagues have been pushing the government to finally acknowledge the flaws at our borders and grant officers the authority to search and seize suspicious packages weighing less than 30 grams. While border agents already intercept dozens of these packages, exporters have found a way to hide illegal substances in toys, silica packages, and products that ultimately could not be searched without permission. Removing the “30 grams or less” exemption from the Customs Act is a much-needed step in combatting the opioid crisis facing our country.

Another weakness that has been recognized by many of my colleagues, but most passionately by Senator Vern White, is the need to target devices, specifically pill presses. These devices are capable of turning out thousands of deadly pills per hour, and under the current law, anyone can import one legally. That is not okay.

Abbotsford Police Deputy Chief Mike Serr stated:

Right now, they are not regulated and the importation of them—there really is very little from an intelligence perspective the police can do.... To have these machines registered would be at least one step for us.... We could then have a better sense for ensuring they are for legitimate purposes.

Again, granting the Canada Border Services Agency the authority to detain unregistered pill presses is something that must be done. It is important that all information obtained at the border be available to law enforcement agencies across the country so that they can take the appropriate steps in ensuring the safety of all citizens. Ultimately, that is what we are trying to ensure here: that all Canadians are protected and that access to illicit, dangerous substances is avoided any way possible.

That is what I find quite contradictory. The government is so quick to encourage the approval of supervised injection sites. Injection sites are known to give access to illicit and dangerous drugs, yet the government appears to want more of them. This is where there are some major inconsistencies in the government's policies.

• (1045)

The minister's mandate letter states, “Canadians need to have faith in their government's honesty and willingness to listen. I expect that our work will be informed by performance measurement, evidence, and feedback from Canadians”. Yet, the bill would severely weaken the Respect for Communities Act, which was put in place to ensure that feedback from Canadians was taken into consideration before a supervised injection site was approved.

Under the previous Conservative government, we took steps to ensure there was a robust consultation process which included residents, local law enforcement agencies, and elected officials to be on board with an injection site in their community. Bill C-37 proposes to significantly change those requirements. While the

expression of community support for opposition is a requirement, the specific requirements have been removed to allow the Liberals to easily change them as they see fit. This is a way to completely avoid parliamentary oversight. The minister's attempt to avoid community approval will fail.

We heard from numerous witnesses in the health committee that an injection site could not be successful without the support of the entire community. I will use the city of Ottawa as an example.

The mayor, the chief of police, and the former chief of police all have openly stated that they are opposed to an injection site in their community. Yet, under this bill, there is no assurance their views would even be taken into consideration. The minister has given herself the power to approve a site, regardless. What the minister does not realize is that not all communities want injection sites. Usually there are a few advocacy groups that are in support of a site, and no other legitimate stakeholder.

The Prime Minister's own parliamentary secretary for justice stated, “They have been doing it in Vancouver for some years and there have been issues that have arisen there. I don't know of any place in Toronto where that couldn't have a significant negative impact on the communities.”

The Liberals are using harm reduction strategies as temporary solutions, band-aid solutions, and are refusing to offer any long-term solutions such as treatment and prevention. This is concerning.

In the minister's mandate letter, the Prime Minister states, “When Canadians are in good physical and mental health, they are able to work better, be more productive, and contribute more fully to our economy while living healthier, happier lives”. I agree with this statement, which is why injection sites should not become the norm. These sites are not helping people become productive. They are not encouraging good physical and mental health; in fact, they are doing the complete opposite. All injection sites are doing is providing a safe place for addicts to get their fix and if they overdose, someone will revive them. This is not a life. Injection sites do not save lives. They revive people who, from what I have heard from meeting with many recovered addicts over the year, do not want to be alive if drugs, crime, and overdosing is all they have to look forward to.

The parliamentary secretary for justice also said, “the ambiguous messaging that comes out from a society that says you can't use these drugs, they're against the law — but if you do, we'll provide a place [for you] to do it in.” This is exactly the type of conflicting message Canadians do not want children to be raised with. Drugs are dangerous. They are illegal because they ruin lives.

The Prime Minister and the Liberal Party are simply building a co-dependent relationship with drug addicts. To elaborate on what I mean, a co-dependent relationship is a dysfunctional relationship in which one party enables and supports another's addiction such as drugs. That is what the Liberals want society to become: an enabler as opposed to a preventer.

The president of the Canadian Police Association, Tom Stamatakis, said, "We should be treating addiction as a health issue and if harm reduction is part of a holistic approach to dealing with this issue, there should be a treatment pillar that focuses ultimately on how we get people away from engaging in harmful activities."

Injection sites simply provide a place for drug users to get high, but offer no treatment. I will use Insite as an example.

In 2015, 6,531 people visited the injection site and only 464 were referred to Insite, the site's apparent detox treatment centre. Only seven per cent were referred to or offered detox treatment at Insite. To elaborate on the statistics, when I went for a visit, I was basically told by an employee that it was not in the business of treating these people. The site was there to provide them with needles and ensure that they would wake up. These sites are not saving lives; they are enabling and giving up on people whose lives have taken a bad turn.

The government's desire to quickly approve these sites without community support, especially law enforcement, is absolutely outrageous.

• (1050)

We cannot support the government's attempt to improve these dangerous enabling sites without knowing and being assured that residents, law enforcement, and elected officials are 100% on board.

Once the minister approves the site, the responsibility to ensure the safety of all residents rests in the hands of local police. Crime rates do not drop as the government keeps stating. Addicts are still illegally obtaining these drugs through break-ins, robberies, prostitution, etc. As Toronto Police Association president Mike McCormack said, "They're (VPD) seeing more of what we'd call street disorder—more people using drugs on the street, smoking drugs, congregating, minor thefts."

I worry about my community of Oshawa. Oshawa is an up-and-coming area with many new businesses and new residential areas for families to settle into. Oshawa and Durham region continue to work to improve the crime rates, and we have seen a drastic decline in assault, robberies, and drug crimes since 2009. This is thanks to the community as a whole working together to make it a better and safer place to raise our families. I worry that the approval of an injection site in my riding would lead to people looking for somewhere else to live, which ultimately would negatively affect these thriving businesses. It would cause alarm if local residents, the mayor, and local police were not consulted prior to an approval. This is something my local community would not be in favour of, and that is why I cannot support this portion of the bill.

Another issue we heard quite a bit about throughout the opioid study was the fact that new dangerous and deadly substances were constantly being made. This causes serious concerns. As the current rules stand, new psychoactive substances that are designed to mimic

illegal drugs are chemically different enough not to be considered illegal.

I was happy to see that that the bill proposed to grant the Minister of Health the authority to temporarily and quickly schedule and control a new and dangerous substance under the Controlled Drugs and Substances Act. This will allow the minister to take immediate action for the public good, while launching a thorough review of the new substance. This means action is being taken while a decision on whether to permanently schedule the substance is warranted.

I think all members agree that the opioid crisis must be addressed. I also think that all members are in agreement on the severity of the issue.

The right steps are being taken to address security concerns at the border. Acknowledging that an international source is massively contributing to the opioid crisis is the first beneficial step the Liberals have taken to combat the issue.

Ensuring that the Canada Border Services Agency can now open any suspicious package under 30 grams will stop the inflow of illegal substances dramatically.

Unregulated devices such as pill presses are another massive contributor to the opioid crisis, and that is acknowledged in the bill. These devices are allowing organized crime to produce mass amounts of deadly drugs. Giving the CBSA authority to share information with law enforcement agencies will allow police forces to do their jobs and shut down these illegal activities.

The bill also acknowledges the notion that new dangerous substances are constantly being manufactured. In order to control the quick turnaround of newly designed psychoactive substances, under new regulations, the minister would be able to temporarily and quickly schedule control of a dangerous substance.

These are public safety measures that look out for the best interests of all Canadians. These measures look to negatively affect organized crime and make it harder for organized crime to produce and sell dangerous drugs.

However, severely weakening the consultation process with Canadians before the approval of an injection site is the exact opposite of these other measures. Approving these sites all around the country will normalize substance abuse. Drug addicts will still be committing extreme numbers of crimes to obtain these drugs. They will still be contributing to organized crime, and they are all to use freely in a government-sanctioned facility.

I acknowledge that every province has different needs. What is happening in British Columbia is not the same as what is happening in Prince Edward Island. However, I cannot acknowledge that injection sites save lives. I heard the analogies from a medical addiction specialist who said that, "If I was a lifeguard and saw someone drowning, I would run in and pull them out of the water. Once they started breathing again, I would not throw them back into the water". That is exactly what injection sites do.

Government Orders

Streamlining the application process for approving injection sites is irresponsible. It would put communities at risk and it would put individuals with severe drug dependencies at risk. Drug addiction should be seen as a treatable illness. Until I see the government take appropriate steps to help these people get off these dangerous and deadly drugs, I cannot, and will not, support this harm reduction band-aid solution.

• (1055)

Mr. Kevin Lamoureux (Parliamentary Secretary to the Leader of the Government in the House of Commons, Lib.): Madam Speaker, although I appreciate the member speaking to the legislation, I do not necessarily agree with a number of the points and conclusions that he has brought to the chamber.

The Vancouver Insite injection site has received overwhelmingly positive feedback since its creation. Its creation was based on consultation and had a federal minister working with the provincial entities and different stakeholders, including first responders and the community as a whole. I recall when the Conservatives brought in legislation to try to expand the area. There was a great deal of concern and scepticism toward the Conservatives back then because they did not support these injection-type sites, even though science and statistics clearly indicated that society benefits from these sites.

I take it from the member's statements that we will no doubt have to agree to disagree on the validity of the injection sites, but that we do agree on the crisis of opioids. This legislation will assist in dealing with that crisis. Given the urgency of the opioid crisis in Canada, at the very least, would the member not agree that we should attempt to get this to committee as soon as possible?

Mr. Colin Carrie: Madam Speaker, I think everyone in the House agrees this is urgent. When we look at addiction as a health problem, it is clear we would treat no other health condition like this. Even if we were to define the harm in the term "harm reduction" as an addict putting heroin into his or her arm, I think the approach would be to try to help that addict so he or she would not do that.

We have seen statistics. I remember talking to Vernon White. He said that the average addict committed four to eight illegal crimes every day to get his or her fix. Therefore, by allowing addicts to go into one of these injection sites to inject an illicit substance, which as far as we know could be filled with kerosene, and then giving them a little shake and letting them go back out again saying that we have saved their life, we are enabling them to go out in that community and commit four to eight crimes again. Whether it is break and enter or prostitution, let us imagine that happening four to eight times per day and all we are saying is, "Come back in again. We'll see what we can do to help you."

My colleague from Vancouver was adamant and passionate. This was a band-aid solution. We need to work on long-term detox programs. I find it uncomfortable that the minister just finished renegotiating the health accord and did not get a firm commitment from the provinces and territories to open up these detox centres. That is what really saves lives.

• (1100)

Ms. Linda Duncan (Edmonton Strathcona, NDP): Madam Speaker, what is stunning to me is that the member appears to be saying that he agrees that we are facing an opioid epidemic.

We have been told by the minister that there has been an 80% increase in deaths from overdose since 2015. There have been huge increases in deaths from overdose in my city alone.

More than 87 organizations that work with the homeless, the HIV-infected, and the addicted came forward to oppose the legislation of the member's government. They said that safe injection sites were proven to decrease overdose, death, injury and risk behaviour, that access to health care for the marginalized increased, that it saved health care costs, and that it decreased open drug use and publicly discarded equipment.

Therefore, given the member supports the fact that there is an opioid epidemic, will he support our call for a national public emergency to be declared so federal resources will be made available immediately, and at least temporary safe injection sites?

Mr. Colin Carrie: Madam Speaker, what my colleague says is quite true. The crisis is getting worse. Sometimes people get caught up in thinking they need to do something. However, as I said in my speech, if only 7% of the people who attended what some people call this "safe" injection site were offered treatment, why would we be repeating that around the country?

As the minister said herself, there are no good statistics being collected to determine the proper way to move forward. Is it injection sites or needle exchanges? Therefore, before we move forward, it is important that we maintain the rights of communities to provide their input where these injection sites have been proposed. That is the most disturbing thing I find with the bill. It would remove a lot of the safeguards we had put in place as a government. The basic fact is this. We should not be normalizing these injection sites. They should be rare and should not be made the go-to way of treating these addictions. Rather, it should be detoxification treatment.

Mr. Don Davies (Vancouver Kingsway, NDP): Madam Speaker, it is a privilege to work with my hon. colleague on the health committee. I very much respect his contributions to that committee, but with the greatest of respect, I must vehemently disagree with a number of the theses he is advocating here today.

If health policy is to be based on evidence and not on ideology, then we must look to the best evidence we have. The validity and accomplishments of safe injection sites were exhaustively examined by the Supreme Court of Canada when it ruled on the Insite case back in 2011. In that case, mountains of evidence were placed before the court, including from *The Lancet*, which is one of the world's most respected medical journals. Evidence gathered around Insite itself showed that it results in fewer overdoses, and in fact, no deaths. There has not been a single death at a supervised injection site in this country ever. As my colleague from Edmonton Strathcona said, it results in there being less open drug use in the streets, less crime, and fewer discarded needles in our communities as well.

His own government brought in legislation that did permit safe injection sites to open, albeit it made it extremely difficult to open them. His own government must have acknowledged that there was some value to this, or perhaps it was just forced to do so by the Supreme Court of Canada.

Why did his government do nothing about the CBSA's prohibition on opening envelopes under 30 grams, which it took the present government to fix, so that we could stop the flow of fentanyl into this country? Why did his government not catch that and do something about it?

• (1105)

Mr. Colin Carrie: Madam Speaker, I want to acknowledge my colleague for the good work he has done on committee. I think we agree on most things, except the injection site issue.

If he looks at the community where Insite is, Vancouver's Downtown Eastside, I think he would agree with me that it is an exceptional neighbourhood. Before Insite was put into that neighbourhood, it was a horrible situation. The injection site was put there basically as an experiment. We had to do something. In that particular community, there was a lot of support for it. I think he is very aware of the strong support among all stakeholders.

That is one exceptional neighbourhood. I do not see any neighbourhood in Canada as bad as that one is or was in the past. If we look at the evidence, and he was there in health committee, unless communities are actually supportive and on side with these facilities, they do not have a chance of being successful. There is not a lot of evidence to support taking this template and just moving it across the country. As he said, there has only been one. To duplicate that based on that one experience is not the responsible thing to do.

Some things have been brought up over and over again, such as saving lives. I would suggest that if someone is injecting in front of them, that is to be expected, but to send them back out without proper treatment and moving them into a treatment program, as we would with any other disease in Canada, is that the best we can do? If that was our child or our friend, is that really the best we could do?

I look forward to working with my colleague on seeing what we can do to move that agenda forward, because I think that is something all Canadians in all communities can agree on.

Mr. Don Davies (Vancouver Kingsway, NDP): Madam Speaker, Canada is currently in the grips of an unprecedented opioid overdose crisis. According to David Juurlink, one of Canada's leading drug safety experts:

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This is the greatest drug safety crisis of our time, and it's not hyperbole to say that every one of you knows somebody with an opioid use disorder. Whether you realize it or not, you do, and it's quite possible that you know someone who's lost a loved one to these drugs.

He went on to say:

The scope of the problem in Canada is completely unknown. We know that in the U.S., the CDC estimates that over the last 20 years, about a quarter of a million people have died from opioids, more than half of them from prescription opioids.... We have no corresponding numbers in Canada. I speculate that somewhere in the order of 20,000 Canadians have died over the last 20 years from these drugs. The fact that no federal politician can tell you that number is a national embarrassment.

In my home province of British Columbia, illicit drug overdoses claimed the lives of at least 914 people last year, making it the deadliest on record for overdoses. This places it at the same level as Alabama, the worst state in the United States in terms of overdose rates.

Last year two Ontarians died every single day from drug overdoses, with one of every eight deaths of young adults due to opioids, and 338 Albertans died last year. Quebec overdose deaths have increased by 140% over the last 10 years.

Although Canada does not track overdose deaths at the national level, which again is an inexcusable deficiency in national health policy, it is estimated that in 2015 alone, 2,000 Canadians died from overdoses. That number is certainly much higher for 2016 due to the rapid proliferation of extremely potent illicit opioids throughout Canada.

It is patently clear that drug overdoses and deaths are increasing in every region of the country and will continue to do so without extraordinary and effective action. The significant increase in overdoses in 2016 prompted B.C.'s provincial health officer, Dr. Perry Kendall, to declare a public health emergency last April for the first time in the province's history. Notwithstanding this extraordinary step, the crisis has deepened.

December saw another record spike in deaths in B.C., with Vancouver alone now registering 15 overdose deaths per week. This is truly a crisis of epidemic proportions.

Fentanyl, an opioid 100 times more potent than heroin, has been called a game-changer for drug overdose deaths in Canada, and now we are seeing overdoses caused by carfentanyl, an opioid so powerful that it poses overdose risks to those exposed to it simply through inhalation or contact with their skin. These drugs are so dangerous that a dose the size of a grain of salt can cause overdose or death.

I think we can all acknowledge that there are many aspects to this complex crisis. Fentanyl is strong, cheap, easy to transport, and small amounts can be made into thousands of doses. For \$10,000 or \$20,000, manufacturers can obtain a kilogram of fentanyl, an amount so compact it can fit in a shoebox, and turn it into \$20 million in profit.

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Many overdoses are being caused by inexperienced young people experimenting with non-opioid recreational drugs, unaware that they are contaminated with fentanyl. For example, this past fall in Vancouver, there were nine overdoses recorded within 20 minutes in people who were using cocaine that was unknowingly laced with fentanyl.

Opioids have been overused and over-prescribed by doctors for pain management, leading to many patients becoming dependent and addicted. Canada has among the highest per capita volume of opioids dispensed in the world, totalling 19.1 million prescriptions in Canada in 2015, up from 18.7 million the year before. That is about one opioid prescription written for every two Canadians.

Even though there are no credible peer-reviewed studies that demonstrate that opioids afford more benefit than harm for chronic pain, opioid use has been marketed beyond palliative and cancer patients for regular use for people experiencing back pain and other common ailments. Prescribers were incorrectly taught that addiction was a rare consequence of using prescription opioids long term, that less than 1% of patients would become addicted.

• (1110)

In reality, the addiction rate is estimated to be 10%, with 30% suffering from opioid use disorder. This misuse of opioids reveals the absence of broad and effective treatment for chronic pain in Canada. Critically, there is an alarming lack of public detox and treatment facilities available across Canada, caused by under-investment for decades at both provincial and federal levels, and even fewer resources dedicated to education and prevention.

Bluntly, our health care system has an appalling lack of publicly covered treatment options for Canadians suffering from substance use disorder, a pox on both Liberal and Conservative governments over the last number of decades.

In indigenous communities, inconsistent federal support for community governed and culturally based treatment has made addressing the opioid crisis a particular challenge. Nurses employed by Health Canada do not possess the scope of practice to support indigenous people in addressing opioid addiction in their own communities beyond 30 days by federal edict.

As Dr. Claudette Chase, a family physician at the Sioux Lookout First Nations Health Authority recently told our health committee:

I tear up every time I think about this, because our workers are putting themselves on the line to hear the stories of incredible trauma. We have little funding to train them. These are community members who, because Health Canada has refused to step up, have stepped up themselves. They do this and they get traumatized daily, and I have little or no means to support them other than being their family doctor. It's not acceptable.

Addiction is a complex psychosocial disease with genetic, environmental, and social determinant influences of every type. Although this crisis has been garnering increased media attention in recent months, make no mistake that it has been allowed to escalate for years, recently under a Conservative government blinded by superficial ideology and now under a Liberal government paralyzed by timid expediency.

What both Conservative and Liberal governments have in common, however, is a refusal to act on evidence in a timely fashion, and decades of history of failure to make the investments

necessary to provide Canadians with essential health options to treat substance use disorder.

Over the last 10 years, the previous Conservative government slashed Health Canada's addiction treatment budget, removed harm reduction as one of the four pillars of Canadian drug policy, and spent nearly a decade trying to discredit the clear and overwhelming evidence that supervised consumption sites save lives.

Indeed, this crisis has undeniably been exasperated by barriers erected by a Conservative government that prevented supervised consumption sites from opening across Canada. Despite an abundance of research that conclusively established that Vancouver's supervised consumption facility, Insite, significantly reduced overdose deaths, the Conservative government obstinately refused to accept that evidence.

In 2011, it took the Supreme Court of Canada to rule that Insite and other supervised consumption sites must be granted a section 56 exemption from the Controlled Drugs and Substances Act because they "decrease the risk of death and disease, and there is little or no evidence that it will have a negative impact on public safety".

In response, in 2015, the Conservative government introduced Bill C-2, which sets out a lengthy and arduous list of criteria that supervised consumption site applicants must meet before the minister would grant them an exemption. In practice and by design, these criteria made it effectively impossible for organizations to open new supervised consumption sites in Canada.

For example, Montreal has had applications pending Health Canada approval since May 2015, almost two years, for three fixed services in three neighbourhoods and one mobile service. Indeed, not a single supervised consumption site has opened in Canada since Bill C-2 was passed. Of course, that was exactly the Conservatives' intention.

Only an hour after Bill C-2 was initially introduced, in a move so vile it would impress Donald Trump, Conservative campaign director Jenni Byrne issued a fundraising letter stating that the Liberals and NDP wanted addicts to shoot up in the backyards of communities all across the country. This went beyond a juvenile refusal to accept evidence that ran contrary to their moralizing ideology. It was a clear and utterly disgraceful attempt to campaign on the backs of the most vulnerable Canadians, sick Canadians.

• (1115)

For those Conservative MPs who now claim to have found religion on the issue, who have recently echoed the NDP's long-standing call to declare a national public health emergency, I must remind them that it was Conservatives who blocked my attempt to move this bill swiftly through the House in December, to save lives faster.

Though the Liberals claim to support the expansion of supervised consumption sites, their government has not approved a single new facility since coming to office. In fact, the Minister of Health initially and stubbornly argued that legislative changes to Bill C-2 were not even necessary, since she had directed Health Canada officials to facilitate the application process under the existing law. She refused to acknowledge that the problem was the act itself with its 26 separate requirements acting as effective barriers to any new sites, as had been consistently pointed out by stakeholders, the NDP, and even some of her own colleagues. This tepid response stood in stark contrast to the view espoused by the member for Vancouver Centre, the Liberal member for Vancouver Centre, when she was the Liberal health critic in opposition.

When Bill C-2 was introduced, the member for Vancouver Centre publicly stated that the bill was deliberately written in a way that would ensure no supervised consumption sites were approved in Canada. She also questioned the constitutionality of the bill. It has frequently been observed that Liberals campaign from the left and govern from the right, that they talk progressively in opposition, but act conservatively when in power. I am afraid their conduct on the opioid crisis is yet one more example of this unfortunate truism.

Unacceptably, it took a mounting death toll and universal pressure from medical experts, public health officials, provincial governments, municipal leaders, and the federal NDP before the Minister of Health finally relented and outlined legislative changes she was willing to make to Bill C-2, on December 12, 2016. This came on the heels of an announcement from the B.C. government that it was no longer willing to wait for federal approval and would take the extraordinary measure of signing a ministerial order making the provincial operation of temporary overdose prevention sites legal. This was in turn a response to the unsanctioned, makeshift supervised consumption sites that were being established throughout B.C. by activists like Ann Livingston and Sarah Blyth, who founded the Overdose Prevention Society last September with crowdfunding, due to the severity of the crisis.

While the current government was waiting, while people were dying, people in British Columbia and on the street were acting. Thus, the bill is an overdue acknowledgement that this is, in fact, a crisis and contains some important steps to address it.

I do want to credit the government for taking some positive measures.

The Liberals hosted an opioid summit, where they committed to better informing Canadians about the risks of opioids, supporting better prescribing practices, and improving the evidence base. They made naloxone available in a non-prescription status. They reversed the federal prohibition on the use of pharmaceutical heroin for treatment. They scheduled fentanyl precursors. They reinstated harm reduction as one of the four pillars of drug policy. Now the government has introduced amendments to the Controlled Drugs and Substances Act and other acts, to streamline supervised consumption site applications.

These changes are all welcome, if overdue, and New Democrats are in agreement with all of them. However, they do not go nearly far enough, fast enough. There is much more that we can and must do.

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That is why I must take serious exception to comments made by the Minister of Health in a recent interview. The minister said:

I would argue with the fact as to whether or not there's been progress made. I know that the number of deaths are rising, but we have been extremely active on this file....

I do not know how the minister measures progress, but I do know one thing. When Canadians are dying at unprecedented rates, when month after month we see increased death tolls from opioid overdoses, there can be no legitimate talk of progress. We in the New Democratic Party will measure progress by one factor and one factor only: when the death toll of Canadians goes down, not up. However by that standard, the crisis is getting dramatically worse, not better. Annually since 2012, the number of fatal overdoses in B.C. has increased significantly: 273 deaths in 2012, 330 in 2013, 366 in 2014, 510 in 2015, and now 914 in 2016.

Last month alone, we recorded the highest number of overdose deaths in B.C.'s history, with 142 lives lost. That is more than double the monthly average of overdose deaths since 2015 and a sharp increase from the fall. There were 57 overdose deaths in B.C. in September, 67 in October, and 128 in November. That is not progress.

• (1120)

To understand the scale of this epidemic, I would remind the House that during the SARS crisis in 2003, 44 people died in an outbreak of the disease across all of Canada. We are losing that many people every week to opioid overdoses.

I would suggest to members of the House that if 40 to 50 Canadians were dying every week from SARS, Ebola, or any other infectious disease, the House would not rest until it saw a response from the federal government that matched the severity of the crisis. Every life lost to overdose is a heart-wrenching tragedy that leaves devastated loved ones in its wake. The lives cut short by overdose matter just as much as anyone's, and this epidemic deserves the same attention and urgency as any other disease.

Moreover, we must remember that the consequences of inaction are felt severely by those on the front lines of this crisis. As Chris Coleman, a firefighter who works on Vancouver's Downtown Eastside, told the health committee:

...it takes a toll on an individual's mental health to see such helplessness and suffering up close on a daily basis; to work extremely hard but to feel that you are having little or no impact on a problem that is growing exponentially, like a tidal wave, on the streets of your city. There is mental strain in watching a population repeatedly harming itself and in ultimately witnessing death and deceased persons who have succumbed to this human tragedy....

I must stress that our brothers and sisters who work in the Downtown Eastside are in trouble.... In conversations with these firefighters, I hear a lot of "It's driving me nuts" and "I can't take it". I'm told stories of their being in an alley with 20 or 30 drug users. They're unprepared and untrained for that. Part of their hopelessness comes from having to deal with the same particular overdose patient who has a needle in their neck, who's rolling around in urine and feces, more than once on the same shift. They feel abandoned and they feel hopeless.

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We must not condemn our courageous first responders to the fate of Sisyphus, rolling an immense boulder up a hill over and over again for eternity. They need the Government of Canada to have their backs.

Indeed, the federal government's failure of leadership on the opioid crisis has led to renewed pleas for help from public officials from all across Canada. These include the mayors of Calgary, Toronto, Ottawa, and Vancouver, B.C.'s health minister, and health professionals from every discipline.

I know that the Minister of Health has repeatedly stated in public that the federal government is doing everything it can. Of course, that is utter nonsense. There are literally dozens of measures and recommendations made by health experts and stakeholders across Canada that remain unimplemented by the government.

Recently, the City of Vancouver sent a list of nine recommendations to the federal government to help address this crisis, including calling for a central command structure, daily meetings with Health Canada, and improved treatment services. A coroner's jury in British Columbia recently issued a list of 21 recommendations for action, and the Standing Committee on Health in December issued a report detailing 38 recommendations for the government alone, most of which remain unimplemented.

To demonstrate this leadership and illustrate the federal government's understanding of the scope of this crisis, the New Democrats have been calling on the federal Minister of Health to declare a national public health emergency for months. We are now joined in this call by municipal, provincial, and federal politicians of all stripes, including, recently, the Conservatives.

A declaration of a national public welfare emergency under the Emergencies Act would empower Canada's top doctor with the authority to take extraordinary measures to coordinate a national response to the crisis. This could include an allocation of emergency funding on the scale required to actually address the mounting death toll, as well as sanctioning the operation of temporary supervised consumption sites on an emergency basis.

Inexplicably, the minister continues to claim that a national public welfare declaration is unnecessary and untimely. With respect, she is utterly and demonstrably wrong. For example, such a declaration would allow overdose prevention sites across the country to open and operate legally, something they cannot do now. Not only are such sites needed desperately in every major city in Canada, but they would start saving lives today.

New Democrats have worked in good faith with successive federal governments to address the crisis with the urgency it deserves. We led the fight against the Conservatives' Bill C-2 from the day it was introduced, and then pressed the Liberal government to repeal or amend it. Last fall, we moved a motion at the standing committee to conduct an emergency study on the crisis. We tried to expedite this bill through the House in December; and we were the first to call for a declaration of a national public health emergency to address the crisis.

● (1125)

The New Democratic Party will support this bill and work in committee to improve it. We will continue to press the government to take every action it can to address this national public health crisis.

Mr. Kevin Lamoureux (Parliamentary Secretary to the Leader of the Government in the House of Commons, Lib.): Madam Speaker, I support many of the comments the member made in reference to Bill C-2, especially his reflections on the Conservative government at the time. I was here, like him, and I like to think it was not only the NDP. The Liberals were also in great opposition to Bill C-2 and made commitments to look at making changes. What we are talking about today addresses some of the issues that were raised during the debate on Bill C-2 by both opposition parties.

I agree, in good part, with the beginning of the member's comments. Where I take some exception, and where the member needs to get a better appreciation, is on the statement that the national government has not demonstrated leadership. The Minister of Health and the Prime Minister have demonstrated leadership on the opioid crisis here in Canada.

The Minister of Health has been very proactive. The member himself made reference to a series of things the Minister of Health has done. We have to take into consideration an enormous amount of work with the different stakeholders, whether they are provincial administrations, indigenous people, first responders, and so forth. It has to be a coordinated approach.

My question for the member is this. Does he not recognize the importance of working with others, since it will not be just Ottawa that resolves this particular problem? Maybe he could comment further on how the House today can assist in expediting the passage of this legislation.

Mr. Don Davies: Madam Speaker, sometimes Liberals say that the New Democrats are Liberals in a hurry. The corollary to that is that Liberals are New Democrats who will not take action.

My hon. colleague brings up something that I made a central point of my speech, which is that when Liberals were in opposition, they stood in the House and told Canadians that they opposed Bill C-2, that they believed that supervised consumption sites save lives, and that Bill C-2 was deliberately designed to prevent the opening of supervised injection sites in this country. In fact, the member for Vancouver Centre, the senior Liberal in British Columbia and the Liberal critic for health at the time, called the bill unconstitutional.

That is why New Democrats, as soon as the Parliament changed back in October of 2015, at first opportunity, called on the government to introduce legislation to amend or repeal Bill C-2. New Democrats started the call in February of last year. Why? It was because we saw that there was a crisis. People were dying every week.

What did the Liberals do? They told the NDP they did not think, while in government, that there was any problem with the legislation, that they just thought it was an administrative problem. Every month, New Democrats stood in the House and told Liberals they had to act to change it because supervised consumption sites save lives and the bill was a barrier. Month after month, Liberals stalled and did nothing while Canadians died. It took them until December, after over a year in office, before they actually introduced legislation, which will now take months to pass.

I am going to give the Liberal government no credit for its inaction and delay on introducing legislation that is so critical to saving lives in this country, and New Democrats will continue to push the government to take the dozens of recommendations that are necessary to continue to do so.

● (1130)

Ms. Dianne L. Watts (South Surrey—White Rock, CPC): Madam Speaker, I am looking at some of the embedded criteria regarding injection sites. I was not here at the time, but as I go through this, I see they include support from local government with respect to health and safety, a letter from the head of the police, a letter from health professionals in relation to public health, information on the vicinity of the site, information on the inappropriate discarding of drug-related paraphernalia, a number of issues on data gathering, drug treatment, and trends. All of those things were embedded, and I am wondering which piece was a roadblock to establishing a consumption site. Insite has been there for 13 years and was established under the Conservative government.

I am wondering what piece of the consultation he is not supporting.

Mr. Don Davies: Madam Speaker, the legislation that the Conservative Party brought in was forced upon that government after fighting Insite in the Supreme Court of Canada. Instead of listening to the evidence and working with health professionals, a decision by that member's government forced Insite to spend millions of dollars going to the Supreme Court of Canada to establish that supervised consumption sites save lives. In that decision, the Supreme Court identified five factors that ought to be met before a community permitted the opening of a supervised consumption site. The Conservatives took that Supreme Court decision and they exploded those five factors to 26, and a number of those factors have absolutely nothing to do with health.

For those of us who view addiction as a health issue, for those of us who view the operation of these clinics as being pivotal to saving lives, I will point out that not a single person has died in a supervised consumption site facility in this country. As my former colleague Libby Davies used to say, "dead addicts don't get recovery".

From a health point of view, when a community wishes to have such a site we should focus on criteria that would help to address the health issues there.

It is not a question of finger-pointing; it is a question of establishing facts. The previous Conservative government slashed Health Canada's budget for addictions treatment by 15%. It did nothing about the CBSA's problem in being unable to open 30-gram-or-under envelopes. The Conservative government fought super-

vised consumption sites in this country right to the Supreme Court of Canada.

I will take no lectures from the Conservative Party about how to save lives in the opioid crisis.

● (1135)

Mr. Murray Rankin (Victoria, NDP): Madam Speaker, I would like to thank my colleague from Vancouver Kingsway for a thoughtful and passionate speech on the opioid use disorder crisis in Canada.

Nine hundred and fourteen people died last year in my province of British Columbia. In my riding of Victoria, dozens of people have died, while we watched the government take no action over the last year on this issue. I am delighted to hear the minister make commitments today. This is very personal. I know people whose family members have died as a consequence of inaction over the last while.

I would ask my colleague to elaborate a bit on what this national health emergency means and what the Emergencies Act might allow by way of powers. My colleague talked about the 38 recommendations from the health committee. He talked about recommendations from the City of Vancouver and in coroners' reports. If we have a crisis, which we do, I would ask the member what powers would be available to the government were it to trigger that?

Mr. Don Davies: Madam Speaker, I would like to thank the member for Victoria for his excellent work on this issue when he was our party's health critic.

A piece of federal legislation called the Emergencies Act permits the declaration of a public welfare emergency when one of two situations exists. The first is if a province is experiencing a problem that is so serious and severe that it overwhelms its own ability to deal with it. The second situation is when an issue affects more than one province across the country. It is the latter situation that is clearly the case in Canada right now. All provinces across this country are experiencing problems with the opioid overdose crisis.

There are a number of extraordinary powers that would be given to Canada's top doctor under the Emergencies Act were the government to declare a public welfare emergency. There are two in particular. The act would allow the flow of emergency funds commensurate with the emergency without having to go through this process in the House. Second and most important, the act would allow the government to open emergency hospitals or clinics, for example, if a disease was spreading across this country and we needed mobile units immediately.

The overdose prevention sites that are really currently operating against the law right now would be deemed legal were the government to declare a public welfare emergency and cities across this country could open those up today and start saving lives today.

The Liberal government will not do it and I have no idea why it will not.

Mr. Ron McKinnon (Coquitlam—Port Coquitlam, Lib.): Madam Speaker, I will be splitting my time with the hon. member for Edmonton Centre.

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I am pleased to rise today to speak in support of Bill C-37, an act to amend the Controlled Drugs and Substances Act and to make related amendments to other acts. My private member's bill, Bill C-224, the good Samaritan drug overdose act, is currently in the other place. Just like Bill C-37, it is just one piece in the harm reduction tool kit that would help to save lives.

Protecting the health and safety of Canadians is a key priority for this government. That is why on December 12, 2016, the Minister of Health, with support from the Minister of Public Safety and Emergency Preparedness, introduced Bill C-37 in the House of Commons.

[Translation]

This bill makes several amendments to the Controlled Drugs and Substances Act and the Customs Act in support of the government's efforts to respond to the current opioid crisis and problematic substance abuse in general.

[English]

This comprehensive bill aims to balance the important objectives of protecting public health and maintaining public safety. It is designed to better equip both health professionals and law enforcement with the tools they need to address the issue.

Over the last decade, the harms associated with problematic substances abuse in Canada have become more complex and have been changing at a rapid pace. The line between licit and illicit substances has blurred with the opioid crisis, prescription drug misuse, and the rise of new designer drugs.

The government has committed to helping Canadians affected by these problematic substances and their use. Legislative and regulatory controls are certainly an important part of this approach. However, as we know, drug use and dependency pose significant risks for individuals, families, and communities. Our approach to addressing problematic substances abuse must include preventing and treating addiction, supporting recovery, and reducing the negative health and social impacts of drug use on individuals and their communities through evidence-based harm reduction measures. This must also be a part of our approach to addressing problematic substances abuse.

Harm reduction is viewed by experts as a cost-effective element of a well-balanced approach to public health and safety. Harm reduction connects people to other services in the health and social systems related to treatment and recovery. It recognizes that individuals and whole communities benefit when people with substance misuse and addiction issues can obtain the support and services they need rather than being marginalized or stigmatized. The evidence regarding harm reduction is absolutely clear. Harm reduction measures are a critical piece of a comprehensive approach to drug control.

• (1140)

[Translation]

That is why the government is determined to take a balanced, evidence-based approach that supports rather than creates obstacles to harm reduction.

[English]

To that end, on December 12, 2016, in addition to introducing Bill C-37 in the House, the Minister of Health announced that a national anti-drug strategy would be replaced with a new, more balanced, and health-focused approach, called the Canadian drugs and substances strategy. The new strategy will strengthen Canada's approach to drug policy by providing a comprehensive, collaborative, compassionate, and evidence-based approach to the protection of public health and safety and the reduction of harm from misuse of licit and illicit substances. To reflect the new health-focused approach, the strategy will be led and coordinated by the Minister of Health, in close collaboration with her colleagues.

Canada has had successive drug strategies in place since 1987 that have aimed to balance public health and public safety. In 1992, the government launched Canada's drug strategy, which was intended to reduce the harms associated with alcohol and other drugs to individuals, families, and communities. In 1998, harm reduction was added as a pillar alongside prevention, treatment, and enforcement.

However, the balance between public health and public safety in Canada's approach to drug policy shifted in 2007, with the release of the national anti-drug strategy. This strategy reflected the previous government's priorities of public safety, crime reduction, and safe communities.

The national anti-drug strategy focused primarily on youth and illicit substance use and did not retain harm reduction as a pillar. This shift brought Canada out of step with other like-minded countries, most of which include harm reduction in addressing problematic substance abuse.

The new strategy will retain and build upon the aspects of the national anti-drug strategy that worked well and, specifically, the new strategy will maintain the existing and well-established areas of prevention, treatment, and enforcement. These pillars, respectively, aim to prevent problematic drug and substance use, support innovative approaches to treatment and rehabilitation, and address illicit drug production, supply, and distribution.

However, perhaps the most important aspect of the new strategy is that it will improve upon the national anti-drug strategy by formally restoring harm reduction as a pillar. This shift to a more health-focused approach has been welcomed by stakeholders, including the Centre for Addiction and Mental Health, and our provincial partners.

Our government is committed to ensuring that its policies under the new strategy will be informed by a strong foundation of evidence, including data related to harm reduction policies, programs, and interventions. This will enable the government to better identify trends, target interventions, monitor impacts, and support evidence-based decisions. It will help ensure that Canada has a comprehensive national picture of drug use and drug-related harms and can fully meet our international reporting requirements.

Even before the new strategy was announced, our government included harm reduction measures in our efforts to reduce the negative health and social impacts associated with problematic drug use, including the transmission of infectious diseases, overdose deaths, and stigma.

• (1145)

[Translation]

For example, under federal legislation, we have improved access to naloxone, an overdose reversal drug, by making it available without a prescription specifically for emergency use in cases of opioid overdose outside of hospital settings.

This important measure broadens access for emergency workers and will help address a growing number of opioid overdoses.

[English]

We have also demonstrated our support for the establishment of supervised consumption sites, a key harm reduction measure.

After a thorough and rigorous review, in January 2016, Health Canada granted an exemption from the Controlled Drugs and Substances Act for the Dr. Peter Centre to operate a supervised consumption site.

Not long after, on March 16, 2016, Health Canada granted Insite an unprecedented four-year exemption.

If passed, Bill C-37 would go further to support the implementation of evidence-based harm reduction measures. In particular, it would reduce the burden on communities that wish to apply for an exemption to operate a supervised consumption site.

The proposed amendments would streamline and simplify the application criteria, while ensuring that community consultation continues to be an integral part of the process. By streamlining the application and renewal process and adding a new transparency provision, applicants could be assured that the process would not cause unreasonable burden or delay.

In conclusion, our government's approach to drug policy strives to balance the important objectives of protecting public health and maintaining public safety.

The Canadian drugs and substances strategy will restore harm reduction as a pillar, alongside prevention, treatment, and enforcement, and will formalize our commitment to a comprehensive, collaborative, compassionate, and evidence-based approach to Canada's drug policy.

It would mean that harm reduction-focused policies, such as support for properly established and maintained supervised con-

sumption sites and increased access to naloxone, would now officially be part of Canada's drug strategy.

Implementing measures proposed in Bill C-37 would be a key step in realizing the objectives of the Canadian drugs and substances strategy.

[Translation]

Ms. Anne Minh-Thu Quach (Salaberry—Suroît, NDP):

Madam Speaker, the Liberals have been in power for more than a year now and we have been asking that the Conservatives' Bill C-2 be withdrawn and reworked in order to consider the possibility of opening injection sites to help reduce the number of overdoses and overdose-related deaths.

We know that it is often the young, inexperienced users who end up overdosing. Some do not know that certain drugs contain fentanyl. Why have the Liberals still not reinvested in awareness and prevention? There is a desperate lack of resources for this. Front-line workers are saying that they need more resources to work on prevention.

What is the Liberal government doing to save lives and ensure that young people are not the primary victims of its inaction?

[English]

Mr. Ron McKinnon: Madam Speaker, it is plain that the Liberal government is taking meaningful action on this matter. We have undertaken a number of initiatives such as the conference, bringing together all provincial and territorial stakeholders involved in this crisis. We have also committed \$5 million for support of mental health and addictions issues. I certainly urge all provinces that have not done so to step up and make use of this.

• (1150)

Mr. Peter Julian (New Westminster—Burnaby, NDP): Madam Speaker, I appreciate the member opposite. He lives in the Lower Mainland. I am sure he is as aware, as I and other Lower Mainland MPs are, of the depth and breadth of the crisis taking place right now. Every day, two people die in the Lower Mainland. Every day in Ontario two people die. Every day in Alberta a person dies. This is a health crisis of an unimaginable extent. It is something that should be calling the government to take immediate action. Instead, for over a year, we saw the government drag its feet and refuse to do anything as the death toll rose, doubling and tripling. We are now talking about thousands of Canadians dying over the past couple of years.

The implications are enormous if nothing much happens. The government has moved very slowly on legislation. It has waited 15 months now. We are coming up to February tomorrow. The Liberals took office and could have moved something in December 2015. They have done nothing really to in any way fight to put in place the addiction treatment programs that are needed across the country, and they have refused to call a public health emergency.

Government Orders

Why is the government moving so dreadfully slowly in the midst of this crisis?

Mr. Ron McKinnon: Madam Speaker, I see no profit in fighting old battles and worrying about who did or did not do what when. What remains a fact at this time is that we are taking definitive and meaningful action, and moving forward in a substantive way on this issue. This bill shows that very well.

We have taken action all through our time in office, such as improving access to naloxone to controlling the availability and the supply of the precursors to the manufacture of things like fentanyl, all of which are meaningful actions. However, we are moving forward. It is time we all move forward and solve this problem together in a meaningful way, as we are setting about to do.

Mr. Randy Boissonnault (Edmonton Centre, Lib.): Madam Speaker, I am very pleased to rise today to speak in support of Bill C-37, an act that would better equip both health and law enforcement officials to reduce the supply of illicit opioids and other drugs and to reduce the risk of diversion of controlled substances.

[Translation]

Bill C-37 confirms once again our government's continued commitment to ensuring that our legislative frameworks for public health and safety are modern and effective.

[English]

Protecting public health through efforts to prevent disease, prolong life, and promote health is a key priority for the government. The recently announced Canadian drugs and substances strategy and the proposed legislative changes to streamline the application process for supervised consumption sites are just two ways the Government of Canada is demonstrating this commitment to public health.

This new strategy is comprehensive, collaborative and compassionate. It is comprised of four key pillars: prevention, treatment, harm reduction and enforcement, which are built upon a strong foundation of evidence.

While the new strategy places an increased emphasis on public health, our government recognizes that effective drug policy must balance both public health and public safety.

[Translation]

Therefore, not only does Bill C-37 address harm reduction measures such as supervised injection sites, it also proposes new ways to deal with controlled substances that are obtained through illicit sources.

[English]

Bill C-37 would amend the Controlled Drugs and Substances Act, or the CDSA, Canada's drug control statute. The CDSA provides a framework to control substances that can alter mental processes and that may produce harm to health and to society when diverted or misused. It has the dual purpose of protecting public health and maintaining public safety.

We know that the use of illicit substances can increase the risk of harm to health. The CDSA maintains public safety by restricting the

activities such as import, export and trafficking of controlled substances and precursors.

• (1155)

[Translation]

The Controlled Drugs and Substances Act has been in effect for two decades now and some of its regulations, enacted under previous legislation, have been in place much longer. While the CDSA serves us well in many areas, there has been a significant evolution in both the legitimate controlled substances and precursors industries as well as the illicit drug market.

[English]

As we all know, problematic substance use is a serious public health issue. Our government is very concerned about the increasing rates of opioid-related overdose deaths occurring across Canada right now, and the devastating impact this crisis is having on individuals, families and communities at large, including in my own riding of Edmonton Centre. Opioid-related overdoses in British Columbia and Alberta have reached a crisis point and urgent action is needed to protect public health and safety, and disrupt illegal production and trafficking. It is becoming increasingly critical to ensure that the CDSA is modernized in order to better protect Canadians, their families, and the communities in which they live.

[Translation]

The Government of Canada is taking concrete action that will help address the current crisis and keep deadly drugs such as fentanyl and carfentanil out of Canadian communities. If the proposed amendments in Bill C-37 were adopted, they would further strengthen and modernize the tools available to the government to combat the illegal production and distribution of drugs and reduce the risk of controlled substances being diverted to the illegal market.

[English]

One such action would prohibit the import of unregistered pill press and encapsulator devices.

Pill presses and encapsulators can be used legitimately to manufacture pharmaceuticals, food and consumer products as well. However, they may also be used to make illegal counterfeit drugs that look like legitimate pharmaceuticals. These counterfeit pills can contain dangerous substances such as fentanyl and W-18. Pill presses can produce thousands of illegal pills in a short period of time, which poses significant risks to the public health and safety of Canadians. Currently these devices can be legally imported into Canada without specific regulatory requirements.

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Bill C-37 would require that every pill press and encapsulator imported into Canada be registered with Health Canada. This would serve as a tool to better equip law enforcement to reduce the supply of illicit opioids and other drugs in Canada. Proof of registration would have to be shown upon importation and unregistered devices could be detained by officials at the border. The devices captured under this provision are aligned with those for the import and sales that must be reported in the United States. A new schedule to the CDSA would be created, allowing additional devices to be controlled in the future to respond to changes in illicit drug production.

[Translation]

The proposed legislation would enable better information sharing about imports of pill presses and encapsulators with border officials and police forces during an investigation.

[English]

Bill C-37 would also make amendments to expand the offences and punishments for pre-production activities of any controlled substance. Pre-production includes buying and assembling the chemical ingredients and industrial equipment that are intended to be used to make illicit drugs, but are not specifically listed in the CDSA schedules. These activities are not currently controlled under the CDSA unless the intent is to produce methamphetamine.

Members of the House may recall that concerns about the growing popularity of methamphetamine prompted private member's bill, Bill C-475, An Act to amend the Controlled Drugs and Substances Act (methamphetamine and ecstasy), in 2011. The passage of this bill made it illegal to possess, produce, sell, or import chemicals with the knowledge that they would be used to produce or traffic methamphetamine.

• (1200)

[Translation]

Given the growing opioid crisis and the evidence of illegal production of other drugs in Canada, including fentanyl, we must go further. The amendments proposed in Bill C-37 would extend the provisions that were added in 2011 so that penalties would apply to the illegal production, distribution, import, export, and transport of anything used to produce or traffic any controlled substance.

The government recognizes the complex challenges faced by individuals who are involved in problematic substance use. We remain committed to working with our territorial and provincial partners to address the issues related to illegal drug use.

[English]

Bill C-37 is one part of our government's response to Canada's growing opioid crisis. The legislative changes proposed in the bill will make the CDSA a more robust act and increase law enforcement's ability to take early action against suspected drug production operations, and better equip enforcement to respond to the evolution of the illicit drug market.

[Translation]

I encourage all members of this House to support this bill.

[English]

Mrs. Cathy McLeod (Kamloops—Thompson—Cariboo, CPC): Mr. Speaker, I hear what the member is saying and I agree there are some very important features in the bill. He talked about pill presses and encapsulators.

Back in April 2016, British Columbia declared a state of emergency over the fentanyl opioid crisis. Why is it taking until 2017 to take action when we have a state of emergency, with 900 people who have died in British Columbia? It will be almost a year later before the bill is passed. The member should be ashamed.

Mr. Randy Boissonnault: Mr. Speaker, Bill C-37 is part of a comprehensive strategy of the Government of Canada to address this opioid crisis.

The Minister of Health has been very clear in her meetings with territorial and provincial counterparts from coast to coast to coast that this is a crisis. We see it in Alberta as well. We take every life that has been lost due to this crisis seriously.

The changes in Bill C-37 are part of a comprehensive strategy. It is a whole-of-government approach. We take this issue seriously. We are moving as a government, and that is our commitment, to save the lives of Canadians.

Ms. Linda Duncan (Edmonton Strathcona, NDP): Mr. Speaker, I appreciate the member for Edmonton Centre supporting the bill brought forward by his government. However, I have a question for him.

Our party has a long-standing call for his minister, who has the powers under the Emergency Act, to declare this a public emergency. The member is aware, as I and my city are, of the crisis we are facing with deaths from opioid addiction.

Will the member support our call for a declaration of an emergency so the minister can demand more funds be made available, and to at least have temporary injection sites? More than 87 organizations in Edmonton are desperately calling for immediate action, not for waiting until the bill finally passes through the House and Senate.

Mr. Randy Boissonnault: Mr. Speaker, I respect my hon. colleague's question as we are both from the city of Edmonton.

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Our government clearly understands the crisis that Canadians and marginalized populations are facing when it comes to the use of illicit substances. We are taking all action and all steps to make sure that our work not only in Bill C-37 but with our provincial counterparts is moving apace. We are looking at how to make sure we have controlled use substance sites in place where wraparound supports can be made available. That is the kind of federal, provincial, and territorial partnerships we see not only in this proposed legislation but in our approach as a government to address this very serious issue not only in the city of Edmonton but in all cities and communities across the country.

• (1205)

[Translation]

Ms. Anne Minh-Thu Quach (Salaberry—Suroît, NDP): Mr. Speaker, the Standing Committee on Health conducted an emergency study of the opioid crisis. Of the 38 recommendations set out in the report, the very first recommendation, which has the support of all parties, calls on the government to declare the opioid overdose crisis a national public health emergency. However, the Minister of Health has refused to do so, despite the fact that experts, municipalities, and even provinces have been calling on her to do so.

If a national public health emergency were to be declared, funds would be allocated, which would make it possible to invest more in helping victims and to urgently approve the creation of safe injection sites.

How is it that, a year later, a public health emergency still has not been declared despite the fact that British Columbia has never before seen such a high rate of overdoses and deaths from overdoses? The problem is only getting worse. How many people have to die before Canada will say enough is enough, declare a national public health emergency, and do something to save lives?

Mr. Randy Boissonnault: Mr. Speaker, I thank my hon. colleague for his question.

What is clear about this matter in Bill C-37 is that it is only one part of our comprehensive strategy to combat the use of illicit substances. In terms of the opioid crisis, the work of the Minister of Health with her provincial and territorial counterparts is clearly very important.

Bill C-37 provides us with other tools to prevent the production and trafficking of these illicit substances. It is important to note that we take very seriously the deaths caused by the use of illicit drugs. We have a comprehensive strategy. We will continue this fight to safeguard the lives of all Canadians.

[English]

Mrs. Cathy McLeod (Kamloops—Thompson—Cariboo, CPC): Mr. Speaker, I will be sharing my time with the member for South Surrey—White Rock.

I am rising to speak to Bill C-37, an act to amend the Controlled Drugs and Substances Act and to make related amendments to other acts.

As we all know, addiction issues have been a challenge throughout the history of mankind. As noted by the Canadian Centre on Substance Abuse, addiction touches everyone. As of 2013, one in five Canadians, or six million people, met the criteria for

substance use disorder, causing harm and heartache among families and communities throughout the country. Today, however, we are facing an unprecedented crisis: the casual or addictive use of drugs now includes a much higher risk of death.

I would note there were some questions in the previous exchange where the government talked about how it worked very hard with the provinces in terms of moving forward, but what the Liberals did not say is that they worked hard with the opposition.

There are many pieces of the bill that are very supportable and should move forward in a rapid and timely way, but the Liberals know very well that there is one component that we have a few concerns with, and I will articulate the reasons a little later. If the Liberals are talking about being concerned about this crisis, they should have proposed something that would allow us to immediately move forward with all the things we know we can agree on, and take a little bit more time for the conversation over the one piece that is giving us a bit of a challenge. This is a big concern.

The other big concern which people who are listening and watching need to be aware of is that on April 14, 2016, B.C. declared a public health emergency in response to this rise in drug overdoses and deaths. Now it is months later, at a time when pill presses and encapsulators, and border issues have been identified, but what did the government first talk about in its call for debate yesterday? It was a bill on Statistics Canada. It is absolutely shameful. The government had the opportunity to move forward on some important issues, but Statistics Canada was more important on our first day back. They presented a bill that the Liberals knew there were some challenges with instead of presenting something that we could all immediately support and move forward in a timely way. I think the Liberals should look at how they have dealt with this issue.

An emergency was declared in April, and it was recognized. Maybe it has not hit some of the other provinces, but it is interesting that it was a Liberal member, the member for Vancouver Centre, who said that if this crisis was happening in Ontario or Quebec, action would have been taken much sooner. That was said by a Liberal member, a family physician, who called out her own party on how it responded to this particular crisis. That is absolutely shameful.

The recent epidemic is characterized by an increasing proportion of death related to fentanyl, which is an illicit opioid substance. Back in 2012, fentanyl was seen in about 5% of the illicit drugs, and in 2016 it was seen in 60%. Fentanyl is dramatically increasing in use. In British Columbia in 2016, there were 914 deaths, with 142 in December alone.

Many might have read the Facebook page of the grandmother who was grieving for her young granddaughter saying that she just needed some help. She felt that maybe she could have dealt with her granddaughter who died a couple of days before Christmas.

In Kamloops, a community I represent, there were 40 deaths over the year. It typically had 10 deaths, steady over years and years, but in 2016, 40 people died in Kamloops from a drug overdose. With SARS, there were 40 deaths across Canada, and H1N1 had 400 deaths across Canada. I was on the health committee when H1N1 was happening. I remember that we had daily briefings from the chief public health officer of Canada. It was Dr. Butler-Jones at the time. He kept parliamentarians up to date every day on what was happening. That was for 400 deaths across Canada. We are talking about 900 deaths in British Columbia alone.

●(1210)

We do have in Bill C-37 a partial response to this crisis. As I indicated earlier, there are measures in the bill that are very supportable, such as the prohibition of designated devices, encapsulators, and adding to the schedule of substances reasonable grounds to represent health risks. There are more powers proposed for Canada Border Services Agency. We knew a year ago those were some of the things that could have been done to avert this crisis. The addition to broaden the prohibition and penalties to now apply to the possession, sale, importation, or transport of anything intended to be used is an important measure.

However, if the government had been concerned, it could have dealt with this many months ago instead of debating a bill about Statistics Canada. This is about people who are dying in British Columbia, and soon across the country.

I want to talk about the areas in which I have what I think are reasonable concerns. That is the part we need to be debating as parliamentarians. There is one area where there is a bit of a difference of opinion and it has to do with the process that should be in place for what they call safe consumption sites, or what are more commonly known by the public as injection sites, to move forward. That is a reasonable discussion.

Our Conservative government brought in the Respect for Communities Act. Certainly, there are some people who felt it made it too difficult, but it is a valid place for us to talk about what that should look like. We originally had 26 criteria that were to be addressed when people applied for a safe injection site. This bill changes it from 26 criteria to five factors. That is a little vague.

When I talked to the minister at committee, I tried to go through the 26 criteria. I asked her what objection she had to them, but I really did not get an answer. None of them said they were really concerned about any one piece, “I don’t think the RCMP should be able to have a say”, or “I don’t think municipal council should have a say”. Those are the criteria that are in place. What is being proposed now is a few factors.

The other thing the government has done is there were six principles that should be part of the thinking around whether the minister would approve a site or not. These principles have been totally removed and there are no principles left. Those are principles that recognize the issue of crime profits or criminal activity that is supported with illicit substances. We have gone from 26 criteria to five and there are no other checks and balances.

Using Kamloops as an example, the mayor and council voted unanimously to support a safe injection site. They have talked to the

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RCMP. They are having a consultation process under former Bill C-2, which is now the Respect for Communities Act. That process allows the mayor and council to have input. They supported the safe injection site. I am not sure how they would feel if they were told they would not even be talked to about it, that it was just going to happen. They can write a letter and say whether they like it or not. They endorsed it unanimously. Interior health will be looking at it. That is important. As we know, Ottawa has not endorsed it. Those are pieces of public consultation that the government is looking to replace with vague references to talking to the community, but it really does not matter because communities do not tend to like these things. Kamloops council voted 100% for it. Why does the government not trust the community process that is specific and methodical?

There are some good pieces in the bill. We should move forward on those important pieces immediately. We should have done it a year ago. We should have a reasoned and appropriate debate around the changes to the safe injection sites. However, there are some pieces that are missing when it comes to the government's response to the crisis.

●(1215)

My colleague from South Surrey—White Rock and I both have said to listen to British Columbia. Let us call a state of emergency to raise the elevation so that people know about what is happening, because it is happening in B.C. now, and it will be going across the country. Youth councils are saying that there should be a national education campaign. Moms and dads need to be having that conversation. They will not have the conversation if they do not know.

In conclusion, let us look at the pieces, move forward on those critical ones, then look at doing those additional recommendations.

Mr. David de Burgh Graham (Laurentides—Labelle, Lib.):

Mr. Speaker, I listened to the speech from the member for Kamloops—Thompson—Cariboo with great interest. I heard her talk at length about the need to do this quickly. I agree with her. I wonder, if the member is so excited to get this done quickly, if she is willing to pass this through at all stages immediately.

Mrs. Cathy McLeod: Mr. Speaker, I think I was very clear that there are pieces that should pass at all stages quickly. It is interesting. Kamloops looked at having a safe injection site. We went to the coroner to find out how many of the 40 deaths had been from the casual ingestion of pills and whether people would actually use a safe consumption site. That data is not available.

Points of Order

There are pieces of information that need to be part of making decisions. We have to be very thoughtful as we move forward on these measures. Let us move forward on some of the important pieces, but let us have a good debate and a good conversation about where we disagree.

[Translation]

Mr. Pierre-Luc Dusseault (Sherbrooke, NDP): Mr. Speaker, I thank my colleague for her speech.

I have trouble understanding the Conservatives' stance on the fundamental issue of supervised injection sites. Do they support the establishment of more than one site, a site other than the one we already know in Vancouver?

When the Conservatives were in power, they passed a bill allowing the establishment of supervised injection sites, but it was clear that the unstated objective was to make it as difficult as possible to create and open new sites.

I have a hard time understanding their position today. My colleague talked about the benefits of supervised injection sites. I would therefore like to know whether the Conservatives are now in favour of opening and setting up additional supervised injection sites.

• (1220)

[English]

Mrs. Cathy McLeod: Mr. Speaker, we created Bill C-2. There are 26 criteria, which include things like the mayor and council having consultations, the chief of police knowing what is going on, and letting the community know. In Kamloops, I had someone come to me who would have really liked to have had some input in terms of Kamloops and the locations. Under even the current system, the comment period had already closed.

What I am saying is that the Liberals have gutted a lot of reasonable processes around community decision-making on consumption sites. Something that really needs a good conversation in this House is Bill C-2, the Respect for Communities Act, and those 26 criteria. Maybe one or two were overdone, but there were a whole bunch that were great, and the current government has gutted those.

Ms. Tracey Ramsey (Essex, NDP): Mr. Speaker, I appreciate my colleague for her speech today on such a critical, important issue, certainly for her riding in B.C. but also across all of Canada. I can say that in my riding of Essex, in southwestern Ontario, we also see this impending crisis coming our way. People and families are very concerned, very worried. We are going to be holding a round table this month to address the issue to prevent possible deaths, to prevent addiction, and to provide all of the contacts and the outreach the member is talking about.

Would the member not agree that the best way to do this is to declare a national health crisis so that we can have the funding find its way down to these levels and have the education set from a national directive, as opposed to right now municipalities and provinces trying to patch together things to help those who are impacted by the crisis?

Mrs. Cathy McLeod: Mr. Speaker, I know my colleague from South Surrey—White Rock and I are on record as supporting the British Columbia minister in this call.

Again, I have to contrast the response to H1N1, where there was a massive, quickly activated national education program. There were regular briefings. There was a focused effort, in terms of a public health perspective, in dealing with that particular crisis. In this case, I am seeing delay and no sense of urgency.

As I noted before, we were talking about Stats Canada before talking about Bill C-37. The Liberals should look at what their priorities are in terms of dealing with what is a horrific crisis in Canada.

* * *

POINTS OF ORDER**INQUIRY BY ETHICS COMMISSIONER**

The Deputy Speaker: Before we resume debate, I see the hon. member for Regina—Qu'Appelle rising on a point of order.

The hon. member.

Mr. Andrew Scheer (Regina—Qu'Appelle, CPC): Mr. Speaker, I would like to rise today in regard to the investigation of the Prime Minister's recent trip to the Aga Khan's private island by the Ethics Commissioner. As you may know, it was my letter to Mary Dawson that started the inquiry into his actions.

In June 2015, a new section was added to the Conflict of Interest Code that requires MPs who launch an investigation to await confirmation that the MP under investigation has been informed of the complaint before making public comment. When I sent my letter to Ms. Dawson, I copied the Prime Minister at the same time to make sure that he was made aware of my complaint. I also copied his office.

As you can imagine, there was a great deal of media interest in this affair, and I did respond to questions from journalists.

[Translation]

The commissioner has since informed me that I should have waited for her to get back to me before I commented on the matter publicly. I can assure you and the House, Mr. Speaker, that the error was totally inadvertent, because I believed that my actions were in accordance with the law. As a former Speaker of the House, I have the greatest respect for her office, for the rules governing ethics and conflicts of interest, and for the process by which those investigations are conducted.

Therefore, I want to apologize unreservedly to the Ethics Commissioner, to the House, and to yourself, Mr. Speaker.

I thank Ms. Dawson for having clarified the rules relating to this section of the act, for providing us with guidelines on how to proceed in the future, and for the attention she is giving to this matter.

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[English]

The Deputy Speaker: I appreciate the comments on the part of the hon. member for Regina—Qu'Appelle and appreciate his intervention this afternoon. I do not think, by the sentiments expressed, that there is any need for follow-up, but again, I am sure the House appreciates the clarification on the part of the hon. member.

Resuming debate, the hon. member for South Surrey—White Rock.

* * *

● (1225)

CONTROLLED DRUGS AND SUBSTANCES ACT

The House resumed consideration of the motion that Bill C-37, An Act to amend the Controlled Drugs and Substances Act and to make related amendments to other Acts, be read the second time and referred to a committee.

Ms. Dianne L. Watts (South Surrey—White Rock, CPC): Mr. Speaker, I am pleased to speak to Bill C-37, an act to amend the Controlled Drugs and Substances Act and to make related amendments to other acts. In essence, this is the government's response to the fentanyl and opioid health crisis facing this country.

I want to be clear that this health crisis is not just a B.C. issue. Many police raids have taken place in B.C., Alberta, and Saskatchewan. Over 20 fentanyl labs have been shut down across this country, and an entire fentanyl ring was successfully shut down in Montreal. However, I want to bring everyone's attention back to British Columbia, as it is ground zero and has been for quite some time, as communities struggle to deal with the fentanyl, carfentanil, and opioid issue. I want to talk about the impact, the government's response, and how we need to be addressing this growing issue.

I will first talk about some simple facts. It is well known that the chemicals and illicit drugs are manufactured in China. They can be ordered online and shipped overseas. There are thousands of illegal labs right across China. Pills and raw materials are shipped into Canada through our ports, our borders, and the mail.

Several thousand people have died across Canada. In B.C. alone, 914 people died last year. That is an 80% increase in deaths over 2015. In Vancouver, the increase was 60%; in Surrey, 42%; in Victoria, 267%; in Kelowna, 153%; and in Kamloops, 471%. This past December was the deadliest month of all, claiming the lives of 142.

Let us look at the response from the Liberal government. On December 12, just two days before the House rose for the Christmas break, this bill was introduced. In November of last year, the health minister refused to declare this a national health emergency, despite B.C. public health officer Dr. Perry Kendall declaring a public health emergency in April of last year, the recommendations from the House of Commons Standing Committee on Health, and yet another call from B.C. health minister Terry Lake, who said, "We haven't seen the response that I think this type of epidemic requires on a national scale". Many MPs from all parties have requested the same, so we collectively, again, issue a call to declare a national public health emergency.

We need to raise awareness of this epidemic to the level it deserves. We need to embark upon a national educational awareness campaign to ensure that the general public, young adults, and students have the information and are informed. In fact, my youth council has requested that. There are ongoing fentanyl forums being undertaken in high schools, but there is still a perception that this is just a Downtown Eastside Vancouver issue and that consumption sites are the answer to this issue and need to be set up in every single community across the country.

Let us take a quick snapshot. A Delta mother of two lost both of her children within 20 minutes of each other. Both of those kids were 20 years old. Jordan died at 21. Ryan died at 23. Kelsea died at 24. David died at 21. Danny died in Edmonton at 25. Scott was 21. A young Abbotsford woman was in her mid-20s. Tyler died at 23 and had a four-year-old son. Hardy and Amelia, both in their 30s, leave behind a two-year-old son. They were celebrating moving into their new home. The list goes on.

● (1230)

This is where the complexities of this issue intersect. There is one strategy for those who are street-entrenched, who will inject and use consumption sites; there is another strategy for those who use pills and prescription drugs; and there is another strategy for those who are using recreationally and not realizing what they are taking. One size does not fit all.

I would argue that to assume that multiple consumption sites in every community would fix this health epidemic is short-sighted. This is a piece of a multifaceted response. We need to use some critical thinking around this issue. Our first responders and medical personnel are getting burnt out trying to respond to the overdoses and deaths. The federal government must assist those on the front lines who are dealing with this crisis on a daily basis.

For the first time, a pilot project is being undertaken that will test the street drugs that are being brought into the consumption site in Vancouver. I was thrilled at the proposition that the people who are suffering from addiction would now be advised as to what they are injecting and the potential outcomes.

Does this model fit all users? It does not. Therefore, let us explore these sides of the equation: treatment, mental health, dual diagnosis, and opioid substitution.

Methadone was once the answer for those addicted to heroin, back in 1996. Obviously, we can see that program is not working. Many communities have stand-alone methadone dispensaries, where prescriptions are bought and sold on the street and where individuals would trade their methadone for other drugs. This was the answer to the opioid addiction in 1996. Perhaps we need to re-evaluate that program or redirect some of that funding into other programs.

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What are our needs? We do need treatment, and not just detox and 30-day programs. Rather, we need wraparound services. We need to care for the whole person, with mental health support as well as physical dependency and addiction support. This is a multi-faceted approach to a very complex problem, and it is a long-term solution. The holistic approach includes treatment beds and therapeutic communities, a place for those who want support, because the window of opportunity in an addict's life is fleeting. The response must be immediate and the resources must be available. This is not new information, but it is expensive and costly, and it is easier to focus on short-term solutions.

There has been a long-standing call for law enforcement to interrupt the flow of fentanyl and carfentanil in China. The response by the Liberals in Bill C-37 would allow border services the power to open packages weighing less than 30 grams, prohibition for the unregistered pill presses, and the illegal importation of precursors. We fully support those initiatives. However, as the Prime Minister moves forward with his trade negotiations with China and his extradition agreements, I would suggest that a topic of exporting fentanyl powder and pills be top of mind and that he undertake wholesome and meaningful discussions on the deadly effects that the exportation of this product has on the people of Canada and their loved ones.

This is a national health emergency, and those who have lost loved ones most certainly need to know that all three levels of government, the community, law enforcement, and first responders collectively care enough to do the right thing.

Mrs. Deborah Schulte (King—Vaughan, Lib.): Mr. Speaker, I listened with great interest to the previous two speakers and heard them identify the complexity of this issue and wanting to move quickly on it. I am hoping that they both spent time listening to the minister this morning, because she very clearly identified how complex it is and the work that she and the government have already been doing with her partners, the health ministers of the provinces and territories.

My question is this. Can I have the member's acknowledgement that she will move quickly with us and approve all stages of this bill so we can expedite what needs to be done? Also, I heard this from the previous speaker but did not have a chance to ask a question. Perhaps the member can answer it. Why would the member challenge the work we want to do with Statistics Canada when in her very speech she spoke about the need for data? Obviously, this is a complex issue, and we need data-guiding, yet her party is challenging that piece of our legislation. Could the member respond to that?

• (1235)

Ms. Dianne L. Watts: Mr. Speaker, I appreciate the question. I cannot answer or speak for another member of Parliament.

I will say, however, that the gathering of data nationally on the opioid issue is extraordinarily important because we do not know how many people are taking pills or injecting, what that data looks like, and how much fentanyl, carfentanil, or W series drugs there is. All of those things are components, as well as the coroners' reports.

I was here to listen to the minister this morning as she spoke very passionately, and I have a lot of respect for the work she has done.

The treatment and issues around the mental health piece are so important. It always gets pushed to the side because it is easier for short-term solutions to come to the forefront. We cannot forget that side.

If we are ever going to get to the root causes, and if we are ever going to really effect change and make a difference in an addict's life, we have to have treatment available and we have to have options. We have to do all the things that we need to do so individuals get all the supports they need.

Mr. Peter Julian (New Westminster—Burnaby, NDP): Mr. Speaker, I know that the member for South Surrey—White Rock and I share a region that is living through an appalling crisis in deaths. This issue is something that has seized the population. Everyone knows somebody who has been affected by this. There have been almost 1,000 deaths in the past year alone, and yet the government did not seem willing to do anything more than drag its feet on something that is a public health crisis.

Does the member agree with us that what we need is an immediate move toward the declaring of a public health emergency? I think both of us agree that there needs to be an expansion in addiction treatment programs. They were cut back under the former Conservative government and have not really been restored under the new Liberal government. Canadians are crying out for them to be in place so the communities can have those kinds of supports.

Finally, there was a question just a moment ago as to whether or not the Conservatives would facilitate the passage of Bill C-37, and I did not hear the member answer that. I would be very interested in hearing her response to that.

Ms. Dianne L. Watts: Mr. Speaker, most certainly, I support many of the members of Parliament who have come out and said that this is a national public health emergency. It needs to be elevated to really give communities the assistance they require, our first responders, as well as the awareness and the education so that people have the correct information.

I have always been a proponent of treatment of mental health and addictions. For many years I have been working and supporting detox facilities, a continuum of care, addiction precincts, and all of those things. I go back to critical thinking.

I have no particular issue with this bill, except for one. I think there are a lot of good things, but to not have communities engaged is really problematic when we look at consumption sites. I have been involved in consumption sites before, and in some areas they will work, and in other areas, different communities, it is a different strategy. There is not one fit for all.

There has been a process and engagement from the community, law enforcement, the health community, and the federal and provincial health ministers. All of those people need to be brought to the table to see if this is an effective piece that is going to work. It may be a component in that community, or it may not be. It depends on how that data is looked at, and how many people would use those consumption sites.

● (1240)

Mr. Nathaniel Erskine-Smith (Beaches—East York, Lib.): Mr. Speaker, I will be splitting my time with the member for Pitt Meadows—Maple Ridge.

We can, and should, treat drug use and abuse as a health issue and not as a crime. Our government has committed to a sensible and evidence-based approach to drug policy; that approach is emphasized by the recent task force report on cannabis regulation, and it is emphasized by our health minister's actions. Those include restoring harm reduction as a key pillar of Canada's drug strategy, permitting physicians to prescribe heroin to severe drug addicts, and introducing Bill C-37, effectively repealing the previous Conservative government's attack on evidence and supervised consumption sites.

The story of that attack and how we have ultimately come to Bill C-37 begins with Insite and the former Conservative health minister's refusal to renew its exemption from the Controlled Drugs and Substances Act.

Insite is a supervised injection clinic in Vancouver. It is North America's first government-sanctioned such facility, having received a conditional exemption in September 2003. Since that time, it has been open seven days a week; users are provided with clean injection equipment to use; they are monitored by staff during injection; health professionals provide treatment and support in the event of overdoses; and users are provided with health care information, counselling, and referrals to health authorities and service providers.

In the fall of 2007, a detox centre opened above Insite, named Onsite, to provide detox on demand. It is a drug-free environment, supported by addiction specialists, physicians, nurses, and peers.

Since opening, Insite has saved lives and improved health outcomes, with the support of local police as well as municipal and provincial governments.

The benefits of Insite and supervised injection facilities and the lack of any related negative impacts have been well documented in leading scientific journals, including *The New England Journal of Medicine*, *The Lancet*, and the *British Medical Journal*.

An expert advisory committee's report to the former Conservative health minister concluded that there was no evidence of increases in drug-related loitering, drug dealing, or petty crime around Insite; there was no evidence that Insite increased the relapse rate among injection drug users; the police data showed no changes in rates of crime recorded in the area; and a cost-benefit analysis was favourable.

Despite all of this, that minister refused to grant a continued exemption and stated that Insite represents a failure of public policy.

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Contrary to the claims of that Conservative minister, Insite did not represent a failure of public policy, but the Conservative minister's actions did represent a failure of decision-making in the public interest.

In fact, it was such a failure that the Supreme Court of Canada, in a unanimous nine to nothing decision in 2011, ordered the minister to grant an exemption to Insite and stated, as follows, at paragraph 133:

Insite saves lives. Its benefits have been proven. There has been no discernable negative impact on the public safety and health objectives of Canada during its eight years of operation. The effect of denying the services...to the population it serves is grossly disproportionate to any benefit that Canada might derive from presenting a uniform stance on the possession of narcotics.

At paragraph 153, the Supreme Court held that a minister must consider a number of factors in exercising discretion to grant an exemption from the CDSA, including:

...[one] evidence, if any, on the impact of such a facility on crime rates, [two] the local conditions indicating a need for such a supervised injection site, [three] the regulatory structure in place to support the facility, [four] the resources available to support its maintenance, and [five] expressions of community support or opposition.

Yet, in the face of that landmark decision, the previous Conservative administration remained wilfully blind to the evidence and continued to attack safe injection facilities.

With the introduction of then Bill C-2, the previous government ignored our Supreme Court and, in the words of the Canadian Nurses Association, created “unnecessary and excessive barriers to establishing supervised injection facilities”.

Bill C-37 would remove those unnecessary and excessive barriers. Bill C-37 would simplify the process of applying for an exemption from the CDSA for supervised consumption sites, as well as the process for subsequent exemptions.

Specifically, Bill C-37 would replace the excessive 26 criteria imposed by the Conservatives with the five factors I have reiterated, as set out by our Supreme Court. It would simplify documentation, it would require reasons for a minister's decision, and it would remove the moralizing principles regarding illicit substances.

Bill C-37 would save lives, and one need not condone drug use to want to save lives.

This is a good beginning to a modern drug policy, with public health and harm reduction front and centre.

● (1245)

In addressing the United Nations last year on April 20, our Minister of Health said:

I am proud to stand up for drug policy that is informed by solid scientific evidence and uses a lens of public health to maximize education and minimize harm.

Government Orders

That commitment to evidence is important, but it also demands that we go further. Fentanyl and illicit drug overdoses killed hundreds of Canadians in 2016. B.C. health officials and medical experts have called it a public health emergency. It is so serious that the B.C. government opened two new supervised consumption sites without waiting for federal approval. We need new solutions. The current approach, the so-called war on drugs of criminal sanctions and preaching abstinence, is not working.

In 2011, the Global Commission on Drug Policy called for an end to drug prohibition stating that government expenditures on futile supply reduction strategies and incarceration displace cost-effective and evidence-based instrument investments in demand and harm reduction.

That commission included former presidents and prime ministers of Brazil, Colombia, Greece, Mexico, and Switzerland, former UN Secretary-General Kofi Annan, and former Supreme Court of Canada judge and UN High Commissioner for Human Rights, Louise Arbour. Prohibition has failed to effectively curtail the supply or consumption of illicit drugs, and its unintended consequences can be devastating, creating a lucrative and violent black market and shifting resources from public health to law enforcement instead.

Those enforcement efforts only serve to divert problems to new geographic areas or to inadvertently promote the use of alternative and potentially less safe drugs, and the use of the criminal justice system marginalizes those who are already often at society's margins, diminishing the likelihood that they seek treatment.

Prohibition treats the very people we want to help, the victims, the users, the addicts, as criminals. Looking outside of Canada, we know there is a better path.

In 2001, Portugal decriminalized low-level possession and use of all drugs. Those caught with drugs are sent before dissuasion commissions, which include representatives from law, medicine, and social work. More than 80% of cases are dismissed without sanction, and the number of people arrested and sent to criminal courts declined by more than 60%. There has been no major increase in drug use. In fact, the level of drug use is below the European average. Adolescent and problematic drug use has decreased, and the number of deaths from drug overdoses has dropped significantly.

As Donna May, a woman who lost her daughter to overdose on August 21, 2012, said that we have to get ahead of this crisis and the fastest and most effective way of successfully accomplishing this may well be done by taking away the profit from the black market and dangerously produced counterfeit opioids by legalizing and regulating all substance use. She said that at the very least following the lead of other countries which have decriminalized drugs and substituted criminalization with a health protocol needs to be seriously considered.

I am not suggesting that I have all of the answers, but I am asking our government and this House to consider additional public health and harm reduction measures. I am asking us to work together to save lives.

Ms. Tracey Ramsey (Essex, NDP): Mr. Speaker, there is only one measure of success to be had in the opioid crisis and that is

simply to have fewer people dying. That is the only measure, and what we are seeing is an increase month over month.

When the health committee conducted an emergency study into the opioid crisis, the very first recommendation that was made with all-party support was to declare opioid overdoses a national public health emergency. This would give the public health officer of Canada extraordinary powers immediately while Bill C-37 works its way through Parliament. This call was echoed by Dr. David Juurlink, who I believe lives near the member in his riding of Beaches—East York, the keynote speaker at the Minister of Health's own opioid summit, and now by B.C. health minister Terry Lake and stakeholders across Canada.

In the face of a mounting death toll, does the member for Beaches—East York agree that we should declare a national public health emergency so that we can start saving lives today?

Mr. Nathaniel Erskine-Smith: Mr. Speaker, I hope it is an acceptable answer to give in the House to say that I do not know. I have not reviewed the evidence that the health committee took seriously.

I can say our Minister of Health has indicated some concerns about usurping provincial authority, but at the end of the day, whatever saves lives is what we ought to do.

• (1250)

Mr. Garnett Genuis (Sherwood Park—Fort Saskatchewan, CPC): Mr. Speaker, I know we have had quite a bit of occasion to discuss these issues and I am sure we will continue to do so. I will be giving a speech later on where I will outline more substantively my views on this.

I want to ask the member two specific questions. One is that there are many aspects of this legislation that all parties in fact agree with. There are some that we have, I think, well-grounded concerns about. Does my friend think there should be an openness on the part of the government to move forward quickly in separate form with the parts of the legislation on which there is a consensus and then have a separate debate on the sections on which there is not consensus? That would allow a more rapid response.

The other thing is I noticed he used the phrase, and I have heard others use the phrase, “supervised consumption site”, instead of “injection site”. I find it interesting when language is used which is perhaps if not inaccurate, less accurate, as part of a public debate, perhaps with the objective of creating a certain kind of impression.

If the member is in favour of more safe injection sites, which I gather he is, why not use the clearest terminology?

Government Orders

Mr. Nathaniel Erskine-Smith: Mr. Speaker, I do not need to see a consensus in the House to move forward with parts of the legislation provided those parts of the legislation are grounded in evidence. We ought to be guided in the House by evidence.

Supervised injection versus supervised consumption is simply this: where there are drugs that are causing overdose deaths that do not require injection but it would be better for those to be consumed on site under the guidance and supervision of health professionals quite apart from injections, those drugs should be consumed on site, and it is perfectly accurate to call those sites supervised consumption sites.

[*Translation*]

Mr. Pierre-Luc Dusseault (Sherbrooke, NDP): Mr. Speaker, I thank my colleague for his speech.

If there is one issue on which I do not have a definite opinion, it is the legalization of simple possession, if nothing else, of all drugs in Canada. He talked about that in the media and again here in the House. This draws on what other countries are doing. As I said, if there is one issue on which I do not have a firm opinion, this is it.

Can the member tell us more about whether these measures will truly help reduce drug use, which is the ultimate goal that everyone in the House wants to achieve because we value health and we want our communities and our youth to be drug- and addiction-free?

[*English*]

Mr. Nathaniel Erskine-Smith: Mr. Speaker, I would say a few things in response to the member's question.

First, I pointed to evidence from Portugal, but there is evidence from other jurisdictions as well. We know the criminal sanction is not effective, specifically the criminal sanction with respect to use and small possession of drugs. It is not an effective sanction. People continue to use drugs, to abuse drugs. When we look at the international evidence, there is no substantial impact at reducing consumption or supply of drugs through the criminal sanction. What we know about the criminal sanction is that it means resources are put toward law enforcement that should go to health, so there is a displacement of resources as explained in the literature.

We also know that preaching abstinence crowds out our ability to educate about effective and responsible drug use and to encourage education. We saw it previously with the debate, and thankfully a debate where the evidence won, with respect to safe sex, and so too with the safe use of drugs. Preaching abstinence does not work, has not worked, and we need new solutions.

Mr. Dan Ruimy (Pitt Meadows—Maple Ridge, Lib.): Mr. Speaker, it is always an honour to rise in the House to speak on behalf of the constituents of my riding of Pitt Meadows—Maple Ridge. Today, I rise to speak in support of Bill C-37, an act to amend the Controlled Drugs and Substances Act and to make related amendments to other acts.

The bill is particularly important for my community and the communities in the greater Vancouver region that have been facing a crisis of such horrific and disturbing magnitude. To date, over 1,000 children, mothers, fathers, brothers, and sisters have died from the opioid crisis in our region. These are not numbers. These are people

and victims of addiction, each with their own incredibly painful story.

In my riding we are facing a homelessness crisis. To live in the midst of a riding that is facing an unprecedented number of homeless and drug addicted members of the community, we know first-hand that these are folks who are battling serious mental illnesses with very few to no resources. In crafting the bill, we are doing so with an understanding that addiction is a health problem.

To quote the hon. Minister of Health, “Addiction is not a crime. Addiction is not a mark of moral failure. It is a health issue. For many, it is a mechanism to manage unbearable pain, an attempt to relieve suffering when life offers few alternatives”.

For too long we have not been paying attention to the closely tied relationship between drug addiction and mental health. Too many people in our communities are sick and our policies must begin to reflect this.

Protecting the health and safety of Canadians is a key priority for this government. That is why on December 12, 2016, the Minister of Health, with support from the Minister of Public Safety, took action to end this crisis and introduce policies that get serious about ending drug addiction in Canada.

The bill supports our government's goal of creating a comprehensive, collaborative, compassionate, and evidence-based approach to drug policy in Canada. It aims to balance the important objectives of protecting public health and maintaining public safety. Bill C-37 would better equip both health and law enforcement officials with the tools they need to reduce the harms associated with drug and substance use in Canada.

Specifically, the bill would improve the government's ability to support the establishment of supervised consumption sites as a key harm reduction measure; address the illegal supply, production, and distribution of drugs; and reduce the risk of controlled substances used for legitimate purposes being diverted to the illegal market by improving compliance and enforcement tools.

While all aspects of the bill are important, I would like to focus my remarks today on how the bill would modernize the Controlled Drugs and Substances Act to strengthen law enforcement and the government's ability to monitor, promote, and enforce compliance. This would reduce the risk of diversion of controlled substances that are used for legitimate purposes, such as prescription opioids, to the illegal market. This is a pressing concern as the diversion of controlled substances to the illicit market contributes to problematic substance use in Canada.

The Controlled Drugs and Substances Act came into force in 1997. While it has been amended over the years, it has not kept pace with the significant changes seen in the illicit controlled substances industry and the illicit drug market. In particular, the current troubling and growing rates of opioid overdoses and deaths highlight certain gaps and weaknesses within the existing legislation.

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Bill C-37 would modernize compliance and enforcement powers by improving inspection authorities by bringing them in line with authorities in other federal legislation. Under the Controlled Drugs and Substances Act, Health Canada regulates more than 600 licensed dealers who manufacture, buy, sell, distribute, import, export, and transport controlled substances for legitimate purposes. At present, Health Canada's inspectors are only able to inspect sites where authorized activities with controlled substances and precursors are taking place.

• (1255)

This bill proposes to allow Health Canada inspectors to enter places where they believe, on reasonable grounds, that activities with controlled substances or precursors are taking place. For example, Health Canada would be able to inspect establishments whose licences to conduct activities with controlled substances have been suspended or revoked to verify that illegal activities are not taking place.

To be clear, the proposed inspection authorities would not allow inspectors to enter private dwellings without the consent of an occupant or a warrant. As always, should Health Canada inspectors believe that illicit activities with controlled substances are taking place, they would refer the case to law enforcement officers.

Bill C-37 would also improve compliance and enforcement under the Controlled Drugs and Substances Act by providing the Minister of Health the authority to compel regulated parties or persons importing a designated device to provide information regarding their activities. This authority could be used in only two circumstances: to verify compliance or prevent non-compliance with the act, or to address a risk to public health or public safety. Having access to timely information would alert the minister to potential diversion risks and improve the minister's ability to address a public health or safety threat. This authority is in line with other modern federal legislation, such as the Food and Drugs Act.

This bill also provides for an administrative monetary penalty scheme. Currently, Health Canada has limited options to address non-compliance within the Controlled Drugs and Substances Act. Health Canada can send a warning letter, which may not be effective at resolving a non-compliance situation, or suspend or revoke a licence. However, licence suspension or revocation is often considered to be a disproportionate penalty and may not always be appropriate or in the public interest. For example, revocation of a pharmaceutical company's licence could result in a shortage of critical drugs used in medical care.

Further, not all regulated parties are issued licences under the Controlled Drugs and Substances Act. For example, pharmacists, health care practitioners, and hospitals are subject to specific requirements set out in regulations under the act but are not licensed per se.

The introduction of an administrative monetary penalty scheme would offer Health Canada a greater range of tools to promote compliance with the act and its regulations. For example, regulated parties could be liable to pay a fine in cases where they do not follow the required security or record-keeping procedures. While exercising this authority will require regulations, the bill provides a legislative authority to introduce an administrative monetary penalty scheme.

Another aspect of this bill would introduce a new, expedited process for the disposal of seized controlled substances, precursors, and chemical offence-related property whose storage or handling poses a risk to health and safety. The current rules related to the handling and disposal of seized controlled substances, precursors, and other drug-related property are cumbersome and complex. Law enforcement agencies must seek a court order and approval from Health Canada before they dispose of these items, which takes time. This results in large quantities of controlled substances, potentially dangerous chemicals, and other offence-related property needing to be stored for longer periods of time. This poses a risk to public health and public safety. It is also costly, particularly for law enforcement.

The new process proposed in this bill would not require a court order for the disposal of controlled substances, nor for precursors and chemical offence-related property that pose a risk to health and safety. This would therefore reduce the burden on courts, government, and law enforcement agencies.

As members can see, this integrated approach puts evidence-based public health and public safety measures at the forefront of our drug policy here in Canada. Tackling this crisis will require commitment and innovation from all levels of government: federal, provincial, and municipal. We must work together in solidarity to put an end to this crisis that is tearing at our communities and taking lives.

I encourage all members of this House to put saving lives and securing our communities before ideology. I ask all members to support Bill C-37, to stand up for the best interests of our communities, and be part of ushering in a new era of evidence-based drug policy.

• (1300)

Mrs. Cathy McLeod (Kamloops—Thompson—Cariboo, CPC): Mr. Speaker, I note that my colleague is from British Columbia, which is at the coalface of this crisis.

Back in April, British Columbia called a public state of emergency. Quite stunningly, the member's colleague for Vancouver Centre just a few months ago said that the government was not acting because this happened in British Columbia, and that if this crisis had been in Ontario, it would have acted right away.

First of all, does my colleague agree with the member for Vancouver Centre? Second, can he justify that, when we came back to the House, with this legislation that he deems is going to be so critical, the first thing we were debating was Statistics Canada?

Government Orders

• (1305)

Mr. Dan Ruimy: Mr. Speaker, first of all, I cannot comment on why another member of Parliament would make a comment or what their intention is.

However, we have a crisis in B.C. What has to stop is the pointing of fingers. We have worked very closely with the provincial government to help it to put together the programs that it needs to help it overcome the challenges it faces.

Again, it is so important that we are here today talking about this.

Mr. Kevin Lamoureux (Parliamentary Secretary to the Leader of the Government in the House of Commons, Lib.): Mr. Speaker, I appreciate the comments from my colleague. I look at this whole debate. What I find most interesting coming from across the way is when the members question the Government of Canada's priorities.

Would my colleague concur with me that there is not one answer? The national government needs to demonstrate leadership, and we have done that. This piece of legislation was actually brought back in December. The Conservatives would not allow it to be passed back in December. The NDP were in favour of passing it. Only the Conservatives ultimately said no to allowing it to be dealt with in December. Now we have to deal with it today, in a very timely fashion.

Would my colleague concur with my thoughts?

Mr. Garnett Genuis: Mr. Speaker, on a point of order, I think the member meant to refer to the fact that unanimous consent was not given to expedite a bill at all stages without debate. I do not think he meant to say that we objected to the discussion of the bill at that time. I think he might want the opportunity to clarify that—

The Deputy Speaker: Order. That probably goes outside the category of a point of order. We are closer to the category of debate as to the facts that have been rendered to the House. Perhaps there will be another occasion where the hon. member might bring that matter up. We will go back to the hon. parliamentary secretary. I think he was essentially finished raising his question, but I will let him finish and then we will go back to the hon. member.

Mr. Kevin Lamoureux: Mr. Speaker, the essence of the question was there, just reinforcing that the Conservatives did have the opportunity to have this bill expedited, and the NDP members were supporting the inclination to do so.

Would my colleague concur that we, as a government, are very much aware of the national crisis, and we are doing what we can to make sure that this crisis is dealt with?

Mr. Dan Ruimy: Mr. Speaker, I am a new MP. What I can remember is that years ago when the first consumption site in B.C. was brought in there was so much uproar against it. It was challenged over and over again.

I am a member of Parliament today, able to respond and able to actually implement this. What would have happened if we had done this years ago? Would we still be where we are today? Would we still be in a crisis situation?

The time for talk is over. That is why I am proud of Bill C-37. It is taking action when it needs to be taken.

Mr. Garnett Genuis (Sherwood Park—Fort Saskatchewan, CPC): Mr. Speaker, very briefly, with respect to the claims about safe injection sites saving lives, I have read a lot of the data. What it points to is overdose interventions that have taken place at safe injection sites, so called.

I have not read any evidence on the impact of those safe injection sites on overall drug use and the possible risks that are associated with, in general, the creation of a more permissive attitude towards drug use. I am open to the information if the member is aware of such data. I would be very interested in hearing it.

Mr. Dan Ruimy: Mr. Speaker, the information on safe consumption sites and the science behind it is very clear. That is just one part of the puzzle.

If we do not address mental health at a young age, that is what they turn to. This is just a piece of a puzzle in a complex equation. We need to have the means for people to go, and for them to remember that while they are there, people are trying to help them find a better way. That is part of the success of that program.

The alternative is to do nothing and double the number of deaths we see going on in my province. That is not acceptable to me. We need to move forward on this. That is why I am supporting Bill C-37.

• (1310)

Mr. Garnett Genuis (Sherwood Park—Fort Saskatchewan, CPC): Mr. Speaker, it is a pleasure for me to rise and join this debate. The record will show that my colleague who just spoke, although he had some important and thoughtful comments in response to my question, did not address my specific question about the evidence. I will come back to that later in my speech.

Let me just start with a brief overview of the context of what we are debating. Certainly, we all appreciate the critical importance of this discussion. We agree throughout the House on the critical importance of action in response to the crisis that we see. It is a crisis indeed of public health, a crisis around drug use in Canada. The government has come forward with legislation with a number of different components to it, some of which we agree with, some of which we think could be done right away even without legislation. We certainly have a concern around the government's view with respect to supervised injection, with respect to the consultation process in particular envisioned by this new legislation.

I want to say at the outset that it is unfortunate that we are confronted with a piece of legislation that seeks to combine, in my view, a number of disparate and unconnected elements. They are not wholly unconnected of course. They deal with, broadly speaking, the same subject but they move in a different direction from each other. Our view of the need to move quickly on this would certainly be around some of the provisions but not around others.

Government Orders

The parliamentary secretary earlier in the debate alluded to the fact that there was an effort to get unanimous consent around this entire bill. In general, in almost every case I would be very concerned about proposals to give unanimous consent without debate to any legislation. Certainly it is up to the government to schedule that legislation in a way that reflects its priorities, but to ask for unanimous consent without debate raises some concerns. I am sure there would have been a willingness to move much faster had the government not intentionally combined in the same piece of legislation certain measures that are necessary for public safety and that we all support and certain measures that are much more controversial.

All of us are concerned about the crisis. All of us want to see action. That is why to see from the government this playing of politics, this fusing of disparate elements in one bill to try to obviously create a poison pill when we could be moving faster with action on which we agree is unfortunate, again given the urgency of the situation that we confront.

Let me now proceed to identify specifically the different sections of the bill and share my perspective on them.

This bill seeks to prohibit the importation of designated devices unless registered with the Minister of Health. We agree with that section. We think that makes sense.

The bill seeks to grant Canada Border Services Agency more powers to search packages if the CBSA has reasonable grounds to suspect that the mail contains goods that are prohibited, controlled, or regulated. This is a simple and sensible enforcement measure that again would limit the importation of certain things into Canada and we see that as a positive.

The bill seeks to expand the offence of possession, protection, sale, or importation of anything intended to be used to produce or traffic any controlled substance out of the legitimate supply chain by adding substances under schedule V. These are further changes again around the importation and enforcement area. Again, I am supportive of that.

The bill seeks to authorize the minister to quickly and temporarily add substances to a schedule under the act that the minister has reasonable grounds to believe pose a risk to the public's health and safety.

So far, there is a lot that we would find a consensus in this House around because these are measures oriented toward effective enforcement and certainly things that speak to an opportunity and an urgency of responding.

Then we have this problem that the bill calls for mechanisms that would significantly expedite the process for application to open a supervised injection site. It would limit the consultation. It would reduce the consultation window and would reduce the number of people who have to be involved in that consultation.

• (1315)

I do not support that change. It is not a helpful way of moving forward in response to this problem, and it raises other problems as well.

As much as there is the consultation piece that we need to discuss, I do not have a problem saying that I have broader concerns about the evidence around and the impact of supervised injection sites. There are legitimate questions about what actually is the most effective and compassionate response, the response most likely to save lives.

I had the opportunity to visit the safe injection site in Vancouver. I do not know how many members have had that opportunity, but it was before I was a member of Parliament. About 10 years ago, I was visiting Vancouver as a student. It might surprise members to know that even then I was very interested and engaged in public policy debates. I went to visit the area of the community where this injection site was. While I was walking in the area, I met a gentleman who was involved in the whole area of drugs. He offered to show me around the neighbourhood and to introduce me to some people. He then took me to see the supervised injection site. It was a really useful opportunity for me to get an understanding of an important public policy question and to talk directly to the people who were affected.

One question I recall specifically asking that gentleman was how he got into this, what things happened in his life that had led him down this path. I will not go into all the details, but he spoke about some of the challenges in his family, some of the ways in which drugs were normalized in the environment in which he grew up, and the kinds of relationships and interactions with his family.

It was striking to me that the most compassionate response to people in this situation was not to assume that the continuation of their use of drugs was inevitable. I do not think that is the most compassionate response. I know that those who believe in safe injection sites are motivated by compassion, but I would regard it in a certain sense as a rather pessimistic form of compassion. It assumes the response has to be one of providing access to something that is extremely dangerous and yet trying to reduce that danger as much as possible.

My honest view is that a better kind of compassion is a more optimistic sort of compassion, one that in every interaction with people suffering with the challenges of addiction and drug use seeks to provide them with opportunities and tools to stop using these dangerous substances. It is not, as one member of the government suggested, a choice between these supervised injection sites and doing nothing. There are many other alternatives. We need to work aggressively for those alternatives. Perhaps that means more investment in chemical detox facilities. Perhaps that means having a conversation about mandatory detox. I am not here to come out definitively in favour of that, but that is an option to be discussed. Perhaps it means enhancing education and early intervention. All of these are with the direction of saying that we are not going to develop a permissive attitude to something where the harm is so significant and so present.

We all have a shared motivation in what we want to see happen, but the kind of compassion that motivates my concerns around supervised injection sites is fundamentally more optimistic in what I believe is possible for people who are in these kinds of difficult situations. That is an important distinction to be drawn in this discussion.

Government Orders

● (1320)

With respect to drug policy, there is sometimes the implication from those who favour a more liberal regime with respect to drug laws that criminalization inherently entails some kind of moral judgment. I do not think that is true. The law should criminalize behaviour that is dangerous and that criminalization creates opportunities for the police to intervene. However, that does not in any way, necessarily, entail moral judgment.

That intervention, in fact, may be in the best interest of the person in terms of protecting his or her safety. It may create opportunities for legal intervention that would start the person on a road to greater awareness, greater support, and to access resources that, in the absence of this intervention, he or she might not access or know exists. I will not pretend that this happens in every case where there is a legal intervention, but I would like to believe that in a multi-pronged approach that emphasizes public health and dealing with root causes, we need to also recognize that legal intervention can play an important role in helping people go in a different direction.

I was speaking earlier about the opportunities I have had to have conversations with people who are struggling with these issues. I know one of the most important parts of this discussion is the way in which people's own families can engage with them and support them. This is an area that needs further discussion and perhaps further investment from government.

There is an organization in my community called Parents Empowering Parents. It works directly with the parents and families of those who are struggling with drug use issues. This organization is so effective because it empowers those who are necessarily right on the front lines of dealing with these problems, not because they are in some professional capacity but because they have close, intimate, personal relationships with those who are in this situation. So often family can be the critical support involved. Therefore, this is another area where further discussion and investigation is merited.

There are a few other comments I want to make with respect to the legislation. I have talked about the principles around having supervised injection sites, but what the legislation deals with specifically is the process of consultation for opening a supervised injection site. It is legitimate that the neighbourhoods, communities, and municipalities that will be affected profoundly by these decisions have a fair and full opportunity to be involved in the consultation and ensure not only that they are informed but that the consultation actually gives them the opportunity to have some say with respect to the outcome.

We should recognize that communities, neighbourhood groups, and municipalities are aware of these problems, are compassionate in their desire to respond, and to respond in a way that is most effective and appropriate for their communities. It is not reasonable to assume that we should somehow take away their power to influence the process and that this will make the situation better. Communities on the front lines of these issues are certainly made up of people who want to help, but they may also want to have input about what kind of strategy to respond to the challenge of drug use makes the most sense in the context of their communities. Community groups, mayors, and individuals would want to be part of that discussion.

I would ask members across the way to reflect on how they would feel if a supervised injection site were proposed within their immediate communities. I am sure there are some members who would be supportive of that. There are others who would perhaps not be supportive. However, I suspect that all members, if it were their families in the immediate area, would want to be aware of and given an opportunity to have some constructive input with respect to the form of response taken within that community. They might have ideas and insights that an external organization coming into the community would not have. They might know things or appreciate opportunities and resources that are not on the radar of some external organization.

● (1325)

If something like that were contemplated in my own community, I would want to ensure that I and others in my community had the fulsome opportunity to be part of the discussion.

With respect to the specific changes to the consultation framework for example, right now there is a requirement for support from the mayor of a city. Some mayors have raised concerns about the appropriateness of these supervised injection sites in their communities.

The bill would also change the consultation period, and this is an important point. When we talk about the development of a supervised injection site, something that is likely going to be in place for quite a long time, it is important to have the proper timeline for consultation upfront. The bill would change the current discretionary 90-day public consultation period to a period that is "not to exceed 90 days".

In my previous career, I was involved in public opinion research and in that context also consultation. The window given for time is already not that large a window to create opportunities for meaningful debate and discussion that would give people the opportunity to have feedback, to ensure they engage with the information and to suggest and propose alternatives. We have to be concerned that there is no minimum in the proposed new legislation on what the public consultation will look like. There is nothing to suggest the community would have to give its approval either. The implication is that the community would be informed, but it would not necessarily have meaningful opportunities for feedback at all.

Obviously there will be some disagreements about overall drug policy and about the wisdom of these injection sites. Some members of the House favour the decriminalization wholesale of all different kinds of drugs, and I do not doubt with the best intentions, but ultimately that path would be misguided.

Could we at least all agree about the importance of better engaging communities? It seems that we cannot because this legislation involves changes that would just remove the capacity for effective community engagement, and it is unfortunate.

As I said before, many provisions in the legislation are supportable, but with something that would have such a significant impact on communities, it is difficult to suggest that it should be given a pass in spite of the fact that there are certain things in the bill that are worthwhile.

Government Orders

I would like to make a point with respect to the question of whether these supervised injection sites save lives. This has been said by members across the way, and it is an important point.

A lot of the data I have looked at with respect to these sites has looked at the number of overdose interventions and makes the assumption that the overdose interventions therefore necessarily show that there is a net benefit in lives saved. What the arguments do not consider is the possibility of a more permissive environment for drug use in general, the social signal sent by this, the ease of access without the possibility of intervention but also in comparison to other possible alternatives, other policy responses which are motivated by what I have called a more optimistic as opposed to more pessimistic compassion.

I have not heard data from members that show that overall we are talking about lives saved just in that very narrow and specific sense of overdose interventions. There may be other ways to have supports within communities that can be prepared to respond to overdoses that do not involve the kind of legal exceptions that exist in a supervised injection site model.

We need to look not just at this model or nothing. We need to look at alternatives that have as their goal minimizing the use of drugs and helping people to get off drugs completely, providing them with the supports and investments they need to do it. That would provide a better alternative.

• (1330)

Certainly, if we cannot agree on that, let us at least agree on the importance of more effective consultation. If we cannot agree on the importance of more effective consultation, let us look at expediting the sections of this bill we can all agree on without getting bogged down in terms of the urgent need to respond or on the sections that do require time and sufficient debate.

Mr. Nathaniel Erskine-Smith (Beaches—East York, Lib.): Mr. Speaker, the member suggested that those on our side have been saying that Bill C-37 would save lives. Certainly, I am one of those speakers.

I cited the Supreme Court's unanimous judgment of nine to nothing. I believe it was paragraph 133 that stated, "Insite saves lives. Its benefits have been proven."

The member now casts doubt on that unanimous conclusion of our Supreme Court and suggests that there might be evidence that permissive and increased usage has occurred because of the safe injection clinics. Perhaps he can point us to that evidence.

Mr. Garnett Genuis: Mr. Speaker, I know that the member would be shocked and horrified to find that I might, in some cases, disagree with the members of the Supreme Court. However, I was much more humble than that. What I did in my remarks was raise a question. I said that the evidence I have read with respect to these supervised injection sites is specifically on this issue of overdose response, and I raised the question of whether that is sufficient to demonstrate a net benefit to society and to those who are struggling with drug use, especially when we consider the fact that there are other possible responses. That was the question. If the members of the government have evidence, perhaps contained in the Supreme Court judgment or perhaps elsewhere, I invite them to present that evidence.

Ms. Tracey Ramsey (Essex, NDP): Mr. Speaker, I heard the member speak about interactions he has had with family members and others in the community. He mentioned an organization for concerned parents.

I think it is a fundamental mistake to not go back to the beginning of addiction for people in Canada. A lot of that addiction crosses all socio-economic boundaries. There is no designation of only young people being addicted. The middle class and people from all economic standings in life are addicted for many different reasons, partially because of the over-prescription by doctors of certain opioids that have been deemed safe by our own Health Canada, which we now know is not the case. These prescription medications are becoming a gateway, where people become addicted and then find themselves on the street. I had one such woman in my office who had two young children. Her husband had worked in a very physical type of job, found himself addicted to prescription medication, and is now homeless, living on the street, and addicted to meth and crack cocaine.

I think we need to go back to the root of addiction, which has to include detox and addictions treatment. Unfortunately, under the previous Conservative government, 15% was slashed in the budget for addictions treatment. Does this member now support an increase in the upcoming budget to address the very alarming lack of funding for detox and addictions treatment in Canada?

• (1335)

Mr. Garnett Genuis: Mr. Speaker, I am not aware of the numbers the member raised with respect to the previous government. However, I think I agree with almost everything she said about the way in which drug addiction affects many different people across different kinds of communities, certainly belying many of the stereotypes or what some people might think someone who struggles with drug addiction looks like.

There are many paths that lead people into drug addiction, and there are many paths out. I said quite concretely in my speech that I personally think it is important that we focus our efforts on looking at how we can get people out of addiction and on making those investments in treatment and detox. I think that should be our focus.

Mrs. Cathy McLeod (Kamloops—Thompson—Cariboo, CPC): Mr. Speaker, I also want to talk about the addictions detox issue, which is, of course, predominantly a provincial responsibility.

Many times, I hear from people that safe injection sites provide a route to detox and treatment. In my former experience as a nurse, I can remember people who were desperate for support, but often we would have to tell them it was going to take six months before they would have the care they needed. At that point, we had actually lost them. People who had been very motivated, in terms of it being time to turn their lives around, missed those opportunities because of the lack of detox and rehab.

I do not understand, to be honest, when there is such a lack of detox and rehab available, whether it be in communities, remote faraway places, or at Insite, how they can be a pipeline that is as effective as some people indicate.

Government Orders

Mr. Garnett Genuis: Mr. Speaker, I thank my colleague for her question and her work and for sharing her experience before coming to this place.

Absolutely, it is horrendous if someone is willing to take those steps necessary but does not have access to a facility that allows them to go through the process of detoxification and addictions treatment. Clearly, even if we think of it in the crudest terms of economic cost, it makes sense to make those upfront investments, given the costs later on. However, that is not the most important consideration at all. It is the effect on people's lives.

This is why our view is that the focus should be on investing in those things that allow people to effectively get on that road to complete recovery and on allowing municipalities and provincial governments to make those investments as well. What is envisioned in this legislation is moving forward with injection sites without necessarily the sign-off of the municipalities, which puts them on the hook for them financially and less able to invest at the local level in alternative programs that may actually be much more effective.

[Translation]

Mr. Pierre-Luc Dusseault (Sherbrooke, NDP): Mr. Speaker, I thank my colleague for his comments.

Does the member realize that the supervised consumption site model also includes access to detox programs to help people break their addictions? That is part of the model. These facilities offer programs that give people the professional support they need to battle their addictions.

Does my colleague recognize that this is part of what supervised consumption sites offer? Does he recognize that, when these programs are available at supervised consumption sites, and when people can go to these sites rather than be relegated to the streets as they are in all but one of our Canadian communities, it is easier for them to access the professional services that can help them overcome their addictions?

Mr. Garnett Genuis: Mr. Speaker, I thank my colleague for his important question.

It is correct that the institutions have certain programs. However, one thing is clear.

• (1340)

[English]

The legal exception is still there that a person can use illegal drugs without the possibility of a legal intervention. I take the view that a legal intervention, recognizing the danger and illegality of these drugs, can be an important step in terms of bringing someone toward that path of recovery. I do not think it is enough to say that people can come here, use illegal drugs, and by the way, if they want to get well again, we have this option as well. As a society, as communities, a fully compassionate and also optimistic response is one that insists on providing the resources, the mechanisms, and every possible encouragement for people to get well again.

Ms. Julie Dabrusin (Toronto—Danforth, Lib.): Mr. Speaker, I am going to be splitting my time with the member for Winnipeg North.

[Translation]

Today I am proud to speak on Bill C-37, which I unreservedly support. This is an essential step in overcoming the opioid crisis that is afflicting our country.

The bill amends the Customs Act and the Proceeds of Crime (Money Laundering) and Terrorist Financing Act, but I will actually be addressing its proposed amendments to the Controlled Drugs and Substances Act.

[English]

The changes to the Controlled Drugs and Substances Act are important to our government's revision of the Canadian drugs and substances strategy, which restores harm reduction as a core pillar of Canada's drug policy. The return of this evidence-based approach to substances marks a return of our drug policy to a health matter once again.

I want to acknowledge the pain that has been experienced by so many families across our country as a result of the opioid crisis. My hope is that by passing this bill, we will be preventing further deaths from the use of opioids.

[Translation]

This bill gives health professionals the freedom to plan and implement harm reduction strategies to help people with substance abuse issues. It helps to de-stigmatize this disease that is taking lives every day across Canada. It will let people get medical assistance when they need it most. It is important that we all stand and support these changes.

[English]

First, I will address the situation in Ontario, specifically in my community.

The chief coroner for Ontario, Dr. Dirk Huyer, reports annually on deaths from opioid toxicity. If we look at the numbers, we see quickly that it is not just fentanyl that is killing people in Ontario. It is also codeine, heroin, hydromorphone, methadone, morphine, and oxycodone, sometimes mixed with alcohol.

The number of deaths is rising. In 2004, there were 246 deaths from opioid and opioid-alcohol toxicity. In 2015, that number had risen to 707 deaths.

[Translation]

It is estimated that one in eight deaths of Ontarians between the ages of 25 and 34 is related to opioid use. Toronto has seen a 77% increase in overdose deaths over the past decade.

[English]

The toll in east Toronto, where my community is located, has been high. Research cited by the South Riverdale Community Health Centre shows a disproportionately high number of injection drug users in our community and higher rates of emergency department visits due to opioid or cocaine use than in Toronto overall.

Government Orders

In 2013, a memorial was unveiled at Queen St. and Carlaw Avenue in my riding. The memorial, believed to be the first of its kind in North America, helps us to remember the people in our community who have died from drug overdoses.

● (1345)

[Translation]

It is a space to help families and friends heal. It encourages us to support public education and highlights the impact the war on drugs has had on the lives of people who are with us and those who have gone beyond.

[English]

More than 60 people contributed to the creation of the memorial, with the guidance of artist Rocky Dobey. Regarding the memorial, he stated:

But the sculpture is only a small part of this project; many more ideas have been generated, including a print exhibit, an annual memorial at the sculpture, and the simple storytelling of memories at these meetings; hopefully the project will continue to draw this community together.

[Translation]

At the time that it was unveiled, there were 79 names. By this summer we had 130 names, and more are being added. The stories and memories that are embodied in the sculpture should recall to all of us that work remains to be done to support our neighbours in this struggle.

[English]

This past summer, the sculpture was the site of a memorial for a young community peer and street outreach worker who specialized in harm reduction, Brooklyn McNeil. She was a strong advocate for safe consumption sites in Toronto.

She appeared before the Toronto Board of Health and spoke very eloquently in favour of harm reduction. I listened to her deputation last night, and her presentation hits hard. She spoke of how accidental overdoses could be prevented by safe injection sites, and she recounted her own overdose experiences.

She closed her statement saying that “respect for all members of the community is so important, especially not looking at addicts as invaders but as part of the community.” Unfortunately, she died of a drug overdose in June at the age of 22. She died before the Toronto Board of Health voted to approve three safe consumption sites in Toronto.

I do feel that Brooklyn McNeil's view of community is echoed, however, in the deputation made by the chair of the Leslieville BIA, Andrew Sherbin, who spoke at Toronto City Hall in favour of a safe consumption site in my community at the South Riverdale Community Health Centre. He stated, “We will always be a neighbourhood that welcomes people, not turns them away.”

Both of their statements strike to the very point of harm reduction, that we do not help people by turning them away. As we face a growing opioid crisis we need to look directly at this problem, we need to help people get the health care they need.

● (1350)

[Translation]

The bill we are discussing today helps communities to apply for exemptions to allow for the creation of safe consumption sites. It puts into place five benchmarks to be met for a safe consumption site to be approved. The benchmarks are:

[English]

One, demonstration of the need for such a site to exist; two, demonstration of appropriate consultation of the community; three, presentation of evidence on whether the site will impact crime in the community; four, ensuring regulatory systems are in place; and, five, site proponents will need to prove that appropriate resources are in place.

By putting these benchmarks into place, the bill returns our law to the state it was in after the Supreme Court of Canada's 2011 decision that allowed Insite to operate in British Columbia, without the overbearing, harmful, and unnecessary regulatory framework set up by the former Conservative government.

An organization in my community, as I have mentioned, the South Riverdale Community Health Centre, has applied to expand the harm reduction services they already provide. The centre is one of three that was approved by the Toronto Board of Health, and it has been operating a harm reduction needle exchange since 1998. That is about 20 years. It is one of the busiest harm reduction needle exchange programs in Toronto, and in 2015 served over 3,000 people who use drugs.

The South Riverdale Community Health Centre states in their background document relating to their application for a supervised injection site that international and Canadian research shows that such sites have benefits for individuals using the services and the community, including reducing the number of drug overdoses and deaths, reducing risk factors leading to infectious diseases such as HIV and hepatitis, increasing the use of detox and drug treatment services, connecting people with other health and social services, and reducing the amount of publicly discarded needles.

[Translation]

The centre's study of clients who seek help relating to injection drugs showed that around 30% of the clients injected in public. Ensuring needles are not discarded in public is an important health goal, and is something that this bill helps us achieve.

[English]

Members of my community signed a petition in support of a safe consumption site, and the wording of the petition stated as follows:

Leslieville is a progressive, welcoming and inclusive community. As individuals who live and work in the community, we support the establishment of a small-scale safe injection service at the South Riverdale Community Health Center (SRCHC). With a 41% increase in fatal overdoses over a 10 year period in Toronto and the existence of discarded needles in the neighbourhood, this service will not only prevent unnecessary deaths but keep the community safer. South Riverdale CHC has been operating a robust and successful Harm Reduction program for almost 20 years and this small but important addition will protect both individuals who already use the program and the community at large.

I would like to conclude with the comments that one of my constituents made at the Toronto Board of Health. Her name is Margaret Harvey, and she said, “As a community, we owe it to ourselves and to each other to make harm reduction a priority, to give the vulnerable a chance to get the help they need and to make our streets, parks, and other public spaces safer for everyone”.

So too, as a country, do we owe it to the vulnerable to make sure that they do not face barriers to access the health care that they need to keep them safe.

Mrs. Cathy McLeod (Kamloops—Thompson—Cariboo, CPC): Mr. Speaker, my colleague talked about the importance of this legislation, and I will agree with her that there are many important measures in it. There is one area of course that we do have concerns about. More important, and I have to say this again, it was back in April 2016 when B.C. declared a state of emergency. It is now February and the Liberals have finally gotten around to putting some legislation for consideration.

I have to note that yesterday we were busy talking about Stats Canada. Can I ask the member this: How does she feel both about her colleague, the member for Vancouver Centre, who says that the government is moving too slowly and if it were happening in Ontario it would be moving faster; and second, is dealing with the Statistics Act more important than this bill, in her opinion?

Ms. Julie Dabrusin: Mr. Speaker, I appreciate that my colleague is pointing out the importance of this issue and the fact that we all see that we need to urgently address the opioid crisis. There is no question about it; that is something that we need to respond to. That is why I am so happy that we are having this debate in this place today.

I want to point out, though, that we as a government have been taking action on this issue already. We made the overdose antidote naloxone more widely available in Canada. In fact, one of the points that was brought up at the deputation that I mentioned at the board of health was that the use of naloxone had saved this woman's life once in the past. Also, we granted section 56 exemptions for the Dr. Peter Centre and extended the exemption for Insite for an additional four years.

We are taking steps, and we are now debating this legislation right here. This is what we need to do to make it happen.

Ms. Tracey Ramsey (Essex, NDP): Mr. Speaker, I thank my colleague across for sharing her experience in her community around this crisis. I have shared some of the experiences in my own riding of Essex today in this House, and this is something that we need to get ahead of. Unfortunately, this is coming at a time when it is almost too late because of the number of deaths that we have seen. We need to get ahead of this now and we need to move faster than we are moving on this issue.

Government Orders

We in the NDP welcome the changes that are being proposed here and of course will support them, but we need to do more. In my riding, there is no access to any type of treatment facility. People have to travel from southwestern Ontario up to the Toronto region in order to get treatment, and they are waiting eight days to detox.

My question for the member is around the medical experts who have been very clear that there is an alarming lack of access to publicly funded detox and addiction treatments in Canada. I want to ask the member if budget 2017 contains significant new funding for addictions treatment.

● (1355)

Ms. Julie Dabrusin: Mr. Speaker, one of the things that I was very happy to see when we are talking about the different types of actions that are required is we need to gather the experts together and get the evidence that we need to respond to this issue. This bill is one step that brings us closer to getting to those solutions. The Minister of Health also had a summit bringing together experts to discuss opioids and how we should be addressing this crisis. That is exactly what we need to get the proper answers to where we are going. We need to get evidence put together. We had that summit. That was a great place. Now we have this legislation, and we will keep moving forward to get this done.

Ms. Elizabeth May (Saanich—Gulf Islands, GP): Mr. Speaker, this is my first opportunity to get to my feet in today's debate on Bill C-37. We are all terribly concerned. I am desperately concerned, as a member of Parliament from British Columbia, about the fentanyl crisis. Over 900 people died last year; I think it was 162 in December alone.

While this bill is definitely helpful, we must be able to have safe injection sites available to Canadians where we need them. I know the hon. member is not the Minister of Health, but could she outline for us the Liberal government's position on why this is not a national health emergency? A lot of us want to see a national health emergency declared.

Ms. Julie Dabrusin: Mr. Speaker, ultimately, this is about making sure that we are doing what we need to do to address the opioid crisis. As I mentioned, this bill would be one step in that direction. I see the need in my own community. That is why I specifically wanted to bring up the experience of South Riverdale Community Health Centre.

I mentioned some of the steps that the Minister of Health has already taken, with making the antidote naloxone more available across Canada, as well as providing an extension for the exemption for Insite for an additional four years and granting section 56 exemptions for the Dr. Peter Centre. We are working on this right now.

I understand the urgency. That is why I want to press this forward and bring everyone in the House together to agree to move the bill through as quickly as we can.

Statements by Members

Ms. Dianne L. Watts (South Surrey—White Rock, CPC): Mr. Speaker, I want to thank my colleague. I know that, predominantly, the focus of her speech was around the consumption sites and a new one going into her community. I guess not everybody will use a consumption site and they do not inject. They snort. They have pills.

What is the strategy under that umbrella and where is the treatment piece, in terms of her government's plan?

Ms. Julie Dabrusin: Mr. Speaker, the bill would be one part of the solution that we are putting together. There is, obviously, a larger question about the opioid crisis. That is exactly why having a summit and bringing experts together to try to find solutions is what we need.

The Deputy Speaker: It is just a couple of minutes before we get to statements by members. I think most of the members are here, so we are going to start just a minute or two early and give ourselves lots of time to get into question period thereafter.

STATEMENTS BY MEMBERS

[English]

SECRETARY-GENERAL OF THE UNITED NATIONS

Ms. Julie Dzerowicz (Davenport, Lib.): Mr. Speaker, as of January 1, a new secretary-general, António Guterres of Portugal, took up the responsibility as head of the United Nations. The selection of Mr. Guterres as the United Nations secretary-general is a point of pride for Canada's Portuguese community, particularly in my riding of Davenport, home to the largest Portuguese community in our great nation.

On the first day of his mandate, Secretary-General Guterres launched an immediate appeal for the world to put peace first. He reminded us that the things we all collectively strived for, dignity and hope, progress and prosperity, depended on peace and that peace depended on all of us, citizens, governments, and leaders. It is an important message, especially given the recent attack in Quebec City.

As our Prime Minister has said, let us not meet violence with more violence and let us ensure that fear and hatred is met with love and compassion. Let us put peace first.

* * *

HALIBURTON—KAWARTHA LAKES

Mr. Jamie Schmale (Haliburton—Kawartha Lakes—Brock, CPC): Mr. Speaker, I have a number of people and organizations from my riding that I would like to congratulate and thank for their hard work, both at home and abroad.

The township of Dysart in Haliburton county recently celebrated its 150th anniversary.

The 2017 world dogsled championship was held in Haliburton Forest & Wild Life Reserve, bringing competitors from a dozen countries to Haliburton county.

Haliburton's Scotty Morrison, whom many will know, received the Governor General's Sovereign Medal for Volunteers.

Cam Lamport, captain of the Lindsay Muskies, was named the Ontario Junior Hockey League player of the month for the northeast conference.

Lindsay's Karleigh Toth competed at the world tap dance championships in Germany.

Downeyville's Ab Carroll qualified for the world livestock auctioneer championship, being held in Billings, Montana this June.

Wendy Babin of Nanna's Diner was named Citizen of the Year by the Kirkfield Lions Club.

I would also like to encourage every Canadian to attend the Beaverton winter carnival taking place this weekend, a great family-friendly event for all.

* * *

● (1400)

NEW BRUNSWICK ICE STORM

Mrs. Alaina Lockhart (Fundy Royal, Lib.): Mr. Speaker, last week, New Brunswick was hit with an ice storm that cut off electricity to more than 130,000 people across the province. Despite all efforts, many still remain without power today. Sadly, these outages have led to two deaths and dozens of hospitalizations due to carbon monoxide poisoning.

During times of struggle, we see the true resilience and resourcefulness of communities, something I saw first-hand last week while I visited warming centres in Alma and Salisbury. I would like to thank those who went door-to-door to check on our most vulnerable individuals, businesses that provided assistance to their neighbours, and the Canadian Armed Forces that mobilized and responded at the province's request.

I would also like to thank the emergency service personnel and power workers who continue to work day and night to restore power to every household.

Events like this make us all thankful for our neighbours, and no more so than in rural Canada where we can always count on someone to offer an extra blanket, a hot shower, or a home-cooked meal.

* * *

[Translation]

SAINTE-ROSE-DU-NORD

Ms. Karine Trudel (Jonquière, NDP): Mr. Speaker, 2017 marks the 75th anniversary of the founding of Sainte-Rose-du-Nord, one of the most beautiful villages in Quebec.

In 1942, after 100 years of settlement that included progress and setbacks, this beautiful village was officially created on the north shore of the Saguenay River.

I am honoured to represent the people of Saint-Rose-du-Nord, which is known as the pearl of the fjord. These good people have put down strong roots there, and they welcome over 80,000 visitors every year. That is quite something for a village of 400 people, but it is also not surprising, considering the beauty of its landscapes and the wide range of activities it offers, in winter and summer alike.

On this 75th anniversary, I want to wish everyone in Sainte-Rose-du-Nord all the best as they celebrate the anniversary of their village.

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[English]

DR. ROBERTA BONDAR DAYS

Mr. Terry Sheehan (Sault Ste. Marie, Lib.): Mr. Speaker, I rise in the House today to honour the groundbreaking accomplishments of my fellow Saultite, Dr. Roberta Bondar, who is visiting Ottawa today.

Yesterday, January 30, marked the final day of the recently proclaimed “Dr. Roberta Bondar Days” in my riding. Dr. Bondar has had an influential career as a medical doctor, scientist, author, photographer, and Canada's first woman in space.

Born and raised in Sault Ste. Marie, Dr. Bondar has received a number of Canada's highest awards, including recognition from the Order of Canada and the Royal Canadian Mint.

The year 2017 marks the 25th anniversary of Dr. Bondar's historic space flight. Her remarkable career inspires Canadians of all ages from coast to coast to reach for the stars and continues to inspire young women, and boys as well. I congratulate Dr. Bondar.

* * *

LUNAR NEW YEAR

Hon. Alice Wong (Richmond Centre, CPC): Mr. Speaker, it is my pleasure to extend greetings to all my colleagues and Canadians across our country on the occasion of the lunar new year. This year, as we celebrate the Year of the Rooster, we recognize the importance of hard work and seek success in our workplaces. The rooster is punctual, responsible, and dynamic.

As those with Chinese, Korean, and Vietnamese heritage gather to celebrate this joyous occasion, I am reminded of how fortunate we are to live in Canada, where there is such a rich and diverse multicultural mosaic.

I encourage all my colleagues to participate in local lunar new year events, join us as we welcome in the new year, and continue our celebration for at least two more weeks.

On behalf of my family, I wish everyone a happy and prosperous Year of the Rooster.

Gong Hey Fat Choy. Xin Nian Kwai Le.

* * *

● (1405)

SHOOTING IN QUEBEC CITY

Mrs. Brenda Shanahan (Châteauguay—Lacolle, Lib.): Mr. Speaker, on behalf of the people of Châteauguay—Lacolle, I rise today to condemn the shooting perpetrated at the Quebec City Islamic cultural centre last Sunday night.

[Translation]

This Islamophobic attack, which took the lives of six people and injured many others, was a wanton act that has no place in Canada.

Statements by Members

Ours is a welcoming country built on values like openness, tolerance, and diversity. That is why we must oppose all forms of persecution against minorities, including ethnic and religious minorities.

I offer my condolences to the grieving families, and I want to express my solidarity with the people of Quebec City and all followers of Islam.

The people of Châteauguay—Lacolle stand with the members of our Muslim community. My thoughts go out to them, and I want them to know that they should always feel at home here in Canada.

* * *

[English]

CAPE BRETON

Hon. Mark Eyking (Sydney—Victoria, Lib.): Mr. Speaker, today I rise to recognize some very good news for Cape Breton.

Last week, I was proud to announce, on behalf of our government, the federal contribution to the creation of a \$20-million second berth in Sydney Harbour for the cruise ship industry. This is following the \$67 million that we announced last fall for the Cape Breton Highlands National Park and the Cabot Trail.

I would also like to recognize the member for Cape Breton—Canso for his announcement last week on the \$1.5-million upgrade to another popular tourist attraction, the Glace Bay Miners Museum. These investments show that our Prime Minister and our government are making tourism and job creation a priority.

Speaking of announcements, Mr. Speaker, you may recall that 10 years ago today we made the announcement of \$400 million for the Sydney tar ponds, to clean up the toxic site, which I can inform the House is now a beautiful park enjoyed by all residents.

Stay tuned, because the government will be announcing more investments in the wonderful island of Cape Breton.

* * *

RETIREMENT CONGRATULATIONS

Mrs. Cheryl Gallant (Renfrew—Nipissing—Pembroke, CPC): Mr. Speaker, it is my pleasure to bid a happy retirement to one of the longest-serving fire chiefs in the Ottawa Valley, Chief Terry McHale of the Douglas Fire Department.

Terry has served with the Douglas Fire Department continually since 1972, a 44-year commitment to his community.

After briefly serving as chief in 1978, Terry took on the responsibility full time in 1987, and held the position for the last 30 years until his reluctant retirement in December.

This will be a big change for the township of Admaston/Bromley, as Terry is the only fire chief many residents have ever known.

Government Orders

However, he became minister of immigration and did the magnificent job on behalf of the Prime Minister and the commitment of Canadians to open our arms to Syrian refugees. He will know that I had many specific families, and I went to him over and over again begging, and he always listened and took action. I am so deeply grateful, as are nearly 40,000 families who live in Canada now because of his enormous effort.

I worried about his health then. I thought he was working himself down to nothing, and I know his wonderful wife Nancy shared some concerns, but now I think he will just have an easy time. I think his workload will be enormous, but there is one thing that will not happen in China: he will not be allowed a place as a smoker any more, so perhaps we can wish him good luck and that he still try to give up the smoking, and take care of Canada's interests.

• (1615)

[Translation]

I will now say a few words about my friend and hero the minister who was the MP for Saint-Laurent and who is now saying goodbye in the House. For me, he is a hero because of the work he did as minister of the environment in 2005.

[English]

That was the last good conference of the parties of all those that led right up to Paris, and it was not easy. It was 24-hour, round-the-clock work. People do not understand what it is like to take that stress, and as minister of the environment in 2005, the current member for Saint-Laurent worked tirelessly to get Kyoto confirmed, and against the objections of the Bush administration. It was not easy. I do not say this just out of friendship. I do not just have admiration for people across party lines without it being deeply deserved.

From there he went on to be leader of the Liberal Party, a colleague again.

It is one of the greatest honours I have ever had knowing both the member for Markham—Thornhill and the member for Saint-Laurent as friends, having the enormous honour to be the member for Saanich—Gulf Islands and being able to work with them, alongside them, both in opposition and now across the aisle.

I am so glad, so grateful, that the member for Saint-Laurent has accepted the Prime Minister's offer. With COP 23 being hosted by Fiji, and Fiji not having capacity to welcome the world to negotiate, the negotiations will be in Bonn. I do hope the member, our ambassador for Germany and the European Union, will find a way to participate and help along those negotiations at COP 23, so I do not have to say *au revoir*, but only *à la prochaine*.

[Translation]

My heartfelt thanks to the two hon. members for all their hard work and remarkable talents.

The Speaker: It is always nice to see MPs kissing here in the House. I would like to echo the sentiments that have already been expressed by my colleagues.

Both of them have been my long-time colleagues.

[English]

I have admired them for their intelligence, their dedication, and their devotion to Canada and to their work. I have also appreciated their friendship over many years, and I want to wish them the very best in their new endeavours in the diplomatic community.

[Translation]

Thank you very much and good luck.

GOVERNMENT ORDERS

• (1620)

[English]

CONTROLLED DRUGS AND SUBSTANCES ACT

The House resumed consideration of the motion that Bill C-37, An Act to amend the Controlled Drugs and Substances Act and to make related amendments to other Acts, be read the second time and referred to a committee.

Mr. Kevin Lamoureux (Parliamentary Secretary to the Leader of the Government in the House of Commons, Lib.): Madam Speaker, it is with pleasure that I rise today to talk about important legislation that the government brought forward late last fall. To a certain degree, there was an expectation from some members, and hope from others, that members would recognize the value of trying to expedite the legislation. However, although I was one of those who hoped we could get the bill passed as early as late December, I appreciate the need of members to contribute to the discussions and debates at all times.

The Minister of Health said it best when she talked about how as a nation we recognized that the opioid crisis was just that, a very serious crisis that needed to be addressed. This government views this as an issue of the utmost importance. Day in and day out, we have seen a very proactive Minister of Health try to ensure that what can be done will be done.

A number of things have been noted. I appreciated it when one of the New Democrat speakers, and I am unsure but I believe it was possibly the critic for health, made reference to a number of things the government had done. It is important to recognize that a series of things have been done to date, and it is understandable as to why that has happened.

In 2015, it was estimated that as many as 2,000-plus people had succumbed to death as a direct result of accidental overdoses. It is a serious crisis. People are dying virtually every day. If we want to average that out, we are talking about more than one or two people dying every day in this most tragic way. We see young and old alike dying as a direct result of an overdose from opioids, fentanyl in particular.

There are a couple of things I would like to emphasize.

Government Orders

We have talked a lot about these supervised safe sites. The legislation would go a long way to ensure that where it is clearly demonstrated that there is a need, that need will be met somehow. I want to spend a bit of time on this because I know a number of people from the Conservative Party in particular are somewhat critical of why we want to allow for more supervised injection sites.

In certain areas of the community I represent, people can walk on some of those streets and see used needles and all sorts of instruments that have been used for drugs, and who knows what else. There are serious issues. However, it is not just in one area of the country. It is throughout many of our communities. It is not just in the hard-luck areas where we find poverty. We will find it in inner cities and the suburbs. The last time I had the opportunity to speak on this issue, three individuals from the Meadows West area of the constituency I represent had overdosed. This issue crosses many different socio-economic barriers. Therefore, we have a responsibility.

In the questions I put forward, I often make reference to the fact that what we want from the national government, and what the national government has indeed provided, is leadership on the file. The minister and the government recognize that Ottawa alone cannot resolve the problem. To have the desired impact that Canadians want, we must work with the many different stakeholders to make a difference, and we saw that.

• (1625)

The Standing Committee on Health had the opportunity to study the issue and came up with numerous recommendations. Many of those recommendations can only be effective if multi-level governments and stakeholders come to the table and play a significant role to fight this crisis.

One of the things we have been very successful with, in a relatively short time period, is bringing those stakeholders together, recognizing what needs to get done to have the desired impact that is so very important in taking on this crisis.

In terms of the opioid crisis and saving lives, a policy is necessary to protect Canadians. We need to deal with the causes. We need to recognize that this is a health issue in so many ways. It causes so much harm to our society, not only to individuals who are addicted to these drugs but to their family and friends, and the heart of the community itself.

I understand and appreciate that what we do collectively is very important.

I have had the opportunity to ask a number of questions today on the legislation. I do believe that there is always room to improve. The Prime Minister has always challenged members of the House, of all political stripes, to bring ideas to the committee if they believe they will make a difference and if they have done the background work to demonstrate it through science or facts.

We have seen amendments made at the committee level. We are open to ideas that would make a difference if they can be incorporated. I would encourage members from all political entities to share their thoughts with the Department of Health, particularly when the bill goes to committee.

In having discussions, I am pleased the New Democratic Party has taken a fairly proactive approach to the legislation. It has recognized and been constructive in its critique. It recognizes the benefits of passing the legislation sooner as opposed to later.

It was not an easy feat to ultimately get the legislation ready based on the amount of consultation that had to take place in a relatively short time span, but we were able to bring it forward last December. I will give the New Democrats credit for recognizing the benefits of seeing if there is a way to expedite the passage of the legislation.

I request that all members give serious consideration to what we can do to, at the very least, to move the bill out of second reading to committee. The health committee could then deal with the legislation, and members could provide input there, as well as at third reading.

I have heard a number of members from the B.C. region and others talk about where this impacts Canada. It impacts every region of Canada. It is not isolated in one, or two, or three provinces. All provinces are finding it challenging. They want to see action coming from Ottawa. This is just one aspect, a very important aspect, in the fight against this national crisis.

I would like to highlight a couple of things the bill proposed to do, and they have been pointed out in some of the debates thus far. In essence, it will simplify the process of applying for an exemption that will allow certain activities to take place at supervised consumption sites, as well the process of applying for subsequent exemptions.

• (1630)

The bill proposes to prohibit the importation of designated devices unless the importation is registered with the Minister of Health, as well as prescribed activities in relation to designated devices. It authorizes the minister to temporarily add to a schedule of the act substances that the minister has reasonable grounds to believe pose a significant risk to public health or safety, in order to control them. Additionally, it authorizes the minister to require a person who may conduct activities in relation to controlled substances, precursors, or designated devices to provide the minister with information or to take certain measures in respect of such activities. It adds an administrative monetary penalties scheme, which is long overdue.

We are looking at streamlining the disposition of seized, found, or otherwise acquired controlled substances, precursors, and chemical and non-chemical offence-related property. We are looking at modernizing the inspection powers and expanding and amending certain regulation-making authorities to include “in respect of the collection, use, retention, disclosure and disposal of information”.

I understand my time has expired, but there might be a question so I can continue.

Mr. Colin Carrie (Oshawa, CPC): Madam Speaker, I have been listening to some of the things my colleague has said throughout the afternoon. I wonder if the member has actually gone to one of these injection sets and knows what it is all about.

Government Orders

According to my colleague, Senator Vern White, the average addict commits four to eight crimes in order to get the money to pay for his or her illegal heroin. It is usually an illegal opioid. It could be laced with anything. It could be kerosene, for heaven's sake. The addicts go into one of these injection sites, self-inject and then they are sent back out into the community to do it over and over again.

The minister has repeatedly said that these injection sites save lives, but I think everyone agrees that treatment centres save lives. The minister is renegotiating the health accord. She said she is willing to use levers. Why has the minister not encouraged the provinces to invest in detox treatment programs instead of only pushing the harm reduction measures in communities?

Mr. Kevin Lamoureux: Madam Speaker, I disagree with what the member has tried to imply. The supervised injection sites do in fact save lives. Canada does not have very many of these sites. We have Insite and another one in the Vancouver area. There have been many other applications, but the former Conservative government went out of its way to discourage these supervised injection sites. That is to the detriment of the safety of our communities and causes a great deal of harm not only to the individuals who are addicted but to family members and the community as a whole.

By providing that environment, we are in fact allowing for the community to be healthier. If I had more time, I would like to expand on that.

Mr. Don Davies (Vancouver Kingsway, NDP): Madam Speaker, when the health committee conducted our emergency study into the opioid crisis last fall, the very first recommendation we made, with all-party support, was to declare the opioid overdose crisis a national public health emergency. This would give the public health officer of Canada extraordinary powers to act immediately, primarily by flowing emergency funds where they needed it and by declaring overdose prevention units as health units to legalize them so cities could actually get supervised consumption sites operating immediately instead of waiting for the application process under the bill, which the hon. member knows will take months before it is passed.

This call was echoed by Dr. David Juurlink, the keynote speaker at the health minister's opioid summit, by B.C. health minister, Terry Lake, and mayors across the country.

In the face of the mounting death toll and his acknowledgement that supervised consumption sites save lives, why will the government not declare a national public health emergency so we can actually get these temporary emergency sites operating today and start saving lives today?

• (1635)

Mr. Kevin Lamoureux: Madam Speaker, it is important to recognize that we have responded to every request the provinces have raised with our government in this crisis and we continue to work with them. In fact, in the event that a public welfare emergency under the Emergencies Act were declared, the chief public health officer would not have any new or special powers. The Emergencies Act is considered a tool of last resort and an emergency has never been declared under this act. Prior to its enactment, its predecessor, the War Measures Act, was used only three times: during the First World War, the Second World War, and the October crisis of 1970.

What is important for us to recognize is that this government has demonstrated strong national leadership in working with our provincial counterparts, indigenous people, municipalities, the many different stakeholders that have a vested interest, our first responders, and so many more, bringing people together in order to have a coordinated comprehensive approach to deal with this national crisis.

This government is doing whatever can be done in order to get the job done.

Mr. Bob Saroya (Markham—Unionville, CPC): Madam Speaker, I will be sharing my time with the member for Calgary Nose Hill.

Today I rise in the House to address a grave situation. Bill C-37, which was introduced by the Minister of Health, is supposedly a solution to combat the ongoing opioid crisis in Canada. However, if carried through, the bill would have the potential to devastate communities, while creating no real solution for addicts.

I have no issues with certain parts of the bill. It must be acknowledged that certain sections are steps in the right direction.

It is appropriate that the bill would grant more authority to the Canada Border Services Agency in order for it to open international mail of any weight. We know that imports from certain countries are a major contributor to Canada's growing opioid problem. As it stands, the Canada Border Services Agency is not permitted to open, search, or test suspicious packages that weigh less than 30 grams. As a result, drug dealers in Canada have been able to order chemicals and illicit drugs online and have them shipped here.

It is vital that the government continue to ensure that these deadly chemicals are not crossing our borders and that those importing them are punished and held accountable.

I support the bill's prohibition of importing unregistered devices, such as pill pressers, which are used to manufacture bootleg fentanyl.

Broadening prohibitions so they apply to the possession, production, sale, importation, or transportation of anything intended to be used in the production of any controlled substance, including fentanyl, is welcome. However, the penalties, especially for the schedule I substances, are far too soft.

I also support the section of the bill that would allow the addition of a temporary schedule to the Controlled Drugs and Substances Act, because often new substances are designed to mimic illegal drugs while being different enough to avoid existing laws.

Government Orders

For the most part, these are steps in the right direction. However, there exist dangerous flaws in the rest of Bill C-37, which I cannot in good conscience support as is.

It is immensely disappointing that the Liberals refuse to acknowledge that prescription opioids are a major contributor to the opioid crisis.

In 2014, the previous Conservative government announced a plan to pursue tamper-resistant properties in prescription drugs. This would make it tough for people to crush, inject, or snort the pill. The Liberals have decided to abandon this plan, claiming it would not help Canada's growing drug problem. This decision is ill-informed and irresponsible. We encourage the Liberals to reintroduce tamper-resistant properties in order to save the lives of Canadians.

I am especially disturbed by the portion of the bill that severely weakens the Respect for Communities Act, which is crucial to ensuring that communities are consulted before a supervised injection site is approved.

Bill C-37 would make the consultative process surrounding injection sites practically non-existent. It would prevent communities from voicing legitimate concerns regarding proposed injection sites. Ironically, the government promised to engage and listen to the concerns of Canadians. It is essential that all members of communities have the opportunity to give input on proposed injection sites. This must include police, neighbourhood groups, public health organizations, the province, and the municipal government.

● (1640)

It ought to be mandatory to acquire a letter of support from the mayor of the city in which an injection site is to be located. It is not acceptable that if this ill-advised bill is enacted, a supervised injection site may be approved after meeting only five criteria as opposed to 26 previous safeguards.

Last year I held a public round table on these so-called safe injection sites in my riding of Markham—Unionville. Over 100 residents attended. They all told me they fear these injection sites are normalizing illegal behaviour and creating an unsafe environment for children. They are worried these sites will decrease their property values. Furthermore, they are furious that the Liberal government is wasting taxpayer dollars on purchasing drugs and paraphernalia for addicts.

I also wrote a letter to each Markham councillor asking whether they would support a safe injection site in Markham. Any response other than a definitive no is unsatisfactory for me and all residents of Markham—Unionville. I have yet to receive such a reply.

Markham council will have the final say on whether or not a safe injection site is located in Markham. I am extremely concerned that if presented with a proposal to open a safe injection site in Markham, council will approve this request. Markham residents can expect to hear more from me on this issue. I will not stop until I am satisfied that there will be no safe injection site in Markham.

This bill proves that the Liberals would rather encourage drug users than help them get back on their feet through rehabilitation and treatment.

Drugs that are used in supervised injection sites are illegally obtained. The Liberal government's actions would enable criminal behaviour and give addicts a safe space to get their fix instead of investing in proper treatment. Substance abuse experts, medical experts, and law enforcement officials all agree that the best way to spend money is on effective treatment programs, not injection sites.

The Liberals have given up on people who need help. Instead of allocating money to programs that can treat addicts, the Liberals are attempting to push ahead with a plan that would jeopardize the safety of communities. We ask ourselves, why would the Liberals do this? The answer, it seems, is that they are pursuing a shocking hidden agenda.

I was alarmed last Thursday when I read a Liberal MP's bombshell opinion editorial for *Vice News Canada* with the headline "Decriminalize all drugs". This is a dangerous and irresponsible proposal.

Only a couple of weeks ago, a drug lab was discovered in the heart of a residential neighbourhood in Markham—Unionville, forcing residents to evacuate.

For concerned families and communities like ours, these reckless Liberal ideas are reprehensible and also highlight the minister's out-of-touch ideas about drug policies. Helping rehabilitate drug addicts is a noble policy, but handing out drug paraphernalia and decriminalizing the most dangerous illicit narcotics are not.

While I support certain sections of the bill that would make it more difficult to import drugs and chemicals from overseas, I strongly condemn the parts of the bill regarding injection sites that encourage drug use instead of helping drug users quit and get back on their feet.

I urge members of the House to stand up for their communities and for all Canadians and reject this disturbing and careless bill until it protects Canadians instead of jeopardizing communities and to reject the Liberals' hidden drug agenda.

● (1645)

Mr. David de Burgh Graham (Laurentides—Labelle, Lib.): Madam Speaker, I listened intently to the speech by the member for Markham—Unionville. I am wondering if the member could explain to us how he expects to put drug users back on their feet by putting them in jail and giving them a criminal record. Maybe we should think about treating this as a medical issue. Maybe using controlled injection sites as a medical environment to encourage safe use and get people away from drugs might be better.

Does my colleague find it important to act on the opioid crisis or does he think the status quo works? It is really important. I would like to hear the member's support for real action going forward quickly.

Government Orders

On December 12, the member for Vancouver Kingsway asked for consent to have this legislation advance at all stages and I think that would be a good avenue for us to follow.

Mr. Bob Saroya: Madam Speaker, treatment is the way to go. As I said, at the round table in Markham—Unionville, over 100 people came, and 95% said no to an injection site. If the member is asking to go to injection sites, I know that people would rather have treatment than injection sites to have illegal drugs injected. This is what the people said in Markham—Unionville. Injection sites are not the solution.

Treat them. Give them a chance to recover for long-term health results. Jail the drug traffickers who are making illegal money for the long term so that kids can live safely in their neighbourhoods. It would stop the drug flow from other nations.

Prescription opioids is a bigger issue. There are many who have died from them.

Mr. John Brassard (Barrie—Innisfil, CPC): Madam Speaker, I want to start by acknowledging the work the hon. member has done with respect to this issue. He has held several round tables in his riding with the opposition critic for health.

One of the proposals in the bill, and the member spoke briefly on this issue, is a consultation period, with various communities, of up to 90 days, which effectively means that within one day, a decision can be made on whether a safe injection site comes to a community or not.

I wonder if the member could share with the House some of what he heard at some of those round tables and the concerns of his residents, which I expect would be concerns for a lot of residents across this country.

• (1650)

Mr. Bob Saroya: Madam Speaker, the previous Conservative government brought in the Safe Streets and Communities Act. There are 26 restrictions. They are restricted to certain areas. They have to talk to the neighbourhoods and talk to the police. That is what people said to me at my round table discussions. They were extremely happy that this was put in by the Conservative government. However, in Bill C-37, that is all gone. As the member said, it can be done in five hours. Instead of 26 restrictions, there are only five restrictions left.

What I heard at my round tables was about the Liberals' hidden agenda on legalizing drugs. They are dangerous, deadly, addictive drugs. We know that street drugs tear families apart as well as users' own lives.

The Liberal member for Beaches—East York made the argument a couple of days ago that the criminal aspect of drug use stigmatizes users and makes them less likely to seek help. The problem is that there is no proper help to offer addicts seeking it across the country. We are hearing that when a drug addict finally decides to take the steps to seek treatment, there are no beds available for them.

In this opioid crisis, it is irresponsible for any member of Parliament to be advocating the legalization of all life-ruining drugs.

Hon. Michelle Rempel (Calgary Nose Hill, CPC): Madam Speaker, this is a really important issue for me, because I represent a

riding in Calgary. Calgary has been basically one of the epicentres of this particular crisis in Canada. While we are seeing the impact of this crisis to a large extent in British Columbia and Alberta, it is really important to note that this is a problem that is going to affect every area of Canada in a very short period of time.

I cannot express strongly enough how concerned I am. "Concerned" does not actually carry the weight I want it to carry. I will say how deathly afraid I am that if we do not act quickly and in a very non-partisan way to manage this particular crisis and some of the key factors that are enabling this to explode, we are going to have a much larger and deadlier crisis on our hands and a lot of parents with dead kids who we will have to explain our actions to.

I want to speak to the bill and its structure from a point of gravitas and ask my colleagues on the opposite side of the House to consider some portions of the bill in that spirit.

We are here today, first and foremost, to do what we can to stop the flow of this particular substance, fentanyl, into Canada and to ensure that adequate laws are in place to stem the tide as much as we can. That is first and foremost.

I know that there has been a lot of talk today about why certain measures in this bill are so important. I agree with certain components of it. The component that would allow the Canada Border Services Agency to open packages that are under 30 grams is absolutely critical, because we know that the substance is highly potent. It is coming in from Chinese factories, for lack of a better term, or manufacturers, and because it is so potent, these manufacturers overseas are able to say not to worry about it, because Canada Border Services cannot open these packages. It is coming in inside things like cellphone cases, urine strip bottles, tiny packages. Because it is so potent, it can then be cut or mixed in larger centres and distributed. It is very lucrative, very easy, and so deadly.

I cannot tell the House some of the stories I have heard in my constituency office. In six years, I have seen a lot with the Calgary Police Service. The city has gone through a lot, but this is something that has first responders very unsettled. First responders in my city who have to deal with these deaths are really shaken up by this and are screaming out to us, telling us that we have to change some of these things.

There are measures in this bill that I strongly support. We need to pass them in the House and in the other place as soon as possible and without delay. Those measures would be things like the power to open packages under 30 grams, the prohibition of unregistered pill presses, and the illegal importation of precursors to the substance.

Government Orders

There are a variety of other initiatives in the bill, which include authorizing a minister “to require a person who may conduct activities in relation to controlled substances, precursors or designated devices to provide the Minister with information or to take certain measures in respect of such activities”; adding an administrative monetary penalties scheme; streamlining “the disposition of seized, found or otherwise acquired controlled substances”; modernizing inspection powers; and expanding and amending certain regulation-making authorities, including in respect of the collection, use, and disclosure of information.

All of these things are going to send a very strong message to the people making this, and it is going to stop a lot of it from coming in. These measures are a first line of defence. There is a broader problem to deal with, but this is low-hanging fruit that I do not think anyone in this place is going to argue with.

On that note, I will quote one of my Liberal colleagues from Vancouver, the member for Vancouver Centre. She stated, “I feel it’s something we need to be doing something about faster than we are doing it”.

• (1655)

There are components in the bill that are strong, smart, and should be supported. However, there is another component in the bill that requires a lot more debate and that I do not think should be fast-tracked through the House.

My objection to the bill is its structure. There are elements that I think require unanimous consent. They just need to be passed through as quickly as possible. However, there are some components that require further debate and that many Canadians would be unhappy about should we just let them go through. They are, frankly, the consultation process and the requirement for review criteria for the opening of safe consumption sites.

I know that this is a very controversial debate. As to how long and under what circumstances a community should be consulted in terms of allowing a safe consumption site, we had a very rigorous debate about this in the last Parliament. It took a lot of time. We heard from a lot of witnesses at committee. That debate should happen again. However, I do not want to be sitting here looking at the mother of a dead kid saying that we are holding the bill up because we have a debate component here.

The government has made a mistake in pairing these two issues. I do not understand why they are put together in the same piece of legislation. I could speculate on motive, but I do not want to, because it does a disservice to the gravity of the situation or some of the other measures that just need to pass as quickly as possible.

This component needs more debate. I do not want to get into the form or substance or reason for that, because it could take hours, but the reality is that there are 25 different criteria currently for the consultation process, very specific criteria, for opening a safe consumption site. In this bill, they are reduced to five. These criteria are as follows:

- a) the impact of the site on crime rates;
- (b) the local conditions indicating a need for the site;
- (c) the regulatory structure in place to support the site;
- (d) the resources available to support the maintenance of the site; and

(e) expressions of community support or opposition.

Regardless of one's personal opinion on safe injection sites and whether or not they are beneficial, my issue is that the bill does not adequately define these characteristics or these criteria. They are very vague. In this debate, we need to have community buy-in and social licence. Reducing these criteria from something that is so specific to something that is so vague and not defined is worthy of a larger and longer debate, regardless of what our position is. We should be bringing in witnesses and taking the time at committee to define these things, but this is time we do not have, especially for the Border Services Agency having the power to open packages of less than 30 grams. Let us just get that done.

My objection to this is simply that I do not understand why these have been paired together. If we want to make the argument about safe consumption sites being part of the overall fentanyl crisis, fine, but those two things can be done in separate bills so that at least we can get a stopgap measure on some of these things. That is what really struck me first and foremost. That was my first concern when I looked through the bill.

To drive home the point about how critical it is for us to get some of these measures through the House as quickly as possible, I want to give members some statistics from Calgary. This happened on December 29, 2016. There was a bust in Calgary, and it was a record. There were 35,321 pills in a home in Calgary. That is a lot of deaths waiting to happen. When I read this, my first reaction was, “Oh my God, how is this possible? How can this happen? What can I do as a legislator to stop the production of this so that this is not happening?”

We should not be relying on our first responders to find this before it goes out into the marketplace. We should be doing everything possible to make it difficult for this stuff to be created in the first place.

• (1700)

When we think about the potency and potential street impact of that number of pills, it should actually humble and just shock every person in this place. What does this mean? What is the human component of that? It is 193 deaths in my province between January and September of last year.

I implore the government to look at the two components of this bill and structure it better so that we can stop kids from dying.

Mr. Raj Grewal (Brampton East, Lib.): Madam Speaker, I just have a question. Does the hon. member agree with the Supreme Court of Canada's 2011 ruling on *Insite*? In that ruling, the Supreme Court laid out five criteria for safe injection sites. I would like her comments on that, and specifically whether she agrees with the Supreme Court.

Hon. Michelle Rempel: Madam Speaker, in the last Parliament we had dozens of witnesses who came before committee who verified the need and the desire to have a more robust and clearly defined consultation process.

Government Orders

I reject the notion that the Supreme Court of Canada defines everything we do in this place. It is our responsibility as legislators to come up with the best possible legislation, and I still argue that the health minister has not defined these criteria in here. Just because the Supreme Court says something does not mean that we have to abdicate our responsibility to come up with legislation that makes sense and is clear.

Again, my colleague here is missing the point. He is missing the entire point of my debate. This is a debate that requires more time. The whole consultation process around safe injection sites, social licence, whether it is effective, and all of those types of questions is a matter for committee study and for extreme examination. There are other elements in this bill that just need to happen right now. I do not understand why the government has paired these two together.

[Translation]

Ms. Karine Trudel (Jonquière, NDP): Madam Speaker, I thank my colleague for her speech and for helping us to get to know her riding, albeit as the result of unfortunate events, the loss of human lives.

I would also like to talk about my province, Quebec. I would specifically like to talk about the current situation in Montreal. On average, 70 people in that city die of drug overdoses every year. According to a report published in 2013 by the Institut national de santé publique du Québec, from 2005 to 2009, the number of fatal overdoses caused by medical opioids increased by 70% in the province.

I would like to know my colleague's opinion. Does she agree that Canada should revise its guidelines on prescribing and using opioids?

• (1705)

[English]

Hon. Michelle Rempel: Madam Speaker, I believe that there actually was a UN report that was published some time ago that shows that Canada is actually the highest user of opioids, be they prescription or street drugs, in the world. Certainly I agree, and I want to re-emphasize and not diminish the fact that this is probably one of the biggest crises facing Canada's health right now, and it is mushrooming.

We need to have a very comprehensive and robust debate about how we best address those issues: everything from some of the components in the bill here that talk about stopping the production and access to these drugs, to the best methodology for treatment, to the fact that treatment is not a one-size-fits-all issue. My colleague from South Surrey—White Rock made a very good case earlier today, talking about how we need to have treatment methods for people who are using it as part of an entrenched street issue, injecting it; for people who are using it recreationally and do not know what they are doing; and for people who are abusing prescriptions. If we talk to medical professionals, we will hear them say that different strategies are needed for different users. On top of all of that, we need to be talking about how we block access and prevent the production of these.

Certainly I would agree with my colleague, and there is more debate to be had. There is action that we need to take right now, for

which our first responders and our law enforcement officials are crying out. What I do not want to see is those components being delayed because there are other components that require a more fulsome debate.

Mr. John Oliver (Oakville, Lib.): Madam Speaker, I will be sharing my time with the member for Brampton East.

The emergence of fentanyl and its analogues, an opioid at least 100 times more potent than morphine, has given rise to a public health crisis in Canada that requires urgent action.

Bill C-37 proposes to amend the Controlled Drugs and Substances Act in a number of ways to address this crisis. In terms of harm reduction, it proposes to simplify the process of applying both for a supervised consumption site and for the exemptions that would allow certain activities to take place at a supervised site. I am pleased to see an evidence-based health-centric focus on harm reduction return to our health policy and legislation.

With regard to law enforcement and border security, among many changes, it would prohibit the importation of designated devices, unless they are registered with the Minister of Health. This would specifically prohibit unregistered importation of pill presses and encapsulators. It would expand the offence of possession, production, sale, or importation of anything with the knowledge that it will be used to produce or traffic in methamphetamines.

The bill would authorize the minister to temporarily add to a schedule substances that the minister has reasonable grounds to believe pose a significant risk to public health and safety. It would modernize inspection powers allowing border officers to open mail weighing 30 grams or less in order to stop drugs like fentanyl from entering Canada illegally through the mail system.

I would like to add my support for this bill and the proposed amendments to the CDSA. I would frame my support with particular reference to the recommendations from the December 2016 report by the House of Commons Standing Committee on Health, entitled "Report and Recommendations on the Opioid Crisis in Canada". I am pleased to be a member of the standing committee.

My following remarks draw heavily on this report and the excellent summation of the witnesses' testimony and the committee's deliberations, as provided by the committee's members and supporting staff. The members of the standing committee agreed to undertake an emergency study of the opioid crisis in Canada. During the course of its study, the committee held five meetings, where it heard from a range of stakeholders, including federal and provincial government representatives, health care professionals, addiction experts, emergency front-line responders, representatives of first nations communities, and individuals with lived experience in substance abuse and addiction.

These witnesses outlined specific ways to address the opioid crisis and implored the committee to make recommendations that would lead to concrete action. I cannot emphasize enough the powerful, emotional, and compelling testimony that we heard from all witnesses urging the government to take action on this crisis.

The committee heard from witnesses that this situation began reaching crisis proportions in July 2013, when fentanyl, a prescription opioid 100 times more potent than morphine, became increasingly available on the illicit drug market. The assistant commissioner for federal policing special services with the Royal Canadian Mounted Police advised the committee that, because of the high demand for this drug, organized crime groups began importing illegal fentanyl from China. These are then transformed into tablet forms in clandestine labs in Canada using pill presses and are disguised as legal prescriptions, such as OxyContin, or are used in powder form as cutting agents for other illicit drugs.

The unknown potency of illegal fentanyl and other synthetic opioids, coupled with the fact that users are often unaware that they are taking the drug, has resulted in a dramatic increase in drug deaths in Canada. British Columbia has become the epicentre of the crisis because of its maritime ports and relative proximity to China.

According to the chief coroner for British Columbia, the percentage of drug deaths involving fentanyl increased from 5% in 2012 to 60% in 2016, with the involvement of fentanyl doubling the rates of drug deaths in the province. According to the coroner, the province had experienced—and this at the date of the testimony—488 illicit drug deaths at the end of August 2016, or approximately 61 deaths a month.

In addition—and again, I am drawing from the text of the committee's report—the committee heard that the RCMP is collaborating with law enforcement agencies in China to combat international drug trafficking networks, as well as to gain support for regulatory control of fentanyl analogues to prevent their distribution in Canada.

In terms of federal efforts at the border, the committee heard that Canada Border Services Agency is using innovative technologies and dogs to detect fentanyl at borders and maritime ports, resulting in more than 115 seizures since 2010.

• (1710)

However, the vice-president of the operations branch of the CBSA explained to the committee that the agency faces challenges detecting and intercepting fentanyl sent through the postal system. Fentanyl powder and equivalent substances are most often smuggled into Canada through the postal stream. Due to the increased volume of packages sent through postal and courier services, it can be a challenge for the CBSA to identify and intercept all shipments of concern. Postal and courier shipments are often accompanied by false declarations or are intentionally mislabelled. The RCMP further elaborated that these shipments are disguised or labelled in a variety of ways, such as printer ink, toys, and DVDs. To address this issue, Canada Border Services was reviewing the Customs Act to see if it could remove the restrictions on the agency's ability to open packages weighing less than 30 grams.

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With respect to harm reduction strategies, the committee heard that supervised consumption sites are an evidence-based harm reduction measure. A number of witnesses expressed the opinion that changes to the CDSA, introduced in 2015, through Bill C-2, were a barrier to establishing new supervised consumption sites across the country and should be repealed or significantly amended.

After much deliberation, the committee made a number of recommendations.

Specific to harm reduction measures is recommendation number eight: "That the Government of Canada repeal or significantly amend the Controlled Drugs and Substances Act where it creates barriers to communities in establishing supervised consumption sites...". Bill C-37 addresses this recommendation specifically.

Specific to law enforcement and border security, the committee made the following recommendations:

Recommendation 33 says:

That the Government of Canada take measures to grant authority and lawful privilege to Canada Border Services Agency officials to search and/or test suspect packages that weigh under 30 grams.

Recommendation 34 says:

That the Government of Canada develop a federal enforcement and interdiction strategy around the importation of illicit opioids.

Recommendation 35 says:

That the Government of Canada adopt measures to regulate commercial pill presses to limit their possession to pharmacists and others who hold an appropriate licence.

Recommendation 36 says:

That stronger criminal penalties for having a production machine be established.

Finally, recommendation 37 says:

That the Government of Canada provide more resources for drug testing packages and other shipments.

I am pleased to see that Bill C-37 addresses these recommendations and is consistent with the cited findings of the committee.

Looking beyond Bill C-37 and the amendments to the Controlled Drugs and Substances Act, the committee heard that this crisis should be considered a public health crisis, and the committee produced many other recommendations related to harm reduction, addictions prevention including prescribing practices and public education, addictions treatment, the need for mental health supports, and issues unique to first nations.

The Minister of Health has already responded to this crisis through a five-point action plan that includes better informing Canadians about the risks of opioids, supporting better prescribing practices, reducing easy access to unnecessary opioids, supporting better treatment options for patients, improving the evidence base and improving data collection, and also by making naloxone available as an emergency treatment.

Progressive action was also initiated by the minister through a pan-Canadian opioid summit held in November 2016.

Further, the minister has responded to every request that the provinces have raised with the government, and she continues to work with the provinces.

Government Orders

Finally, while this public health crisis must be addressed through the measures proposed in Bill C-37, and while as Canadians we battle the addictions brought on by opioid usage, it is important to remember that some Canadians, like Christina in my riding of Oakville, suffer from unrelenting and incurable pain. My thoughts are with her today. We must always ensure that their needs are addressed and that appropriate pharmaceutical care remains available to them.

I want the residents of my riding of Oakville to be protected from the opioid crisis and illicit fentanyl distribution. I will be supporting Bill C-37, and I encourage all members of the House to support this bill and to work to address this terrible public health crisis. Let us get this bill through the House and the other place as quickly as we can to help these Canadians.

• (1715)

Mr. Colin Carrie (Oshawa, CPC): Madam Speaker, my colleague and I serve together on the health committee. I would like to thank him for a lot of the good work that has been done.

As my colleague from Calgary said, we are all in agreement with much of what Bill C-37 contains, but one of the things we are not in agreement with is the Liberals' idea of a consultation process. During the election campaign, they said they would consult with Canadians. We saw them do that with their policy on pipelines, but here, on something to do with public health, the bill basically guts the consultation process.

From the testimony we heard in committee, my colleague knows it is essential that there be community buy-in for these injection sites or consumption sites to be successful. Everybody wants anything to do with addicts to be successful in its implementation.

If an injection site goes into a community, it is going to be the local community that will have to pay for police enforcement. The province has to put out money for these things.

Ottawa, for example, has a Liberal mayor who is on the record as saying he is opposed to having an injection site in this community. The chief of police and the former chief of police have also stated that they are not in favour of this type of intervention in this community. Because the Liberals have cut the consultation process on this issue, does my colleague think that if the mayor, the chief of police, and stakeholders who are going to be responsible for enforcement and payment, are not onside with it, the minister should still put an injection site in Ottawa?

Mr. John Oliver: Madam Speaker, it is a pleasure to serve with the member on the health committee. We have worked together to make some really good recommendations and directions in our report.

With respect to supervised consumption sites and harm reduction, we heard from many witnesses how important these sites are as part of early treatment and early intervention and better management for people who are consuming.

We also heard from witnesses that the previous government's Respect for Communities Act, Bill C-2, introduced such stringent rules and 26 application criteria that we have not been able to open a new safe consumption site across Canada since Bill C-2 was

introduced. The Supreme Court has ruled on this and Bill C-37 would simply enshrine the court's ruling.

I would note that one of the five criteria is support and expressions of community support for the centre. I do believe there is appropriate response to community concerns and that part of the process of approval deals specifically with hearing from and looking for communities' expressions of support or their expressions of opposition.

• (1720)

Mr. Don Davies (Vancouver Kingsway, NDP): Madam Speaker, I would also like to express my appreciation to the hon. member for his contributions on the health committee. It is truly a pleasure working with him and note his leadership not only on the opioid file but on other issues that have come before our committee.

I do want to take issue with one fact that he represented in his speech, which is that the Minister of Health is doing everything possible under the circumstances. He specifically mentioned that the federal Minister of Health has implemented every single request that has been made by a provincial minister of health, but that is demonstrably not true. The provinces and cities have requested a number of things from the federal government, including improved treatment options, setting up a national command centre, requesting daily Health Canada briefings, and declaring a national public welfare emergency. The minister of health from my province of British Columbia specifically asked for that declaration. We know that the federal health minister has thus far rejected that request, so she is not doing everything that could be done.

Does my hon. colleague know how many of the 38 recommendations from the health committee, which he sat on, including the very first one which was to declare a public health emergency, the government has implemented to date?

Mr. John Oliver: Madam Speaker, likewise, it is an honour to serve with the hon. member on the health committee. I do find that we work together quite collaboratively on these issues.

It is really important that we remember in the House as we are debating Bill C-37 that there are federal and provincial jurisdictions at work here. Many of the situations and cases that the hon. member mentioned are really provincial authority. We are in the middle of a health accord negotiation. There is \$6 billion available for mental health and addictions for provinces from the federal government which would go a long way toward implementing the treatment programs and services that some of these people need.

The Assistant Deputy Speaker (Mrs. Carol Hughes): Before I recognize the next member on debate, I just want to advise him that unfortunately, I will have to cut the debate off, but he will be able to continue the next time the bill is before the House.

Resuming debate. The hon. member for Brampton East.

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Mr. Raj Grewal (Brampton East, Lib.): Madam Speaker, before I present my thoughts on Bill C-37, I do want to say that I come from Brampton East, which has the second most diverse population in the entire country. We have five Sikh gurdwaras, four Hindu temples, four mosques, two churches, and we all live in great harmony. The events that happened in Quebec affected all of us across this country. A place of worship where people go to pray is no place for violence. We stand with our Muslim brothers and sisters and we pray for all of them that we recover united as Canadians.

I am pleased to rise today to speak to Bill C-37, an act to amend the Controlled Drugs and Substances Act and to make related amendments to other acts.

The bill proposes important legislative changes that would help to support the new recently announced Canadian drugs and substances strategy, a comprehensive, collaborative, and compassionate strategy made up of the four key pillars of prevention, treatment, harm reduction, and enforcement, all of which are built on a strong foundation of evidence.

We are in the midst of a national public health crisis in Canada. In 2016, thousands of Canadians tragically died of accidental opioid overdoses, and more will die this year. Just last year in British Columbia alone, more than 900 people died from drug overdoses. That is an 80% increase from 2015. This is proof that the situation is getting worse. Deaths from overdoses will now be greater than deaths by car accidents. This tragic crisis continues to move eastward in Canada, with increasing drug seizures of fentanyl across our country.

As every member in this House knows, problematic substance use and addiction are serious public health issues. It seems that not a day goes by without seeing a story published in a Canadian newspaper about yet another overdose, another life lost, or another new dangerous drug on the streets. At the heart of these stories are everyday Canadians, their families, our communities.

Our government has taken action from day one. We are building on our five-point action plan to address opioid misuse. We have taken concrete steps, such as granting section 56 exemptions for the Dr. Peter Centre and extending the exemption for Insite for an additional four years. We made the overdose antidote more widely available in Canada. Last autumn, the Minister of Health co-hosted a conference and summit on opioids which resulted in 42 organizations bringing forward concrete proposals of their own. However, we must continue to respond to this tragedy in a way that is comprehensive, collaborative, and compassionate.

Bill C-37 would provide the government and law enforcement with the tools needed to support Canadian communities in addressing problematic substance use, including the opioid crisis.

With the dramatic increase in overdose deaths due to opioids occurring in Canada right now, it is crucial that the bill be passed swiftly.

Bill C-37 would demonstrate true support for communities grappling with the crisis by, among other things, removing unnecessary barriers to establishing supervised consumption sites. These barriers were put in place by the previous government in 2015.

When Bill C-37 passes, it will streamline the application process for supervised consumption sites by replacing the current 26 criteria set out in the Controlled Drugs and Substances Act to establish such a site with the requirement to submit evidence related to the five factors set out by the Supreme Court of Canada in its 2011 decision regarding Insite. These factors include: impact on crime rates; location conditions indicating need; a regulatory structure in place to support the facility; resources available to support its maintenance; and expressions of community support or opposition.

By reducing the number of criteria, the administrative burden on communities seeking to establish a supervised consumption site would be lessened. However, the health and safety of those operating these sites, their clients, and the surrounding community would not be compromised.

• (1725)

I want to take a moment to address the misunderstanding about these proposed amendments.

Some members of this House have contended that the views of a community would no longer be important in the assessment of an application to establish a supervised consumption site. Nothing could be further from the truth. The Supreme Court of Canada determined that the Minister of Health must consider expressions of community support or opposition when reviewing such applications.

Our government is respecting the Supreme Court of Canada's decision by proposing to include these factors in the legislation. The Government of Canada supports the need for community consultation in the application process for considering the establishment of supervised consumption sites. We understand and respect that communities may have valid concerns about a proposed site and that these concerns deserve to be heard and should be adequately addressed by applicants in their applications.

The proposed amendments would demonstrate that respect for communities is a multi-faceted issue. Yes, it means that the concerns of the community must be considered and addressed by the applicants; however, it also means that the federal government should not place any unnecessary barriers in the way of communities that want to establish a supervised consumption site as part of their local drug strategies.

Under Bill C-37, communities can be assured that their voices will be heard and that each application will be subject to a comprehensive review, yet it would do so without inevitably stalling the implementation of these life-saving programs in communities where they are wanted and needed. Just like any other regulated program, our government has a responsibility to the public.

• (1730)

The Assistant Deputy Speaker (Mrs. Carol Hughes): The member will have two and a half minutes to finish his speech and five minutes for questions and comments the next time this bill is before the House.

It being 5:30 p.m., the House will now proceed to the consideration of Private Members' Business as listed on today's Order Paper.

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Wednesday, February 15, 2017

—

Speaker: The Honourable Geoff Regan

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[Translation]

I would like to thank the hon. members for Carleton and for Calgary Shepard for having raised these matters, as well as the Parliamentary Secretary to the Leader of the Government in the House of Commons for his comments.

[English]

In his arguments, the member for Carleton indicated that, although the minister did provide a response to his written question, he was dissatisfied with the response which, in his opinion, lacked the specific information he had requested.

He later argued that he discovered that the government had concealed information in the answer it had provided to his written question. The member even suggested: “that this matter may rise to the seriousness of contempt.” Finally, he contended that, as Speaker, I had an obligation to compel the government to provide this information.

As for the member for Calgary Shepard, he explained that, although the government did answer three sections of his written Question No. 510, he did not receive an answer to the other parts. Although satisfied with the answers that he did receive, he explained: “I am not asking you, Mr. Speaker, to review the quality or accuracy of the response. I am asking you to address the lack of a response.”

[Translation]

For his part, the Parliamentary Secretary to the Leader of the Government in the House of Commons contended, on February 7, 2017, that it was not the role of the Speaker to judge the content or quality of answers to written questions.

[English]

Written questions are a mechanism by which members of Parliament can obtain information from the government and hold it to account. The member for Carleton was correct in his assertion that, “It is a basic right of members of Parliament to ask these questions on behalf of Canadians.”

By raising their dissatisfaction with the responses to their written questions, both members are in effect asking the Chair to assess the quality and completeness of answers provided to written questions.

● (1525)

[Translation]

Members are fully aware that it is not the first time such issues have been raised in the House and members will note that the Chair has been consistent in its response to these concerns. My predecessor, on May 26, 2015, in ruling on a similar matter, stated on page 14137 of the *Debates*, and I quote:

Invariably, when members deem that the content or quality of responses to written questions falls short, the Chair is asked to adjudicate. In each instance, the Chair has sought to remind members of the clear and long-standing limitations of the role of the Speaker in this regard.

These limitations are made clear on page 522 of *House of Commons Procedure and Practice*, Second Edition, which I cited on September 27, 2016, at page 5175 of *Debates*, in a ruling concerning a similar question. To quote it again:

There are no provisions in the rules for the Speaker to review government responses to questions.

On February 8, 2005, Speaker Milliken confirmed this, at page 3234 of *Debates*, stating, and I quote:

[English]

Any dispute regarding the accuracy or appropriateness of this response is a matter of debate. It is not something upon which the Speaker is permitted to pass judgment.

This is much like the quality of questions and answers during question period.

[Translation]

My predecessor, on April 3, 2012, in ruling on a similar matter, further stated that it is not the Speaker's role to determine if the contents of documents tabled in the House are complete.

[English]

Members place great importance on their right to hold the government to account, either by asking oral or written questions. It is a right that is legitimized by parliamentary procedure and the role of the Speaker in those instances is to make sure the rules have been followed.

In the cases before us, both the member for Carleton and the member for Calgary Shepard put their respective written questions on notice, pursuant to Standing Order 39, and pursuant to Standing Order 39(7), their questions were each made an order for return and the answer was tabled.

In view of the precedents available to me, the Chair is bound to conclude that the government has complied with the requirements of the Standing Orders. The Chair is not empowered to rule on the quality or completeness of the answers. I therefore cannot find that there has been any breach of the rules and practices of the House in these cases.

I thank hon. members for their attention.

GOVERNMENT ORDERS

[English]

CONTROLLED DRUGS AND SUBSTANCES ACT

Hon. Jane Philpott (Minister of Health, Lib.) moved that Bill C-37, an act to amend the Controlled Drugs and Substances Act and to make related amendments to other acts, be read the third time and passed.

She said: Mr. Speaker, it gives me great pleasure to rise on the third reading of Bill C-37. I am particularly gratified at the speed with which the bill has moved through the House of Commons. I want to thank all members, including all parties, who have been very helpful in agreeing to time allocation, agreeing to expediting the committee process, and the fantastic work at the committee level to move the bill along. This demonstrates the serious nature of the bill, and recognizes the ongoing opioid crisis and the need for urgent action.

Bill C-37 is one of a range of comprehensive responses to this very challenging issue. We are eager to advance the bill through Parliament to help protect the health and safety of Canadians and their communities.

It has been said before in the House that problematic substance use is an issue that affects Canadians of all ages. It affects people from all socio-economic groups. We should also point out that there are, however, particular groups that are excessively vulnerable to the risks associated with problematic substance use, people living in poverty, people who have experienced trauma in their lives, and indigenous peoples of Canada.

We are facing nothing short of the greatest drug crisis our country has faced. It is a national public health crisis related to opioids. For example, one may draw attention to the fact that in British Columbia last year more than 900 people died from overdoses. That was an 80% increase over 2015. The majority of those deaths were related to the rapid spread of the drug fentanyl.

Elsewhere in Canada, we are hearing from law enforcement officials that there are increasing numbers of seizures of fentanyl and carfentanil.

Last week, we heard about the distressing number of deaths linked to opioids in Alberta. For example, in 2016, 343 people died in Alberta from fentanyl overdoses. That was an increase over 257 the previous year.

It is necessary that the Government of Canada use every single tool at our disposal to help turn the tide on this crisis. We need a policy approach that is comprehensive, collaborative, compassionate, and evidence-based.

Bill C-37 would further strengthen our government's response to the opioid crisis.

Lest there be any doubt that we are pulling out all the stops to respond to this crisis, let me review what we have done over the past year. It includes things like ensuring naloxone, which is the antidote to overdose, is available on a non-prescription basis across the country. That involved me ensuring that we had naloxone nasal spray available on an emergency order so it would be available to Canadians, and expediting the approval of naloxone nasal spray.

We also launched Health Canada's opioid action plan. This is a plan to improve access to education for both the public, as well as prescribers, to ensure that we support better treatment options, that we reduce access to unnecessary opioids, and that we expand the evidence base.

In the matter of expanding the evidence base and getting better data, we supported McMaster University to produce guidelines for prescribing opioids in situations of chronic pain. Those new guidelines are now available for consultation.

We overturned a ban on prescription heroin so doctors might use it through Health Canada's special access programs to treat the most severe cases of addiction.

We have supported the good Samaritan drug overdose act, which offers immunity against charges for simple possession for individuals

so they will call 911 if they witness an overdose and they will stay at the scene to help.

We have also put in place a number of regulations to schedule fentanyl precursors for controlled substances, making it harder for illicit substances to be manufactured in Canada.

I co-hosted, along with the minister of health for Ontario, the opioid conference and summit. At that summit, we had nine provincial and territorial health ministers. We also had 30 other organizations. We produced a joint statement of action that had 128 commitments.

In addition, in collaboration with the provinces and territories, we have put together a special advisory committee that includes the Council of Chief Medical Officers of Health. This committee is very active at ensuring we have better access to data that is up to date about the state of the circumstances.

We also have a task force within the federal health portfolio to work with all federal departments in a comprehensive response to the crisis.

We funded the Canadian research initiative on substance misuse. It is providing now evidence-based guidelines for medication-assisted treatment.

• (1530)

In December, I joined the Minister of Public Safety and Emergency Preparedness in introducing Canada's new drugs and substances strategy. We reintroduced at that time harm reduction as a key pillar in drug policy.

I would like to talk now a bit about what we have done to support the establishment of supervised consumption sites. Early on, we granted an exemption to the Dr. Peter Centre in Vancouver to operate a facility, and we provided an unprecedented four year exemption to Insite to continue the good work it was doing.

For communities that have demonstrated a need and desire to have such a site in their community, we want to create an environment that will encourage applicants to come forward. That is why, pending passage of the bill, we have adjusted operational procedures in the interests of removing unnecessary barriers to the review and approval of supervised consumption sites.

Just last week, I was very pleased that we were able to issue exemptions for three new supervised consumption sites at fixed locations in Montreal. The time frame to approve these sites was unacceptable. It took a year and a half, and that was due to the onerous 26 criteria that existed under the previous legislation. However, finally we were able to get an exemption for them. These new sites, located in Hochelaga, Maisonneuve and Ville-Marie districts and operated by the Centre intégré universitaire de santé et de services sociaux du Centre-Sud-de-l'Île-de-Montréal, will be able to provide care for people in those areas.

Health Canada has expedited a review of 10 pending requests for approval in other communities. There is an additional site in Montreal, three sites in Toronto, two in Vancouver, two in Surrey, one in Ottawa and one in Victoria.

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Even while doing this, we have maintained the key essential criteria to ensure we protect the health and safety of staff, people who use drugs, and the neighbours who are in the areas of the proposed sites. We are working with all applicants to ensure that those applications are complete and that the department has received the necessary information.

Passing Bill C-37 will be so helpful to streamline the application process and it will be a big step forward for these communities.

Some have wondered why we have not declared a public health emergency. What I have said for months is that clearly we are in the midst of a national public health crisis of unprecedented proportions related to a growing number of opioid overdose deaths. However, the Federal Emergencies Act, which was formerly called the War Measures Act, is a tool of last resort. It is there to ensure public safety and security when a national emergency cannot be addressed by any other law. This act was not used in the case of SARS, H1N1 or Ebola. It is not the right instrument, but as I have already noted, we will make use of every tool at our disposal. We have already taken extraordinary steps at the federal level, and Bill C-37 is another essential step.

Bill C-37 needs to be passed without delay. This is not a political matter or an ideological matter; it is a matter of saving lives.

With the current growing rates of opioid overdoses and deaths, we have recognized there are gaps and weaknesses in the current federal legislative framework as it relates to controlled substances. To address those under Bill C-37, we will provide the government with the ability to more easily support the establishment of supervised consumption sites, a key measure in harm reduction.

We will also address the illegal supply, production and distribution of drugs. We will reduce the risk of diversion of controlled substances that are used for legitimate purposes to the illegal market by providing improved compliance and enforcement tools.

Bill C-37 would simplify and streamline the application process for communities that want and need supervised consumption sites. It would replace the 26 application criteria with the five factors that were identified by the Supreme Court in its 2011 decision regarding *Insite*.

It is important for all members to understand that Bill C-37 retains the need for community consultation, and it also adds increased transparency, making it a requirement for the Minister of Health to make public decisions on applications, including any reasons for denial.

To support these proposed changes, Health Canada will post information online about what is required in applications, how the process works, and the status of applications.

• (1535)

Supervised consumption sites are an essential part of a harm reduction measure. There is a vast abundance of international and Canadian evidence that shows that when they are properly established and maintained, they save lives and improve health without increasing drug use or crime in surrounding areas, they prevent infection, and, best of all, they provide a safe, non-

stigmatizing, non-judgmental way for people to be introduced to the health care system.

Harm reduction measures in Bill C-37 complement a number of other actions that the government is taking to protect community safety. For example, the RCMP is working with the Chinese ministry of public safety to combat the flow of illicit fentanyl and other opioids into Canada.

Bill C-37 is proposing to prohibit the unregistered importation of pill presses and encapsulators, which would make it more difficult to produce illicit drugs and, in turn, keep these illicitly produced opioids and other substances off our streets. Bill C-37 would also give border services officers greater flexibility to inspect suspicious incoming international mail. As has been said before, just a standardized envelope can contain enough fentanyl to cause thousands of overdoses.

Before I conclude, I want to say a few words about treatment. It is absolutely essential to understand that we will not turn this crisis around by harm reduction alone. People need to have access to the broadest range of treatment options. Delivery of health services, including the treatment of addictions, falls largely under provincial and territorial jurisdiction. That is why I am very pleased to say that this fiscal year the federal government is transferring \$36 billion to the provinces and territories to support the delivery of care. With the support of the Prime Minister, we identified new funding for the provinces and territories, in the order of \$5 billion for mental health over the next decade, which will help people facing mental illness, including addiction.

We need to address the social drivers of the opioid overdose crisis. That includes things like poverty, social isolation, unresolved trauma, sexual abuse, and mental illness. It is widely understood that untreated mental illness is a common cause of addiction and early intervention is absolutely essential if we are going to counter such addiction.

I want to emphasize in the House that we need to include all four pillars in our Canadian drugs policy: prevention, treatment, harm reduction, and law enforcement. Prevention is so essential, as we understand that issues like social equity are absolutely important, cultural continuity, people having the opportunity to have healthy and safe childhoods, and making sure people heal from any unresolved trauma and grief in their lives, which might drive them to problematic substance use.

There is no single action that, on its own, is going to end this opioid crisis immediately, but Bill C-37 is an absolutely essential step in the process of moving to that end. We need a balanced approach. We need to work collaboratively with all other levels of government and civil society organizations. All Canadians need to work together. We need to have partnerships across the country, including, as I said, with provinces, territories, and municipalities that are very much engaged on this matter and, of course, indigenous leaders. We need to protect Canadians, to save lives, to address the root causes of this crisis, to give people hope, and to make sure that all matters are addressed in order to turn the tide of the opioid overdose crisis.

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I encourage all hon. members to recognize the importance of this bill and to support its speedy passage through the House. I look forward to working with all members to that end.

• (1540)

Mr. Harold Albrecht (Kitchener—Conestoga, CPC): Madam Speaker, I want to thank my colleague, the Minister of Health, for her work on the health file. There is no question in my mind that she has the best interests of Canadians at heart. However, we may agree to disagree on a couple of facts.

First, we agree on this side of the House that the opioid crisis needs attention quickly and forcefully. There is no question about that. The other part of Bill C-37 refers to supervised injection sites. I think we would find on this side of the House, and, indeed, probably within each party, that there are differing opinions on that. In fact, some of the opinions are supported, clearly, by front-line police officers in terms of their safety and efficacy and public safety.

My question for the minister is this. Why did her party not allow the bill to be split into two component parts, which would have clearly allowed fulsome debate on both issues, and then, more importantly, why are Liberals shutting down debate and minimizing the amount of time that members of Parliament, who were elected to represent their communities here in the House, can debate this issue?

• (1545)

Hon. Jane Philpott: Madam Speaker, I wonder if the hon. member can understand the kind of pressure we receive when members of the communities are telling us every day that they are going out and literally seeing people dying in the streets. I recognize that the hon. member may struggle with the challenges associated with this, and there is always some anxiety related to how we best respond, but the evidence is clear. The hon. member should meet with the chief of police in Vancouver, and meet with the chief of police in Calgary, and talk to them. Although some leaders at first doubted whether supervised consumption sites would be helpful, they have become absolutely convinced that it is essential to save lives. It is reprehensible for us to not move forward on this. The lives of people are at stake.

Ms. Tracey Ramsey (Essex, NDP): Madam Speaker, the NDP will be supporting Bill C-37. It is so incredibly important to my riding of Essex. I am holding an opioid round table this Friday with stakeholders, and very concerned families who are desperate for help for their family members, and for those in their community who are suffering under this crisis.

As a member of a committee of this House, it is incredibly important that we honour the work that is done at committee. Therefore, my question to the minister revolves around the health committee and the emergency study that it conducted into the opioid crisis. The very first recommendation that was made with all-party support was to declare opioid overdoses a national public health emergency. This would give the public health officer of Canada extraordinary powers to act immediately while Bill C-37 works its way through Parliament.

My question to the minister is this. In the face of this mounting death toll across our country, will the minister stand today and declare a national public health emergency so we can start saving lives in Canada?

Hon. Jane Philpott: Madam Speaker, I want to thank the hon. member for her work, and the members of the NDP for their support in passing this bill in a rapid way.

With respect to the recommendations of the health committee, it has made an excellent series of recommendations, and has done fantastic work. I would encourage the member to read the Emergencies Act to make sure that it is well understood, and to realize that this particular circumstance does not require the invoking of the Emergencies Act. If the member can tell me a single thing that we could do by invoking that act that we cannot already do, I would be happy to hear it. I have told this House repeatedly that I will pull out every stop and will take every action that is necessary. However, there is nothing that act would allow that we cannot already do. We have the authority to do what needs to be done. I want to encourage provinces, territories, municipal leaders, and health care providers to also do their part. We cannot solve this alone. We will do everything within our power to make sure that it is turned around.

Mr. Bill Casey (Cumberland—Colchester, Lib.): Madam Speaker, I am pleased to rise on this bill because I was a member of the health committee that studied it. We heard from doctors, nurses, scientists, and police, but the most compelling testimony was from paramedics. I want to mention the paramedics from Vancouver especially, because they deal with this issue day in, day out, all day long. I do not know how they can do it repeatedly. They told stories about finding young people unconscious in alleys with needles still in them, how they would bring them back to life, and then two days later they would get another call and come back to the same situation with the same person. It was an incredible story. What we are dealing with is an incredible emergency, and Bill C-37 is designed to deal with that emergency.

I want to ask the minister this. How can passing Bill C-37 help those paramedics especially, because I do not know how they can do it, day in, day out? It must have a tremendous effect on them and their families.

Hon. Jane Philpott: Madam Speaker, I want to thank the member for his excellent leadership role on the committee, which has done such outstanding work on this crisis. He draws attention to something that is very important, which is that we need to recognize the incredible work of first responders, in particular, paramedics. The pressure on these paramedics is remarkable, and I have heard similar stories.

Bill C-37 would allow the increasing availability of supervised consumption sites so that these paramedics would have somewhere to take people where they would be welcomed, where people would know that they can be introduced safely into the health care system, and where we can prevent death from overdose. They might have an opportunity as well to be introduced to treatment when they are ready for that. Therefore, we encourage the availability of these sites, and encourage all players to make sure that we increase access to treatment so that lives will be saved, so that people will find that there is a way to find hope for their future, and so that we can also make sure that first responders are respected and do not have to go through this terrible ongoing crisis.

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• (1550)

Mr. Garnett Genuis (Sherwood Park—Fort Saskatchewan, CPC): Madam Speaker, I wonder if the health minister can very clearly explain to us why the government did not accept our request for unanimous consent to split the bill. Had the government accepted that, four-fifths of the provision of this bill would already be in the Senate and perhaps would already be law. Why did the government not accept our offer to expedite those sections of the bill so that we could have gotten on with the parts we agree on faster without forestalling the debate on the one section on which we disagree? Why was the government not willing to work in that non-partisan way to actually get those key sections done?

Hon. Jane Philpott: Madam Speaker, I am very pleased that the Conservatives were able to vote in favour of the expedited process in the committee that agreed to move on this. It speaks to the fact that some of their members recognized that this is an urgent matter. When we look at the data from British Columbia, we see there are four, five, six people dying every single day. This is absolutely unacceptable, that we would stand by and continue to debate a matter when we have a bill that could help communities like not only Vancouver but Edmonton, Calgary, and Toronto to be able to have the facilities available. I would be happy to speak with members about any additional ideas they have, but we have to get this bill through.

Ms. Sheila Malcolmson (Nanaimo—Ladysmith, NDP): Madam Speaker, as members know, New Democrats support the bill. I spoke at length yesterday about the impact that it would have to support front-line RCMP, ambulance attendants, firefighters, and community volunteers who are doing their best to fight this huge epidemic. My community of Nanaimo has been hit very hard.

I would love, though, to hear more about the minister's reasons for not calling a national health emergency. I note that Dr. David Juurlink, the keynote speaker at the minister's own opioid summit; B.C. health minister Terry Lake; and stakeholders across Canada are all still calling for a declaration of a national emergency by the federal government. It is my understanding that this would facilitate more federal funding, community-based detox, addictions treatment, and emergency pop-up safe injection sites and safe consumption sites on an emergency basis.

Hon. Jane Philpott: Madam Speaker, I would encourage the member to speak to Dr. Juurlink, who now understands the reasons why it is not appropriate to declare a national health emergency, but there are many features that the member asked for that we are already doing. If she wants more funding, I encourage provinces across this country to accept the \$5 billion that we have offered through the health accord, and to put that money to work to provide better access to mental health care and treatment.

We have offered mobile units. The Public Health Agency of Canada has said to many communities, including those in British Columbia, "Let us know when you need our emergency mobile units. We will get in there and set them up."

Let those communities know we are prepared to do everything that it takes.

Mr. Garnett Genuis (Sherwood Park—Fort Saskatchewan, CPC): Madam Speaker, it is a pleasure for me to rise and address Bill C-37, certainly a very important discussion as we confront what

is a national crisis around drug use. However, we have seen a funny pattern from government members, where they draw our attention to a significant problem yet actually refuse to collaborate in a non-partisan way to move these things forward. That is very clearly on the record. Members can laugh, but this is not a funny topic, and it is not funny that we tried to move this forward quickly and the Liberals got in the way.

Let us review the record of what happened. The bill contains certain provisions that are vital for addressing the challenges we face. It also, though, contains a provision that would remove effective community engagement on supervised injection sites. We have a big problem with that, and I will talk about why that is later on in my speech.

It is important for people to understand what the government has done here. Recognizing the need to move quickly on certain provisions but also the need to have thorough debate on this one particular provision on community consultation, our very hard-working member for Oshawa, our health critic, brought forward a request for unanimous consent to split the bill.

What he proposed was very reasonable, and it would have effectively addressed this issue. What he proposed was to split the bill into two sections. The sections on which we all agreed there be urgent action, and I will talk about what those are, he and all of us would agree to immediately deem adopted at third reading, fully adopted by the House, and sent to the Senate. Very likely the Senate would have moved quickly on that as well. Those provisions could already be law today and already addressing this problem right now as we speak. That was our proposal brought forward by the member for Oshawa.

However, the government said no. Why? It insisted that removing an effective voice for communities in the process had to be tied to these other important life-saving measures. It was the Liberals' decision to slow this down by refusing to split the bill. In fact, the offer we proposed in our unanimous consent motion was not just to expedite the provisions on which we agreed. It was also to immediately deem referred to the Standing Committee on Health the provisions on which we disagreed. We were even willing to move that immediately to committee for study while immediately adopting those things on which we agreed. This is how we proposed to work in a non-partisan fashion to move quickly on the things we could move quickly on to get this done.

The government, while pleading about the need and the urgency of this crisis, actually refused to give unanimous consent to our proposal to expedite those sections. Given the strong words coming from the health minister and other members of the government, it is utterly shameful that they refused to work to move this forward.

I would like to highlight the sections of the bill we agree on and the sections of the bill that could today already be law had the government been willing to work in a non-partisan manner. They will still become law eventually, but it is unfortunate that we were not able to move on the timeline we wanted.

The bill proposes to regulate the import of pill presses. Currently, pill presses, which are used for putting together illegal drugs, can be imported freely. The bill contains important provisions that would have any pill press imported registered with Health Canada and that would give our border services officials the authority to detain unregistered pill presses at the border. This is a very important measure that we have strongly supported. It could be law today if the government had been willing to work to expedite this in a non-partisan manner.

Another great provision in the bill would increase prohibitions against certain actions related to controlled substances. This would enhance the ability of the government to stop, in this instance, the transportation of illicit substances. It would enhance the power to do that under the relevant legislation. Again, it is a very positive provision. It would be making a difference if it were law today. It is something we could have moved forward on more quickly.

The bill would grant increased powers to the Canada Border Services Agency to open and inspect packages entering Canada, packages that it suspects may contain contraband such as drugs. Again, it is an important provision that CBSA be given the power to move forward and open packages that it believes contain illicit substances. Again, there is no reason anyone should oppose that. That is why it should have been done by now. It should have been passed quickly. It would have been passed quickly had the government agreed to work with the opposition and split the bill, as we proposed.

• (1555)

In terms of the category of things we agree on, the bill proposes temporarily accelerated scheduling, essentially allowing the Minister of Health to quickly, but temporarily, schedule and control new drugs and substances under the relevant legislation. This is important, because we have seen new drugs coming to the fore on a regular basis. These powers are important.

Four out of the five changes that we would say yes to on this side of the House could already have been law today had the government been willing to work with us.

Why was it so important for us to raise concerns and to insist on further debate on the one provision on which we disagree? The government is proposing to change the community consultation process on supervised injection sites. I have talked before about broader concerns about supervised injection sites. I know that there are many Canadians who do not believe we should have legal islands that allow people to use drugs legally. If we want to send the strongest possible message about the dangers of drug use, we may want to be optimistic in our compassion instead of pessimistic in our compassion. Many Canadians reflecting on that have broader concerns about these supervised injection sites.

Let us be very clear. That is not the question in this legislation. The question in this legislation is the degree to which, and the nature

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of how, communities should be engaged in the conversation about that.

The original provisions that were put in place under the previous government established some key requirements with respect to how communities had to be engaged. There had to be strong engagement with the community to maximize the chances that these types of facilities would be successful. The previous legislation put in place a reasonable process to get that done.

The government is proposing in this legislation to significantly pare down any kind of engagement. Previously, there was a requirement that the period of consultation be at least 90 days. The new provisions would allow a period of consultation of up to 90 days. There would actually be no minimum. They could spend two days undertaking the consultation. The requirements in the legislation they put forward are pared down. It says:

An application for an exemption under subsection (1) shall include information, submitted in the form and manner determined by the Minister, regarding the intended public health benefits of the site and information, if any, related to (a) the impact of the site on crime rates; (b) the local conditions indicating a need for the site; (c) the administrative structure in place to support the site; (d) the resources available to support the maintenance of the site; and (e) expressions of community support or opposition.

They have to provide some of that basic information.

They would satisfy the provisions of the new bill if applicants simply said that they talked to a few people in the community about opening a supervised injection site and no one liked it, but at least they talked to some people. That would be sufficient under the proposed legislation.

Let us talk about what the Liberals took out. We hear a lot from the government about the importance of scientific evidence. Actually, the existing application requirements we put in place require “scientific evidence demonstrating that there is a medical benefit to individual or public health associated with access to activities undertaken at supervised consumption sites”. Among other things, the previous legislation actually requires that scientific evidence be presented on what the impacts would be in the context of the application. That would be removed by these new requirements.

We put requirements in place for consultation with local law enforcement and local governments, which are going to be called upon to respond to the challenges and situations that are in place. Those were things that were in place before and would now be pulled back.

One of the defences we hear often from the government and the NDP about supervised injections sites is that there are actually some drug treatment services available at the sites. I know that still does not allay many people's concerns, but the consultation process that currently exists, that we put in place, requires that a description of drug treatment services available at the site be provided with the application. If people are going to apply to open a supervised injection site, they actually have to provide information to the government about the kind of drug treatment services that would be available.

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• (1600)

If that is one of the key arguments for allowing supervised injection sites, because it seems that it is, listening to the comments that have been made, then it should be particularly emphasized and required that the person who is applying to open a supervised injection site actually provide some information to the government about what is going to exist in that space vis-à-vis drug treatment. That should be there.

The existing legislation requires, for example, that we have criminal record checks for those who are going to be involved with these facilities. There are a lot of important requirements the existing legislation has in place, and these are basic things, like consultation and engagement with the community and providing information about what is going to be in place in terms of support for people who are trying to get off drugs.

All these things should be there, but we have this vastly pared down proposal in terms of what would actually be required for the application. It is going to be so much easier for people to apply to open these supervised injection sites, and there are no requirements to ensure that we will have the due diligence in place.

Again, members can debate the merits of supervised injection sites, but the existing legislation at least ensures that they are doing the kinds of things they are supposed to be doing. The new proposed legislation by the government completely turns the page on that by not engaging communities and not requiring the kind of due diligence we included in that application at all.

I will conclude by saying again that we had an opportunity to move forward with those provisions on which we all agree. Those could be law today, but instead, we are still debating the entire bill, because the government refused to split it. The Liberals brought in closure on these important community consultation measures.

I say that we move forward with the things that will save lives now, but let us continue an important conversation about whether communities should be engaged when these types of injection sites are opened.

I think it is important that communities be engaged in conversations. I believe that communities are compassionate and that they care about these issues. It is not only the federal government that cares. If we engage communities, if we engage local law enforcement, we will get better solutions that will be more responsive to the needs of the community and will be more likely to solve this problem.

The government needs to know that it cannot fix this problem on its own. It needs to work with the opposition. It needs to work with other levels of government. It needs to work with communities. If we are going to address this problem, we need more voices at the table and more collaboration. That is what we are standing for in the opposition, and that is why, in its current form, I have to oppose the bill.

• (1605)

Mr. Joël Lightbound (Parliamentary Secretary to the Minister of Health, Lib.): Madam Speaker, the section the member's party is suggesting be separated from the bill is the section that would

change the 26 criteria the previous government put in place to five criteria, which would streamline the application for safe consumption sites in communities where they are needed and where they are appropriate.

Under the current criteria of the previous government, three sites were approved in Montreal. Does the member know how long it took for these three sites to be approved? It took 22 months, nearly two years.

Does the member think it is reasonable, when we know that there are people dying in various cities across Canada, in record numbers, to wait such a long period of time before we approve these sites? These are sites that are asked for by local health professionals, by communities, and by provincial governments.

Does he think it is reasonable, when we have people dying in record numbers, to wait such a long period of time? Does he not think instead that we are better off moving to what the Supreme Court of Canada has stated should be the five guiding principles when we approve these safe consumption sites?

Mr. Garnett Genuis: Madam Speaker, Winston Churchill said that it is not enough to do your best. One has to know what to do and then do one's best.

This is why having a proper review process in place is important. It is not enough to say that we just have to do something, without actually having the proper due diligence in each case to make sure that we are doing the right thing and that it is going to have the greatest impact and save the greatest number of lives.

If we are concerned about scientific evidence, the government should have left the criterion in that required the presentation of scientific evidence as part of the application. If the Liberals are concerned about people getting off drugs, they should have left the criterion in that requires the government to receive information about what is going to exist at a facility in terms of drug treatment.

Of course we have to respond to this crisis, but we have to do it in the right way. If we remove the due diligence that is involved in setting up these facilities, there is no guarantee at all that we will save more lives. In fact, we may well put more lives at risk. This is why we have to get it right. This is why we should expedite the sections on which we can agree, but we need to have full debate. I think we need to reinsert some of these criteria back in to ensure that these things are being done in an appropriate and effective way that maximizes the chances that we can give people the best hope we can.

Ms. Sheila Malcolmson (Nanaimo—Ladysmith, NDP): Madam Speaker, it is a little hard to listen to the member in this debate. I am part of a community that has been very hard hit by the opioid overdose crisis. I have observed the operation of the supervised injection site, Insite, in Vancouver, and the Conservatives thwarted every effort to open additional health-based life-saving supervised injection sites for the 10 years that they were in power. It is a little hard to listen to the words of my colleague.

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Only an hour after the Conservatives introduced Bill C-2, the Conservatives were fundraising, stating that Liberals and New Democrats wanted addicts to inject heroin in people's backyards. It is no wonder we ended up with communities being concerned about the impact of actually delivering a health care service to people who are addicted and whose lives are now in peril because of the fentanyl crisis that no one has been able to get ahead of.

I would like to hear the member's thoughts on that. Even though he was not in Parliament last time around, I would also like his thoughts about his own party having cut addictions treatment funding by 15% while the Harper Conservatives were in power.

•(1610)

Mr. Garnett Genuis: Madam Speaker, obviously we have wider philosophical disagreements about whether somebody using dangerous hard drugs really should be considered in the same category as other health care services. We can have a longer discussion about supervised injection sites specifically. Again, my view is, and I do not have a problem saying it, that we should be focusing our efforts and resources on things to get people off of drugs, such as rehab, more investments in chemical detox, and these kinds of things.

I am very supportive of those kinds of investments. Of course, generally speaking, more of that activity happens at the provincial level, but there is a role for the federal government as well. I see the importance of that and I am happy to advocate for it. I do think, though, it does not follow that if we believe action is needed, we need to take power away from local communities in terms of determining the process of that action.

Communities, families, local governments, and provincial governments are compassionate and seized with this problem, so taking authority away from them to be engaged with their communities is not an effective way to address this crisis. We should, in fact, be doing more to mobilize the knowledge and experience of communities and families in terms of building the kinds of strategies that are going to address specific issues in specific areas.

The response that makes sense in one community may not be the same as the response that makes sense in another community. When an external group makes an application, and all it has to do is provide some general information to the government about whether the community was supportive or opposed with no timeline prescribed, I do not think that is an effective way to engage the community to actually respond to the problem.

Mr. Kevin Lamoureux (Parliamentary Secretary to the Leader of the Government in the House of Commons, Lib.): Madam Speaker, I would ask my colleague first and foremost to recognize this issue as the national crisis it is. The Minister of Health and the government have taken a very aggressive and proactive approach to try to deal with this in a number of ways. A big part of it is working with others. Whether it is provincial or municipal jurisdictions, first responders, just name it, all of the stakeholders need to come together to try to resolve a very serious problem, a crisis, as the Minister of Health herself indicated.

There has been an immense amount of co-operation from the New Democratic Party on this issue. The issue that the Conservatives seem to be stuck on is the supervised safe injection sites. That was

part of the legislation, which many of the stakeholders are very anxious to see.

Does the member not recognize that this is, in good part, a holistic approach? It is not just the legislation, even though the legislation is absolutely critical, and that is the reason we are trying to advance this issue. The member desires further debate, but the issue was well debated in Parliament under Prime Minister Harper. The former questioner pointed out that the Harper regime had a fundraising scheme based on a theory that the Conservative Party is still advocating today. We disagree with that theory.

Mr. Garnett Genuis: Madam Speaker, there are some specific questions that the parliamentary secretary and the government need to answer about why the government refused to split the bill to actually allow it to move forward if the Liberals are so concerned about this crisis, because we all should be concerned about this crisis. At the end of the day, it does seem to be the case, with the NDP co-operating with the government, that we are the only party in this House that is standing up firmly for the role of local communities to be involved in these decisions. If we are the only party that has to stand up for that principle, so be it, because I am so convinced that we are right and that Canadians are on our side on that point.

Communities are compassionate. Local governments are compassionate. Local families are compassionate. We need to engage them in a conversation, in a meaningful consultation that gives them time to present ideas, looking at local evidence, and looking at the scientific evidence about the impact. What is wrong with engaging communities and looking at that local evidence? If we are the only party that stands up for it, so be it. If people donate to the Conservative Party, as is being criticized by others, because of our commitment to engaging communities in the process, well people donate to political parties for all kinds of different reasons and we are certainly going to stand up for our principles, whatever the consequences of that are.

•(1615)

Mr. Don Davies (Vancouver Kingsway, NDP): Madam Speaker, I have to point out something that is just demonstrably false from the Conservative Party. It is right in the legislation before us, if my hon. colleague cared to read it. The bill would specifically require an applicant to furnish evidence of the local conditions giving rise to the site, the potential health benefits, and more important, expressions of public support or opposition. When the member tells this House and Canadians that the community's wishes are not part of this legislation, he is simply wrong.

I wonder if he could comment on that. Has he read the legislation?

Mr. Garnett Genuis: Madam Speaker, if the member had listened to my speech, he would know that not only have I read the legislation, but I actually have read into the record the specific section that he refers to.

Government Orders

Here is the point, and the member would know it if he had been listening to my remarks. It is that the previous section requires scientific evidence demonstrating what the impacts would be in the community. It requires engagement with law enforcement. It requires specific engagement and support of local governments. Just asking the applicant to make some statement of expression of community support or opposition is not sufficient. It would not actually mean that the community would have had more time or ability to rule on the decision.

Mr. Don Davies (Vancouver Kingsway, NDP): Madam Speaker, for any Canadians who are watching, I am glad that they can see that the Liberal Party, the New Democratic Party, the Green Party, and I am not sure about the Bloc, are willing and ready to move quickly on this legislation and not sit here and debate and slow down legislation when Canadians are dying every day.

It has been well established that Canada is currently in the grips of an unprecedented national public health emergency. I am glad to hear both my Liberal and Conservative colleagues increasingly using that term to describe the opioid crisis. The New Democratic Party started using the term back in November, and that is because this is a national public health emergency and our fellow Canadians are suffering and dying every single day.

Fifty Canadians are dying every week from opioid overdoses in this country. That is a national crisis. It also bears repeating that this crisis has become dramatically worse in recent months.

In 2016, in my home province of British Columbia alone, there were 914 drug overdose deaths. That is an 80% increase from the year before. In December, just a couple of months ago, we recorded the highest number of overdose deaths in B.C.'s history with 142 lives lost. That is more than double the monthly average of overdose deaths since 2015 and a sharp increase over September, October, and November. There were 57 overdose deaths in B.C. in September, 67 in October, 128 in November, and 142 in December. I can only guess that the number will be even higher for January. While the Conservatives want us to debate and consult, New Democrats want to act and save lives.

In December, the B.C. Coroners Service announced that morgues in the city of Vancouver were frequently full as a result of the unprecedented number of overdose deaths, forcing health authorities to store bodies at funeral homes.

This crisis is in large part the legacy of Canada's now defunct anti-drug strategy. Decades of a misguided criminal approach to drug policy has proven to be counterproductive, fuelling Canada's unregulated illegal drug market and leaving a scarcity of evidence-based health services, including harm reduction and treatment programs for people suffering from substance use disorder.

The Conservatives cut 15% from the addiction service budget in their last year in office. International research demonstrates that the criminalization of drugs increases rates of drug production, consumption, availability, and adverse drug-related health effects, but that is the evidence, and for the last 10 years our drug policy in this country was not based on evidence. It was based on ideology.

Because this crisis has been years in the making, it will not be solved by any one action or piece of legislation. I think we all know

that. The passage of Bill C-37 must be the beginning of a much deeper examination of how we understand and respond to drug use and addiction in Canada.

For many years, New Democrats have been advocating for an evidence-based and health-focussed approach to drug use and addiction. Our party understands that substance use is not a moral failure. We also understand that criminal approaches that aim to punish or isolate those with addiction issues only serve to compound the suffering of those already experiencing tremendous pain.

As Dr. Gabor Maté, a Canadian physician who specializes in addictions has said:

Not all addictions are rooted in abuse or trauma, but I do believe they can all be traced to painful experience. A hurt is at the center of all addictive behaviours. It is present in the gambler, the Internet addict, the compulsive shopper and the workaholic. The wound may not be as deep and the ache not as excruciating, and it may even be entirely hidden — but it's there.

That is why New Democrats have pushed the federal government to reinstate harm reduction as one of the four pillars of Canadian drug policy ever since it was removed by Stephen Harper. That is why New Democrats led the fight against the Conservatives' Bill C-2 from the day it was introduced. That is why we have pressed the Liberal government to repeal or amend Bill C-2 since February 2016, one year ago, when the opioid overdose crisis was in its earliest stage.

Last fall, the NDP successfully moved a motion at the Standing Committee on Health to conduct a study on the opioid overdose crisis. This led to a report with 38 recommendations to the federal government, most of which have not yet been implemented, I would point out.

• (1620)

We were the first to call for a declaration of a national public health emergency. Such a declaration would empower Canada's Chief Public Health Officer to take extraordinary measures to coordinate a national response to the crisis, a measure the Liberal government, still to this day, refuses to take.

Last December, we attempted to fast-track Bill C-37 because of the dire need to deal with this crisis as quickly as possible, but that, again, was blocked by the Conservatives.

Indeed, Bill C-37 continues to be delayed because the Conservatives refuse to acknowledge the crucial importance of harm reduction, and the evidence that supervised consumption sites save lives now.

Today, I am saddened to see that the Conservatives still have not learned from their mistakes, and I am deeply troubled that they continue to liken supervised consumption sites and the approval of same to pipeline approval processes.

Government Orders

After their bizarre offer to trade supervised consumption site approvals for pipelines, at the health committee, the Conservative member for Lethbridge argued that these health facilities should require the same social licence as energy projects before they are permitted to save lives. The member argued that we must maintain Bill C-2's unnecessary barriers because the placement of a site will impact the communities in which they are located.

For once, I agree with the member for Lethbridge. It is absolutely correct that these sites do indeed impact communities: by saving lives, by reducing crime, and by providing opportunities for recovery to people suffering from a disease.

The Conservative Party likes to imagine that supervised consumption sites might be imposed on communities by the federal government. The opposite is true. Supervised consumption sites only exist in Canada due to the tireless efforts of advocates and community members who contribute their time and talent to provide evidence-based, life-saving health services. Sometimes, they have even done so at the risk of their own liberty.

Vancouver's Dr. Peter Centre provided supervised consumption services, in violation of federal law, for over a decade, since 2002, before the federal government finally granted it a legal exemption.

Vancouver's Insite had to fight the federal government all the way to the Supreme Court of Canada to keep its doors open. Even then, instead of complying with the spirit of the ruling, the Conservative government of Stephen Harper passed Bill C-2 as a thinly veiled attempt to prevent any new site from opening in Canada.

Today, as we speak, at least three overdose prevention sites are operating in the open in Vancouver without a legal exemption, against the law, exposing the staff who work there to criminal sanction because they are answering a higher call. They are answering the call of saving lives. That is why they are doing it.

The truth is supervised consumption sites do not harm communities; they help them. The evidence from Insite has been overwhelming and crystal clear.

By the way, the Conservatives talk about the negative impact of supervised consumption sites on communities. They never quote a single piece of evidence, not a shred, from any operating supervised consumption site because there are only two in Canada. Those two in Canada have been studied and written up in periodicals as respected as *The Lancet* and the evidence is crystal clear. They save lives. They reduce crime around the area. They stop open drug use. They reduce the spread of disease, and they stop the detritus of used needles in consumption sites from being out in the community where they can harm our community members and our children. That is the evidence.

When the Conservatives say that these sites impact communities, darn right they do, and they do so by helping the community. There is not an iota of evidence to the contrary.

Perhaps the Conservatives should listen to Edmonton's Mayor Don Iveson who recently said, "This is not a homeless, addicted issue. This is in pretty much every neighbourhood."

The opioid crisis is here. It is already affecting our communities. Every day, it is claiming the lives of our friends, our family members, our neighbours.

The Conservative Party's argument that supervised consumption sites will somehow introduce opioid addiction to unaffected communities is baseless fearmongering, and it is deeply stigmatizing to Canadians with substance use disorders.

The truth is communities across Canada have been asking to open supervised consumption sites for years. It was by refusing to grant section 56 exemptions that the federal government was overruling both my home city of Vancouver and my home province's repeated requests. Indeed as Vancouver's Mayor Gregor Robertson has said: "Factors such as the impact of the site on crime rates and expressions of community support or opposition should not be relevant to the federal government's approval process. Those issues are local matters, and as such, are best dealt with by local officials, such as municipalities, health authorities, and local police agencies, who understand the issue."

• (1625)

I will leave it to the Conservative Party to explain why it does not trust local authorities to make those determinations.

It has been community heroes, not the federal government, who have been on the front lines showing leadership throughout the current crisis. The efforts of these selfless people have undoubtedly saved lives and although there are too many to name individually here, I would like to specifically acknowledge the Herculean efforts of a few people.

They are: Ann Livingston and Sarah Blyth, founders of B.C.'s Overdose Prevention Society; Hugh Lampkin, long-time member of the Vancouver area network of drug users; Daniel Benson of the Portland Hotel Society; Gregor Robertson, mayor of Vancouver; Kerry Jang, city councillor of Vancouver; Maxine Davis, executive director of Vancouver's Dr. Peter AIDS Foundation; Katrina Pacey, executive director of Vancouver's Pivot Legal Society; Dr. Perry Kendall, B.C.'s Chief Medical Officer, the first and only medical officer in the country who has declared a public health emergency in British Columbia because he recognizes the extent of the crisis facing our community; and Dr. Gabor Maté, who is an internationally-renowned expert in addictions.

Having repeated requests for a declaration of a national public health emergency ignored by the current federal Liberal government, these front line organizations and the Government of British Columbia were forced to take the extraordinary measure of disregarding federal law by opening non-exempt pop-up supervised consumption sites which are operating right now as I speak. These sites have operated for months despite the daily risk of prosecution faced by those working at them as staff and volunteers.

Here is what the College of Registered Nurses of B.C. said to its membership last month.

This crisis may be prolonged and continue to worsen; as these overdose prevention services are being established across our province, in any place there is a need, we are being asked by nurses, "Is my licence at risk if I provide nursing care in these sites and conditions that can be less than ideal?"

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Our courageous front line health workers should never be forced to ask that question.

That is why the NDP introduced an amendment at the health committee that would have allowed provincial health ministers to request in writing from the federal health minister emergency approval for supervised consumption sites in response to a local crisis.

Such an exemption would bypass the normal application process, and go into effect immediately for up to a year with the possibility of renewal. The federal minister would be required to post a provincial request online and post the response within five days.

This change was aimed at removing the potential for distant political considerations in Ottawa, many of which we hear expressed by members of the House today, to undermine or impede timely evidence-based decision responses to provincial public emergencies.

In the unusual situation where a province has declared a provincial health emergency, instead of forcing it to go through the application process which takes time, and time in a crisis like this costs lives, it gives the federal health minister the ability to grant a temporary approval quickly.

The Liberal government has repeatedly claimed that, with this legislation, it is now doing everything in its power to address this crisis, but that is demonstrably false. The government has failed to take many actions. There are literally dozens of them that are open to the government to take to respond to this crisis which it seems reluctant to do.

Recently, the City of Vancouver sent a list of nine recommendations to the federal government to help address this crisis, including calling for a central command structure, daily meetings with Health Canada, and improved treatment services.

A coroner's jury in British Columbia recently issued a list of 21 recommendations for action and the Standing Committee on Health in December issued a report detailing 38 recommendations for the government alone, again most of which remain unimplemented. The Liberal government is not doing everything it can to address the opioid crisis. It is taking some measures, but not all the measures it needs to.

When the health committee conducted the emergency study last fall into the crisis, the first recommendation made with all-party support was to declare opioid overdoses a national public health emergency. This call was echoed by Dr. David Juurlink, the keynote speaker at the health minister's own opioid summit last fall and now by B.C. Health Minister Terry Lake, a Liberal, and stakeholders across the country. In the face of a mounting death toll, a declaration of a national public health emergency would allow us to start saving more lives today.

• (1630)

Furthermore, during our study, the health committee heard that access to treatment for opioid addiction is almost nonexistent in indigenous communities, and where there is access, it is short-term access. That is because nurses employed by Health Canada do not have the scope of practice to support indigenous people in addressing opioid addiction in their own communities beyond 30

days. Yet, the Liberal government has made absolutely no commitment to ensuring full access to long-term, culturally appropriate addictions treatment in indigenous communities.

Finally, the health committee's recent report on the crisis made three separate and specific recommendations, calling for significant new federal funding for public community-based detox and addictions treatment. But the federal government will not commit to making any new funding available for detox and treatment in budget 2017, so far.

The health minister continues to recycle money dedicated to mental health, and claims that money can be used for addictions treatment. We are looking for new, specific, targeted funds for addictions treatment in this country. Mental health is a huge area, and there are many needs in this country. We all know that. We wanted targeted money from the government, and the government has refused to make that commitment so far.

I believe it behooves this House to be honest with itself. Would the federal government be so noncommittal and cautious in its approach if these deaths were caused by any other disease? As we look to the future, we must let go of our prejudices in order to hold on to our loved ones. Donna May, the founding member and facilitator of mumsDU, moms united and mandated to saving drug users, lost her daughter Jac to addiction at the age of 35. She said:

Most people would think that the hardest thing I've ever had to face was her death; the death of a child; the death of my only girl. However, that's not it at all.

The hardest thing I've had to face in my life is realizing how my ignorance towards my daughter's addiction cost me years with her that I will never get back. There are no 'do-overs' when your child is dead! Now I can only share my experience and what I've learned since, so that other parents can take something from it.

In many respects, substance abuse is one of the last remaining acceptable targets for health care discrimination. With all the evidence available to us, we should know better. If we are to succeed in treating addiction as a disease, which it is, we need to acknowledge that fear, stigma, and ignorance about those who suffer from addiction are widespread and in many respects have framed our approach to this crisis.

That is why, although these legislative changes are long overdue, they do not go far enough, fast enough. We need federal coordination and funding to address the crisis right now and over the long term. Canada's failure to treat addiction and substance use disorders by successive federal governments as a medical condition was explained to the health committee by Dr. Evan Wood from UBC.

He said:

I'll just ask you to imagine a scenario of somebody having an acute medical condition like a heart attack. They would be taken into an acute care environment. They would be seen by a medical team with expertise in cardiology. The cardiovascular team would then look to guidelines and standards to diagnose the condition and to effectively treat it. Unfortunately, in Canada, because we haven't traditionally trained health care providers in addiction medicine, we have health care providers who don't know what to do, and routinely do things that actually put patients at risk.

In addition to the lack of training for health care providers, the overall lack of investments in this area has meant that there aren't standards, guidelines [or beds] for the treatment of addiction.

Dr. Mark Ujjainwalla, medical director of Recovery Ottawa, said:

The problem we face here is that the real issue with addiction is not opiates. The real issue is the inability of the present health care system to treat the disease of addiction. An addiction is a biopsychosocial illness that affects 10% of society, probably more if you include families, and it is the most underfunded medical illness in our society.

The problem is that it's also a highly preventable and very highly treatable illness. It's very unfortunate that people don't see that. When it affects your family or you, you can feel the pain and suffering, and you watch the tragedy unfold in front of you.

I would like to conclude my remarks by imploring this House to take a lesson from Estonia, a country that recently overcame an opioid crisis very similar to Canada's. The head of Estonia's drug abuse prevention department said, "I think the most important thing is you don't waste time. If you really want to learn from us, that's the mistake we made. Don't look for some new solutions, because you have them."

We could say that history does not look kindly on those who dither in times of crisis. To put it bluntly, it is not the history books that should keep us up at night; it is the lives that we continue to lose every single day to entirely preventable causes.

Canadians are looking to us to provide leadership in a crisis. It is time for us to deliver.

• (1635)

Mr. Adam Vaughan (Parliamentary Secretary to the Minister of Families, Children and Social Development (Housing and Urban Affairs), Lib.): Madam Speaker, first, I would like to acknowledge the presentation by the hon. member for Vancouver Kingsway. Members of his caucus have been raising this issue with great clarity, great intelligence and with great compassion. I would like to acknowledge the efforts they have made to get the House to act faster, not just this year but over the last couple of decades, on this issue, and in particular the MPs who come from Vancouver.

Some of the issues he has raised we have addressed. I have sat with the big city mayors, and in particular Mayor Gregor Robertson of Vancouver, and listened to their calls for action. I immediately approached the Minister of Health. We are moving on those urban issues very quickly in concert with our cities, because cities and towns are on the front lines of this issue.

We have the call for a national disaster and immediate action, which is being taken by the government. What actions in the national disaster designation are not being taken as a result of us not designating it that could not be taken as a result of good advice from the member opposite? In other words, we believe we are doing everything we can. What would the additional designation do that we are not doing now?

• (1640)

Mr. Don Davies: Madam Speaker, first, I would like to thank the hon. member for Spadina—Fort York not only for his kind and generous words in here, but for approaching this issue in the spirit from which it ought to be approached, which is one of collegiality and working together on all sides of the House. Addiction knows no ideology. Our children, who are exposed to death, illness and overdose, are not interested in politics, so I really appreciate those kind words.

Government Orders

He asks an excellent question. Under the Emergencies Act, the declaration of what is called a public welfare emergency is open to the government, and it is clearly written in the spirit of some sort of natural disaster or outbreak of disease, if we read the legislation. There is a number of powers it gives the national chief public health officer in a case like that, and two of them in particular I would encourage my hon. colleague to consider.

One is that it would authorize the government to flow emergency funding in an expedited fashion, as opposed to having funding go through the normal processes of this place. Second, and more important, it sanctions the opening of hospitals and clinics on an emergency basis.

If there were a virus spreading around the country and we were losing 50 people a week, we would be opening pop-up clinics, almost like MASH, all over the place where people could go to get vaccinated, to get treatment. Those are the kinds of clinics I believe these supervised overdose prevention facilities could be designated as. Then they would not be operating illegally as they are now. Cities and towns could be opening these supervised consumption sites on an emergency basis and do so legally under the Emergencies Act.

[Translation]

Mr. Robert Aubin (Trois-Rivières, NDP): Madam Speaker, I thank my colleague for his speech.

Anyone who was lucky enough to hear his speech will understand the emotional intensity triggered by this problem. This is something my colleague has to deal with every day, which was reflected in his comments.

I think he was right to slam the Conservative Party, because we have been debating this problem, namely, the injection site issue, not the opioid crisis, over the past several Parliaments, with still no resolution.

I appreciate the collegiality among most parties of the House, since most of us want to expedite the passage of this bill. However, the Liberal government is expected to present its upcoming budget perhaps next week, or in two weeks' time at the latest, and my concern is this: what if there are no new investments to address this crisis? Would that not be truly Machiavellian, the perfect example of doublespeak?

[English]

Mr. Don Davies: Madam Speaker, I think all members of the House would probably agree that one of the fundamental solutions to the crisis facing us is its prevention and treatment as a health issue. That means our words are not particularly helpful unless they are backed up by actions. The action I would like to see by the government is significant and substantial new funding for addictions treatment facilities of every kind across the country. There is no one size fits all. We need facilities for young people, women, and indigenous communities. There are differences with respect to alcohol and drug addictions. We need the full panoply of resources for the country to really start making a dent in this.

Government Orders

In generosity to the Conservative colleagues, I will say this. They express in the House the perspective that drugs are a dangerous product, and they are right. I think everyone in the House views drugs as unhealthy, and we wish Canadians would not use or abuse them. Ultimately, we need to get to that next level where we take an evidence-based, health-based approach to drugs. That will start with the Liberal government providing significant funding.

I asked a question today about the fact that 90% of Canadians right now were operating without a new health accord. While the government is negotiating with the provinces, I would ask it to recognize the emergency before us and find money in its budget that can be diverted from other places and put into addictions services. It would be money well spent and it would help save the lives.

Ms. Elizabeth May (Saanich—Gulf Islands, GP): Madam Speaker, I want to thank my hon. colleague from Vancouver Kingsway for his work on this, and on the health committee. I had a chance to be part of the clause-by-clause on Bill C-37, and I appreciate all his efforts there.

I want to thank him for raising the comparison to pipelines, which has been made all too often here, that somehow there is a contradiction in trying to save lives and reducing the obstacles to saving lives that can be compared to the reasonable regulatory hurdles for building thousands of kilometres of pipeline across first nations lands, which would threaten every stream it crosses, and the oceans and coastlines that will be traversed by tankers carrying bitumen and diluent, which cannot be cleaned up. I found the comparison distasteful, and I appreciate him dealing with it in the House this afternoon.

Mr. Don Davies: Madam Speaker, in the spirit of generosity, I understand where the Conservatives are coming from. What they are talking about is the need to have appropriate regulatory processes for the approval of varying projects in our country. However, we would all do well in the House if we viewed the issue before us as one of public health. Although it is tempting to draw on analogies from other areas, I do not think we can really do justice to this issue unless we focus on the fact that the decisions we make today and the steps we take as parliamentarians will have not only an economic impact but one of life or death.

Everybody in the House probably has a family member, a relative, a friend, a colleague or a workmate who has suffered from an addiction. None of us are immune to that. Therefore, let us work together in a spirit of collegiality, look at the evidence, move swiftly, and deal with this very serious social issue, which has been ignored for far too long by every level of government in our country.

• (1645)

Ms. Sheila Malcolmson (Nanaimo—Ladysmith, NDP): Madam Speaker, I appreciate my colleague's support for real action on addressing the opioid overdose.

My own community of Nanaimo—Ladysmith has seen a tremendous effort by first responders and community organizations that have worked very hard to fill the gap in the failure of federal and provincial leadership.

I hope the member can describe the human cost on the first responder side, and what this government action might do to

alleviate pressure on firefighters, nurses, and community organizations.

Mr. Don Davies: Madam Speaker, the front-line workers, the firefighters, police, paramedics, nurses, and volunteers across the country, are nothing short of heroes and heroines for what they have been doing for us. They have been responding to people in the most extreme circumstance, literally when they are dying or dead, and they have been bringing them back to life. They are doing this day after day. These are the people we need to be supporting. Let us do that by moving the bill forward as soon as we can.

[Translation]

The Assistant Deputy Speaker (Mrs. Carol Hughes): Order. It is my duty, pursuant to Standing Order 38, to inform the House that the questions to be raised tonight at the time of adjournment are as follows: the hon. member for Selkirk—Interlake—Eastman, National Defence; the hon. member for Mégantic—L'Érable, Rail Transportation; the hon. member for Vancouver East, Foreign Affairs.

[English]

Mr. Darrell Samson (Sackville—Preston—Chezzetcook, Lib.): Madam Speaker, I will be splitting my time with the member for Brampton South.

The bill before is an extremely important one. We have a health crisis, and we need to respond quickly. Our government, with the support of many members in the House, is doing just that.

I would like to begin by extending my sympathy to all those who have lost a friend, neighbour, family member, or co-worker through this crisis.

In the past eight years in Nova Scotia alone there have been over 800 overdoses, and half of those have been due to the use of opioids. This is the situation in Nova Scotia, but the situation is much greater in other provinces. For example, in British Columbia, 900 people lost their lives through overdose in the last year, which is 80% more than in 2015. At a national level, overdoses now outnumber the deaths due to motor vehicle accidents. This gives us an interesting comparison, and shows how sad this crisis is.

This crisis has no boundaries. There is no age, gender, or income factor. This is an addiction; it is an illness. All governments need to respond to this crisis. We have to find the root causes and then find solutions through the most current evidenced-based policies to support that. Addictions can take hold of someone trying to cope with physical or emotional pain.

• (1650)

[Translation]

The tragic thing about fentanyl is that the drug is so powerful, a minuscule amount can have dramatic effects and even cause death. As little as 30 grams, enough to fill a regular envelope, can cause as many as 15,000 people to die of an overdose.

That is why our government and all members of the House must pass a bill quickly, because every moment counts.

[English]

This legislation would roll back changes made by the previous government, the so-called Respect for Communities Act. That legislation added an unnecessary burden on provinces, local governments, and communities in applying for an exception under the Controlled Drugs and Substances Act to establish a safe consumption site. Bill C-37 would accomplish this by simplifying and streamlining the previous process and its 26 application criteria. That is why only three sites in the last two years have been established under those criteria.

Our government is applying the wisdom of the Supreme Court of Canada, which indicated five important factors: one, evidence on the impact of such facilities on crime rates; two, local communities indicating that there is a need for those types of sites; three, establishing regulatory structures and making sure they are in place to support the sites; four, having the necessary resources; and, five, having communities express support or opposition. That is what is important and what the bill would provide. In addition, whichever applications are denied or approved, the decisions would be made public. It is important that they be public.

[Translation]

The fact is that supervised consumption sites save lives. That is the important thing here: they save lives. The Vancouver sites help integrate people with addiction problems into the health system in an environment where they are not judged or stigmatized.

Harm reduction is not our government's only strategy. Our government has made it clear that we will invest \$5 billion in mental health as part of the health agreement.

[English]

Prior to 2006, the Government of Canada had a federal drug strategy that had a balanced approach between public health and public safety that included the four key pillars: prevention, treatment, enforcement, and harm reduction. The previous government removed harm reduction as a pillar in our national drug strategy. This was unfortunate, because evidence has shown time and time again that harm reduction strategies are needed to ensure good public health outcomes.

As part of this government's commitment to evidence-based policy-making, the Minister of Health has reinstated harm reduction as a pillar of our strategy.

Along with harm reduction, our government has also eased access to the life-saving overdose treatment naloxone. Canadians can now access this drug antidote without a prescription and we have ensured emergency supplies are available for all Canadians.

In terms of enforcement, the RCMP has been diligently working to try to stop the flow of fentanyl. An agreement was recently reached with China on this issue. Furthermore, under this legislation, the Canada Border Services Agency would have more flexibility to inspect suspicious mail which it believes may contain prohibited goods. This measure would only apply to incoming international

mail from areas of the world where prevalence of illicit drugs is greater.

In closing, I would like to commend the Minister of Health for her hard work in combatting this crisis and working toward a solution, and her leadership in bringing this legislation forward. I also want to thank members in all parties in the House for their contribution to this debate, as well as the NDP, the Bloc, and the Green Party that have directly supported this bill.

• (1655)

Ms. Tracey Ramsey (Essex, NDP): Madam Speaker, in my community what I am hearing is that there are a lot of people who are working on the opioid crisis and who are helping people with addictions but there is no coordinated effort. They are looking for federal leadership. They want this crisis to be declared a public emergency so that all of their efforts can come together in a coordinated way so they can use their resources to help more people. There is a desperate cry in my riding of Essex and also in southwestern Ontario for the federal government to show leadership.

Medical experts have also been clear that there is an alarming lack of access to publicly funded detox and addiction treatment centres. This is very true in my area.

I have heard the minister talk about funding for mental health, but could the member tell me if budget 2017 will contain significant new funding for addiction treatment specifically?

Mr. Darrell Samson: Madam Speaker, I thank the member opposite for her hard work on this file. I cannot speak for our government with respect to what is going to be in the budget, but I can say that our government has already promised to advance \$5 billion over the next 10 years for health issues.

This bill would clear the way for the government to take immediate steps moving forward. Members must remember that our government has been working with provincial governments and local communities as well to move this forward.

Mr. Michael Cooper (St. Albert—Edmonton, CPC): Madam Speaker, I agree with the hon. member for Sackville—Preston—Chezzetcook that there are many positive aspects in Bill C-37 but the real problem with the bill is that it would gut the Respect for Communities Act.

Some say that the criteria in the Respect for Communities Act is too onerous and I disagree with them. Nonetheless, we on this side of the House try to work with the government. We put forward some simple amendments that, for example, would require a letter of support from the local municipality and local police force, an amendment that would require that persons within a two-kilometre radius of a supervised injection site be consulted, and an amendment that would require a 45-day consultation period, given that Bill C-37 would gut the minimum 90-day consultation period.

What could possibly justify the government rejecting all three of these common-sense amendments? Is it really just because the government wants to gut—

Government Orders

The Assistant Deputy Speaker (Mrs. Carol Hughes): There is only five minutes for questions and comments. We cannot be giving speeches during questions and comments. It is very long.

The hon. member for Sackville—Preston—Chezzetcook.

Mr. Darrell Samson: Madam Speaker, we have to keep in mind that the Conservative government in the last 10 years did all it could to close these centres and made it so difficult that it was unachievable.

This bill would allow us to move forward quickly and get it done. The debate has been going on for years and it is now time to move forward. This is a first step but there are many steps to take. This is an extremely important first step that will help people on the ground today.

• (1700)

Mr. Sukh Dhaliwal (Surrey—Newton, Lib.): Madam Speaker, last July, the city of Surrey had more than 60 fentanyl overdoses in a 48-hour stretch. Our office held an emergency summit and we asked all first responders, health care professionals, and members of all parties to come together to come up with a strategy. I am glad that the minister has taken the lead on this.

The hon. member mentioned safe consumption sites. How would safe consumption sites help my riding of Surrey—Newton and the city of Surrey in general? My constituents are asking the government to expedite safe consumption sites.

Mr. Darrell Samson: Madam Speaker, research clearly shows that these sites save lives. We plan to do this as quickly as possible.

Ms. Sonia Sidhu (Brampton South, Lib.): Madam Speaker, I am grateful for the opportunity to speak in support of Bill C-37, an act to amend the Controlled Drugs and Substances Act and to make related amendments to other acts.

While I am supporting this positive move, I must say I am still deeply troubled by this crisis that continues to hit communities. On a personal note, I was deeply touched after hearing from those affected. As a member of the Standing Committee on Health, I, with my colleagues from all parties, studied this crisis. In fact, we chose to pass a motion to undertake an emergency study of the crisis.

We were all in lockstep with the minister, trying to make a positive difference and to make choices that would save lives. That motivation drove us to work hard, and work together. We worked collectively and openly on this. That is something I am quite proud of and something I have valued in my time as the MP for Brampton South, and as a fellow parliamentarian of all who serve together in this place.

In committee, we heard from wide-ranging front-line perspectives, experts, and from the Minister of Health directly on this. I would like to make particular note of the testimony the committee heard from indigenous peoples on October 25, which I feel was compelling, honest, and a real wake-up call about what we need to do to ensure we address the needs of indigenous communities. For starters, improving access to naloxone treatment, the life-saving medication used in the case of an opioid overdose, was needed for rural and remote first nations in particular. That was a key part of the minister's action plan coming out of the summit, and goes to show what we can do when we consult all communities.

In looking at the bill, I see that Bill C-37 addresses what we heard from the Canada Border Services Agency about practical changes that would help prevent drug-making materials from entering the country. I applaud the minister's work also to check suspicious international mail packages that are 30 grams or less, which could be used to smuggle in any amounts of substances that may cause harm. This is a good precaution to benefit Canadians.

I want to remind colleagues that the bill is the product of hundreds of voices coming together. Our committee members were graciously invited to join in the health minister's summit on this as well. Coming out of the summit, we saw action. In fact, the joint statement of action by 42 organizations to address the opioid crisis was a broad but concrete approach that includes all those involved, from health care providers, to first responders, to educators, to researchers, and to families as well. I want to applaud our Minister of Health, and Ontario's minister of health as well, for leading that conference, which focused on concrete steps and delivering clear results.

Our government has taken action from day one, building on our five-point action plan to address opioid misuse. We have taken concrete steps, such as granting section 56 exemptions for the Dr. Peter Centre and extending the exemption for Insite for an additional four years. We made the overdose antidote naloxone more widely available in Canada. Our government recently approved three safe consumption sites in Montreal that the community asked for.

Further, at the local level, we have seen action already undertaken. In the city of Toronto, the mayor met with the mayor of Vancouver and other officials in order to plan a proactive not reactive response for Ontario as the crisis drifts eastward. The mayor of Hamilton held a discussion about this as well, and other municipalities have been doing the same. I hope more municipalities will reach out, learn from one another, and take proactive measures in their communities.

The numbers and the experts support this as the right way to public health, and it also delivers cost savings. I see how various aspects of the bill address a lot of the concerns we heard at committee and at the opioids summit. While many members have made note of the urgency of passing the bill, I think the majority of members showed time and time again in recent weeks that they were willing to collaborate to move quickly on this.

I want to reassure members that I believe the bill is an extremely collaborative and well-thought-out bill that responds to experts in the field as well as front-line needs. It gives me comfort to know that this bill would make a difference.

Government Orders

• (1705)

As others have said before, and I agree, we are in a national public health crisis in Canada. In 2016, thousands of Canadians tragically died of accidental opioid overdoses, and more will die this year. Our government and its partners must work together aggressively to save lives.

If people have friends or neighbours who are hearing the Conservatives' argument that facilities like Insite are the wrong approach, I would encourage them to contact me or other members on the health committee who would be happy to provide non-partisan, evidence-based information on why that does not reflect the safe consumption site model we see working already in Canada. All members of this House can agree that our hearts go out to the families and friends affected personally when a loved one has lost his or her life instead of having another chance. Last year in British Columbia alone, more than 900 people died from a drug overdose, an 80% increase from 2015.

This legislation simply proposes to ease the burden on communities that wish to open a supervised consumption site, while putting stronger measures in place to stop the flow of illicit drugs and strengthening the system in place for licensed controlled substances facilities. Experts and stakeholders told the previous government and then told our government that Bill C-2 as it stood was not helping this crisis. That is why we took action to reverse the barriers that were holding back communities that have long been asking for the ability to save their citizens' lives.

We know there is more to be done as we move forward. We know that sadly the situation is getting worse. The deaths from overdoses will now be greater than deaths caused by car accidents. This tragic crisis continues to move eastward in Canada, with increasing drug seizures of fentanyl and carfentanil across the country. We will continue to work with our partners across the country to continue bringing forward evidence-based solutions to save lives and ensure that 2017 is the year that will mark a turn in this national public health crisis.

Many people in Brampton South have asked me about my work on the health committee, and I have mentioned over and over that we all agreed we should turn our focus to this study due to the emergency at hand. They ask me why and they are always engaged when hearing about how we can work together at committee to address real problems and issues that our fellow Canadians face. Again, the way our committee worked together is one of the cherished moments I have of being an MP, and I hope we get more chances to work collaboratively again. This crisis called on us as leaders in our communities and as parliamentarians to take action.

In October 2016, I put forward a motion that the health committee call upon the Minister of Health to move as quickly as possible to conduct a review of the laws and regulations in place with regard to safe injection sites. I suggested that the review have an end goal to improve the health and safety of Canadians, using a strong evidence-based approach. With Bill C-37, I feel the minister and government have responded fully to the motion that the health committee passed in October of last year.

I am proud to be supporting this legislation that would save the lives of Canadians who need our help.

• (1710)

Mr. Harold Albrecht (Kitchener—Conestoga, CPC): Madam Speaker, certainly on this side of the House we have unanimous agreement that we need to work on this challenging problem.

A number of weeks ago in committee, our health critic offered to actually split this bill into two parts to deal with the crisis part and then to work on the issues that we might have some disagreement on. In fact, the parts of the bill that should be implemented could actually be law right now had the Liberal government agreed to do that.

My question has two parts. One, why did the Liberal government not agree to allow us to split the bill into two parts and facilitate the quick movement of this bill? Two, now that the bill is here, why did the Liberals limit debate on this bill for those of us in Parliament who have been elected by our constituents to represent them to be able to give their voice here in Parliament? Why did the Liberals limit debate by closing down debate?

Ms. Sonia Sidhu: Madam Speaker, I appreciate my colleague's passion on this issue, but as he heard, 900 lives were lost in Vancouver. This is an urgent matter. We have to take steps. Evidence shows that when properly established and maintained, supervised consumption sites save lives and improve health without negatively impacting the surrounding communities.

Our minister brought forward Bill C-37. I want all members to support this valuable bill so we can save Canadian lives.

[Translation]

Mr. Angelo Iacono (Alfred-Pellan, Lib.): Madam Speaker, I thank my colleague for her speech on this important bill.

The government is taking the necessary steps to respond to the fentanyl overdose crisis across the country. I think my colleague would agree that our government bases its decisions on facts, science, and sound evidence. That is why we want to support the establishment of supervised consumption sites in cities that want them, because this reduces harm.

I wonder if my colleague could tell the House about other beneficial effects the bill will have on the health and safety of all Canadians.

[English]

Ms. Sonia Sidhu: Madam Speaker, our government made the overdose antidote naloxone more widely available in Canada. It saves Canadians' lives. I appreciate that our Minister of Health took this step.

Last November, the Minister of Health co-hosted a conference on opioid overdose crisis which resulted in 42 organizations bringing forward concrete proposals on their own.

Government Orders

Our government is also continuing to respond to the tragic crisis in the way that is comprehensive, collaborative, and compassionate. We will continue to work with our partners across the country to continue bringing forward evidence-based solutions to save lives. That is why all members, as well as those across the way, are debating Bill C-37. We are all working together to save Canadians' lives.

Mr. Larry Maguire (Brandon—Souris, CPC): Madam Speaker, I would like to ask my colleague about the situation she has looked at. She indicated there were some 900 deaths in Vancouver. They have injection sites, as has been pointed out by colleagues and others and I just want to also follow up. We still have not received an answer to the question that we have placed multiple times today about why the government did not split the bill. There is about 80% of it that we have agreed with. It could very well have been enacted by now and perhaps saved even more lives, yet the government seems to be against community consultation. I am wondering if she can provide an answer to both of those.

• (1715)

Ms. Sonia Sidhu: Madam Speaker, we need to have a comprehensive approach in order to face this crisis. This is not the time to play politics. This is a time to act. We need to act urgently.

[Translation]

The Assistant Deputy Speaker (Mrs. Carol Hughes): Order. The question is on the motion. Is it the pleasure of the House to adopt the motion?

Some hon. members: Agreed.

Some hon. members: No.

The Assistant Deputy Speaker (Mrs. Carol Hughes): All those in favour of the motion will please say yea.

Some hon. members: Yea.

The Assistant Deputy Speaker (Mrs. Carol Hughes): All those opposed will please say nay.

Some hon. members: Nay.

The Assistant Deputy Speaker (Mrs. Carol Hughes): In my opinion the yeas have it.

And five or more members having risen:

The Assistant Deputy Speaker (Mrs. Carol Hughes): Call in the members.

• (1750)

(The House divided on the motion, which was agreed to on the following division:)

(Division No. 199)

YEAS

Members

Aldag
Alleslev
Anandasangaree
Arya
Ayoub
Bagnell
Barsalou-Duval

Alghabra
Amos
Arseneault
Aubin
Badawey
Bains
Baylis

Beaulieu
Bennett
Bittle
Blaney (North Island—Powell River)
Bossio
Boulerice
Bratina
Brisson
Caesar-Chavannes
Caron
Casey (Charlottetown)
Chan
Choquette
Cormier
Cuzner
Damoff
DeCoursey
Di Iorio
Dubé
Duclos
Duncan (Etobicoke North)
Duscault
Dzerowicz
Ehsassi
Ellis
Eyking
Fergus
Finnigan
Fonseca
Fortin
Fraser (West Nova)
Fry
Gameau
Gerretsen
Goldsmith-Jones
Gould
Grewal
Hardcastle
Harvey
Holland
Hussen
Iacono
Jolibois
Jones
Jowhari
Khalid
Kwan
Lamoureux
Lauzon (Argenteuil—La Petite-Nation)
Lebouthillier
Lemieux
Levitt
Lockhart
Ludwig
MacKinnon (Gatineau)
Maloney
Masse (Windsor West)
Mathysen
McCrimmon
McGuinity
McKenna
McLeod (Northwest Territories)
Mendicino
Miller (Ville-Marie—Le Sud-Ouest—Île-des-Sœurs)
Monsef
Morneau
Mulcair
Nantel
Nault
Oliphant
O'Regan
Paradis
Peterson
Philpott
Plamondon
Quach
Ramsey
Ratansi
Robillard
Romanado
Rudd
Rusnak
Sahota
Samson

Beech
Bibeau
Blais
Boissonnault
Boudrias
Boutin-Sweet
Breton
Brosseau
Cannings
Casey (Cumberland—Colchester)
Chagger
Chen
Christopherson
Cullen
Dabrusin
Davies
Dhaliwal
Drouin
Dubourg
Duguid
Duncan (Edmonton Strathcona)
Duvall
Easter
El-Khoury
Erskine-Smith
Eyolfson
Fillmore
Fisher
Foote
Fragiskatos
Fraser (Central Nova)
Fuhr
Garrison
Gill
Goodale
Graham
Hajdu
Hardie
Hehr
Hughes
Hutchings
Johns
Joly
Jordan
Kang
Khera
Lametti
Lapointe
Laverdière
Lefebvre
Leslie
Lightbound
Longfield
MacGregor
Malcolmson
Marcil
Massé (Avignon—La Mitis—Matane—Matapédia)
May (Saachich—Gulf Islands)
McDonald
McKay
McKinnon (Coquitlam—Port Coquitlam)
Mendès
Mihychuk
Morrissey
Murray
Nassif
O'Connell
Oliver
Ouellette
Pauzé
Petipas Taylor
Picard
Poissant
Qualtrough
Rankin
Rioux
Rodriguez
Rota
Ruimy
Saganash
Saini
Sangha

*Private Members' Business***PRIVATE MEMBERS' BUSINESS**

● (1755)

*[English]***NATIONAL SICKLE CELL AWARENESS DAY ACT**

The House resumed from February 8 consideration of the motion that Bill S-211, An Act respecting National Sickle Cell Awareness Day, be read the second time and referred to a committee.

The Speaker: The House will now proceed to the taking of the deferred recorded division on the motion at second reading stage of Bill S-211.

● (1800)

(The House divided on the motion, which was agreed to on the following division:)

*(Division No. 200)***NAYS**

Members

Aboultaif	Albas
Albrecht	Allison
Ambrose	Anderson
Arnold	Barlow
Bergen	Berthold
Bezan	Block
Boucher	Brown
Calkins	Carrie
Chong	Clarke
Clement	Cooper
Deltell	Diotte
Doherty	Dreeshen
Egliniski	Falk
Gallant	Généreux
Genuis	Gladu
Godin	Gourde
Harder	Hoback
Jeneroux	Kelly
Kent	Kitchen
Kmiec	Lake
Lauzon (Stormont—Dundas—South Glengarry)	Lebel
Liepert	Lobb
Lukiwski	MacKenzie
Maguire	McCauley (Edmonton West)
McLeod (Kamloops—Thompson—Cariboo)	Miller (Bruce—Grey—Owen Sound)
Nater	Nicholson
Obhrai	Poilievre
Rayes	Reid
Rempel	Richards
Ritz	Saroya
Scheer	Schmale
Shields	Shipley
Sopuck	Stanton
Strahl	Stubbs
Sweet	Tilson
Van Kesteren	Van Loan
Viersen	Wagantall
Warkentin	Watts
Waugh	Webber
Wong	Yurdiga — 80

PAIRED

Nil

The Speaker: I declare the motion carried.

(Bill read the third time and passed)

YEAS

Members

Aboultaif	Albas
Albrecht	Aldag
Alghabra	Alleslev
Allison	Ambrose
Amos	Anandasangaree
Anderson	Arnold
Arseneault	Arya
Aubin	Ayoub
Badawey	Bagnell
Bains	Barlow
Barsalou-Duval	Baylis
Beaulieu	Beech
Bennett	Bergen
Berthold	Bezan
Bibeau	Bittle
Blaikie	Blaney (North Island—Powell River)
Block	Boissonnault
Bossio	Boucher
Boudrias	Boulerice
Boutin-Sweet	Bratina
Breton	Brisson
Brosseau	Brown
Caesar-Chavannes	Calkins
Cannings	Caron
Carrie	Casey (Cumberland—Colchester)
Casey (Charlottetown)	Chagger
Chan	Chen
Chong	Choquette
Christopherson	Clarke
Clement	Cooper
Cormier	Cullen
Cuzner	Dabrusin
Damoff	Davies
DeCoursey	Deltell
Dhaliwal	Di Iorio
Diotte	Doherty
Dreeshen	Drouin
Dubé	Dubourg
Duclos	Duguid
Duncan (Etobicoke North)	Duncan (Edmonton Strathcona)
Duscault	Duvall
Dzerowicz	Easter
Egliniski	Ehsassi
El-Khoury	Ellis
Erskine-Smith	Eyking
Eyolfson	Falk
Fergus	Fillmore
Finnigan	Fisher
Fonseca	Foote
Fortin	Fragiskatos
Fraser (West Nova)	Fraser (Central Nova)
Fry	Fuhr
Gallant	Garneau
Garrison	Généreux
Genuis	Gerretsen

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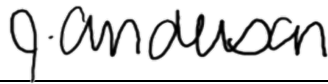
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This is **Exhibit “D”** to the Affidavit of Lauren Costoff
Affirmed Remotely Before Me in the City of Barrie, Province of Ontario
this 10th day of January, 2025.

A handwritten signature in black ink, appearing to read "J. Anderson", written over a horizontal line.

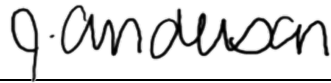
A Commissioner for oaths, etc.

JANICE ANDERSON

[CLICK HERE TO VIEW](#)

Cable Public Affairs Channel (CPAC) site containing the video of Ontario's deputy premier and Minister of Health Sylvia Jones speaking with reporters on August 20, 2024.

This is **Exhibit “E”** to the Affidavit of Lauren Costoff
Affirmed Remotely Before Me in the City of Barrie, Province of Ontario
this 10th day of January, 2025.

A handwritten signature in black ink, appearing to read "J. Anderson".

A Commissioner for oaths, etc.

JANICE ANDERSON



Protecting Communities and Supporting Addiction Recovery

ONTARIO — The Ontario government is protecting the safety of children and communities by banning supervised drug consumption sites within 200 metres of schools and child care centres. The government is also mandating new protections to better protect community safety near remaining sites, including new requirements for safety and security plans, as well as new policies to discourage loitering and promote conflict de-escalation and community engagement. In order to restrict access to dangerous and illegal drugs moving forward, the government will also introduce legislation this fall that would, if passed, prohibit municipalities or any organization from standing up new consumption sites or participating in federal so-called “safer” supply initiatives. If passed, the legislation will also prohibit municipalities from requesting the decriminalization of illegal drugs from the federal government.

“We don’t need more drug injection sites, we need less. I am opposed to providing free needles and free supervision for people to consume illegal drugs,” said Anthony Leardi, MPP for Essex. “Drugs from these sites are being trafficked and mixed with lethal drugs like fentanyl. We don’t want any of this in Essex County.”



ANTHONY LEARDI
MEMBER OF PROVINCIAL PARLIAMENT
ESSEX



MPP Anthony Leardi and Minister of Health Sylvia Jones

As part of a comprehensive system of care that prioritizes community safety and focuses on giving people their lives back through treatment and recovery, as well as upstream investments in prevention, the province is investing \$378 million in 19 new Homelessness and Addiction Recovery Treatment (HART) Hubs. These new hubs are in addition to more than \$3.8 billion the province is currently investing through its Roadmap to Wellness and nearly \$700 million for supportive housing through the Homelessness Prevention Program and Indigenous Supportive Housing Program each year.

"Communities, parents and families across Ontario have made it clear that the presence of consumption sites near schools and daycares is leading to serious safety problems," said Sylvia Jones, Deputy Premier and Minister of Health. "We need to do more to protect public safety, especially for young school children, while helping people get the treatment they need, which is why we're taking the next step to expand access to a broad range of treatment and recovery services, while keeping kids and communities safe."



Minister of Health Sylvia Jones

Crime in the vicinity of these sites is significantly higher compared to surrounding neighbourhoods. In Toronto, reports of assault in 2023 are 113 per cent higher and robbery is 97 per cent higher in neighbourhoods near these sites compared to the rest of the city. Near the Hamilton site, reports of violent crime were 195 per cent higher compared to the rest of the city, and the crime rate near the Ottawa site was 250 per cent higher than the rest of the city. The government's new direction is also informed by reports from police services in Ontario and across Canada that hydromorphone distributed at consumption sites is being diverted and trafficked, increasing the supply of dangerous and illegal drugs in communities where these sites operate.

In response to these concerns, Ontario is taking the next step to create a system of care that prioritizes community safety, treatment and recovery. HART Hubs, similar to existing hub models in Ontario that have successfully provided people with care, will reflect regional priorities by connecting people with complex needs to comprehensive treatment and preventative services that could include:

- Primary care



- Shelter and transition beds
- Supportive housing
- Other supplies and services, including naloxone, onsite showers and food

HART Hubs will add up to 375 highly supportive housing units, in addition to addiction recovery and treatment beds, that will help thousands of people each year transition to more stable long-term housing. With a focus on treatment and recovery, HART Hubs will not offer “safer” supply, supervised drug consumption or needle exchange programs.

The ban on consumption sites within 200 metres of a school or child care centre will result in the closure of nine provincially-funded sites and one self-funded site, located in Ottawa, Guelph, Hamilton, Thunder Bay, Kitchener and Toronto, no later than March 31, 2025. These provincially-funded sites will be encouraged to submit proposals to transition to HART Hubs and will be prioritized by the province during the review process and could be eligible on average, for up to four times more funding under the HART Hubs model than they receive from the province as a consumption site.

The development of HART Hubs is one of the many investments the Ontario government makes to build a health care system that connects people with mental health and addictions care, including:

- Investments through the Roadmap to Wellness and Addictions Recovery Fund, including \$124 million over the next three years as part of Budget 2024, are creating more than 500 addiction recovery beds and new models of treatment like mobile mental health clinics
- \$152 million over three years for supportive housing to assist individuals facing unstable housing conditions and experiencing mental health and addictions challenges



bringing the total number of Youth Wellness Hubs to 32 across the province

- More than \$650 million in annual funding for the Homelessness Prevention Program and \$41.5 million for the Indigenous Supportive House Program, which the government increased by \$202 million annually in the 2023 provincial budget
- \$20 million to support more than 100 Mobile Crisis Response Teams in communities across the province so that health care professionals can attend crisis situations in partnership with police

"We are investing more than any government in Ontario's history to create a nation-leading system of mental health and addictions care," said Michael Tibollo, Associate Minister of Mental Health and Addictions. "The new HART Hubs are a next step in the vision first outlined in the Roadmap to Wellness and expanded on in the Addictions Recovery Fund to provide the substantial regional resources that are needed to keep our communities safe and give people their lives back through treatment and recovery."

Through [Your Health: A Plan for Connected and Convenient Care](#) and building on the Roadmap to Wellness, the province is taking action to make it easier and faster for individuals to connect to mental health and addictions services in your communities.

Quick Facts

- The creation of HART Hubs will be done in partnership with the Ministry of Health, the Ministry of Municipal Affairs and Housing, the Ministry of Children, Community and Social Services, and the Ministry of Labour, Immigration, Training and Skills Development.



- Through the Roadmap to Wellness, Ontario is investing \$3.8 billion over 10 years to fill gaps in mental health and addictions care, create new services and expand programs, in addition to funding provided for supportive housing, homelessness prevention and other social services.
- As part of [Budget 2024](#), Building a Better Ontario, the government is building on its work through the Roadmap by investing an additional \$396 million over three years to improve access and expand existing mental health and addictions services and programs.

Quotes

"Today's announcement is a real game changer. This major investment will truly support people to get their lives back on track through needed treatment and recovery, while ensuring that neighbourhoods in Windsor and across Ontario remain safe."

– Drew Dilkens
Mayor, City of Windsor

"I commend the provincial government for moving forward with a detailed plan to save lives, restore families and improve communities struggling with the stranglehold of addictions. I am confident that the new HART Hub model, focused on recovery, will show the positive results cities have been desperately requesting for our most vulnerable citizens, not just in Guelph, but across Ontario."

– Cam Guthrie
Mayor, City of Guelph



well as preventing injection sites from being located next to daycare centres and schools. I commend the provincial government for taking these necessary steps to protect our children and residents."

– Alex Nuttall
Mayor, City of Barrie

"Grateful for the Ford government's focus on treatment for addictions and not band-aid solutions. I share their concern about the proliferation of safe injection sites in area close to families and children. This needs to stop."

– Patrick Brown
Mayor, City of Brampton

"Collaboration between the province and municipalities is key to addressing community wellness. The HART Hubs reflects a focus on treatment and recovery, which mirrors efforts Greater Sudbury and local health providers have been using. I look forward to working with the province on helping people transition to stable, long-term housing."

– Paul Lefebvre
Mayor, City of Greater Sudbury



Meet Anthony Leardi

Services



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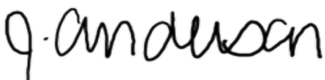
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This is **Exhibit “F”** to the Affidavit of Lauren Costoff
Affirmed Remotely Before Me in the City of Barrie, Province of Ontario
this 10th day of January, 2025

A handwritten signature in black ink, appearing to read "J. Anderson".

A Commissioner for oaths, etc.

JANICE ANDERSON

CLICK HERE TO VIEW

Global News video, posted on YouTube, with Ontario premier Doug Ford at a press conference in St Catherines related to Ontario's investment into the ship building sector on August 21, 2024.

This is **Exhibit “G”** to the Affidavit of Lauren Costoff
Affirmed Remotely Before Me in the City of Barrie, Province of Ontario
this 10th day of January, 2025

A handwritten signature in black ink, appearing to read "J. Anderson", is positioned above a horizontal line.

A Commissioner for oaths, etc.

JANICE ANDERSON

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Cable Public Affairs Channel (CPAC) site containing the video of the News Conference held by Ontario Ministers on November 18, 2024, following the introduction of Bill 223.

This is **Exhibit “H”** to the Affidavit of Lauren Costoff
Affirmed Remotely Before Me in the City of Barrie, Province of Ontario
this 10th day of January, 2025

A handwritten signature in black ink, appearing to read "J. Anderson", is positioned above a horizontal line.

A Commissioner for oaths, etc.

JANICE ANDERSON



Premier of Ontario
Premier ministre
de l'Ontario

Legislative Building
 Queen's Park
 Toronto, Ontario
 M7A 1A1
 Édifice de l'Assemblée législative
 Queen's Park
 Toronto (Ontario)
 M7A 1A1

December 5, 2024

Alex Nuttall
 Mayor
 City of Barrie
Alex.Nuttall@barrie.ca

Patrick Brown
 Mayor
 City of Brampton
patrick.brown@brampton.ca

Kevin Davis
 Mayor
 City of Brantford
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Jan Liggett
 Mayor
 City of Cambridge
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Darrin Canniff
 Mayor
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Dan Carter
 Mayor
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Adrian Foster
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Kevin Ashe
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Mat Siscoe
 Mayor
 City of St. Catharines
mat@stcatharines.ca

Paul Lefebvre
 Mayor
 City of Greater Sudbury
Paul.Lefebvre@greatersudbury.ca

Drew Dilkens
 Mayor
 City of Windsor
mayoro@citywindsor.ca

Dear mayors:

Thank you for your recent letter outlining the serious challenges communities across Ontario are facing when it comes to homeless encampments and their impact on community safety.

Our government shares your concerns about the need to keep our children, families and communities safe. That's why we are acting to put an end to the public disorder, drug use and trafficking and loss of public space that have resulted from the widespread growth in encampments. These are serious problems that are impacting communities across Ontario, with people rightly demanding action. Enough is enough.

.../2

- 2 -

Solving the homelessness crisis starts with more treatment beds and places to call home. Ontario is making unprecedented investments in mental health, addiction recovery and homelessness prevention services, including nearly \$700 million annually through our provincial homelessness prevention programs to ensure we can provide more roofs over the heads of people experiencing homelessness. More recently, our government announced \$378 million to create 19 Homelessness and Addiction Recovery Treatment (HART) Hubs, which will add up to 375 highly supportive housing units, in addition to addiction recovery and treatment beds and other services to help people facing homelessness and addiction.

There is an urgent need to do more and I am thrilled that you have shown considerable leadership in putting forward concrete and actionable solutions. Ontario is finalizing the details of new initiatives, including enhanced legislative powers, that will be responsive to your requests. I want to be clear: Our government will be there to support municipalities in restoring public order in your communities every step of the way.

The new legislation and supporting initiatives will achieve the outcomes all of us agree are necessary in order to protect public safety and dismantle encampments, including:

- Greater service manager accountability and alignment with provincial and local priorities.
- Additional funding to create more capacity in our shelter systems, supported by the new accountability measures to ensure these funds support dismantling encampments.
- Explicitly and unequivocally prohibiting the use of illicit drugs in public, with new tools and authorities to help police enforce this prohibition.
- Enhanced penalties for people who deliberately and continually break the law.
- New approaches to treatment and rehabilitation that prioritize pathways to recovery over incarceration in the cases of minor and non-violent drug-related crimes.

.../3

- 3 -

I am confident that the legislative authorities the province is preparing are common sense, practical and entirely aligned with the Charter of Rights and Freedoms, especially for the law-abiding residents who simply want to enjoy the benefits of their local public spaces. For that reason, I do not expect the legislation will need to proactively invoke Section 33 of the Charter of Rights and Freedoms. However, should the courts interfere with our shared goal of effectively addressing and clearing out encampments using these enhanced tools, with your support, our government is fully prepared to use the Notwithstanding Clause. This includes the province becoming an intervenor in any court case that restricts the ability of municipalities to regulate and prohibit encampments, so long as the approach you pursue is aligned with provincial best practices.

Finally, we are ready to continue to advocate on behalf of Ontario's municipalities to the federal government to ensure that you receive your fair share of federal funding needed to deal with the challenges you have outlined and that these resources are allocated in a manner that meets your needs.

While municipalities are on the front lines of protecting our communities, it will require all levels of government to solve the homelessness crisis that is spilling into public parks and spaces. Our government will continue to stand shoulder to shoulder with you as we work to keep our communities safe and support people in need.

Best regards,

A handwritten signature in black ink, appearing to read 'Doug Ford', with a stylized flourish at the end.

Doug Ford
Premier of Ontario

This is **Exhibit “I”** to the Affidavit of Lauren Costoff
Affirmed Remotely Before Me in the City of Barrie, Province of Ontario
this 10th day of January, 2025

A handwritten signature in black ink, appearing to read "J. Anderson", written over a horizontal line.

A Commissioner for oaths, etc.

JANICE ANDERSON

NEWS RELEASE

Ontario Restoring Safety to Parks and Public Spaces

Province taking action to end encampments and crack down on public use of illegal drugs while investing \$75.5 million in homelessness prevention

December 12, 2024

[Office of the Premier](#)

TORONTO — The Ontario government will introduce legislation today that will, if passed, better protect community safety by providing municipalities and police with new resources and enforcement tools to address the growing problem of homeless encampments and crack down on illegal drug use in parks and public spaces. Ontario is also investing \$75.5 million to further support homelessness prevention and provide people living in encampments with access to reasonable alternative accommodation. This is in addition to the province's ongoing \$700 million investment in homelessness prevention programs each year, as well as the \$378 million the province is investing in 19 Homelessness and Addiction Recovery Treatment (HART) Hubs.

"Mayors and residents from communities across Ontario have been clear that enough is enough when it comes to encampments and illegal drug use in our parks and public spaces," said Premier Doug Ford. "Families deserve to enjoy their local parks and playgrounds without fearing for their kids. People facing homelessness or addiction and mental health challenges should be supported in the right settings. The federal government's approach of legalizing dangerous drugs for use in our communities has failed and it needs to end."

The province is dedicating \$75.5 million for programs that provide more long-term stable housing and temporary accommodations for those living in encampments, including:

- \$5.5 million to top up the Canada-Ontario Housing Benefit (COHB) to immediately free-up emergency shelter spaces for people living in encampments by helping people living in shelters move into longer-term housing, building on the nearly \$400 million Ontario and the federal government invested in COHB between 2023 and 2024.

- \$20 million to expand shelter capacity and create additional temporary accommodation spaces, like tiny modular units and climate-controlled semi-permanent structures, to provide people living in encampments with accessible alternative living options.
- \$50 million in funding designated for ready-to-build affordable housing projects across the province. This funding will be allocated based on how close a project is to completion, as well as its value for money, to help projects near completion but in need of targeted additional funding to open their doors faster.

This investment includes \$44.5 million in new provincial funding and \$31 million from the Canada-Ontario Community Housing Initiative.

Service managers who receive funding will be required to report back to the province on the number of individuals moved from encampments into new accommodations. They will also be required to submit spending plans to the Ministry of Municipal Affairs and Housing for review and approval, to ensure the province's \$654 million yearly investment in the Homelessness Prevention Program is being used effectively and in line with the shared provincial and municipal goal of ending encampments by providing safe and stable housing for people at risk of homelessness.

To help clear parks and public spaces of encampments, the *Safer Municipalities Act, 2024* includes amendments to the *Trespass to Property Act*, which applies to private business, offices, stores, hotels, parks and vacant land. These amendments, if passed, will enhance penalties for people who deliberately and continually break the law by adding the new aggravating factors of continuous trespassing and the likelihood to reoffend. In cases where these factors are present, these new tools will be applied by the court during sentencing.

The government is further protecting communities by introducing the *Restricting Public Consumption of Illegal Substances Act, 2024* that will, if passed, allow police officers and other provincial offences officers to direct individuals to stop using illegal substances or to leave the public space. This will allow them to issue a ticket or arrest someone who does not comply, providing an important additional tool to stop the consumption of illegal drugs in public spaces. People found guilty of violating this legislation, including those doing so in encampments, could face fines of up to \$10,000 or up to six months in prison.

As part of the province’s focus on long-term treatment and recovery, the government is exploring new judicial approaches that provide the option of rehabilitation as an alternative to incarceration in the event of minor or non-violent drug crimes.

Quick Facts

- The [Trespass to Property Act](#) provides property owners and occupiers with tools to deal with trespassing on their property.
- As of October 2024, service managers report approximately 3,300 people in about 1,000 encampment locations across Ontario.

Quotes

"We have heard from the people of Ontario that they want their communities to be safe and clean. Encampments are a public safety concern and not a solution to homelessness. Mayors have asked us for help in managing this complex issue and we are ready to provide more funding for those municipalities that show results in winding down these sites so they can address the specific needs of people in encampments and quickly move them from crisis into safer accommodation and ultimately stable, long-term housing."

- Paul Calandra
Minister of Municipal Affairs and Housing

"Using illegal drugs in public is unacceptable. Everyone should feel safe when going to a park, riding transit, or walking through their neighbourhoods. Public safety is our top priority and that is why we are providing police with the tools they need to confidently keep our communities safe, knowing we stand with them every day."

- Michael Kerzner
Solicitor General

"Encampments are a serious issue in communities across the province. Our government's proposed changes to the Trespass to Property Act will provide additional tools to support restoring public order. These amendments are one facet of a balanced broader strategy to address this difficult issue and support both communities and those currently living in encampments."

- Doug Downey
Attorney General of Ontario

"Illicit drugs and particularly opioids such as fentanyl used in public spaces in encampments are a serious community safety threat. There is a clear risk to families and children that live around the growing number of encampments in Ontario. I am very pleased Premier Ford is taking bold action to address this."

- Patrick Brown
Mayor of Brampton

"Today's announcement represents an important step in addressing the interconnected challenges of health, homelessness and public safety. By investing in pathways to stable housing and expanding the supports available to those in need, we can ensure people receive the care they require while respecting the use of public spaces for everyone, which includes new tools to restrict the prevalence of open drug use."

- Josh Morgan
Mayor of London

"I am encouraged once again by the provincial investments and commitment to address the most complex health care issue our nation has faced. Today's announcement will provide vulnerable individuals who are living in encampments with safe, stable accommodations as well as ensure that our public spaces are safe for everyone to enjoy. All levels of government need to continue to work together as partners to find innovative solutions to address this national humanitarian crisis."

- Dan Carter
Mayor, City of Oshawa

"Premier Ford has found a sensible balance to deal with a complex issue. Adding resources to support more housing solutions while providing municipalities tools to enhance public safety will help make a positive difference in communities across Ontario."

- Drew Dilkens
Mayor of Windsor

"The actions in this legislation are what we asked for. It feels great to work with a government that listens. We are united to support our most vulnerable and create safer environments for everyone."

- Rob Burton
Mayor, Town of Oakville

"Premier Ford's announcement of additional funding for more shelter spaces, temporary housing and affordable housing units is welcome news. This approach prioritizes the dignity and well-being of individuals in need, while balancing other residents' right to feel safe in public spaces."

- Paul Lefebvre
Mayor of Greater Sudbury

"The legislation being brought forward today by Premier Ford is going to help municipalities maintain safety for residents while providing supports for those who are seeking help. We can't thank the Ford government enough for supporting municipalities in these very difficult times."

- Alex Nuttall
Mayor of Barrie

"This much needed funding to help transition those in encampments to safer shelter or housing is key and I applaud the Premier for this focus. Guelph is ready to partner with our Social Services Manager and with the government to ensure we have positive outcomes for those struggling with addictions, mental health and housing needs in our community. A top complaint I receive as mayor from citizens and businesses alike is about the open illegal drug use in our parks, downtown cores and other public spaces. This legislation looks to tackle these challenges head on and are most welcome."

- Cam Guthrie
Mayor, City of Guelph

"This issue affects the families, community and professionals who have been struggling for a long time without enough financial resources and legislative tools. The proposed legislation will curb the loss of lives and destruction of families, keep the peace and provide supports to those in need. Almost two decades ago, the Select Committee on Mental Health and Addictions made recommendations, that all parties could get on board with, to solve our ever-escalating mental health and addictions crisis. After successive governments, I am pleased that the Premier is introducing legislation that will make a difference in the lives of many."

- Jan Liggett
Mayor of Cambridge

"I am happy that Premier Ford and the provincial government have taken action that prioritizes the health and well-being of the residents of St. Catharines. The additional funding and focus will help provide the services the most vulnerable members of our community desperately need and the new legislation around open drug use protects the members of our community who know this illegal activity can't continue in public. The issues our cities face are complicated and all levels of government must work together to build more supportive housing units, expand shelter capacity and clean up encampments."

- Mat Siscoe
Mayor of St. Catharines

"The health and safety of our residents is critical and its no secret municipalities across the province are grappling with large unsafe encampments and increasing drug use in public spaces. All levels of government need to continue to come together to help those suffering with mental health and addictions challenges, while also ensuring our parks and public spaces are safe for everyone to enjoy. Today's announcement is an important step in addressing a very complex and challenging issue for municipalities."

- Bryan Paterson
Mayor of Kingston

"I am glad to see the Premier responded to our group's plea for help by providing enhanced funding for shelter and housing diversion programs and strengthening trespass and open drug use laws. This is a good first step in helping municipalities deal with the issues of homelessness and public disorder on our streets and in our parks."

- Kevin Davis
Mayor of Brantford

"Vulnerable people need help to navigate drug addiction, mental health and social supports. It's time for tough love and definitive action to help them achieve that and to restore dignity and safety to public spaces."

- Jim Diodati
Mayor of Niagara Falls

"We thank the Government of Ontario for its decisive actions and meaningful investments in addressing the complex and pressing issue of homelessness and encampments. This significant funding will provide much-needed support for those experiencing hardship - enabling us to create safer and more vibrant communities for the benefit of all residents, visitors and businesses. We are committed to working with the province to ensure these vital resources are used effectively to help people transition into stable housing and access the essential support services they need."

- Kevin Ashe
Mayor, City of Pickering

"Orillia Council's top priorities are looking at ways to help support our most vulnerable and ensuring public safety. We would like to thank the province for listening to us and taking action to provide further support to service providers as we all work together to address homelessness in our communities. The initiatives announced today by Premier Ford go a long way to support us as we partner together to navigate these difficult issues."

- Don McIsaac
Mayor of Orillia

"As a growing small urban municipality with hundreds of people experiencing homelessness, addiction and mental health issues, this new funding for shelters, supportive and transitional housing aligns with the housing first principles that will help us safely transition people out of encampments and connect them to the social and health services they need while also ensuring greater accountability. Today's announcement provides meaningful funding, actionable tools, compassion and a commitment to helping us keep our communities and public spaces safe for everyone."

- Bill Gordon
Mayor of Midland

"Emergency shelters are a critical part of the housing spectrum. Outreach and shelter are the first points of contact where we build trust and spark hope for individuals experiencing homelessness. Additional funding enhances The Salvation Army's capacity to connect with individuals and welcome them into a dignified spaces with comprehensive wrap around support services that meet their unique needs. Together, we can help more Ontarians start their journey towards home."

- Lt. Col. Brian Armstrong
Ontario Divisional Commander of The Salvation Army

"Drug paraphernalia and encampment health and fire issues are among the top community safety concerns for Ontario's small business owners. Many have told us about having to clean used needles and other garbage off their property, often on a daily basis. This is unsafe and unsustainable for small business owners, their employees and their customers. Our members across Ontario overwhelmingly agree that all levels of government should work together to address these multi-faceted challenges."

- Julie Kwiecinski
Director of Provincial Affairs for Ontario, Canadian Federation of Independent Business (CFIB)

Related Topics

Government

Learn about the government services available to you and how government works.

[Learn more](#)

Health and Wellness

Get help navigating Ontario's health care system and connecting with the programs or services you're looking for. [Learn more](#)

Home and Community

Information for families on major life events and care options, including marriage, births and child care. Also includes planning resources for municipalities. [Learn more](#)

Law and Safety

Ontario's laws and related information about our legal system, emergency services, the Ontario Provincial Police and victim services. [Learn more](#)

Media Contacts

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Brent Ross

Ministry of the Solicitor General

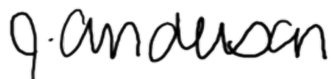
Brent.Ross@ontario.ca

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This is **Exhibit “J”** to the Affidavit of Lauren Costoff
Affirmed Remotely Before Me in the City of Barrie, Province of Ontario
this 10th day of January, 2025.

A handwritten signature in black ink, appearing to read "J. Anderson".

A Commissioner for oaths, etc.

JANICE ANDERSON

Carlo Di Carlo
Direct Line: 416-593-2485
carlodc@stockwoods.ca

December 20, 2024

Via Email: (cara.davies@toronto.ca)

Cara Davies
Legal Services Division – Litigation Section
City of Toronto
Metro Hall – 26th Floor
55 John Street
Toronto, ON M5V 3C6

Dear Ms. Davies

Re: The Neighbourhood Group Community Services et al. v. His Majesty The King in Right of Ontario | Court File No. CV-24-00732861 (the “Application”) – Request for Evidence

We are counsel to The Neighbourhood Group Community Services, Katharine Resendes, and Jean-Pierre Aubry Forgues, who are the applicants in the above-noted Application, challenging the constitutionality of ss. 2 and 3 of the *Community Care and Recovery Act* (the “**CCRA**”). The applicants contend that the *CCRA* will have disastrous public health consequences for the people of Ontario, and the people of Toronto specifically, if it is allowed to come into effect.

We understand that yesterday, December 19, 2024, the Toronto Board of Health passed a motion to direct the Medical Officer of Health (the “**MOH**”) or Acting Medical Officer of Health, as the case may be, to provide evidence in support of the Application if requested by the applicants and as determined appropriate by the City Solicitor.

We believe that the Toronto Board of Health, as a body that is directly affected by the *CCRA* and that has a mandate to promote public health in Toronto, has relevant evidence to give in this Application, and we request that it do so.

Currently, we are seeking for the MOH to provide evidence relating to the following:

- (1) Information regarding Toronto Public Health’s supervised consumption site, The Works, including:

- a. Basic factual information about The Works and how it is structured and operated;
 - b. The services provided by The Works, including but not limited to its supervised consumption services;
 - c. The client base that is served by The Works; and
 - d. How The Works will be impacted by the *CCRA*.
- (2) Data and related reporting collected, tracked, and/or prepared by the Toronto Board of Health/Toronto Public Health related to the drug overdose crisis and supervised consumption sites, including:
- a. Data relating to opioid and/or drug toxicity fatalities (both numbers and location information);
 - b. Data relating to overdoses, overdose prevention, and overdose reversal (i.e. at The Works, including any other supervised consumption sites for which Toronto Public Health has data); and
 - c. Any other data relating to impacts on public health of supervised consumption services (including any impacts as they pertain to the delivery of other services, such as childcare).
- (3) Information regarding any contingency planning being undertaken by Toronto Public Health with respect to the closure of supervised consumption sites when the *CCRA* comes into effect (including but not limited to the closure of The Works).

Should you have any questions about the above, please do not hesitate to contact us.

Yours truly,



Carlo Di Carlo

CDC/scb

cc. Fred Fischer, City of Toronto Legal Services Division
Persia Etemadi, City of Toronto Legal Services Division
Rahool Agarwal, Lax O'Sullivan Lisus Gottlieb LLP
Olivia Eng, Stockwoods LLP
Avnish Nanda, Nanda & Company

Lauren Costoff

From: Susan Bartlett <SusanB@stockwoods.ca>
Sent: Friday, December 20, 2024 4:58 PM
To: cara.davies@toronto.ca
Cc: avnish@nandalaw.ca; ragarwal@lolg.ca; fred.fischer@toronto.ca; Persia.Etemadi@toronto.ca; Olivia Eng; Carlo Di Carlo
Subject: The Neighbourhood Group Community Services el al v His Majesty the King - Court File No. CV-24-00732861
Attachments: 20241220 Letter to Toronto Board of Health Counsel.pdf

Ms. Davies,

Please see attached correspondence from Carlo Di Carlo.

Susan Bartlett

Legal Assistant to L. Ritacca, C. Di Carlo and O. Eng



Direct: 416-593-7200, 2507
Fax: 416-593-9345

Stockwoods LLP, TD North Tower
Suite 4130 - 77 King Street West
Toronto, Ontario, Canada M5K 1H1



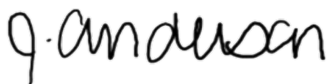
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SusanB@stockwoods.ca

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This is **Exhibit “K”** to the Affidavit of Lauren Costoff
Affirmed Remotely Before Me in the City of Barrie, Province of Ontario
this 10th day of January, 2025.

A handwritten signature in black ink that reads "J. Anderson". The signature is written in a cursive, flowing style.

A Commissioner for oaths, etc.

JANICE ANDERSON



645

**Wendy Walberg LL.B.,
LL.M., *C.S.**
City Solicitor
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as a Specialist in Municipal
Law: Local Government*

Reply To: Fred Fischer
Tel: 416.392-7224
Fax: 416.397-5624
E-Mail: fred.fischer@toronto.ca

File No. N/A

December 24, 2024

VIA EMAIL (carlodic@stockwoods.ca)

Carlo Di Carlo
Stockwoods LLP Barristers
77 King Street West, Suite 4160
Toronto, ON M5K 1H1

Dear Mr. Di Carlo:

**Re: The Neighbourhood Group Community Services et al. v. His Majesty The
King in Right of Ontario | Court File No. CV-24-00732861 – Request for
Evidence**

We are in receipt of your letter dated December 20, 2024.

Our client has considered your request and compiled the attached list of responsive evidentiary sources. These are public records, reports and data sources that should benefit from the [public documents exception](#) to the hearsay rule.

Our client does not currently have any records or reports that are responsive to your request for information regarding contingency planning with respect to the closure of supervised consumption sites.

We hope that these sources assist.

Your truly,

Signed by Fred Fischer

Fred Fischer

RESPONSIVE RECORDS, REPORTS AND DATA SOURCES	
Source	Description / Notes
Data related to the Drug Overdose Crisis and Supervised Consumption Sites	
1. Toronto Overdose Information System (TOIS)	- Data available from 2017 to present (updated monthly) for: - Paramedic Response, - Hospital Visits, - Deaths, - TPH Supervised Consumption Services, and - Drug Checking
2. SCS Information and Resources, 2024	TPH developed; Document attached, not hosted on a website but prepared for public use and broadly distributed.
3. Fact Sheet on Drug Toxicity, 2024	- TPH developed; Document attached, not hosted on a website but prepared for public use and broadly distributed. - Contains city-wide SCS data (for the 10 currently operating sites)
Information regarding the Works and Supervised Injection Services in Toronto	
4. Services Provided by The Works – City of Toronto	- The Works is a harm reduction service that has been operated by Toronto Public Health since August 9, 1989. - The Works offers a myriad of harm reduction supplies and services at its own clinic currently located at 277 Victoria St. - The Works also supports over 60 agencies across Toronto at over 100 locations and access points. - While the Works hosts a supervised consumption site, that is only one of the many services offered by the Works.
5. The Toronto Drug Strategy (2005)	The Board of Health and Toronto City Council approved the Toronto Drug Strategy in 2004, which recommended a needs assessment and feasibility study for supervised consumption services in Toronto.

6. TOSCA report (2012)	An independent research study concluded that Toronto would benefit from supervised injection services integrated into health services already serving people who inject drugs
7. Supervised Injection Services in Toronto - MOH Report to Board of Health (June 21, 2013) 8. Agenda Item History - 2013.HL23.1	MOH report and Board of Health decision supporting the implementation of supervised injection services in Toronto, and request more feasible exemption application process.
9. Supervised Injection Services for Toronto: Next Steps - MOH Report to the Board (March 7, 2016) 10. Agenda Item History - 2016.HL10.1	MOH report and Board of Health decision indicating that three health services in Toronto are planning to add small-scale supervised injection services to their existing clinical services, outlining the process for implementation, and seeking Board of Health support to begin stakeholder consultations.
11. Implementing Supervised Injection Services in Toronto - MOH Report to the Board of Health (June 16, 2016) 12. Agenda Item History - 2016.HL13.2	- MOH report and Board of Health decision regarding the implementation of supervised injection services in Toronto. - Board of Health received a summary of the consultation and supported the implementation of small-scale supervised injection services at Toronto Public Health (The Works), Queen West-Central Toronto Community Health Centre and South Riverdale Community Health Centre. - The Medical Officer of Health and the Board of Health submitted an exemption request to Health Canada.
Board of Health Exemption Request for Personal Drug Possession (contains information related to overdose crisis)	
13. Actions to Respond to the Drug Poisoning Crisis in Toronto - MOH Report to Board of Health (November 23, 2021) 14. Agenda Item History - 2021.HL32.3	- MOH report and Board of Health Decision addressing the drug poisoning crisis in Toronto. - Board of Health direction to submit a CDSA request for an exemption for personal possession of drugs in Toronto.
15. Exemption Request, January 2022	Request to Health Canada for exemption to the CDSA to allow for the possession of drugs for personal use in Toronto January 2, 2022.

16. Toronto's Model of Decriminalizing Drugs for Personal Use, 2023	Supplementary submission to Health Canada for exemption for personal possession made March 24, 2023
17. Review of the Harms Caused by the Disproportionate Impact of Drug Criminalization on African, Caribbean, and Black People in Toronto.	Document prepared by Mass LBP for the ACB Working Group, 2023
Strategic Planning	
18. Toronto Overdose Action Plan Update – MOH Report to Board of Health (January 10, 2017) 19. Agenda Item History - 2017.HL17.4	MOH report and Board of Health decision regarding the development of a Toronto Overdose Action Plan
20. Toronto Overdose Action Plan: Prevention & Response , March 2017 21. Toronto Overdose Action Plan: Prevention and Response , MOH Report to the Board of Health (March 10, 2017) 22. Agenda Item History - 2017.HL18.3	- The Toronto Overdose Action Plan - Related MOH report and Board of Health decision adopting the Action Plan
23. Update on Toronto's Overdose Action Plan – (September 25, 2017) 24. Agenda Item History - 2017.HL21.1	MOH presentation and Board decision regarding the Toronto Overdose Action Plan
25. Toronto Overdose Action Plan Implementation Update - MOH Report to the Board of Health (January 22, 2018) 26. Agenda Item History - 2018.HL27.1	MOH report and Board of Health decision regarding status of Toronto Overdose Action Plan
27. Toronto Overdose Action Plan: Status Report	MOH report and Board of Health decision regarding status of Toronto Overdose Action Plan

2018 – MOH Report to the Board of Health 28. Agenda Item History - 2018.HL27.1	
29. A Public Health Approach to Drug Policy, June 2018 30. Agenda Item History - 2018.HL28.2	• MOH Report and Board of Health decision regarding promotion of a public health approach to drug policy.
31. Toronto Overdose Action Plan: Status Report 2019 - MOH Report to the Board of Health 32. Agenda Item History - 2019.HL7.1	• MOH Report and Board of Health decision regarding status of Toronto Overdose Action Plan
33. Toronto Overdose Action Plan: Status Report 2020 - MOH Report to the Board of Health 34. Agenda Item History - 2020.HL17.2	• MOH Report and Board of Health decision regarding status of Toronto Overdose Action Plan
35. Toronto Overdose Action Plan: Status Report 2021 - MOH Report to the Board of Health 36. Agenda Item History - 2021.HL29.2	• MOH Report and Board of Health decision regarding status of Toronto Overdose Action Plan
37. Toronto Overdose Action Plan Status Report, 2022 - MOH Report to the Board of Health 38. Agenda Item History - 2022.HL38.3	• MOH Report and Board of Health decision regarding status of Toronto Overdose Action Plan
39. Our Health, Our City Strategy, 2023	• City-wide, 5-year strategy
40. OHOC Annual Progress Report, 2024 - MOH Report to the Board of Health	• MOH report to the Board of Health on progress of the Our Health, Our City Strategy
41. TPH Strategic Plan, 2024-2028	• Identifies 5 priorities, one of which is: “Promote the conditions to support positive mental health and reduce the harms of substance use.”

42. Report on TPH Strategic Plan, 2024 - MOH Report to the Board of Health	• MOH report to the Board of Health on TPH Strategic Plan • Provides context on how the strategic plan was developed

SCS Services - Information & Resources
April 2024

Supervised Consumption Services - Information & Resources

Supervised Consumption Services (SCSs) are clinical spaces for people to bring their own drugs to use in the presence of trained health professionals. Canadian and international evidence shows that SCSs save lives, connect people to social services and are pathways to treatment.

SCSs are designed to improve the health status of people who use drugs by having trained health professionals available immediately should a person overdose or experience an unwanted side effect of taking drugs. They are also a place for people who use drugs to connect with other health and social services, including mental health services. They have been shown to prevent overdose deaths and reduce the spread of infectious diseases. The first SCS in Toronto opened in 2017.

Toronto Public Health works in close partnership with community health providers, housing providers, and emergency responders to improve community health and wellbeing for everyone living in Toronto, including people who use drugs.

There are ten sites currently providing supervised consumption services in Toronto (See Appendix 1 for list) and six of these sites are provincially designated as a [Consumption and Treatment Service \(CTS\) site](#). Toronto Public Health operates a SCS site (located at 277 Victoria St.) and inspects the six provincially designated CTS sites in Toronto, as mandated by a protocol under the Ontario Public Health Standards. Inspection results are posted on the City's [website](#), as required by the provincial protocol.

These sites are essential in reducing the harm of drug use because the unregulated drug supply in Toronto is increasingly unpredictable and toxic, elevating the risk of overdoses and preventable deaths. The Office of the Chief Coroner for Ontario reported over 500 deaths per year for the last few years (591 deaths in 2021; 509 deaths in 2022) due to opioid toxicity in Toronto.

Questions, Concerns or Complaints about Infection Control at CTS Sites

- Members of the public can submit questions, concerns or complaints about the CTS sites to the Toronto Public Health Control of Infectious Diseases/Infection Control Program online by submitting a [CTS Complaint Intake Form](#), by phone at 416-338-8400 or email CTSComplaints@toronto.ca.

Questions, Concerns or Complaints about Public Safety

- Members of the public can call 911 in case of emergency.
- If it is not an emergency, the public can call 416-808-2222 or [file a report online](#) for: illegal parking, damage to property, damage to vehicle, local traffic issues or concerns, general driving complaints, graffiti, fraud and theft.

Questions or Concerns about Helping Someone in Crisis

- There are resources available for individuals experiencing a mental health or substance use related crisis, please see the Crisis Resources Table on page 2.

Crisis Resources

ConnexOntario:

24/7 service information for people experiencing problems with gambling, drugs, alcohol and/or mental health.

Call: 1-866-531-2600

Text: CONNEX to 247247

Visit: [ConnexOntario.ca](https://www.connexontario.ca)

Gerstein Crisis Centre:

24/7 telephone support, in-person mobile crisis team, community support referrals, substance use crisis management, follow-up, and access to short-term crisis beds.

Call: 416-929-5200

Visit: [GersteinCentre.org](https://www.gersteincentre.org)

Toronto Community Crisis Service (TCCS):

Community-based service with multidisciplinary teams of crisis workers who will respond to non-emergency calls from people in crisis and requests for wellbeing checks.

Call: 2-1-1

Visit: [Toronto.ca/CrisisService](https://toronto.ca/CrisisService)

Supervised Consumption Services: FAQs

What is the impact of supervised consumption services on people who use drugs?

- As of January 2024, Toronto Public Health's supervised consumption sites, have seen 149,627 visits, 3,812 overdoses and reversed 2,262 overdoses.ⁱ
- A recent study found that following implementation of supervised consumption services in Toronto, there were less fatal overdoses in the surrounding neighbourhoods. Fatal overdoses declined by 67 per cent within 500 metres following implementation of SCS.
- People who use drugs face drug-related harms which increase when accessing the unregulated street drug supply which is unpredictable in both composition and potency and increasingly toxic. This places people who use drugs at increased risk of accidental overdose and death. They are also at an increased risk of contracting HIV, hepatitis C, skin and soft tissue infections.

What is the impact of supervised consumption services on the surrounding community?

- Most of the [available peer reviewed research](#) on supervised consumption services suggests that SCSs do not increase crime and may help improve public order in their surrounding communities.
- CTS sites are typically located in areas already identified as high-need, as determined by the provincial government.
- Insite (*North America's first sanctioned supervised injection site, located in Vancouver, BC*) was associated with reductions in public injecting, discarded needles, and other injection-related litter.ⁱⁱ One year after Insite opened, there were no increases in drug trafficking, assaults, robberies, and there was a significant decline in vehicle break-ins/vehicle theft.ⁱⁱⁱ
- SCSs can have a positive impact on healthcare expenditures. For example, a 2010 cost-benefit analysis found that Insite saved over \$6 million per year by preventing HIV infection and death.^{iv}
- A recent study of an SCS in Calgary found that every overdose that was managed at the SCS provided approximately \$1,600 in cost savings (offsetting costs required to manage overdoses in emergency departments and through pre-hospital ambulance services).^v

What advice does Toronto Public Health provide to people who use drugs to prevent and respond to overdose?

- People who use drugs should try not to use alone, and use a supervised consumption service, if possible. If you must use alone, get someone to check on you or call the National Overdose Prevention Line at 1-888-688-NORS (6677); get your drugs checked through Toronto's Drug Checking Service; get naloxone and use it, and call 911 if somebody is experiencing an overdose.

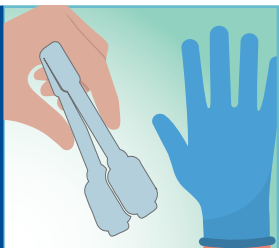
What to do if you find drug-related litter (e.g., needles) in your neighbourhood?

- Please see the poster on page 4 for an overview of how to safely dispose needles. This poster can be accessed online [here](#), and shared. Additional information is available on the City's [website](#).
- Report improperly discarded needles found in: roadways, sidewalks, boulevards, city laneways, and municipal parks to 311.

Appendix 1: Site Name	Supervised Consumption Service	CTS	Inspected by Toronto Public Health	Ward	Police Service Division
1. Fred Victor 139 Jarvis St. (Queen St. E./Jarvis St.)	Yes	Yes	Yes	13	51 Division
2. Moss Park CTS 134 Sherbourne St. (Queen St. E./Sherbourne St.)	Yes	Yes	Yes	13	51 Division
3. Parkdale Queen West Community Health Centre 168 Bathurst St. (Bathurst St./Queen St. W.)	Yes	Yes	Yes	10	14 Division
4. Parkdale Queen West Community Health Centre 1229 Queen St. W. (Queen St. W./Dufferin St.)	Yes	Yes	Yes	4	14 Division
5. South Riverdale Community Health Centre KeepSIX 955 Queen St. E.	Yes	Yes	Yes	14	55 Division
6. Street Health 338 Dundas St. E. (Dundas St. E./Sherbourne St.)	Yes	No	No	13	51 Division
7. The Neighbourhood Group Kensington Market Overdose Prevention Service 260 Augusta (at College St.)	Yes	No	No	11	14 Division
8. Toronto Public Health The Works 277 Victoria St. (Yonge St./Dundas St. E.)	Yes	No	No	13	51 Division
9. Regent Park Bevel Up CTS Site (Regent Park Community Health Centre) 465 Dundas St. E.	Yes	Yes	Yes	13	51 Division
10. Casey House 119 Isabella St. (Isabella/Jarvis St.)	Yes	No	No	13	51 Division

How to Safely Pick Up a Discarded Needle

1



Protect your hands by using tongs or puncture resistant gloves.

2



Hold the needle tip away from you.

3



Put the needle into a sharps container or plastic container with a lid.

4



Do not put the container into the garbage or recycling bin.

Call 311 for information on safe disposal locations.



Toronto Public Health

| toronto.ca/health 416.338.7600

ⁱ TPH Supervised Consumption Services. (2017-2024). Toronto Overdose Information System (TOIS), Toronto Public Health. Available at: https://public.tableau.com/app/profile/tpheu/viz/TOISDashboard_Final/ParamedicResponse

ⁱⁱ Wood, E., Kerr, T., Small, W., Li, K., Marsh, D. C., Montaner, J. S., & Tyndall, M. W. (2004). Changes in public order after the opening of a medically supervised safer injecting facility for illicit injection drug users. *Cmaj*, 171(7), 731-734.

ⁱⁱⁱ Wood, E., Tyndall, M. W., Lai, C., Montaner, J. S., & Kerr, T. (2006). Impact of a medically supervised safer injecting facility on drug dealing and other drug-related crime. *Substance abuse treatment, prevention, and policy*, 1(1), 1-4.

^{iv} Andresen, M. A., & Boyd, N. (2010). A cost-benefit and cost-effectiveness analysis of Vancouver's supervised injection facility. *International Journal of Drug Policy*, 21(1), 70-76.

^v Khair, S., Eastwood, C. A., Lu, M., & Jackson, J. (2022). Supervised consumption site enables cost savings by avoiding emergency services: a cost analysis study. *Harm Reduction Journal*, 19(1), 32.

Factsheet on the Drug Toxicity Epidemic in Toronto September 2024

Factsheet on the Drug Toxicity Epidemic in Toronto

October 2024

The opioid toxicity crisis has significantly impacted Toronto for the past decade, with an escalation after 2015 that further deepened during the COVID-19 pandemic.

This factsheet provides an overview of current data on the opioid toxicity crisis in Toronto, and the range of services provided through Consumption and Treatment Service Sites and Supervised Consumption Service sites.

Opioid toxicity deaths

Based on preliminary data, there were **525** confirmed and probable opioid toxicity deaths among Toronto residents in 2023. The preliminary number of opioid toxicity deaths in 2023 is comparable to 2022 (**N=510**) but remains high when compared to pre-pandemic years representing a **74%** increase from 2019.

Although many people are impacted by the crisis, in 2023, **more than three-quarters** of all accidental opioid deaths in Toronto were among males. Almost **half** of all accidental opioid toxicity deaths were among individuals between the ages of 25 and 44, followed by **41%** in the 45 to 64 years age group.

The unregulated drug supply and opioid toxicity deaths

The vast majority of opioid toxicity deaths (**96%**) are accidental. This is largely due to the toxicity and unpredictability of the unregulated drug supply, where the use of highly potent opioids is combined with more unexpected and concerning substances. For example, the unregulated fentanyl supply contains varying concentrations of fentanyl, as well as unexpected drugs that include other central nervous system and respiratory depressants. More information about the unregulated supply can be found on [Toronto's Drug Checking Service website](#).

Between 2018 and 2023, fentanyl has consistently been the **highest** direct contributing opioid to accidental opioid toxicity deaths in Toronto. In 2023, fentanyl contributed to **86%** of accidental deaths. Non-opioid drugs have increasingly been identified in accidental opioid toxicity deaths since 2018 as well, with cocaine being the highest direct contributor at **56%** in 2023, followed by benzodiazepines (**39%**) and methamphetamines (**32%**).

Impact on the health care system and emergency response

The opioid toxicity crisis also has a direct impact on the health care system, and on emergency response services. There were **2,932** emergency department visits and **449** hospitalizations due to opioid poisoning at Toronto hospitals in 2023. In addition, Toronto Paramedic Services attended to an average of **24** fatal suspected opioid overdose calls and **376** non-fatal calls every month throughout 2023. This has continued into 2024, with an average of **21** fatal and **367** non-fatal suspected overdose calls attended by paramedics each month as of August 2024.

Geographic concentration of Toronto Paramedic Service calls

The highest concentration of calls attended by paramedic services for suspected opioid overdoses between July 1, 2023 to June 30, 2024 were in downtown Toronto, with the **top five** neighbourhoods being **Downtown Yonge East, Moss Park, Church-Wellesley, Kensington-Chinatown** and **Yonge-Bay Corridor** (Figure 1).

They also responded to a high volume of calls in multiple neighbourhoods surrounding the downtown core and parts of Scarborough. Figure 1 shows that Toronto Paramedic Services attended suspected opioid overdose calls across the entire city.

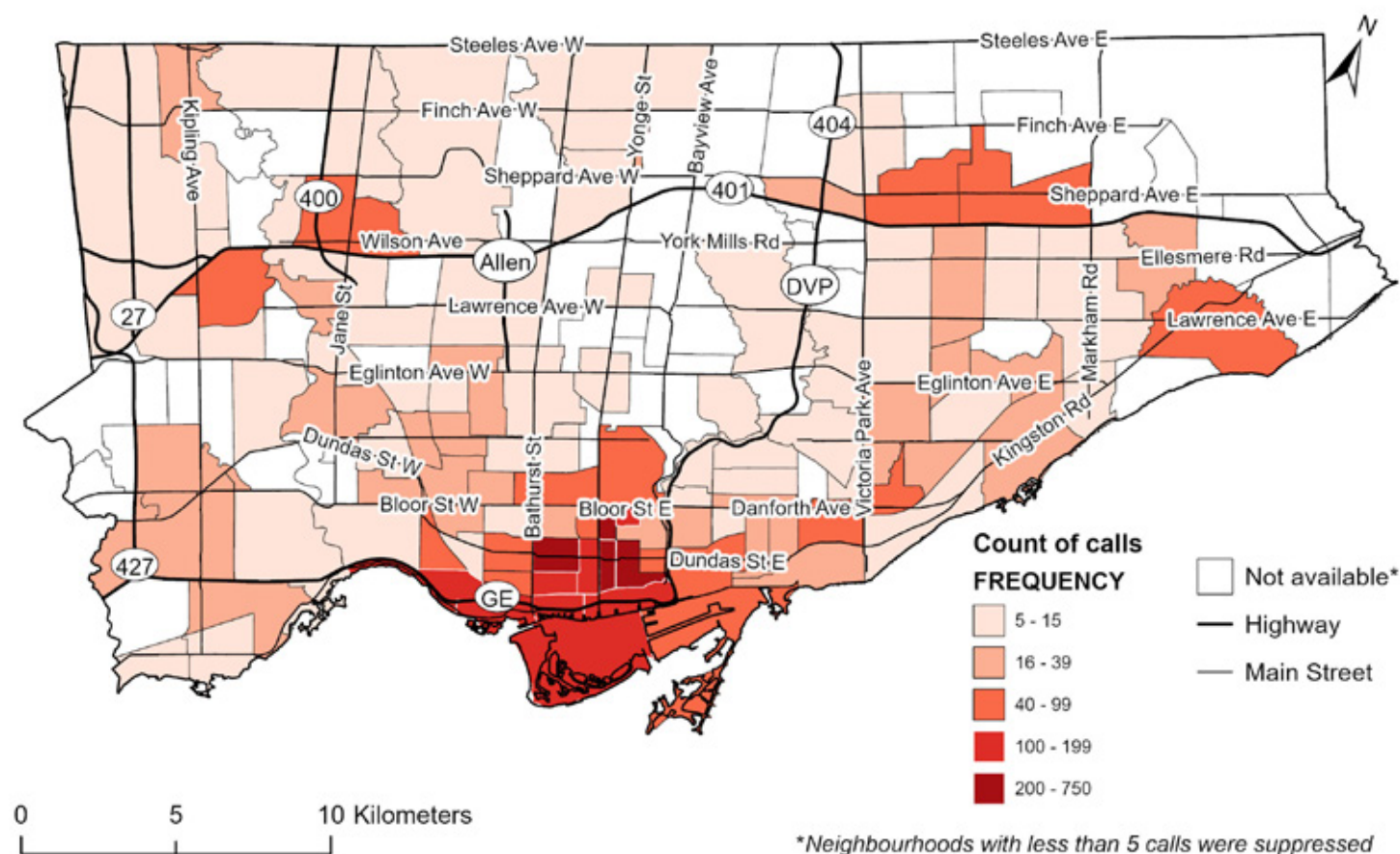
Use of supervised consumption service sites

Supervised Consumption Service (SCS) sites and Consumption and Treatment Service (CTS) sites are clinical spaces for people to bring their own drugs to use in the presence of trained health professionals. Canadian and international evidence show that SCS sites save lives, connect people to social services, and are pathways to treatment. In Toronto, SCS sites have provided programs and services to clients across the city in the form of overdose reversals, health care interventions, needle exchange programs and referrals to a full range of health and social supports.

Across the ten SCS sites in Toronto, there were a total of **96,002** client visits in 2022, and **94,872** client visits in 2023. SCS staff responded to **1,776** visits where overdoses occurred in 2022 and **2,296** in 2023, along with **446** overdoses that required naloxone in 2022, and **523** in 2023. A total of **584,215** needles were collected in 2022 across eight SCS sites, and **507,476** needles were collected in 2023. In terms of referrals to other health and social services, nine SCS sites provided **6,466** referrals in 2022 and **9,867** referrals in 2023.

On April 1, 2025, it is anticipated that Toronto will go from ten SCS sites to four sites located in the downtown core. With the proposed restrictions and closures of these clinical healthcare service sites, the impact of the drug toxicity epidemic and pressure on other services across the city is anticipated to increase.

Figure 1: Map of suspected opioid overdose calls by neighbourhood, Toronto, July 1, 2023 to June 30, 2024.



Technical Notes

Opioid toxicity deaths

Data Source

- Office of the Chief Coroner for Ontario, January 2018 to December 2023.
 - Yearly counts extracted September 2024.
 - Detailed socio-demographic characteristics and nature and origin of substances via September 5, 2024 Public Health Ontario Quarterly Public Health Unit Opioid-related Death Report, extracted on July 23, 2024.

Data Notes

- Data is preliminary and subject to change as the coroner completes their investigations.
- Confirmed and probable opioid toxicity deaths include deaths with an accidental or intentional manner of death, or deaths with undetermined intent.
- Deaths included are caused by opioid toxicity, with or without other drugs also contributing to death.
- Deaths due to chronic substance use, medical assistance in dying, homicides and trauma where an intoxicant contributed to the circumstances of the injury are excluded.
- Counts of less than 5 are assessed for risk of identification and potentially suppressed.
- Drug categories are not mutually exclusive; some deaths are attributed to multi-drug toxicity where a death can include more than one drug as a cause.

Healthcare Utilization

Data Source

- National Ambulatory Care Reporting System (NACRS), January 1, 2023 to December 31, 2023. Ontario Ministry of Health, IntelliHealth Ontario. Extracted April 2024.
- Discharge Abstract Database (DAD), January 1, 2023 to December 31, 2023. Ontario Ministry of Health, IntelliHealth Ontario. Extracted April 2024.

Paramedic Response

Data Source

- Toronto Paramedic Services. Electronic Patient Care Record.
 - Monthly counts: January 2023 to August 2024. Extracted September 5, 2024.
 - Geographic information: July 1, 2023 to June 30, 2024. Extracted July 3, 2024.

Data Notes

- Information is preliminary and subject to change pending further review of the data source.
- The data includes instances where 911 is called and likely underestimates the true number of overdoses.
- The data include cases where the responding paramedic suspected an opioid overdose. This may differ from the final diagnosis in hospitals or cause of death determined by the coroner.

- The geographic information refers to the total number of calls (i.e. fatal and non-fatal calls combined). Between July 1, 2023 and June 30, 2024, there were 4,874 calls with valid geographic information occurring within the boundaries of the City of Toronto. Information on other neighbourhoods can be found in the [Calls to Paramedic Services for Suspected Opioid Overdoses](#) report found on the [Toronto Overdose Information System](#).
- The location refers to where paramedics made contact with patients, which may be different from where 911 was called.
- Neighbourhood refers to the boundaries as defined by the City of Toronto. To search neighbourhoods by address or location, use the Neighbourhood Listing Location Lookup tool.
- For neighbourhoods with five or more suspected opioid overdose calls, Toronto Paramedic Services attended 42 calls on average across neighbourhoods between July 1, 2023 to June 30, 2024. Areas surrounding the downtown core and Scarborough had more than one neighbourhood with calls higher than the average.

Supervised Consumption Services

Data Source

- Supervised consumption services data, January 2022 to December 2023. Received September 2024.

Data Notes

- Data includes information from the following Supervised Consumption Service sites and Consumption and Treatment Service (CTS) sites across Toronto where available: The Works, Moss Park CTS, KeepSIX CTS, Fred Victor, Street Health Overdose Prevention Site, Regent Park Bevel Up, Kensington Market Overdose Prevention Site, Parkdale, Parkdale Queen West Community Health Centre and Casey House.
- The numbers for each site are for the duration they were operational and based on the reporting periods that were submitted.
- There might be slight differences between how visits and overdoses are recorded by supervised consumption sites.

	<i>ONTARIO</i> SUPERIOR COURT OF JUSTICE Proceeding commenced at TORONTO
	AFFIDAVIT OF LAUREN COSTOFF
	LAX O'SULLIVAN LISUS GOTTLIEB LLP Suite 2750, 145 King Street West Toronto, ON M5H 1J8 Rahool P. Agarwal LSO#: 545281 Direct: 416 645 1787 Email: r.agarwal@lolg.ca STOCKWOODS LLP Suite 4130, 77 King Street West Toronto, ON M5K 1H1 Carlo Di Carlo LSO #: 62159L Direct: 416-593-2485 Email: CarloDC@stockwoods.ca Olivia Eng LSO #: 84895P Direct: 416-593-2495 Email: OliviaE@stockwoods.ca Lawyers for the Applicants

TAB 11

Court File No. CV-24-00732861-0000

ONTARIO
SUPERIOR COURT OF JUSTICE

B E T W E E N:

THE NEIGHBOURHOOD GROUP COMMUNITY SERVICES, KATHARINE
RESENDES, and JEAN-PIERRE AUBRY FORGUES

Applicants

and

HIS MAJESTY THE KING IN RIGHT OF ONTARIO

Respondent

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

AFFIDAVIT OF AHMED BAYOUMI

I, AHMED BAYOUMI, of the City of Toronto, in the Province of Ontario, MAKE OATH
AND SAY:

1. I have been retained by Stockwoods LLP, Lax O’Sullivan Lisus Gottlieb LLP and Nanda and Company on behalf of their clients the Neighbourhood Group Community Service, Katharine Resendes and Jean-Pierre Aubry Forgues as an expert in the above-noted proceeding.
2. A copy of my expert report is attached hereto as **Exhibit “A”**. A copy of my *curriculum vitae* is included as an appendix to my expert report.

3. A copy of my Acknowledgement of Expert's Duty is attached hereto as **Exhibit "B"**.

SWORN by Ahmed Bayoumi of the City of Toronto, in the Province of Ontario, before me at the City of Toronto, in the Province of Ontario, on January 8, 2025, in accordance with O. Reg. 431/20, Administering Oath or Declaration Remotely.

Carlo Di Carlo

Commissioner for Taking Affidavits
(or as may be)

Carlo Di Carlo
LSO 62159L



AHMED BAYOUMI

TAB A

This is Exhibit “A” referred to in the Affidavit of
Ahmed Bayoumi sworn January 8, 2025.

Carlo Di Carlo

Commissioner for Taking Affidavits

Court File No. CV-24-00732861

**ONTARIO
SUPERIOR COURT OF JUSTICE**

BETWEEN:

THE NEIGHBOURHOOD GROUP COMMUNITY SERVICES, JEAN-PIERRE AUBRY
FORGUES and KATHARINE RESENDES

Applicants

and

HIS MAJESTY THE KING IN RIGHT OF ONTARIO

Respondent

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

EXPERT REPORT OF DR. AHMED BAYOUMI

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I. MY BACKGROUND

1. I am a Professor in the Department of Medicine, Faculty of Medicine, at the University of Toronto. I hold status-only appointments in two graduate departments: the Institute of Health Policy, Management, and Evaluation and the Institute of Medical Sciences. I am a full member of the School of Graduate Studies. Attached as **Appendix “A”** is a copy of my *curriculum vitae*, which sets out my education, work experience, and academic and service contributions.
2. I am a clinician scientist at St. Michael’s Hospital, Toronto, which is part of Unity Health Toronto. I am a Scientist in the MAP Centre for Urban Health Solutions. I am also a Senior Adjunct at ICES (formerly, the Institute for Clinical Evaluative Sciences). I graduated as a Medical Doctor in 1989, and I am a fellow of the Royal College of Physicians and Surgeons of Canada in Internal Medicine (i.e., I am an Internal Medicine specialist). I hold a Masters of Science degree in Community Health with a subspecialization in Clinical Epidemiology from the University of Toronto. I completed a post-doctoral fellowship in the Department of Health Policy at Stanford University.
3. I am an expert in health services research with a focus on modelling, measurement of preferences, access to care, analysis of large databases, and health technology assessment. I concentrate on issues relating to people who use drugs, people living with HIV, and other people facing marginalization and have over 220 publications.
4. I hold the Alma and Baxter Ricard Chair in Inner City Health, in recognition of my expertise in studying health and health service for people experiencing marginalization.
5. I have conducted numerous studies evaluating health service interventions related to drug use and HIV and in decision-science based methods for measuring quality of life, trade-offs, and resource allocation. My work has been published in top-ranked journals, including *The New England Journal of Medicine*, *The Lancet Public Health*, *Annals of Internal Medicine*, and *Addiction*. My work has had impact on public policy, the adoption of routine screening for HIV infection as a policy recommendation by the Centres for Disease Control in the United States. I have received multiple competitive research grants, many of which focus on substance use, from the Canadian Institutes of Health Research and other funding agencies.
6. I have published extensively on the topic of supervised consumption facilities, including economic analyses, qualitative studies, and epidemiological analyses. In this role, I visited numerous supervised consumption services sites, conducted interviews of clients attending these services as well as staff and operators of the sites in order to generate evidence. This allowed me to obtain firsthand knowledge of how these services were impacting lives. I discuss some of these observations that I obtained below. I also reviewed and appraised the available research regarding the effectiveness of supervised consumption services, particularly in

Canada and in Ontario. I was co-principal investigator of the Toronto and Ottawa Supervised Consumption (TOSCA) study, a team of 20 that worked with decision makers, community members and service providers to establish the evidence base for Toronto and Ottawa facilities using mixed-methods research. We published extensively, including an invited commentary in *The Lancet*, and were awarded the Goering award in Collaborative Research and Knowledge Translation in Mental Health and Addictions at the University of Toronto.

7. I have served on several committees and organizations to implement research knowledge into better care for people experiencing marginalization. I sat on the Toronto Public Health's Drug Strategy advisory panel and on their Decriminalization Evaluation Working Group. I am also the evaluation lead for the Toronto Opioid Overdose Action Network, which consist of hospital, community, and public health partners working together to provide a systems-level approach to address the ongoing drug poisoning crisis in Toronto. I sit on the steering committee of an annual meeting for people engaged in simulation modelling related to opioid use.
8. I was a member of the South Riverdale Community Health Centre Consumption and Treatment Service Review. My research team conducted community consultations and drafted the Community Engagement Report that was submitted as a Companion Document to the report. Attached as **Appendix "B"** are copies of the reports.
9. I have held several leadership positions. I am past Scientific Director of Converge3, an Ontario multi-institution network that conducted complex policy analyses for provincial ministries. I have held several roles in the international Society for Medical Decision Making, including President and Past President. I was a member of the Canadian Drug Expert Committee of the Canadian Agency for Drugs and Technology and Health from 2011 to 2021, and I was Director of the Clinical Epidemiology and Health Care Research graduate program at the University of Toronto from 2006-2012.
10. I have won awards in recognition of my research expertise, including the John M. Eisenberg Award for Practical Application of Medical Decision Making Research internationally and the Dr. David Sackett Senior Investigator Awards from the Canadian Society of Internal Medicine. I have been recognized as an Outstanding Reviewer by the College of Reviewers of the Canadian Institutes of Health Research. I have previously held a Canadian Institutes of Health Research (CIHR)/Ontario Ministry of Health and Long-term Care Applied Chair in Health Services and Policy.
11. I have been an Invited Speaker nationally and internationally on drug policy, in general, and supervised consumption sites, specifically, including presentations at Stanford University in California, the Stanford University Hong Kong Club, the University of Pittsburgh, Dartmouth University, and Weill Cornell University. I was an advisor to the New York City Department of Health and Mental Hygiene and to the province of Alberta on issues related to supervised consumption sites.

12. I am also a practicing clinician at St. Michael's Hospital in the Division of General Internal Medicine. My inpatient clinical care is on the General Internal Medicine service. My outpatient clinical care is predominantly in the Positive Care Clinic, which is the hospital's clinic for people living with HIV infection. I have had a hospital appointment since 1998.
13. A large number of my inpatients and outpatients use substances, including drugs that are unregulated (also referred to as illicit drugs. Throughout this report, I use the terms substance use and drug use interchangeably). I have cared for innumerable numbers of people who inject drugs. Many of these people have substance use disorders (a term I will define below). I am familiar with and have experience diagnosing and treating patients who have this disorder, and I am familiar with the impact this disorder has on their lives.

II. DESCRIPTION OF MY MANDATE

14. I have been retained by Stockwoods LLP, Lax O'Sullivan Lisus Gottlieb LLP and Nanda & Company as an expert witness in relation to *The Neighbourhood Group Community Services et al. v. His Majesty The King in Right of Ontario* | Court File No. CV-24-00732861 (the "**Application**")
15. I have been asked to prepare a report that provides my answers to the following questions:
 - What is the history of supervised consumption services in Ontario and in Canada?
 - What health effects do supervised consumption services have on the individuals who use these services?
 - What are the socio-demographic characteristics of individuals who are most likely to use supervised consumption services?
 - What are the concerns that community members have about supervised consumption services? How can/do supervised consumption services address those concerns?
 - What are, in your opinion, the likely ramifications for users of supervised consumption services and the community if the *Community Care and Recovery Act* goes into effect?
16. In preparing this report and addressing those questions, I relied on my experience and expertise and reviewed the documents listed in Section "V" of this Report. I also reviewed the Notice of Application filed by the Plaintiffs in this matter.
17. Counsel did not provide me with any factual assumptions on which my opinion is based. Any facts that I relied on in coming to the opinions I have set out in this report below.

III. SUMMARY OF OPINIONS

18. My opinion respecting each question is as follows:

- Supervised consumption services have been available across Canada and internationally as a form of public health intervention for those living with substance use disorder. Substance use disorder is a recognized chronic health condition with established diagnostic criteria. In some instances, this disorder can impair an individual's ability to function. In these circumstances, it could be considered a disability. Based on my experience and research, the majority of individuals who use supervised consumption services have a substance use disorder to an extent that can be considered a disability. Supervised consumption services are a core and evidence-based component of the public health response to the current overdose crisis.
- There is a strong scientific consensus that supervised consumption services improve the health of individuals who use their service, including decreased overdose, reduced mortality risk, increased access to other services for people who use drugs such as opioid agonist treatment, and other health outcomes. There is no evidence of harm from supervised consumption services to individuals who use their services.
- Individuals who access supervised consumption services are disproportionately experiencing homelessness. Limited access to supervised consumption services is a barrier for many people who will not travel far for services, and the closure of those services will exacerbate those barriers. Many individuals who access supervised consumption services have been recently incarcerated. Women, Indigenous and racialized groups are also overrepresented.
- Community members have concerns about social disorder, crime, public litter, and safety of children. The evidentiary basis for making causal inferences about introducing supervised consumption services and exacerbating social disorder is weak or non-existent. In fact, the evidence suggests that supervised consumption services result in decreased rates of public drug consumption and a decrease in drug-related litter (two of the concerns that community members have raised). Supervised consumption services can improve communication and consultations with communities to address perceptions.
- If the Community Care and Recovery Act ("**CCRA**") comes into effect, a large proportion of people who are currently clients of supervised consumption services will no longer have access to them. My conclusion, based on my research and experience, is that many will have unsupervised overdoses, and some will die. I also expect that there will be an increase in the rate of bloodborne infectious diseases, as many will not have access to sterile drug consumption equipment. The HART Hubs outlined within the CCRA will be not address the harm reduction needs of current supervised consumption service clients.

IV. BASIS OF MY OPINIONS

A. *The History of Supervised Consumption Services in Ontario and Canada*

19. As alluded to above, I have either extensively researched or have firsthand knowledge of the history of the development of supervised consumption services in Canada, and in Ontario in particular. Below I have detailed and described this history.

i. *Substance Use Disorder*

20. As I noted above, many of the people who use supervised consumption services have a substance use disorder. Substance use occurs along a spectrum. Substance use disorder is a term that has been adopted by the American Psychiatric Association in their *Diagnostic and Statistical Manual, Fifth Edition, Text Revision* (“**DSM-5-TR**”). The DSM-5-TR is the widely recognized standard for diagnosing conditions related to mental health and substance use. Substance use disorder encompasses a wide range of drug taking. The DSM-5-TR does not endorse use of the term “addiction,” which is considered both imprecise and stigmatizing.¹
21. Substance use disorders include cognitive, behavioural, and psychological symptoms and apply to a wide range of substances. Disorders are considered a problematic pattern of use leading to clinically significant impairment or distress, as manifested by at least two criteria (as demonstrated below), occurring within a 12-month period.
22. The DSM-5-TR has specific diagnostic criteria for different substance use disorders based on the substance at issue. However, the criteria across different substances are similar (the main differences relate to the reference to the substance at issue). For example, the diagnostic criteria for opioid use disorder are¹:
- Opioids are often taken in larger amounts or over a longer period than was intended.
 - There is a persistent desire or unsuccessful efforts to cut down or control opioid use.
 - A great deal of time is spent in activities necessary to obtain the opioid, use the opioid, or recover from its effects.
 - Craving, or a strong desire or urge to use opioids.
 - Recurrent opioid use resulting in a failure to fulfill major role obligations at work, school, or home.
 - Continued opioid use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of opioids.

- Important social, occupational, or recreational activities are given up or reduced because of opioid use.
 - Recurrent opioid use in situations in which it is physically hazardous.
 - Continued opioid use despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance.
 - Tolerance, as defined by either of the following:
 - a) A need for markedly increased amounts of opioids to achieve intoxication or desired effect.
 - b) A markedly diminished effect with continued use of the same amount of an opioid.
 - Withdrawal, as manifested by either of the following:
 - a) The characteristic opioid withdrawal syndromeⁱ
 - b) Opioids (or a closely related substance) are taken to relieve or avoid withdrawal symptoms.
23. The DSM-5-TR offers general estimates of substance use disorder severity: mild (2 to 3 symptoms), moderate (4 to 5 symptoms), and severe (6 or more symptoms).¹
24. Almost two-thirds of all opioid-related deaths in Ontario occur among people with a diagnosis of opioid use disorder, as inferred from medical records.² The number of deaths from opioid-related overdose is increasing among both people with a prior opioid use disorder diagnosis and those without a prior diagnosis.³ The increase in people without a prior diagnosis may indicate people who have an opioid use disorder but have not been diagnosed or people who do not have an opioid use disorder (i.e., do not meet the criteria listed above). Thus, there is a

ⁱ The DSM-5-TR has separate diagnostic criteria for Opioid Withdrawal Syndrome. These criteria are:

A. Presence of either of the following:

1. Cessation of (or reduction in) opioid use that has been heavy and prolonged (i.e., several weeks or longer).
2. Administration of an opioid antagonist after a period of opioid use.

B. Three (or more) of the following developing within minutes to several days after Criterion A:

1. Dysphoric mood.
2. Nausea or vomiting.
3. Muscle aches.
4. Lacrimation or rhinorrhea.
5. Pupillary dilation, piloerection, or sweating.
6. Diarrhea.
7. Yawning.
8. Fever.
9. Insomnia.

C. The signs or symptoms in Criterion B cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

D. The signs or symptoms are not attributable to another medical condition and are not better explained by another mental disorder, including intoxication or withdrawal from another substance.

need to support people across the range of substance use to prevent overdose deaths.

ii. *Supervised Consumption Services as a Public Health Response*

25. Supervised consumption services have been available in Canada for over 20 years. The first sanctioned supervised consumption site in Canada was in Vancouver, before access to this form of public health intervention gradually spread to the rest of the country.
26. Supervised consumption services arose as a public health response to address issues related to drug consumption, including the health needs of those with substance use disorders. Access to these services expanded in part as a response to the large mortality and morbidity losses attributable the crisis in unregulated drugs that started in Canada in 2016. This crisis is largely due to changes in the unregulated opioid supply in Ontario and many other regions of Canada, which now largely consists of synthetic opioids.⁴ Fentanyl and analogues contributed to 87% of opioid-related deaths in Toronto in 2022.⁵ Adulterants, such as benzodiazepines and xylazine, are also contributing to the increased number of overdoses.⁴
27. Increased use of multiple substances (also referred to as drugs), particularly use of opioids along with stimulants, has also been documented in Canada in recent years.⁶ In national data from the first 6 months of 2022, 47% of opioid-related deaths also involved a stimulant and 83% of stimulant-related deaths involved an opioid; 64% of stimulant-related deaths involved cocaine and 51% involved methamphetamines.⁷
28. The unregulated drug crisis is a leading cause of preventable death and disability. In 2019, substance use was the tenth highest cause of disability adjusted life years lost in Canada; it was also the most rapidly increasing cause since 1990.^{7,8} In 2023, there were 524 opioid-related deaths in Toronto, with more than 510 deaths per year from 2020-2023.⁹
29. Supervised consumption refers to situations in which people use drugs in an environment where they are observed by trained personnel (peers, volunteers, health professionals, etc.), where sterile supplies are available, and where overdoses can be immediately treated. The most common substances that people use at supervised consumption sites are opioids and amphetamines, which are typically unregulated. Supervised consumption sites typically offer supervised injection; some may also offer supervised consumption of drugs by other routes (by mouth or inhalation).
30. Supervised consumption sites are sanctioned when organizations operate with an exemption from federal drug laws, such that individuals cannot be prosecuted for drug possession within that environment; unsanctioned supervised injection typically refers to community-organized “pop-up” sites. Overdose prevention sites (“**OPS**”) offer a more limited range of services than supervised consumption

sites. Whereas supervised consumption sites were typically implemented within established health centre and offered services beyond supervised consumption (such as referral to other health and social services), OPSs in Ontario were led by healthcare or community-based organizations and were required to offer only supervised injection, naloxone, and harm reduction supplies, although some offered additional services. Urgent Public Health Needs Sites (“UPHN”) are a type of OPS that was established during the COVID-19 pandemic.

31. Over 100 supervised consumption facilities exist internationally (some estimates are as many as 200 sites in 12 counties).¹⁰⁻¹²

iii. The Development of Supervised Consumption Services

32. The first unsanctioned Canadian site opened in Vancouver in 1995, against the background of an alarming increase in HIV rates in the downtown eastside neighbourhood, which led to a declaration of emergency in 1997. The unsanctioned site closed after a year. Other unsanctioned sites operated in Vancouver during 2002.¹³
33. Insite, the first legally sanctioned supervised consumption site in Canada opened in Vancouver in September 2003.¹³ Insite was granted an exemption under the Controlled Drugs and Substances Act to allow it to operate. At one point, the federal government indicated that it would not continue to renew the exemption to federal drug laws. The issue went to the Supreme Court of Canada, which found that the failure to grant an exemption contravened the *Charter*.
34. The Supreme Court of Canada’s decision created opportunities for additional facilities to operate. This eventually resulted in a new regulatory process and an increase in the number of supervised consumption service sites throughout Canada.
35. In 2012, Dr. Carol Strike and I released a research project in Ontario entitled the Toronto and Ottawa Supervised Consumption Assessment Report (TOSCA). This was the seminal report that examined the need for, and feasibility of, supervised consumption services in these two Ontario cities specifically.¹⁴ To the best of my knowledge, this was the first report that addressed the need for supervised consumption services in any part of Ontario. The assessment used multiple methods, including quantitative analyses and qualitative evaluation.
36. The Minister of Health announced, after the release of our report, that “We have no plans to pursue supervised sites at this time.” However, the Toronto Medical Officer of Health endorsed the implementation of supervised injection services in 2013. He also publicly opposed newly introduced federal legislation entitled “The Respect for Communities Act,” which established requirements for supervised consumption service providers that many public health experts and community advocates considered to be too onerous. In 2013, the Toronto Board of Health also voted in favour of establishing supervised consumption service sites in Toronto.

37. In 2016, in Toronto, a newly elected mayor was open to implementing supervised injection services. This was in part in response to our report, as well as to broader epidemiological and social issues related to substance use. As part of this process, I gave a deputation to the Toronto Board of Health.
38. Toronto Public Health announced their intention to establish three supervised injection services, and the Toronto Board of Health unanimously voted to start a public consultation. A large group of prominent individuals, including five former mayors, representing a broad spectrum of political opinions, endorsed supervised injection. The Police chief offered few initial comments but expressed support after community consultations indicated support. In July 2016, Toronto City Council voted to implement three services (which submitted applications for approval in December 2016) and sought provincial funding, which was secured in January 2017.
39. This policy discussion, however, occurred against the background of a dramatic increase in opioid-related overdose deaths in Ontario and other Canadian jurisdictions due to the introduction of unregulated fentanyl in the illegal street-sourced opioid supply, which started in 2016 and accelerated afterwards. I both researched this dramatic increase and had firsthand knowledge of it from my work. I also published on this crisis (in subsequent years).
40. In response, groups in Ottawa and Toronto opened unsanctioned OPSs in 2017. In Toronto, the unsanctioned OPS consisted of tents in a public park (replaced by a trailer in the winter) and included supervised smoking and assisted injection. The police, local politicians, and provincial politicians did not move to close the unsanctioned site. Several sanctioned sites opened soon thereafter, and the unsanctioned site moved into an indoor facility and received federal approval to operate and provincial funding (i.e., became a sanctioned site).
41. In 2018, the Ontario government paused several open applications to establish new supervised consumption sites and brought in four changes.
42. First, most sites were approved under a new model, termed a Consumption and Treatment (“**CTS**”) service.
43. Second, Toronto’s busiest site, The Works, was put under review; its funding and operation continued but it was directed to find an alternative location, predominantly due to concerns about loitering and public litter near the site.
44. Third, funding for two sites, including The Kensington Market site, were withdrawn. Both sites continue to operate with alternative funding.
45. Fourth, the province announced its intention to cap the number of sites across the province at 21.
46. Notable aspects of the CTS model included:

- a. The CTS must be in Community Health Centres, Aboriginal Health Access Centres or similar organizations that offer “integrated, wrap-around services”;
 - b. Services must include supervised consumption, pathways to addiction treatment services, primary care, mental health care, housing and/or other social supports, harm reduction education and supplies, naloxone, oxygen, and removal of “inappropriately discarded harm reduction supplies” surrounding the CTS area;
 - c. The CTS will not be concentrated in one area or neighbourhood, and proximity to childcare centres, parks and/or schools (including post- secondary institutions) will be considered;
 - d. The CTSs should be located at least 600 m (i.e. two large city blocks) from each other;
 - e. CTS operators will be required to support ongoing community engagement and liaison initiatives to address local community and neighbourhood concerns on an ongoing basis;
 - f. Each CTS must have a designated health professional present at all times and the staffing model must include peers / persons with lived experience; and
 - g. Each site has structural requirements, including on-site post-consumption space.
47. Starting in 2022, the federal government gave the provinces the ability to operate UPHNs under a class exemption from the federal drug laws. UPHNs offer a more limited range of services than supervised consumption sites.
 48. As of December 2, 2024, Health Canada lists 39 sites that operate in 19 cities across Canada under a Health Canada exemption (note that this does not include OPSs or UPHNs). In Ontario, 23 sites that serve community clients have received exemptions (an additional supervised consumption site serves inpatients of Casey House, a specialty hospital): 10 in Toronto, 4 in Ottawa, and 1 each in Greater Sudbury, Guelph, Hamilton, Kingston, London, Ottawa, Peterborough, St. Catharines, and Thunder Bay. Toronto has the largest number of supervised consumption service providers of any city in Canada. Of the ten Toronto community sites, five are listed as being mandated to close under the government’s directive. An additional site will likely close as its lease will expire and it may not be approved to open in a new location.¹⁵
 49. According to Health Canada:
 - 39 (100%) sites in Canada, 23 (100%) of sites in Ontario, and 10 (100%) community sites in Toronto offer supervised injection;
 - 37 (95%) sites in Canada, 22 (96%) of sites in Ontario, and 9 (90%) community sites in Toronto offer supervised intranasal use;

- 37 (95%) sites in Canada, 22 (96%) of sites in Ontario, and 9 (90%) community sites in Toronto offer offered supervised oral use;
- 2 (5%) sites in Canada, 1 (4%) of sites in Ontario, and 1 (10%) community site in Toronto offer offered supervised inhalation;
- 30 (77%) sites in Canada, 20 (87%) of sites in Ontario, and 8 (80%) community sites in Toronto offer offered drug checking; and
- 29 (74%) sites in Canada, 20 (87%) of sites in Ontario, and 8 (80%) community sites in Toronto offered peer assistance with injecting.

B. The Health Effects of Supervised Consumption Services on Those Who Access Them

50. The data is clear that supervised consumption services have positive health effects for people who use these services, including people who have substance use disorders. These sites result in decreased mortality and morbidity resulting from drug use. Below I will describe these effects in greater detail.

i. Data Available from Health Canada

51. A starting point to understand the effectiveness of supervised consumption services is to assess the data available from Health Canada. This provides a reader with both information about how frequently these services are used and data about the number of overdoses treated.
52. Supervised consumption sites that operate under a federal exemption routinely report data to Health Canada, which is publicly available online at <https://health-infobase.canada.ca/supervised-consumption-sites/>
53. Between January 2017 and August 2024, Health Canada reports that sites across Canada have received 4,961,166 visits from 467,080 unique clients, responded to 60,288 non-fatal overdoses, and made 547,582 referrals to other health services.
54. The sites standardized their reporting starting in March 2020 and data is available until August 2024, a 54-month period. The following data are limited to this period.
55. In all of Canada, there were a total of 2,751,716 visits (average of 50,958 per month). The number of unique clients per month was 7,585. The average number of visits per client was 6.7. The total number of overdoses was 43,566 and the percentage of visits in which there was a non-fatal overdose was 1.4%. No visit resulted in a fatal overdose. Emergency medical services were called 4,328 times, (9.9% of all overdoses), with an additional 3,516 calls for other medical emergencies.
56. In Ontario, there were a total of 1,180,815 visits (average of 21,867 per month). The number of unique clients per month was 3,476. The average number of visits per client was 6.3. The percentage of visits in which there was a non-fatal overdose was 1.9%.

57. At the Kensington site, there were a total of 15,807 visits (average of 293 per month). The number of unique clients per month was 73. The average number of visits per client was 4.0. The percentage of visits in which there was a non-fatal overdose was 1.4%.
58. Across all months and all sites, the average percentage of visits that resulted in an overdose was 1.6% (standard deviation 0.4%, range 0.7% to 2.3%). The average percentage of overdoses that required naloxone was 40.1% (standard deviation 5.3%, range 26.5% to 52.9%).
59. A copy of Health Canada's summary data from the March 2020 to August 2024 period (showing number of visits, number of unique clients, number of non-fatal overdoses, and number of service referrals) is attached as **Appendix "C"**.

ii. Review of the Published Literature – Health Concerns Associated with Substance Use Disorder

60. In addition, the scientific literature includes general evidence that provides information regarding the beneficial impacts of supervised consumption.
61. Substance use disorders are associated with a wide range of health concerns. Some concerns are related to the route by which substances are used and are particularly relevant for people who inject or smoke drugs. Other concerns are related to the specific substance that an individual uses. For example, an individual who uses opioids may have different health risks than someone who uses stimulants. A third category of conditions relates to social conditions that are more common among people who use drugs than among people who do not use drugs, including homelessness and poverty. A fourth category of conditions are associated with drug use, either because they make substance use disorder more severe or because substance use makes the condition more severe. While there is overlap between these categories, I think this classification is a helpful approach to understanding the broad range of associated health conditions and harms associated with drug use. I will briefly provide examples of each category below.
62. Harms related to injection include local infections of the skin and soft tissues (such as cellulitis, abscesses, and infected skin ulcers), infections that are introduced into the blood while injecting and spread to internal organs including the heart valves (endocarditis) and bones (osteomyelitis), and bloodborne infections that are associated with sharing of injection equipment (i.e., they are spread from one individual to another), including Human Immunodeficiency Virus (HIV) infection, hepatitis B, and hepatitis C.^{16,17} Some of these conditions can be chronic and may themselves lead to complications, such as infections and malignancies related to HIV and hepatitis B. The risks of injection-related harms are increased with the use of shared drug equipment, use of non-sterile drug equipment, injecting public, and rushed injection.¹⁸ Harms related to smoking may include lung injury.

63. I will also provide examples of specific harms related to use of opioids and stimulants (the two most common drugs used at supervised consumption services), including overdose. Specifically:
- Opioid overdose is characterized by respiratory depression (decreased breathing) and can result in death. Individuals who are resuscitated from an opioid overdose and have had a prolonged period without oxygen may have irreversible brain injury.¹⁹ Opioid use disorder is also associated with bowel problems, liver fibrosis, and endocrine dysfunction.
 - Stimulant overdose is characterized by cardiac disease and can also be fatal.²⁰ Stimulant use disorder is associated with malignant hypertension, arrhythmias, myocardial infarction, stroke, aortic dissection, pulmonary arterial hypertension, and cardiomyopathy.
64. Tuberculosis is more common among people who use drugs due to social conditions such as homelessness, incarceration, and poverty. Sexually transmitted infections other than HIV (including syphilis, gonorrhea, and chlamydia) are more common among individuals who use drugs and engage in transactional sex. Tobacco- and alcohol-related harms also fall within this category, since determinants of tobacco / alcohol use and of unregulated substance use often overlap.
65. Conditions associated with substance use that have a complex bi-directional relationship are predominantly mental health diagnoses, including psychotic disorders, depression, anxiety, bipolar disorder, post-traumatic stress disorder, obsessive-compulsive disorders, sleep disorders, and some personality disorders.¹ These conditions may make substance use disorder more severe or harder to treat; in addition, substance use disorder may exacerbate these conditions. Of note, many substance use disorders are associated with higher than average suicide rates.
66. Substance use is also associated with significant stigma and discrimination, with consequences such as lifelong labeling for people with criminal records, barriers to obtaining housing and employment, and disruption to families.^{21,22} Stigma and discrimination also present barriers for people who use drug to access health care and can result in a lower quality of care.²³

iii. Review of Published Literature – Beneficial Impact of Supervised Consumption

67. The evidence suggests that supervised consumption services can prevent, avoid, or ameliorate many of these harms.
68. To begin with, the epidemiological evidence demonstrates that overdoses managed at supervised consumption sites are treated safely and effectively. Data published in 2004 from Sydney, Australia, and in or around 2006 from Vancouver indicated that when overdoses occurred at a supervised consumption site, they did not result in deaths.²⁴⁻²⁶ In Sydney, there was a 68% decrease in average

ambulance attendances in the vicinity of a supervised consumption service provider, a statistically significant greater decrease than in the rest of the province.²⁷

69. A systematic review published in 2021 found additional studies that were of lower methodological quality but supported the overall conclusion of decreased overdoses or no increased overdose.²⁸
70. Published evidence also supports a decrease in mortality in neighbourhoods where supervised consumption service were introduced. In Vancouver, the overdose rate declined by 35% in neighbourhoods within 500 m of a supervised consumption site, comparing rates before and after opening of the site (while remaining constant in other Vancouver neighbourhoods).²⁹ In Sydney, death rates declined similarly in the vicinity of the supervised consumption site and in other areas.³⁰ A recent Vancouver study demonstrated that frequent supervised consumption service use was inversely associated with all-cause mortality with an adjusted hazard ratio of 0.46 (95% confidence interval [CI] 0.26-0.80).³¹
71. More recently, a study, on which I was a co-author, evaluated overdose mortality events in Toronto between May 1, 2017, and Dec 31, 2019. The overdose mortality rate decreased significantly in neighbourhoods that provided access to supervised consumption services (8.10 deaths per 100 000 people for May 1-July 31, 2017, vs 2.70 deaths per 100 000 people for May 1-July 31, 2019; $p=0.037$), but not in other neighbourhoods.³²
72. Several systematic reviews of the medical evidence regarding supervised consumption have been published. These reviews predominantly focused on injection. They independently concluded that supervised injection services are consistently associated with a range of positive outcomes.^{12,26,28,33-37} These positive outcomes include the following:
 - **Ameliorating Risky Injection Practices.** Risky injection practices that are associated with transmission of bloodborne infections, such as syringe sharing. A systematic review of quantitative studies found consistent effects across eight studies that regular users of supervised consumption services decreased syringe sharing and syringe reuse.²⁶ A meta-analysis (pooled estimate of four estimates across three cohort studies) found that supervised consumption use was associated with an odds ratio of 0.31 (95%CI 0.17 to 0.55), or a 69% reduction in sharing, lending, and borrowing drug injecting equipment.³⁸ In a review of qualitative studies, those who accessed supervised consumption services articulated how the spaces enhances access to sterile equipment, increased capacity to practice harm reduction, and decreased risky practices such as rushed injection.³³
 - **Increased Safer Sex Practices.** In a cohort study, supervised consumption use was associated with increased safer sex practices (8% increase in condom use), which can prevent transmission of sexually transmitted infections.³⁹

- **Improved Treatment of Skin and Soft Tissue Infections.** Another study found that treatment for skin and soft tissue infections related to injection were common among people using supervised consumption services and that frequent attendance was associated with 49% lower odds of developing such an infection, although the estimates were imprecise.⁴⁰
 - **Increased Referrals to Services.** A systematic review identified 5 studies, which consistently showed an increased rate of referral to social and health services, including detoxification, opioid agonist therapyⁱ, and other treatments for substance use disorder.²⁶ A more recent review identified two additional studies with consistent effects.²⁸
 - **Improved Client Safety.** In a systematic review of 29 qualitative research studies, supervised consumption sites were identified as important refuges from structural and everyday violence, where individuals felt protected from the danger associated with street-level drug use.³³ Safety, in this context, incorporated both physical safety as well as a space in which clients did not experience stigma and discrimination.³³
73. The opening of a supervised consumption service site was not associated with an increase in the local number of people who inject drugs, relapse rates, or a decrease in the number starting methadone therapy (which is an opioid agonist therapy).^{41,42} Together, these results indicate that the availability of supervised consumption services does not encourage more drug use among people who inject drugs.

C. *Socio-demographic Characteristics of Individuals Most Likely to Access Supervised Consumption Services*

74. Although supervised consumption services are an intervention that are available to all community members, they are used most frequently by people who have a substance use disorder and experience other forms of marginalization, particularly homelessness and incarceration. In a cohort study of people who use Toronto supervised consumption sites, 90.5% were homeless or unstably housed and 38.0% of people who use supervised consumption sites in Toronto report being recently incarcerated.⁴³
75. Providing services to people who are homeless is particularly important because of their overdose risk. In a study by my research group, we surveyed 249 individuals who inject drugs and use one of four community harm reduction services in Toronto.⁴⁴ We found that among people who use drugs, being homeless was associated with a higher rate of having overdosed more than once in the past month (35% vs. 17%).
76. In qualitative studies done by my study group, we interviewed both staff and clients of supervised consumption sites. Both groups emphasized the supportive

ⁱ Opioid agonist therapy are prescribed opioids that are administered with the goal of decreasing or stopping the use of unregulated opioids. Conventional opioid agonist therapy drugs in Canada includes methadone and buprenorphine,

environments that supervised consumption sites offer for people who use drugs and are experiencing homelessness, particularly those who have mental health challenges. For many people, no other facility offers the same combination of services. In this way, supervised consumption sites serve clients with high health and social needs, many of whom are not well served by other components of the health care system.

77. A systematic review of 14 quantitative studies found that housing insecurity, unemployment, and previous incarceration were common.²⁶ The same review found that involvement in sex work was reported by 10 to 39% of clients.²⁶
78. In a systematic review of qualitative studies of safer environment interventions, including access to supervised consumption services, found that “participants in every study were highly marginalized, and in particular disproportionately affected by poverty and homelessness, and challenges to meeting everyday survival needs were common.”³³
79. It is critical that these sites remain nearby and local to people who use drugs. Research shows that individuals are unlikely to travel far distances to use supervised consumption services. A 2006 survey of people who inject drugs in Toronto found that 51% would not travel more than 10 blocks (approximately 500 to 600 m) and 72% would not travel more than 1000 m to an injection site.¹⁴ In London, Ontario, the proportion who use drugs who would not walk more than 20 minutes (roughly 1.5 km) was 60% in the summer months and 84% in the winter months.⁴⁵ In Sudbury, many clients reported that needing to walk 20 minutes was a significant barrier to accessing the site.⁴⁶
80. It is particularly relevant that these services remain local for people experiencing homelessness because of the structural barriers that they face in obtaining transportation. It is also important for people who are housed, but have a substance use disorder, because many are unable or unwilling to travel far distances to use a site, as noted above. Reasons for not traveling far distance relate to both structural barriers to traveling, such as poverty or difficulty ambulating, and issues related to substance use, such as the need to address withdrawal symptoms without delay.
81. In a recently released report, my research team looked at the potential impact of the CCRA on the City of Toronto. This report is attached as **Appendix “D”** to this report.ⁱ This report described the anticipated site closures of the CCRA as follows:

Toronto has 10 supervised consumption sites that serve community clients, the largest number of any city in Canada. An additional supervised consumption site serves inpatients of Casey House, a specialty hospital, and several UPHNs operate in Toronto shelters. Of the 10 community sites, 5 are listed as being mandated to close under the

ⁱ The Report can be found here: [Estimating the effects of closing supervised consumption sites in Toronto: Use of services – MAP Centre for Urban Health Solutions](#)

government's directive.⁴⁷ An additional site may close as its lease will expire and it may not be approved to open in a new location.ⁱ

82. My team estimated the following using administrative health data and reports from operators of supervised consumption sites in Toronto:

- The number of people who accessed any health service for an opioid or stimulant related health issue in 2022;
- The forward sortation area ("FSA" — the first 3 digits of the postal code) where people accessed services; and
- The location of existing supervised consumption services in relation to these FSAs.

83. In that report we found the following:⁴⁸

- Existing supervised consumption sites are centred in south-central Toronto and in FSAs that had moderate to high rates and absolute numbers of people who use opioids and stimulants;
- Of people who used opioids or stimulants and had an encounter with health care in Toronto in 2022, 3558 (9.6%) were located within 500 m of an existing supervised consumption site; and
- If 5 sites were to close, we estimated the number of people who would be within 500 m of a site would decrease 44% from current levels. If 6 sites close (4 remain open), the decrease would be 48%.

84. The figure below maps the rate of people who use opioids or stimulants per 1000 population by FSA in 2022, overlaid with the location of supervised consumption service providers. Sites slated to remain open are indicated by a green dot, those slated to close by a red dot, and the site whose status is uncertain by a yellow dot. Darker colours indicate higher rates.⁴⁸

ⁱ The sites in Toronto that the Ontario government announced will close are:

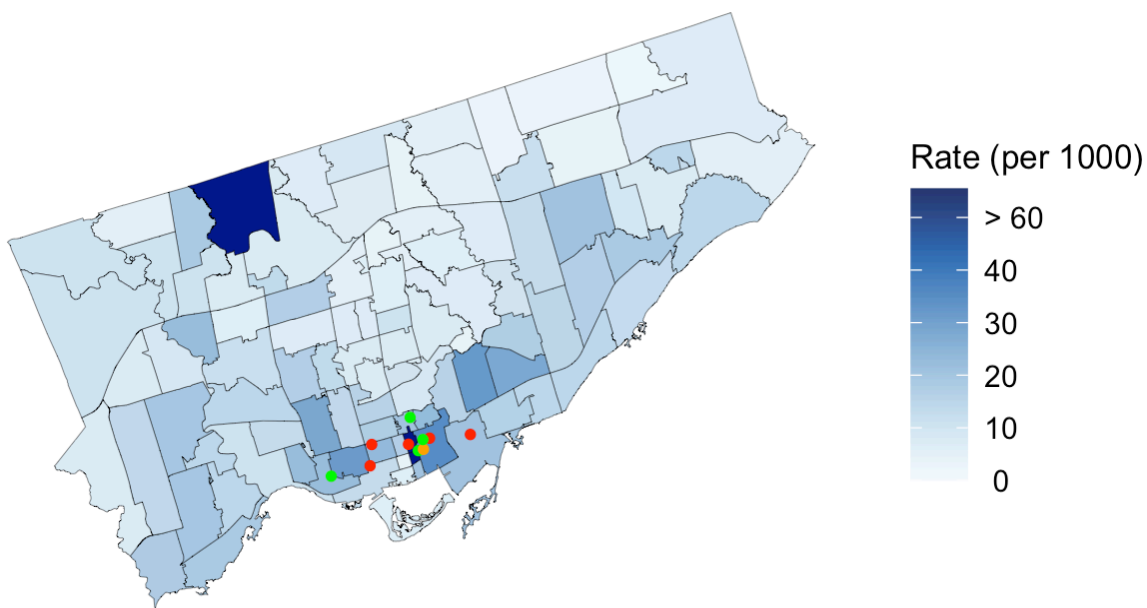
- Parkdale Queen West Community Health Centre (Bathurst) – 168 Bathurst Street
- Regent Park Community Health Centre – 465 Dundas Street East
- South Riverdale Community Health Centre (Queen) – 955 Queen Street East
- Toronto Public Health (The Works) – 277 Victoria Street
- Kensington Market Overdose Prevention Site, The Neighbourhood Group - 260 Augusta Avenue

The site that will likely close because of a lease ending is:

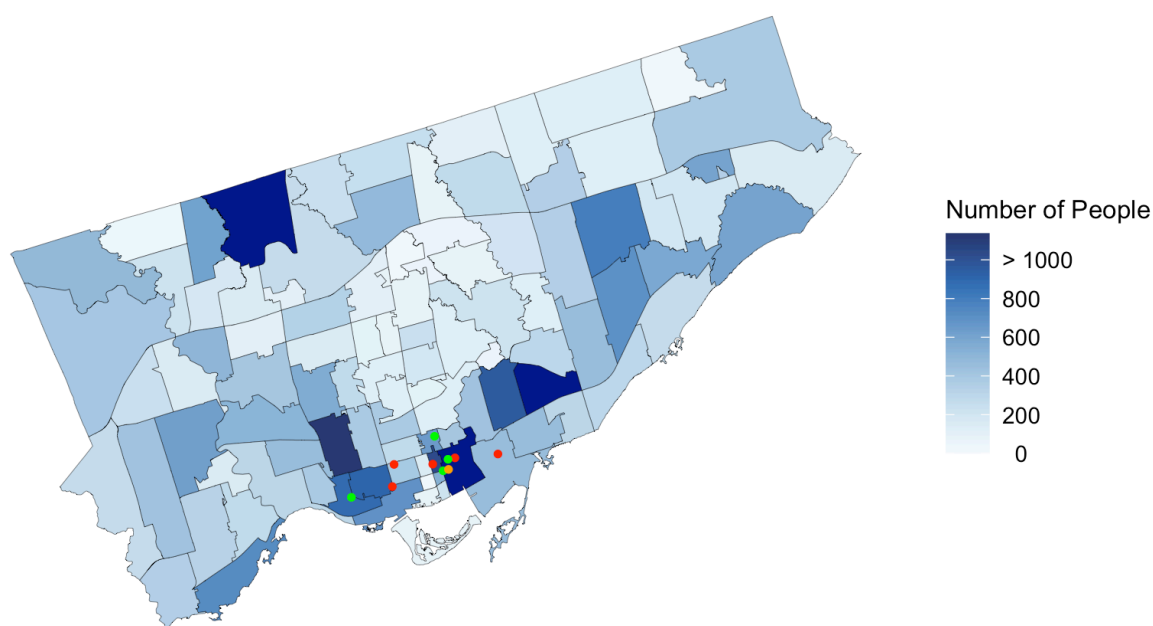
- Moss Park Consumption & Treatment Service (South Riverdale Community Health Centre) - 134 Sherbourne St

The sites outside of Toronto that will close are:

- Guelph Community Health Centre – 176 Wyndham Street North, Guelph
- Hamilton Urban Core Community Health Centre – 70 James Street South, Hamilton
- NorWest Community Health Centre – 525 Simpson Street, Thunder Bay
- Region of Waterloo Public Health and Emergency Services – 150 Duke Street West, Kitchener
- Somerset West Community Health Centre – 55 Eccles Street, Ottawa



85. The figure below maps the number of people who use opioids or stimulants by FSA in 2022, overlaid with location of supervised consumption sites. Sites slated to remain open are indicated by a green dot, those slated to close by a red dot, and the site whose status is uncertain by a yellow dot. Darker colours indicate higher numbers.⁴⁸



86. Together with our finding that drug use in Toronto is distributed throughout the city, these findings suggest Toronto continues to need many sites distributed throughout the city, and that closure will have a significant effect on access for people who would benefit from supervised consumption services.
87. In the cohort study of people who use Toronto sites, 30.9% of all clients and 38.1% of clients who accessed supervised consumption services for all or most injections were cisgender women.⁴³ The proportion who were transgender or gender diverse were 4.7 and 3.9%, respectively.⁴³ The proportion who engaged in sex work or transactional sex were 17.1% and 19.8%, respectively.
88. Supervised consumption sites similarly serve other groups experiencing marginalization at rates higher than they exist in the general population. For example, the proportion of all clients who belonged to a sexual minority was 18.6%; the proportion among clients who accessed supervised consumption services for all or most injection was 17.2%.⁴³ The proportion of all clients who identified as Indigenous was 33.6%; the proportion among clients who accessed supervised consumption services for all or most injection was 32.6%.⁴³ The corresponding numbers for people who identified as racialized non-Indigenous were 12.9% and 11.0%.⁴³
89. For comparison, in 2021, among Toronto adults (18 years and older), 3% self-identified as homosexual and 3% as bisexual.⁴⁹ According to the 2021 Census, 0.7% of the total Toronto population are Indigenous, although this is likely an under-estimate and may be as high as 3.1%.⁴⁹ The 2021 Census estimates that 56.0% of Torontonians belong to a racialized group.⁴⁹

D. Community Concerns

90. I was a member of the group at Unity Health that performed an external review of the CTS at South Riverdale Community Health Centre. In the following paragraphs, I focus on what we learned in the report about community concerns and how these can be addressed.
91. Although much of the public discussion has focused on safety concerns regarding schools and childcare centres, comments during the community consultations from people who worked at schools and day cares in the community consultation reflect a nuanced understanding of the complexities of serving people who use drugs.
92. While representatives of schools and daycares were understandably concerned about people using drugs on school property and litter, they also noted that other litter (alcohol bottles, condoms) were not necessarily associated with the presence of the CTS. Furthermore, the community consultation noted that daycare and school officials did not call for closing the CTS but instead suggested ways to improve communication and coordination.
93. The daycare and school officials suggested that communication could be improved by dispelling myths about the site through publicizing what services are being offered, how the CTS is supporting people, and sending a message that the CTS will not “distribute drugs” or “let their clients out” when they are intoxicated.
94. The public dialogue around supervised consumption services at South Riverdale Community Health Centre and other locations attributes public disorder, litter, and other harms to the CTS. The Minister of Health, in her announcement about the closure of supervised consumption sites in Ontario, cited data that crime rates are high near supervised consumption sites.
95. However, supervised consumption sites are often located in neighbourhoods with high crime rates. This is by design, since the structural determinants of drug use and crime overlap. In other words, to be effective, these services need to be close to the communities that most need them.
96. More generally, some community membersⁱ, editorialists⁵⁰, and government officials⁴⁷ have attributed incidents that occur in the neighbourhood of supervised consumption sites to those sites. In my opinion, such associations are often spurious or naïve.
97. To explain, investigating associations between the location of a supervised consumption site and measures of social disorder requires thoughtful epidemiological analysis to assess how much, if any, of the observed neighbourhood effects are attributable to the availability of supervised

ⁱ Community views are detailed in the South Riverdale Community Health Centre Consumption and Treatment Service Review Community Engagement Report (Appendix “B”)

consumption services. In particular, longitudinal studies, ideally with control groups, are required to study these issues rigorously.

98. To the contrary, research suggests that the availability of supervised consumption services tends to be associated with a decrease in the phenomena that community members tend to raise concerns about in relation to the consumption of substances. For example:
 - In a Vancouver study, regular supervised consumption service clients had markedly decreased public injecting and increased disposal of used syringes;⁵¹
 - A systematic review identified 6 studies which indicated a drop in the number of publicly discarded syringes and other injection-related litter and in the number of people injecting in public;²⁶ and
 - Public surveys also indicated decreased visible drug injection, litter, and complaints about behaviour, although there was no change in visible drug selling.²⁶
99. In my opinion, the evidence for attributing community concerns such as social disorder to the availability of supervised consumption services is weak and insufficient for decision making. At the neighbourhood level, drug use is often associated with poverty, crime, and marginalization. However, attributing worsening social disorder to the implementation and operation of supervised consumption sites is complex. To date, I do not believe that there is sufficient scientific evidence to support this causal association.
100. As a result of my review of the evidence, as well as my expertise and experience, I do not believe that restricting access to supervised consumption services in Ontario, including with the closure existing supervised consumption sites, will enhance community safety.

E. Likely Ramifications if the CCRA goes into effect

i. My Research Regarding the Impact of the CCRA

101. As noted above, my study team conducted a report that looked at the impact of the site closures that the CCRA will cause. This report is found at **Appendix D** above,⁴⁸
102. In the Report, we estimated, on average, 1,366 unique individuals accessed supervised consumption services each month in Toronto between April 2022 and March 20223 (95% confidence interval 1,303 to 1,429).
103. If 5 sites close, we estimated that 35 of 561 clients of these sites are located within 500 m of a site that will remain open and 526 will be beyond this radius and thus, will lose access; this represents 38% of current clients. This assumes that

sites that remain open can accommodate the 35 clients who will lose access. If 6 sites close, and with the same assumptions, 47% would lose access.

104. We repeated these calculations assuming the service radius for the sites was 1,000 m (31 to 34% would lose access) or 2,000 m (20 to 22% would lose access). If 4 sites remain open and the service radius is 1,000 m, service capacity would need to increase by more than 50% to maintain services for 60% of clients of current sites.
105. These estimates assume that sites that remain open can accommodate clients from closed sites within their service radius. If the increase in capacity among existing sites is constrained (for example, by budget, staffing, and space considerations), the expected losses are greater. For example, if capacity can only increase by 10%, the site service radius is 500 m, and four sites remain open (six close), we predict that 735 clients (54%) will lose access.
106. In an additional analysis specific for the Kensington Market site, we estimated that if people are not willing to travel more than 500 m or 1000 m, all existing clients would lose access. If people are willing to travel 2000 m, 94.4% of clients would still lose access. In summary, no supervised consumption services will be available for the vast majority of individuals who access the Kensington Market supervised consumption site after it closes.
107. We have estimated above that 526 clients would lose access. Using Health Canada averages, this represents about 3,261 visits per month, or 39,134 per year, where an injection that was otherwise supervised would now be unsupervised if the CCRA goes into effect. Again, using Health Canada estimates of the proportion of injections that result in overdose, this represents 496 overdoses per year that would otherwise have been prevented in Toronto. Because many of these overdoses may now be unsupervised, the proportion that result in an overdose death may be high.
108. A limitation of this analysis is that it has only focused on Toronto. The number of clients who will lose access in other Ontario cities is likely to be substantial, particularly because almost all other cities have only a single supervised consumption service provider. The cities with only a single supervised consumption service are Guelph, Thunder Bay, and Kitchener. Using data reported to Health Canada, I estimate the average number of clients per month who will lose access in each of these cities is 109, 200, and 165, respectively.
109. My research colleagues and I have also explored the potential impact of supervised consumption site closures from the perspectives of their clients. To do so, we drew on a qualitative research study in which we asked participants about their experiences with reduced access to services during the COVID-19 pandemic.
110. We conducted 72 semi-structured interviews between October 2022 and October 2023 with people who use drugs in 5 Ontario cities, each with one or more

supervised consumption sites. We focused on experiences with supervised consumption services when there was pandemic-related decreased access due to temporary closures, decreased capacity, or time-related restrictions on use. We analyzed the data using thematic analysis.

111. We identified six likely consequences of Ontario's planned closure of supervised consumption service sites
 - i. **Longer queues, with attendant discrimination and privacy risks.** Participants described how, because of reduced operating hours for supervised consumption service providers during the pandemic, they often had to queue outside to enter a site. Participants indicated how this "outed" them as someone who uses drugs to members of the public, thereby exposing an element of their personal health information that they wanted to remain private. Many also felt that being forced to queue in public put them at risk of discrimination from members of the public who stigmatize people who use drugs. In cities where some supervised consumption sites remain open but overall capacity is reduced, it is reasonable to assume that remaining sites will not be able to accommodate all clients, resulting in queuing.
 - ii. **Increased public drug use due to reduced capacity or greater distances to sites.** Many participants described visiting a supervised consumption sites only to find it had closed. A common response was for individuals to use the drugs they had planned to inject in a public space, such as an alleyway or park, near the supervised consumption site. Few individuals were prepared to travel to an open supervised consumption site to use their drugs. Accordingly, it is reasonable to expect that the closure of supervised consumption sites will result in increased public drug use. Public injections are more likely to be unsupervised, resulting in a risk of an overdose that is not reversed, and/or injection that is less sterile or rushed, increasing the risk of bloodborne infections.
 - iii. **More public intoxication due to decreased aftercare capacity in remaining sites.** Supervised consumption sites that operate under the Consumption and Treatment Site model are required to have aftercare sites, where people who have used drugs can wait before exiting. Many participants described how less capacity during pandemic restrictions often manifested as decreased aftercare capacity, requiring them to leave the supervised consumption site before they would otherwise have wished to do so. As a result, there was more public intoxication, which was undesirable for both the client and the public. It is reasonable to expect similar effects as remaining supervised consumption service providers are required to accommodate more clients with limited capacity.
 - iv. **Client avoidance of sites where they feel uncomfortable, leading to riskier use.** Several participants described how, in cities with multiple supervised consumption service providers, the culture at each site varied.

For many participants, the ability to choose the site that best fit their needs and preferences was critical; some described that they would not go to another site. Their next choice, when their site was unavailable during the pandemic, was to inject alone or in public, both of which increased their injection-related risks. Similar responses are likely among clients whose preferred sites are slated to close due to the CCRA.

- v. **Increased demands to accommodate clients who were previously “restricted” due to behavioural concerns.** Some participants described how a few supervised consumption service clients have been “restricted” from a site due to behavioural or safety concerns. In cities with multiple sites, such clients could be accommodated at other sites. With fewer sites available, there will be increased pressure for sites that remain open to accommodate such clients, which may put other clients’ safety at risk. These concerns may be particularly prominent for women, non-binary people, and sexual minorities.
- vi. **Less client-centred experiences due to conflicts with security staff.** Several participants reported that supervised consumption sites hired new security staff during the pandemic to address pandemic-related restrictions. In many instances, security staff did not have training in harm reduction and the experiences of clients included conflicts with staff. Increased oversight and security among sites that remain open may change the experience of supervised consumption use and further deter clients from visiting.

112. Participants did not report rushed injections or changes in overdose response at supervised consumption sites during the pandemic, suggesting that sites that remained open during pandemic restrictions continued to prioritize client safety within existing capacity.

ii. *The HART Hub Model Will Not Suffice*

113. The Government has introduced the Homelessness and Addiction Recovery Treatment (“**HART**”) Hub model, which will provide housing and integrated care for people who use drugs. However, based on the Government’s description of this service, the HART Hubs will not provide supervised consumption services or other harm reduction interventions such as needle and syringe distribution.^{52,53}
114. The HART Hubs will also have limited capacity, which I believe will be insufficient to address the number of people who use drugs in Ontario. Using administrative data, my colleagues and I have previously estimated that there were 122,811 individuals who were eligible for opioid agonist therapy in Ontario between 2005 and 2019.⁵⁴ Of these, approximately 50%, or about 50,000 people, were not receiving opioid agonist therapy. The Government has proposed 19 HART Hubs with a total capacity of about 375; over the course of a year, these are proposed to help “thousands of people each year.” I believe the HART Hubs’ capacity will be

inadequate to serve the large number of people who are not receiving opioid agonist therapy.

115. Because the HART Hubs will not offer harm reduction services, I believe they will also be inaccessible to the large number of people who are not interested in the HART Hub model of care. In the study noted above, we estimated that about 20% of people who were eligible for opioid agonist therapy never accessed it over the 14 year period.⁵⁴ Accordingly, I do not think the HART Hub models are either a sufficient “replacement” for access to supervised consumption services or an adequate response to the scale of opioid use in Ontario.

iii. Impacts on Communities Experiencing Marginalization

116. Women and men have divergent risks of death from opioid-related causes and women’s experience of drug use are often markedly different from those of men.⁵⁵ For example, women who use drugs have high rates (relative to the general population) of unintended pregnancies and poor birth outcomes, although more research is needed.⁵⁵⁻⁵⁷ In addition, experience of care is often markedly different by sex and gender. For example, women experience sex-specific barriers to seeking care, such as fear that knowledge of their drug use makes it more likely that their children will be removed into social services.⁵⁸ Women who participate in sex-work have distinct barriers to care.⁵⁹ We have interviewed men and women who use drugs about their preferences for health care. Women and pregnant people had distinct concerns. Trust was especially important for women and could be enhanced by working with staff with lived experience of drug use and having environments that they visit regularly.
117. These data underscore the nature of many supervised consumption service providers in Ontario, which have established longitudinal and trusting relationships between staff and clients within a harm reduction framework. In my opinion, no other service for people who use drugs has a similar structure or capacity to provide such services. Distinct features of supervised consumption services include the exemption from drug laws, the absence of police, the repeated and frequent visits, the hiring of people with lived experience of drug use as peer workers, and the incorporation of harm reduction principles. Services that are not harm-reduction focused do not have the same capacity to address issues of substance use from a client-based perspective. In my research, I have heard repeatedly from clients and staff about the importance of interpersonal relationships and safe environments.
118. Supervised consumption sites also offer opportunities to address fragmented care for people who use drugs. Many people who use drugs have multiple complex needs related to social conditions, mental and physical health needs, and drug use. However, health care for people who use drugs has historically been provided by an array of clinicians, including addiction specialists, primary care practitioners, psychiatrists and other mental health practitioners, emergency room physicians, hospitalists, and infectious disease physicians.^{60,61} Partitioning of care among multiple clinicians leads to fragmented and discontinuous care.⁶⁰

Despite long-standing calls for integrating primary care with substance use treatment, including case management, community engagement, and coordinated clinical and social policy responses, few published models exist outside of integrated HIV care (however, the large majority of PWUID in Ontario are HIV-negative).^{62,63}

119. Integrated care models have been proposed as either co-located services (one site where patients receive multiple services) or distributive models (multiple sites with effective communication and care integration).⁶³ Care models composed of integrated clinical teams with support staff who were advanced practice clinicians (nurses, nurse practitioners, and pharmacists) can increase retention in addictions and general medical care.⁶⁴⁻⁶⁶
120. Care models built around delivering supervised consumption services have the potential to effectively coordinate these complex needs. However, such models will only work if clients continue to access the core service, supervised consumption. In my opinion, models that are not founded on harm reduction principles will leave clients without access to critically needed services.

Dr. Ahmed Bayoumi

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52. Ontario Ministry of Health. *Homelessness and addiction recovery treatment hubs call for proposals: program guideline and application.* 2024: <https://www.ontario.ca/files/2024-08/moh-hart-hubs-call-for-proposal-guideline-and-application-document-en-2024-08-29.pdf>. Accessed 7 January 2025.
53. Ontario protecting communities and supporting addiction recovery with new treatment hubs [press release]. Government of Ontario, 20 August 2024. <https://news.ontario.ca/en/release/1004955/ontario-protecting-communities-and-supporting-addiction-recovery-with-new-treatment-hubs>. Accessed 7 January 2025.

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55. Mazure CM, Fiellin DA. Women and opioids: something different is happening here. *Lancet*. 2018;392:9-11.
56. McNamara KA, Murnion B, Fotheringham P, Terplan M, Lintzeris N, Oei JL, Bond DM, Nassar N, Black KI. Interconnections between unintended pregnancy, alcohol and other drug use, and pregnancy, birth, infant, childhood and socioeconomic outcomes: a scoping review. *BMJ Sex Reprod Health*. 2024;50:285-93.
57. Meyer JP, Isaacs K, El-Shahawy O, Burlew AK, Wechsberg W. Research on women with substance use disorders: Reviewing progress and developing a research and implementation roadmap. *Drug Alcohol Depend*. 2019;197:158-63.
58. Haynes CJ, Beck AK, Wells M, Hatton EL, Kelly PJ, Tan WJ, Larance B. Women and opioid use disorder treatment: A scoping review of experiences, use of patient-reported experience measures, and integration of person-centred care principles. *Int J Drug Policy*. 2024;130:104520.
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60. Samet JH, Friedmann P, Saitz R. Benefits of linking primary medical care and substance abuse services: patient, provider, and societal perspectives. *Arch Intern Med*. 2001;161:85-91.
61. Substance Abuse and Mental Health Services Administration (US), Office of the Surgeon General (US). Health care systems and substance use disorders. *Facing addiction in America: The Surgeon General's report on alcohol, drugs, and health [Internet]*. Washington DC: US Department of Health and Human Services; 2016.
62. Levin SM, Trumble JG, Edmunds M, Statman JM, Petersen RC. Perspectives on linkage of primary health care and substance abuse treatment. *J Addict Dis*. 1993;12:1-8.
63. National Research Council. *Improving the quality of health care for mental and substance-use conditions: quality chasm series*. 2006:
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64. Lagisetty P, Klasa K, Bush C, Heisler M, Chopra V, Bohnert A. Primary care models for treating opioid use disorders: What actually works? A systematic review. *PLoS One*. 2017;12:e0186315.
65. Evidence Exchange Network for Mental Health and Addictions. *Effective care coordination approaches for individuals with mental health and substance use concerns*. Porivincial System Support Program, CAMH; 2017: <https://kmb.camh.ca/eenet/resources/effective-care-coordination-approaches-individuals-mental-health-and-substance-use-concerns>. Accessed 7 January 2025.
66. Jeffries V, Slaunwhite A, Wallace N, Menear M, Arndt J, Dotchin J, GermAnn K, Sapergia S. *Collaborative care for mental health and substance use issues in primary health care*. 2013: https://www.mentalhealthcommission.ca/sites/default/files/PrimaryCare_Overview_Reviews_Narrative_Summaries_ENG_0.pdf. Accessed 7 January 2025.

Curriculum Vitae

Ahmed Bayoumi

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 Li Ka Shing Knowledge Institute
 St. Michael's Hospital
 30 Bond Street
 Toronto, Ontario, Canada
 M5B 1W8

Telephone 416-864-5438
 Fax 416-864-5558
 Email ahmed.bayoumi@utoronto.ca

1. EDUCATION

Degrees

1997 MSc, Community Health, subspecialization in Clinical Epidemiology, University of Toronto
 1989 MD, University of Toronto

Postgraduate, Research and Specialty Training

2019 San'yas: Indigenous Cultural Safety Training. Ontario Core ICS Health.

1996 - 1998 Post-Doctoral Research Fellow, Department of Health Policy, Stanford University, Stanford, California

Qualifications, Certifications and Licenses

1993 FRCPC, Fellowship in Internal Medicine, Royal College of Physicians and Surgeons of Canada

2. EMPLOYMENT

Current Appointments

HOSPITAL

1998 - present Staff Physician, General Internal Medicine, Department of Medicine, St. Michaels' Hospital, Toronto, Ontario

RESEARCH

1998 - present Scientist, MAP Centre for Urban Health Solutions (formerly the Centre for Research on Inner City Health), Li Ka Shing Knowledge Institute, St. Michaels' Hospital, Toronto, Ontario

2016 - present Senior Adjunct Scientist, ICES (formerly Institute for Clinical Evaluative Sciences), Toronto, Ontario

2020 – present Fondation Baxter and Alma Ricard Chair in Inner City Health Research, St. Michael's Hospital/ University of Toronto, Toronto, Ontario

UNIVERSITY

2023 – present Status-only appointment, Full Member, Institute of Medical Sciences. University of Toronto, Toronto, Ontario

2015 - present Professor, Department of Medicine, Faculty of Medicine, University of Toronto, Toronto,

Ahmed BAYOUMI

	Ontario
1998 - present	Status only appointment (Primary Graduate Appointment), Institute of Health Policy, Management and Evaluation. University of Toronto, Toronto, Ontario
2006 - present	Full member, School of Graduate Studies, University of Toronto, Toronto, Ontario

Previous Appointments

HOSPITAL

1994 - 1996	Clinical Associate, The Wellesley Hospital, Toronto, Ontario
1993 - 1996	Courtesy Staff, St. Michael's Hospital (Casey House), Toronto, Ontario
1993 - 1994	Clinical Fellow in HIV, The Wellesley Hospital, Toronto, Ontario

RESEARCH

2017 - 2020	Scientific Director, Converge3 (formerly the Centre for Evidence and Health in All Policies), University of Toronto
2008 - 2016	Adjunct Scientist, Institute for Clinical Evaluative Sciences, Toronto, Ontario
2003 - 2004	Research Director, HIV Information Infrastructure Program, Ontario HIV Treatment Network, Toronto, Ontario
2001 - 2002	Director of Science, HIV Information Infrastructure Program, Ontario HIV Treatment Network, Toronto, Ontario
1998 - 2000	Senior Research Scientist, HIV Ontario Observational Database, Toronto, Ontario

UNIVERSITY

2006 - 2012	Director, Clinical Epidemiology and Health Care Research, Institute of Health Policy, Management and Evaluation, Faculty of Medicine, University of Toronto, Toronto, Ontario
2010 - 2012	Member, International Society for Pharmacoeconomics and Outcomes Research / Society for Medical Decision Making Joint Modeling Good Research Practices Task Force (State-Transition Modeling Group)
2005 - 2006	Associate Director, Clinical Epidemiology and Health Care Research Field, Health Policy, Management and Evaluation, Faculty of Medicine, University of Toronto, Toronto, Ontario
1996 - 1998	Post-doctoral Research Fellow, Stanford University, Stanford, California

UNIVERSITY - RANK

2009 - 2015	Associate Professor, Medicine, Faculty of Medicine, University of Toronto, Toronto, Ontario
2000 - 2009	Assistant Professor, Medicine, Faculty of Medicine, University of Toronto, Toronto, Ontario
1998 - 2000	Lecturer, Medicine, University of Toronto, Toronto, Ontario

3. HONOURS AND CAREER AWARDS

Distinctions and Research Awards

Received

2024 Oct	John M. Eisenberg Award for Practical Application of Medical Decision Making Research , Society for Medical Decision Making
2023 Jun	Dr. Michael Ward Mentorship Award , Department of Medicine at St. Michael's Hospital.
2023 Sep	Fellowship , Canadian Academy of Health Sciences
2021 Oct	Dr. David Sackett Senior Investigator Award , The Canadian Society of Internal Medicine (CSIM)
2021 Sep	Outstanding Reviewer , College of Reviewers, Canadian Institutes of Health Research

Ahmed BAYOUMI

2020	SMDM Award for Distinguished Service , Society for Medical Decision Making
2020 – 2023	Chair, Fondation Baxter and Alma Ricard Chair in Inner City Health Research , St. Michael's Hospital/ University of Toronto, Toronto, Ontario
2016	Paula Goering Collaborative Research and Knowledge Translation Award in Mental Health and Addictions, University of Toronto
2015 – 2017	Chair, Fondation Baxter and Alma Ricard Chair in Inner City Health Research , St. Michael's Hospital/ University of Toronto, Toronto, Ontario
2009 - 2014	Canadian Institutes of Health Research (CIHR)/Ontario Ministry of Health and Long-term Care Applied Chair in Health Services and Policy
2004 - 2005	Society of General Internal Medicine Lawrence Linn Award
1995 - 1996	Canadian HIV Clinical Trials Network Associateship
1994 - 1995	Health Research Fellowship , Ministry of Health
1993 - 1994	Goldie Estate Award , University of Toronto (declined)
1993 - 1994	Hillock Estate Award University of Toronto (declined)
1993 - 1994	Spaulding Estate Award , University of Toronto (declined)
1993 - 1994	M.Sc. Fellowship (AIDS) , National Health Research Development Program

Teaching Awards

Received

2018	Department of Medicine Outstanding Postgraduate Teacher Award , Faculty of Medicine, St. Michael's Hospital
2007	Eugenie Stewart Award for M.Sc. / Ph.D. Supervision , Institute of Health Policy, Management and Evaluation, Faculty of Medicine, University of Toronto, Toronto, Ontario. (Graduate Education, PhD)
2002 - 2003	Department of Medicine Outstanding Teacher Award , Faculty of Medicine, St. Michael's Hospital
1999 - 2000	Department of Medicine Outstanding Teacher Award , Faculty of Medicine, St. Michael's Hospital
1998 - 1999	Department of Medicine Outstanding Teacher Award , Faculty of Medicine, St. Michael's Hospital
1997 - 1998	Citation for Excellence in Teaching , Health Policy, Stanford University

Nominated

2021	Department of Medicine Outstanding Postgraduate Teacher Award , St. Michael's Hospital
2008 - 2009	Department of Medicine Outstanding Teacher Award , Faculty of Medicine, St. Michael's Hospital. (Undergraduate Education) Fitzgerald Academy Awards.

4. PROFESSIONAL AFFILIATIONS AND ACTIVITIES

Professional Associations

American Board of Internal Medicine
 American College of Physicians
 Canadian Association for Health Services and Policy Research
 Canadian Association of HIV Researchers
 Canadian Medical Association
 College of Physicians and Surgeons of Ontario
 International AIDS Society

Ahmed BAYOUMI

Ontario Medical Association
Society for Medical Decision Making
Canadian Society of Addiction Medicine

Administrative Activities

INTERNATIONAL

Society for Medical Decision Making

2020 - 2021	Co-chair , Anti-racism Special Task Force
2020	Member , Nominations Committee
2019 - 2022	Reviewer , Abstracts, Annual Meeting of the Society for Medical Decision Making
2008 -2013, 2018- 2021	Judge , Lusted Student Competitoin, Annual Meeting of the Society for Medical Decision Making
2015 - 2016	Past-President
2014 - 2015	President
2013 - 2014	President- Elect
2011 - 2012	Vice President
2011 - 2012	Chair , Education Committee
2008 - 2013	Member , Education Committee
2012 - 2013	Co-Chair , Short course selection committee
2010 - 2011	Vice President- Elect
2010	Co-Chair , Annual Meeting of the Society for Medical Decision Making
2006 - 2009	Trustee
2005 - 2006	Co-Chair , Scientific Review Committee, Annual Meeting of the Society for Medical Decision Making
2004 - 2005	Co-Chair , Scientific Review Committee, Annual Meeting of the Society for Medical Decision Making

National Institutes of Health (NIH)

2015	Ad-Hoc Member , AIDS Clinical Studies and Epidemiology Study Section
2014	Ad-Hoc Member , AIDS and Related Research Integrated Review Group, Special Emphasis Panel.
2009 – 2013	Member , AIDS Research Review Committee, Peer Review Panel
2013	Reviewer , Special Emphasis Panel/Scientific Review Group 2014/01 AIDS 1.
2012	Member , NIAID NRSA Institutional Research Training Grant (T32) Special Emphasis Review Panel
2006 - 2008	Ad-hoc Member , AIDS Research Review Committee, Peer Review Panel
2005 - 2006	Ad-hoc Member , AIDS Research Review Committee, Peer Review Panel

International Society for Urban Health

2008	Reviewer , Abstract Review, 2008 International Conference on Urban Health
2008	Member , Organizing Committee, 2008 International Conference on Urban Health
2005 - 2006	Co-Chair , Abstract Committee, 2005 Annual Meeting
2004 - 2008	Member , Policy and Procedures Committee
2004 - 2005	Member , Planning Committee, International Conference for Urban Health
2003 - 2004	Member , Steering Committee
2001 - 2002	Co-Chair , First International Conference on Urban Health

International Society for Pharmacoeconomics and Outcomes Research

2005 - 2006 **Abstract Reviewer**, Annual International Meeting

Society of General Internal Medicine

2009 **Chair**, Oral Abstract Session
 2009 **Reviewer**, Abstract Review for Annual Meeting
 2002 **Reviewer**, Health Policy Workshop Selection Committee
 2001 **Reviewer**, Research Methods Workshop Selection Committee

NATIONAL

Canadian Institutes of Health Research

2018 - 2022 **Reviewer**, Canadian Institutes for Health Research (CHIR), Project Grant (Health Services Evaluation and Intervention Research)
 2018 **Reviewer**, Canadian Institutes for Health Research (CHIR), Rising Star Award Review Committee
 2018 **Member**, Alberta Supervised Consumption Services Evaluation Methodology Review Committee
 2017 **Grant Reviewer**, Canadian Institutes for Health Research (CHIR), Project Scheme
 2016 **Grant Reviewer**, Canadian Institutes of Health Research (CIHR), Stage 2 of the Foundation Grant Program: 2015 2nd Live Pilot competition.
 2015 **Grant Reviewer**, Canadian Institutes of Health Research (CIHR), Stage 2 of the Foundation Scheme
 2014 **Grant Reviewer**, Knowledge Translation Research (KTR) Peer Review Committee
 2014 **Reviewer**, Rising Star Award Review Committee
 2009 - 2013 **Scientific Officer**, Institute for Health Services Research and Policy Peer Review Committee
 2012 **Reviewer**, Rising Star Award Review Committee
 2011 **Member**, Institute of Health Services and Policy Research (IHSPR) Peer review working group for health services, policy, and population health (pillars 3 and 4) research
 2010 **Member**, Rising Star Award Review Committee
 2008 - 2009 **Grant Reviewer**, Health Services Research and Policy Peer Review Committee
 2006 - 2007 **Member**, CIHR HIV/AIDS Research Advisory Committee Working Group
 2005 - 2006 **Grant Reviewer**, Health Services Research and Policy Peer Review Committee

Canadian Society for Internal Medicine

2021 Jul – Present **Member**. Research / Quality Improvement Committee

Canadian Agency for Drugs and Technologies in Health (CADTH)

2011 Sep – 2021 Sep **Member**, Canadian Drug Expert Committee (CDEC)
 2017 **Reviewer**, Canadian Agency for Drugs and Technology in Health Economic Guidelines.
 2007 - 2016 **Reviewer**, Annual Conference Research Abstracts

Canadian Association for HIV Research

2016 **Abstract Reviewer**, Annual Meeting
 2004 **Abstract Reviewer**, Annual Meeting

Canadian Foundation for AIDS Research

2015 **Grant Reviewer.** Canadian Foundation for AIDS Research

PROVINCIAL / REGIONAL

Ontario Ministry of Health and Long-term Care

2008 - 2012 **Member**, Ontario Public Drugs Program, Cancer Care Ontario Subcommittee of the Committee to Evaluate Drugs.

2005 - 2006 **Member**, Drug Quality and Therapeutics Committee, Cox-2 Review Subcommittee, 3 months

2005 - 2006 **Member**, Drug Quality and Therapeutics Committee, Diabetes Subcommittee, 6 months

2003 - 2007 **Consultant**, Drug Quality and Therapeutics Committee, Drug Programs Branch

2003 - 2004 **Member**, Drug Quality and Therapeutics Committee, Drug Programs Branch, Diabetes subcommittee

1999 - 2001 **Member**, Genotypic Resistance Testing Task Force

Health Quality Ontario

2012 - 2015 **Member**, Decision Determinants Subcommittee, Ontario Health Technology Advisory Committee

Ontario HIV Treatment Network

2011 **Member**, CIHR Centre for REACH in HIV/AIDS, Executive Committee.

2006 - 2008 **Member**, OHTN Cohort Study Genotypic Resistance Testing Working Group

2005 - 2009 **Member**, OHTN Cohort Study Governance Committee

2005 - 2009 **Member**, OHTN Cohort Study Scientific Steering Committee

2002 - 2003 **Member**, HIV Information Infrastructure Project Policy Working Group

2000 - 2001 **Member**, HIV Information Infrastructure Project Advisory Committee

1999 - 2001 **Member**, HIV Information Infrastructure Project Research Advisory Committee

HIV Ontario Observational Database

1998 - 1999 **Member**, Executive Committee

Laurentian University of Sudbury

2008 **Co-Director**, Summer Course in Clinical Research Methods

LOCAL

University of Toronto

2018 - 2023 **Member**, Clinical Epidemiology and Health Care Research Admissions Committee, Institute of Institute of Health Policy, Management & Evaluation. Dalla Lana School of Public Health.

2019 **Judge**, Institute of Health Policy, Management and Evaluation Research Day

2018 **Member**, University of Toronto Institute of Health Policy, Management and Evaluation Faculty Search Committee (multiple positions)

2017 **Member**, Dalla Lana School of Public Health Faculty Branding Committee.

2017 **Member**, Department of Medicine, Mentorship, Equity & Diversity (MED) Committee.

2017 **Member**, Clinical Epidemiology and Health Care Research Admissions Committee, Institute of Institute of Health Policy, Management & Evaluation. Dalla Lana School of Public Health.

2016 - 2022 **Member**, Department of Medicine, Departmental Senior Promotions Committee.

2012 - 2019 **Member**, Clinical Epidemiology Executive Committee, Dalla Lana School of Public Health.

2016 - 2017 **Member**, Dalla Lana School of Public Health Diversity and Equity Committee / Diversity Assessment Plan Subcommittee

2016 - 2018	Member , Research/Impact Working Group: IHPME committee on the Environment, Climate Change and Sustainability / Climate Change Committee
2016	Member , University of Toronto, Institute of Health Policy, Management & Evaluation. Faculty of Medicine. Clinical Epidemiology and Health Care Research Admissions Committee
2015	Member , University of Toronto Dalla Lana School of Public Health and Institute of Health Policy, Management & Evaluation Search Committee for a Tenure-stream Faculty Position in Quality Improvement and Patient Safety
2015	Judge , Institute of Health Policy, Management and Evaluation David Naylor Award
2015	Judge , Institute of Health Policy, Management and Evaluation Research Day
2014-2015	Member , Institute of Health Policy, Management and Evaluation Faculty Search Committee
2014	Member , Hiring committee for Joint Evaluation position (Institute of Health Policy, Management and Evaluation, University of Toronto, and Toronto Central Local Health Integration Network).
2013	Member , Dalla Lana School of Public Health (DLSPH) - Institute of Health Policy, Management and Evaluation (IHPME) Steering Group
2009 – 2012	Member , Toronto Health Economics and Technology Assessment Collaborative Education Committee.
2009 - 2013	Member , Clinical Epidemiology Institute Committee, Institute of Health Policy, Management and Evaluation (IHPME).
2012	Member , Advisory Committee for the Search of Chair, Institute of Health Policy, Management and Evaluation (IHPME).
2008 - 2009	Member , Departmental Research Evaluation Committees for Tenure Review, Faculty of Medicine, Institute of Health Policy, Management and Evaluation (IHPME).
2008	Member , Search Committee, Research Director Department of Family and Community Medicine
2007 - 2012	Member , Executive Committee, Faculty of Medicine, Institute of Health Policy, Management and Evaluation (IHPME).
2006 - 2013	Member , Clinical Epidemiology Admissions Committee, Faculty of Medicine, Institute of Health Policy, Management and Evaluation (IHPME).
2006 - 2012	Member , Faculty Committee, Faculty of Medicine, Institute of Health Policy, Management and Evaluation (IHPME).
2006 - 2012	Member , Curriculum Committee, Faculty of Medicine, Institute of Health Policy, Management and Evaluation (IHPME).
2006 - 2012	Member , Clinician Investigator Program Committee, Faculty of Medicine
2006 - 2008	Co-Director , Clinical Epidemiology Institute Committee, Faculty of Medicine, Institute of Health Policy, Management and Evaluation (IHPME).
2006 - 2007	Member , University of Toronto Department of Public Health Sciences Search Committee for a Tenure-stream Faculty Position in Epidemiology
2005 - 2012	Chair , Clinical Epidemiology Executive Committee, Faculty of Medicine, Institute of Health Policy, Management and Evaluation (IHPME).
2005 - 2006	Chair , Clinical Epidemiology Program Admissions Committee, Faculty of Medicine, Institute of Health Policy, Management and Evaluation (IHPME).
2003 - 2004	Member , Clinical Epidemiology Program Admissions Committee, Faculty of Medicine, Institute of Health Policy, Management and Evaluation (IHPME).
1999 - 2012	Member , PGY4 General Internal Medicine Resident Selection Committee, Faculty of Medicine, Department of Medicine
1999 - 2001	Member , Clinical Epidemiology Program Admissions Committee, Faculty of Medicine, Institute of Health Policy, Management and Evaluation (IHPME).
1992 - 1993	Member , Wightman Division Working Group, Faculty of Medicine, Department of Medicine
1990 - 1991	Member , Wightman Division Working Group, Faculty of Medicine, Department of Medicine
1990 - 1991	Member , Postgraduate Medical Advisory Committee, Faculty of Medicine, Department of

Medicine

St. Michael's Hospital

2022	Member , Tier 1 Canada Research Chair Review Committee.
2022	Member , Search Committee, Scientist in the Centre for Drug Policy
2020	Member , St. Michael's Hospital Department of Medicine, Diversity and Anti-Racism Working Group
2020 – present	Member , St. Michael's Hospital Base Support Committee
2018	Member , St. Michael's Hospital Implementation Scientist Search Committee
2016 – present	Member , St. Michael's Hospital Department of Medicine Promotions Committee
2015 - 2019	Grant Reviewer , St. Michael's Hospital Department of Medicine AFP Innovation Fund
2011 – 2016	Member , Equity Indicators Working Group.
2013 - 2015	Member , Centre for Research on Inner City Health Review / Planning Committee
2014 - 2015	Member , Centre for Research on Inner City Health Executive Committee
2013 – 2014	Co-Chair , LKSKI Research Bridge Funding Committee
2006 - 2007	Member , Culture of Discovery Evaluation Sub-Committee and Exemplars and Management Tools Sub-Committee
2005 - 2008	Member , Information Privacy and Security Committee
2005 - 2006	Member , Accreditation Committee (Information management and vulnerable populations)
2005 - 2006	Member , Strategic Planning Committee, Department of Medicine Retreat
2001 - 2005	Member , Privacy and Security Committee (formerly Information, Privacy, and Security Task Force)
1999 - 2004	Member , Search Committee for Inner City Health Research Unit Chair
1999 - 2001	Member , Research Ethics Board
1999 - 2001	Member , General Internal Medicine Task Force
1999 - 2000	Member , Women's Health Working Group
1999 - 2000	Member , HIV Post-Exposure Prophylaxis Guidelines Committee
1999 - 2000	Member , Postgraduate Medical Advisory Committee
1992 - 1993	Member , Search Committee, Head of Division of General Internal Medicine
1992 - 1993	Member , Postgraduate Medical Advisory Committee

City of Toronto

2022 - Present	Member , Toronto Public Health Drug Strategy Panel
2022 - Present	Member , Toronto Public Health Decriminalization Evaluation Working Group
2021 – 2022	Member , Toronto Public Health Decriminalization Quantities/Interactions Working Group
1995 - 1996	Member , Task Force on Work and Health

Community Research Initiative of Toronto

1994 - 1996	Member , Ethics Review Committee

Sunnybrook Hospital

2008	Member , Interview Committee, MSK Knowledge Translation Scientist Search Committee

THETA (Toronto Health Economics and Technology Assessment Collaborative)

2015	Member , Decision Determinants (DD) Sub-committee.
2010 - 2012	Chair , HTA Research Methods Committee

Peer Review Activities**ASSOCIATE OR SECTION EDITING**Associate Editor

2007 - 2014	Medical Decision Making

Section Editor

2005	Journal of Urban Health, Associate Supplement Editor of Special Supplement to 4th International Conference on Urban Health

EDITORIAL BOARDSEditorial Board Member

2003 - 2007	Medical Decision Making

GRANT REVIEWSReviewer

Permanent membership on grant review panels is listed under Administrative Committees

2011	Health Research Board (Ireland)
2008	Ontario HIV Treatment Network

REPORT REVIEWSReviewer

2018	British Columbia SUPPORT Unit, Methods Cluster in Health Economics & Simulation Modelling Workplan
2012	U.S. Veterans Administration Evidence-based Synthesis Program

EXTERNAL GUIDELINES REVIEWERReviewer

2016	Canadian Agency for Drugs and Technology in Health Economic Guidelines.

PROMOTION REVIEWExternal Reviewer

2022	New York University
2022	University of Michigan
2022	University of British Columbia
2022	American University of Beirut
2021	University of Alberta
2021	University of Pittsburgh
2021	University of British Columbia
2020	University of Victoria
2020	UMIT - Private University for Health Sciences, Medical Informatics and Technology, Austria (2)
2018	Virginia Commonwealth University and School of Medicine
2018, 2020	Yale School of Public Health
2016	The Geisel School of Medicine at Dartmouth University
2016	Harvard University

Ahmed BAYOUMI

2015-2016	Stanford University (2)
2015	Department of Health Management and Policy, University of Michigan School of Public Health
2013	Hospital for Sick Children
2012	Ottawa Hospital Research Institute
2012-2014	Sunnybrook Hospital (3)
2012	Women's College Hospital
2010	University of British Columbia (2)
2009	Department of Family and Community Medicine, University of Toronto
2009	Department of Paediatrics, University of Toronto (2)

Internal Reviewer

2018, 2020	Institute for Health Policy, Management and Evaluation, University of Toronto

C. Research Funding**1. GRANTS, CONTRACTS AND CLINICAL TRIALS****PEER-REVIEWED GRANTS**

2023-2025	Co-Principal Investigator. Bayoumi AM, Dashwood T, Dodd Z, Firestone M (Co-Principal Applicants), Altenberg J, Boyce N, Caudarella A, Chu S, Gariépy G, Gaspar M, Gomes T, Graham E, Irvine M, Kenny K, Kolla G, Long C, McClelland A, Young S (Co-Applicants), Baldwin D, Bond-Gorr J, Challacombe L, Davis E, Hall J, Harper L, Hogan M, Johnson C, Kent P, Laurence G, Maharaj K, Martin M, Ruston J, Tousenard N, Vakharia S, Whitebird W, Young M (Collaborators). Alternatives to Criminalization of Drugs: Community-based Systems Mapping of Social and Health effects (ACDC SMASH). Canadian Institutes of Health Research Project Grant. CAD\$401,625
2022 - 2027	Co-Investigator. The Toronto Disparities, Overdose, and Treatment (T-DOT) Study: Investigating clinical outcomes among people who inject drugs during a period of rapid programmatic and policy change. Canadian Institutes of Health Research (CIHR). Project Grant. PI: Werb D. Co-Investigators: Bayoumi AM , Gomes T, Kerr T, Owusu-Bempah A, Scheim A. \$1,560,600 CAD.
2022 - 2024	Co-Investigator. Demystifying the 'black box' of prisoner re-entry and addressing the mental health and substance use needs and service disruptions for people release from custody during the COVID-19 pandemic. Canadian Institutes of Health Research Operating Grant.: Addressing the Health Impacts of COVID-19 - Indigenous. PI: Matheson F, Waters LB, Mashford-Pringle A (Co-PI). Co-Investigators: Almond K, Bayoumi A , Firestone M, McLuhan A, Mejia Lancheros C, Moineddin R, O'Campo P. \$489,524 CAD.
2022 - 2023	Consultant. Investigating disparities and barriers in research and care of patients with Hereditary Hemorrhagic Telangiectasia. National Institutes of Health (NIH) (USA). PI: Kim H. Co-Investigators: Hetts S, Faughnan M, Clancy M, Bayoumi AM . \$227,946 USD.
2022 - 2023	Co-Principal Investigator. Promoting Mental Health and Reducing HIV Risk Behaviours through Self-Compassion, Mindful Acceptance & Resilience Transformation (SMART): An Evidence-informed Pilot Randomized Trial with Diaspora MENA Gay, Bisexual and Trans Youth in Ontario. Canadian Institutes of Health Research. CIHR Canadian HIV Trials Network. PI: Kteily-Hawa R, Bayoumi A , Wong J (Co-PI). Co-Investigators: Boake P, Eloulabi R, Salam K, Saleib K, El Tal J, Abdallah N, Ezzedine A. \$50,000 CAD.
2022	Co-Principal Investigator. Decriminalization of Drugs: A Community-Based Systems Approach to Planning for Evaluation. Canadian Institutes of Health Research Planning and Dissemination Grant. Bayoumi AM, Dodd Z, Firestone M (Co-Principal Applicants), Whitebird

W, Chu S, Dashwood T, Gomes T, Kaminski N, Kenny K, Kolla G, Owusu-Bempah, A, Strike C, Watson TM, Young SV. \$20,000 CAD.

- 2021 - 2025 **Co-Investigator.** Ontario's Opioid Drug Observatory: Generating evidence on the evolving opioid crisis to inform and evaluate drug policy and clinical practice in Ontario. Canadian Institutes of Health Research. Project Grant. PI: Gomes T. Co-Investigators: Antoniou T, **Bayoumi AM**, Caudarella A, Clarke H, Juurlink D, Kolla G, Leece P, Mamdani M, Paterson M, Sproule B, Tadrus M. \$1,002,152 CAD.
- 2021 - 2023 **Co-Investigator.** The Future of PrEP is Now: A mixed-methods, community-based study to inform equitable and strategic implementation of long-acting PrEP in Canada. Canadian Institutes of Health Research. Operating Grant - HIV/AIDS CBR Program - General. PI: Tan DHS, Kwag M. Co-Investigators: Arkell C, **Bayoumi AM**, Draenos C, George C, Grace D, Hull M, Jollimore J, Lachowsky N, Montess M, Pico Espinosa O, Pruden H, de la Cruz. \$300,000 CAD.
- 2021 - 2022 **Principal Investigator.** MARCO:POLO Marginalization & COVID-19: Promoting Opportunities for Learning & Outreach. Canadian Institutes of Health Research. Operating Grant: Emerging COVID-19 Research Gaps & Priorities. Co-Investigators: Co-Principal Applicants: Firestone M, Boucher L, Dodd Z, Durbin A, Hayman K, Isaacs BJ, Kolla G, Matheson FI, Steer LA, Yakubovich AR, Young SV. Co-Applicants: Beder M, Brothers T, Dobrow M, Du Mont J, Holness L, Huijbregts M, Hwang S, Hynie M, Kendall C, Kenny K, Long C, Maguire J, Nisenbaum R, Shankardass K, Strike C, Walker D. Collaborators: Arcenal M, Delgado R, Heineck K, Lunsy Y, Marcolin A, Pepper V. \$313,804 CAD.
- 2021 - 2022 **Principal Investigator.** Supervised Consumption and COVID-19 in ON: an Evaluation (SCCONE). Canadian Institutes of Health Research. Operating Grant: Evaluation of Harm Reduction Approaches. Co-Investigators: Bodkin C, Boucher LM, Caudarella A, Chan T, Cipriano LE, Elton-Marshall T, Enns EA, Firestone M, Hyshka E, Imtiaz Sameer, Kendall C, Kennedy MC, Kenny KS, Kerr TH, Kolla G, Leece P, Martin N, Suen S, Sprakes A, Strike CJ, Werb DM, Young SV, Altenberg J, Lawson J. \$250,000 CAD.
- 2021 - 2022 **Co-Investigator.** Health equity and the post COVID-19 condition. Canadian Institutes of Health Research Operating Grant: Emerging COVID-19 Research Gaps & Priorities. PI: Kendall C, Hawken S, Tanuseputro P. Co-Investigators: **Bayoumi AM**, Bloch G, Boucher L, Dahrouge S, Funnell S, Hsu A, Kiran T, Kitagawa K, Lofters A, Manuel D, Myran D, Ponka D, Rayner J, Shoemaker E, Smith B, Wanigaratne S, Zygmunt A. \$221,728 CAD.
- 2021 - 2022 **Co-Investigator.** Investigating access to and outcomes from supervised drug consumption services in British Columbia before and during the COVID-19 pandemic. Canadian Institutes of Health Research. Operating Grant: Evaluation of Harm Reduction Approaches. PI: Kerr T (Nominated PI), Kennedy MC (Co-PI). Co-Investigators: Compton M, Heinrichs K, **Bayoumi AM**, Boyd J, Milloy M-J, Olding M, Puri N, Firestone M, Johnson C, Strike C. \$250,000 CAD.
- 2021 - 2022 **Co-Investigator.** A rapid assessment of the impact of the COVID-19 pandemic on supervised consumption services in Canada. Canadian Institutes of Health Research. Operating Grant: Evaluation of Harm Reduction Approaches. PI: Hyshka E. Co-Investigators: McDougall P, **Bayoumi AM**, Kennedy MC, Larney S, McNeil R, Wild C. \$281,639 CAD.
- 2020 - 2025 **Co-Investigator.** Preventing Injecting and Overdose by Disrupting Injection Drug Use Transitions: The PRIMER II Study. Canadian Institutes of Health Research. Operating Grant. PI: Werb DM. Co-Investigators: **Bayoumi A**, Caudarella A, Genberg B, Milloy M, Scheim A, Strathdee S. \$761,175 CAD.
- 2020 - 2021 **Co-Investigator.** Converging epidemics and the health for people who use drugs: Using evidence to move decision making into action in the context of COVID-19. Canadian Institutes of Health Research (CIHR) Knowledge Synthesis Grant. PI: Guta, A. Co-Investigators: Bayoumi A, Benoit A, Bonn M, Bungay V, Challacombe L, Dutt M, Elliott R, Gagnon M, Hyshka E, Ibanez-Carrasco F, Ka Hon Chu S, Kolla G, Manning E, Perri M, Rai N, Rudzinski K, Strike C. \$50,000 CAD.
- 2020 - 2023 **Co-Investigator.** Connecting Health Assessments with INterventions for Healthy Aging with

HIV (CHAIN Study): Advancing the Utility of a Short-Form HIV Disability Questionnaire (SF-HDQ) for use in Community-Based Settings. Canadian Institutes of Health Research, Operating Grant: HIV/AIDS and STBBI Community-Based Research. PI: O'Brien KK, Ibanez Carrasco F (CoPIs). Co-Investigators: **Bayoumi AM**, Bergin C, Chan Carusone S, Erlandson K, Hanna S, Harding R, Quigley A, Solomon P, Stewart A, (Researcher Co-Applicants); Ahluwalia P, Baltzer Turje R, Baxter L, Krizmancic K, Laliberte G, Welham C, (Knowledge User Co-Applicants), Bradford G, Brown D, Hodge L, Matejcic A, McClellan N, McDonnell E, Murray C, Price C, Vera J, Yates T (Collaborators). \$450,000 CAD.

2020 - 2022

Co-Investigator. Patient preferences in treatments for myasthenia gravis: a DCE experiment. Muscular Dystrophy Canada. PI: Barnett-Tapia C. Co-Investigators: **Bayoumi AM**. \$69,100 CAD.

2020 - 2022

Co-Investigator. Community voice and leadership from within institutionalized care models: lessons from COVID-19. University of Toronto. Connaught Community Partnership Research Program. PI: Firestone M. Co-Investigators and Collaborators: **Bayoumi AM**, Strike C, Kolla G, Guta A, Steer L, John J, Robertson A, Laurence G, Dodd Z, Schlosser L, Raybourne R, Gallardo-Lopez N, Davis S. \$50,000 CAD

2020 - 2022

Co-Investigator. Tele-Coaching CBE Study: Evaluating the Implementation of an Online Community-Based Exercise (CBE) Intervention using Tele-coaching to Enhance Physical Activity Among Adults Living with HIV in Ontario. OHTN Endgame Program Game Changer Award: Breaking New Ground (EFP-1121-BNG). PI: O'Brien KK. Co-Investigators: **Bayoumi AM**, Chan Carusone S, Ibáñez-Carrasco F, Solomon P, Tang A, Zobeiry M, Ahluwalia P, Godi C, Islam S, Krizmancic K, Lindsay J, Price C, Avery L, Brown D. \$297,438 CAD.

2020 - 2021

Academic Advisor and Principal Investigator. The Effects of the COVID-19 Pandemic Response for People who are Marginalized: Centre of Learning & Development Evaluation. MITACS. PI / Academic Supervisor: **Bayoumi AM**. Co-Investigators: Mawani F (Post-Doctoral Fellow). \$15,000 CAD.

2020 - 2021

Co-Principal Investigator. Alterations in Prescribing of Opioid Agonist Therapy due to the Pandemic (ALT-POP) Study. Canadian Institutes of Health Research (CIHR) Operating Grant and Ontario Ministry of Health and Long-Term Care (Co-Funders). CIHR Operating Grant: COVID-19 Mental Health and Substance Use. PI: **Bayoumi AM**, Wyman J, Young SV. Co-Investigators: Altenberg J, Boucher L, Caudarella A, Corace K, Crichlow F, Dodd Z, Firestone M, Greenspan N, Holowaty M, Kendall C, Kolla G, Sequeira K, Spithoff S, Strike C, Werb D. \$187,446 CAD.

2020 - 2021

Co-Investigator. Promising Practices in Accessing Virtual Mental Health: Supporting Refugees during COVID-19. Canadian Institutes of Health Research (CIHR) Operating Grant. Operating Grant: COVID-19 MS & Substance Use. PI: Hynie M, Agic B, McKenzie KJ. Co-Investigators: Agarwal A, Ahmad F, Arya A, Ashraf A, **Bayoumi AM**, Beukeboom C, Bokore N, Diaz M, Friesen C, Hyndman J, Ives N, Jaimes MA, Kuo B, McGrath S, Sherrell K. \$158,061 CAD.

2020 - 2021

Co-Investigator. Assessing mental health and substance use needs and service disruptions for people released from custody during the COVID-19 pandemic. Canadian Institutes of Health Research (CIHR) Operating Grant and Ontario Ministry of Health and Long-Term Care (Co-Funders). CIHR Operating Grant: COVID-19 Mental Health and Substance Use. PI: Matheson F, Almond K, Mashford-Pringle A (Co-PI). Co-Investigators: **Bayoumi AM**, McLuhan A, Mejia Lancheros C, O'Campo P, O'Grady W. \$200,000 CAD.

2020 - 2021

Principal Investigator. The Effects of the COVID-19 Pandemic Response for People who are Marginalized. St. Michael's Hospital Foundation. COVID Fund Related. Co-Investigators: Caudarella A, Du Mont J, Durbin A, Firestone M, Holness L, Hwang S, Maguire J, Mason R, Matheson F, Nisenbaum R, O'Campo P, Persaud N, Strike C, Werb D, Kolla G, Long C, Young S, Beder M, Dell E, Vozzolo B, Brillinger C, Davis S, Klaiman M, Schlosser L, Younie K, Raybourne R, Sheth P, Steer L, Hewitt T, Heineck K, Lunskey Y, Ibrahim S, John J, Thompson C, Kenny K, Brothers T, Dodd Z, Kendall C, Mawani F. \$125,000 CAD.

2020 - 2021

Principal Investigator. The Effects of the COVID-19 Pandemic Response for People who

are Marginalized. University of Toronto, Toronto COVID-19 Action Initiative. Co-Investigators: Caudarella A, Du Mont J, Durbin A, Firestone M, Holness L, Hwang S, Maguire J, Mason R, Matheson F, Nisenbaum R, O'Campo P, Persaud N, Strike C, Werb D, Kolla G, Long C, Young S, Beder M, Dell E, Vozzolo B, Brillinger C, Davis S, Klaiman M, Schlosser L, Younie K, Raybourne R, Sheth P, Steer L, Hewitt T, Heineck K, Lunskey Y, Ibrahim S, John J, Thompson C, Kenny K, Brothers T, Dodd Z, Kendall C, Mawani F. \$325,000 CAD.

- 2020 - 2021 **Co-Principal Investigator.** Rapidly assessing the impact of the COVID-19 pandemic and response on clinical and social outcomes, service utilization, and the unregulated drug supply experienced by people who use drugs in Toronto. Canadian Institutes of Health Research (CIHR) Operating Grant. Operating Grant: COVID-19 May 2020 Rapid Research Funding Op. PI: Werb D (Nominated PA). Co-Investigators: Caudarella A, **Bayoumi AM**, Bowles J, Gomes T, Kolla G, Scheim A (Co-PI). \$206,760 CAD.
- 2019 - 2023 **Principal Investigator.** Study of Post-Hospital care for Opioid Overdoses that are Non-Fatal (SPOON). Canadian Institutes of Health Research (CIHR). Project Grant. Co-Investigators: Antoniou T, Gomes T, Orkin A, Caudarella A, Guilcher S, Powis J, Challacombe L, Guimond T, Strike C, Firestone M, Kendall C. \$459,000 CAD
- 2019 - 2022 **Co-Investigator.** Economic impact of falls prevention interventions: We know the “value”, but what about the “value for money”? Canadian Institutes of Health Research (CIHR) Operating Grant. Project Grant. PI: (Co-PIs) Isaranuwachai W, Tricco A. Co-Investigators: (Co-Is) Straus SE, **Bayoumi AM**, Hemmelgarn BR, Holroyd-Leduc JM, Liu B, Marr SA, Pechlivanoglou P; (Collaborators) Anderson C, Feldman F, McDonald K, Silvius J, Jain R, Weldon J., Campo M, Yurga E. \$306,001 CAD.
- 2019 - 2021 **Co-Investigator.** Advancing Assessment of Episodic Disability to Enhance Healthy Aging among Adults with HIV: Developing a Short-Form HIV Disability Questionnaire (HDQ) for use in Clinical Practice. National Institute On Aging of the National Institutes of Health (Award Number R21AG062380). PI: O'Brien KK (NPI), Erlandson K (Co-PI). Co-Investigators: Solomon P, Bergin C, **Bayoumi AM**, Chan Carusone S, Harding R, Hanna S, Davis AM. \$346,945 USD
- 2019 - 2020 **Principal Investigator.** Analysis of Spatial and Temporal Relationships in Ontario for Supervised Consumption and Overdose Prevention Evaluation (ASTROSCOPE). Canadian Institutes of Health Research (CIHR) Operating Grant: Evaluation of Interventions to Address the Opioid Crisis. Co-Investigators: Robertson A, Altenberg J, Boyd R, Hopkins S, Raskin L, Firestone M, Greenspan N, Guimond T, Leece P, Strike C, Williams D. \$100,000 CAD.
- 2019 - 2020 **Co-Principal Investigator.** Health system evaluation of the gap in treatment for the delivery of opioid agonist treatments among individuals with opioid use disorder in Ontario. Canadian Institutes of Health Research (CIHR) Operating Grant: Evaluation of Interventions to Address the Opioid Crisis. PI: Leece P, **Bayoumi AM** (Co-PI). Co-Investigators: Fairclough L, Kahan M, Taha S, Gomes T, Kendall C, Manson H, Nosyk B, Rosella L, Smith B, Strike C, Yu M. \$99,997 CAD.
- 2019 - 2021 **Principal Investigator.** Impacts of Overdose Study. Ontario Node Development Fund. CRISM Community Competition. PI: **Bayoumi AM**. Co-Investigators: Strike C, Firestone M, Altenberg J, Bannerman M, Dodd Z, Julien R, Massey S, Perreault Y, Steer L. \$35,000 CAD.
- 2019 - 2020 **Co-Investigator.** Implementation evaluation of barriers and facilitators to buprenorphine use in Canada using a behaviour change framework to identify effective strategies for change. Canadian Institutes of Health Research (CIHR) Operating Grant: Evaluation of Interventions to Address the Opioid Crisis. PI: Leece P. Co-Investigators: Fairclough L, Ahamad K, Holowaty M, Taha S, **Bayoumi AM**, Corace K, Manson H, Marks E, Straus S, Strike C. \$99,965 CAD.
- 2019 - 2020 **Co-Investigator.** Evaluation of Overdose Prevention Sites (OPS) in Toronto: An Urgent Public Health Response to the Opioid Crisis. Canadian Institutes of Health Research (CIHR) Operating Grant: Evaluation of Interventions to Address the Opioid Crisis. PI: Firestone M. Co-Investigators: Dodd Z, Altenberg J, Ko J, Steer L, **Bayoumi AM**, Greenspan N, Kenny K, Kolla G, Strike C (Co-I), Hales J, Heath M, White K (Collaborators). \$100,000 CAD.
- 2018 - 2022 **Co-Investigator.** Strengthening the implementation of “Health in All Policies” at the county/municipal level in Ontario and Quebec using realist explanatory case studies and

- knowledge mobilization. Canadian Institutes of Health Research (CIHR). Population and Public Health. PI: Shankardass K, Pellizzari Salvaterra R. Co-Investigators: **Bayoumi AM**, Finn D, Freiler A, Guglielmin M, Kokkinen L, Lebel A, Lock J, Loney K, Muntaner C, O'Campo P, Renahy E. \$428,400 CAD.
- 2019 **Co-Principal Investigator.** Economic modeling to inform the public health response to opioid use disorder. Canadian Institutes of Health Research (CIHR). Planning and Dissemination Grant - Institute Community Support. PI: Nosyk BP, **Bayoumi AM**. Co-Investigators: Irvine M, Krebs E. \$18,100 CAD.
- 2018 - 2019 **Principal Investigator.** Homelessness, Mortality and Housing: Evidence Based Solutions for Housing Individuals with Complex Needs. Ontario Ministry of Housing. Innovation, Evidence and Capacity Building Fund. Co-Investigators: Nikolai L, Steer L. \$100,000 CAD.
- 2018 - 2019 **Principal Investigator.** Impacts of overdose on HIV risk behaviours: Evaluating the effects of grief and loss from overdose on people who inject drugs and developing an intervention to address them. Canadian Institutes of Health Research (CIHR). Catalyst Grant - HIV/AIDS Community-Based Research. Co-Investigators: Perreault Y, Altenberg J, Demetrakopoulos A, Dodd Z, Steer L, Kenny K, Kolla G, Strike C (Co-I) Cavalieri W, Hopkins S, MacDonald J, Mason K, Raskin L, Robertson A, Shepherd S (Collaborators). \$40,000 CAD.
- 2017 - 2022 **Co-Investigator.** Scaling up PrEP for HIV Prevention: Optimizing strategies for targeting and delivering PrEP to MSM in British Columbia and Ontario. Canadian Institutes of Health Research (CIHR). CIHR Team Grant - HIV Implementation Science – Component 2. PI: Tan DH, Hull M. Co-Investigators: Bannar-Martin S, Blake-Evans L, Chris A, Gustafson R, Hoyano D, Oickle P, Tran N, Arkell C, Chown S, Diemert J, Doupe G, Edward J, Fraser C, Griffiths D, Holliday E, Jollimore J, Junek K, Knox D, Maxwell J, Mitterni L, Ortiz Nunez R, Tilley L, Wong J, **Bayoumi AM**, Bogoch I, Burchell A, De Wet J, Gilbert M, Grace D, Grennan T, Hall D, Isaranuwachai W, Lachowsky N, Lima V, MacPherson P, Mishra S, Moore D, O'Byrne P, Sharma M, Wilton J, Woodward K (Co-Investigators). \$398,800 CAD.
- 2017 - 2018 **Co-Investigator.** Aging and living with HIV (ALHIV): Multimorbidity prevention and successful aging for people living with HIV in Canada. Canadian Institutes of Health Research (CIHR). Team Grant: HIV/AIDS Comorbidities Prevention and Healthy Li. PI: Kendall C, O'Brien K. Co-Investigators: Ahluwalia P, Baxter L, **Bayoumi AM**, Becker M, Burchell A, Carusone SC, Hart T, Ibáñez-Carrasco F, Jaglal S, MacPherson P, Marshall Z, Nixon S, Packer T, Presseau J, Rourke SB, Solomon P, Worthington C, Quigley A, Payne M, Reimer T, Rosenes R, Bibeau C, McDougall P, Turje(RB, Rogers T, Smith SS, Vader K. \$25,000 CAD.
- 2017 - 2018 **Co-Investigator.** Public Genomics: Examining public uptake and use of genome sequencing. ARCC Seed Grant 2016. PI: Bombard Y. Co-Investigators: **Bayoumi AM**, Baxter N, Scheer A, Thorpe K, Laupacis A, Glogowski E, Schrader K, Kim R, Lerner-Ellis J. \$30,000 CAD.
- 2016 - 2017 **Co-Investigator.** HIV prevention, supervised injection services, and collaborative relationships with police: Development of a training program. Canadian Institutes of Health Research. Planning and Dissemination Grant. PI: Strike CJ, Hopkins SM. **Co-Investigators: Bayoumi AM**, Challacombe LA, Watson TM. \$9,945 CAD.
- 2016 - 2021 **Co-Investigator.** Vaccination & screening for control sexually transmitted infections (STIs) and STI-related cancers. Canadian Institutes of Health Research (CIHR). Foundation Scheme. PI: Burchell AN. Co-Investigators: Allen V, Antoniou T, **Bayoumi AM**, Brisson M, Cooper C, Coutlee F, Cox J, de Pokomandy A, Deeks S, Fisman D, Franco E, Gardner S, Gilbert M, Gough K, Grennan T, Hart T, Hogg R, Kendall C, Lambert G, Lofters A, Loutfy M, MacPherson P, Mishra S, Moore D, Murray J, Ogilvie G, Raboud J, Rachlis A, Rourke S, Salit I, Sullivan F, Tan D, Walmsley S. \$1,061,091 CAD.
- 2016 - 2021 **Co-Investigator.** Refugee integration and long-term health outcomes in Canada. Canadian Institutes of Health Research (CIHR). Project Scheme. PI: Hynie M. Co-Investigators: McGrath S, McKenzie K, Agic B, Ahmad F, Arya N, **Bayoumi AM**, Clark-Kazak C, Cleveland J, Diaz M, Kuo B, Rummens J, Shakya Y. \$1,353,165 CAD.
- 2016 - 2017 **Co-Investigator.** Decentralizing the delivery of HIV pre-exposure prophylaxis (PrEP) through family physicians and sexual health clinic nurses. Canadian Institutes of Health Research

(CIHR). HIV implementation science component 1. PI: Tan D. Co-Investigators: **Bayoumi AM**, Bogoch I, Chan A, Gilbert M, Grace D, Knox D, Maxwell J, McEwen O, Mishra S, Rogers T, Shahin R, Sharma M. \$150,000 CAD.

- 2016 - 2017 **Co-Investigator.** Developing New Tools to Project the Value of More Data versus Changing Clinical Practice Using Epidemic Models: A Case Study of 2014-2015 Ebola Outbreak in West Africa. St. Michael's Foundation's Translational Innovation Fund. PI: Mishra S, Isaranuwachai W. Co-Investigators Chan A, **Bayoumi AM**, Fowler R, Hajek J, Khan K, Hoch J. \$50,000 CAD.
- 2016 - 2017 **Co-Investigator.** From prison to community: developing a Transition Intervention Program for formerly incarcerated persons with HIV. St. Michael's Foundation's Translational Innovation Fund. PI: Antoniou T, Mishra S. Co-Investigators Kouyoumdjian F, Matheson F, **Bayoumi AM**, Rowe J. \$50,000 CAD.
- 2015 - 2022 **Co-Investigator.** Expansion of Antiretroviral Therapy and its Impact on Vulnerable Populations in Canada and Global Settings. Canadian Institutes of Health Research (CIHR). Foundation Scheme. PI: Hogg RS. Co-Investigators: Barrios R, **Bayoumi AM**, Burchell AN, Cooper C, Hull M, Kaida A, Klein M, Lachowsky N, Lima V, Loutfy M, Milloy M, Montaner J, Moore D, Nosyk B, Parashar S, Raboud J, Roth E, Smieja M. \$6,533,866.
- 2015 - 2020 **Co-Investigator.** Integrating genomic technologies in health care: evidence, values and health policy. Canadian Institutes of Health Research (CIHR). Foundation Scheme. PI: Bombard Y. Co-Investigators: **Bayoumi AM**, Caulfield T, Laupacis A, Lerner-Ellis J, Scheer A, Scherer S, Sullivan T. \$976,589.
- 2015 - 2020 **Co-Investigator.** Mathematical Modeling and Epidemiology to inform HIV Program Science. Canadian Institutes of Health Research (CIHR). Foundation Scheme. PI: Mishra S. Co-Investigators: Alary M, Baral S, **Bayoumi AM**, Becker M, Blanchard J, Boily M, Burchell A, Cori A, Fisman D, Gilbert M, Lortie, Pickles M, Rourke S, Sandstrom P, Schwartz S, Tan D, Tuite A, Vickerman P, Volz E. \$1,327,031.
- 2015 - 2018 **Co-Investigator.** Translating Exercise into the HIV Community: Evaluating a Community-Based Exercise Intervention to Improve the Health of Adults Living with HIV. Canadian Institutes of Health Research (CIHR), CIHR HIV/AIDS Community-Based Research Program. PI: O'Brien K, Zobeiry M. Co-Investigators: Bayoumi AM, Davis A, Godi C, King K, Solomon P, Tang A. \$149,255.
- 2015 - 2016 **Co-Investigator.** Size Matters Study - an investigation of needle gauge on illicit injection drug use outcomes. Ontario HIV Treatment Network (The) (OHTN), Community Based Research & Evaluation Fund PI: Altenberg, J. Co-Investigators: Mason K, Bayoumi AM, Strike C, Balian R. \$25,000.
- 2015 - 2016 **Principal Investigator.** Establishing Longitudinal Cohort Studies of People who Use Drugs in Ontario. Canadian Institutes of Health Research (CIHR), Planning and Dissemination Grant. Nominated PI: Bayoumi AM. Co-Principal Investigators: Kendall C, Strike C. Co-Investigators: Altenberg J, Antoniou T, Boyd R, Challacombe LA, Cooper C, Guilcher SJT, Guimond TH, Hendriks A, Hopkins SM, LeBlanc SJ, Marshall Z, Martin AJ, Pinto AD, Powis J, Raboud JM, Rudzinski K, Tyndall MW. \$10,000
- 2014 - 2019 **Co-Principal Investigator.** Canadian HIV Observational Cohort (CANOC) Collaborative Research Centre. Canadian Institutes of Health Research (CIHR). PI: Hogg RS, Antoniou T, Bayoumi AM, Burchell AN, Cooper CL, Hull MW, Kelly DV, Klein MB, Loutfy MR, Machouf NN, Montaner JSG, Nosyk BP, Raboud JM, Sanche SE, Tsoukas CM, Wong ACH. Co-Investigators: Cescon A, Cotterchio M, Goldsmith C, Guillemi SA, Harrigan RP, Harris M, Hosein SR, Johnston SE, Kendall C, Liddy CE, Lima VD, Marsh DC, Moore DM, Patterson SE, Phillips P, Rachlis AR, Rourke SB, Samji H, Smieja MJ, Trottier B, Wainberg MA, Walmsley SL. \$2,726,760.

- 2014 - 2017 **Co-Investigator.** Development and Assessment of an Instrument for Evaluating Public and Patient Involvement in Resource Allocation Decisions. Canadian Institutes of Health Research (CIHR). PI: Rosenberg-Yunger ZR. Co-Investigators: MacPhail EH, Bayoumi AM, O'Brien KK, Tiessen J. \$161,980.
- 2014 - 2015 **Co-Investigator.** The Coming Revolution in HCV Therapy: Will HIV-HCV co-infected patients really benefit? Canadian Institutes of Health Research (CIHR), Operating Grant - Priority Announcement: Hepatitis C. PI: Klein MB. Co-Investigators: Anis A, Barrett L, Bayoumi AM, Conway B, Cooper C, Cox J, Gill M, Hull M, Martel-Laferrière V, Moodie E, Vachon M, Walmsley S. \$100,000.
- 2014 - 2016 **Co-Investigator.** IGNITE (addressInG iNcome securITy in primary carE) Study: a pragmatic randomized controlled trial. Physicians' Services Incorporated (PSI) Foundation. PI: Pinto AD. Co-Investigators: Bayoumi AM, Bloch G, Persaud N, Thorpe KE, Mamdani M. \$58,000.
- 2014 - 2015 **Co-Investigator.** Exploring the Acceptability and Feasibility of New HIV Prevention Technologies for African, Caribbean and Black Populations in Toronto. Canadian Institutes of Health Research (CIHR), Catalyst Grant. PI: Tan D. Co-Investigators: Luyombya H, Patten S, Ryan S, Tharao W, Wilton J, Bayoumi AM, Kerr J, Logie C, Loutfy M. \$33,000.
- 2014 - 2015 **Co-Investigator** Public Genomics: Examining public values, uptake and use of genome sequencing. McLaughlin Centre Accelerator Program. PI: Bombard Y. Co-Investigators: Bayoumi AM, Davis J, Szego M, Robson ME, Schrader KA, Offit K, Glogowski E, Hamilton JG. \$50,000.
- 2014 - 2015 **Co-Investigator.** From prison to community: removing barriers to care for formerly incarcerated persons with HIV. Canadian Institutes of Health Research (CIHR), Catalyst Grant: HIV/AIDS CBR Program. PIs: Antoniou T, Dicenso AM, Strike CJ. Co-Investigators: Bayoumi AM, Challacombe LA, Kendall C, Loutfy MR, Smith-Merrill D, Wobeser WL. \$32,850.
- 2014 - 2016 **Co-Investigator.** Strengthening the Implementation of Health in All Policies. Canadian Institutes of Health Research (CIHR). PI: Shankardass K. Co-Investigators: Bayoumi AM, O'Campo P, Molnar A, Renahy E, Mah C, Muntaner C. \$260,134.
- 2014 - 2016 **Co-Investigator.** Toronto Central LHIN Evaluation Collaboration Project. Toronto Central Local Health Integration Network (TCLHIN). PI: O'Campo P. Co-Investigators: Glazier RH, Bayoumi AM, Stergiopoulos V, Smylie J, Matheson F. \$700,000.
- 2014 - 2015 **Co-Investigator.** Health services utilization and outcomes of persons with HIV originally from Africa and the Caribbean. Ontario HIV Treatment Network, RFA Operating Grant. PI: Antoniou T. Co-Investigators: Remis R, Tharao W, Loutfy M, Bayoumi AM, Glazier R, Raboud J, Burchell A, Uddin Z, Mbulaheni T, Kendall C. \$79,002.
- 2013 - 2018 **Co-Investigator.** A Randomized Controlled Trial of Housing First for Homeless People with Mental Illness: Long-term Outcomes. Canadian Institutes of Health Research (CIHR). PI: Hwang SW, O'Campo PJ, Stergiopoulos V. Co-Investigators: Bayoumi AM, Goering PN, Nisenbaum R, Tsemberis S. \$1,984,383.
- 2013 - 2018 **Co-Investigator.** Advancing Primary Healthcare for persons living with HIV in Canada. Canadian Institutes of Health Research (CIHR), Team Grant: Community-Based Primary Healthcare. PI: Liddy CE, Caetano PA, McGee FA, Asghri S, Becker M. Co-Investigators: Arbess G, Bacon J, Burt K, Carnochan TN, Ireland L, Kitson CP, Lundrigan PA, McLaren M, Moore L, Rosenes R, Schulz CI, Sorensen TA, Allison JD, Antoniou T, Bayoumi AM, Burchell AN, Christie T, Collins KD, Farrell GJ, Glazier RH, Guenter D, Hogg WE, Johnston SE, Keely EJ, Kelly DV, Kendall C, Kerr J, Kovacs SC, Loutfy MR, Manuel DG, Marshall ZM, Mugford GJ, Muggah E, Pinto AD, Pottie K, Rachlis AR, Remis RS, Taljaard M, Tyndall MW, Wilson MG, Yu BN. \$2,498,494.

- 2013 - 2017 **Co-Investigator.** Centre for the Evaluation of Technological Innovation (CETI). Canada Foundation for Innovation (CFI) New Initiatives Fund. PI: Krahn M. Co-Investigators: Alibhai S, Bayoumi AM, Coyte P, Wijeyesundera H, Grootendorst P, Zwarenstein M, Cadarette S, Ungar W, Miller F. \$1,199,915.
- 2013 **Co-Investigator.** Examination of preventative health services for persons with multimorbidity in Ontario: Do geography, primary care models, and complexity matter? Ontario Ministry of Health and Long-Term Care. Health System Performance Research Network. PI: Jaglal S. Co-Investigators: Guilcher S, Lofters A, Glazier R, **Bayoumi AM**. \$29,367.
- 2012 - 2014 **Principal Investigator.** Retention in Care for People Living with Human Immunodeficiency Virus in Ontario. Canadian Institutes of Health Research (CIHR). PI: **Bayoumi AM** Co-Investigators): Antoniou T, Burchell A, Glazier, RH, Kendall C, Loutfy MR, Millson ME, Raboud JM, Remis RS, Rourke SB, Worthington CA. \$249,357.
- 2012 - 2014 **Co-Investigator** Development and Validation of an Algorithm to Impute Missing Stop Dates of Antiretroviral Therapy Regimens. Canadian Institutes of Health Research (CIHR). PI: Raboud JM. Co-Investigators: Bayoumi AM, Burchell A, Klein M, Loutfy M, Walmsley S. \$152,269.
- 2012 - 2014 **Co-Investigator.** A population-based study of HIV-associated maternal and neonatal health using Ontario's administrative databases. Ontario HIV Treatment Network. PI: Antoniou T. Co-Investigators: Bayoumi AM, Brophy J, Glazier RH, Loutfy M, Margolese S, Masinde K, Tharao W, Yudin M. \$93,175.
- 2012 **Co-Investigator.** Validation of the Standardized Universal Pain Evaluations for Rheumatology providers for children and youth (SUPER-KIDZ). Canadian Arthritis Network. Discovery Advancement Program. PI: Stinson J. Co-Investigators: Luca N, Feldman B, Benseler S, **Bayoumi AM**, Beaton D, Campillo S, LeBlanc C. \$49,992.
- 2011 - 2014 **Co-Investigator.** Determining the Need for Diagnostic Lumbar Puncture in HIV-Infected Individuals with Syphilis: A Pilot Study. Ontario HIV Treatment Network. PI: Tan D. Co-Investigators: Mishra S, Gough K, Tsang R, Bayoumi AM, Arbess G. \$139,540.
- 2011 - 2014 **Co-Investigator.** Interdisciplinary HIV Pregnancy Research Group: Care and Research to Optimize HIV-positive Women's Health during Preconception, Pregnancy and Motherhood. Canadian Institutes of Health Research (CIHR). Emerging Team Grant - Maternal Health: From Pre-conception to the Empty Nest. PI: Loutfy MR, Serghides L, Yudin MH. Co-Investigators: Angel JB, Bayoumi AM, Bitnun SA, Brophy JC, Calzavara L, Carvalho A, Doolittle-Romas M, Greene S, Gruslin AM, Hamilton GS, Ion A, La Porte AC, Leader A, Linklater G, Lye SJ, Maggi JD, Margolese SL, Masinde KI, Maxwell JD, McGee F, Muchenje M, Murphy KE, Newmeyer TS, O'Brien-Teengs D, Peltier DJ, Raboud JM, Rachlis AR, Ralph ED, Ringlein M, Rosenthal KL, Said T, Sandre R, Shapiro HM, Sharp M, Shynlova O, Silverman M, Small FM, Smith ML, Tharao WE, Walmsley SL, Wobeser WL. \$900,000.
- 2011 - 2013 **Co-Investigator.** Epidemiology of sexually transmitted co-infections among HIV-infected persons in care in Ontario. Canadian Institutes of Health Research (CIHR). PI: Burchell AN, Rourke SB. Co-Investigators: Allen V, **Bayoumi AM**, Gardner S, Kaul R, McGee F, Millson M, Remis RS. \$107,782.
- 2011 - 2012 **Co-Investigator.** Creating Responsive Community-Based Primary Healthcare Models for HIV in Canada. Canadian Institutes of Health Research (CIHR). Planning Grant. PI: Kendall C, Rourke, SB, Tyndall, MW. Co-Investigators: Hranilovic S, Rosenes R, Arbess G, **Bayoumi AM**, Cohen J, Glazier RH, Guenther D, Hogg RS, Hogg WE, Loutfy MR, McLaren M, Meili R, Pottie K, Rachlis AR, Tu DT. \$24,940.
- 2011 - 2012 **Co-Investigator.** A realist synthesis of initiation of health in all policies (HiAP): Intersectoral perspectives. Canadian Institutes of Health Research (CIHR). Knowledge Synthesis Grant. PI: O'Campo PJ. Co-Investigators: Murphy KA, **Bayoumi AM**, Shankardass K. \$99,866.

- 2011 **Co-Investigator.** Knowledge for Urban Intersectoral Action for Health: A Population Health Interventions Research Program to Advance Health Equity in Cities. Canadian Institutes of Health Research (CIHR). Programmatic Grants to tackle health and health equity-LOI. PI: O'Campo, PJ. Co-Investigators: **Bayoumi AM**, Dunn J, Glazier RH, Hwang, S, Muntaner C, Murphy KA, Stergiopoulos V. \$15,000.
- 2010 - 2012 **Co-Investigator.** Assessing the Measurement Properties of an Instrument to Describe Disability Experienced by Adults Living with HIV. Canadian Institutes of Health Research (CIHR). PI: Solomon, P. Co-Investigators: Alexander RD, King KC, Tebeje MW, **Bayoumi AM**, Norman GR, O'Brien K. \$190,287.
- 2010 - 2012 **Co-Investigator.** Model-based economic evaluation of hepatitis C treatment strategies in individuals co-infected with HIV in Canada. Canadian Institutes of Health Research (CIHR). PI: Bauch C, Krahn MD. Co-Investigators: **Bayoumi AM**, Klein M, Thein H, Wilson D. \$188,120.
- 2010 - 2011 **Co-Investigator.** An IHPREG Pilot Study: Feasibility of the Ontario HIV Pre-conception Cohort Study. Canadian Institutes of Health Research (CIHR). PI: Loutfy, MR. Co-Investigators: Angel J, **Bayoumi AM**, Bitnun S, Brophy J, Carvalho A, Greene S, Margolese S, Masinde K, Murphy K, Newmeyer T, Raboud J, Rosenthal K, Serghides L, Smaill F, Yudin M. \$96,075.
- 2010 - 2011 **Principal Investigator.** Dissemination of Findings from the Toronto and Ottawa Supervised Consumption Site Assessment (TOSCA). Canadian Institutes of Health Research (CIHR). PI: **Bayoumi AM**. Co-Investigators: Strike, C. \$22,494.
- 2009 - 2015 **Co-Investigator.** Health Care, Technology and Place (HCTP): A CIHR Strategic Training Initiative. Canadian Institutes of Health Research (CIHR). PI: Coyte P. Co-Investigators: Andrews G, Baecker R, **Bayoumi AM**, Boydell K, Cameron J, Carter M, Colantonio A, Dunn J, Gignac M, Hoch J, Holmes D, Jadad A, Laporte A, Letourneau N, Maki B, Mihailidis A, Miller F, Mykhalovskiy E, O'Brien-Pallas L, Rosenberg M, Upshur R. \$1,915,970.
- 2009 - 2015 **Co-Investigator.** The CIHR ACHIEVE Research Partnership: Action for Health Equity Interventions. Canadian Institutes of Health Research (CIHR), Strategic Training Initiative in Health Research. PI: O'Campo PJ. Co-Investigators: Murphy K (co-PI), Bayoumi AM, Dunn J, Fafard P, Flicker S, Glazier R, Hoch J, Hwang SW, Khan K, Lavery J, Nisenbaum R, Rourke SB, Smylie JK, Sridharan S, Travers R, Walks A, Wheaton B. \$1,790,000.
- 2009 - 2014 **Co-Investigator.** CIHR Centre for REACH in HIV/AIDS (Research Evidence into Action for Community Health) / Centre des IRSC d'action sur le VIH/SIDA (Mise en pratique des résultats de la recherche en santé communautaire). Canadian Institutes of Health Research (CIHR). PI: Rourke S. Co-Investigators: Adam B, Bayoumi AM, Gahagan J, Hogg R, Johnson A, Jolly R, Kirkland S, Klein M, Mugford J, Mykhalovskiy E, Nixon S, Orsini M, Otis J, Ristock J. \$2,500,000.
- 2009 - 2014 **Principal Investigator.** Applied Chair in Health Services and Policy Research. Canadian Institutes of Health Research (CIHR)/ Ministry of Health and Long-term Care. PI: **Bayoumi AM**. \$925,000. [Salary Award]
- 2009 - 2013 **Co-Investigator.** Randomized controlled trial of Housing First for homeless persons with mental illness. Mental Health Commission of Canada, Research Demonstration Project in Mental Health and Homelessness, Toronto Site. PI: Hwang SW, Stergiopoulos V, O'Campo P. Co-Investigators: Sridharan S, Dunn J, McKenzie K, George T, **Bayoumi AM**, Murphy K. \$22,200,000.
- 2009 - 2011 **Co-Investigator.** Comparative effectiveness of ART for HIV in patients with comorbidities. National Institutes of Health (NIH) (USA). Department of Health and Human Services. PI: Owens, DK. Co-Investigators: Barnett P, **Bayoumi AM**, Brandeau ML, Bendavid E, Holodniy M, Olshen RA, Sanders G. \$499,243 USD.

- 2009 - 2010 **Co-Investigator.** A program of health technology assessment in children: Assessing the use of biologic response modifiers for juvenile idiopathic arthritis and the use of thiopurine methyltransferase genetic testing for predicting mercaptopurine doses in children with acute lymphoblastic leukemia. Ontario Ministry of Health and Long-Term Care. Drug Innovation Fund. PI: Ungar WJ. Co-Investigators: Ito S, **Bayoumi AM**. \$308,150.
- 2008 - 2010 **Principal Investigator.** Preference Measures for HIV Antiretroviral Decision Making. Canadian Institutes of Health Research (CIHR). PI: **Bayoumi AM**. Co-Investigators: Antoniou T, Hoch JS, Park-Wyllie L, Strike CJ, Taback NA. \$261,446.
- 2008 - 2010 **Co-Principal Investigator.** Safe Consumption Sites: Potential Impact and Cost-Effectiveness in Toronto and Ottawa. Ontario HIV Treatment Network. PI: **Bayoumi AM**, Strike C. Co-Investigators: Zaric G, Leonard L, Glazier R, Fischer B, Millson M, Smith C, Degani N, Hopkins S, Shepherd S, O'Campo P. \$292,312.
- 2007 - 2012 **Co-Investigator.** Canadian Observational Cohort (CANOC) Collaboration. Canadian Institutes of Health Research (CIHR)/CIHR Canadian HIV Trials Network (CTN242). CIHR Canadian HIV Trials Network. PI: Hogg RS. Co-Investigators: Klein MB, Machouf NN, Rourke SB, Tsoukas CM, Aykroyd GR, Balfour LC, **Bayoumi AM**, Cairney J, Calzavara L, Cooper CL, Gough KA, Guillemi SA, Harrigan RP, Harris M, Hatzakis GE, Kilby DL, Lima VD, Loutfy MR, Mills EJ, Millson ME, Montaner JS, Moore DM, Raboud JM, Rachlis AR, Read SE, Salit IE, Smieja MJ, Trottier B, Walmsley SL, Wobeser. \$2,362,250.
- 2007 - 2009 **Principal Investigator.** HIV Health Services Research: Efficiency, Equity, Access, and Quality of Life. Ontario HIV Treatment Network. PI: **Bayoumi AM**. \$144,000.[Research Award]
- 2007 - 2008 **Principal Investigator.** OHTN Cohort Study Capacity Building Grant. Ontario HIV Treatment Network. PI: **Bayoumi AM**. Co-Investigators: Gough K, Cornelson B. \$199,693. [Research Award]
- 2007 - 2008 **Co-Investigator.** CIHR Clinician Scientist Phase 1 Award (Sang Joseph Kim): The Impact of Comorbidity and Health-Related Quality-of-Life of Waitlisted Hemodialysis Patients on Kidney Transplant Outcomes: A Longitudinal Study. Canadian Institutes of Health Research (CIHR). PI: Sang JK. \$18,125. Supervisor: **Bayoumi AM**
- 2007 - 2008 **Co-Investigator.** Guidelines for the Determination of Medical Inadmissibility for Canadian Immigration Applicants with HIV/AIDS. Ontario HIV Treatment Network. Co-Investigators: Coyte PC, **Bayoumi AM**, Li A, Holmes D, Battista M, Elliot R. \$42,035.
- 2007 **Co-Investigator.** Literature Review and Secondary Analysis of Current Data Pertaining to Safe Consumption Sites. Ontario Ministry of Health and Long-Term Care. Community Health Division, Hepatitis C Secretariat. PI: Strike C. Co-Investigators: Millson P, Shepherd S, Hopkins S, Fisher B, O'Campo P, **Bayoumi AM**, Leonard L. 29,052 CAD. [Research Award]
- 2006 - 2009 **Co-Investigator.** Ontario Women's Health Report Card: Improving Health and Promoting Equity for the Women of Ontario AKA Project for an Ontario Women's Health Evidence-Based Report Card (POWER). Ontario Ministry of Health and Long Term Care. PI: Bierman AS. Co-Investigators: Abramson B, Angus J, Anderson G, Bayoumi AM, Booth G, Dunn J, Dunn S, Dusek J, Ferris L, Glazier R, Hawker G, Jaakkimainen L, Khanlou N, Krzyzanowski M, Lin E, McDonald L, Manuel D, Moineddin R, Rabineck L, Rhodes A, Rochon P, Stewart D, Stukel T. \$4,289,300.
- 2006 - 2007 **Principal Investigator.** Health Services Research: Efficiency, Equity, Access, and Quality of Life. Ontario HIV Treatment Network. PI: **Bayoumi AM**. \$72,000. [Research Award]
- 2006 - 2007 **Principal Investigator.** OHTN Cohort Study Capacity Building Grant (Renewal). Ontario HIV Treatment Network. PI: **Bayoumi AM**. Co-Investigators: Gough K, Cornelson B. \$198,071.

- 2006 - 2007 **Co-Investigator.** Crossover Pilot Study of Norfloxacin in Hepatopulmonary Syndrome. The Physicians' Services Incorporated Foundation. PI: Faughnan ME. Co-Investigators: Gupta S, **Bayoumi AM**, Stewart DJ, Lilly LB, Hutchison SJ. \$83,500. [Research Award]
- 2006 - 2007 **Principal Investigator.** OHTN Cohort Study Capacity Building Grant. Ontario HIV Treatment Network. PI: **Bayoumi AM**. Co-Investigators: Gough K, Cornelson B. \$198,071. [Contracts]
- 2006 - 2007 **Principal Investigator.** HIV Health Services Research: Efficiency, Equity, Access, and Quality of Life. Ontario HIV Treatment Network. PI: **Bayoumi AM**. \$72,000. [Research Award]
- 2006 - 2007 **Principal Investigator.** A pilot study of human immunodeficiency virus antiretroviral decision making. Canadian Institutes of Health Research (CIHR). PI: **Bayoumi AM**. Co-Investigators: Feldman-Stewart DR, Park-Wyllie L. \$80,000. [Research Award]
- 2005 - 2007 **Co-Investigator.** Disability in the Context of HIV. Wellesley Central Urban Health Research Program. PI: O'Brien K. Co-Investigators: Co-Investigator and Principal Supervisor of Student Investigator. **Bayoumi AM**. Co-Investigator: Davis A. \$19,966.
- 2005 - 2007 **Co-Investigator.** Effects of Smoked Cannabis on Body Weight, Food Intake, and Appetite Stimulation in HIV/AIDS: A Open-Label, Single Arm, Dose Titration Study. Ontario HIV Treatment Network. PI: Rueda S. Co-Investigators: **Bayoumi AM**, Singer J, Streiner D, Darling P, Chin T, Walker S, Gough K, Rourke SB. \$256,500.
- 2005 - 2006 **Principal Investigator.** Weighted Study End Points: An Innovative Tool for Assessing Evidence in Therapeutic Trials. Canadian Coordinating Office of Health Technology Assessment. PI: **Bayoumi AM**. Co-Investigators: Ray JG. \$95,910. [Contracts]
- 2004 - 2008 **Co-Investigator.** Disability in the Context of HIV: Building a Foundation for an Instrument to Describe "Disability" Experienced by Adults Living with HIV. Canadian Institutes of Health Research (CIHR). Inst of Infection and Immunity HIV/AIDS Research Initiative. PI: O'Brien K. Co-Investigator and Principal Supervisor of Student Investigator. **Bayoumi AM**. Co-Investigator: Davis AM. \$144,168.
- 2004 - 2006 **Principal Investigator.** HIV Health Services Research: Efficiency, Equity, Access, and Outcomes. Ontario HIV Treatment Network. PI: **Bayoumi AM**. \$143,000.
- 2004 - 2006 **Principal Investigator.** The Cost-Effectiveness of Treating People Living with HIV: A Program of Research. Ontario HIV Treatment Network. PI: **Bayoumi AM**. Co-Investigators: Zaric GS, Hoch J, Rueda S, Strike C. \$144,627.
- 2004 - 2005 **Principal Investigator** HIV-related Utility Elicitations: Reliability and Relevance to Current Treatments. Society of General Internal Medicine Lawrence Linn Award. \$9,898 USD.
- 2004 - 2005 **Principal Investigator.** Explicit Considerations of Equity in Health Technology Assessments. Canadian Coordinating Office of Health Technology Assessment. PI: **Bayoumi AM**. Co-Investigators: Hoch J, Johri M. \$97,610.
- 2004 - 2005 **Co-Investigator.** Development of a quality of life instrument for homeless persons and street youth. Canadian Institutes of Health Research (CIHR). PI: Palepu A, Hubley A. Co-Investigators: Aubry T, **Bayoumi AM**, Hwang S, Roy E. \$60,160.
- 2004 - 2005 **Co-Investigator.** An Evaluation of Dosage-Adjustment Interventions on Patient Outcomes for Adverse Drug Interactions. Ontario HIV Treatment Network. PI: Park-Wyllie L. Co-Investigators: Levine M, Holbrook A, Thabane L, **Bayoumi AM**. \$57,150.
- 2003 - 2007 **Co-Investigator.** Effects of return-to-work on health-related quality of life in HIV/AIDS: A prospective cohort study. Canadian Institutes of Health Research (CIHR). PI: Mustard CA. Co-Investigators: Rueda S, Lavis JN, **Bayoumi AM**, Raboud JM, Rourke SB. \$116,678.

- 2003 - 2004 **Co-Investigator.** Family and community medicine for patients without health insurance: Epidemiology, sociocultural determinants and outcomes. Canadian Institutes of Health Research (CIHR). PI: Caulford PG. Co-Investigators: **Bayoumi AM**, Drummond NA, Glazier RH, Little D. \$99,484.
- 2003 - 2004 **Principal Investigator.** The Cost-Effectiveness of Treating People Living with HIV: A Program of Research. Ontario HIV Treatment Network. PI: **Bayoumi AM**. Co-Investigators: Zaric GS, Hoch J, Rueda S. \$66,600.
- 2003 - 2004 **Co-Investigator.** Cost Effectiveness of HIV Screening and Treatment in the Elderly. National Institute on Aging (USA). Center on the Demography and Economics of Health and Aging. PI: Owens DK. Co-Investigators: Sanders S, **Bayoumi AM**, Sundaram V. \$70,832.54.
- 2003 - 2004 **Co-Investigator.** The impact of GBV-C coinfection on perinatal HIV transmission. Canadian Institutes of Health Research (CIHR). HIV/AIDS Research Program. PI: Remis RS. Co-Investigators: Millson ME, **Bayoumi AM**, King SM, Raboud JM. \$112,501.
- 2003 - 2004 **Co-Investigator.** Exploring the social and risk networks of female and male injection drug users in Toronto. Canadian Institutes of Health Research (CIHR). PI: Degani N. Co-Investigators: **Bayoumi AM**, Millson ME. \$20,917.
- 2002 - 2003 **Co-Investigator.** A Pilot Evaluation of a Quality of Life in HIV infected individuals: Does HAART have a negative impact on quality of life and is the MOS-HIV scale able to detect the negative impact of HAART on quality of life? Ontario HIV Treatment Network. PI: Park-Wyllie L. Co-Investigators: **Bayoumi AM**, Antoniou T. \$19,856.
- 2001 - 2002 **Co-Investigator.** Quality of life assessment for people with Human Immunodeficiency Virus Infection. University of Toronto Dean's Fund. PI: **Bayoumi AM**. \$9,500.
- 2000 - 2001 **Principal Investigator.** Optimal Methods to Improve Adherence: Individual and Population Perspectives. Ontario HIV Treatment Network. PI: **Bayoumi AM**. Co-Investigators: Zaric G, Tseng A, Glazier R. 49,232.
- 2000 **Co-Investigator.** HAART Adherence in HIV-infection Project: Identification of necessary factors for medication management of HAART and Maximizing HAART adherence through behavioural interventions. Ontario Ministry of Health and Long-Term Care. AIDS Program Committee. PI: Rourke SB. Co-Investigators: Saunders D, Lancee, W, **Bayoumi AM**, Foisy M. , Glazier R. , Halman MH, Kovacs C, Rachlis AR, Salit I, Seidelman W, Walmsley S, Wong J, Zaretsky A, Tseng A. \$250,000.
- 1998 - 2003 **Principal Investigator.** Resource Allocation in Health Care: Focus on HIV. Ontario HIV Treatment Network. PI: **Bayoumi AM**. \$307,500.
- 1998 - 1999 **Co-Investigator.** Viral load testing: access and economic impact. Canadian Foundation for AIDS Research. PI: McMurchy D. Co-Investigators: **Bayoumi AM**, Palmer R, Rachlis A. \$59,474.
- 1998 - 1999 **Principal Investigator.** The role of cost-effectiveness analysis in resource allocation decisions. St. Michael's Hospital Health Sciences Research Program. PI: **Bayoumi AM**. \$9,650.
- 1996 - 1997 **Co-Investigator.** Preventing Mycobacterium avium complex infection in people living with HIV and AIDS: A cost-utility analysis. Health Canada. PI: Redelmeier DA. Co-Investigators: **Bayoumi AM**. \$112,000.

NON-PEER-REVIEWED GRANTS AND CONTRACTS

- 2016 – 2017 Consultant and Member, Technical Advisory Group and Expert Advisory Panel. New York

City Supervised Injection Facility Feasibility Impact Study. \$5,000 USD

- 2008 - 2010 **Co-Principal Investigator.** Exploration of access to and data quality of EAPs in the St. Michael's Hospital HIV Service in Toronto, Ontario. Ontario HIV Treatment Network. PI: Co-PI: **Bayoumi AM**, Gough K. \$357,250.
- 2008 - 2009 **Principal Investigator.** OHTN Cohort Study, St. Michael's Hospital. Ontario HIV Treatment Network. Co-Investigators: PI: **Bayoumi AM**. Gough K, Cornelson B. \$200,000.
- 2005 **Principal Applicant.** Undergraduate and Postgraduate Medical Training in Cardiac Auscultation. University of Toronto McGraw-Hill Ryerson Teaching Technology Integration Fund. PI: **Bayoumi AM**. Co-Investigators: Kitchens J. \$600. [Contracts]
- 2001 - 2004 **Principal Investigator.** HIV Ontario Observational Database / HIV Information Infrastructure Project. Ontario Ministry of Health and Long-Term Care/Ontario HIV Treatment Network. Ontario HIV Treatment Network. PI: **Bayoumi AM**. \$9,000,000.
- 2001 - 2003 **Co-Investigator.** Efficacy of Smoked Cannabis on Appetite Stimulation in Persons Living with HIV/AIDS: A Randomized, Double Blind, Placebo-Controlled Crossover Pilot Study. Health Canada. PI: Gough K. Co-Investigators: Rueda S, Singer J, **Bayoumi AM**, Chin T, Kilby D, Darling P, Schwartzberg S, Walker S, Rourke SB. \$840,000
- 1998 - 1999 **Principal Investigator.** Cost-effectiveness of Post-Exposure Prophylaxis. Health Canada. PI: **Bayoumi AM**. \$9,295.63.

D. Publications

1. PEER-REVIEWED PUBLICATIONS

Journal Articles

1. Persaud S, Fitzgerald M, Hawken S, Tanuseputro P, Boucher L, Petrich W, Wellman M, Webber C, Shoemaker E, Ducharme R, Dahrouge S, Myran D, Bayoumi AM, Wanigaratne S, Bloch G, Ponka D, Smith BT, Lofters A, Zygmunt A, MacLeod KK, Turcotte LA, Sander B, Howard M, Funnell S, Rayner J, Kitagawa K, Ibrahim S, Kendall CE. The association of combinations of social factors and SARs-CoV-2 infection: A retrospective population-based cohort study in Ontario, 2020-2021. *Dialogues Health*. 2024 Oct 29;5:100197. doi: 10.1016/j.dialog.2024.100197. PMID: 39717675; PMCID: PMC11664076.
2. Scheim AI, Bouck Z, Greenwald ZR, Ling V, Hopkins S, Johnson M, Bayoumi A, Gomes T, Werb D. Frequency of supervised consumption service use and acute care utilization in people who inject drugs. *Drug Alcohol Depend*. 2024 Dec 1;265:112490. doi: 10.1016/j.drugalcdep.2024.112490. Epub 2024 Nov 8. PubMed PMID: 39546979.
3. Torres S, Bayoumi AM, Abrahao ABK, Trudeau M, Pritchard KI, Li CN, Mitsakakis N, Liu G, Krahn M. Implementing routine collection of EQ-5D-5L in a breast cancer outpatient clinic. *PLoS One*. 2024;19(8):e0307225. doi: 10.1371/journal.pone.0307225. eCollection 2024. PubMed PMID: 39190702; PubMed Central PMCID: PMC11349211.
4. Greenwald ZR, Werb D, Feld JJ, Austin PC, Fridman D, Bayoumi AM, Gomes T, Kendall CE, Lapointe-Shaw L, Scheim AI, Bartlett SR, Benchimol EI, Bouck Z, Boucher LM, Greenaway C, Janjua NZ, Leece P, Wong WW, Sander B, Kwong JC. Validation of case-ascertainment algorithms using health administrative data to identify people who inject drugs in Ontario, Canada. *J Clin Epidemiol*. 2024 Mar 22;111332. doi: 10.1016/j.jclinepi.2024.111332.
5. Kolla G, Khorasheh T, Dodd Z, Greig S, Altenberg J, Perreault Y, Bayoumi AM, Kenny KS. "Everybody is impacted. Everybody's hurting": Grief, loss and the emotional impacts of overdose on harm reduction workers. *Int J Drug Policy*. 2024 May;127:104419. doi: 10.1016/j.drugpo.2024.104419. Epub 2024 Apr 9. PMID: 38599035.

6. Ledlie S, Tadrous M, Bayoumi AM, McCormack D, Cheng C, Besharah J, Munro C, Gomes T. Trends in opioid toxicities among people with and without opioid use disorder and the impact of the COVID-19 pandemic in Ontario, Canada: A population-based analysis. *Int J Drug Policy*. 2024 Mar 23;127:104392. doi: 10.1016/j.drugpo.2024.104392.
7. Behrends CN, Leff JA, Lowry W, Li JM, Onuoha EN, Fardone E, Bayoumi AM, McCollister KE, Murphy SM, Schackman BR. Economic Evaluations of Establishing Opioid Overdose Prevention Centers in 12 North American cities: A Systematic Review. *Value Health*. 2024 Feb 22:S1098-3015(24)00073-1. doi: 10.1016/j.jval.2024.02.004.
8. Rammohan I, Gaines T, Scheim A, Bayoumi A, Werb D. Overdose mortality incidence and supervised consumption services in Toronto, Canada: an ecological study and spatial analysis. *Lancet Public Health*. 2024 Feb;9(2):e79-e87. doi: 10.1016/S2468-2667(23)00300-6.
9. Kolla G, Tarannum CN, Fajber K, Worku F, Norris K, Long C, Fagundes R, Rucchetto A, Hannan E, Kikot R, Klaiman M, Firestone M, Bayoumi A, Laurence G, Hayman K. Substance use care innovations during COVID-19: barriers and facilitators to the provision of safer supply at a Toronto COVID-19 isolation and recovery site. *Harm Reduct J*. 2024 Jan 20;21(1):17. doi: 10.1186/s12954-024-00935-w.
10. O'Brien KK, Erlandson KM, Brown DA, Carusone SC, Vera JH, Bergin C, Avery L, Bayoumi AM, Hanna SE, Harding R, Solomon P, Clair-Sullivan NS, O'Shea N, Murray C, Boffito M, Da Silva G, Torres B, McDuff K, Davis AM. Episodic disability questionnaire (EDQ) measurement properties among adults living with HIV in Canada, Ireland, United Kingdom, and United States. *BMC Infect Dis*. 2024 Jan 10;24(1):71. doi: 10.1186/s12879-023-08958-7. PubMed PMID: 38200425; PubMed Central PMCID: PMC10782617
11. Long C, Guimond T, Bayoumi AM, Firestone M, Strike C. The multiple makings of a supervised consumption service in a hospital setting. *Int J Drug Policy*. 2024 Jan;123:104260. doi: 10.1016/j.drugpo.2023.104260. Epub 2023 Nov 29.
12. Young S, Gomes T, Kolla G, McCormack D, Dodd Z, Raboud J, Bayoumi AM. Initiations of safer supply hydromorphone increased during the COVID-19 pandemic in Ontario: An interrupted time series analysis. *PLoS One*. 2023 Dec 19;18(12):e0295145. doi: 10.1371/journal.pone.0295145. eCollection 2023.
13. Hu T, McCormack D, Juurlink DN, Campbell TJ, Bayoumi AM, Leece P, Kent JT, Gomes T. Hu T, McCormack D, Juurlink DN, Campbell TJ, Bayoumi AM, Leece P, Kent JT, Gomes T. *CMAJ*. 2023 Dec 17;195(49):E1709-E1717. doi: 10.1503/cmaj.231014.
14. Guglielmin M, Shankardass K, Bayoumi A, O'campo P, Kokkinen L, Muntaner C. Tools for local health in all policies implementation: evidence from an explanatory case study of Kuopio, Finland. *Scand J Public Health*. 2023 Dec;51(8):1196-1204. doi: 10.1177/14034948221090076. Epub 2022 Jun 29. PubMed PMID: 35766538.
15. Guglielmin M, Shankardass K, O'Campo P, Bayoumi AM, Kokkinen L, Muntaner C. Developing a Research Agenda for HiAP Implementation: A Response to the Recent Commentaries. 2023 Nov. *Int J Health Policy Manag*. 2023;12:8326.
16. Schmidt RA, Kaminski N, Kryszajtyś DT, Rudzinski K, Perri M, Guta A, Benoit AC, Bayoumi AM, Challacombe L, Hales J, Kenny K, Kolla G, O'Reilly E, Sereda A, Rai N, Strike C. 'I don't chase drugs as much anymore, and I'm not dead': Client reported outcomes associated with safer opioid supply programs in Ontario, Canada. 2023 Nov. *Drug Alcohol Rev*. 2023;42:1825-1837.
17. Ali F, Russell C, Kaura A, Leslie P, Bayoumi AM, Hopkins S, Wells S. Client experiences using a new supervised consumption service in Sudbury, Ontario: A qualitative study. *PLoS One*. 2023 Oct 16;18(10):e0292862. doi: 10.1371/journal.pone.0292862. eCollection 2023.
18. Martin NK, Beletsky L, Linas BP, Bayoumi A, Pollack H, Larney S. Modeling as Visioning: Exploring the Impact of Criminal Justice Reform on Health of Populations with Substance Use Disorders. *MDM Policy Pract*. 2023 Oct 11;8(2):23814683231202984. doi: 10.1177/23814683231202984. eCollection 2023 Jul-Dec.
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E. Presentations and Special Lectures

1. INTERNATIONAL

- 2023 Dec 6 **Invited Speaker.** Lessons from Studying Supervised Injection. Weill Cornell Population Health Sciences Grand Rounds. New York, NY. USA
- 2017 April 10 **Invited Speaker.** Supervised Injection Facilities: From Models to Policies. University of Pittsburgh Public Health Dynamics Laboratory Seminar Series. Pittsburgh PA.

- 2016 Sept 28 **Invited Lecturer.** Introduction to the analysis of cost-effectiveness data. North American Primary Care Research Group Webinar.
- 2016 Jan 8 **Invited Lecturer.** Utilities, Preference Measures, and QALYs. Society for Medical Decision Making, 2nd Biennial Asia-Pacific Conference The Chinese University of Hong Kong, Shatin, New Territories, Hong Kong. January 6 - 8, 2016.
- 2016 May 20 **Invited Speaker.** Supervised Injection Sites as a Health Intervention: Evidence and Application. Dartmouth Hitchcock Medicine Grand Rounds. Dartmouth-Hitchcock Medical Center, Dartmouth NH.
- 2016 Jan 7 **Invited Speaker.** Co-presenter: Global Health Policy and the Challenges Facing Asia: The Roles Stanford Plays. Stanford University Hong Kong Club, Hong Kong.
- 2015 Oct 20 **Invited Speaker.** Presidential Address. Society for Medical Decision Making. 37th Annual Meeting of the Society for Medical Decision Making, St. Louis, MO
- 2014 Jun 9 **Invited Presenter.** Concurrent validity of the EQ-5D-3L in homeless adults with mental illness. Society for Medical Decision Making, 15th Biennial European Meeting. Antwerp, Belgium. June 8-10, 2014.
- 2014 Feb 26 **Invited Speaker.** Supervised Injection Facilities in Ontario, Canada: Evidence, Models, and Policies Stanford University Health Policy Research in Progress Seminar, Stanford University, Palo Alto, CA USA.
- 2014 Jan 7 **Invited Lecturer.** Utilities, Preference Measures, and QALYs. Society for Medical Decision Making, Asia Pacific Meeting. Singapore.
- 2014 Jan 6 **Co-instructor.** Health Technology Assessment. (Short course co-taught with Murray Krahn, Jeffrey Hoch, and Jeremy Goldhaber-Fiebert). Society for Medical Decision Making, Inaugural Asia-Pacific Conference. Singapore. January 6 - 8, 2014.
- 2014 Jan 6 **Instructor.** Short course on Utilities, Preference Measures, and QALYs. Society for Medical Decision Making, Inaugural Asia-Pacific Conference. Singapore. January 6 - 8, 2014.
- 2013 Oct 20 **Instructor.** Analyzing Person-level Cost-effectiveness Data: Estimates and Uncertainty (Short course co-taught with Jeffrey Hoch). 35th Annual Meeting of the Society for Medical Decision Making, Baltimore Maryland, October 19 - 23, 2013.
- 2012 Oct 20 **Co-instructor.** Analyzing person-level cost-effectiveness data: Estimates and Uncertainty. (Short course co-taught with Katia Noyes). 34th Annual Meeting of the Society for Medical Decision Making. Phoenix, AZ. October 17 - 20, 2012
- 2012 Oct 17 **Invited Speaker.** The Cost-effectiveness of Supervised Consumption Facilities in Toronto, Canada. 34th Annual Meeting of the Society for Medical Decision Making. Phoenix, AZ. October 17 - 20, 2012. Joint Session of INFORMS and SMDM.
- 2011 Jan **Visiting Professor** King Abdullah International Medical Research Center, Riyadh and Jeddah, Saudi Arabia.
- 2009 Oct 18 **Invited Speaker.** Using the Net Benefit Regression Framework to Analyze Person-level Cost-effectiveness Data (Short course co-taught with Jeffrey Hoch, Elizabeth Fenwick, Katya Noyes). 31st Annual Meeting of the Society for Medical Decision Making, Hollywood, CA. October 18-21, 2009
- 2008 Jul 31 **Invited Speaker.** Equity Considerations in cost-effectiveness analysis. Operational Research Applied to Health Services Conference. Toronto, Ontario.
- 2007 Jul 7 **Speaker.** Using the Net-Benefit Regression Framework to Analyze Person-Level Cost-Effectiveness Data. International Health Economics Association. Copenhagen, Denmark. Presenter(s): Jeffrey Hoch and **Ahmed Bayoumi**. Pre-Conference Session at the International Health Economics Association 6th World Congress.
- 2006 Dec 1 **Speaker.** An Analysis of Published Cost-Effectiveness Analyses. European Commission. Workshop on Ex Ante Economic Evaluations of New Health Technologies. Brussels, Belgium.

- 2006 Oct 14 **Speaker.** Using the Net-Benefit Regression Framework to Analyze Person-Level Cost-Effectiveness Data. Short Course at the 28th Annual Meeting of the Society for Medical Decision Making. Boston, MA. October 15-18, 2006.
- 2006 Aug 19 **Speaker.** Decision Analysis Tools: Basics of cost-effectiveness and its use as a tool for decision analysis. University of Toronto, Faculty of Medicine and The Centre for Global Health Research in collaboration with the International AIDS Society. Toronto, Ontario.
- 2004 Aug 9 **Speaker.** The ICER Age: An Uncertain History. Joint Statistical Meeting. Toronto, Ontario Canada.
- 2003 Oct **Chair.** Panel at the Second International Conference on Urban Health: What is Urban Health? Why does it Matter? International Conference on Urban Health. New York, NY.

2. NATIONAL

- 2023 Dec 13 **Invited Speaker.** Working with People with Lived and Living Experience of Substance Use in Research, Knowledge Translation and Policy. Canadian Centre for Substance Use and Addiction, Ottawa, ON. Canada
- 2021 Oct 27 **Invited Speaker.** Research, Change, and the Internist. Dr. David Sackett Senior Investigator Award Lecture. Canadian Society for Internal Medicine. Virtual Meeting.
- 2020 Mar 26 **Invited Speaker.** Coping with COVID-19: Insight from the front lines of HIV, hepatitis C and harm reduction. CATIE Webinar.
- 2018 Feb 9 **Invited Speaker.** Patient and Public Involvement in Drug Reimbursement Decisions. BC Support Unit Health Economics Research Group, Vancouver, BC.
- 2018 Feb 7 **Invited Speaker.** Health Care Access and Costs Related to Drug Use from Linked Survey and Administrative Health Data in Ontario. Forefront Lecture. British Columbia Centre for Excellence in HIV/AIDS, Vancouver, BC.
- 2017 Feb 1 **Invited Speaker.** The Common Drug Review and Patient Input. CTAC Treatment Access Conference, Toronto, ON.
- 2016 April 11 **Invited Speaker.** Panel Discussion: Taking Account of What Can't Be Counted: The Place of Qualitative Evidence in Health Technology Assessment Drug Reviews. CADTH Symposium, Ottawa ON.
- 2016 April 10 **Invited Speaker.** Workshop: Patient Input in the CADTH Common Drug Review. CADTH Symposium, Ottawa ON.
- 2015 May **Presenter.** Physician experience and retention in care for people living with HIV in Ontario: A population-based approach. 24th Annual Canadian Conference on HIV/AIDS Research (CAHR 2015) [oral presentation], April 30-May 3, 2015, Toronto, Ontario.
- 2014 Apr 6 **Invited Lecturer.** Use of Cost-Effectiveness in Reimbursement Decisions – Canadian Perspectives. The CADTH Symposium - Panel on health economics. April 6-8, 2014. Ottawa, ON. (Presentation and Panel Discussion).
- 2013 Nov 11-15 **Invited Lecturer.** Several Lectures for the Clinical Epidemiology Institute. University of Toronto Institute of Health Policy, Management & Evaluation. Clinical Epidemiology Institute. Toronto, Ontario.
- 2013 Sep 16 **Panelist.** New Treatments, Less Access. Treatment Access Conference, Canadian Treatment Action Council. Toronto, Ontario.
- 2012 Oct 23 **Invited Speaker.** Retention in Care. CIHR Canadian HIV Trials Network Fall Scientific Workshop. Toronto, Ontario.
- 2012 Jul 24-27 **Guest Lecturer.** Several Lectures for the Health Technology Institute, University of Toronto. Toronto,

Ontario.

- 2012 Jun 15 **Invited Speaker.** HIV and Comorbidities. Canadian Working Group on HIV and Rehabilitation, Toronto, Ontario.
- 2012 May 14-18 **Invited Lecturer.** Several Lectures for the Clinical Epidemiology Institute, University of Toronto Institute of Health Policy, Management & Evaluation. Clinical Epidemiology Institute. Toronto, Ontario.
- 2011 Jul 20-22 **Guest Lecturer.** Several Lectures for the Health Technology Institute, University of Toronto. Toronto, Ontario.
- 2011 Apr 16 **Panelist.** Ending HIV By 2020: Mission Possible? 20th Annual Canadian Conference on HIV/AIDS Research. Toronto, Ontario.
- 2010 May 18 **Guest Lecturer.** Decision Analysis. University of Toronto Institute of Health Policy, Management & Evaluation. Clinical Epidemiology Institute, Toronto, Ontario.
- 2009 Nov 9-12 **Invited Lecturer.** Several Lectures for the Clinical Epidemiology Institute, University of Toronto Institute of Health Policy, Management & Evaluation. Clinical Epidemiology Institute. Toronto, Ontario.
- 2008 Nov 9-13 **Invited Lecturer.** Several Lectures for the Clinical Epidemiology Institute, University of Toronto Institute of Health Policy, Management & Evaluation Clinical Epidemiology Institute. Toronto, Ontario.
- 2008 Jul 14 **Invited Lecturer.** Several Lectures for the Laurentian University Summer Institute in Research Methods July 14-18, 2008. Laurentian University Summer Institute in Research Methods. Sudbury, Ontario.
- 2007 Apr 25 **Speaker.** The Critical Consumption of Research. Canadian AIDS Treatment Information Exchange, Toronto, Ontario.
- 2007 Apr 22 **Speaker.** Directly Measuring Patients' Preferences. Canadian Nephrology Young Investigators Group, Toronto, Ontario.

3. PROVINCIAL / REGIONAL

- 2020 Nov 26 **Invited Presenter.** Addressing Inequalities during a pandemic. Health Promotion Ontario. Webinar.
- 2019 Mar 29 **Invited Presenter.** Challenges of economic evaluation in the public health context. Ontario Public Health Convention (TOPHC) Workshop Presentation.
- 2019 Mar 25 **Invited Presenter.** What I have learned from sitting on the Canadian Drug Expert Committee. Health Quality Ontario, Toronto, ON.
- 2014 Mar 31 **Invited Presenter.** How to Design and Undertake an Economic Evaluation of a Public Health Intervention Ontario Public Health Convention (TOPHC) 2014. March 31 – April 2, 2014 Workshop presented with Jeffrey Hoch and Beate Sander.
- 2014 Mar 31 **Invited Presenter.** Introduction to Cost-effectiveness analysis. Ontario Public Health Convention (TOPHC) 2014. March 31 – April 2, 2014. Workshop presented with Jeffrey Hoch and Beate Sander, Toronto Ontario.
- 2013 Nov 26 **Speaker.** Evidence, Values, and Ideology in Public Health Decision Making: The Debate over Supervised Injection Facilities. Public Health Ontario Rounds, Toronto Ontario.
- 2013 Nov 22 **Speaker.** Public Participation in Drug Review Committee. Research to Policy Dialogue. Ministry of Health and Long-term Care. Toronto Ontario.
- 2012 Feb 28 **Invited Speaker.** Health Care Elective Session Debate: Private versus Public Funding for health care. McMaster University Health Sciences Centre. Hamilton, Ontario.

- 2009 Oct 3 **Invited Speaker.** Economic Modeling The Good, The Bad, and The Ugly. Ontario Ministry of Health and Long-term Care, Public Drugs Program, Committee to Evaluate Drugs Retreat. Toronto, Ontario.
- 2009 Aug 6 **Invited Speaker.** Health Services for Vulnerable and Marginalized HIV-Positive Populations. Queen's University, Infectious Disease Rounds. Kingston, Ontario.
- 2009 June 8 **Invited Speaker.** Health Equity Choices: Models for Decision-Making Ontario Training Centre in Health Services and Policy Research, Toronto, Ontario.
- 2008 June 9 **Invited Panelist.** Facilitated Roundtable Discussion: Knowledge Translation and Health Care for Stigmatized Groups: Understanding the Interplay of Evidence, Values, & Politics. Ontario Training Centre in Health Services and Policy Research
- 2008 June 9 **Invited Panelist.** Facilitated Roundtable Discussion: Policy Windows Now: Health Equity Goals, Roles, and Measures for Ontario. Ontario Training Centre in Health Services and Policy Research
- 2007 Sep 28 **Invited Lecturer.** A Pilot Study of Human Immunodeficiency Virus Antiretroviral Decision Making. Ontario Ministry of Health and Longterm Care. Toronto, Ontario. HIV Outpatient Clinic Coordinators Meeting.
- 2005 Nov 25 **Invited Speaker.** Economic Measures of Quality of Life, Medications, and Symptoms In People Living With HIV. Ontario HIV Treatment Network 2005 Research Conference, Toronto, Ontario.
- 2005 Nov 24 **Invited Speaker.** The OHTN Cohort Study – The Achievements to Date. Ontario HIV Treatment Network 2005 Research Conference, Toronto, Ontario.
- 2003 Nov 4 **Invited Speaker.** The Evolution and Implementation of HIIP. Ontario HIV Treatment Network 2003 Research Conference, Toronto, Ontario.
- 2003 Nov 4 **Invited Speaker.** The HIV Information Infrastructure Project. Ontario HIV Treatment Network 2003 Research Conference, Toronto, Ontario.
- 2000 Nov 18 **Invited Speaker.** HIV Update. 4th Annual Miramichi Clinical Day, Miramichi Regional Hospital, Miramichi, New Brunswick
- 1999 Oct **Invited Speaker.** Evidence-Based Practice Course for WSIB Physicians. Workplace Safety and Insurance Board, Toronto Ontario.

4. LOCAL

Invited Lectures and Presentations

- 2022 Jul 15 **Invited Panelist.** Life Sciences Career Symposium.
- 2022 Apr 5 **Invited Speaker.** Will More Choices for HIV Prevention Technologies Increase Uptake? Modeling Predicted Health Services Use From Stated Preferences. Evaluative Clinical Sciences/ICES Rounds, Sunnybrook Health Sciences Centre, Toronto.
- 2022 Mar 16 **Invited Lecturer.** Mathematical Modeling. Adult Infectious Disease/ Microbiology Academic Half-day Seminar Series.
- 2022 Feb 2 **Invited Lecturer.** What Decriminalization of Drugs Will Mean for Clinicians. St. Michael's Hospital Medical Grand Rounds.
- 2019 Sept 17 **Invited Speaker.** On The Limited Usefulness of Cost-Effectiveness Analysis. Evaluative Clinical Sciences/ICES Rounds, Sunnybrook Health Sciences Centre, Toronto.
- 2019 Mar 15 **Panelist.** Harm Reduction. Inner City Health Associates. Toronto.
- 2018 Dec 12 **Panelist.** Community Consultation on Supervised Injection. Streethealth, Toronto.

- 2018 Jun 26 **Invited Speaker.** Harm Reduction. Parkdale-Queen West Community Health Centre All Staff Meeting.
- 2018 May 23 **Invited Speaker.** Tackling the Opioid Crisis. University of Toronto, Department of Psychiatry Advocacy Day.
- 2018 May 1 **Panelist.** Decriminalizing Opioids and Addiction in Canada. Dalla Lana School of Public Health, University of Toronto. Toronto.
- 2018 Feb 15 **Invited Speaker.** Harm Reduction. Art of Medicine Lecture Series. Toronto Western Hospital, Toronto, ON.
- 2018 Feb 2 **Invited Speaker** with Alex Caudarella. Prescribing Heroin and Hydromorphone to Treat Opioid Use Disorder. South Riverdale Community Health Centre, Toronto, ON.
- 2017 May 23 **Invited Speaker.** "Can Research Change the World?" St. Michael's Hospital Higgins Day. Toronto, ON.
- 2017 Jan 10 **Invited Speaker** with C. Strike, S. Hopkins and S. Shepherd. Supervised Injection in Toronto: Research to Action. Paula Goering Integrated Knowledge Translation Awards.
- 2016 Dec 9 **Invited Speaker** with C. Strike and S. Shepherd. Supervised Injection in Toronto: Research to Action. University of Toronto Public Health Policy Rounds.
- 2016 May 19 **Invited Speaker.** The Care of Hospitalized Patients who Inject Drugs. St. Michael's Hospital Palliative Care Rounds
- 2015 Apr 1 **Invited Speaker.** How Drugs Make it on to the Provincial Formulary. Department of Medicine, St. Michael's Hospital Medical Grand Rounds.
- 2016 Mar 22 **Invited Speaker.** Retention in HIV Care in Ontario. Dignitas International Youth Club. HIV/AIDS Seminar.
- 2016 Feb 10 **Invited Speaker.** The Care of Hospitalized Patients Who Inject Drugs. Department of Medicine, St. Michael's Hospital Medical Grand Rounds.
- 2016 Jan 28 **Presenter.** How to Conduct A Prospective Cohort Study of People Who Use Drug. CRICH Work-In-Progress Rounds
- 2016 Jan 27 **Co-presenter.** Harm reduction: key policy issues impacting services, spaces and experiences in Toronto. CRICH Centre Talks.
- 2015 Jan 19 **Invited Speaker.** Clinical Epidemiology Synthesis Sessions 2015. Clinical Epidemiology & Health Care Research program, Institute of Health Policy, Management & Evaluation, University of Toronto.
- 2014 Oct 6 **Invited Speaker.** Retention in HIV Care in Ontario. Toronto General Hospital HIV Rounds.
- 2014 Sep 30 **Invited Speaker.** On the Measurement of Quality of Life among Homeless Adults with Mental Illness. Evaluative Clinical Sciences/Institute for Clinical Evaluative Sciences (ICES) rounds.
- 2014 Sep 11 **Invited Speaker.** Retention in HIV Care in Ontario. St. Michael's Hospital Clinical and Population Research Rounds.
- 2013 Nov 13 **Invited Speaker.** The Treatment of Patients with Advanced HIV Infection: What Every Internist Should Know. St. Michael's Hospital Medical Grand Rounds.
- 2013 Oct 9 **Guest Lecturer,** Utilities, QALYs, and Thresholds. Economic Evaluation Methods for Health Services Research. University of Toronto, Institute of Health Policy, Management and Evaluation.
- 2013 May 13 **Invited Speaker.** Considerations for Supervised Consumption Facilities in Toronto. AIDS Committee of Toronto Research Day. Toronto, Ontario.
- 2012 Oct 24 **Invited Speaker.** Using administrative data to support decision analysis modelling: an example and some considerations. ICES Primary Care and Population Health Program. Toronto, Ontario.

- 2012 Oct 10 **Invited Speaker.** Harm Reduction. University of Toronto Dalla Lana School of Public Health MPH Student Global Health Roundtable. Toronto, Ontario.
- 2012 Sep 6 **Invited Speaker.** Predicting the Optimal number of Supervised Consumption Sites in Toronto and Ottawa: Mapping and Modelling Approaches. St. Michael's Hospital Clinical and Population Research Rounds.
- 2012 Sep **Invited Speaker.** HCTP Academic Hiring Workshop. Health Care, Technology, and Place CIHR Strategic Research Training Program, Toronto, Ontario.
- 2012 Jun 8 **Speaker.** How to lose friends and influence people. Centre for Research on Inner City Health KT in progress: CRICH faculty seminar series. Toronto, Ontario.
- 2012 Apr 27 **Invited Speaker.** Learning about Inner City Health: A Celebration. St. Michael's Hospital, Inner City Health Program. Toronto, Ontario.
- 2012 Mar 27 **Guest Lecture.** Cost Effectiveness Analysis and HIV Prevention. University of Toronto undergraduate course on HIV Prevention. Toronto, Ontario.
- 2012 Feb 23 **Invited Speaker.** Clarifying Values in Health Equity Research. Centre for Research on Inner City Health ACHIEVE Ethics and Collaborative Research seminars. Toronto, Ontario.
- 2012 Feb 13 **Invited Speaker.** Optimizing the Thesis Training Experience. 2012 CHES Research Day Trainee Track, Hospital for Sick Children. Toronto, Ontario.
- 2012 Feb 13 **Invited Panelist.** Research Partnerships with Patients and Communities. 2012 CHES Research Day Trainee Track, Hospital for Sick Children. Toronto, Ontario.
- 2012 Jan 31 **Invited Speaker.** Clinical Epidemiology and Health Care Research at the University of Toronto: The State of the Nation. ICES/CEU Conjoint Rounds. Toronto, Ontario.
- 2012 Jan 26 **Invited Speaker.** The University and the Hospital: Some Reflections from Working at the Interface. St. Michael's Hospital - Clinical and Population Research Rounds. Toronto, Ontario.
- 2011 Mar 2 **Invited Speaker.** HIV, Aging, and Co-morbidities. Department of Medicine, Medical Grand Rounds, St. Michael's Hospital. Toronto, Ontario.
- 2010 Nov 1 **Invited Speaker.** Difficult Clinical Decisions, Sunnybrook Hospital, Toronto, Ontario. Nephrology Noon Rounds, Sunnybrook Health Sciences Centre. Toronto, Ontario.
- 2010 Mar 17 **Invited Speaker.** HCTP Academic Hiring Workshop. Health Care, Technology, and Place, CIHR Strategic Research Training Program, Toronto, Ontario.
- 2010 Feb 16 **Invited Speaker.** "Is it worthwhile to screen for HIV in the elderly? A cost-effectiveness analysis". University of Toronto, Institute for Life Course and Aging, Toronto, Ontario.
- 2009 Jun 24 **Invited Speaker.** Medical Care of the Injection Drug Using Patient. Department of Medicine, Medical Grand Rounds, St. Michael's Hospital. Toronto, Ontario.
- 2009 Mar 27 **Invited Speaker.** The Evaluation of Supervised Consumption Sites for Illicit Drugs. "Assessing Health Technology for People, Settings, and Work Places" HCTP Annual Interdisciplinary Workshop. Toronto, Ontario.
- 2009 Feb 26 **Speaker.** Supervised Consumption: Some Consequences and Scrutinized Consequentialism. St. Michael's Hospital, Clinical & Population Research Rounds. Toronto, Ontario.
- 2008 Nov 16 **Invited Speaker.** Update on HIV. University of Toronto General Internal Medicine Faculty Day. Toronto, Ontario.
- 2008 Nov 4 **Invited Speaker.** Cost-Effectiveness of the Vancouver Safe Injection Site. St. Michael's Hospital HIV Rounds. Toronto, Ontario.

- 2008 Sep 16 **Invited Speaker.** Supervised Consumption Sites: Potential Impact and Cost-Effectiveness in Toronto and Ottawa. Toronto Drug Strategy Subcommittee. Toronto, Ontario.
- 2008 Sep 12 **Invited Speaker.** Models for Resource Allocation Decision-Making. Toronto Central LIHN. Toronto, Ontario.
- 2008 Mar 12 **Invited Speaker.** Equity and Resource Allocation. St. Joseph's Hospital, Ethics Rounds. Toronto, Ontario.
- 2007 Dec 5 **Speaker.** Measuring Patient Preferences. Women's College Hospital. Toronto, Ontario. Women's Health Research In Progress Rounds. Women's College Research Institute, Toronto, Ontario.
- 2007 Nov 21 **Speaker.** Health Reform: Which Direction? Guest Lecture in Clinical Behavioural Science I: Individual and Social Issues in Health Care, (Instructor: Lori Boyd). College of Medical Radiation Technologists of Ontario. Toronto, Ontario.
- 2007 Jun 4 **Invited Lecturer.** Urban Health and Equity. Ontario Institute for Studies in Education. Invited Lecturer in OISE course "Environmental Health Transformative Higher Education", Toronto, Ontario.
- 2007 Jan 23 **Speaker.** Should we routinely screen for HIV in Ontario? St. Michael's Hospital HIV Rounds, Toronto, Ontario.
- 2006 Dec 8 **Speaker.** Should We Routinely Screen All Ontarians for HIV? Community Medicine Rounds. University of Toronto.
- 2006 Dec 7 **Speaker.** Access to HIV Genotypic Resistance Testing in Ontario. SMH Clinical and Population Research Rounds, Toronto, Ontario.
- 2006 Nov 29 **Speaker.** An Embarrassment of Riches? How to Read and Interpret Clinical Trials with Multiple End Points. Department of Medicine, Medical Grand Rounds, St. Michael's Hospital. Toronto, Ontario.
- 2006 Nov 22 **Speaker.** What is Economic Evaluation? "Deconstructing the ICER: A Workshop for Users of Pharmacoeconomic Assessments." Toronto, Ontario.
- 2006 Nov 13 **Speaker.** Should We Routinely Screen All Ontarians for HIV? Insights from Economics. University Health Network HIV Rounds, Toronto, Ontario.
- 2006 Jun 7 **Speaker.** Fair Game? Equity and Cost-Effectiveness Analysis. Sunnybrook and Women's College Clinical Epidemiology Unit / Institute for Clinical Evaluative Sciences Conjoint Evaluative Sciences Rounds, Toronto, Ontario.
- 2006 May 23 **Invited Lecturer.** Urban Health and Equity. Ontario Institute for Studies in Education course on Environmental Health Transformative Higher Education, Toronto, Ontario.
- 2006 Feb 16 **Speaker.** Fair Game? St. Michael's Hospital Clinical Epidemiology Rounds, Toronto, Ontario.
- 2005 May 4 **Speaker.** Practical Evidence-Based Medicine. St. Michael's Hospital Grand Rounds, Toronto, Ontario.
- 2005 Mar 8 **Speaker.** Are Advances in HIV Care Affordable? St. Michael's Hospital HIV Rounds, Toronto, Ontario.
- 2004 Jun 24 **Speaker.** The Cost Effectiveness of Treating Advanced Human Immunodeficiency Virus Disease. St. Michael's Hospital Clinical Epidemiology Rounds, Toronto, Ontario.
- 2004 Jun 16 **Speaker.** The Cost Effectiveness of Treating Advanced Human Immunodeficiency Virus Disease. Sunnybrook and Women's' College Clinical Epidemiology Unit / Institute for Clinical Evaluative Sciences Conjoint Evaluative Sciences Rounds, Toronto, Ontario.
- 2004 Mar 25 **Speaker.** Is HIV Resistance Testing Effective? St. Michael's Hospital Clinical Epidemiology Rounds, Toronto, Ontario.
- 2004 Jan 14 **Panelist.** Health and Human Rights: The Globalised Perspective. Program for Health & Human Rights, Toronto, Ontario.

- 2003 Jul 9 **Speaker.** Diagnosing HIV Infection. Department of Medicine, Medical Grand Rounds, St. Michael's Hospital, Toronto, Ontario.
- 2002 Nov 26 **Speaker.** Building an Urban Research Agenda: Sharing Ideas and Visions. Workshop presenter on Health services for disadvantaged communities. Community Social Planning Council of Toronto Conference, Toronto, Ontario.
- 2002 May 29 **Speaker.** Post-Exposure Prophylaxis for HIV: When is it worthwhile? St. Michael's Hospital Medical Grand Rounds, Toronto, Ontario.
- 2002 May 27 **Speaker.** A Good DEAL? Why, Bull! A Modeller's Perspective on Survival Distributions. University Health Network Clinical Epidemiology Rounds, Toronto, Ontario.
- 2001 Oct 29 **Speaker.** AIDS in Africa. Co-presentation with Stephen Lewis, United Nations' Special Envoy for AIDS in Africa and Dr. Harvey Bale, Director General of the International Federation of Pharmaceutical Manufacturers Association. Convocation Hall, University of Toronto.
- 2000 May 31 **Speaker.** HIV Resistance Testing. Department of Medicine, Medical Grand Rounds, St. Michael's Hospital. Toronto.
- 2000 Mar 15 **Speaker.** Future Imperfect? Modelling Long-Term Outcomes from Short-Term Data. St. Michael's Hospital Clinical Epidemiology Rounds, Toronto, Ontario.
- 1999 Dec 16 **Speaker.** Access to HIV Care. St. Michael's Hospital Inner City Health Rounds, Toronto, Ontario.
- 1999 Jan 18 **Speaker.** HIV Viral Load Testing: Efficiency and Access. Clinical Epidemiology Rounds, Toronto Hospital, Toronto, Ontario.
- 1998 Jan 7 **Speaker.** Are New HIV Interventions Cost-Effective? Health Services Research in Progress Seminar, Stanford University.
- 1997 Apr 9 **Presenter.** Cost-effectiveness of Preventing MAC in Patients with Advanced HIV. Health Services Research in Progress Seminar, Stanford University.
- 1995 Nov 22 **Speaker.** Do small changes have big meanings? Clinical vs. Statistical significance. Clinical Epidemiology Rounds, Wellesley Hospital, Toronto, Ontario.
- 1994 Dec 21 **Speaker.** Cost - Utility Analysis of Rifabutin for MAC Prophylaxis in AIDS. Clinical Epidemiology Rounds, Wellesley Hospital, Toronto, Ontario.
- 1993 Jul 29 **Speaker.** Dermatological Manifestations of HIV Disease. Dermatology Grand Rounds, St. Michael's Hospital, Toronto, Ontario.

F. Research Supervision

1. UNDERGRADUATE EDUCATION

- 2022 Jun- 2022 Aug **Summer Student Supervisor**, Lisa Wright. Supervisee Position: Student. Supervisee Institution: Queen's University. *Critical Events in COVID-19 Recovery and Isolation Sites*
- 2021 Jun- 2021 Aug **Summer Student Supervisor**, Amal Mohamed. Supervisee Position: Student. Supervisee Institution: York University. *Marginalization and COVID-19*
- 2007 Jul - 2008 Jun **Student Research Project Supervisor**, Stephanie Law, Supervisee Position: Student, Supervisee Institution: University of Toronto. *Decision analysis based decision aids.*
- 2005 Jul - 2006 Jun **Student Research Project Supervisor**, Justine Cohen, *Decision analysis of treatments for HHT.*

2. GRADUATE EDUCATION

2023 Jan – Present	Co-primary Supervisor. PhD. Aaron Miller. Supervisee Institution: University of Toronto, Institute of Medical Sciences. Developing and validating a multi-criteria decision analysis (MCDA) model to support hospital value analysis deliberations
2021 Jul – Present	Thesis Committee Member. PhD. Supervisee Details: Shaleesa Ledlie. Supervisee Institution: University of Toronto, Faculty of Pharmacy. The Pathways of Care Among People Hospitalized for a Non-Fatal Opioid Poisoning in Ontario
2023 Jan – Present	Primary Supervisor. Graduate Diploma in Health Research. Jacqueline Fleisig. Supervisee Institution: University of Toronto. Outcomes after Non-Fatal Opioid Overdoses.
2022 Jun 14	Internal Examiner. Institute of Health Policy, Management & Evaluation. PhD Final Oral Examination. Supervisee Details: Erik Loewen Friesen. Supervisee Institution: University of Toronto, Institute of Health Policy, Management & Evaluation.
2021 Jul – Present	Thesis Committee Member. PhD. Supervisee Details: Ahmed Hassan Supervisee Institution: University of Toronto, Institute of Health Policy, Management & Evaluation.
2021 Mar - Present	Primary Supervisor. PhD. Sofia Torres. Supervisee Institution: University of Toronto, Institute of Health Policy, Management & Evaluation. Quality of Life in Women with Breast Cancer.
2020 Jul – 2022 Jul	Thesis Committee Member. MSc. Indhu Rammohan. Institution: University of Toronto, Institute of Health Policy, Management & Evaluation. A spatial analysis of overdose mortality incidence and supervised consumption services in Toronto, Canada
2020 May 15	Examiner. Institute of Health Policy, Management & Evaluation. PhD Proposal defense. Supervisee Details: Zachary Bouk. Supervisee Institution: University of Toronto, Institute of Health Policy, Management & Evaluation.
2020 Jan 31	Examiner. Institute of Health Policy, Management & Evaluation. PhD Proposal defense. Supervisee Details: Douglas Cheung. Supervisee Institution: University of Toronto, Institute of Health Policy, Management & Evaluation.
2019 Nov - 2022 Nov	Thesis Committee Member. PhD. Denise Jaworsky. Institution: University of Toronto, Institute of Health Policy, Management & Evaluation. Geography as a determinant of HIV health outcomes for individuals living in rural, remote, and northern Canada
2019 Jul - Present	Primary Supervisor. PhD. Samantha Young. Supervisee Institution: University of Toronto, Institute of Health Policy, Management & Evaluation. Opioid Use in Ontario.
2019 Sep – Present	Co-primary Supervisor. PhD. Mariana Morales Vazquez. Supervisee Institution: University of Toronto, Institute of Health Policy, Management & Evaluation. Comparative Analysis of HIV Prevention Policies in Canada and Mexico.
2019 Sep – 2022 Jul	Primary Supervisor. MSc. Julia Calabria-Yaworski. Supervisee Institution: University of Toronto, Institute of Health Policy, Management & Evaluation. Retention in HIV Care in Ontario.
2019 Sep 12	Examiner. Institute of Health Policy, Management & Evaluation. PhD Proposal defense. Supervisee Details: Eric Wong. Supervisee Institution: University of Toronto, Institute of Health Policy, Management & Evaluation.
2019	Examiner. Institute of Health Policy, Management & Evaluation. MSc proposal defense. Supervisee Details: Shantel Walcott. Supervisee Institution: University of Toronto, Institute of Health Policy, Management & Evaluation.
2019	External Examiner. Population and Public Health. PhD. Supervisee Details: Mary Clare Kennedy. Supervisee Institution: University of British Columbia.
2018 – 2020 Jun	Thesis Committee Member. PhD. Supervisee Details: Maria Kristiina Guglielmin. Supervisee Institution: University of Toronto, Dalla Lana School of Public Health.
2018 – 2019.	Project Supervisor. Masters in Medical Education. Supervisee Details: Gabrielle Inglis. Supervisee Institution: Harvard University.
2018 Dec 20	Examiner. Institute of Health Policy, Management & Evaluation. PhD Proposal defense. Supervisee Details: Narhari Timilshina. Supervisee Institution: University of Toronto, Institute of Health Policy, Management & Evaluation.

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2018 Jul 5	Examiner. Institute of Health Policy, Management & Evaluation, PhD Defense. Supervisee Details: Derrick Tam. Supervisee Institution: University of Toronto, Institute of Health Policy, Management & Evaluation.
2018 Nov 20	Internal Examiner. Institute of Health Policy, Management & Evaluation, PhD. Supervisee Details: Naazish Bashir. Supervisee Institution: University of Toronto, Institute of Health Policy, Management & Evaluation.
2018 – Dec 2021	Thesis Committee Member. Clinical Epidemiology and Health Care Research. PhD. Supervisee Details: Marcello Schmidt. Supervisee Institution: University of Toronto, Institute of Health Policy, Management & Evaluation. (Withdrew)
2017 – 2022 Apr	Thesis Committee Member. PhD. Supervisee Details: Cathy Long. Supervisee Institution: University of Toronto, Dalla Lana School of Public Health.
2017 Jan – 2017 Apr	Practicum Supervisor. Dalla Lana School of Public Health, University of Toronto. Master of Public Health. Supervisee Details: Tayla Smith. Supervisee Institution: University of Toronto.
2017 Jan	Internal Examiner. Institute of Health Policy, Management & Evaluation, MSc. Supervisee Details: Elaine Goh. Supervisee Institution: University of Toronto, Institute of Health Policy, Management & Evaluation.
2015 Oct – 2016 Mar	Practicum Supervisor. School of Public Health and Health Systems, University of Waterloo. Master of Public Health. Supervisee Details: Nasser Jamal. Supervisee Institution: University of Waterloo.
2015 Sept – present	Primary Supervisor. Institute of Health Policy, Management & Evaluation, Dalla Lana School of Public Health. PhD. Supervisee Details: Hadeel Al-Yacoob. Supervisee Institution: University of Toronto, Institute of Health Policy, Management & Evaluation. Research Project: Economic Evaluations of Palliative Care.
2015 Nov	Internal Examiner. Institute of Health Policy, Management & Evaluation. PhD. Supervisee Details: Glen Hazlewood. Supervisee Institution: University of Toronto, Institute of Health Policy, Management & Evaluation.
2015 Mar	External Examiner. Department of Population and Public Health. PhD. Supervisee Details: Lianping Ti. Supervisee Position: PhD Student, Supervisee Institution: University of British Columbia. Research Project: Improving hospital care for patients who use illicit drugs in Vancouver, Canada.
2015 Apr	Internal Examiner. Institute of Health Policy, Management & Evaluation. MSc Thesis Examiner. Supervisee Details: Abhijit Duggal. Supervisee Institution: University of Toronto, Institute of Health Policy, Management & Evaluation.
2015 Feb 11	Internal Examiner. Institute of Health Policy, Management & Evaluation. MSc Thesis Examiner. Supervisee Details: Natasha Saunders. Supervisee Institution: University of Toronto, Institute of Health Policy, Management & Evaluation.
2015 Feb 9	Reviewer. Dalla Lana School of Public Health. PhD Thesis Proposal. Supervisee Details: Tyler O'Neill. Supervisee Institution: University of Toronto, Dalla Lana School of Public Health
2014 Sep	Examiner. Institute of Health Policy, Management & Evaluation. PhD Thesis Defense. Supervisee Details: Teja Voruganti. Supervisee Institution: University of Toronto, Institute of Health Policy, Management & Evaluation.
2013 Sep – 2021 Apr	Primary Supervisor. Institute of Health Policy, Management & Evaluation, Dalla Lana School of Public Health. PhD. Supervisee Details: Michelle Letchumanan. Supervisee Institution: University of Toronto, Institute of Health Policy, Management & Evaluation. Research Project: Economic Evaluations of Co-morbidity Prevention Strategies in People Living with HIV.
2012 Sep	Thesis Committee Member. Institute of Health Policy, Management & Evaluation. MSc. Supervisee Details: Kelly Riedel. Supervisee Institution: University of Toronto, Institute of Health Policy, Management & Evaluation.
2010 Mar - 2015	Primary Supervisor, Institute of Health Policy, Management & Evaluation. MSc (withdrew). Supervisee Details: Jennifer Haig. Supervisee Institution: University of Toronto, Institute of Health Policy, Management & Evaluation. Research Project: Cost-effectiveness of opioid

	regulation.
2009 Apr – 2015 Nov	Primary Supervisor. Institute of Health Policy, Management & Evaluation, Faculty of Medicine. PhD (withdrew). Supervisee Details: Soroush Mortaz Hedjri Supervisee Institution: University of Toronto, Institute of Health Policy, Management & Evaluation. Research Project: Decision analysis and marginalized populations.
2008 May – 2016 Feb	Thesis Committee Member, Institute of Health Policy, Management & Evaluation, Faculty of Medicine. Carol Oliveira, Supervisee Institution: Institute of Health Policy, Management & Evaluation, PhD, <i>Costs and effects of treating children with bowel pathology.</i>
2013 Aug 21	Internal Reviewer, Beth Rachlis, Supervisee Institution: University of Toronto, Dalla Lana School of Public Health. PhD.
2012 Sep - 2013 Apr	Thesis Committee Member, Institute of Health Policy, Management & Evaluation. Vivian Ng, Supervisee Institution: University of Toronto, Institute of Health Policy, Management & Evaluation. PhD, <i>Cost effectiveness of Parkinson's disease treatment.</i>
2011 - 2013	Primary Supervisor, Nadia Luca, Supervisee Institution: University of Toronto, Institute of Health Policy, Management & Evaluation. MSc, <i>Validation of Standardized Universal Pain Evaluations for Rheumatology Providers in Children and Youth (SUPER-KIDZ).</i>
2010 Jun	External Reviewer, Paul Arora, PhD thesis proposal defense. Supervisee Institution: University of Toronto, Dalla Lana School of Public Health. PhD.
2010 May	Internal Reviewer, PhD Defense, Lusine Abrahamyan, Supervisee Institution: University of Toronto, Institute of Health Policy, Management & Evaluation. PhD.
2008 Jul - 2011	Thesis Committee Member, Michelle Barton Forbes, Supervisee Institution: University of Toronto. MSc, <i>Screening for MRSA.</i>
2008 Jul - 2011	Mentor, Susy Hota, Supervisee Institution: University of Toronto, Institute of Health Policy, Management & Evaluation. MSc (non-thesis),
2007 Dec - 2013	Thesis Committee Member, Olga Gajic-Veljanoski, Supervisee Institution: University of Toronto, Institute of Health Policy, Management & Evaluation. <i>Quantifying Uncertainty in the Efficacy of Vitamin K on Fractures in Postmenopausal Women: Economic Evaluation, Evidence Synthesis and Bayesian Meta-Analysis.</i>
2007 Jul	Internal Appraiser and Examiner, Ruben Tavares, Supervisee Institution: University of Toronto, Institute of Health Policy, Management & Evaluation. MSc, <i>Uncover: Understanding Near-Term Care of Very Early Rheumatoid Arthritis in a National, Multi-Centre, Randomly Selected, Historical Inception Cohort of Newly Diagnosed Disease.</i>
2007 Jul	External Examiner, Proposal Defense, Lusine Abrahamyan, Supervisee Institution: University of Toronto, Institute of Health Policy, Management & Evaluation. PhD.
2007	Internal reviewer, Sandra Gardner, Supervisee Institution: University of Toronto, Institute of Health Policy, Management & Evaluation. Student's Current Position: Assistant Professor, University of Toronto. Dalla Lana School of Public Health. PhD, <i>Change Point Models for Discontinuation Rates of Pneumocystis Carinii Pneumonia Prophylaxis in an Ontario HIV Patient Database.</i>
2006 Jul - 2010 Apr	Primary Supervisor, Susan Graham, Student's Current Position: Assistant Professor, University of Washington. Supervisee Institution: University of Toronto, Institute of Health Policy, Management & Evaluation. PhD. <i>Sexual risk behavior, HIV and sexually transmitted infections in a cohort of Kenyan sex workers 1993-2007.</i>
2006 Jul - 2007 Jun	Research Internship Supervisor, Elizabeth Stephenson, Supervisee Institution: University of Toronto, Institute of Health Policy, Management & Evaluation. MSc, <i>Decision analysis of ablation for WPW in children.</i>
2006 Jul - 2007 Jun	Internal Examiner, Phillip McFarlane, Supervisee Institution: University of Toronto, Institute of Health Policy, Management & Evaluation. PhD, <i>The cost-effectiveness of home nocturnal hemodialysis.</i>
2006 Jul - 2007 Jun	Research Internship Supervisor, Samir Gupta, Student's Current Position: Assistant Professor, University of Toronto. Research Internship. MSc. <i>Treatment of Interstitial Lung Disease.</i>
2005 Jul - 2008 Jun	Primary Supervisor, Samir Gupta, Supervisee Institution: University of Toronto. Institute of

	Health Policy, Management & Evaluation. MSc, <i>A pilot study of antibiotic therapy for the hepatopulmonary syndrome.</i>
2005 Jul - 2006 Jun	Research Internship Supervisor , Louis Valiquette, Institute of Health Policy, Management & Evaluation. MSc, <i>Cost-effectiveness of pre-operative antibiotic therapy.</i>
2005 Jul - 2006 Jun	Research Internship Supervisor , Matthew Muller, Supervisee Institution: University of Toronto. Institute of Health Policy, Management & Evaluation. PhD, <i>Cost-effectiveness of pre-operative antibiotic therapy.</i>
2005 Jul - 2006 Jun	Research Internship Supervisor , Diego Delgado, Institute of Health Policy, Management & Evaluation. MSc, <i>Cost-effectiveness of cardiac transplantation drugs.</i>
2005 Jul	External Examiner , Laura Park-Wyllie, McMaster University. MSc, <i>Outcomes of Dosage Adjustments for Antiretroviral Drug Interactions.</i>
2005 Jul	External Reviewer , Ava John-Baptiste, Student's Current Position: Assistant Professor, Western University. Institute of Health Policy, Management & Evaluation. PhD, <i>Cost-effectiveness of antiviral therapy for HCV positive injection drug users.</i>
2005	Internal Reviewer , Alberto Espay, Institute of Health Policy, Management & Evaluation. MSc, <i>Classification and Measurement of Speed and Amplitude Impairments in Patients with Parkinson's Disease: A Pilot Study.</i>
2002 - 2003 Jul	Co-Supervisor , Andrea Gershon, Supervisee Institution: University of Toronto. Institute of Health Policy, Management & Evaluation. MSc, <i>Factors Associated with the Initiation of Treatment for Latent Tuberculosis.</i>
2003 - 2004	Thesis Committee Member , Tonia Forte. Public Health Sciences MSc, <i>An evaluation of gender differences in virologic and immunologic responses to highly active antiretroviral therapy.</i>
2002 Jul - 2010 May	Thesis Committee Member , Sergio Rueda. Institute of Health Policy, Management & Evaluation. PhD, <i>Effects of different employment trajectories on health-related quality of life in HIV/AIDS.</i>
2002 Jul	External Reviewer , Tatiana Vidykha. Public Health Sciences MSc, <i>Characteristics and Correlates of Sexual Partner Concurrency among Men who have Sex with Men in Montreal, Quebec.</i>
2001 Jul - 2008 Jun	Co-Supervisor , Kelly O'Brien, Student's Current Position: Assistant Professor, Graduate Department of Rehabilitation Sciences, University of Toronto. Institute of Health Policy, Management & Evaluation. PhD, <i>Disability in the Context of HIV: Building a Foundation for an Instrument to Describe Disability Experienced by Adults Living with HIV.</i>
2001 Jul - 2006 Jun	Thesis Committee Member , Naushaba Degani, Student's Current Institution: Health Quality Ontario. Public Health Sciences PhD, <i>Exploring the social and risk networks of male and female injection drug users in Toronto.</i>
2000 Jul	External Reviewer , Alexandra Moses. Public Health Sciences MSc, <i>Injection Drug Users in Toronto: Gender Differences and HIV Risk Taking.</i>
2000 Jul	Thesis Committee Member , Marie Faughnan, Supervisee Institution: University of Toronto. Institute of Health Policy, Management & Evaluation. MSc, <i>Sensitivity and Specificity of Screening for Pulmonary Arteriovenous Malformations.</i>
1999 Jul	Internal Reviewer , Jolie Ringash, Student's Current Position: Professor, University of Toronto. Institute of Health Policy, Management & Evaluation. MSc, <i>Quality of Life in Laryngeal Cancer Patients.</i>
1999 - 2003	Thesis Committee Member , Alissa Scalera. Public Health Sciences. PhD, <i>The impact of highly active antiretroviral therapies on health-related quality of life in adults with HIV-infection.</i>

3. UNDERGRADUATE MD

2022 Mar – Present	Student Research Project Supervisor . Ramy Gabarin. Supervisee Position: Student. Supervisee Institution: University of Toronto. Alcohol Withdrawal during the COVID-19 Pandemic.

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2021 Jun- 2021 Aug	Summer Student Supervisor , Amna Majeed. Supervisee Position: Student. Supervisee Institution: University of Toronto. <i>Supervised Injection and COVID-19</i>
2020 Jun- 2020 Aug	Summer Student Supervisor , Mia Kibel. Supervisee Position: Student. Supervisee Institution: University of Toronto. <i>Marginalization and COVID-19</i>
2014 Jun- 2014 Aug	Student Research Project Supervisor . Department of Medicine, Faculty of Medicine. Supervisee Details: Tinya Lin. Supervisee Institution: Western University. Research Project: <i>Preference Measures for HIV Antiretroviral Decision Making</i> .
2012 Jun – 2012 Aug	Student Research Project Supervisor , Linda Lee, <i>“Discrete Choice Experiments”</i> .
2005 Jul	Student Research Project Supervisor , Melanie Campbell, <i>Determinants of Community Health. “Teaching Internal Medicine Residents Health Advocacy”</i> .

4. POSTGRADUATE MD

2022-2023	Primary Supervisor, Resident Research . Thomas Dashwood
2021-2023	Primary Supervisor, Resident Research . Shima Shakory
2021-2023	Primary Supervisor, Resident Research . Kara Hounsell
2020	Primary Supervisor, Resident Research . Khuloud Al Dhaheri
2019	Primary Supervisor, Resident Research . Hourmazzd Hagbayan
2019	Primary Supervisor, Resident Research . Ann Zalucky
2018 - 2019	Primary Supervisor, Resident Research . Geetanjalee Sadi
2017-2018	Primary Supervisor, Resident Research . Evan Ailon
2017	Primary Supervisor, Resident Research . Hourmazzd Hagbayan
2000 Jul	Student Research Project Supervisor , Michael Miletin, <i>The Management of Pulmonary Arteriovenous Malformations in Hereditary Hemorrhagic Telangiectasia</i> .
1999 Jul	Student Research Project Supervisor , Nigel Livesley, <i>Access to Protease Inhibitors in Ontario</i> .

5. OTHER

2022 Jun – 2023 Jun	Primary Supervisor . Cathy Long, Post-Doctoral Fellow, Supervisee Institution: MAP Center for Urban Health Solutions, LKSKI/St. Michael's Hospital.
2022 – present	Faculty Mentor . Danielle Buell. St. Michael's Hospital, Toronto, ON.
2021 – present	Mentor, Community Scholar . Zoë Dodd. MAP Centre for Urban Health Solutions, St. Michael's Hospital, Toronto, ON.
2018 – 2020	Member, Faculty Mentorship Committee . Czarina Navos Behrends. Weill Cornell Medicine, New York, NY.
2012 Sep – 2013 April	Primary Supervisor , Sara Guilcher, Post-Doctoral Fellow, Supervisee Institution: Center for Inner City Research on Inner City Health (CRICH), LKSKI/St. Michael's Hospital. Student's Current Position: Associate Professor, University of Toronto.
2011 Sep -2013 Aug	Primary Supervisor , Andrew Pinto, Post-Doctoral Fellow, Supervisee Institution: Center for Inner City Research on Inner City Health (CRICH), LKSKI/St. Michael's Hospital. Student's Current Position: Associate Professor, Department of Family and Community Medicine, University of Toronto.
2012 Jan - 2013 Aug	Primary Supervisor , Zahava Rosenberg-Yunger, Post-Doctoral Fellow, Supervisee Institution: Center for Inner City Research on Inner City Health (CRICH), LKSKI/St. Michael's Hospital. Student's Current Position: Assistant Professor, Ryerson University. Post-doctoral fellow, Center for Inner City Research on Inner City Health (CRICH), LKSKI/St. Michael's Hospital.
2010 Sep – 2011	Primary Supervisor , Sara Allin, Post-Doctoral Fellow, Supervisee Institution: Center for Inner City Research on Inner City Health (CRICH), LKSKI/St. Michael's Hospital. S. Student's Current Position: Associate Professor, University of Toronto.

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2008 - 2010

Primary Supervisor, Gabrielle van der Velde, Post-Doctoral Fellow, Supervisee Institution: University of Toronto. Student's Current Position: Assistant Professor, Student's Current Institution: Leslie Dan Faculty of Pharmacy, University of Toronto. Post-doctoral fellow. *Cost-effectiveness analysis of a return-to-work model of care for occupational musculoskeletal injuries*. Co-supervisor: J. David Cassidy.

2008 - 2009

Primary Supervisor, Sophie Kim, Student. Supervisee Institution: Center for Inner City Research on Inner City Health (CRICH), LKSKI/St. Michael's Hospital. *The Use of HIV Services by Toronto's Socially Marginalized Populations*". Student's Current Institution: Harvard University, Harvard Law School and Harvard Kennedy School of Government.

South Riverdale Community Health Centre Consumption and Treatment Service Review

Prepared by Unity Health Toronto

FEBRUARY 28th, 2024

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EXECUTIVE SUMMARY

On July 7th, 2023, a fight between alleged drug sellers broke out near the Consumption and Treatment Service (CTS) at 955 Queen Street East, operated by the South Riverdale Community Health Centre (SRCHC). Gunshots were fired and a stray bullet killed Karolina Huebner-Makurat, a mother of two who had been walking nearby. Public outcry and media coverage followed. Two men face criminal charges and a third is being sought on a Canada-wide warrant related to the homicide. Toronto Police also charged a CTS staff member with being an accessory after the fact and obstructing justice. Some neighborhood residents and members of the local business improvement association said that they had been raising significant concerns related to the CTS site and its operations, including in the months and weeks prior to the fatal shooting, without an adequate response.

In late 2023, the Ministry of Health appointed Jill Campbell as a supervisor of the CTS at 955 Queen Street East, and also asked Unity Health Toronto to conduct an external review as a means of identifying opportunities for improvement. Unity Health Toronto is a hospital network affiliated with the University of Toronto offering a range of health services spanning the City of Toronto, and expertise in mental health and addictions care and process improvement initiatives.

Parameters for the review set by the Ministry of Health included:

- i) whether services are provided as expected in accordance with the CTS Program Application Guide and the CTS Transfer Payment Agreement
- ii) whether there is sufficient oversight of Consumption and Treatment Services to ensure health service quality and program success based on the review questions, and where appropriate, identify recommendations for improvement
- iii) the responsiveness to local community concerns (including any school related concerns)
- iv) the suitability of maintaining CTS funding for the site
- v) the general suitability for CTS to be integrated within community health centres

Unity Health Toronto assembled a team and conducted an external review from October 2023 to February 2024. The review team's conclusions related to the five parameters are below:

- i) In general, the CTS is providing services in accordance with the CTS Program Application Guide and the CTS Transfer Payment Agreement. The review team has made recommendations on how these services can be improved. Implementation of these recommendations may require additional resources that SRCHC does not currently have.
- ii) In general, there is sufficient oversight of the CTS to ensure health service quality and program success. The review team has made a number of recommendations on how oversight can be improved.
- iii) The CTS has been somewhat responsive to local community concerns with room for improvement. The review team has made a number of recommendations to help increase responsiveness, some of which may require resources that SRCHC does not

currently have. An accompanying report details the community engagement process and findings, including suggestions from community members.

- iv) It is suitable to maintain funding for the CTS at 955 Queen Street East and the review team has made a number of recommendations related to funding.
- v) The review team found it is suitable and desirable for CTS to be integrated within community health centres.

The review team thanks everyone who has engaged in this process, including all of the stakeholders who opened their doors to the review team, answered questions and shared their insights and experiences.

INTRODUCTION

Supervised Consumption Services are health services that require a federally-granted exemption under section 56.1 of the Controlled Drugs and Substances Act. Since 2018, Ontario has required that provincially funded supervised consumption services provide additional health and support services. This expanded model is known as a Consumption Treatment Service (CTS).

South Riverdale Community Health Centre (SRCHC) oversees operations for two CTS, including Moss Park CTS, which operates as a satellite of SRCHC, and a CTS housed within the SRCHC at 955 Queen Street East (sometimes referred to as KeepSix CTS). The following is a selected timeline of events related to the implementation and operation of the CTS at 955 Queen Street East:

2012

- A report finds Toronto has the highest number of people who use drugs in Ontario and that drug use is dispersed throughout the city, which is unlike other cities, where drug use is concentrated in one or a few neighbourhoods (Toronto and Ottawa Supervised Consumption Assessment [TOSCA] Study). The TOSCA investigators find public support for locating supervised consumption facilities where there is visible public drug use and where people who use drugs are homeless or unstably housed. The report recommends three facilities be established in Toronto.

2013

- The Toronto Board of Health approves a recommendation from the Medical Officer of Health regarding the implementation of integrated supervised injection facilities in three locations: Toronto Public Health (near Dundas and Yonge), Queen West-Central CHC, and South Riverdale CHC.

2016

- South Riverdale CHC applies for exemption under section 56.1 of Health Canada's Controlled Drugs and Substances Act to operate a Supervised Consumption Site.
- A staff report to the City of Toronto Board of Health says, "compared to the city overall, there are disproportionately high numbers of people who inject drugs within South Riverdale's catchment area, as well as higher rates of emergency department visits due to opioid or cocaine use in Toronto."

2017

- With support from community members through online surveys, the South Riverdale Community Health Centre opens a SCS at 955 Queen Street East on November 27.

2018

- The Ontario government introduces a shift in the province from Supervised Consumption Sites (SCS) to Consumption and Treatment Services (CTS), reflecting an expanded approach that goes beyond providing a space for people to consume drugs

under supervision. The shift includes additional requirements to integrate pathways to treatment and to offer additional support services.

- The SCS at 955 Queen Street East meets the new requirements and becomes a CTS.

2019

- Toronto's Drug Checking Service launches at five community harm reduction organizations, including the CTS at 955 Queen Street East.

2020

- Coincident with the COVID-19 pandemic, there is a large increase in the number of opioid-related deaths in Ontario. Isolation and an increasingly unpredictable drug supply are factors.

2021

- Residents living in close proximity to the CTS at 955 Queen Street East, along with other Leslieville residents and business owners, report that they have been contacting SRCHC management, the local city councillor's office and Toronto Police Service in 2020 and 2021 about illegal and concerning activity. Specifically, they said they reported visible drug use, inappropriately discarded drug equipment and safety concerns, especially for children, in the area.
- At a meeting between SRCHC management and community members in June, meeting notes show potential responses offered by SRCHC management included using pylons in front of the building to permit a safe flow of people traffic, creating direct communication pathways for addressing concerns/complaints, continuing with outside monitoring, ongoing needle patrol, and exploring other opportunities to address concerns where possible.

2022

- Residents living near the site escalate concerns to the CTS Community Liaison Committee through their volunteer representative. Stated concerns included break-ins and property damage to businesses. Residents and business owners also email, call and walk into SRCHC to share concerns, and email or call the city councillor and police.
- The Community Liaison Committee meets three times this year. Minutes from these meetings indicate that there is opportunity to discuss community concerns at each meeting but no concerns are noted until November. Minutes from the November meeting indicate that the SRCHC responded to concerns around safety with increased staff presence outside the site.

2023

- May 11th – Toronto Public Health conducts its first routine inspection of the CTS at 955 Queen Street East and does not highlight any concerns.
- Community concerns around illegal activity and children's safety are reported on social media, according to some residents.

- The SRCHC Community Liaison Committee meets twice this year. Additional meetings are held between community residents and SRCHC management because of growing concerns. During one of the earliest meetings, on June 26th, 2023, the SRCHC agrees to contact One Community Solutions to explore temporary security measures at the site.
- July 4th – a follow-up meeting is held and SRCHC reports not yet being successful in implementing temporary security measures.
- July 7th – a fatal shooting occurs very near the CTS. Toronto Police later charge one man with second-degree murder, and a second man with manslaughter, robbery, and failure to comply with probation. A third man is being sought on a Canada-wide warrant related to the homicide. A woman from Pickering faces charges that include accessory after the fact to an indictable offence and obstruction of justice. She is identified as a staff member from SRCHC.
- July 10th, 17th, and 24th – SRCHC leaders and a resident group meet to discuss residents' concerns.
- July 26th – a town hall is organized by residents with panelists including the SRCHC CEO, the Member of Parliament for the area, the Medical Officer of Health for the City of Toronto, the City Councillor for the area, the Superintendent for the Toronto Police Service and the Ontario Deputy Minister of Health. Hundreds of people attend and perspectives on the relation of the CTS to the safety of the community are mixed.
- July 27th - September 19th – SRCHC develops the Safer Community Committee to develop recommendations to improve community safety. The committee includes community members, business owners, Toronto Police Services, and service organizations and meets five times in total. Before the recommendations are published, several members resign stating that they feel that the focus of the group does not meaningfully centre their concerns.
- The SRCHC continues to meet with local residents through the summer of 2023 and into October. A group of residents organizes as the Leslieville Neighbours for Community Safety Group. Meetings between this group and SRCHC continue monthly.
- October – Toronto Public Health conducts a complaints-based inspection of the CTS at 955 Queen Street East. The report for this inspection indicates education was provided to the CTS. According to the CTS, the education was about clarifying where the 15m perimeter is around the building.
- October – Ministry of Health appoints Jill Campbell supervisor of the CTS at 955 Queen Street East and commissions this review from Unity Health Toronto.

REVIEW METHODS

The Ministry of Health presented assessment parameters and questions to Unity Health Toronto to guide and shape the review. Unity Health Toronto assembled a review team comprising more than a dozen individuals and assigned subject matter experts to support specific areas of the inquiry, which took place between October 2023 and February 2024.

The review team examined documentation supplied by SRCHC, the Ministry of Health, and community members. A list of some of these documents can be found in Appendix C

The review team also gathered input directly from a number of internal and external stakeholder groups. Internally, this involved seeking feedback from SRCHC leadership, management and staff. The review team visited the CTS at 955 Queen Street East on more than 10 occasions for interviews, walkabouts and to gather input from stakeholders at the site.

In addition, the review team identified and engaged with seven types of external stakeholder groups. They included clients who access the CTS; clients who access general community health centre services; neighbourhood residents; neighbourhood families; neighbourhood business owners and employees; local daycares; and local schools. The team collected information through in-person and on-line consultation groups, an online survey form (which members of the community also helped circulate through their social media groups), email submissions, and prior documents and reports. More than 150 emails were received and read by the review team and themes and questions from these messages helped inform the review.

The review team established a regular weekly meeting to discuss key findings and to determine additional steps that should be taken to complete the review.

REVIEW FINDINGS

Parameters establish criteria and standards by which an external group can evaluate services, practices, and operations of an organization. The five parameters set by the Ministry of Health were tailored to the specific needs of CTS at 955 Queen Street East and the clients they serve. This led to focused observations, conclusions and recommendations from the review team.

Assessment parameter 1: Assess whether services are provided as expected in accordance with the CTS Program Application Guide and the CTS Transfer Payment Agreement.

Review team conclusion: The review team found that, in general, the CTS is providing services in accordance with the CTS Program Application Guide and the CTS Transfer Payment Agreement. The review team has made recommendations on how these services can be improved. Implementation of these recommendations may require additional resources that SRCHC does not currently have.

Observations

CAPACITY TO PROVIDE CONSUMPTION AND TREATMENT SERVICES

INTEGRATED WRAPAROUND, MANDATORY SERVICES

Supervision of Consumption: In compliance with requirements, the CTS at 955 Queen Street East provides supervision for consumption of substances via injection, oral, and nasal routes. Consumption via inhalation is not mandatory as per requirements, nor is the site (or most CTS in Toronto) supported in providing this service. Because the site is not set up to allow inhalation inside, anyone wishing to do so must leave the building. In these instances, staff sometimes accompany the client outside and supervise the consumption outside the building.

Pathways to Addictions, Mental Health, and Social Services: Because the CTS at 955 Queen Street East is embedded within a community health centre, pathways to services primarily focus on referrals to services that can be provided within the centre, including opioid agonist therapies, HIV/sexually transmitted infection testing and treatment, Hepatitis C virus (HCV) testing and treatment, Indigenous services, primary care, mental health supports, and food and housing services. Additionally, the CTS team supports clients to connect with other programs at the community centre, helping ensure that clients are able to attend individual and group appointments. This type of support falls outside of traditional referral pathway categories and is not reflected in the monthly reporting from the CTS.

Harm reduction services and education: Harm reduction education is woven into service provision, but may also be requested by clients or offered by staff at the CTS at 955 Queen Street East. The staff provide education to clients on safer drug use including vein finding, injection techniques, and needle exchange. Staff also help supervise needle and equipment

disposal within the site. Staff provide oxygen and naloxone as required in all overdose response situations inside the site. Nurses provide injection-related care such as wound care, and HIV and HCV disease screening and testing. All staff do assessments for injection-related first aid as necessary.

Removal of inappropriately discarded harm reduction supplies surrounding the CTS area: CTS staff at 955 Queen Street East remove inappropriately discarded harm reduction supplies such as needles and other drug use equipment five days a week and on an as-needed basis, and as resources such as staffing and time allow. Additionally, since the fatal shooting in July 2023, a company called One Community Solutions has conducted needle sweeps during the week and on weekends.

Public Education: SRCHC provides public education formally and informally to broad stakeholders, including through open houses, newsletters, and group education to various groups including public health units and community health centres throughout the province.

SERVICE DELIVERY MODEL

CTS staff at 955 Queen Street East deliver team-based care, such that staff working onsite are responsible for the supervision and safety of all clients using the site at one time, including those recovering or resting in the adjacent post-consumption space. Clients at the CTS can socialize with each other and with staff at the site. This socialization is a valuable strategy to increase comfort and avoid isolation.

Hours of Operation: The CTS application guide specifies that preference is given to sites that offer consistent hours of operation seven days a week. Additionally, while the initial Transfer Payment Agreements did not specify open hours for the site, the 2019/20 Transfer Payment Agreement specifies that the CTS at 955 Queen Street East be open 11 hours per day, 7 days per week. The site has not been able to achieve these hours for a number of reasons including staffing/compensation challenges and alignment with the CHC's opening hours. The CTS currently operates during the hours of 8:00 am until 5:00 pm, Monday to Friday.

Staffing Model: As per the CTS application guide, a designated health professional must be present at all times, though the guide does not specify whether this professional needs to be present within the CTS or within the premises. In this regard, there has always been a designated health professional – a registered nurse (RN) – onsite at the SRCHC who could respond if needed, even if not always in the CTS itself. The site also hires its own Registered Nurse (RN) to work specifically within the CTS, but has had challenges retaining a person in this full-time role, with stretches of up to eight months without a full-time RN. During these periods, the site used SRCHC casual RNs as a replacement as much as possible.

The CTS at 955 Queen Street East operates in a model where at least three staff service the area at all times. The site receives funding for 2.6 Registered Nurse (RN) Full Time Equivalents (FTEs), 2.6 Health Promoter FTEs, and 2.6 Peer Workers FTEs to work within the CTS. The

staffing model, as per the CTS application guide, includes peers/people with lived and living experience of drug use (PWLE). Challenges leading to less than planned staffing at times include: not having replacement staff when full-time staff are away, salaries that are significantly lower than in other sectors (e.g., RN salaries in community health centres are significantly lower than RN salaries in hospital), and the challenging nature of the work, especially for staff with lived or living experience of drug use, in addition to insufficient mental health supports for staff.

PROXIMITY

The CTS at 955 Queen Street East is located in the heart of Leslieville, a vibrant Toronto neighborhood. The next nearest CTS or SCS is Regent Park Bevel Up CTS at 465 Dundas St. E, which is approximately two kilometres west of the site.

The CTS is located less than 200m from each of Morse Street Junior Public School, Mighty Kids Daycare, Brightpath daycare, Sprouts childcare, and Liberty Prep school. The site is located within 600m of John Chang Neighbourhood Park, Jimmie Simpson Park, and McCleary Playground.

The service is within close proximity (less than 200 meters) to schools/daycares/parks, so according to provincial requirements it must specify how community concerns will be addressed via community consultation and through ongoing community engagement.

COMMUNITY SUPPORT AND ONGOING ENGAGEMENT

The service has a number of mechanisms in place to allow the community to voice concerns, however, the review team found areas where this process could be improved. Further observations by the review team regarding community engagement can be found in the separate report on Community Engagement and Communications.

ACCESSIBILITY

The CTS at 955 Queen Street East fosters accessibility by allowing clients to access the site and use services without having to show identification or make appointments.

The CTS at 955 Queen Street East gives priority access to individuals who are at highest risk of overdose (for example, individuals who have recently been incarcerated) by ensuring that these individuals (identified as high risk during intake) get to use the site as soon as possible once they present. The site is also located between two public transit streetcar stops on a frequently traveled street in the city, along which open drug use has been observed for many years (TOSCA, 2012).

Indigenous cultural safety is promoted by access to traditional medicines, cultural activities, and the presence and expertise of staff who are Indigenous.

A policy is in place to allow drug splitting and sharing. Separate protocols are in place to ensure access for high-risk clients, including pregnant people, youth, and those who cannot self-inject (SCS Policies and Procedures).

FUNDING

The review team found that, overall, services are provided as expected according to funding requirements, with some areas, including hours of operation and staffing that require additional focus. Further observations and details surrounding the funding of the CTS are in the section on Funding, page 36.

ACCOUNTABILITY

REPORTING

The CTS must report monthly, quarterly, and annually to the Ministry of Health, as well as annually to the Toronto Board of Health. Data required by the province for monthly reporting include a range of criteria from hours of operation to overdose events, substances consumed and community engagement.

In accordance with provincial requirements, the CTS at 955 Queen Street East has reported monthly data, on time, to the Ministry. General concerns from community engagement were mentioned in some reports, however, required details about community engagement including who participated and how any concerns were addressed were lacking. In response to the reports, the site received requests for supplementary information from the Ministry as needed. Supplementary information requests included clarification of numbers, use of funds, or additional information such as details around the plan to be open for longer hours and on Sunday, which, as noted above, did not meet provincial requirements.

SAFETY AND SECURITY

Security mechanisms are in place at the CTS site and have included Toronto Police Service access after-hours and SRCHC reaching out to TPS when needed. The review team has found areas where improvements can be made to enhance overall safety and security at SRCHC. Further information can be found in the section on Safety and Security, page 15.

ENFORCEMENT

The CTS at 955 Queen Street East complies with reporting requirements to the Board of Health, the Ministry of Health and Health Canada. Further observations from the review team on enforcement and oversight can be found below.

Assessment parameter 2: Assess whether sufficient oversight of consumption and treatment services to ensure health service quality and program success based on the review questions, at minimum, and, where appropriate, identify recommendations for improvement.

Review team conclusion: The review team found that, in general, there is sufficient oversight of the CTS to ensure health service quality and program success. The review team has made a number of recommendations on how oversight can be improved.

Observations:

Reporting: As previously mentioned, the CTS at 955 Queen Street East complies with reporting requirements to the Board of Health and the Ministry of Health. These include annual reports to the Board of Health and to the Ministry of Health. It is also required to provide quarterly and annual financial and monthly program reports to the Ministry of Health. The review team found that communication from these bodies to the CTS has centred around the need for clarification of data provided by the site in these reports.

Inspections: According to the 2022 Consumption and Treatment Services Compliance and Enforcement Protocol, the CTS is supposed to be subject to routine annual inspections by Toronto Public Health, compliance evaluations annually by the Ministry of Health, complaints inspections as needed by Public Health, and other inspections by Health Canada and the Ministry of Labour for occupational health and safety compliance, as needed.

The review team found that the first routine inspection by Toronto Public Health was held on May 11th, 2023. This inspection did not highlight any operational concerns. The report from this inspection is publicly available on the TPH website. In October 2023, TPH conducted its second inspection. The report from this inspection indicated that education was provided.

The review team also found that the federal government conducted an inspection of the site from September 19th through 22nd, 2023. The review team received emails from SRCHC leadership that indicate that the inspectors made no observations that required immediate attention; however, the site was encouraged to make sure that records of staff training on policies and procedures are kept up-to-date. Additionally, the site was reminded to notify the Office of Controlled Substances of any updates to site operations after an exterior light and camera were noted to be positioned incorrectly on the floor plan.

Assessment parameter 3: Assess responsiveness to local community concerns (including any school related concerns).

Review team conclusion: The review team found that the CTS has been somewhat responsive to local community concerns with room for improvement. The review team has made a number of recommendations to help increase responsiveness, some of which may require resources that SRCHC does not currently have.

Observations:

Mechanisms are in place to allow SRCHC to receive and respond to community concerns. These mechanisms, and related communications supports, were enhanced following the fatal shooting incident on July 7th, 2023. However, the review team has found areas where improvements can be made to further enhance communications and community engagement between SRCHC, the CTS site and residents and improve responsiveness to local community concerns. See Communications and Community Engagement section, page 18. In addition, community members had suggestions about how to improve communication and engagement, which are included in a separate Community Engagement companion report. This companion report also includes suggestions from community members that address some areas of concern that are outside the mandate of this review.

Assessment parameter 4: Assess suitability of maintaining CTS funding for the site.

Review team conclusion: The review team found that it is suitable to maintain funding for the CTS at 955 Queen Street East and the review team has made a number of recommendations related to funding.

Observations:

The review team found a clear need for the services at 955 Queen Street East, based on the number of clients being served and the broad range of health services clients are accessing via referrals and integrated services in the community health centre. The review team's observations related to this parameter are found in the Service Provision section (Access, Referral pathways to wrap-around services, Integrated services), page 12.

Assessment parameter 5: Assess general suitability for CTS to be integrated within community health centres.

Review team conclusion: The review team found it is suitable and desirable for CTS to be integrated within community health centres.

Observations:

Clients at the CTS at 955 Queen Street East have low-barrier, walk-in access to substance use and addictions counselling, treatment including opioid agonist therapy, medications for withdrawal, referrals, and resources. They also have access to immediate counselling or mental health crisis support from CTS staff as required, and referrals to other services and service providers. Clients can access primary care directly from the Registered Nurse at the CTS or through SRCHC's interdisciplinary team (which includes doctors, nurses, nurse practitioners, dietitians, chiropodists, a physiotherapist, health promoters, educators, and the midwifery team.) They can access employment support, referrals to external service providers, and nutritious snacks and coffee.

Clients seem to have the greatest access to care when a CTS is integrated within a CHC offering a broad range of services, due to ease of access to these services and referrals. This is especially important for people who use drugs, who often have complex health and social needs. Further, when integrated within facilities that already work with people who use drugs, establishing relationships with these individuals is easier for CTS staff, and other community members. Additionally, embedded CTS provides an opportunity for privacy and confidentiality compared to stand-alone CTS since it is not necessarily obvious if clients are accessing CTS services or other CHC services when they come to the site.

SERVICE PROVISION

Assessment Questions:

Access

- i. Where do clients come from?
- ii. How many clients are being served?
- iii. Are clients having to wait for services or being turned away?
- iv. What measures are taken to promote equitable access?

Referral pathways to wrap-around services

- i. Are clients connected to appropriate wrap-around services?
- ii. Are there opportunities for improvement with partnerships to strengthen wrap-around services for CTS clients?

Integrated services

- i. Is the service setting appropriate to meet CTS clients and community needs?

Access

i. Where do clients come from?

CTS staff who are familiar with the clients say most clients are local residents and come from a range of locations within the M4M postal code including social housing buildings, as well as clients who are experiencing homelessness and shelter residents. However, supporting data is lacking, as clients are not required to show ID or proof of address.

ii. How many clients are being served?

Number of unique individuals per year:

- April 1, 2021 to March 31, 2022 = 202
- April 1, 2022 to March 31, 2023 = 126
- April 1, 2023 to Sept 30, 2023 = 104

From September 2022 to September 2023, unique individuals to the site averaged 47 per month. In the same period, there were 11,858 total visits for supervised consumption.

iii. Are clients having to wait for services or being turned away?

Clients are not turned away from the CTS but at times need to wait for services. Whether or not people have to wait, and for how long, varies depending on the day, how many clients are at the site, and whether staff are managing any prolonged or complex overdoses.

Clients who smoke or inhale substances cannot be served inside the CTS. In the summer of 2022, SRCHC explored an inhalation pilot with the Ministry of Health and Long Term Care and is awaiting feedback.

iv. What measures are taken to promote equitable access?

A number of measures promote equitable access at the CTS at 955 Queen Street East:

- ID is not required for clients to access the site.
- Policies and protocols are in place to accommodate access for people who cannot self-inject, need to share their drugs, who may be pregnant, are intoxicated, or are youth
- Appointments are not required
- Overdose response is trauma informed
- Indigenous cultural safety is promoted through access to traditional medicines, cultural activities and the presence and experience of staff who are Indigenous
- Priority access is given to individuals who are at highest risk of overdose (for example individuals who have been recently incarcerated).

Referral pathways to wrap-around services

i. Are clients connected to appropriate wrap-around services?

As a CTS that is integrated within a community health centre, CTS clients at 955 Queen Street East access and receive referrals from health and social service providers beyond the CTS.

SRCHC has internal referral pathways for primary care, hepatitis C treatment and other chronic disease care. SRCHC has low barrier, non-appointment-based access to primary care two times weekly for clients of their harm reduction via outreach. The team that offers care includes family physicians, nurse practitioners, social workers/navigation support, as well as access to other allied health including physiotherapy and chiropody services. In addition, there are a number of group-based programs that clients can choose to access, to address determinants of health, such as community kitchen, kit-making circles, seeking safety, the hepatitis C group, and women's program.

From January to July 2023, at least 165 individuals who use drugs received clinical support from health centre providers for services beyond the CTS. This group would include people who used the CTS as well as people who did not.

In 2022, the staff at the CTS at 955 Queen Street East made more than 100 referrals to each of primary care and hospital services, and social services including Indigenous health promoter, shelters, group programs, ID replacement, legal support, social assistance support, and housing. They also made 59 referrals to substance use services including withdrawal management, treatment programs, and safer supply, and 11 referrals to mental health services.

The CHC is transitioning the site team to an electronic medical record to better track both internal and external referrals.

ii. Are there opportunities for improvement with partnerships to strengthen wrap-around services for CTS clients?

The review team found there are opportunities for SRCHC to improve partnerships and strengthen wrap-around services for CTS clients. For example, in their Ontario Health Team work with the East Toronto Health Partners, the CHC explored the possibility of having RAAM (Rapid Access Addiction Medicine) clinic services available at least one day per week at SRCHC, which may be a possibility in the future. The centre is also currently in discussion with the Comprehensive Treatment Clinic, another member of the East Toronto Health Partners, about offering OAT services through SRCHC or through virtual platforms for interested CTS clients. Additionally, the centre is hoping to explore ways to better define and formalize referral pathways to withdrawal management and treatment services to help improve access to people seeking this care.

Integrated services

i. Is the service setting appropriate to meet CTS client and community needs?

The location is accessible to clients by several routes including by public transit, as it is on a major TTC streetcar line and located in a neighbourhood that has had historically high rates of substance use. It is also integrated with primary care and various other harm reduction services.

During the week of July 7th, 2023, SRCHC surveyed twenty-one clients. Nineteen said that the CTS at 955 Queen Street East should remain in its current location, one person skipped the question, and one person responded, “no – a lot of people in this community don’t want drug users here.” People surveyed commented on the need for the site to stay where it is since there are no other supervised consumption services in East Toronto. They also commented on concerns regarding intimidation and surveillance from community members stemming from stigma and fear of drug users.

The characteristics of the local community have changed in the last 25 years since SRCHC began offering harm reduction services at 955 Queen Street East. It is possible that some of these changes may have contributed to making the services and client group feel less welcome.

SAFETY AND SECURITY

Assessment Questions:

Safety and security

- i. Are safety and security measures sufficient for staff, clients and the community?
- ii. How is the organization responding to community safety concerns (including any school related concerns)?

i. Are the safety and security measures sufficient for staff, clients and the community?

The review team conducted a security review via three site visits, document reviews and discussions with leadership from SRCHC and CTS staff at 955 Queen Street East.

The review team found that after the fatal shooting incident on July 7th, 2023, several improvements related to safety and security were completed including the hiring of One Community Solutions. Toronto Police Service (TPS) conducted a Crime Prevention Through Environmental Design (CPTED) audit on July 19th, 2023. SRCHC implemented recommendations from this report that included:

- Increased exterior lighting on the north, east and west part of the building
- Additional cameras and related signage
- Fencing west property line between SRCHC and the Church
- Reducing the size of shrubs
- Strategic use of planters to help discourage loitering
- Signing of a trespass authorization form with TPS to allow for enforcement of the Trespass to Property action on SRCHC property.

These completed recommendations have improved community safety. The review team found additional areas where improvements can be made to enhance overall safety and security at SRCHC.

Video Surveillance: Existing cameras located at SRCHC record for up to 60 days and are visible on screens located at the front desk on the first floor. Cameras for the lobby and external areas are not visible to the staff of the CTS. Through document review and discussions with staff, there does not appear to be a documented camera maintenance program, which would help ensure proper operation of the system and appropriate recording quality of video images. Signage on the exterior of the building indicates that there is 24 hour CCTV Surveillance which can be misleading to the community as the cameras are recorded 24 hours a day but staff are not actively watching the cameras during the opening hours of the health centre and there is no monitoring after hours.

Exterior: During site visits by the review team, the grounds, sidewalks and the parking lot appeared well maintained with no evidence of sharps or other drug equipment on the property. Some loitering on the east and north sides of the building were noted. Staff from One Community Solutions did not appear to be taking any action in regards to the loitering that was taking place. The benches located on the north side of the building seem to attract loitering that would likely increase in summer months.

Security Staffing/One Community Solutions: During discussions with leadership at SRCHC and in the document reviews, it was found that One Community Solutions (OCS) staff are referred to as “security”. The One Community Solutions staff observed working at the health centre are not in uniforms that conform to the Ontario Private Security and Investigative Services uniform regulations. A check of the One Community Solutions website indicates that they are a security alternative. The Registered Security Employer database does not list One Community Solutions as being licensed to provide Security Guard Services in the province of Ontario.

The review team examined the contract between One Community Solutions and SRCHC. It is not clear if One Community Solutions is adhering to the scope of work outlined in their contract with the health centre. The timing of the shift agreed upon is 6:00am until 12:00am. SRCHC staff and OCS staff have noted that at times there is only one guard present (instead of two, as per the contract) at the start of the shift, and SRCHC staff have not yet been able to verify whether guards stay until their shift ends. The contract states that One Community Solutions will do outreach with local partner organizations. In speaking with One Community Solutions and with SRCHC staff, the review team found that this does not appear to be working. Staff from One Community Solutions do not engage Toronto Police directly, but rather communicate through SRCHC staff, who then contact the police. The proposal of services states that One Community Solutions staff are trained in crisis management, de-escalation and non-violent conflict resolution. In speaking with some One Community Solutions staff, the review team found that they do not receive formal training in these areas. SRCHC staff have also indicated that the skill level for handling of incidents varies widely. Additionally, the One Community Solutions staff observed working during site visits did not appear comfortable in dealing with persons loitering around the health centre.

Policies: The CTS at 955 Queen Street East has an 885-page policy document that includes Emergency Management policies (Section 11) and a section on Use of Surveillance Cameras (Section 9). In discussions with CTS staff, the review team found that CTS staff were aware of a lockdown policy but unsure of specifics or whether lockdown drills had been performed. There does not appear to be a Code Silver Code/policy in place at this time to deal with incidents of a person with a weapon/active attacker on the premises.

Toronto Police Services: The review team found that there does not seem to be an ongoing, formal avenue of communication between SRCHC and TPS that could help build relationships and address ongoing community and staff safety concerns. An ongoing relationship between SRCHC and TPS would also help bring clarity to the community regarding what SRCHC is and is

not responsible for, and what TPS is and is not responsible for. The review team found that TPS has increased community patrols of the areas surrounding the health centre. These patrols provide an increased sense of safety for the community. TPS were involved in completing a Crime Prevention Through Environmental Design (CPTED) audit of the site and recommendations were made and appropriate actions taken by SRCHC.

Public Areas: During site visits, the review team observed that the area outside of the CTS is an area where clients can sit while waiting for a space to open with the CTS. Staff from the CTS do not have camera access to be able to view this space to help ensure the safety of clients and individuals entering the space. Washrooms are locked and monitored by staff who check the washrooms every 5 minutes when they are occupied.

ii. How is the organization responding to community safety concerns (including any school related concerns)?

After the fatal shooting on July 7th, 2023, SRCHC completed several improvements related to safety and security. This included hiring One Community Solutions (see above). Toronto Police Service also conducted a Crime Prevention Through Environmental Design (CPTED) audit on July 19th, 2023, and SRCHC implemented recommendations from this report (see above).

While these completed recommendations have improved the overall safety and security of SRCHC, it is important to note that some residents feel more can be done to respond to community safety concerns (see Communication section, page 18 and Community Engagement report).

COMMUNITY ENGAGEMENT AND COMMUNICATIONS

Assessment Questions

- i. How can community engagement and communications strategies be strengthened?
- ii. Is the process for responding to community concerns or complaints effective and responsive?

i. How can community engagement and communications strategies be strengthened?

The review team found that SRCHC has detailed communications policies, which provide guidelines of how their external and internal communication channels are used, including processes for social media and media relations. Leaders are educated about these policies as part of orientation, which is a good practice to help them understand how SRCHC engages with key stakeholders. It also ensures consistent communication alignment to corporate brand guidelines, values and strategy.

After the fatal shooting on July 7, 2023, the centre's leadership recognized the need for additional resources and brought in external consultants to help supplement its communication strategy, including third-party facilitated community engagement sessions to inform recommendations for changes to its operations.

A town hall organized by community members later that month included participation from SRCHC leadership. The SRCHC also responded by:

- Contracting Public Progress to conduct a community engagement and consultation process with local residents and business to better understand community safety concerns (Security Update for Health Canada, Sept 2023).
- Creating a temporary Safer Community Committee, whose members (neighbours, police, schools, SafeTO, elected officials) pursued opportunities to strengthen coordination between the community health centre, police, and other city services in the interest of public safety (Summary Report for Health Canada, Sept 2023).
- Contracting One Community Solutions in July 2023 for one year to increase security measures (One Community Solutions contract).
- Creating a back-to-school plan with the help of concerned community members to enhance security and community engagement, which includes increased patrols by One Community Solutions during school travel hours and during community health promotion events held next to the CHC.
- Conducting a Crime Prevention through Environmental Design (CPTED) audit with Toronto Police Services on July 19th; changes have been implemented (Incident Response Summary Report, Aug 22, 2023).
- Updating the service's loitering policy to discourage loitering by clients around the site (Loitering Policy, Aug 2023)

- Enhancing communication and site tours with local police and other emergency responders to include community education sessions on CTS and other services at SRCHC for approximately 20 community police officers and 3 fire fighters (Incident Response Summary Report, Aug 22, 2023).
- Enhancing communication and clarification with community members about how to address drug litter outside of the SRCHC vicinity.

Since July 7th, 2023, the communications team at SRCHC and the communications teams at other CHCs operating a CTS have started to meet to share learnings and communication strategies. This is an excellent approach and the review team recommends formalizing this group. The review team also recommends exploring the possibility of extending this networking group model to other leadership roles, if not already in place. Initial discussions within the communication group have broached the idea of creating a shared communications resource which could play a crucial role in ensuring consistent messaging about CTS sites and services, as well as enhancing communication with the communities surrounding them. The review team encourages these conversations to continue and for the SRCHC and other CHCs to explore this as a possible way to explore this augment their limited communication resources.

The review team found an overall increased need from the community for regular two-way communication. The need for more external communication and regular community engagement should be considered in the centre's communication strategy and in any future adjustments to the communications team's roles and scope.

The creation of the SRCHC's Community Liaison Committee, and after the fatal shooting, the Safer Communities Committee, have been avenues to hear from members of the Leslieville community. SRCHC should engage the community to foster a better understanding of the work happening and to demonstrate steps taken to ensure safety or changes made as a result of conversations with the community. These could include, but are not limited to:

- Hosting open houses of the CTS to invite the community in to meet staff and see the facility. Collaborating with the local resident associations and holding a standing spot for updates and Q&A at their meetings would be beneficial to increasing public engagement and communication. These kind of approaches were also noted in the Safer Communities Committee Final Report. After the fatal shooting, SRCHC's senior leadership attended community organized town halls and meetings. The review team encourages SRCHC leaders to continue to attend such events to enable ongoing dialogue. The centre could explore collaborating and co-hosting these meetings with the lead volunteers in the community who organized previous town halls.
- The review team recommends reviewing and redesigning the centre's external communication strategy with the goal of sharing more frequent information about the CHC and the CTS. The centre could ask the community for input to inform communication preferences and the type of information they would find helpful.

SRCHC should continue to refine and develop its system for tracking, triaging and responding to complaints or concerns from members of the community, with the goals of improving two-way communication with the community, setting expectations for timely responses, helping to monitor impact, and rebuilding trust with the community. The complaints and concerns system should strive for maximum transparency regarding how concerns will be addressed, acceptable time frames for addressing responses, and appeals processes for people who feel that their concerns have not been addressed.

Further developing this function, and the role that would oversee it, would improve two-way communication with the community by setting expectations of a timely response, help monitor impact, and rebuild trust with the community.

ii. Is the process for responding to community concerns or complaints effective and responsive?

The review team conducted its own community engagement between October 2023 and January 2024 to hear independently from external stakeholder groups on this question. Detailed findings are presented in a separate report (Community Engagement companion report). This section summarizes what the review team heard from diverse stakeholder groups, focusing especially on areas within the review mandate. Five separate two-hour group consultations were held, with a total of 64 participants belonging to the following stakeholder groups: Clients who access the CTS, clients who access general CHC services, neighborhood residents, neighborhood businesses and employees, and a group of concerned neighbours. Groups are not necessarily representative of the community. Individual consultations were held with local daycares and local school administrators. Additionally, an online form generated 141 responses.

SRCHC Communications and Community Engagement: Many respondents expressed frustration about the level of communication and emphasized that there was no effective process to raise concerns or file complaints. Many respondents felt that the SRCHC staff were dismissive of their concerns, and did not answer their emails or other queries. Many respondents reported that when there was a response, it was weak and consisted of excuses about not having the power or resources to make changes. Some perceived a culture of passing responsibility to others within the SRCHC and asked for a clear “chain of responsibility and accountability,” including an appeal mechanism. Several respondents felt that communication was worse after the pandemic started. Respondents also noted that the SRCHC website did not clearly indicate who should be contacted about concerns or provide detailed information about site operation.

Daycare and school officials said that communication could be improved by dispelling myths about the site through publicizing what services are being offered, how the CTS is supporting people, and sending a message that the CTS will not “distribute drugs”. However, many respondents felt that newsletters and emails were of limited use.

In contrast, people who were clients of the SRCHC felt that staff were very approachable and responsive, although less so after the start of the pandemic. Another perspective shared by clients was that SRCHC and the board had been open to feedback and have welcomed, encouraged, and incorporated feedback.

Security and safety concerns: Respondents expressed a range of security and safety concerns. Overall, the concerns shared by respondents were consistent with findings from the Public Progress Report published in September 2023.

Several people reported incidents of harassment (including threats) and physical assault from CTS clients, including to children. Some respondents and CTS clients added that SRCHC staff and security have sometimes been present during altercations but do not intervene, appearing neglectful. Many respondents, including clients of SRCHC, were concerned about crowding and loitering outside of the CTS, when individuals outside of the CTS are visibly intoxicated, belligerent, and acting erratically.

Many respondents were concerned about public drug use, including people overdosing in public (fatal and non-fatal); drug use has been observed directly outside of the CTS, in alleyways, on the street, in parks and other public spaces in the neighbourhood. Schools and daycares have found people using drugs in their parking lots or in their entryways. Respondents have also observed excrement, discarded needles and substances, and other garbage in the neighbourhood. Residents and daycare staff have witnessed individuals having sex, defecating and urinating in public and on daycare property.

Many respondents were concerned about the effects on children of public drug use, disruptive behaviour, and discarded equipment and drugs. Residents and families are concerned about the long-term impacts on the emotional and mental wellbeing of children and no longer feel a sense of safety in their neighbourhood.

Several residents and businesses have experienced theft, property damage and break-ins in their homes and cars.

Many responders emphasized that there is a noticeable presence of drug selling both outside the CTS and in the neighbourhood. Respondents also fear that sellers are armed and directly responsible for an increase in guns and violence in the neighbourhood.

Many of the safety concerns reported are more pronounced for residents who live on Heward Avenue, which is in very close proximity to SRCHC. These residents feel their concerns are distinct.

Some respondents expressed different opinions about safety and security related to the CTS.

CTS clients stated that SRCHC is not the only site where there are problems. CTS clients felt that their own sense of safety has been compromised. They have experienced residents in the neighbourhood photographing them without consent and making remarks when walking by.

CTS clients share concerns with other participant groups about CTS staff not having enough training. Most respondents felt that there is insufficient attention from SRCHC management to address their concerns.

Some respondents had no concerns about security and safety related the CTS. The 2023 Public Progress Report found that some businesses were supportive of the CTS and SRCHC overall, while others had concerns only after fatal shooting on July 7th, 2023. The report also found that residents who have lived in the Leslieville neighbourhood for more than 20 years feel safer now than they have in the past.

The review team considered that some concerns mentioned frequently by community members existed outside the scope of the CTS's responsibilities in the community. For example, many concerns are related to the lack of stable housing, including public drug use, visibility of people with mental illnesses, and a lack of easy access to public restrooms. Such issues are not specific to CTS clients, but are common among people experiencing poverty and other forms of marginalization.

HUMAN RESOURCES

Assessment Questions

- i. How can hiring and retention practices be improved?
- ii. Is existing training for staff sufficient?

Unity Health is aware that the police have charged one of the SRCHC employees with accessory after the fact to an indictable offense, and obstructing justice in connection with the fatal shooting in July 2023. Although the review did not look into the specifics surrounding the hiring of that individual employee, the review team did pay particular attention to the rigour and application of the general practices for human resource screening, selection, training and performance management, which remain a cornerstone of any organization's risk mitigation strategies. Through this review, specific recommendations have been made with respect to updates to the organization's criminal check policy. The SRCHC leadership team also noted that they routinely have discussions with staff regarding professional boundaries and maintaining a therapeutic relationship, which SRCHC was able to demonstrate are codified in policy. Ensuring this type of training is in place and is regularly refreshed will continue to be important to reinforce organizational expectations and ensure that professional boundaries are maintained.

i. How can hiring and retention practices be improved?

While SRCHC has approximately 190 staff in total, the CTS itself is staffed by a small team made up of Registered Nurses (RNs), community health workers and overdose response workers.

The current CTS headcount consists of 1 full time RN, 1 part time community health worker, one full time community health worker (and another full time community health worker hire in process as of January 2024), and 1 full time overdose response worker. There are also two casual staff (one RN and one overdose response worker) who work regularly. Additional casual staff are employed but have limited availability and have not worked in some time. On occasion, an RN may be re-assigned from the Moss Park CTS to support staffing.

Within the CTS, three staff are currently scheduled on each shift. These three scheduled staff can be any combination of a RN, community health worker and overdose response workers, although a minimum of one RN is scheduled on each shift.

The current Human Resources (HR) team at SRCHC consists of three Full Time Equivalents (FTEs) and is led by an HR manager who has had significant experience with the CTS. A HR business partner and an HR administrator report to the HR manager. There is no designated role responsible in the organization for occupational health and safety, which means that it must be managed entirely through the Internal Responsibility System largely relying on the work of the

Joint Occupational Health and Safety Committee and the accountability for safety that is held by individual managers/directors for their programs.

During scheduled site visits with the review team, SRCHC representatives in HR and leadership described a culture of collaboration and consultation across their management team, as well as a desire for continuous learning and quality improvement. The strong values and sense of purpose held by the staff of the organization were demonstrated through the commitment and passion demonstrated by the individuals that the review team spoke to. A clear commitment to the clients of the CTS and to the SRCHC more broadly was also clearly demonstrated by the individuals that the review team engaged with. Health equity was frequently mentioned in the context of what was important to ensure accessible and quality service to SRCHC and CTS clients.

As noted earlier in this report, SRCHC has grown significantly in recent years and recruitment and retention have been a key area of challenge and focus particularly in light of the current system-wide health human resources challenges and increased competition for clinically trained professionals. Specific to the CTS, vacancies in key roles have prevented the CTS from being able to fulfill its objective of implementing extended hours. Roles within the CTS have also become progressively more difficult to fill over time mirroring the experiences of healthcare organizations more broadly in the context of the health human resources challenges post pandemic. The shortage of trained health workers combined with surging needs across all health sectors has served to exacerbate challenges that were pre-existing with recruitment for community based roles. The RN role in particular has posed significant challenges with notable periods of vacancy. At the start of January 2024, the CTS was in the process of hiring new RN and community health worker roles with the goal of increasing the daily staffing to four staff scheduled and expanding hours on Monday, Tuesday and Thursday shifts.

While no formal compensation benchmarking exercise has taken place, HR and CTS leadership have both received feedback from staff that compensation is a key factor hindering their recruitment and retention. The HR manager also spoke to observations from postings of other organizations as indications that compensation may be a hindrance to recruitment and retention.

As a part of this review, the review team reviewed all HR policies, recruitment and selection materials and relevant procedures. SRCHC has robust and current HR policies that address all aspects of the employment relationship and meet all minimum legal requirements. The review team did not identify any missing legislatively required policies, nor deficiencies in terms of compliance with employment legislation within the policies reviewed. Additional evidence was provided of employee programs across a broad spectrum of the employee life cycle, from recruitment activities, to onboarding, to training, to the evaluation of employee performance and the management of employee exits. Despite the small size of the HR team and resources limitation inherent to an organization in this sector, the overall HR program demonstrated a high level of sophistication and maturity with all large components appearing to be in place from our perspective.

The individuals who had accountability for Occupational Health and Safety demonstrated a reasonable knowledge of Health and Safety legislation, programs and policies. As previously mentioned, it was noted by the review team that responsibilities for Health and Safety appeared to be decentralized across multiple individuals and stakeholders. This occupational health and safety environment, including the inherent hazards, were acknowledged by the reviewers to be complex and dynamic. An observation by the review team is that such environments may benefit from the co-ordination and oversight of a dedicated resource to ensure all safety risks are managed.

Police Records Check Policy & Process: SRCHC has a robust police check policy (“Police Checks Policy”) that clearly outlines requirements and procedures. However, the policy includes a number of exceptions to the requirements for either a criminal record check or a Vulnerable Sector Screening (VSS) as may be applicable. Specifically the policy details exclusions for individuals in dedicated positions for people with lived experience formally referred to as peer positions, and employees on contracts less than 6 months, as well exemptions for BIPOC persons on a case by case basis and subject to the discretion of the CEO. According to the policy, the exception for individuals with lived experience exists for the following reason:

“...in consideration of SRCHC’s employment of individuals in dedicated positions for people with lived experience (formerly referred to as peer positions) who by nature of their role may have a relationship with the law, the Centre acknowledges it may be difficult to attract individuals if this is a condition of employment.”

The SRCHC team interviewed described the purpose of the exception generally is to ensure that the police check policy is not a barrier to applicants who have lived experience of drug use. While this is a noble intention it does create unmitigated risk to the organization of employing individuals within a safety sensitive environment with vulnerable persons who may have criminal records with offenses that would be incongruent with their role performed as a part of the SRCHC.

The Criminal Record Check Policy accepts police checks and vulnerable sector screens from applicants as “active” provided they have been completed within the previous 12 months. SRCHC staff shared in follow-up correspondence that all positive criminal record checks are reviewed by the CEO to determine if the decision to hire may proceed based on the results of the police records. The CEO confirmed that criteria considered include date of offense, age at time of offense, nature of offense, and any relationship to substance use; however, this is not formalized in a specific document.

Roles with Lived Experience (Peer Support Model): The SRCHC operates a highly integrated interdisciplinary model within its consumption treatment facility. Staff expressed clarity with

regard to the designated acts for each profession working within the CTS as well as the limitations on actions and client interactions designated to certain roles given their qualifications and training. According to current Ministry of Health requirements, the CTS staffing model must include peers/persons with lived experience. SRCHC does not have a defined/titled “Peer Support” position in the CTS and observations of other comparator organizations support that the move away from this title is a sector-wide trend. This has been described as being driven by dual forces with one objective being to move away from language that is “othering” for staff and clients and diminishing of the contributions of staff with lived experience. The other has been the desire to “professionalize” the role of positions, which historically required only lived experience. SRCHC team also noted that in order to fill the Overdose Response Worker & Community Health Worker positions in the current labour market conditions, they have been hiring staff without lived experience although it is still noted as preferred on both postings.

While the leadership of the CTS stated they do have some longer serving staff with lived experience who currently work in the Overdose Response Worker positions, CTS leadership indicated that they no longer see these roles as requiring lived experience as a mandatory condition of employment. New hires recently have been described as largely being made up of new graduates without lived experience.

Staff Safety & Internal Responsibility System: Leaders interviewed about workplace safety and the Internal Responsibility System appeared committed to workplace safety and were reasonably well informed about workplace safety practices as required for their fulfillment of their accountabilities related to workplace safety. They appear to have a functioning Joint Health and Safety Committee and this group attests to rigorous practices in terms of maintaining their regular schedule of workplace inspections. The Interviewees acknowledged that they work in a safety sensitive environment, but also pointed out that they do not have any dedicated or shared resource within the organization who is entirely dedicated to workplace safety. Currently responsibilities for health and safety are decentralized across various leaders at the organization and are centrally coordinated by the Joint Occupational Health and Safety Committee.

The interviewees described a culture within the CTS of staff who recognize the critical role that they play in the preservation of human life. A testament to their leadership is that this appears to be a strong and enduring purpose that resonates throughout this organization.

Interviewees described a rule that staff are not to support client overdoses outside of a distance of 15 metres from the building. They qualified this expectation by making a permissive statement along the lines of: if a staff thinks that they can save someone’s life then they will do what has to be done.

There is no policy for Code Silver (Lockdown for Active Shooter) despite a significant incident in the proximity of the centre very recently. It was not apparent in discussion with CTS leadership that a plan was in place should a similar event occur again in future. They have indicated that they have not done lockdown drills recently.

During the first of two site visits, the review team noticed that security personnel did not appear to be present upon entering and exiting the facility. The review team was informed that there is one security individual who patrols inside and outside of the building and into alleyways within the community close to the site. During the second site visit, the review team found that security was present in the vicinity of the front entrance.

Staff Trauma Supports: The leadership of the CTS demonstrated that they have extensive ongoing approaches to engage and support staff including routine daily de-briefing sessions at the start and end of each shift, individual and group counselling services, manager support, ad hoc use of grief and trauma counsellors and Employee Assistance Program resources. SRCHC confirmed that for their group benefits, full time and part time (17.5 hours/week, or more), including full time and part time (17.5 hours/week, or more) contract employees on contracts greater than one year, have access to group benefits. For mental health benefits through the group benefits, they provide \$20 per visit to a psychologist and up to \$300 per calendar year.

Through the course of the review, some concerns were voiced that the current limits on mental health support (cap of \$20.00 per visit), effectively meant that staff were unable to access these benefits due to the out of pocket costs. All staff, no matter the employment status, have access to EAP. Innovative wellness options such as acupuncture and shiatsu have been offered on an ad hoc basis and interviewee described a special wellness fund as a means for managers to make wellness resources available to staff in the CTS.

The work in the CTS was described as hard, demanding hyper-vigilance and requiring the tact and resilience to manage complex client responses throughout the shift. The interviewees acknowledge that the work environment is challenging and that there is no form of mitigation that can fully remove the frequent exposure to events such as overdoses or aggressive responses from some clients. The interviewees reported that monitoring of staff for signs of stress or trauma is done informally by the manager and the director. While information shared suggests the organization intervenes when staff exhibit signs of needing support, there is no program in place for proactive support or monitoring for staff with a history of substance use, in part because of a desire to treat all employees equitably and to avoid “othering” employees who have used substances. However, the lack of a proactive policy can lead to a delay of support until staff exhibit signs of unmanaged substance use. The review team identified a need to provide additional resources and support to staff with a history of substance use disorder; these supports should be provided in sensitive ways to avoid making staff feel singled out or targeted.

Staffing Model: Both HR and CTS program leadership have highlighted challenges with recruitment and staffing. With respect to the CTS, this has had a negative impact on clients because of their inability to extend service hours into the evenings and weekends. Staffing challenges experienced by SRCHC are unsurprising given broader HHR context and the organization has made reasonable efforts to advertise and recruit staff. When asked about employees' reasons for leaving or reasons why job offers are not accepted, concerns were raised about the lack of competitiveness of wage rates. The HR representative and CTS leadership indicated that they believe that pay rates may be below comparable CHC organizations, but this is based on reviews of job postings rather than on any sort of formal analysis.

Reporting/Complaint Mechanisms: While interviewees described an open environment where employees were enabled to bring forward concerns regarding their work environment or with their colleagues to HR or management, no current mechanism exists for staff to report concerns anonymously.

Policies: The HR policies are well done and address all routine employment terms and condition as well as legally mandated items. While department leadership indicated that expectations around drug use at work and requirement to be at baseline are communicated to staff in the CTS, expectations for all staff with respect to fitness to work in do not appear to sit formally in any organizational policies.

ii. Is existing training for staff sufficient?

Based on a documentation review, legislatively required Human Resources and Occupational Health and Safety trainings are in place for employees (*AODA Training, WHMIS, Occupational Health and Safety Training for Workers and/or Supervisors, and Workplace Violence Training.*) In addition to legislatively required trainings, SRCHC provided records outlining a variety of other mandatory trainings for staff, including but not limited to privacy training, hand hygiene, mental wellness in the workplace, resolving conflict and de-escalating challenging behaviours. Additional training opportunities related to anti-Black racism and Indigenous learnings are also offered. The CTS leadership reported, in discussion with the review team, that CTS staff received specific training on trauma informed care, Crisis Prevention Institute (CPI) training, Basic Life Support (BLS) certification and ASIST training (suicide intervention). From a Human Resources and Occupational Health and Safety perspective, the training records appear to support legislative obligations and while the specific training content was not reviewed, the topics appear to be sufficient to promote positive job performance. A system for delivery and monitoring of training was produced.

CRITICAL INCIDENTS

Assessment Questions

- i. Are appropriate measures in place to respond to critical incidents?
- ii. Is an appropriate definition of “critical incidents” being used?
- iii. Are appropriate measures in place for notifying the leadership of the organization, funding partners and Health Canada of critical incidents (as appropriate)?

i. Is an appropriate definition of “critical incidents” being used?

In the healthcare sector the only common definition for a “critical incident” is outlined in the Public Hospitals Act and refers specifically to patient harm. It defines a critical incident as:

*Any unintended event that occurs when a patient receives treatment in the hospital,
(a) that results in death, or serious disability, injury or harm to the patient, and
(b) does not result primarily from the patient’s underlying medical condition or from a known risk inherent in providing the treatment*

The review team confirmed that SRCHC does not have a formal *critical incident* definition.

While the fatal shooting on July 7, 2023 outside of the South Riverdale Health Centre (SRCHC) was a very serious and tragic event, it is not an incident that healthcare organizations would refer to as a critical incident. This is due to the fact that the incident was external to the SRCHC property and the individual who was injured was neither an SRCHC client nor an employee. When a serious event like this occurs outside and in proximity to a healthcare facility it is essential that the organization be equipped to respond in a manner that mitigates potential threats to their clients and staff. This type of response is referred to as an emergency response plan and is typically part of a larger organizational integrated risk framework. Therefore, the focus of the following sections is on the existing policies, procedures and emergency response plans at SRCHC.

The review team found through documentation review and consultation with SRCHC leadership with oversight for the CTS at 955 Queen Street East that there is a *critical incident response framework*, which includes policies and procedures focused on supporting a safe environment for all and pertains to all sites of SRCHC including the CTS. The policies/procedures include i) procedure for dealing with challenging situations ii) de-escalating disruptive behavior and crisis response iii) emergency lockdown procedure iv) procedure for working with emergency personnel v) severing, limiting and/or terminating challenging clients of the centre vi) incident/accident report and vii) critical incident response and follow-up protocol.

Within the *de-escalating disruptive behavior and crisis response* policy there are procedures for incident response, follow-up and restrictions. These procedures are solely linked to an incident where a client's behavior has escalated and attempts to de-escalate have been unsuccessful. The policy refers to critical situations that include i) presence of a weapon or ii) physical violence or harm to self or others. These policies and procedures are currently under review by SRCHC leadership based on learnings from the fatal shooting outside of the SRCHC on July 7th, 2023.

In addition to this there is an Incident Reporting policy requiring staff to complete an incident/accident report for anything that: i) causes injury or harm to people ii) damage to property iii) theft iv) unusual occurrence or v) privacy or security breach. An incident is defined as an event that was unpleasant or unusual in nature. An accident is defined as an unfortunate incident that happens unexpectedly and unintentionally, typically resulting in damage or injury.

The intent of the critical incident framework along with other policies, procedures and practices is to support the organization's response to what could be considered a critical incident including internal and external threats to i) safety of clients and staff and ii) service provision. Further details and assessment of the critical incident response framework, associated policies, procedures and practices are outlined in the following section.

ii. Are appropriate measures in place to respond to critical incidents?

SRCHC has several policies and procedures that contribute to managing serious events and emergency situations that present a potential or actual threat to the organization, clients and staff. The following provides an overview of these with additional context gathered from interviews with SRCHC senior leaders. This information has been aligned with common stages of risk identification, mitigation and response which would all be central to a robust emergency response plan and broader integrated risk framework.

Risk Identification: SRCHC has a *Risk Management Operational Framework* that provides guidelines and processes to identify, assess and plan to mitigate risks aligned with organizational priorities, mission, vision, values and strategic objectives. It identifies the Board and CEO with Senior Leadership as being responsible for the determination of the organization's overall risk appetite and risk tolerance. Risk management is seen as a shared responsibility amongst all staff, board members, volunteers and students. There are also several organizational level standing committees who are accountable to manage and monitor day to day risks and develop strategies to reduce current risk. This includes Joint Occupational Health & Safety, Infection Control Committee, Communications Committee, IT/IM Steering Committee, Management Teams, Leadership Teams and Senior Leadership Team. It is unclear how these various committees contribute to the overall identification, assessment, mitigation, management and reporting of key organizational risks.

A *Risk Management Tool* was implemented in the past year and is in the early stages of its development and utility. In its current state it provides a retrospective assessment of risks based on a checklist of questions pertaining to traditional operational dimensions. The risk

management tool is reviewed and updated by Senior Leadership twice per year. It is also reviewed by the Board once per year. Currently the tool does not highlight nor rate inherent risks, current or future state risks associated with the CTS. It is important to note that the application process for the CTS did not require a comprehensive risk assessment and mitigation strategy prior to approval or post.

Having a robust enterprise risk framework and assessment tool is key to identifying and mitigating all inherent risks associated with an organization; including those that could evolve into a serious event or emergency. In the current state, this framework and tool are narrow in scope and needs to transition from reactive risk management of events that have occurred or are occurring to a more proactive risk assessment of future or potential risks with scoring/rating criteria. The SRCHC tool, at present, is very compliance based and there appears to be a disconnect with practice and the application of the framework. SRCHC would benefit from reviewing and implementing *HIROC's Integrated Risk framework* and transition from a balanced scorecard approach to a structured summary of the key risks, also referred to as a structured risk register. This is available free of charge to HIROC subscribers and provides a standardized framework, taxonomy and classification matrix to facilitate the identification, assessment, mitigation, management, and reporting of key organizational risks. This would allow SRCHC the flexibility of using a standardized risk assessment approach to create a concise summary of the most significant risks, assign a risk rating/score, identify immediate and longer-term mitigation, and determine whether the residual risk is at an acceptable level.

In addition to this SRCHC has an incident reporting policy and procedure in place to ensure incidents are recorded and addressed in a timely manner. Incident/accident reports are filled out for anything that:

- i) causes injury or harm to people
- ii) damage to property
- iii) theft
- iv) unusual occurrence and
- v) privacy or security breach.

Completed reports are reviewed and acted on by the most responsible supervisor and administrator. They are also reviewed weekly by the Program Management Team along with quarterly summaries shared with the Senior Leadership Group that highlight operational and programmatic risks. The full leadership team and board also receive a comprehensive report twice a year and inform some aspects of the risk management tool. Operationally, there isn't a process to cascade the risks throughout the organization or a process to identify changes in their risk profile, effectiveness of the mitigation plans previously identified, and any emerging risks quarter over quarter.

In addition to the organizational approaches to risk identification noted above, there are specific operational strategies in place to proactively identify risks to the CTS at 955 Queen Street East on a daily basis. These strategies includes daily shift meetings each morning and at the end of

each day. The morning daily shift meeting is attended by all CTS staff and at least one manager. The purpose of these meetings is to identify any potential challenges for the day based on knowledge of clients, situations that could escalate and how to manage those to maintain a safe environment for all. The end of day meeting, which is attended by all working CTS staff and at least one manager and staff from other areas on the first floor where the CTS is located, focuses on debriefing on the day and planning for the following day. The rationale for including staff from surrounding areas is to ensure any observations they have are shared and included in planning for the subsequent day. This model supports a proactive situational awareness approach to risk identification and is a strength of the CTS model. However, it does not appear that these risks inform the broader organizational risk management tool.

Risk Mitigation: Beyond the risks that are identified through the risk management tool and associated mitigation strategies there are other policies and processes in place to support day to day mitigation of risk. The first is a daily huddle that occurs with all SRCHC directors, managers, VP and the CEO. The purpose of these is to check-in as a leadership group share any key issues for the day including staffing, urgent incidents and debriefs. This provides a daily opportunity to ensure all leadership have situational awareness and an opportunity to plan for and mitigate the impact of key issues. This could be enhanced by the approach taken through the daily shift meetings held by CTS staff to be more proactively risk and future focused. There doesn't appear to be a direct link between these shift meetings and the more administrative daily huddles at SRCHC. Similar to the daily shift meetings in the CTS the daily huddles do not appear to inform the organizational risk management tool for longer-term mitigation and monitoring.

The second mitigation strategy identified was the provision of education to staff to support them in their ability to manage risk including urgent and serious events or emergencies. There are both mandatory educational requirements for all staff and additional requirements specific to different roles and functions. Relevant to risk identification and mitigation all staff are required to complete courses on:

- i) preventing workplace violence
- ii) mental wellness in the workplace
- iii) safety begins with you
- iv) resolving conflict and
- v) de-escalating challenging behaviours.

Staff in the CTS are also required to complete non-violent crisis prevention intervention training annually or more frequently if required. They also complete ASIST suicide intervention training and newly, mental health first aid. These training experiences support staff in identifying and mitigating risks specific to clients and creating a safe environment.

There is also an organizational Training and Evaluation Schedule to support staff in utilizing the five emergency codes:

- i) fire
- ii) assist

- iii) aggressive behavior
- iv) cardiac arrest/medical emergency and
- v) lockdown

The Human Resources department tracks this training and works with the Directors and Joint Occupational Health and Safety to coordinate training. Recent changes to some of these procedures and creation of new procedures have delayed the intended training cycle. In particular, training and reorientation on code lockdown has not been completed since the fatal shooting on July 7th, 2023, which leadership identified as a gap. Leadership is committed to looking at how to be more intentional about the required training. SRCHC has implemented a system to alert leadership when a staff member is due for re-education or certification, which will assist in prompting the appropriate leadership to ensure the required education is provided.

Within the CTS at 955 Queen Street East, there are additional strategies to mitigate risks. As mentioned above in the risk identification section, daily shift meetings are central to identifying any potential or actual risks to the safety and security of clients and staff in the CTS. While this approach is somewhat aligned with the daily huddles that occur every morning for the whole of SRCHC, it is unclear how the two connect and if learnings and best practices from each could be identified and used to enhance each process.

Additionally, the general philosophy of care within the CTS site, referred to as relational care, is viewed as another strategy to mitigate risk. This approach to care is based on being trauma-informed, anti-oppressive and harm reduction focused. It involves modeling to clients how to participate in healthy and respectful interactions and clearly community expectations along with boundary setting and talking through disagreements. This supports the ability to mediate and de-escalate tense situations and focus on restorative processes versus punitive repercussions. This approach to care is seen as an effective risk mitigation strategy and as it builds relationships that lead to trust where people are more likely to engage in co-creating a positive environment for all.

Emergency Protocols and Response: SRCHC has several policies and procedures that support how staff respond to a situations that present a potential or actual threat to the organization, clients and staff. The first is a Business Continuity Planning Framework which is part of the broader risk management framework. It provides critical steps to take when localized disasters such as fires, floods, earthquakes, power interruptions and hazardous chemical spills have occurred and rendered the facility as inoperable or unusable thus impacting the ability of the SRCHC to deliver essential programs and services. The business continuity plan provides strategies to support the continuation of core business functions including the declaration of a disaster/emergency and the implementation of an Incident Management Team (IMT) to manage the disaster/emergency. The use of an IMT to manage such events is beneficial in all emergency situations as it provides a standard chain of command to support decision making, risk mitigation and clearly defined roles. This approach may have been beneficial in managing the events of July 7th, 2023 and in particular the inclusion of a formal debrief process that results in clear actions and accountability.

The management of imminent and actual risk to the safety and security of clients and staff is outlined in the SRCHC Code Lockdown and includes scenarios in the CTS. The code lockdown is implemented when there is danger in the building and all occupants are kept inside and as far away from danger as possible and where there is danger in the community and a lockdown has been implemented to keep all occupants inside until instructed to do otherwise by external emergency personnel.

While this code aims to prevent an individual or individuals entering the building who may threaten the safety and security of clients and staff, it does not include how to manage a scenario where a person is able to enter a SRCHC building who is actively using a weapon or physically attacking individuals. Currently, there is not a procedure in place to manage this type of scenario. In discussions with senior leadership, it was identified that this would be of benefit to the organization and complementary to the code lockdown procedure. All emergency response 'codes' should include a structured process for a hot debrief immediately following the incidents and cold debrief, more formalized to identify what worked well, areas of improvement, immediate actions required. These emergency response codes should also incorporate specific circumstances under which 911 should be called.

Specific to the CTS at 955 Queen Street East, additional strategies are in place to respond to serious or emergency situations where there is a potential or actual threat to the safety and security of clients or staff. The first is the placement of panic buttons; one is in each of the two main CTS spaces under desks. Once pressed, an alert is sent to an off-site third party security company which calls the centre, asks if police are needed, and calls police if appropriate. Additionally, an alert is emailed to leadership so they are aware and can respond to the area to assist. Secondly, the CTS space itself is a locked space and entry can only occur with a fob that only staff have. Exiting from the CTS does not require a fob and thus provides a clear exit path for all. It is also possible to keep the separate spaces of the CTS locked, which supports the code lockdown process and can create space and barriers between a threat and those being threatened.

From within the CTS, there is a side exit to the outside, which provides a further exit path for emergency situations. Staff can also press an intercom button on the phones in the CTS, which allows for everyone in the building to hear what is occurring the CTS overhead and provides another mechanism to alert others in the building of a potential or actual critical situation. Lastly, walkie talkies are used to support communication amongst staff across the entire SRCHC site. Staff in the CTS have access to these and at least one person on each floor including managers and medical staff in the building has one. This provides another mechanism to escalate requests for assistance and to alert others about an emergency or critical incident requiring support.

iii. Are appropriate measures in place for notifying the leadership of the organization, funding partners and Health Canada of critical incidents (as appropriate)?

Upon review of policies and procedures and in conversation with senior leaders it was determined that there is some direction on the process to notify organizations, funding partners and Health Canada (if applicable) of serious events or emergencies. The clearest guidance is found in the business continuity plan and two governance policies that reference the CEO as responsible for communications with the Ontario Health, the Ministry of Health, other funders and any other regulatory/statutory authorities in the face of a disaster or emergency.

In circumstances where the Chief Executive Officer determines the organization may be impacted negatively, the CEO will report to the Board through the Board Chair/President who will determine whether the issue should be brought forward to the Board. The CEO is also expected to make the Board aware of any relevant trends, anticipated or actual adverse media coverage, material external and internal changes, and particularly changes in the assumptions upon which any Board policy has previously been established. There are currently no internally established guidelines or external guidelines from the Ministry for reporting emergency situations or critical incidents where there is a threat to the safety/security of clients and staff to funders and Health Canada.

FUNDING

Assessment Questions

- i. Are CTS program funding requirements being met?
- ii. How can existing CTS site funding be optimized to ensure the right services are available in the right place at the right time?

i. Are CTS program funding requirements being met?

The review team found the CTS at 955 Queen Street East is meeting almost all of its funding requirements.

The Transfer Payment Agreement outlines the terms and conditions under which funds are transferred from the Ministry of Health to the CTS. Funding requirements refer to the specific performance targets set out by the Ministry of Health as well as financial reporting. Performance targets include hours of operation, number of client visits, number of overdose events reversed, substances consumed, and community engagement, which the CTS reports on monthly and annually. Financial reports include quarterly reports, annual reconciliation reports, and annual financial statements.

Funding requirements that are not being met include those related to Sunday operations, staffing, and hours of opening. Specifically, the site receives funding for Sunday operations related to the CHC building (e.g., for heating, etc) but it has not been open as a CHC or CTS on Sundays, unlike other Consumption and Treatment Services. Other elements of funding specific to staff requirements have been difficult to maintain because of staff retention issues. Another area where requirements have not been met relates to hours of operation. The Transfer Payment Agreement specifies that the CTS should be open 11 hours a day, 7 days a week. The CTS has not been able to hire sufficient staff to stay open 11 hours per day.

One area that requires greater clarity is community engagement. SRCHC reports note that engagement has been occurring, but very little detail has been provided in these reports.

The review team found that the site is working on improving a number of areas in reporting, specifically looking at improving data accuracy/ forms completion to support reporting.

ii. How can existing CTS site funding be optimized to ensure the right services are available in the right place at the right time?

Over the past six months, programming within the broader CHC's harm reduction team has expanded, providing more formalized opportunities for clients of the CTS to connect with peers and participate in group care. SRCHC has plans to extend program hours into evenings (a trial was conducted in August 2023) and weekends. One potential avenue to explore is the consideration of hiring Registered Practical Nurses (RPNs) instead of RNs.

There is also opportunity to optimize funding through flexibility in use of current CTS funds. Funding for the CTS at 955 Queen Street East is \$1,311,600 annually each year. Of this amount, \$916,285 is allocated to staffing (salaries and benefits) and \$395,315 to operating expenses (program costs, infection control and cleaning, medical equipment, security, staff training, rent, Sunday opening costs, and admin and IT expenses.)

Spending for fiscal years 2020/21, 2021/22, 2022/23 was less than budgeted. Spending was within 25% of the budget each year for staffing (staff hiring and retention has been an ongoing challenge), and was within 30% of the budget for operating expenses. Approximately 20% of the budget for operating expenses is allocated to Sunday opening costs, but the CTS has not been able to use these funds because of staffing difficulties, the lack of weekend premiums, and the challenge that the rest of the CHC is closed on Sundays.

SRCHC submitted their CTS budgets and spending for fiscal years 2020/21 through the first half of 2023/24 to the review team. Up until the 2023/24 fiscal year, spending had been relatively consistent. For the first six months of 2023/24, spending continues to be under budget for staffing, due to ongoing difficulty in hiring or retaining staff. Meanwhile, over the same period, operating expenses have been significantly over budget for the first time since at least 2020/21, specifically with respect to medical and other program expenses, including security expenses.

Regular security services were not maintained by SRCHC prior to July 14th, 2023 of the current fiscal year. Another anomaly in spending was staff training, for which only 20 per cent of the allocated budget was spent in the first half of 2023/24; in previous years, staff training was fully spent.

FORWARD LOOKING QUESTIONS

Assessment Questions

- i. What have we learned from the review of this model that can be applied to future models?
- ii. Are all program parameters appropriate?
- iii. How can service quality be improved?

i. What have we learned from the review of this model that can be applied to future models?

This review underscores that community engagement is a vital aspect of CTS operations. While community engagement has long been considered essential to the effective operation of a CTS, this review highlights that community engagement and communications require ongoing, focused attention and resources. This theme was raised throughout the review process by community members, staff and clients. Without sufficient attention to community engagement, there is risk of eroded trust and broken relationships, which act as barriers to communication, learning, and understanding. The concerns of community members, as well as the benefits that the CTS at 955 Queen Street East has had on the health and well-being of its clients, are not as easily acknowledged in a hostile climate. Future models should ensure effective processes and allocate sufficient resources to ensure trust and relationships with surrounding communities can be fostered and maintained.

The review team found that two-way sharing of information between the CTS and the community is necessary for ensuring ongoing, robust communication with community members. There is room for improvement in how community engagement activities are reported to the Ministry, including the addition of specific community-relevant indicators. Examples of community engagement indicators include the number or percentage of community members participating in CTS decision-making processes or committees and the number of volunteer hours contributed by community members to CTS initiatives or projects. Moreover, a CTS within close proximity to child-care facilities, parks, and public spaces, requires clear mechanisms for community consultation and engagement focused on children's needs as well as potential plans to enhance these mechanisms as soon as the need should arise.

The review team considered that some concerns mentioned frequently by community members would exist even if the CTS did not operate in the neighbourhood. For example, many concerns are related to the lack of stable housing, including public drug use, visibility of people with mental illnesses, and a lack of easy access to restrooms. Such issues are not specific to CTS clients, but are common among people experiencing poverty and other forms of marginalization.

The review team found that there is opportunity for improvements in government funding and oversight, including clarity around inspections: specifying the level of government responsible for collecting and reviewing community feedback and concerns, communicating the results of inspections to the public, and the detailed results of inspections to CTS.

The review team found that additional requirements added to CTS applications around risk assessment and mitigation strategies would be helpful, and that annual reporting on risk should be incorporated into CTS annual reports.

The review team found that the security needs associated with a CTS should be thoughtfully considered and properly funded to address the safety and security of both, community members and CTS clients. The team found that, as CTS provide for a highly stigmatized and underserved population, a slightly different approach to needs might be required in some instances. For example, a uniformed security guard in hospital might create a feeling of safety amongst the general hospital population, while the same uniformed security guard in a CTS may be more likely to trigger negative emotions like fear amongst CTS clients. For any contracted security or alternative security company, mechanisms should be in place to evaluate how responsibilities are carried out and whether the response of these teams to both CTS clients and community members is appropriate.

While some recommendations presented in this report are specific to wages and benefits for CTS staff, several of the recommendations in this report are contingent upon CTS retaining their staff. The review team found that the issue of staff retention came up frequently during the review process and must be addressed in planning future models.

As the street drug composition and toxicity change, and so too the needs of the people who use drugs, the review team found that the collective response of CTS must be more timely. People who use drugs have been increasingly turning toward inhalation of substances, which is still not supported by most CTS in the province. People are therefore increasingly forced to forego the use of these helpful services, or staff may feel compelled to supervise use outside the site.

ii. Are all program parameters appropriate?

The review team found that the parameters within which the CTS operates are reasonable and appropriate. The team also found that there is opportunity to strengthen some of these parameters and has presented recommendations accordingly.

iii. How can service quality be improved?

The centering of CTS clients and their needs is a commendation to SRCHC that should not be understated. In a society that has historically dismissed and harmed people who use substances, and additionally, in a neighborhood that is rapidly changing, South Riverdale's CTS, and the broader CHC within which it operates, represent a necessary safe space for some of the area's more marginalized individuals.

During site visits, several suggestions were made by CTS staff to improve service quality and increase client comfort. For example, staff suggested adding booths to reach more people at a time, and assigning dedicated space for socialization inside the building, both of which could also help address loitering outside the space. They suggested that overall, the space be made more comfortable for clients, with booths facing inward instead of toward a wall, and that this would also make supervision easier, a full shower instead of a foot wash, as people inject into various areas of the body. Importantly, staff clearly and regularly described a need to support clients who inhale drugs.

The review team found that increasing hours of operation would improve service access, especially outside of standard working hours, which further promotes clients entering the workforce and maintaining steady hours. This would also allow people to use inside the site more and away from the public eye.

RECOMMENDATIONS

SERVICE PROVISION

1. Recommendation: The review team recommends that SRCHC conduct annual, voluntary surveys of CTS clients to better understand the demographics of their clientele and where they live.
2. Recommendation: The review team recommends that SRCHC open its CTS in accordance with the hours specified in the Transfer Payment Agreement, which would include ensuring that the CTS is open on Saturdays and Sundays. Alternatively, the Transfer Payment Agreement should be revised to reflect the hours the CTS is open.

SAFETY & SECURITY

3. Recommendation: The review team recommends that SRCHC hire a licensed security company that can provide licensed security guards with appropriate training who can respond to the internal and external needs of SRCHC.
4. Recommendation: The review team recommends that SRCHC develop and document a plan for cameras:
 - in a maintenance procedure to ensure cameras are recording properly, pointed correctly and cleaned where appropriate.
 - in yearly reviews of camera locations, comparing to incident locations to ensure appropriate coverage of high incident areas.
 - to standardize camera retention so that all cameras are recording for 60 days for consistency.
5. Recommendation: The review team recommends that SRCHC review signage to ensure compliance with the Privacy Commissioners Guidelines on Surveillance from 2015 [2015 Guidelines Surveillance.pdf \(ipc.on.ca\)](https://www.ipc.on.ca/2015-Guidelines-Surveillance.pdf). SRCHC should maintain a list of all cameras noting the views and purpose of the camera. Signage wording should change to avoid stating that there is 24hr surveillance and to include the site phone number and contact for inquiries regarding the cameras. This information should be shared with the community in an effort to discourage community members from filming CTS clients.
6. Recommendation: The review team recommends that SRCHC develop standard operating procedures for staff of contractors (e.g., security services). Procedures should

include but not be limited to hours of work, procedure for reporting for work and departing from work, role expectations, instructions on responding to incidents on SRCHC property and in the community, with specific instructions on reporting of criminal activity on both SRCHC property and adjacent areas.

7. Recommendation: The review team recommends that SRCHC ensure surveillance policy clearly states how video is to be released for requests from Toronto Police Services or through a Freedom of Information request. SRCHC should consider adding a release form in relation to this to the current surveillance policy. The form should outline who the requester is, under what authority the video is being released, and names/signatures of the requester and the staff member releasing the video.
8. Recommendation: The review team recommends that SRCHC develop a policy to have security staff escort staff to their vehicle and or the closest transit stop. Organizations refer to such a policy as “Safe Walk” and implement it when a staff member feels threatened by a patient, client, partner or a member of the community.
9. Recommendation: The review team recommends that SRCHC establish communication and escalation protocols with key contacts at Toronto Police Service 55 Division, which SRCHC leaders, front line staff and security staff can use when necessary.
10. Recommendation: The review team recommends that SRCHC schedule regular, documented meetings with key contacts from Toronto Police Services, 55 Division. Meetings should take place at least quarterly, be attended by key decision-making leaders from SRCHC, Toronto Police Services, and any security contractors. Meetings should have set agendas and minutes should be recorded.
11. Recommendation: The review team recommends that SRCHC provide live video feed to CTS staff so that clients leaving the CTS can be monitored to ensure they depart safely and do not loiter after using the service. Radio communication can be used between CTS staff and security staff to ensure proper monitoring of clients on the 1st floor and on the immediate exterior of the building. This feed can also be used to monitor clients waiting to enter the CTS.
12. Recommendation: The review team recommends that SRCHC remove the majority of benches on the north side of the building, leaving one bench for people who need to sit while waiting for transportation. The review team also recommends that SRCHC change the remaining seating to prevent persons from laying across the benches, post appropriate signage to discourage loitering and advise persons that seats are reserved for persons awaiting transportation. SRCHC should have contracted staff or SRCHC staff enforce appropriate usage of the bench.
13. Recommendation: The review team recommends that SRCHC require proof of training on de-escalation, crisis intervention, overdose response, and communication (with

internal stakeholders and emergency services) for all staff for whom this would be relevant, including staff of contractors.

14. Recommendation: The review team recommends that SRCHC conduct a contract review with currently contracted companies to ensure they are meeting the terms of their current contracts.
15. Recommendation: The review team recommends that SRCHC schedule hours of security staff to reflect the hours of the centre. Best practices indicate that security guards be present one half hour prior to the arrival of the first staff member/patient/client to do a safety check of all external areas including entrances and parking lot. Security should be scheduled to depart after all other staff have departed to ensure their safety. SRCHC should verify that security or other contracted staff are present during the hours outlined in their contract.

COMMUNITY ENGAGEMENT

16. Recommendation: The review team recommends that SRCHC designate an individual who is responsible for intake of and initial response to all community concerns. The review team recommends that SRCHC make the name and contact information of the designated individual clear to the community.
17. Recommendation: The review team recommends that SRCHC further explore opportunities to collaborate on communications with other CHCs, particularly those that operate a CTS.
18. Recommendation: The review team recommends that SRCHC regularly report relevant indicators to community members. The complete set of indicators should be selected as part of the community consultation, but possible indicators can include the number of clients served at the SRCHC, the number of visits to the CTS, the total number of overdoses within the CTS and the number of overdoses requiring naloxone, and the number of new staff hired. These indicators should be updated and posted to the SRCHC website on a regular basis.
19. Recommendation: The review team recommends that SRCHC develop a formal crisis communication strategy framework and align this with corporate crisis response plans based on learnings from this experience. This would ensure there is a pre-established process and tools in place to effectively deal with an emergency. Timely communication will help maintain transparency, reduce misinformation, provide guidance and information to the centre's key stakeholder groups and mitigate impacts that can erode public trust. As part of this crisis communication plan, the centre should have at least two designated spokespersons media trained so that there is good support and coverage in place for this key role during prolonged events.

20. Recommendation: The review team recommends that SRCHC review and redesign the centre's external communication strategy with community members. Communication should include information and updates about the CHC and the CTS. Community members should include, but are not limited to: CTS clients, SRCHC general clients, residents (with a focus on residents with children), local businesses, local employees, local schools, and daycares. Other sources of data regarding community input should be included as available, such as public health and health services data and crime data. When engaging with residents, community consultations should ensure that residents who are in especially close proximity to the CTS, who may have distinct concerns, are included in all consultations. Consultations should also aim to capture a diversity of residents with regard to socio-economic characteristics (in particular, income/wealth, ethno-racial group, and Indigeneity) and duration of residence in the neighborhood.
21. Recommendation: The review team recommends that SRCHC codify its community consultation processes in a document that clearly defines roles within SRCHC for addressing community concerns, responsibilities of people in these roles, expectations about reporting, and mechanisms to address accountability.
22. Recommendation: The review team recommends that SRCHC clearly define roles and responsibilities for communications. Reorganization could include:
- A senior corporate communications role that would provide strategic support, alignment and advice for SRCHC's senior leadership team and community engagement functions; support East Toronto Health Partners Ontario Health Team work; coordinate with externally contracted communication resources; lead the production of the annual report/newsletters.
 - A communications role to support projects that align to the centre's key areas of focus, as well as a content producer, so materials can be used on multiple channels (web, newsletters, social media, etc.).
 - A community events/health promotions role that supports the programs in the community. This could have a fundraising lens as well.
23. Recommendation: The review team recommends that SRCHC ensure clear communication objectives and include: explaining the reasons for change; addressing skepticism about why and how changes are made; and demonstrating how the changes are responsive to identified needs.

HUMAN RESOURCES

24. Recommendation: The review team recommends that SRCHC hire an expert in occupational health and safety within the HR team who would report to the HR Manager for overall accountability for health and safety and to integrate workplace safety and security efforts.

25. Recommendation: The review team recommends SRCHC review its employee benefits program to provide full-time and part-time staff with robust psychological/mental health support at a level that would enable full coverage per appointment up to a defined annual maximum (currently capping coverage to \$20.00 per visit/ \$300 annually).
26. Recommendation: The review team recommends that SRCHC undertake a formal compensation benchmarking exercise to establish alignment of SRCHC compensation with peer organizations and to make adjustments as required, including through collective bargaining if necessary.
27. Recommendation: The review team recommends that SRCHC require staff to sign off on training provided around Emergency Codes. SRCHC should consider having Emergency Code training available online for all staff.
28. Recommendation: The review team recommends that SRCHC review lockdown policy with all staff on yearly basis and include it in orientation for all new staff prior to starting work. The review team recommends that SRCHC keep records of all training completed.
29. Recommendation: The review team recommends that SRCHC amend the Police Check Policy to:
 - i. require all employees to complete a criminal check prior to start date (remove current exclusions/discretion); SRCHC should pay for these criminal checks.
 - ii. include a formal process and decision-making criteria for reviewing situations where employees have police records
 - iii. include a clear policy statement that having a criminal record does not, in and of itself, disqualify someone from employment.
 - iv. require checks provided on engagement to have been done in preceding 6 months (decrease from 12 months) to reflect more common standard;
 - v. clarify what constitutes a “change post-hire that requires notification to SRCHC” (for example, being charged with any offence) and address the associated timelines for disclosure and review process.
30. Recommendation: The review team recommends that SRCHC review the practice of allowing employees to attend to clients outside of the physical building. Some recommendations for staff safety when they attend to emergencies outside of the building could include a clear program of hazard mitigations developed to protect the worker (e.g., respond in pairs, carry an emergency alarm, security accompaniment, use of mobile devices, etc.).

31. Recommendation: The review team recommends that SRCHC implement a more formal and proactive monitoring plan for all staff to identify as individuals who may be experiencing stress/trauma.
32. Recommendation: The review team recommends that SRCHC develop an employee *Fitness for Work (Substance Use)* policy for the organization that outlines expectations with respect to the workplace, resources for external supports and how breaches of the policy will be investigated/addressed, including how the organization will meet any required accommodation needs of staff experiencing substance use challenges.
33. Recommendation: The review team recommends that SRCHC formalize an anonymous reporting procedure where concerns can be shared directly with senior leadership. This procedure, including information on how concerns will be investigated/addressed should be communicated and accessible to staff and it should be clear that this reporting mechanism is not a substitute for addressing harassment, discrimination and employment-related grievances that already have formal procedures in place.

CRITICAL INCIDENTS / SERIOUS EVENTS

34. Recommendation: The review team recommends that SRCHC clearly define what constitutes a serious event where there is an immediate internal or external threat to the safety/security of SRCHC clients and staff and requires an urgent response. Additionally, SRCHC should review all policies, procedures and emergency response frameworks to ensure they reflect the organizational definition of a serious event or emergency.
35. Recommendation: The review team recommends that SRCHC assign an individual on the management team with the functions of identifying, documenting and monitoring the mitigation of all risks, and managing the risk register.
36. Recommendation: The review team recommends that SRCHC prioritize the development, communication and simulation testing of a formal Code Silver (Weapons/Active Attacker) protocol including lock down procedures and it is recommended that this be developed with the support of external expert resources in security and workplace violence.
37. Recommendation: The review team recommends that SRCHC develop structured code/emergency response protocols with clear escalation (that includes calling 911 when appropriate to do so) and specific job action sheets.

Additionally, SRCHC should conduct mock code exercises at all SRCHC sites including the CTS sites and these should be tested annually with a focus on Code White, Code Silver, and lockdown.

38. Recommendation: The review team recommends that SRCHC develop a clear policy and guidelines to indicate when key stakeholders should be notified of serious events including which roles are accountable and expected timelines for notification. The formalized escalation process should be documented as part of the code/emergency response for notifying leadership, funding partners and Health Canada of serious events where appropriate.
39. Recommendation: The review team recommends that SRCHC consider modifying the panic buttons in the CTS at 955 Queen Street East to be routed so that they communicate into an internal person to ensure timely communication and response to a threatening situation.
40. Recommendation: The review team recommends that SRCHC implement post event debriefs and formalize response for areas of improvement and lessons learned that includes plan to address findings.

FUNDING

41. Recommendation: The review team recommends that the Ministry of Health allow CTS sites more flexibility in how they use funds. The review team recognizes that the implementation of some of the recommendations in this report may require additional resources that SRCHC does not currently have.

FORWARD-LOOKING QUESTIONS RECOMMENDATIONS

42. Recommendation: The review team recommends that the Ministry of Health develop a set of criteria that can be used to consider and approve applications for supervised inhalation spaces in proposed and funded consumption and treatment services in Ontario.
43. Recommendation: The review team recommends that the Ministry of Health clarify, in partnership with people with lived experience of drug use and the organizations that provide services, what is expected of CTS sites with respect to the requirements to employ persons with lived experience of substance use and the specific functions they fulfill.

44. Recommendation: The review team recommends that SRCHC develop a specific plan and action steps to determine how the CTS intends to comply with the MOH requirement to include peer support/persons with lived experience of substance use in the staffing model in the short and long term. Additionally, where dedicated roles exist, SRCHC should update job descriptions/postings and interview guides for roles designated for persons with lived experience to incorporate recognized peer support competencies and consider supporting specialized peer support training.
45. Recommendation: The review team recommends that all municipal, provincial, and federal inspections of the CTS include clear communication by the inspecting body to the CTS, especially with respect to opportunities for improvement.
46. Recommendation: The review team recommends that the Ministry of Health incorporate specific requirements around community concerns into the monthly provincial reports submitted by the CTS. These can include details such as the number of complaints, the nature of the complaints, how the complaints were brought to the attention of SRCHC, the time to initial response and any necessary follow-up, and specifics about how the complaints were addressed.
47. Recommendation: The review team recommends that the Ministry of Health require all CTS applications to complete a risk assessment with mitigation strategies prior to formal approval of a CTS application.
48. Recommendation: The review team recommends that the Ministry of Health incorporate into the CTS annual reports a requirement that all CTS programs provide an annual report on their risk register and mitigation plan.

APPENDICES

Appendix A – Terms of Reference of the Review

The review team assessed the services and operation of South Riverdale Community Health Center's Consumption and Treatment Service. The team developed its own work plan to generate a written review by addressing the following parameters and questions set by the Ministry of Health.

Assessment Parameters

1. Assess whether services are provided as expected in accordance with the CTS Program Application Guide and the CTS Transfer Payment Agreement.
2. Assess whether there is sufficient oversight of consumption and treatment services to ensure health service quality and program success based on the review questions below, at minimum, and, where appropriate, identify recommendations for improvement.
3. Assess responsiveness to local community concerns (including any school related concerns).
4. Assess the suitability of maintaining CTS funding for the site.
5. Assess the general suitability for CTS to be integrated within community health centres.

Assessment Questions

Access

- Where do clients come from?
- How many clients are being served?
- Are clients having to wait for services or being turned away?
- What measures are taken to promote equitable access?

Referral pathways to wrap-around services

- Are clients connected to appropriate wrap-around services?

- Are there opportunities for improvement with partnerships to strengthen wrap-around services for CTS clients?

Integrated services

- Is the service setting appropriate to meet the CTS client and community needs?

Safety and Security

- Are safety and security measures sufficient for staff, clients and the community?
- How is the organization responding to community safety concerns (including any school related concerns)?

Community engagement

- How can community engagement and communications strategies be strengthened?
- Is the process for responding to community concerns or complaints effective and responsive?

Human resources

- How can hiring and retention practices be improved?
- Is existing training for staff sufficient?

Critical incidents

- Are appropriate measures in place to respond to critical incidents?
- Is an appropriate definition of “critical incidents” being used?
- Are appropriate measures in place for notifying the leadership of the organization, funding partners and Health Canada of critical incidents (as appropriate)?

Funding

- Are CTS program funding requirements being met?
- How can existing CTS site funding be optimized to ensure the right services are available in the right place at the right time?

Forward looking questions

- What have we learned from the assessment of this model that can be applied to future models?
- Are all program parameters appropriate?
- How can service quality be improved?

Appendix B – Site Visit Information

DATE/TIME SPENT	VISITORS	VISIT AGENDA	SRCHC STAFF
October 23 rd , 2023 1 hour	Sabrina Divell	Initial meeting about communications and timeline of events	CEO, VP Strategy and Systems, and Communications manager
October 26 th , 2023 2 hours	Irfan Dhalla, Nicole Kirwan, Kelly Sequeira	Meet SRCHC leadership and CTS staff, general introductions, tour inside/outside facility	CEO, VP Strategy and Systems, Director Mental Health and Substance Use, other CTS staff
October 30 th , 2023 2 hours	Sabrina Divell, Danielle Pereira	Communication processes	Communications manager
November 2 nd , 2023 1 hour	Irfan Dhalla, Jill Campbell	Discussion on how the reviewers and supervisor will work together	CEO
November 31 th , 2023 1.5 hours	Paul Greenwood	Walk-around of site	
December 1 st , 2023 2 hours	Manson Locke, Liz Hill, Cheryl Croutch	Discussion of HR, occupational health & safety, relationship development	HR personnel
December 5 th , 2023 2 hours	Uzma Ahmed, Michelle Firestone, Cathy Long	Community consultation with CHC clients	CHC staff
December 13 th , 2023 2 hours	Uzma Ahmed, Michelle Firestone	Community consultation with CTS clients	Program Manager Mental Health and Substance Use

December 15 th , 2023 1 hour	Nicole Kirwan, Kelly Sequeira	Discussion on CTS operations, management	Director Mental Health and Substance Use, Program Manager Mental Health and Substance Use
December 21 st , 2023 1 hour	Nicole Kirwan, Kelly Sequeira	Discussion on CTS operations, frontline	Registered Nurse, Community Health Worker, Overdose Prevention Worker
January 9 th , 2024 1 hour	Manson Locke, Liz Hill	HR discussion	HR personnel

Appendix C – Document Review

TITLE/DOCUMENT	AUTHOR	DATE
BACKGROUND and GOVERNANCE		
Health Canada Controlled Drugs and Substances Exemption Application narrative	SRCHC	Dec 2016
Staff report – Implementing Supervised Injection Services in Toronto	Toronto Public Health	June 16, 2016
Letters of Support	Liberty Prep School, Woodgreen, Inner City Health Associates	Dec 2018
CTS Application Guide	Ministry of Health and Long Term Care	Oct 2018
Transfer Payment Agreement	Ontario Minister of Health and SRCHC	Jul 2019
Governance Policies	SRCHC	June 2022
Consumption and Treatment Services Compliance and Enforcement Protocol	Ministry of Health	October 2022
SRCHC CTS Annual Program Report	SRCHC	March 2023
SRCHC Monthly reports to MOH	SRCHC, Ministry of Health	Jan 2022-Sept 2023
Inspection Report	Toronto Public Health	May 2023, October 2023
Compliance Verification Visit Follow-up Email	Health Canada	Oct 2023
Controlled Drugs and Substances Act	Health Canada	1996, last amended Nov 2023
OPERATIONAL		
SRCHC Organization Policies	SRCHC	Updated Aug 2023
CTS Organizational Policies	SRCHC	September 2021
CTS Clinical Policies	SRCHC	September 2021
Drug Splitting and Sharing Policy	SRCHC	November 2021
Client Rights and Responsibilities Policy	SRCHC	September 2022
CTS Budgets and Spending	SRCHC, Ministry of Health	Fiscal year 2020-21, 2021-22, 2022-23, 2023
Communications & Community Engagement		
KeepSix CTS Community Consultations & Engagement plans	SRCHC	Sept 2021

Community Liaison Committee Terms of Reference	SRCHC	Dec 2022, Jan 2024
Community Liaison Committee Meeting Minutes	SRCHC	Jan 2022 – Dec 2023
Residents Group Meeting Minutes	Residents group	June 2021 – Oct 2023
Leslieville Town Hall slide deck and meeting minutes	Town hall organizers	July 2023
Heward, Pape, Boston avenues Activity Capture	Community residents	July 2023
Safer Community Committee Terms of Reference	SRCHC	Sept 2023
Safer Community Committee Resignation	Businesses and Residents	Oct 2023
Safer Community Committee Final Report	SCC	Oct 2023
Community Safety Issues in Leslieville	Public Progress	Sept 2023
Leslieville Neighbours Community Safety Group Meeting Minutes	Residents group	Oct 2023 – Dec 2023
CTSreview emails (151 emails)	Community members	October 2023 – February 2024
Leslieville Harm Reduction Coalition Letter of Support	Leslieville Harm Reduction Coalition	October 2023
Media Review	Various	July 2023 – Feb 2024
Communications Plan 2022-2025	SRCHC	Received November 2023
Communications Policies 2023	SRCHC	Received November 2023
Community Feedback Report	SRCHC	November 2023
KeepSix Program Data Summary	SRCHC	Sept 2023
'How To' Guide for Collecting Drug Samples	Toronto's Drug Checking Service	Feb 2022
Incident Report Logs	SRCHC	2022 – 2023
Client Education documents	SRCHC	
KeepSix Users Rights and Responsibilities	SRCHC	2023
Human Resources		
Job Postings (Director, Substance Use Mental Health; CTS Program Manager; RN CTS; Community Health Worker; Overdose Response Worker)	SRCHC	2019-2023
Job Descriptions (Director, Substance Use Mental Health; Manager Harm Reduction & Hepatitis C; Program Manager CTS; RPIC & ARPIC; RN CTS; Community Health Worker; Overdose Response Worker)	SRCHC	2021-2023

Interview Guides (Director, Substance Use Mental Health; Program Manager CTS; Program Manager Substance Use Mental Health; RN CTS; Community Health Worker ;Overdose Response Worker)	SRCHC	2019-2023
Reference Check Template	SRCHC	Received October 2023
New Employee Orientation Sign-Off	SRCHC	Received October 2023
KeepSix Orientation and Training Checklist	SRCHC	Received October 2023
List of Mandatory Courses for Employees	SRCHC	Compiled October 2023
Cross-organizational Training	SRCHC	January 2022-July 2023
KeepSix Training Log	SRCHC	October 2023
Performance Review Forms (Bargaining and Non-Bargaining Units)	SRCHC	October 2022
Letters of Offer Template (Bargaining and Non-Bargaining Units)	SRCHC	Received October 2023
KeepSix CTS RN Availability	SRCHC	January 2022 – October 2023
Safety & Security		
Access and Security Policy	SRCHC	September 2021
Police Check Policy	SRCHC	July 2022
De-escalating Disruptive Behaviour and Crisis Response policy	SRCHC	December 2022
One Community Solutions and SRCHC Proposal	One Community Solutions	July 2023
One Community Solutions Service Agreement	One Community Solutions	July 2023
Crime Prevention Through Environmental Design (CPTED)	Toronto Police Services	July 2023
Incident Response Summary Report	SRCHC	August 2023
Procedure to Discourage Loitering	SRCHC	Revised August 2023
CTS Safety and Security Updates and Checklist	SRCHC	Oct 2023
Risk Mitigation		
SRCHC Risk Management Framework 2022-2024	SRCHC	November 2022
Operational Monitoring Report FY 22/23 Q2 and Risk Management Framework	SRCHC	December 2022
Incident Report Log	SRCHC	April 2023-March 2024
Occupational Health and Safety Summary Report	SRCHC	June 2023

CCA Accreditation Review	Canadian Centre for Accreditation	July 2023
Incident/Accident Reporting Form	SRCHC	July 2023
Code Response	SRCHC	Received Dec 2023

Appendix D – Review Team Members

1. Uzma Ahmed
2. Ahmed Bayoumi
3. Cheryl Croutch
4. Irfan Dhalla
5. Sabrina Divell
6. Michelle Firestone
7. Paul Greenwood
8. Elizabeth Hill
9. Monica Jacobs
10. Nicole Kirwan
11. Manson Locke
12. Hayley Mick
13. Cathy O'Neill
14. Danielle Pereira
15. Kelly Sequeira

Appendix E – Code Silver Infographic

CODE SILVER - ACTIVE ATTACKER: A QUICK GUIDE		
ACTION	Near Attacker	Away from Attacker
RUN 	- Know your work area, familiarize yourself with the safest and fastest escape route. RUN and help others only if safe to do so. Don't be delayed by those refusing to leave. - Do NOT RUN towards the sound of gunfire or any other violent disturbance. - Leave all belongings behind. - Remain calm.	- Avoid the affected area and run to a safe location. - If you choose to stay, barricade the doors and HIDE. Follow the HIDE guidance. - Remain calm.
HIDE 	- If you cannot safely run away from the assailant, quickly HIDE and secure all doors behind you. - Barricade the doors with furniture, work as a team if possible. - Turn off all electronics and be silent. - Stay away from windows. - Do not compromise your location until you hear a "CODE SILVER-ALL CLEAR"	- Secure your unit and move any patients into rooms that can be secured. - Finish all procedures and stabilize the patients. - Block all doors, turn off the lights, cell phones and pagers. Do not make any noise. - Remain away from windows and public view.
DEFEND 	- As a last resort, and only if your life is in imminent danger, improvise weapons and try to distract and incapacitate the attacker. - Work in a team to overpower and overwhelm the attacker. - Commit to your actions! You are fighting for your life right now.	This is only a last resort and applies to a situation where you are in grave and immediate danger. Every attempt to RUN or HIDE should be made in an Active Attacker situation.

Community Engagement Report

Companion Document to South Riverdale Community Health Centre Consumption and Treatment Service Review

Prepared by Unity Health Toronto

FEBRUARY 28th, 2024

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SUMMARY

The Ministry of Health requested Unity Health Toronto to complete a review of the Consumption and Treatment Service (CTS) at 955 Queen Street East, operated by the South Riverdale Community Health Centre (SRCHC) following the fatal shooting of Karolina Huebner-Makurat that occurred outside the facility on July 7, 2023. That review addressed a set of assessment questions and parameters determined by the Ministry of Health and has been submitted as a separate report.

This document is a companion report to the main document; it focuses on what the review team heard during the community engagement to provide an understanding of community concerns, ensure that these concerns are highlighted, and present suggestions from community members regarding CTS operations. Some of the concerns heard by the review team fell outside of the questions and parameters set for the external review of CTS operations at 955 Queen Street East.

The data for this companion report comes from community consultation groups, (families, residents, businesses, local employees), interviews (daycares, schools), an online form and a review of relevant documents.

It is important to recognize that the recruitment and selection method could not ensure that the people the review team heard from are representative of all the people in the community or of the groups they represent. Of the 68 people interviewed in-depth by the review team, only 13 identified as clients of the CTS who use drugs. The methods also cannot ensure that the review team heard from all people who wanted to speak about the CTS.

The review team heard there was widespread understanding that the CTS offers a space for people to inject unregulated drugs and some harm reduction services, but less understanding of the full range of services offered at the CTS and SRCHC. The review team heard divergent perceptions about whether people who use drugs benefit from the CTS. CTS clients strongly valued the services that they received.

Many respondents expressed security and safety concerns including harassment, assault, vandalism, theft, public drug use, public sex, substances, drug equipment, waste (including condoms and excrement), and other garbage being discarded or deposited in public places and on private property and other concerning and aggressive behaviours. Many respondents were especially concerned about the effect of such events and exposures on children. Frequently, respondents were concerned about drug selling near the CTS. Many ascribed their increasing concerns to CTS management practices. A few respondents felt that the CTS increased community safety. CTS clients felt that their own safety has been compromised by surveillance and bullying from some community members.

Respondents reported changes to the CTS after the fatal shooting, including earlier opening hours, a new fence, new planters in front of the entrance, new security personnel, increased policing, more community safety officers, and new communication updates from the SRCHC

website. While many respondents welcomed these responses, others were skeptical that they were meaningful or effective. Others viewed the construction of the fence as a loss of public space for the neighbourhood. SRCHC clients mostly felt safer using the facilities following the changes.

Many respondents expressed frustration about the level of communication and types of communication from the SRCHC and emphasized that there was no effective process to raise concerns or file complaints, and that the website was not helpful for transmitting information. Other respondents noted that there was no meaningful change to operations after they raised concerns. Daycare and school officials suggested that communication could be improved by dispelling myths about the site. A minority viewed the SRCHC and board as open to feedback and welcoming. Most respondents who had reached out to governments or public health officials expressed frustration with the responses. Some valued the increased police presence in the neighbourhood.

Most respondents described a sense of mistrust that stems from what they experience as SRCHC's lack of transparency, complacency, and inaction with respect to crime and safety. For many who live or work in the neighbourhood, the relationship with SRCHC was positive before the opening of the CTS in 2016, which many supported. Many respondents described a change after the onset of the COVID-19 pandemic and now perceive a lack of accountability, a lack of monitoring, and an ineffective governance structure. Many respondents described an adversarial dynamic between some community members and SRCHC. Residents who support the CTS described an imbalance between their experiences and what they perceived as a small group of neighbors who are 'aggressively' voicing their concerns and dominating the narrative about the CTS.

Respondents suggested a number of changes. These are distinct from Unity Health's recommendations, which are described in a separate report.

Respondents wanted to see the following changes:

1. Most respondents felt strongly that the CTS at SRCHC should be closed or moved to a different location. However, clients of SRCHC and clients of the CTS did not want the CTS to close or move.
2. Many respondents wanted a complete restructuring of SRCHC management and the SRCHC Board of Directors, including replacing current management and leadership and establishing a distinct management structure for the CTS.
3. Many respondents provided suggestions for improved communication, including dedicated communications staff, a hotline, collaboration with schools and daycares, and public education.
4. Respondents suggested a range of community safety policies, including stopping public drug selling, tracking needles that are distributed (or discontinuing distribution), addressing safe disposal of injection equipment, security personnel, and policing. Some

respondents recommended a decreased police presence and training people in community liaison skills to address conflict.

5. Nearly all respondents wanted extended CTS hours with enhanced community outreach, with a focus on reducing people loitering outside of the CTS. Some respondents advocated for supervised smoking or inhalation of drugs within the CTS. All groups emphasized the need for more staff training and support, although the review team heard divergent opinions about hiring staff with lived experience of drug use.

INTRODUCTION

Supervised Consumption Services (SCS) refers to environments where people use drugs while observed by trained personnel, where sterile supplies are available, and where overdoses can be immediately treated. Supervised injection and supervised smoking or inhalation are types of supervised consumption. In 2018, The Ontario Ministry of Health (MOH) adopted the Consumption and Treatment Services (CTS) model, which requires provincially funded SCS in Ontario to provide a wide range of supports and services, known as wraparound services.

In late 2023, the Ministry of Health appointed Jill Campbell as a supervisor of the CTS at South Riverdale, and also asked Unity Health Toronto to conduct an external review as a means of identifying opportunities for improvement. The review addressed a set of assessment questions and parameters determined by the Ministry of Health. Unity Health Toronto assembled a review team and conducted its external review from October 2023 to February 2024. The review team's conclusions related to the questions and parameters are outlined in a separate report.

While completing the report, the review team collected a wealth of data from community members. While much of this information directly informs the mandate of the Ministry review, the review team felt that a companion report was needed for three reasons. First, much of what the review team heard is nuanced and sometimes contested. Such information benefits from more elaborate discussion. Second, many of the concerns that the review team heard address issues that are outside of the mandate of the Ministry review but are fundamental for deciding how CTS should operate. When completing the consultation, many of the people with whom the review team communicated told the team emphatically that they felt that their concerns and issues had not been sufficiently heard by decision makers. They hoped the consultation sessions would help to address that oversight. The review team's aim is to express those voices within this report. Third, some of the people with whom the review team communicated had suggestions about how the CTS should operate, some of which are outside of the Ministry review's scope and others which may disagree with the review team's recommendations. The review team also aims to present these suggestions as faithfully as possible. The review team believes that a comprehensive and transparent discussion of issues related to the CTS is critical for meaningful community consultation, enhanced community safety, effective CTS operation, and improved health and well-being of people who use drugs.

METHODS

The Community Engagement used a diverse range of methods, including community consultation groups, interviews, an online form, and a broad review of relevant documents. Each of these are described below.

Community Consultation Groups

Stakeholders and Recruitment

The review team identified seven types of stakeholders. The team engaged with most stakeholders in a group format except for participants from local daycares and schools, whom the team interviewed individually. Each participant was offered an honorarium for their time (\$60 for 2-hour group meetings, \$30 for 1-hour individual interviews). Participants were given the option to waive or decline the honoraria. Each stakeholder type and the recruitment process is described below:

1. Clients who access the CTS: The team followed the SRCHC recommendation to invite members of the Community Advisory Board and other clients who regularly attend the CTS.
2. Clients who access general CHC services (not targeted to people who use substances): The review team worked with SRCHC staff to recruit clients. SRCHC staff invited members of a Tai Chi Group and other CHC programs.
3. Neighbourhood residents: The team recruited through an online form that was linked from the SRCHC website. The link went live on November 15, 2023. The team asked individuals to self-identify as living or working in the neighbourhood and to provide a home or employment address.
4. Neighbourhood families: The review team asked participants to indicate if they had specific concerns about families in the neighbourhood and if they preferred, if possible, to attend a consultation group that focused on families.
5. Neighbourhood business owners and employees: The review team sent the link to the online form was the Leslieville Business Improvement Association and asked them to share the form with their contacts. The review team included a question about whether respondents owned a business or worked in the neighbourhood. To verify that respondents belonged in this group, the review team sent emails to confirm the name of the business or role of the employee.
6. Local daycares: The review team contacted daycare administrators by phone and email.
7. Local schools: The review team contacted school administrators by phone and email.

Selection

To engage with stakeholder groups 1-5, the review team conducted six separate two-hour group consultations. To recruit group participants, the review team published a registration form on the SHCRC website, because it is a known resource for community members for events related to SRCHC.

The review team received 88 responses to the registration form and excluded responses with unverified phone numbers and businesses that were not verified. The review team randomly selected 15 respondents in each group to receive invitations. If respondents were unable to attend, the review team extended the invitations to additional respondents.

Concerned Neighbours Consultation Group

The engagement team created an additional group to hear directly from a group of neighbours who have previously worked together to express their concerns in several forums. The review team worked with neighbourhood leaders to identify participants and held this consultation group on January 15, 2024.

Online form

To hear from people who could not attend or could not be accommodated in a consultation group or who had not applied to be in a group but still wanted to contribute, the review team created an online form for people to contribute to the review. The form was open for input from December 15, 2023 to January 17, 2024. Please see appendix B for the online form.

Document Review

The review team included several written data sources including: all emails and attachments that were sent to the general review team email address; a media search of news articles published about the CTS at SRCHC since July 7, 2023; and results of a previous door-to-door survey conducted by Public Progress in September 2023.

Analysis

Consultation meetings and interviews were facilitated by members of the review team. The team transcribed and coded all consultations and interviews and consolidated data into key themes.

LIMITATIONS

While the review team's approach strived to be comprehensive and inclusive of as many viewpoints as possible, this companion report has several limitations. First, the recruitment and selection method could not ensure that the people the review team heard from are representative of all the people in the community or of the groups in the community for whom they speak. For example, there was an under-representation of people living in poverty among those who completed the online form. For this reason, the review team has not attempted to quantify the number or proportion of people who endorsed a particular perspective. The review team has indicated majority and minority opinions throughout, but it is important to keep in mind that these refer to the majority (or minority) of views that were heard, not of the population. Second, while the review team strived to provide multiple opportunities for people to participate, recruiting and selecting participants occurred within a compressed time frame, which may have excluded people who do not readily access the SRCHC website or other forums (such as neighbourhood Facebook pages) or who were not available in December and early January. Third, the review team asked individuals to self-identify as being from the neighbourhood but did not have the capacity to verify that all people who responded lived or worked in Leslieville (this is particularly hard to verify for people who completed the online form). Similarly, the review team did not differentiate responses by proximity of individual residents to the SRCHC. However, many individuals in consultation groups identified where they lived. Finally, the review team conducted consultations in a highly charged and politicized environment. Many people who felt strongly about the CTS, from multiple perspectives, had been advocating and organizing for months prior to the consultations. While it is critical to hear from these advocates, there is always a risk that these voices will be much louder than the voices of people who do not have the same level of organization but have equally important perspectives. The review team's aim was to provide multiple venues for expression so that as many people as possible had an opportunity to be heard.

PARTICIPANTS

The number of participants by data source is indicated in Table 1.

Table 1 Participants by Stakeholder Group

Stakeholder Group	Number of Participants
Clients who access the CTS	13
Clients who access general CHC services	12
Neighbourhood residents	7
Neighbourhood business owners and employees	6
Neighbourhood families	11
Local daycares	3
Local schools	1
Concerned neighbours	15
Online form	141

Of the 173 respondents whom the review team invited to complete the individual characteristics survey, 103 (58.4%) responded. Their characteristics, along with the characteristics of 25 people from the client groups (both CTS and general CHC services) are listed in Table 2. Among respondents who provided information about their characteristics, most were over 40, White, had an annual household income over \$100,000, and had lived in the Leslieville community for at least 10 years. Other ethnoracial groups represented by only a few respondents included Black/African, East Asian, Middle Eastern/North African, South Asian, Southeast Asian, and Latin American. More than 60% of respondents identified as female.

Table 2 Self-reported Characteristics of Participants (total=128)

Question	N (%)
What is your age?	
29 and under	6 (4.7)
30-39	24 (18.8)
40-49	49 (38.3)

Over 50	48 (37.5)
Prefer not to answer	1 (0.8)
Would you say that your gender is:	
Female	81 (63.3)
Male	38 (29.7)
Non-binary/gender non-conforming/other	8 (6.2)
Missing	1 (0.8)
How would you describe your race, ethnicity and/or ancestry?	
White	96 (75.0)
Other	24 (18.8)
Indigenous	2 (1.6)
Multiple ethnicity	6 (4.7)
Which of the following best describes your household annual income?	
Less than \$30,000	4 (3.1)
\$31,000 to \$50,000	6 (4.7)
\$51,000 to \$100,000	23 (18.0)
\$100,000 and over	70 (54.7)
Missing	25 (19.5)
How long have you lived in the Leslieville community?	
Less than 6 months	5 (3.9)
6 months to less than 2 years	4 (3.1)
2 to less than 5 years	17 (13.3)
5 years to less than 10 years	15 (11.7)
More than 10 years	62 (48.4)
Missing	25 (19.5)
How long have you worked in the neighbourhood?	
Less than 2 years	4 (3.1)
2 to 5 years	7 (5.5)
5 to 10 years	7 (5.5)
More than 10 years	13 (10.2)
Not applicable or missing	97 (75.8)
How long have you been accessing services at SRCHC? (only asked of clients)	
6 months to 2 years	1/25 (4.0)
Less than 6 months	3/25 (12.0)
2 to 5 years	6/25 (24.0)
5 to 10 years	6/25 (24.0)
More than 10 years	9/25 (36.0)

Of the 141 respondents who completed the online form, 10 (7.1%) owned a business in the neighbourhood, 40 (28.4%) worked in the neighbourhood, and 91 (64.5%) did not own a business or work in the neighbourhood.

THEMES

Knowledge of services provided at SRCHC

The review team asked respondents what they knew of the services offered both at the CTS specifically, and at SRCHC more generally. The review team also asked what their understanding was of the goals of these services, including harm reduction, and their thoughts about the value of these services and whether the CTS has achieved its goals.

There was near unanimous understanding that the CTS offers a space for people to inject unregulated drugs; while most respondents knew of the CTS for several years, others only became aware of the CTS following the fatal shooting on July 2023. Very many respondents also identified other harm reduction services offered at SRCHC, including needle and syringe programs (although several people labelled these as “exchange” rather than distribution programs and), hepatitis C treatment, naloxone distribution, and drug-specific counselling. Some described clients receiving “travel packs” to facilitate off-site drug use. There was some knowledge of other harm reduction programs including safer supply and drug testing, but few respondents had detailed knowledge of how these operated. Some respondents expressed concerns about the lack of sufficient space within the CTS for people to use after they had consumed drugs; their perception was that this resulted in intoxicated people coming out of the site into the local community.

While most respondents recognized that the CTS provided benefits to its clients, a few felt that there were no benefits to clients, with a minority indicating that they felt that the CTS enabled drug use, were skeptical that overdoses were prevented or reversed or that transmission of blood-borne infections was prevented, and believed that the CTS inhibited people from entering recovery; a few indicated they disagreed with a philosophy of harm reduction. Some believed that the site had become a place to sell drugs or stolen goods with impunity.

More commonly, respondents indicated that they agreed with harm reduction and with being compassionate to people who use drugs and thought that there were benefits to individual CTS clients. However, this group also felt that these benefits (which some respondents stressed were to a small number of people) were disproportionate to community harms from the CTS, a sentiment that was closely linked to concerns about that the CTS was unable to manage the volume of people using its facilities, which led to increased neighbourhood drug use both inside and outside of the site. Many people expressing these sentiments felt that harm reduction must be linked to treatment and recovery programs.

A minority of respondents were very strong advocates of the CTS. They viewed it as life-saving, essential for a large city, and critical for addressing the opioid overdose crisis. Many of these respondents saw benefits both to individual clients, including those who would otherwise use drugs alone, and to the community; they perceived that public drug use would be more prevalent without a CTS and people who use drugs would be in more dangerous situations.

Some respondents recognized that the SRCHC offers a wide range of services to all age groups, with a focus on people experiencing marginalization, including people who do not have documentation or status in Canada, Indigenous people, people who do not otherwise have access to primary care, people living in poverty, immigrants, and people experiencing language barriers (for example Chinese-language programs). Some respondents praised the low-barrier nature of this care. Nevertheless, a significant number of respondents indicated that they had little or no knowledge of other programs offered at SRCHC.

Many respondents listed a variety of services offered to all clients, including both those who use substances and those who do not; these included primary care, mental health care, health education, social work, food and income security programs, referrals to other social services, diabetes care, HIV care, maternal health care, vaccinations, chiropody, and community-outreach programs.

Some respondents felt that there had been a change in services over several years (some people said since the pandemic), moving away from family-oriented services and towards more services oriented to people experiencing marginalization; this was variably attributed to diversion of resources to the CTS and parental fear of bringing children to the centre. Some respondents also felt that the clients who use the CTS have changed over time, which they attributed, at least in part, to post-pandemic stressors. Others strongly believed that CTS clients were not neighbourhood residents but were travelling from other locations to use drugs at the site.

Experiences of using services at SRCHC

The review team asked respondents which services they had used at SRCHC, what their experiences was with the services, and what suggestions they had, if any, for change.

CTS clients valued the care they received at the site, including physician and nursing care, crisis support, and community support. Respondents commented on the “family” feel of the site and a sense that it was the “least hectic” of the Toronto CTSs. Some valued that the staff prioritize their confidentiality, although others expressed mistrust of some staff.

Among clients who access general SRCHC services, the range of experiences included primary health care, music therapy, tai chi, diabetes care, virtual exercise and other classes, chiropractic care, foot care, and physiotherapy. Many indicated that they felt that the CTS did not interfere with their ability to access services at the centre and that they felt safe and respected at the centre.

Most neighbourhood respondents had not regularly used SRCHC services although some who lived in the neighbourhood reported using nurse practitioner and physician services, the diabetes clinic, and the mom and babies group. Several had received COVID-19 vaccines and tests at SRCHC.

Security and safety concerns

Respondents expressed a range of security and safety concerns. Overall, the concerns shared by respondents were consistent with findings from the Public Progress Report published in September 2023.

Several people reported incidents of harassment, including threats, and physical assault from CTS clients. Neighbourhood residents, business owners, and employees emphasized that these experiences, which have been directed towards adults, teens and young children, have taken place when walking by the CTS, in nearby alleyways or when walking on streets close to the CTS. Some respondents and CTS clients added that SRCHC staff and security have sometimes been present during altercations but do not intervene, appearing neglectful. Residents perceived that “a few problem clients...1%” are consistently involved in these incidents, yet do not experience any repercussions; “It’s the same characters, the same faces.” Many respondents including service users of SRCHC, were concerned about crowding and loitering outside of the CTS, when individuals outside of the CTS are visibly intoxicated, belligerent, and acting erratically.

Many respondents were concerned about public drug use, including people overdosing in public (fatal and non-fatal). Drug use was observed directly outside of the CTS, in alleyways, on the street, in parks and other public spaces in the neighbourhood. Schools and daycares have found people using drugs in their parking lot or in their entryways.

Respondents have also observed garbage, excrement, used condoms, discarded needles and substances in the neighbourhood, including on the streets, alleyways, schoolyards, daycare property, soccer fields and near residents’ private garages and driveways. While some daycare staff have found spoons, pipes, alcohol bottles and condoms under sand boxes and in the schoolyard, they did not necessarily attribute this to the presence of the CTS. Residents and daycare staff have witnessed individuals fornicating, defecating and urinating in public and on daycare property.

Many respondents were concerned about the effects on children of public drug use, disruptive behaviour, and discarded equipment and drugs. Respondents reported children picking up bags of drugs. Others described children as being desensitized to seeing people injecting and consuming drugs. In response, many parents are providing information and education to their children about drug related safety, even while they feel this education is premature or not age-appropriate. Residents and families are concerned about the long-term impacts on the emotional and mental wellbeing of children and no longer feel a sense of safety in their neighbourhood. Parents fear for the safety of their children, and women and children do not feel safe walking in proximity of the CTS.

Several residents and businesses have experienced home and car thefts, property damage and break-ins. Theft has ranged from small items, such as delivery packages, to large items in stores. Several businesses have been burglarized multiple times, repeatedly suffering financial loss. Most business owners and employees felt that safety problems are acute, specific to the Leslieville neighbourhood, and not explained by citywide trends. Business owners who live outside of Leslieville compared the lack of sense of safety they experience at their business location with that in the broader Leslieville neighbourhood, which they attribute to the CTS.

Many respondents emphasized that there is a noticeable presence of drug selling both outside the CTS and in the neighbourhood. For some, the presence of the CTS “attracts drug dealers and drug users, and diverts them from the downtown core.” Respondents also fear that sellers are armed and “directly” responsible for an increase in guns and violence in the neighbourhood. A news article reported that two clients who regularly use the CTS described that the atmosphere of the CTS is “deteriorating,” due to observing more altercations and more incidents of theft. They attribute this to an increase of new drug sellers. Residents and families also reported seeing people selling their personal prescriptions of safer supply opioids. Businesses perceive that drug sellers are more dangerous and younger than in previous years.

Many respondents described having long time complaints of their concerns but feel the issues escalated during the COVID-19 pandemic. Some families, who have lived in the neighbourhood for several years, described feeling little to no concern about the CTS before the pandemic. Other participants discussed the changing landscape of the toxic drug supply and feeling the CTS “can’t keep up.” Many ascribed their increasing concerns to a shift in management and poor management practices.

Many of the safety concerns reported are more pronounced for residents who live on Heward Avenue, in close proximity to SRCHC. These residents feel their concerns are distinct within their “Zone of Impact.”

Some respondents expressed different opinions about safety and security related to the CTS. CTS clients explained that SRCHC is not the only site where there are problems. Similarly, general clients of SRCHC voiced that concerns have “Always been here. Concerns are not new. It’s just more.”

CTS clients felt that their own sense of safety has been compromised. They have experienced residents in the neighbourhood photographing them without consent and making remarks when walking by; “since the shooting...community has treated us like the plague.” CTS clients also remarked on how “people involved with the shooting were not part of the site, they never were,” yet clients of the SRCHC CTS are blamed for the critical incident that occurred in July 2023. Some clients who use the CTS were mindful when seeing children walk by and others noted that there are a limited number of children who walk near the CTS as they appear to be walking on the other side of the street. CTS clients share concerns with other participant groups about CTS staff not having enough training and explained that some staff view clients as

“beneath” them and are working at the CTS “just for money.” They also discussed concerns about the community safety team (i.e. One Community Solutions), and added that they are “bullies” who blatantly ignore situations in which they are expected to intervene.

Some respondents had no concerns about security and safety related the CTS. Instead, they feel that there is a small group of neighbours who are ‘aggressively’ voicing their concerns and believe there is an imbalance with people who support the site. According to the 2023 Public Progress Report, some businesses canvassed indicated they were supportive of the CTS and SRCHC overall, while others had concerns only since after the fatal shooting. The report also found that older residents who have lived in the Leslieville neighbourhood for more than 20 years feel safer now than they have in the past.

Some respondents feel that safety concerns may escalate if the CTS closes, as children may be more likely to find “dead bodies in alleyways and more needles in parks.” Some noted that the CTS already has constrained services, such as opening hours, which creates risk for people who use drugs, particularly those who are especially vulnerable due to their age; “An 18-year old kid was shooting up in my alley which is 0.7km away from the site. He said the site was closed so had to find a place to shoot. This was Sunday at 1pm.” Some fear that stigma, in conjunction with the toxic drug supply, will create risks for youth who are experimenting with drugs. Additionally, many of the general clients of SRCHC believed that having a CTS actually helps to concentrate and centralize discarded needles and drugs. A long-term resident of Leslieville explained in a news article that the presence of the CTS is helpful, especially in response to a gentrifying neighbourhood, as the services provide value and support to community members. For this reason, they feel it is important not to “vilify” those who rely on the CTS.

Responses to safety concerns

Participants shared many examples of how they have been managing and responding to their safety concerns.

Residents led an initiative to complete an alleyway clean up of discarded needles, garbage and condoms. Several residents have put up security cameras and have been frequently calling 311 and 911; however, many feel that police and 311 are not responsive.

Many children have been avoiding the alleyway behind the CTS when walking to school and some parents do not allow their children to walk in the neighbourhood alone. Some parents no longer feel comfortable sending their children to the local elementary school and have pulled their children out of the local daycare. Parents gave examples of their children avoiding playing and spending time in the neighbourhood, taking different routes home from school, and avoiding eye contact with people outside of the CTS.

Some daycares have implemented safety measures and programming changes. One daycare has changed the location of their evacuation site to be farther from the CTS. Staff now inspect and sweep their property for needles before bringing children outside, such as for fire drills. Staff no longer bring children to the bus stop at the major intersection of Queen and Carlaw and some staff avoid this intersection themselves when walking in the area. Staff now also use a separate entrance when entering the building in the morning to avoid individuals who may be CTS clients. Staff avoid using a laneway near the daycare due to the presence of people using drugs. In response to parents' concerns about their children touching needles, daycare staff have been engaged in pedagogical methods about "what not to touch" and have been attempting to support parents with approaches to speak to their kids directly.

Businesses have had to train their staff (often young people who earn minimum wage with limited experience) on crisis de-escalation approaches in order to interact with people who are intoxicated. Businesses have installed security cameras and many avoid keeping their doors open in the summer. Some businesses are picking up and disposing used needles on their own. Survey responses shared several accounts of individuals who have stopped visiting businesses near the CTS because of safety concerns.

Most respondents felt that there is insufficient attention from management to address violence, overflow of clients, discarded needles and other drug equipment, and that this ultimately creates a sense of "danger towards public safety." One respondent wrote, "It is the concentration of that activity in and around the CTS and the lack of attentiveness of management to address it in any meaningful [way] that I believe poses the risk to safety in this neighbourhood." Participants stressed that there are neither mechanisms to address the safe disposal of needles nor a willingness to implement solutions: "There is no accountability on the centre to ensure those tools are disposed of safely." One family shared that they worked with SRCHC to find a solution to discarded needles in the laneway. While SRCHC installed needle boxes, this installation was neither timely (took 1 month) nor adequate (the boxes did not fully close).

Perceived responses of SRCHC to the fatal shooting

The review team asked participants what changes they thought the CTS has made in response to the fatal shooting on July 7, 2023. They reported changes to opening hours (opening earlier), a new fence, new planters in front of the entrance, new security personnel, increased policing, more community safety officers, and new communication updates from the SRCHC website.

While many respondents described some positive outcomes from these changes, others saw these responses as temporary, crisis-oriented, "Band-Aid" solutions; one respondent called them "short-sighted and a knee jerk decision," that do not address the root of the problem. Another said, "I know the site has implemented many safety measures and has interacted more with the police and levels of government since the shooting, but it does [not] fix my biggest

concern, which is the proximity of the site to local schools and daycares. That can only be addressed by moving the site.” Many feel that SRCHC has responded in ways that is performative and that they are only motivated to implement changes to uphold their image for a “PR stunt.” Residents and families specifically shared that while SRCHC has been posting information on their website, via newsletters and emails, this is too passive of an approach. Some residents reported that the CTS is now open earlier in the morning to reduce the number of people congregating outside when children are walking to school, but they are uncertain if this is a permanent change.

Business owners and employees were not in favour of the new fenced off area as it was previously a place for families to gather for picnics and is now inaccessible to everyone. Some were skeptical about evaluating the effectiveness of the fence over the last few months; they noted that some of the changes might simply be weather dependent, as fewer people frequent the outdoors during the colder months. The increased police presence has made a tangible difference for businesses as they experience less harassment and notice fewer intoxicated people. Most respondents were concerned that the fence has pushed drug related activity into other parts of the neighbourhood. While the increase in policing and security in the direct vicinity of the CTS has decreased the concentration of these concerns, some participants have remarked on how this has led to problems expanding and people “spilling over” from the CTS into other streets and alleyways in the neighbourhood. Some are concerned that this is also not safe for clients of the CTS.

In contrast, general clients of SRCHC feel safer using services due to the new fence and the increase in security and cameras. Many thought that loitering at the SRCHC entrance is tied to larger problems of homelessness and that the CHC is doing the best they can to address a structural problem. The majority expressed their frustration with SRCHC policies in relation to key-only washroom access.

SRCHC communication and community engagement

Respondents listed several ways that they received communication from, and sometimes engaged in dialogue with, SRCHC staff and management. Prior to the fatal shooting in July 2023, these included monthly meetings, the SRCHC website, emails, and dropping in to the centre. After the incident, the Safer Community Committee formed and a town hall meeting was convened. However, some respondents were disappointed with the town hall, which they felt was “staged” or “hijacked” by people from outside of the neighbourhood.

Many respondents expressed frustration about the level of communication and emphasized that there was no effective process to raise concerns or file complaints. Other respondents noted that there was no meaningful change to operations after they raised concerns. Most respondents felt that the SRCHC staff were reluctant to build a relationship with some residents, were dismissive of their concerns, did not answer their emails or other queries, and

characterized them as “NIMBYs” (people who demand that services are delivered “not in my back yard”). Many people reported that when there was a response, it was weak and consisted of excuses about not having the power (“we can only do so much”) or resources to make changes (a few respondents were very mistrustful about claims that SRCHC did not have sufficient funds to implement changes, noting that SRCHC found funds to hire public relations consultants and a security firm after the fatal shooting). Other times complaints were dismissed as trivial with statements about “bigger issues in the world.” Some perceived a culture of passing responsibility to others within the SRCHC and asked for a clear “chain of responsibility and accountability,” including an appeal mechanism. Several respondents felt that communication was worse after the pandemic started.

Respondents noted that the SRCHC website did not clearly indicate who should be contacted about concerns. The website also did not have detailed statistics about the CTS operations, which respondents felt was incompatible with a transparent approach to community relations. Some felt that the website reported “false information.”

The daycare and school officials suggested that communication could be improved by dispelling myths about the site through publicizing what services are being offered, how the CTS is supporting people, and sending a message that the CTS will not “distribute drugs” or “let their clients out” when they are intoxicated. However, many respondents felt that newsletter and emails were of limited use.

In contrast, people who were clients of the SRCHC felt that staff were very approachable and responsive, although less so after the start of the pandemic. A minority perspective was that SRCHC and the board had been open to feedback and have welcomed, encouraged, and incorporated feedback.

Some respondents also felt that the Safer Community Committee had been established in a “biased way.” A few felt strongly that residents who lived closer to the SRCHC (one respondent suggested 200 m) should have a greater voice in community outreach since they have more direct experiences than individuals who live farther away. Others suggested that the SRCHC board meeting minutes should be public.

Engaging with governments, police, and other groups

Residents, families, business owners, daycare and school staff shared a range of experiences engaging with city and provincial government, Toronto Public Health and Toronto Police Services both before and following the fatal shooting.

Daycare staff described that for security concerns including lockdowns like the one that occurred in July 2023, they liaise directly with Toronto Police Services. For needle sweeps and drug equipment disposal, daycares rely on the city of Toronto. This reliance on the city instead of SRCHC is a result of the lack of response or assistance from SRCHC. Daycares are working

directly with the city so that they can be alerted when there are violent threats in the neighbourhood and so that there is a more open and direct line of communication.

Residents, families and business owners have reached out by phone, email and in person to express concerns and frustrations to local and provincial government. For most people, the responses and follow-up from the government have been very limited or non-existent. Responses are mostly automated or generic and viewed as lip service without any tangible action behind them. Increased visibility from city councillors occurred directly after the fatal shooting in July 2023 and at the town hall. In the months that followed, residents, families and businesses have not witnessed much continued support or response.

All groups engaged in the review observed increased police presence in the neighbourhood following the fatal shooting in July 2023. There were split opinions on the role and value of police and police funding in the context of illicit drug use and drug selling. For some residents, families and business owners, police presence in the Leslieville area is desirable and needed to address theft, assault, vandalism, aggression and drug dealing. For others, increased police presence in the neighbourhood is seen as a Band-Aid solution, one that puts racialized community members at risk of racial profiling and increased encounters with law enforcement and divides the community further. Some provided examples of ways police funding could be used for more systemic change like poverty reduction.

Of 141 individuals who completed the online form, 83 (58.9%) indicated that they had voiced concerns about the SRCHC, 26 (18.4%) indicated that they had concerns but did not voice them, and 32 (22.7%) indicated that they did not have concerns. The 83 people who voiced concerns directed them to the individuals and agencies listed in Table 3. Most often, people expressed concerns to the municipal and provincial governments. The “Other” category included community surveys and letters of support, Toronto Public Health, school board trustees, non-profit leaders, and the Town Hall meeting.

Table 3 Expressions of Concern

To whom have you expressed your concern?	N (%)
South Riverdale Community Health Centre	51 (61.4)
Someone in the municipal (city) government	73 (88.0)
Someone in the provincial government	60 (72.3)
Someone in the federal government	53 (63.9)
The police	51 (61.4)
Other	11 (13.2)

For the people who had concerns but did not express them, the reasons for not expressing concerns included not knowing how to do so, fear of “harassment” from the harm reduction and social service community, fear of being labeled “uneducated, a bigot, or worse,” prior negative experiences with raising concerns, lack of faith that raising concerns would result in change, and a feeling that police are too overwhelmed and under resourced to respond to concerns.

SUMMARY AND SUGGESTIONS

In summary, the relationship between many community members and the SRCHC is troubled and characterized by a lack of confidence and trust, which began in the months leading up to the fatal shooting on July 7, 2023, deteriorated shortly thereafter, and continues to be problematic now.

For many, the mistrust stems from what they experience as SRCHC's lack of transparency, complacency and inaction with respect to crime and safety. For many of the residents, families and business owners who have lived or worked in the neighbourhood for a number of years, the relationship with SRCHC was a positive one prior to the opening of the CTS in 2016. Many were supportive of the CTS when it first opened. Several years later, there was a noticeable and marked change after the COVID-19 pandemic when there were more CTS clients accessing the site, coupled with increased drug toxicity and a worsening housing crisis. Residents, families and business owners observed an increase in violence, theft, assault, public loitering and discarded drug equipment as well as an increase in the number of drug dealers and drug dealing outside and around the SRCHC. This was also a time when residents, families and businesses saw changes with the SRCHC management. Although there were mechanisms in place for community members to voice concerns like committees and regular meetings, the residents, families and business owners who were involved in these groups reported very minimal response from the SRCHC and a refusal to publicly share and distribute specific documents. The 2023 report by Public Progress also identified how the "social contract" for residents on Heward Avenue had been broken.

Since the fatal shooting in July 2023, most residents, families and businesses have 'given up' trying to engage or voice their concerns and feel the SRCHC is 'corrupt', 'negligent' and has 'violated' any agreements that were in place to run the CTS. In addition, these groups of individuals reported that SRCHC has lied and hidden information and operated outside of legal parameters by allowing drug selling and other illegal activity to occur in and around the property. Some residents were initially hopeful about the opening of the CTS being able to provide support to clients but now feel that SRCHC ignores any issues that occur outside of their physical building. Residents feel no one is listening and are cautiously optimistic about any change.

There is felt to be a lack of accountability, a lack of monitoring, and a governance structure that is led by a Board of Directors who are 'not equipped to handle these types of concerns.'

As a result, many residents, families and business owners described an 'us vs. them' dynamic between themselves and the SRCHC. Being vocal and advocating for the safety of families in the neighbourhood has been referred to as NIMBYism which many residents and families believe is both an oversimplification of the issues and inaccurate.

There are a number of residents who support the CTS and who described an imbalance between their experiences and those of a small group of neighbors who they feel are ‘aggressively’ voicing their concerns and who are leading the dominant narrative.

What changes community members want to see at the CTS

In this section, the review team presents the main suggestions and demands from community members for changes at SRCHC and the CTS.

Close or Move the CTS

Most residents, families and business owners felt strongly that the CTS at SRCHC be closed or moved to a different location. This opinion was also highlighted in the survey completed by Public Progress. For many respondents, closing the CTS is the only outcome they want to see moving forward. Within this group, there were two main perspectives: 1) CTS services are not effective and therefore should not be operating at all, in any location; and 2) CTS services have health and social value and should exist, just not in this specific location.

For those in the latter group, there was consensus that moving the CTS to a less residential area where there are no schools or daycares was critical. Suggestions for relocation of the CTS included other locations a defined distance away from a childcare facility, school or playground (responses generally were within 100 to 500 m), or in areas of East Toronto that are more industrial. Daycare and school staff also suggested moving the CTS to a larger space where more clients can be accommodated or to spaces where clients can also access showers, meals and short-term shelter. A few respondents suggested that the CTS be moved to a hospital while others suggested mobile CTS services either to augment services at a relocated CTS or instead of a fixed location.

A handful of residents want the CTS to remain at SRCHC. Clients of SRCHC and clients of the CTS also did not want the CTS be closed or moved.

SRCHC Management and Governance

Across resident, family and business groups, there were strong suggestions around the governance and management of SRCHC. Many respondents wanted a complete ‘overhaul’ and restructuring of SRCHC management and the SRCHC Board of Directors, including bringing in new people to replace current management and leadership as well as establishing a completely separate and distinct management structure for the CTS. Under this model, the CTS would be monitored, audited and directly accountable to the Ministry of Health or designated government body for all of its operations.

For several SRCHC and CTS clients, management issues were perceived to stem from a lack of integration between the CTS and the SRCHC. Both SRCHC and CTS clients favoured increased internal referrals and improved access across programming at SRCHC for all clients (e.g. CTS clients who want to access acupuncture or physical therapy). Residents also suggested increased wraparound services within SRCHC and to nearby organizations (e.g. Woodgreen Community Services), such as housing referrals, art/music therapy, Occupational Therapy, Social Work, mental health supports, counselling, and faith and spiritual groups.

SRCHC Communications and Engagement

SRCHC communications, education and engagement were areas where residents, families, and daycare staff provided clear suggestions for areas of improvement. Residents and daycare staff suggested establishing new roles at the SRCHC and the CTS for communications, including a dedicated point person(s) to contact for any concerns and to lead community engagement. Another suggestion was to implement a hotline for businesses and residents located within a one-kilometer radius of the CTS. Daycare staff suggested that SRCHC collaborate with schools and daycares as a way to build understanding, dialogue and raise awareness about the many different programs and services offered at the CHC. Collaboration would also increase visibility; daycare and school staff and children would be recognized by SRCHC staff and clients, which, in turn, would lead to increased safety for all. Residents, daycare staff and SRCHC clients suggested increased general education about harm reduction and the CTS to dispel myths and negative misconceptions about the CTS. Communications from SRCHC needs to be ongoing, consistent and transparent. Given the erosion of trust between residents, families, business owners and the SRCHC, all communications and engagement efforts in the near future need to be initiated and led by the SRCHC and must address ongoing concerns that were raised before and after the fatal shooting.

Safety

Residents, families, daycare and school staff asked for the development and implementation of formal community safety tracking policies. This would include a zero tolerance policy for using drug equipment outside of the CTS and criminal activity such as drug selling. Additional suggested tracking procedures included a system for tracking needles that are distributed at the site, ensuring safe disposal of needles and systematic sweeps for needles and other drug equipment in the alleys and properties close to the CTS. Some people suggested terminating the distribution of needles at the CTS entirely. Many residents, families, business owners and some of the SRCHC clients want the SRCHC to have permanent security moving forward; however, the security should be well trained and 'legitimate'. Some residents and families also

wanted increased and ongoing police presence around the SRCHC, with some people specifying that police presence should focus on arresting people who are using drugs near the CTS. Other residents wanted to see decreased police presence over the long term alongside hiring and training community liaisons who could manage and de-escalate conflict.

CTS Operations

SRCHC and CTS clients, residents and families all want extended CTS hours; ideally the site would be open 24/7 with community outreach available at all times, along with increasing the number of booths within the CTS. This expansion would decrease the number of clients loitering around the building, particularly during times when families are walking to and from school and daycare. Some residents, CTS clients, and respondents to the survey asked for space for inhalation as well as a designated waiting area, private and secure areas such as a drop-in within the CTS, to socialize or spend time when not using drugs. Several residents, families and business owners want to see the CTS provide mandatory drug treatment to its clients while others want to see increased referrals and access to drug treatment for clients.

The need for CTS staffing changes were voiced across all groups engaged in the review. CTS clients felt that security and staff required more training; many did not have the knowledge or skills to prevent or respond to overdoses. Residents and survey respondents also want improved training as well as better compensation for staff at the CTS. For some residents, families and business owners, the hiring of people with lived or living experience of drug use at the CTS is a practice that should stop. According to these groups, staff who advocate for or engage in drug use while at work are 'inviting' drug selling, are a safety concern for residents, families and business owners, and reflect a breakdown in management at SRCHC. In contrast, CTS clients want more CTS staff with lived and living experience, as building trust with staff and feeling safe accessing the space is an essential part of harm reduction. Daycare staff suggested having more regular and comprehensive criminal record checks for CTS staff.

Appendix A – Community Engagement Group Guides

SRCHC CTS Review - Resident Consultation Group Guide

Questions

1. What do you know about the services at SRCHC?
 - a. Do you know what services are offered at the CTS?
2. What benefits does the CTS bring to the local community?
 - a. Can you share some examples?
 - b. What could be improved (overall and for the CTS)?
 - c. What would an ideal CTS look like? *Probe about location, hours, services/programs, etc.*
3. What are your concerns about the CTS? *Probe specifically about public litter, witnessing public drug use, witnessing public selling*
 - a. How do these concerns impact you and the local community?
 - b. How do you think these concerns can be addressed by the CTS? By the government/larger policies?
4. Do you have safety concerns? *Probe around assault, threat of assault, theft, vandalism, public drug use*
5. Do you have safety concerns for children specifically?
6. Have you voiced or shared your concerns with SRCHC?
 - a. If yes, how have you shared your concerns?
 - b. If no, can you tell us a bit about why you made the decision not to share?
 - c. Have you voiced concerns with other groups or organizations?
7. If yes, was there any follow up from SRCHC around these concerns?
 - a. How did they respond?
 - b. Is the process for responding to community concerns or complaints effective?
 - i. What part of the process works well? What part could be improved?

8. Since the incident in July 2023, what do you think are the most important ways that the CTS has changed?
 - a. What hasn't changed that you think should change?
9. How does SRCHC engage and communicate with the community?
 - a. How can engagement and communication be strengthened overall?
10. Is there anything else about SRCHC you want to share?

SRCHC CTS Client Consultation Group Guide

Questions

1. What are some of your experiences using the CTS at SRCHC?
 - a. Why do you choose to access the CTS at SRCHC? *Probe about relationship with staff, the space, the environment, etc.*
 - b. How often do you use services/use the CTS?
 - c. Do you use any other services at SRCHC?
 - d. What services do you use most often and why?
 - e. What services do you avoid using, if any? Why?
2. Do you experience any challenges when using services/the CTS?
 - a. Do you feel safe when using the CTS?
 - i. Can you share an example of a time that you felt respected and safe accessing services?
 - ii. Can you share an example of a time that you felt unsafe while accessing services? What could SRCHC do differently to help you feel safe when accessing services?
3. How does SRCHC engage and communicate with the community?
 - a. How can this be strengthened?
4. Some people have concerns about public drug use near the CTS. Do you have any concerns? *Probe about public litter, public drug use and selling*

5. Some people have concerns about safety for children near the CTS. Do you share these concerns?
6. Have you ever shared your concerns with SRCHC?
 - a. If yes, how did you share your concerns? Was it in person, by phone, email, or another way?
 - i. Whom did you talk to?
 - ii. How long did it take to find someone to talk to?
 - iii. How did SRCHC respond to your concerns?
 - iv. Is the process for responding to community concerns or complaints effective?
 - v. What part of the process works well? What part could be improved?
 - b. If no, can you tell us a bit about why you made the decision not to share?
 - c. Have you voiced concerns with other groups or organizations?
7. Since the incident in July 2023, what do you think are the most important ways that the CTS has changed?
 - a. What hasn't changed that you think should change?
8. From your perspective, what is the public response towards drug use and supervised consumption sites overall? *Probe around people's attitudes, policing and security in general and in specific locations e.g. parks*
9. What are the strengths and benefits of the centre overall? The CTS? What could be improved (overall and for the CTS)?
 - a. What would an ideal CTS look like? *Probe about location, hours, services/programs, etc.*
10. Is there anything else about SRCHC you want to share?

SRCHC CTS Review – Business/Employee Consultation Group Guide

Questions

1. To kick it off we want to understand everyone's awareness of what services are provided at the CHC and the CTS. What do you know about the services that are provided at the CHC and CTS?
2. What are your concerns about the CTS? *Probe specifically about drug equipment, drugs, public litter, witnessing public drug use, witnessing public selling*
 - a. How do these concerns impact you and the local community? Your business/work?
 - b. How do you think these concerns can be addressed by the CTS? By the government/larger policies?
3. Do you have safety concerns? *Probe around assault, threat of assault, theft, vandalism, public drug use*
4. Do you have concerns about **the safety or security of your business/workplace or about other local businesses** related to the CTS operation? If so, can you provide examples and details?
5. Do you have safety concerns for children specifically?
6. What do you know about the opportunities for expressing concerns at SRCHC? Do you think the process for responding to community concerns or complaints is effective? What parts of the process works well? What parts could be improved?
 - a. If you haven't shared concerns, can you tell us a bit about why you made the decision not to share?
 - b. Have you voiced concerns with other groups or organizations e.g. government, police, etc.?
7. Since the incident in July 2023, what do you think are the most important ways that the CTS has changed?
 - a. What hasn't changed that you think should change?

8. In what ways does SRCHC engage and communicate with the community? How well does this work? How can engagement and communication be strengthened overall?
9. We've heard from people that there are benefits the CTS brings to the local community and to its clients. From your perspective what benefits do you think the CTS brings to the community and its clients? After hearing your concerns you may not have any to share and that's okay too. Some people may have a different opinion.
 - a. Can you share some examples?
10. What would an ideal CTS in Leslieville look like? You may want to comment about location, hours, services/programs, or other features.
11. Is there anything else about SRCHC you want to share?

SRCHC Schools/Daycares Individual Consultation Guide

Questions

1. What do you know about the CTS at SRCHC?
 - a. Do you know what services are offered at the CTS?
2. What are the strengths and benefits SRCHC overall? The CTS? Can you share some examples?
 - a. What could be improved (overall and for the CTS)?
 - b. What would an ideal CTS look like? *Probe about location, hours, services/programs, etc.*
3. What are your concerns about the CTS? *Probe specifically about public litter, witnessing public drug use, witnessing public selling.*
 - a. How do these concerns impact your **school/daycare**?
 - b. How do you think these concerns can be addressed by the CTS? By the government/larger policies?
4. Do you have safety concerns for children specifically?

5. Have you voiced or shared these concerns with SRCHC?
 - a. If yes, how have you shared your concerns?
 - b. If no, can you tell us a bit about why you made the decision not to share?
 - c. Have you voiced concerns with other groups or organizations?
6. Was there any follow up from SRCHC around these concerns?
 - a. How did SRCHC respond to your concerns?
 - b. Is the process for responding to community concerns or complaints effective?
 1. What part of the process works well? What part could be improved?
7. Since the incident in July 2023, what has your **school/daycare** done to respond to this event? Have there been any changes to programming? Communication notices?
 - a. How have students/families responded to these changes?
8. Since the incident in July 2023, what do you think are the most important ways that the CTS has changed?
 - a. What hasn't changed that you think should change?
9. How does SRCHC engage and communicate with the community?
 - a. How can community engagement and communication be strengthened?
10. Is there anything else about SRCHC you want to share?

SRCHC CTS Review - Family Consultation Group Guide

Questions

1. What do you know about the services at SRCHC?
 - a. Do you know what services are offered at the CTS?
2. What benefits does the CTS bring to the local community? What benefits does it provide to its clients?
 - a. Can you share some examples?
3. What are your concerns about the CTS? *Probe specifically about drug equipment, drugs, public litter, witnessing public drug use, witnessing public selling*
 - a. How do these concerns impact you and the local community?
 - b. How do you think these concerns can be addressed by the CTS? By the government/larger policies?
4. Do you have safety concerns? *Probe around assault, threat of assault, theft, vandalism, public drug use*
5. Do you have concerns about the safety or security of local businesses related to the CTS operation? If so, can you provide examples and details?
6. Do you have safety concerns for children specifically?
7. What do you know about the opportunities for expressing concerns at SRCHC? Do you think the process for responding to community concerns or complaints is effective? What parts of the process works well? What parts could be improved?
 - a. If you haven't shared concerns, can you tell us a bit about why you made the decision not to share?
 - b. Have you voiced concerns with other groups or organizations e.g. government, police, etc.?
8. Since the incident in July 2023, what do you think are the most important ways that the CTS has changed?
 - a. What hasn't changed that you think should change?

9. In what ways does SRCHC engage and communicate with the community? How well does this work? How can engagement and communication be strengthened overall?
10. What would an ideal CTS look like? You may want to comment about location, hours, services/programs, or other features.
11. Is there anything else about SRCHC you want to share?

SRCHC – General Client Consultation Group Guide

Questions

11. What are some of your experiences using services at SRCHC?
 - a) Why do you choose to access services at SRCHC? *Probe about relationship with staff, the space, the environment, etc.*
 - b) How often do you use services?
 - c) What services do you use most often and why?
 - d) What services do you avoid using, if any? Why?
12. Do you experience any challenges when using services at SRCHC?
 - a) Do you feel safe when using the services?
 - i. Can you share an example of a time that you felt respected and safe accessing services?
 - ii. Can you share an example of a time that you felt unsafe while accessing services? What could SRCHC do differently to help you feel safe when accessing services?
13. How does SRCHC engage and communicate with the community?
 - a. How can this be strengthened?
14. Some people have concerns about public drug use near the CTS. Do you have any concerns? *Probe about public litter, public drug use and selling*

15. Some people have concerns about safety for children near the CTS. Do you share these concerns?

16. Have you voiced or shared your concerns with SRCHC?
 - a. If yes, how did you share your concerns? Was it in person, by phone, email, or another way?
 - i. Whom did you talk to?
 - ii. How long did it take to find someone to talk to?
 - iii. How did SRCHC respond to your concerns?
 - iv. Was there ever any follow-up from SRCHC?
 - v. Is the process for responding to community concerns or complaints effective?
 - vi. What part of the process works well? What part could be improved?
 - b. If no, can you tell us a bit about why you made the decision not to share?
 - c. Have you voiced concerns with other groups or organizations?

17. Since the incident in July 2023, what do you think are the most important ways that the CTS has changed?
 - a. What hasn't changed that you think should change?

18. From your perspective, what is the public response towards drug use and supervised consumption sites overall? *Probe around people's attitudes, policing and security in general and in specific locations e.g. parks*

19. What are the strengths and benefits of the centre overall? The CTS? What could be improved (overall and for the CTS)?
 - a. What would an ideal CTS look like? *Probe about location, hours, services/programs, etc.*

20. Is there anything else about SRCHC you want to share?

SRCHC CTS Review – January 15th – Extra Consultation Group Guide

Questions

1. We would like to start by hearing your concerns about the CTS. *Probe specifically about drug equipment, drugs, public litter, witnessing public drug use, witnessing public selling*
 - a. How do these concerns impact you and the local community?
 - b. How do you think these concerns can be addressed by the CTS? By the government/larger policies?
2. Do you have safety concerns? *Probe around assault, threat of assault, theft, vandalism, public drug use.*
3. Do you have safety concerns for children specifically?
4. What do you know about the opportunities for expressing concerns at SRCHC? Do you think the process for responding to community concerns or complaints is effective? What parts of the process works well? What parts could be improved?
 - a. If you haven't shared concerns, can you tell us a bit about why you made the decision not to share?
 - b. Have you voiced concerns with other groups or organizations e.g. government, police, etc.?
5. Since the incident in July 2023, what do you think are the most important ways that the CTS has changed?
 - a. What hasn't changed that you think should change?
6. In what ways does SRCHC engage and communicate with the community? How well does this work? How can engagement and communication be strengthened overall?
7. We've heard from people that there are benefits the CTS brings to the local community and to its clients. From your perspective what benefits do you think the CTS brings to the community and its clients? After hearing your concerns you may not have any to share and that's okay too. Some people may have a different opinion.
 - a. Can you share some examples?

8. In light of the concerns you've raised, what are your recommendations about a CTS in Leslieville? Please consider location, hours, types of services available, and any other features. You don't have to agree that there should be a CTS in Leslieville at all but some people may have a different opinion about this.
9. Is there anything else about SRCHC you want to share?

Appendix B - Community Engagement Online Feedback Form

CTS Review: Feedback Form

Thank you for taking the time to provide your feedback. We invite you to answer the questions below about the Consumption and Treatment Service (CTS) that is located at the South Riverdale Community Health Centre. The CTS is also sometimes called a supervised injection site or a supervised consumption site. All of these terms refer to the same thing. We will refer to the site as “The CTS.”

As you know, a critical incident occurred near the site in July of 2023. While we are sure that you have a lot of thoughts about the incident, our goal is to understand how the CTS operates generally. We will not be discussing the details of the incident in the questions below. We are interested in learning about your experiences, any concerns you may have, and any recommendations for the future.

We will make all of the information you share anonymous so that you will not be identified in the final report, which will be submitted to the Ministry of Health in the New Year. We do not yet know if the government will make the report public.

Once you have responded to the questions below, we will also ask you to complete a short survey.

****Please note the deadline to complete this form is January 17th, 2024***

**** Indicates required question***

1. What do you know about the services at South Riverdale Community Health Centre? Do you know what services are offered at the CTS?
2. What benefits do you think the CTS brings to the local community? What benefits does it provide to its clients? Can you share some examples?
3. Do you have concerns about **your own safety, or those of neighbourhood residents**, related to the CTS operation (note that the next question asks about child safety)? If so, can you provide examples and details?

4. Do you have specific concerns about **the safety of your children (if applicable), or those of other neighbourhood children**, related to the CTS operation? If so, can you provide examples and details?
5. Do you have concerns about **the safety or security of local businesses** related to the CTS operation? If so, can you provide examples and details?
6. If you have safety concerns, how do you think they can be addressed? Please consider how the CTS could address these concerns as well as others (for example, government, police, etc.)
7. Have you voiced or shared concerns about the CTS at South Riverdale Community Health Centre with the Centre, government, or police?*
- Yes (skip to question 8)
 - No, I have concerns but I have not shared them (skip to question 10)
 - No, I do not have concerns (skip to question 11)
8. To whom have you voiced concerns about the CTS at South Riverdale Community Health Centre? (check all that apply)
 - South Riverdale Community Health Centre
 - Someone in the municipal (city) government
 - Someone in the provincial government
 - Someone in the federal government
 - The police
 - Other:
9. Was there any follow up after you shared your concerns? Who responded? How did they respond?
10. Can you tell us a bit about why you made the decision not to share your concerns?
11. What do you know about the opportunities for expressing concerns? Do you think the process for responding to community concerns or complaints is effective? What parts of the process works well? What parts could be improved?
12. Since the incident in July 2023, what do you think are the most important ways that the CTS has changed? What hasn't changed that you think should change?

13. In what ways does South Riverdale Community Health Centre engage and communicate with the community? How well does this work? How can engagement and communication be strengthened overall?
14. In your opinion, what are the most important aspects of the operation of the CTS that could be improved?
15. In your opinion, what would an ideal CTS in the South Riverdale neighbourhood look like? You may want to comment about location, hours, services/programs, or other features.
16. Which of the following best describes you?*
 - I own a business in the neighbourhood
 - I work in the neighbourhood
 - I do not work or own a business in the neighbourhood
17. Since the incident in July 2023, has your business or workplace changed as a result of this event? How has it changed? You may want to think about security, communication, or other issues.
18. Is there anything else about the CTS at South Riverdale Community Health Centre that you want to share?

[Please use this link to complete a brief demographic survey](#)

Supervised consumption sites

Dashboard

Last updated: 2024-11-22

Data on supervised consumption sites in Canada, including the number of visits, client demographics, client safety, drug used and overdoses.

Supervised consumption sites dashboard Understanding the data

On this page

- [Overview](#)
- [General summary: January 2017 to August 2024](#)
- [Detailed information: March 2020 to August 2024](#)
 - [Map of supervised consumption sites](#)
 - [Overdoses](#)
 - [Number of clients and visits](#)
 - [Personal characteristics of clients](#)
 - [Drugs used](#)
 - [Calls for help, services, and referrals](#)
 - [Reporting SCS per month](#)

Overview

Supervised consumption sites (SCS) provide a safe, clean space for people to bring their own drugs to use in the presence of trained staff. This prevents accidental overdoses and reduces the spread of infectious diseases, such as HIV. Since January 2017, every federally exempted SCS in Canada regularly reports its data to Health Canada, and that data is summarized in this dashboard. However, prior to March 2020, there was no standardized reporting format. Because of this, we separate the dashboard into 2 sections. The first section is a general summary of data for all SCS operating at any point between January 2017 and August 2024. The second section provides detailed information for all SCS operating at any point between March 2020 and August 2024.

General summary: January 2017 to August 2024

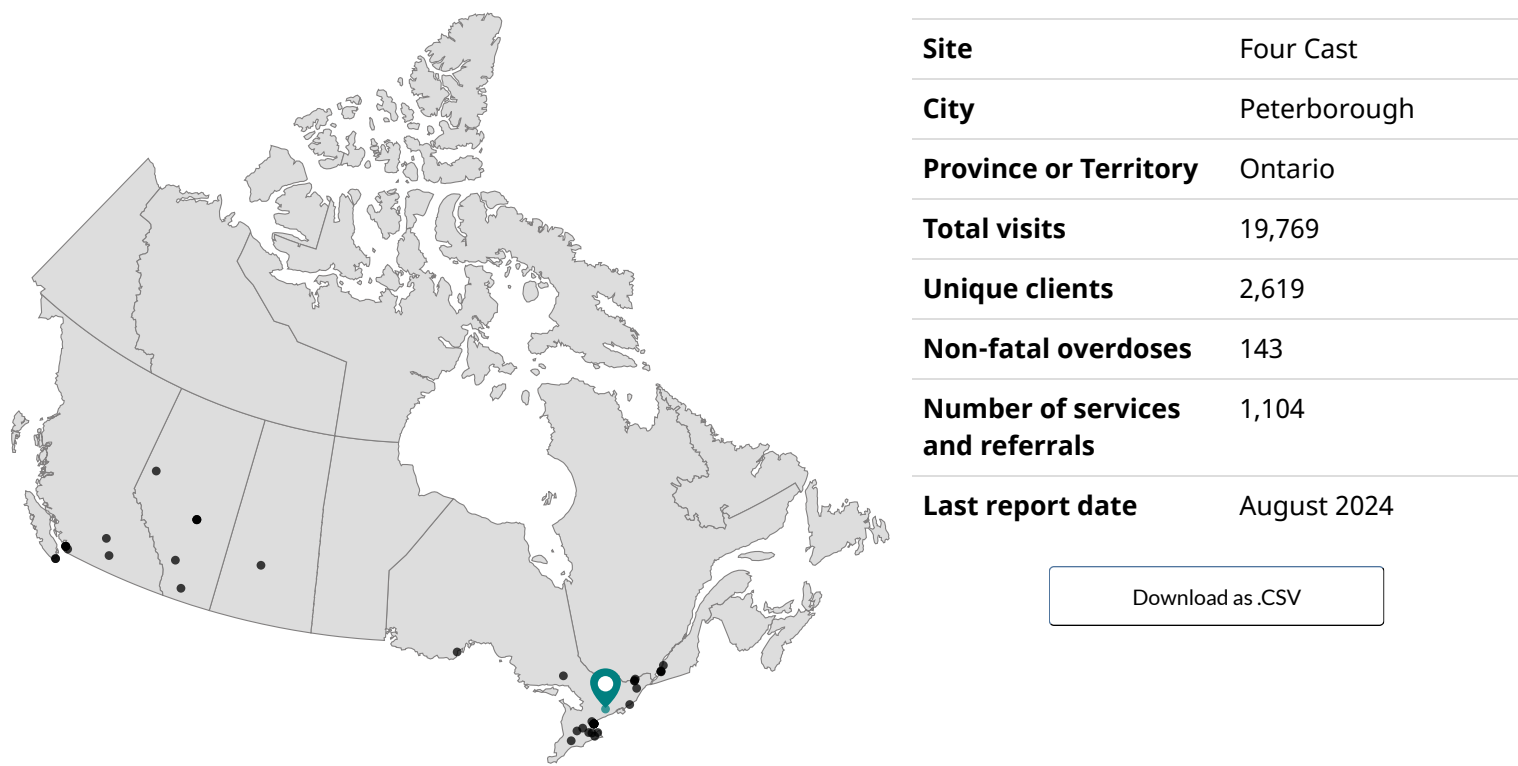
Overall, results from data reported to Health Canada during this period indicate that there were:

4,961,166	467,080	60,288	547,582
Total visits	Unique clients	Non-fatal overdoses	Total referrals

Detailed information: March 2020 to August 2024

Map of supervised consumption sites

Each SCS is represented by a black dot on the map. Zoom, hover over or select a site to view information about that site.



▼ Map: Text description

Search: Show

5

 entries

Site ↑↓	City ↑↓	Province or Territory ↑↓	Total visits ↑↓	Unique clients ↑↓	Non-fatal overdoses ↑↓	Number of services and referrals ↑↓	Last report date ↑↓
Dr. Peter Centre	Vancouver	British Columbia	2,046	511	24	3,516	August 2024
Four Cast	Peterborough	Ontario	19,769	2,619	143	1,104	August 2024
Fred Victor Centre	Toronto	Ontario	141,659	19,544	2,678	22,258	August 2024
George Spady Society	Edmonton	Alberta	N/A	N/A	N/A	N/A	N/A
Guelph Community Health Centre	Guelph	Ontario	30,629	5,904	203	4,461	August 2024

Showing 11 to 15 of 48 entries

► Notes

Overdoses

43,566

Non-fatal overdoses

0

Fatal overdoses

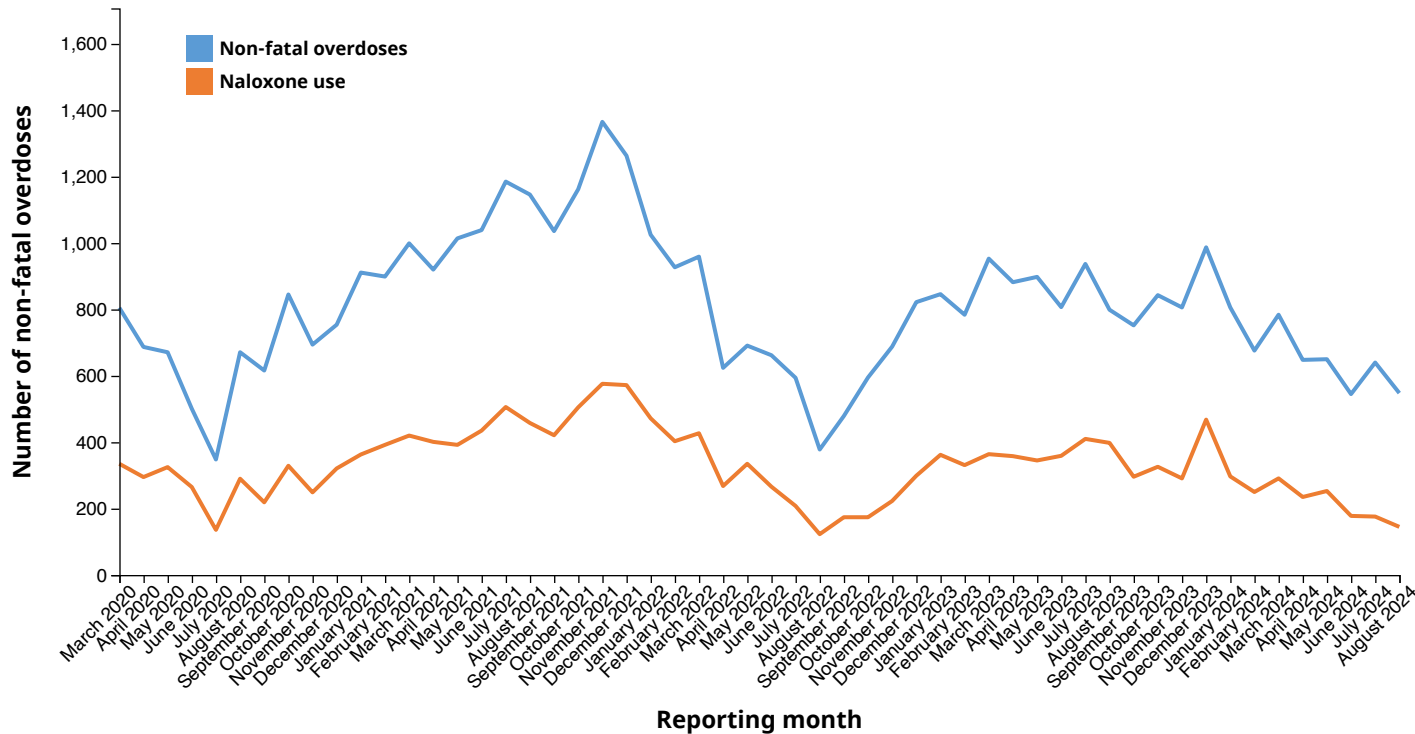
17,713

Overdoses requiring use of naloxone

► About these tiles

Figure 1: Total non-fatal overdoses and overdoses requiring naloxone use between March 2020 and August 2024

Access the data



► Figure 1 - Text description

Number of visits and clients

409,573

Unique clients visiting
SCS on a monthly basis

31

Average number of new
clients per month per
site

2,751,716

Total visits

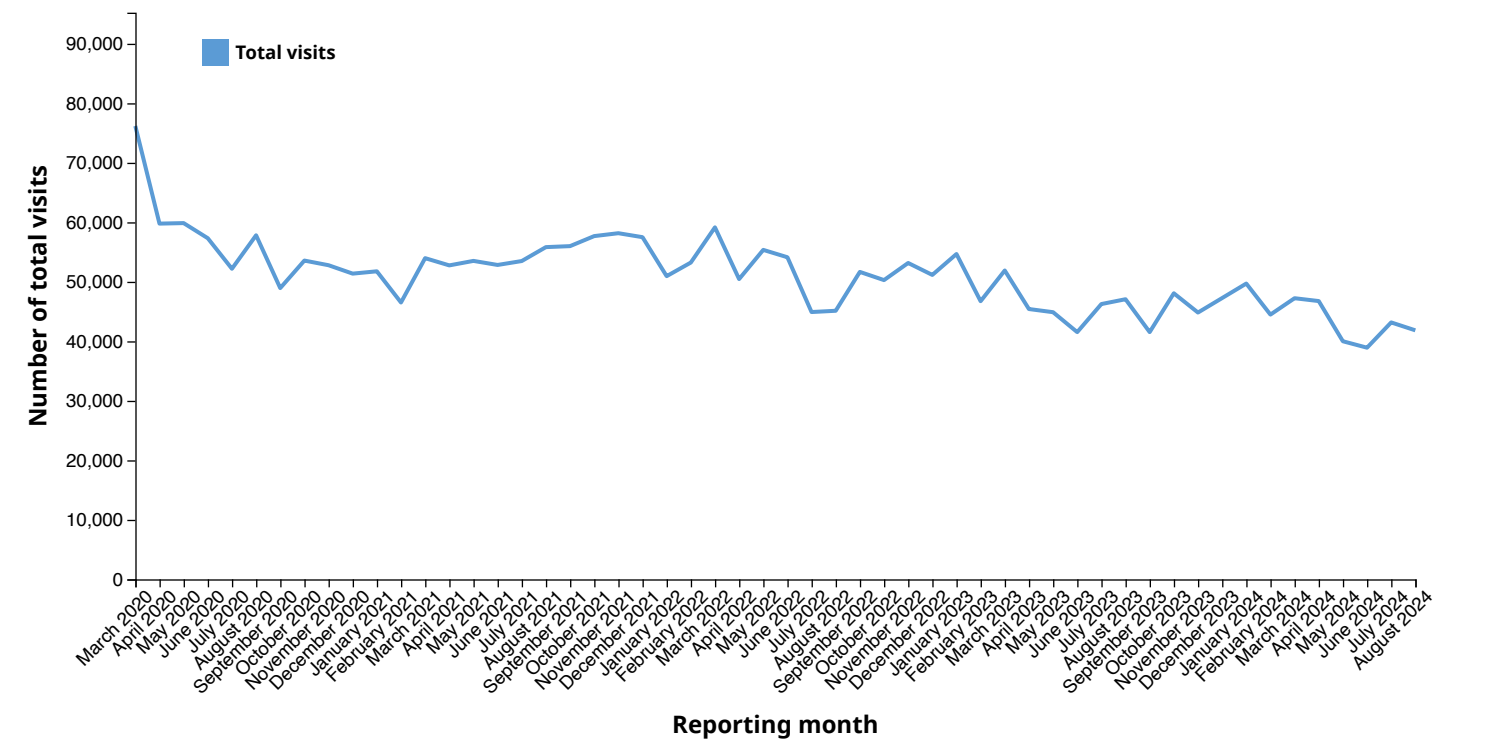
45

Average daily visits per
site

► About these tiles

The following figure shows the number of total visits and unique clients across all SCS between March 2020 and August 2024. Hover over or select a portion of the line graph to see the number of total visits or unique clients in each month.

Figure 2: **Total visits** between March 2020 and August 2024 [Access the data](#)



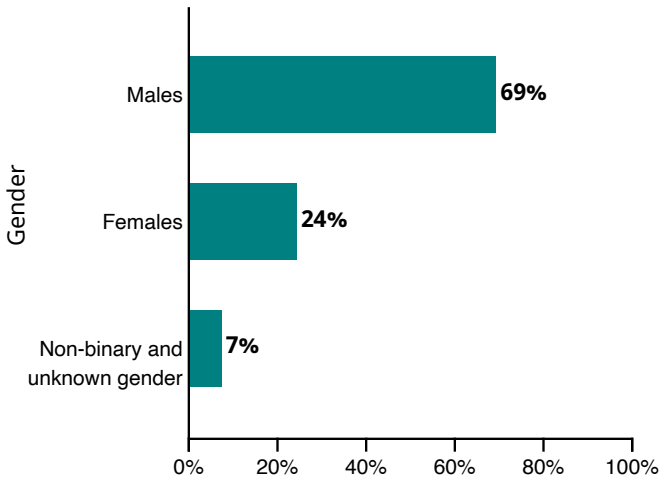
► Figure 2 - Text description

Personal characteristics of clients

The following graphs show SCS clients by age group and gender. Hover over or select a bar to view the data. Most clients identify as males. For all genders combined, the most common age group was 30 to 39.

Figure 3: Gender and age distributions between March 2020 and August 2024

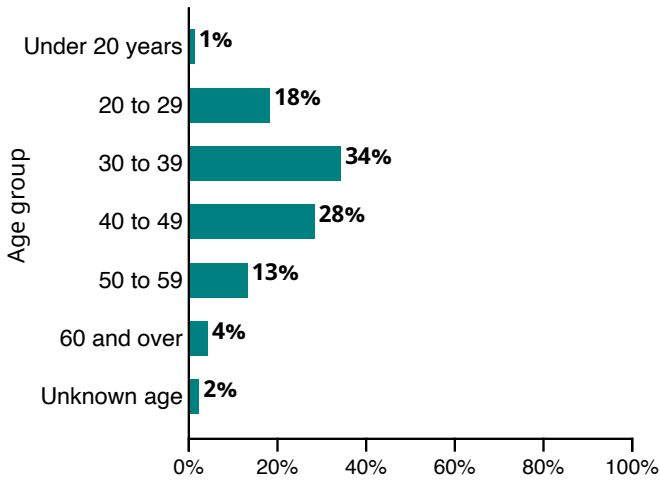
Gender distribution of SCS clients.



[Access the data](#)

► Figure 3 – Gender – Text description

Age distribution of SCS clients



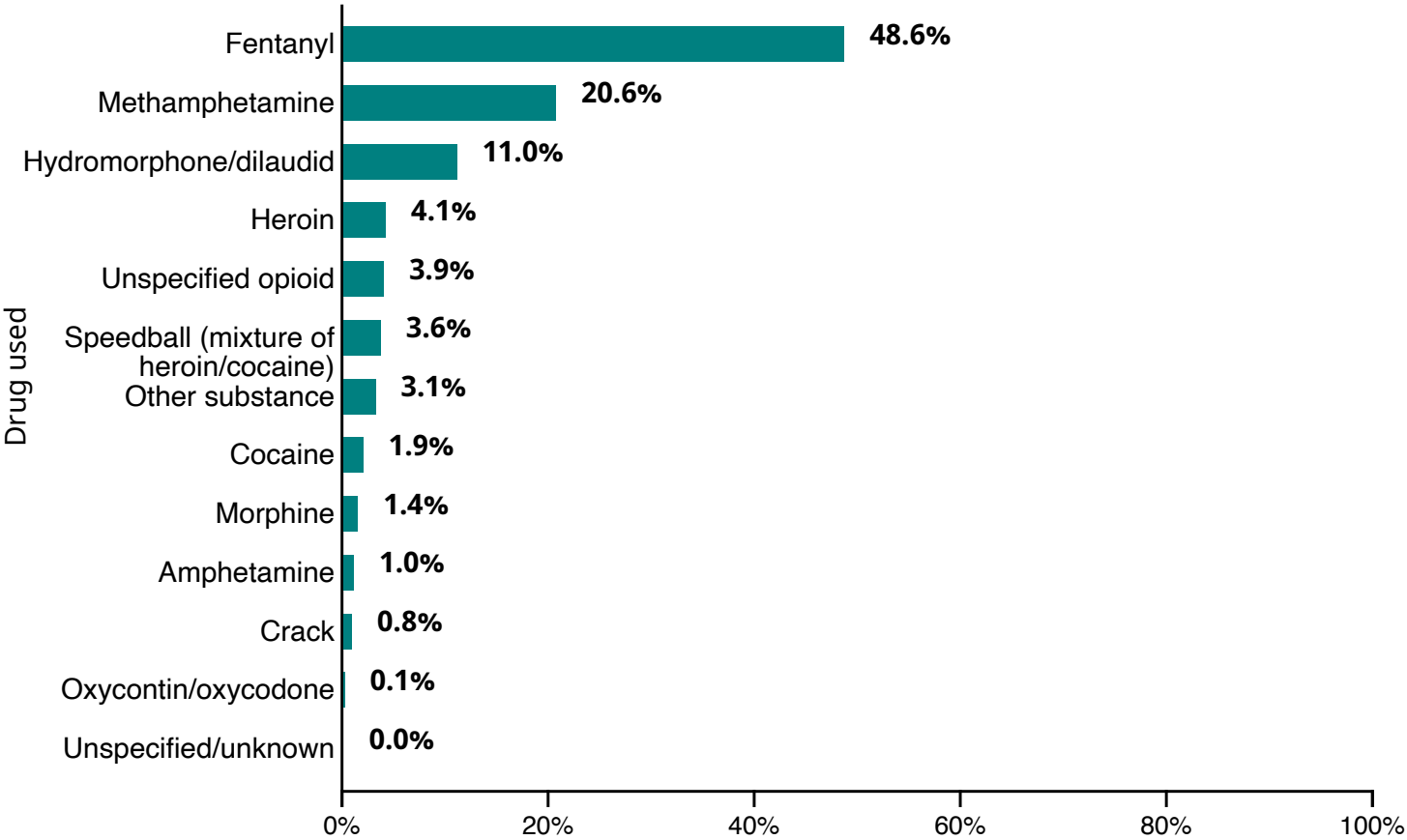
[Access the data](#)

► Figure 3 – Age – Text description

Drugs used

This bar chart shows which drugs were most frequently used by clients during their visits to an SCS between March 2020 and August 2024. Fentanyl is the most commonly used drug at supervised consumption sites.

Figure 4: Distribution of drugs used for all visits between March 2020 and August 2024 [Access the data](#)



► Figure 4 - Text description

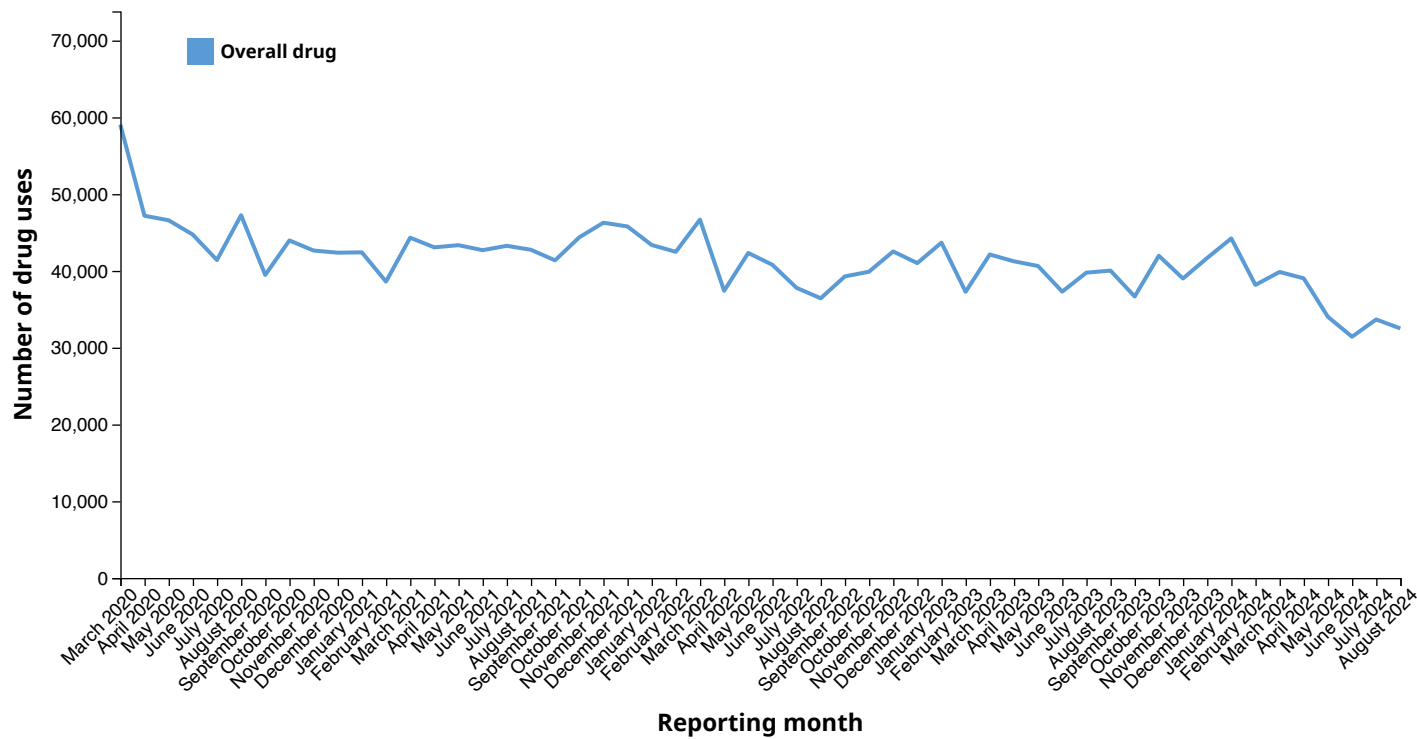
Figure 5 shows the number of drug uses overall and by specific drug at SCS between March 2020 and August 2024. Select a drug from the dropdown menu. Hover over or select a portion of the line graph to see drug uses overall or by drug type in each month.

Figure 5: Number of

overall drug

 uses between March 2020 and August 2024

Access the data



► Figure 5 - Text description

Calls for help, services, and referrals

Calls for help

4,328

Calls to emergency medical services (EMS)

3,516

Calls for other medical emergencies

869

Law enforcement calls

Services and referrals

874,401

Services provided within the SCS

62,763

Referrals to services offsite

156,762

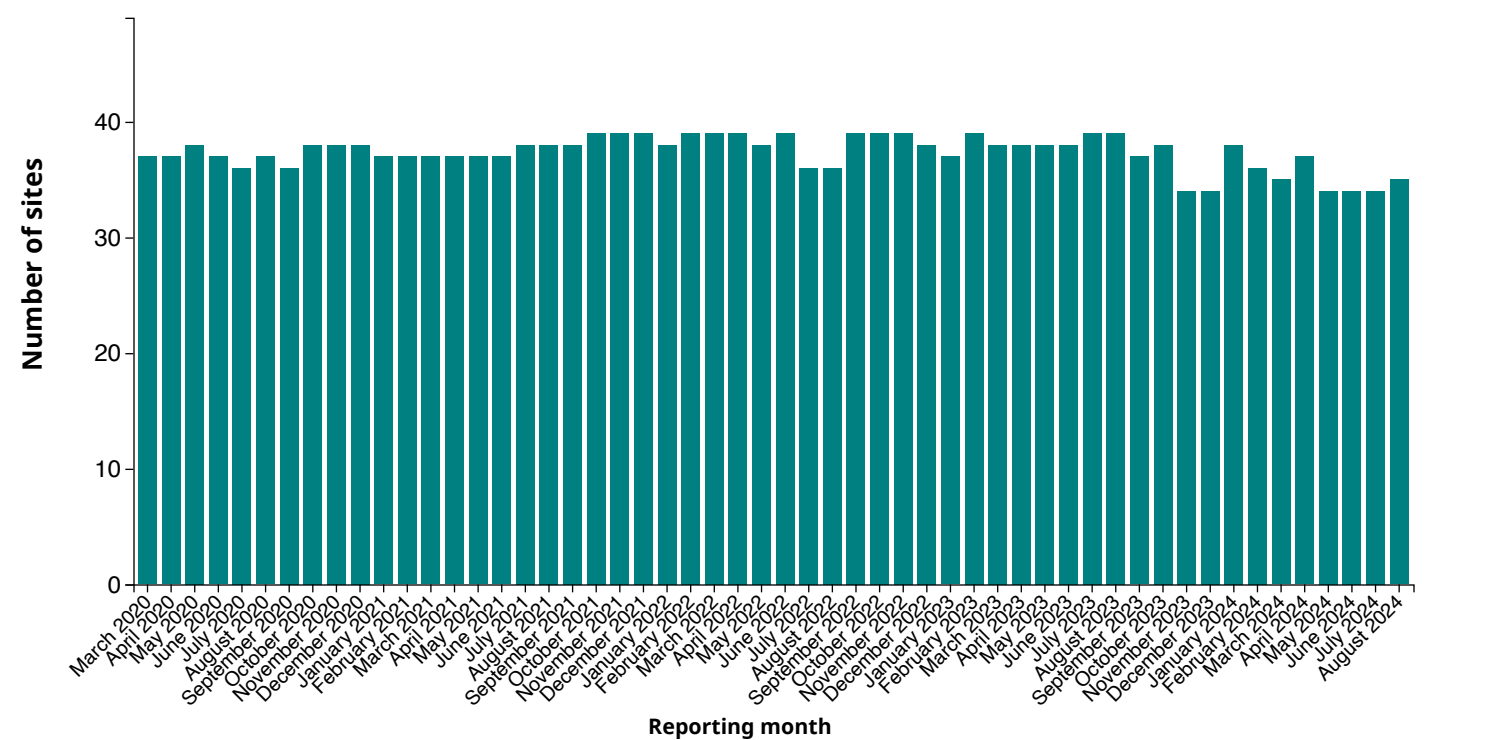
Referrals to services onsite

► About these tiles

Reporting SCS per month

The table below shows the number of reporting sites contributing data to each reporting month.

Figure 6: Number of sites reporting per month [Access the data](#)



► Figure 6 - Text description

Contact us

For comments or questions regarding data, contact us:

- Email: odss-bssd@hc-sc.gc.ca

You might also be interested in



Opioid- and Stimulant-related Harms in Canada

Data on overdoses and deaths involving opioids and/or stimulants from January 2016 to September 2022.



Drug Analysis Service and Cannabis Laboratories

Health Canada's Drug Analysis Service and Cannabis Laboratory operates laboratories across Canada that analyze suspected illicit substances seized by Canadian law enforcement agencies.

[All Health Infobase data products](#)

Did you find what you were looking for?

Yes

No

What was wrong?

Answers to frequently asked questions can be found in the [Understanding the data section!](#)

- ☐ The answer I need is missing
- ☐ The information isn't clear
- ☐ I'm not in the right place
- ☐ Something is broken or incorrect
- ☐ Other reason

Please provide more details

(Don't include any personal information. Note that you will not receive a reply.)

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2024-11-22

Estimating the Effects of Closing Supervised Consumption Sites in Toronto

Use of Services

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Michelle Wu
Frances Pogacar
Tianru Wang
Tara Gomes

2024

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Summary

Introduction

Supervised consumption sites have a strong evidence base for improving the health of people who use drugs but remain politically controversial. The Government of Ontario has announced plans to close 5 of 10 sites in Toronto by March 2025, and another site is likely to close after its lease expires. We estimated the impact of site closures on potential or actual use of SCSs.

Methods

We estimated the number of people who use drugs in Toronto, where they were located, and how many would lose potential access to SCS. We also estimated the number of people who currently use SCSs, the number of current clients who would lose access or shift their use to a different SCS, and the extra capacity required to address these service losses. We used administrative health data, data reported by SCSs to the Ontario Ministry of Health, and data reported directly by SCS operators. We analyzed data by forward sortation area (FSA) and under varying assumptions of each SCS's service radius (the distance clients would travel to access services, analyzed at 500, 1000, and 2000m).

Results

We estimated that, in 2022, 37,144 people used opioids or stimulants and had an encounter with health care in Toronto. People were located across the city, including many FSAs without an SCS. Over 90% of people who used opioids or stimulants and had an encounter with health care are located more than 500m from an existing site and over 75% are located more than 1000m away. Assuming 4 SCSs remain open and the service radius for an SCS is 500m, we estimated that 636 people (47% of current clients) would lose access if remaining sites were able to accommodate all clients within their service radius. Our results were sensitive to assumptions about the number of sites that remain open, the service radius, and the increase in capacity at sites that remain open.

Conclusions

SCSs in Toronto are currently accessible to only a small minority of people who use opioids and stimulants, and closing SCSs would exacerbate this disparity. Slated closures will result in large proportions of existing clients losing access. Sites that remain open would need to expand capacity considerably to accommodate clients who will lose access. Even with large increases in capacity among sites that remain open many current clients will remain very distant from an open SCS and are therefore likely to lose access to supervised drug consumption services once sites close.

- Supervised consumption sites (SCSs) are environments where supervised drug consumption services are available.
- Supervised consumption may include injection, smoking/inhalation, and oral consumption.
- Supervised consumption sites have been associated with many health benefits, including fewer overdoses and decreased mortality.
- The Government of Ontario has announced plans to close SCSs in Ontario, including 5 of the 10 Toronto sites. An additional site may close when its lease expires, as it may not be approved to open in a new location.

People who used opioids or stimulants with a healthcare encounter in 2022

- We estimated that, in 2022, 37,144 people used opioids or stimulants and had an encounter with health care in Toronto.
- Existing SCSs are concentrated in south-central Toronto and in forward sortation areas (FSAs) that had moderate to high rates and absolute numbers of people who use opioids and stimulants.
- Of people who used opioids or stimulants and had an encounter with health care in Toronto in 2022, 3,558 (9.6%) were located within 500m of an existing SCSs.
- If 5 sites were to close, we estimated the number of people who would be within 500m of a site would decrease 44% from current levels. If 6 sites close (4 remain open), the decrease would be 48%.

Individuals who used SCSs in Toronto in 2022-2023

- We estimated that, on average, 1,366 unique individuals used SCSs each month in Toronto between April 2022 and March 2023 (95% confidence interval 1,303 to 1,429).
- Of 561 clients of a site that will close, we estimated that 35 are located within 500m of a site that will remain open and 526 will be beyond this radius and thus, will lose access; this represents 38% of current clients. This assumes that sites that remain open can accommodate the 35 clients who will lose access.
- If 6 sites close, and with the same assumptions, 47% would lose access.
- We repeated these calculations assuming the service radius for the sites was 1000m (31 to 34% would lose access) or 2000m (20 to 22% would lose access).
- If 4 sites remain open and the service radius is 1000m, service capacity would need to increase by more than 50% to maintain services for 60% of clients of current sites.

Supervised consumption refers to situations in which people use drugs in an environment where they are observed by trained personnel, where sterile supplies are available, and where overdoses can be immediately treated. Supervised consumption sites (SCSs) refer to environments where supervised consumption services are available, which may include injection, smoking/inhalation, and oral consumption. In systematic reviews, supervised injection was associated with: decreased risky injection practices that are associated with transmission of bloodborne infections; increased adoption of safer sex practices that can prevent transmission of sexually transmitted infections; increased treatment rates for skin and soft tissue infections; decreased public injection and public litter associated with injecting; increased referral to other social and health services, including treatment for substance use disorder.¹⁻⁴ Studies in Toronto and Vancouver have demonstrated decreased mortality in neighbourhoods that have implemented supervised consumption services.⁵⁻⁷ However, SCSs continue to be controversial, with critics citing safety and security concerns.⁸⁻¹⁰

On August 20, 2024, the Government of Ontario announced plans to close 10 SCS sites throughout Ontario by March 31, 2025.¹¹ The government has indicated it will introduce legislation prohibiting SCSs within 200 meters of schools and childcare centres. Furthermore, the Government of Ontario also announced that sites whose circumstances change (for example, if their lease expires) will not be renewed, that Urgent Public Health Needs (UPHN) sites (which operate within shelters) will also be subject to the proposed legislation, and that other harm reduction initiatives (such as federally funded safer opioid supply programs, needle and syringe distribution within HART Hubs, and municipal decriminalization initiatives) will be prohibited. In short, the government's effects are likely to have a widespread impact on access to supervised consumption services and broad approaches to harm reduction in Ontario.

Toronto has 10 supervised consumption sites that serve community clients, the largest number of any city in Canada. An additional supervised consumption site serves inpatients of Casey House, a specialty hospital, and several UPHNs operate in Toronto shelters. Of the 10 community sites, 5 are listed as being mandated to close under the government's directive. An additional site may close as its lease will expire and it may not be approved to open in a new location.¹² To date, no study has estimated the impact of the planned site closings on the services delivered by SCSs. We studied this potential impact from 3 perspectives: all people who use drugs in Toronto, current clients of SCSs in Toronto, and increased demands on the 4 or 5 sites that will remain open after March 2025.

Methods

We aimed to estimate the impact of potential SCS closings on people who use drugs in Toronto with respect to their potential or actual use of SCSs. Our study had 4 objectives:

1. To visualize the geographic distribution of people who use drugs across Toronto in relation to supervised consumption sites, before and after anticipated site closings.
2. To estimate the population of people who use drugs who are located near a supervised consumption site, before and after anticipated closings, and calculate the anticipated number who would lose potential access.
3. To estimate the number of people currently using SCSs in Toronto.
4. To estimate the number of people currently using SCSs in Toronto who will lose access to services due to anticipated site closing and the increased need for capacity at sites that remain open.

Objectives 1 and 2 focus on estimating the number of people who use drugs in Toronto and then estimating how many would lose potential access to SCS. Objectives 3 to 4 start with estimating the number of people who currently use SCSs and then estimate the number of current clients who would lose access or shift their use to a different SCS.

For each SCS, we sought to collect the number of unique client visits per month and the number of interactions for consumption visits per month. We obtained this information both directly from SCS operators as well as from the Ontario Ministry of Health (2022 data). Some data elements were missing for some sites (most commonly, the number of unique clients), which we estimated probabilistically (see below). In our baseline analyses, we assumed that 6 sites would close; we also included supplementary analyses assuming only 5 sites would close.

We used data from ICES to estimate the following outcomes related to opioid or stimulant use in Toronto. ICES data sources are listed in the [Appendix](#). These datasets were linked using unique encoded identifiers and analyzed at ICES. We calculated outcomes at the level of forward sortation area (FSA), the first 3 digits of the postal code:

- The number of people who have an opioid-dependence related emergency department visit or hospitalization.
- The number of people who have an opioid-toxicity related emergency department visit or hospitalization. Toxicity is also sometimes called overdose or poisoning.
- The number of people who have a stimulant-dependence related emergency department visit or hospitalization.
- The number of people who have a stimulant-toxicity related emergency department visit or hospitalization.
- The number of people who have at least one outpatient physician visit related to substance use.
- The number of people who were dispensed at least one dose of opioid agonist therapy (OAT).
- The number of deaths due to opioid toxicity, stimulant toxicity, or both.

We calculated these numbers for each FSA and each year from 2018 to 2022, except for opioid and stimulant toxicity deaths, for which data were only available up to December 31, 2021.

Estimating the number of people who use opioids or stimulants

To estimate the total number of people who use opioids or stimulants and who might be potential clients of a supervised consumption site, we counted the number of unique individuals who had one or more outcome. Given the nature of our data sources, a single outcome measure may only include a portion of people who use drugs. In contrast, a global outcome measure gives us the best estimate of how many people who use drugs in Toronto and the distribution of people within each FSA.

Mapping drug use in Toronto

We constructed choropleth maps of the rate (number of people who use opioids or stimulants per population) for each FSA in Toronto using 2022 data, overlaid with SCS locations. Our interpretation of these maps was descriptive. We also generated maps of the absolute number of people who use drugs by FSA for 2022. Each map tells a different story: rates are important for estimating the concentration of drug use in neighbourhoods, while numbers are important for determining the required capacity of SCSs by neighbourhood. We also repeated maps using the average of rates and the total numbers of people over all years of the analyses.

The number of people who use opioids or stimulants near any SCS

We estimated the number of people who use opioids or stimulants who are within 500m of an existing SCS. This estimate includes both current clients as well as potential clients. This approach estimates the potential of supervised consumption services at defined locations to address the needs of all people who use drugs in Toronto. We drew a 500m radius around each SCS and calculated the proportion of each intersecting FSA's area within that circle. We avoided double-counting by assigning overlapping circles equally among the SCS that are part of the overlap. As a simplifying assumption, we assumed that the population in each FSA was uniformly geographically distributed. Thus, the product of the proportion in intersecting areas and the FSA population of people who use opioids or stimulants yielded the estimate of the population who were within 500m of an SCS. We summed this number across all FSAs to estimate the number of people across Toronto who were within 500m of any SCS.

Next, we repeated these observations assuming that the SCSs that are slated to close were not operating. The difference between these estimates therefore indicates the number of people whom we expect to lose potential or actual access to an SCS after site close.

Because the distance that people will travel to use a SCS is uncertain, we repeated these analyses using distances of 1000m (1 kilometer) and 2000m (2 kilometers).

Estimating the number of unique clients of SCSs

Our data sources included the number of unique clients who visited an SCS for 6 sites; this includes visits for consuming drugs as well as other visits from April 2022 to March 2023. We also had data on the total number of visits and the number of visits specifically for drug consumption. For each site with available data, we used regression models to investigate the association between the number of unique clients and the number of total visits, the number of visits specifically for drug consumption, and calendar month. We also explored running the regression models for all sites or restricting to those in Toronto. Finally, we noted that one site was an outlier; we additionally explored models where we included an indicator for that site. We compared and selected regression models using model fit statistics.

We used the following approach to estimate the number of unique clients in the 4 sites which did not report these outcomes but did report the total of number of visits by calendar year. We distributed these client visits across months, assuming the distribution was identical to that observed in sites with monthly data. We explored applying distributions from Toronto sites and from all Ontario sites (Toronto distributions yielded a better model fit). Next, we forecasted the number of unique clients using the regression model results and the method of predictive margins.¹³ We checked to ensure that the observed and predicted number of unique clients at sites with complete data were reasonably close. Finally, we summed the total number of predicted clients across all 10 Toronto sites, with 95% confidence intervals (95CI) calculated using the delta method.

These estimates may be imprecise for several reasons. First, we may have included visits that are not related to consumption, leading to an over-estimate. Second, we based our estimates on monthly reports, but the annual number may be greater than twelve times this estimate since some clients may use sites only in some months, leading to an underestimate. Third, some clients may use more than one site, leading to an overestimate.

To address these uncertainties, we asked staff members at each SCS to comment on the face validity of the estimates of the mean number of visits for consumption per month, the mean number of unique clients per month, the proportion of clients who use the site monthly relative to the number who use the site annually, and the proportion who use the staff member's site as well as other sites. Based on the feedback we received from 9 sites, we revised our estimates in two ways. First, one of the sites with the largest number of clients reported that: 1) their monthly estimate, calculated as the number of annual clients divided by 12 was significantly larger than our estimate; and 2) about 40 to 50% of clients used multiple sites. We calculated the proportion of clients who would go to another site each month, assuming this was constant across months. Because our estimate (43%) was within the range of the estimate of clients using multiple sites, we assumed that these clients were counted in our estimates of clients visiting over sites. Second, one of the sites with fewest clients reported that our regression-based estimate (40 clients per month) was double their estimate; we used the site-reported estimate (20) without accounting for uncertainty. For all other sites, our estimates were close to site reports; we assumed that the relatively small number of clients using multiple sites that we did not account for was unlikely to meaningfully change our overall results (in some cases, the proportion using multiple sites was high, but the absolute number was low as the sites had small volumes).

We projected how many current SCS clients would lose access to SCS services. To do so, we made several assumptions. First, we assumed that clients who are within distance of multiple SCSs would be equally distributed between those sites. Second, we assumed that current SCS clients would stay at that SCS. Third, we assumed that clients at SCSs that close who are within 500m of another SCS will move to that SCS (if multiple sites are within 500m, we assumed equal number of clients would go to each site). Finally, we assumed that clients who currently use an SCS that closes and who are further than 500m of remaining open SCSs will lose SCS access. We initially assumed that sites that remain open had no limits in their ability to increase capacity, by which we mean an increase in the number of clients (we did not assess how this capacity could be achieved, such as changing operating hours or the number of booths). We next repeated these analyses assuming sites could only increase capacity by 10% or 20%. We repeated each of these analyses using distances of 1000m (1 kilometer) and 2000m (2 kilometers).

Finally, we examined how the proportion losing access varied across a range of assumptions about increase in site capacity (across all sites). This analysis focusing on identifying threshold increases site capacity that are necessary to minimize specified losses in access. Note that we did not address site-specific capacity constraints.

Results

People who used opioids or stimulants with a healthcare encounter in 2022

We estimated that, in 2022, 37,144 people used opioids or stimulants and had an encounter with health care in Toronto. Assuming that people lived close to where they had these encounters, people who used opioids or stimulants were geographically distributed across Toronto ([Figure 1](#) and [Figure 2](#)). The existing SCSs were concentrated in in the south-central Toronto and were located in forward sortation areas (FSAs) that had moderate to high rates of people who use opioids and stimulants ([Figure 1](#)). All SCSs were located in FSAs that had moderate to high absolute numbers of people who used opioids or stimulants, including sites that are slated to close ([Figure 2](#)). Our results were similar if we used estimates averaged across 5 years (2017 to 2022, [Figure S1](#) and [Figure S2](#)).

Figure 1: Choropleth map of the rate of people who use opioids or stimulants per 1000 population by FSA in 2022, overlaid with location of SCSs. Sites slated to remain open are indicated by a green dot, those slated to close by a red dot, and the site whose status is uncertain by a yellow dot.

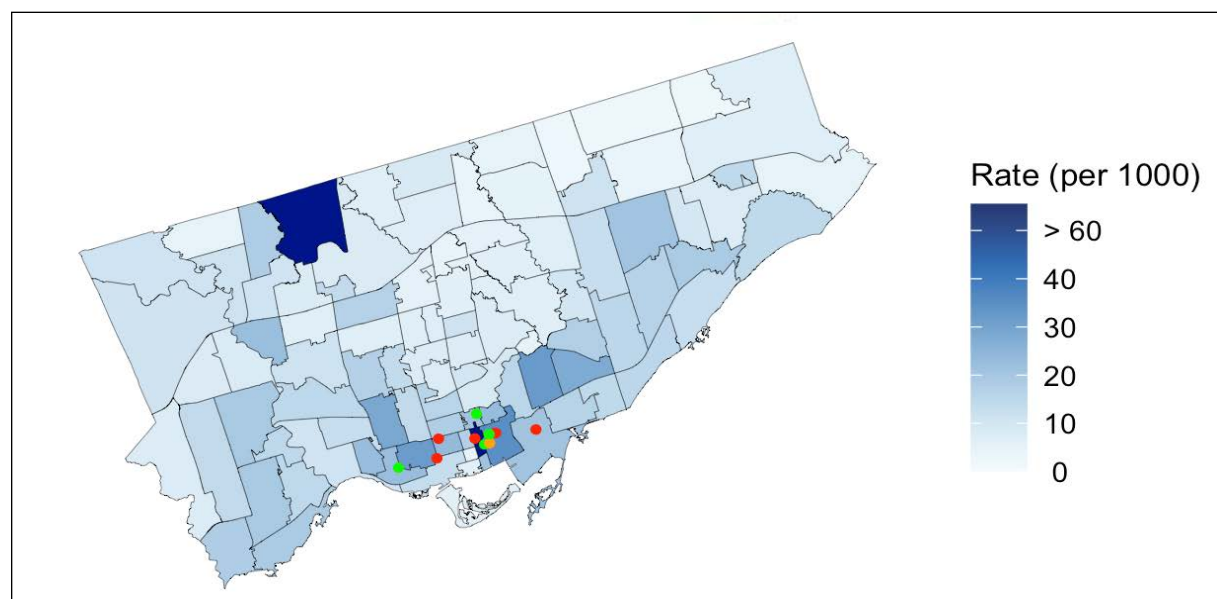
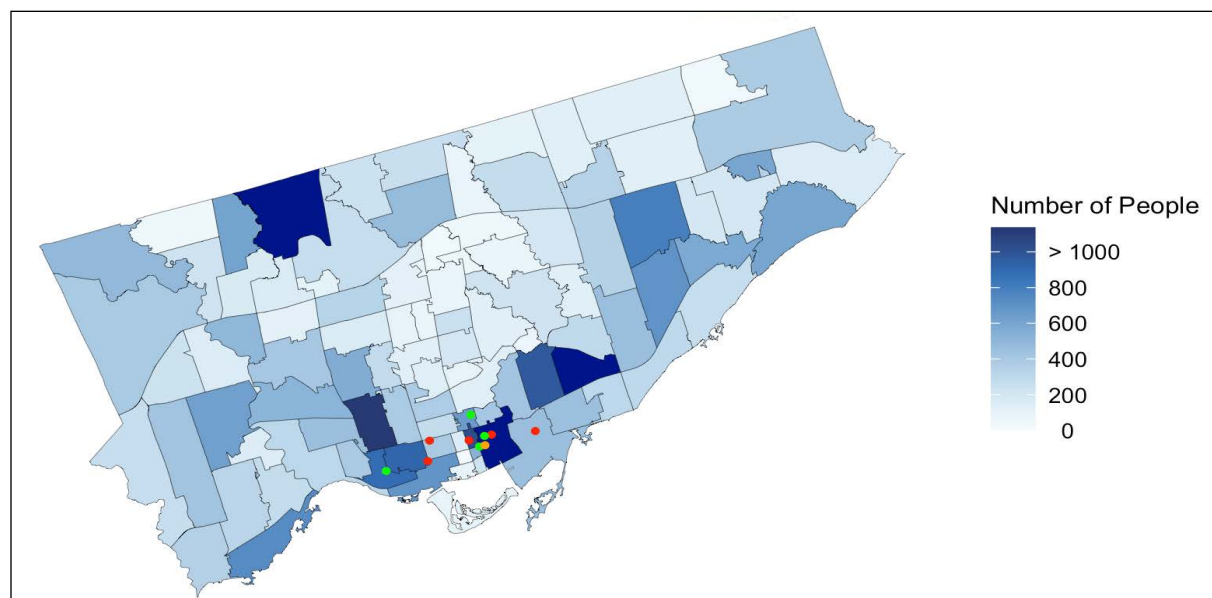


Figure 2: Choropleth map of the absolute number of people who use opioids or stimulants by FSA in 2022, overlaid with location of SCSs. Sites slated to remain open are indicated by a green dot, those slated to close by a red dot, and the site whose status is uncertain by a yellow dot.



Of the 37,144 people who used opioids or stimulants and had an encounter with health care in Toronto in 2022, 3,558 (9.6%) were located within 500m of an existing SCSs (Table 1). If 5 sites were to close, we estimated the number of people who would be within 500m of a site would decrease to 1,978 (1,580 people previously within 500m would now be located more distantly), a 44.4% decrease from current levels. This represents a 4.7% relative increase in the number of people who are located beyond the service radius. If 6 sites were to close (i.e., 4 remain open), we estimated that the number of people who would be within 500m of a site would decrease to 1,886 (1,692 would now be beyond 500m), a 47.6% decrease from current levels. Using a service radius of 1000m, the relative decrease in the number of people located within the service radius was 30.3% (5 sites close) and 32.0% (6 sites close); with a service radius of 2000m, the corresponding estimates were 24.6% and 25.6%.

Table 1: Relative change in number of people who use opioids or stimulants who encountered health care within 500m of an SCS after anticipated closures.

Number of open sites	Total	Number (%) within service radius	Change within service radius after SCS closure	Relative decrease in number within service radius	Relative increase in number outside of service radius
Service Radius: 500m					
10	37,144	3,558 (9.6%)			
5		1978 (5.3%)	1580	44.4%	4.7%
4		1866 (5.0%)	1692	47.6%	5.0%
Service Radius: 1000m					
10	37,144	9,116 (24.5%)			
5		6,350 (17.1%)	2766	30.3%	9.9%
4		6,200 (16.7%)	2916	32.0%	10.4%
Service Radius: 2000m					
10	37,144	17,051 (45.9%)			
5		12,855 (34.6%)	4196	24.6%	20.9%
4		12,680 (34.1%)	4371	25.6%	21.8%

We next focused on the number of current clients of SCSs in Toronto. We estimated that there were, on average, 1,366 unique individuals who used SCSs each month in Toronto in 2023 (95CI 1,303 to 1,429). Of these, 805 (59%) are clients of one the 5 sites that are slated to stay open ([Table 2](#)). Of the 561 who are clients of a site that will close, we estimated that 35 are located within 500m of a site that will remain open and 526 will be beyond this radius and thus, will lose access; this represents 38% of current clients. We repeated these calculations assuming that 4 sites would remain open (6 would close); in this scenario, 636 current clients (47%) would lose access. Finally, we repeated these calculations assuming the service radius for the sites was 1000m (31 to 34% would lose access) or 2000m (20 to 22% would lose access).

Table 2: Estimated number and percent of SCS clients who would lose access to services after anticipated closures

Number of open sites	Current clients	Number at a site that remains open	Number at site that will close	Number at a site that is closed but within service radius of a site that is open	Number (%) losing access
Service Radius: 500m					
10	1,366				
5		805	561	35	526 (38%)
4		585	781	144	636 (47%)
Service Radius: 1000m					
10	1,366				
5		805	561	138	423 (31%)
4		585	781	320	461 (34%)
Service Radius: 2000m					
10	1,366				
5		805	561	284	277 (20%)
4		585	781	484	297 (22%)

Our calculations in [Table 2](#) assume that sites that remain open will have unrestricted capacity to accommodate clients from sites that close. We repeated these analyses assuming that the total capacity across sites can increase by 10%; across a range of assumptions about the number of sites remaining open, service radius, and increase in site capacity, the number losing access ranged from 410 (30%) to 735 (54%) ([Table 3](#)).

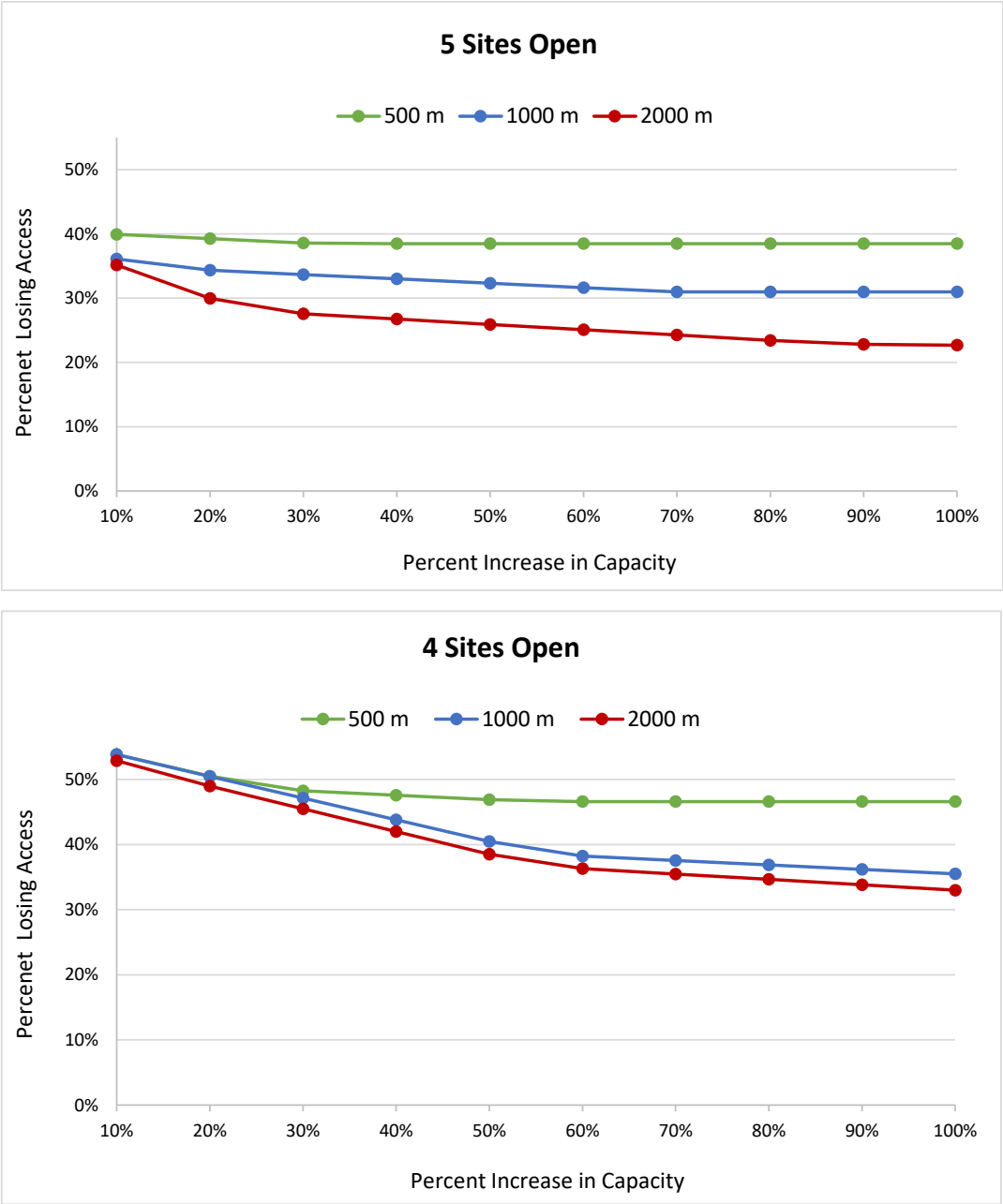
Table 3: Estimated number and percent of SCS clients who would lose access to services after anticipated closures, incorporating maximum increases in site capacity.

	5 Sites Remaining Open	4 Sites remaining Open
Service Radius	Number (%) losing access	Number (%) losing access
10% Increased Capacity		
500m	545 (40%)	735 (54%)
1000m	493 (36%)	735 (54%)
2000m	480 (35%)	722 (53%)
20% Increased Capacity		
500m	536 (39%)	690 (50%)
1000m	469 (34%)	690 (50%)
2000m	410 (30%)	669 (49%)

We also explored how the number losing access would change across a range of increased capacity estimates, from 10% to 100% (Figure 3). If 5 sites remain open and the service radius is 500m, increasing capacity will have little effect on the proportion of people who lose access, since most clients will be located beyond the service radius. If the service radius is 1000m, service capacity would need to increase by more than 100% (i.e., double) to decrease the proportion losing capacity to close to 30%; if the service radius is 2000m, service capacity would need to increase by 20% to reach this threshold. The large proportion who would still lose access represents clients who are located outside of the service radius.

If 4 sites remain open and the service radius is 500m, increasing capacity above 20% will have minimal effect on the proportion of people who lose access, since most clients will be located beyond the service radius. If the service radius is 1000m, service capacity would need to increase by more than 50% to decrease the proportion losing capacity to 40%; if the service radius is 2000m, service capacity would need to increase by about 50% to reach this threshold.

Figure 3: Change in percent of SCS clients losing access to services based on the anticipated percentage increase in capacity of remaining sites and distance from services, assuming 5 (top) or 4 (bottom) sites would remain open.



We analyzed the potential effects of the Government of Ontario's proposed closing of supervised consumption sites in Toronto. Our analyses are based on population-based administrative health data as well as data reported by SCSs, uses recent (2022) estimates, and includes multiple sensitivity analyses to address the robustness of our findings.

Our analysis yields several lessons that can inform the current policy discussion about site number and location. First, existing SCSs serve people in south central Toronto but are not geographically accessible (i.e., within a reasonable service radius) to the large majority of people who use opioids and stimulants in Toronto. Over 90% of people who use opioids or stimulants are located more than 500m from an existing site and over 75% are located more than 1000m away. Thus, in contrast to the proposed policy of closing sites, expanding SCSs accessibility by opening locations in additional neighbourhoods could support a larger population of people who use opioids and stimulants across the city. Second, even in neighbourhoods with an existing SCS, the slated closures will result in 25 to 48% of current or potential clients losing accessibility. Third, among existing SCS clients, we anticipate 20 to 47% will lose access after sites are closed, assuming that sites that remain open can accommodate clients from closed sites within their service radius. If the increase in capacity among existing sites is constrained (for example, by budget, staffing, and space considerations), the expected losses are greater. For example, if capacity can only increase by 10%, the site service radius is 500m, and 4 sites remain open (6 close), we predict that 735 clients (54%) will lose access.

A key factor in our model is the distance that individuals will travel to use supervised consumption services. Data on distance travelled to an SCS is unavailable for sites in Toronto. However, a 2006 survey of people who inject drugs in Toronto found that 51% would not travel more than 10 blocks (approximately 500 to 600m) and 72% would not travel more than 1000m to an injection site; for a smoking site, the percentage who would travel up to 10 blocks and 1000m were 49% and 60%, respectively.¹⁴ In a survey of people who inject drugs in London, the proportion who would not walk more than 20 minutes (roughly 1.5 km) was 60% in the summer months and 84% in the winter months.¹⁵ A study of site clients in Sudbury found that many reported that needing to walk 20 minutes was a significant barrier to accessing the site.¹⁶ Given these uncertainties, we provide estimates across a range of distances (500, 1000, and 2000m). While we have not modeled a distribution of willingness to travel, previous data suggest that our estimates using service radii of 500 and 1000m will include most clients.

Our study is one of the first to estimate the absolute number of people who use opioids, stimulants, or both in Toronto. Our estimate of 37,144 people is likely conservative (i.e., an underestimate), since it includes only people who have encountered the health care system through a physician visit, hospitalization, prescription for opioid agonist therapy, or death. Nevertheless, our estimate has face validity; given a July 2022 population of 3,025,647, our estimate is that at least 1.2% of the population (1.4% of the population over aged 16) uses opioids, stimulants, or both.¹⁷ These estimates are consistent with other population-based estimates.^{18, 19} Importantly, this estimate includes: people with a range of use patterns (for example, one-time use to daily); people who use drugs by injection, inhalation or orally; and people with a spectrum of social supports (for example, housed, living alone, or homeless). For example, our finding of a neighbourhood in north Toronto with high rates of stimulant/opioid use may reflect the location of a concert site at which many drugs are consumed. The value of supervised consumption services to each individual will depend on their drug-use related risks, which include the factors noted above, and others. Nevertheless, our estimated monthly client numbers (1,366) relative to the population size (37,144), suggests that increasing accessibility of supervised consumption sites has the potential to reach a large proportion of people who might benefit from, but are not currently accessing, these services.

We explored the potential demand on sites that are expected to remain open to meet the increased demand from clients of supervised consumption sites that are slated to close. We found that, across all sites, capacity would need to be increase by at least 20% to meet the needs of about 30 to 50% of clients losing access. Importantly,

this estimate represents an increase in capacity across all open sites; analysis with more detailed site-specific data would likely indicate heterogeneity in capacity demands across sites. Our analysis also indicates that increasing capacity by more than 50 to 60% may have little impact on meeting the needs of clients who lose access due to the distance of those clients from the remaining sites. Therefore, meeting the needs of clients at sites that close requires addressing both the capacity and geography.

Our analysis focused on estimating the number of clients – both prospective and current – who would be affected if SCSs were to close in Toronto, but did not estimate the effects on the number of fatal and non-fatal overdoses or other health outcomes. Such estimates require additional analysis and modeling approaches and are a topic for future research. We also did not estimate other neighbourhood effects, which have become the focus of much of the current controversy around SCSs in Toronto, including neighbourhood disorder, discarded injection equipment and other litter, and crime.²⁰ However, the existing literature indicates there is not a strong relationship between SCSs and deleterious neighbourhood effects and suggests that SCSs may decrease neighbourhood crime. Indeed, if drug use is primarily a function of neighbourhood and the impact of SCS is to shift drug use out of public spaces, closing SCSs may have the unintended impact of increasing public drug use; this is an important topic for future research.

The Government of Ontario's strategy is to establish Homelessness and Addiction Recovery and Treatment (HART) Hubs alongside the closure of SCSs. We have not modelled how HART Hubs might substitute for some of the services that SCSs currently offer as our analysis has focused only on supervised drug consumption, which HART Hubs will not be allowed to offer. HART Hubs may offer some of the “wrap-around” social services that SCSs currently offer, such as housing and income support. We have not included non-consumption related visits in our analyses. We also have not accounted for potential increased access to ‘recovery’ (i.e., abstinence-based) services within HART Hubs and how this may decrease demands for supervised consumption services. However, there is no evidence to indicate that clients will seek abstinence-based services as an alternative when supervised consumption services are closed.

Our analysis has some additional limitations to those mentioned above. We have focused on counting the number of monthly visitors, rather than annual visitors to SCS in Toronto. Because some people may visit SCSs only in some months, the number of annual visitors will be higher than our estimate. We also have not accounted for changes in the number of unique clients over time. Notably, some sites reported increasing numbers of clients and visits in 2023. Overall, we feel that our estimates of the number of clients is conservative. We also did not consider UPHNs, whose services are limited to shelter residents. Finally, as noted above, we have classified individuals by the location of health services that they used, which may not correspond to the location of the SCS that they would use. Nevertheless, health service location is likely a more accurate indicator of location than address, given the large number of people who use drugs who experience homelessness, unstable housing, and frequent relocation.

In summary, our analysis indicates that there are likely to be significant impacts on clients from the closure of SCSs in Toronto. Many clients will have to travel for more than 1 or 2 kilometers for services that are currently located close to where they access supervised consumption services. Because it is likely that many people will not travel far distances, we project that a large proportion of people – almost 50% in some scenarios – will lose access to an intervention with a strong evidence base for improving their health and well-being. Our analysis underscores the urgency of reconsidering the planned SCS closures.

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ICES Data Sources

We used the following ICES data sources:

- Canadian Institute for Health Information (CIHI) Discharge Abstract Database, which is a database of acute inpatient hospital discharges
- CIHI National Ambulatory Care Reporting System, which is a database of emergency room visits
- Ontario Drug Benefit Database, which is a database of dispensed medications that are publicly funded, including all naloxone kits distributed by pharmacies
- Drug and Drug/Alcohol Related Death Database, which is a database of substance-use toxicity deaths
- Narcotics Monitoring System, which is a database including all opioids dispensed from community pharmacies
- Ontario Health Insurance Plan (OHIP), which is a database of physician billings
- Registered Persons Data Base (RPDB), which is a database of basic demographic information
- Postal Code Conversion File (PCCF), which is a database of Statistics Canada standard geographical area

Figure S1: Choropleth map of the average rate of people who use opioids or stimulants per 1000 by FSA from 2018-2022, overlaid with location of SCSs and colour-coded by status (red – closing, green – open, yellow – unsure).

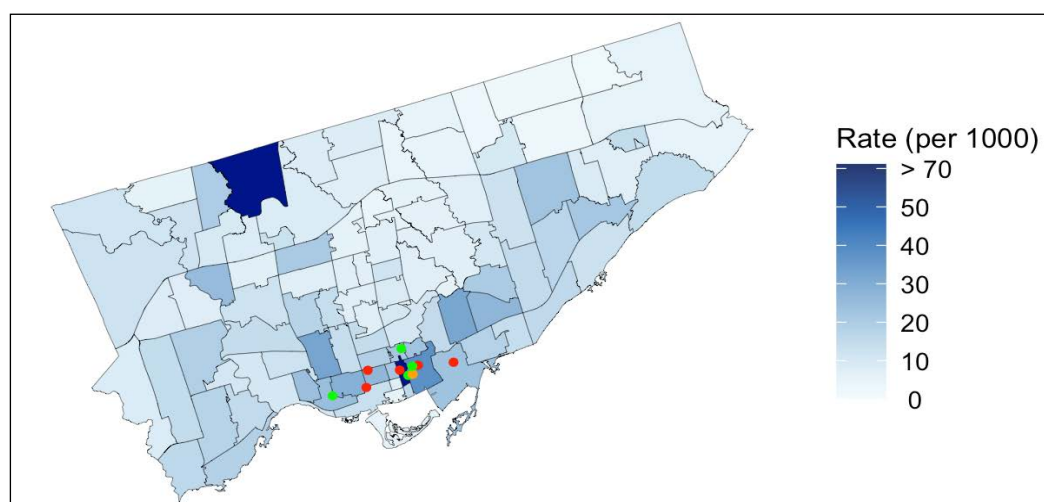
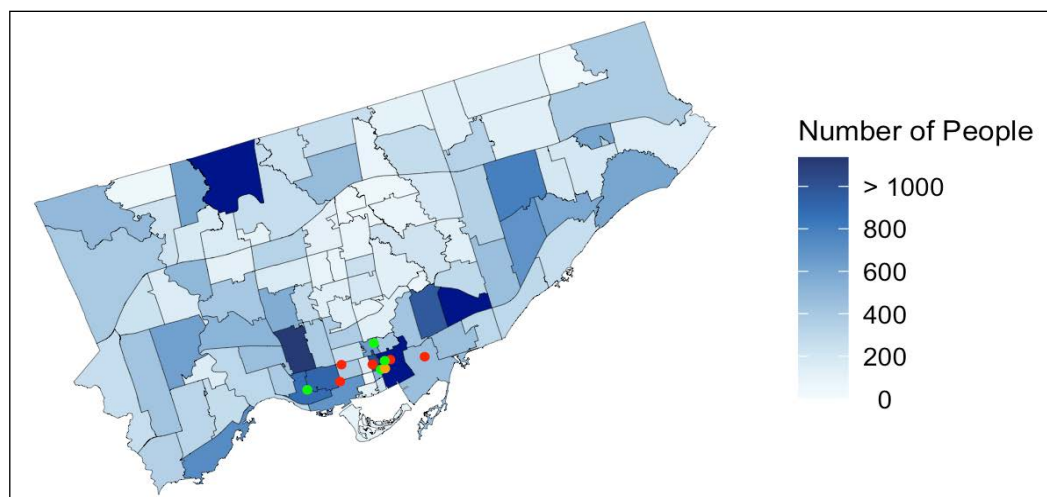


Figure S2: Choropleth map of the total absolute number of people who use opioids or stimulants by FSA from 2018-2022, overlaid with location of SCSs and colour-coded by status (red – closing, green – open, yellow – unsure).



TAB B

This is Exhibit “B” referred to in the Affidavit
of Ahmed Bayoumi sworn January 8, 2025.

Carlo Di Carlo

Commissioner for Taking Affidavits

Court File No. CV-24-00732861-0000

ONTARIO
SUPERIOR COURT OF JUSTICE

B E T W E E N:

THE NEIGHBOURHOOD GROUP COMMUNITY SERVICES, KATHARINE
RESENDES and JEAN-PIERRE AUBRY FORGUES

Applicants

and

HIS MAJESTY THE KING IN RIGHT OF ONTARIO

Respondent

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

ACKNOWLEDGMENT OF EXPERT'S DUTY

1. My name is Ahmed Bayoumi. I live at Toronto, in the Province of Ontario.
2. I have been engaged by or on behalf of Stockwoods LLP, Lax O'Sullivan Lisus Gottlieb LLP and Nanda and Company to provide evidence in relation to the above-noted court proceeding.
3. I acknowledge that it is my duty to provide evidence in relation to this proceeding as follows:
 - (a) to provide opinion evidence that is fair, objective and non-partisan;
 - (b) to provide opinion evidence that is related only to matters that are within my area of expertise; and
 - (c) to provide such additional assistance as the Court may reasonably require, to determine a matter in issue.

-2-

4. I acknowledge that the duty referred to above prevails over any obligation which I may owe to any party by whom or on whose behalf I am engaged.

5. I certify that I am satisfied as to the authenticity of every authority or other document or record to which I have referred in the expert report accompanying this form, other than:

- (a) documents and records provided to me by or on behalf of the party intending to call me as a witness and consisting of evidence or potential evidence in the court proceeding that I have analysed or interpreted in my report;
- (b) authorities and other documents and records to which I have referred in my report only in order to address how another expert witness in the same court proceeding has used them in their report; and
- (c) the following authorities, documents and records, for which I have doubts as to their authenticity as detailed within my report:

Note: Under the Rules of Civil Procedure, an authority or other document or record that is published on a government website or otherwise by a government printer, in a scholarly journal or by a commercial publisher of research on the subject of the report is presumed to be authentic, absent evidence to the contrary. If you are aware of evidence to the contrary, list the authority, document or record under 5.c. and provide further details in the accompanying report.

None.

Date January 8, 2025



Signature
AHMED BAYOUMI

THE NEIGHBOURHOOD GROUP
COMMUNITY SERVICES et al.

and

HIS MAJESTY THE KING IN RIGHT
OF ONTARIO

Court File No. CV-24-00732861-0000

ONTARIO
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Court File No. CV-24-00732861-0000

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Lawyers for the Applicants

TAB 12

Court File No. CV-24-00732861-0000

ONTARIO
SUPERIOR COURT OF JUSTICE

B E T W E E N:

THE NEIGHBOURHOOD GROUP COMMUNITY SERVICES, KATHARINE
RESENDES, and JEAN-PIERRE AUBRY FORGUES

Applicants

and

HIS MAJESTY THE KING IN RIGHT OF ONTARIO

Respondent

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

AFFIDAVIT OF DAN WERB

I, DAN WERB, of the City of Toronto, in the Province of Ontario, MAKE OATH AND SAY:

1. I have been retained by Stockwoods LLP, Lax O’Sullivan Lisus Gottlieb LLP and Nanda and Company on behalf of their clients the Neighbourhood Group Community Service, Katharine Resendes and Jean-Pierre Aubry Forgues as an expert in the above-noted proceeding.
2. A copy of my expert report is attached hereto as **Exhibit “A”**. A copy of my *curriculum vitae* is included as an appendix to my expert report.
3. A copy of my Acknowledgement of Expert’s Duty is attached hereto as **Exhibit “B”**.

SWORN by Dan Werb of the City of Toronto,
in the Province of Ontario, before me at the
City of Toronto, in the Province of Ontario, on
January 9, 2025, in accordance with O. Reg.
431/20, Administering Oath or Declaration
Remotely.

}

Carlo Di Carlo

Commissioner for Taking Affidavits
(or as may be)

Carlo Di Carlo
LSO 62159L

Dan Werb

DAN WERB

TAB A

This is Exhibit “A” referred to in the Affidavit of
Dan Werb sworn January 9, 2025.

Carlo Di Carlo

Commissioner for Taking Affidavits

Court File No. CV-24-00732861

**ONTARIO
SUPERIOR COURT OF JUSTICE**

BETWEEN:

(Court Seal)

THE NEIGHBOURHOOD GROUP COMMUNITY SERVICES, JEAN-PIERRE AUBRY FORGUES and
KATHARINE RESENDES

Applicants

and

HIS MAJESTY THE KING IN RIGHT OF ONTARIO

Respondent

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

EXPERT REPORT OF DR. DAN WERB

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I. MY BACKGROUND

I am the St. Michael's Hospital/University of Toronto Chair of Mental Health and Substance Use Disorders and Executive Director of St. Michael's Hospital's Centre on Drug Policy Evaluation, as well as an Associate Professor with a dual affiliation at the Institute of Health Policy, Management & Evaluation at the University of Toronto and the Division of Infectious Diseases & Global Public Health at the University of California San Diego. Attached as **Appendix "A"** to this Affidavit is a copy of my curriculum vitae, which sets out my education, work experience, and academic research and service contributions.

My expertise is on issues related to substance use, overdose, drug policy, infectious disease, and mental health, with a focus on overdose prevention, implementation science, understanding and preventing the initiation of injection drug use, and identifying the impact of policy and public health interventions on marginalized drug-using populations experiencing psychiatric comorbidities. Part of this expertise includes research regarding the effectiveness of supervised consumption services ("SCS") and overdose prevention services. Specifically, I have reviewed and am familiar with literature and analyses from around the world on this topic and have generated evidence myself through conducting research studies and analyses, visits to such facilities, as well as through interviews of operators, staff and clients of these sites. I completed a PhD in Population and Public Health at the University of British Columbia in 2013. My dissertation focused on characterizing the transition of people into injection drug use and identifying approaches to prevent or delay this transition.

I am the recipient of several competitive research grants from government and other science funding agencies in Canada and the United States, including the Canadian Institutes of Health Research, the U.S. National Institute on Drug Abuse, the U.S. Fogarty International Center, and Canada's New Frontiers in Research Fund. I have published over 135 peer-reviewed studies in the world's leading clinical, scientific, and academic journals. I have authored 21 technical reports for federal and provincial government agencies in Canada and the general public. Currently, I am serving as a member of the Canadian Centre on Substance Use and Addictions's Municipal Leadership Table Expert Group, as well as Co-Investigator of the Ontario node of the Canadian Research Initiative in Substance Matters.

The quality and impact of my scientific research has been recognized with several distinctions and awards. Among other honours, I am an inaugural winner of the U.S. National Institute on Drug Abuse's Avenir Award, awarded to creative new investigators proposing highly innovative research at the intersection of HIV and substance use; the winner of a Trailblazer Award from the Canadian Institutes of Health Research; the winner of an Early Researcher Award from the Ontario Ministry of Research, Innovation, and Science; and the winner of a Pandemic Preparedness and Health Emergencies Early Career Investigator Prize from the Centre for Research on Pandemic Preparedness and Health Emergencies at the Canadian Institutes of Health Research.

I served as a member of the Minister of Health's Federal Expert Task Force on Substance Use in 2021. Our mandate was to generate recommendations to government on the most effective policy, programmatic, and clinical responses to prevent overdose and other drug-related harms. In 2018, I served as Official Country Representative for Canada to the United Nations Office on Drugs & Crime expert working group on improving drug statistics and strengthening the collection of international standardized surveillance data on substance use. In all, I have served as a technical expert on 13 scientific committees in Canada, the United States, and Europe.

Since August 2018, I have served as the Principal Investigator of the Canadian Institutes of Health Research-funded Ontario Integrated Supervised Injection Services (OiSIS) study (renamed in 2022 to the Toronto Disparities, Overdose, and Treatment [T-DOT] study), a multi-methods observational study that investigates the impact of services, including SCS, on drug-related, clinical, and social outcomes among people who use drugs in Toronto, Ontario.

On the basis of my education, credentials, academic research and service, and my role as a Principal Investigator studying the impacts of SCS and other services on overdose and other substance-related outcomes, I have personal knowledge of the information set out in this affidavit, except to such matters based upon information and belief.

II. DESCRIPTION OF MANDATE

I have been retained by Stockwoods LLP, Lax O’Sullivan Lisus Gottlieb LLP and Nanda & Company as an expert witness in relation to *The Neighbourhood Group Community Services et al. v. His Majesty The King in Right of Ontario*, Court File No. CV-24-00732861 (the “Application”).

I have been asked to prepare a report that provides my answers to the following questions:

- a) Do SCS affect crime rates in the communities in which they are located? How so?
- b) Do SCSs affect homicide rates in the communities in which they are located? How so?
- c) Do SCS’s affect overdose-based mortality in the communities in which they are located? How so?
- d) Who accesses SCS? What are the socio-demographic characteristics of individuals who are most likely to use these facilities?
- e) What are, in your opinion, the likely ramifications for users of SCS services and the communities in which they are located if the Community Care and Recovery Act goes into effect?

In preparing this report and addressing those questions, I relied on my experience and expertise and reviewed the documents listed in Section V of this Report, below. I also reviewed the Notice of Application filed by the Plaintiffs in this matter.

Counsel did not provide me with any factual assumptions on which my opinion is based. Any facts that I relied on in coming to the opinions I have set out in this report below.

III. SUMMARY OF OPINIONS

My opinion respecting each of the above-noted questions is summarized as follows:

- a) On the whole, SCS do not appear to meaningfully affect neighbourhood-level violent crime rates in the communities in which they are located, nor do they appear likely to affect neighbourhood-level property crime. To the contrary, the evidence that does exist suggests that neighbourhoods that implement SCS sites experienced a significant downward shift in rates of assault and robbery.
- b) There is no evidence to suggest that homicide rates rise in areas near SCS, in the short term, medium, or long term.
- c) In multiple cities, the evidence suggests that SCS openings have been correlated with a reduced overdose mortality rate in the neighbourhoods in which they are located.
- d) SCS in Ontario have been visited over one million times over the past four years, and SCS clients appear to frequently suffer from homelessness, be precariously housed, at high risk of overdose, and at risk of injecting in public.
- e) The likely ramifications of the closure of SCS in Ontario is a higher overdose mortality rate in neighbourhoods in which they are located, along with a higher prevalence of public injecting, fewer referrals for users of SCS services to social services and clinical care, and the potential for increased transmission of infectious diseases such as HIV and hepatitis C among their clients. Bans on the distribution of sterile syringes by frontline service providers selected as HART hub locations will also likely contribute to infectious disease transmission.

IV. BASIS OF MY OPINIONS

A. Do supervised consumption services affect crime rates in the communities in which they are located? How so?

The literature that I have reviewed on this topic and my own research concludes that the availability of SCS in a community does not result in meaningful increases in crime in surrounding areas. To the contrary, the research suggests that the availability of SCS results, in some cases, in a *decrease* in crime rates (relative to the surrounding area and based on what would be expected according to trends prior to the opening of SCS).

i. General Comments About SCS Studies

SCS sites have been implemented in many settings, with over 100 sites in more than 60 cities across 11 countries globally.¹ A large body of peer-reviewed scientific evaluations of supervised consumption sites undertaken internationally and across Canada over multiple decades has shown that these services have positive impacts on the communities which they are located.^{2,3,4} Of note, in 2018, the existing scientific research was summarized by the Government of Ontario's Ministry of Health and Long-Term Care in an internal report

¹ Roque Camacho ME. Drug consumption rooms: an overview of provision and evidence. *Medicina y ética* 2022; 33(4): 1167-78.

² Levengood, T. W., G. H. Yoon, M. J. Davoust, S. N. Ogden, B. D. Marshall, S. R. Cahill and A. R. Bazzi. (2021). "Supervised injection facilities as harm reduction: A systematic review." *American Journal of Preventive Medicine* 61(5): 738-749.

³ Magwood, O., G. Salvalaggio, M. Beder, C. Kendall, V. Kpade, W. Daghmach, G. Habonimana, Z. Marshall, E. Snyder and T. O'Shea. (2020). "The effectiveness of substance use interventions for homeless and vulnerably housed persons: a systematic review of systematic reviews on supervised consumption facilities, managed alcohol programs, and pharmacological agents for opioid use disorder." *PloS One* 15(1): e0227298.

⁴ Potier, C., V. Laprévote, F. Dubois-Arber, O. Cottencin and B. Rolland. (2014). "Supervised injection services: what has been demonstrated? A systematic literature review." *Drug and Alcohol Dependence* 145: 48-68.

titled “Supervised Consumption Services (SCS) and Overdose Prevention Services (OPS): Summary of Evidence and Expert Consultations”. The report concluded that, based on the existing scientific evidence, “There was no increase in drug-related crime or drug dealing associated with implementation of SCS.” The report also stated that “SCS are associated with a decrease in public drug use and inappropriate disposal of equipment.”

At present, there are 4 scientific peer-reviewed studies^{5,6,7,8} that include primary data and 4 systematic reviews⁹ that have reviewed what is known regarding an association between SCS implementation and crime. These scientific studies have employed a range of methods, including qualitative, quantitative, spatial, and quasi-case-control. Broadly, they have concluded that there is a low likelihood that SCS contribute to neighbourhood crime. Prior to 2023, only two studies, one using data from Sydney, Australia between 1999-2002, and the other using data from Vancouver, Canada between 2002-2004, had investigated the association between SCS and crime. The Australian study examined the incidence of drug-related, property, and violent crime, and compared the neighbourhood in which Sydney’s SCS was located (Kings Cross) with the rest of Sydney. The authors found no

⁵ Freeman K, Jones CG, Weatherburn DJ, Rutter S, Spooner CJ, Donnelly N. The impact of the Sydney medically supervised injecting centre (MSIC) on crime. *Drug and Alcohol Review* 2005; **24**(2): 173-84.

⁶ Chalfin A, Del Pozo B, Mitre-Becerril D. Overdose prevention centers, crime, and disorder in New York City. *JAMA network open* 2023; **6**(11): e2342228-e.

⁷ Hall JJ, Ratcliffe JH. Assessing the impact of safe consumption sites on neighborhood crime in New York City: a synthetic control approach. *Journal of Experimental Criminology* 2024: 1-16.

⁸ Myer AJ, Belisle L. Highs and lows: an interrupted time-series evaluation of the impact of North America’s only supervised injection facility on crime. *Journal of Drug Issues* 2018; **48**(1): 36-49.

⁹ Those listed in footnotes 2, 3, and 4 above, along with: Kennedy MC, Karamouzian M, Kerr T. Public health and public order outcomes associated with supervised drug consumption facilities: A systematic review. *Current HIV/AIDS Reports* 2017; **14**(5): 161-83.

significant association between SCS and crime in the Kings Cross neighbourhood compared to other parts of Sydney. The Vancouver study investigated the incidence of property and violent crime in the police district where Insite, Vancouver's first SCS, was located, and compared it to three other police districts in Vancouver that did not have SCS; the authors found significant reductions in property and violent crime in the police district that contained the SCS, but not in other police districts, after the opening of the SCS.

More recently, two peer-reviewed studies of crime were done in New York City. These may be more useful to inform the Ontario context, given that they reflect the current 'fentanyl era' of substance use as well as current crime trends. Below, I have summarized the findings of these studies.

ii. *New York City Studies*

These two recent studies analyzed changes in the number of crimes after the opening of two SCS in the Washington Heights and East Harlem neighbourhoods of New York City.¹⁰ The most recent study, published in the *Journal of Experimental Criminology*, specifically investigated changes in property and violent crimes within 1000 feet (equivalent to four blocks) using an approach known as ‘synthetic controls’. This method involved using trends from multiple areas in New York City that were ‘unaffected’ (i.e., where SCS were not implemented) and combining them to create synthetic control areas. This synthetic control area was then compared to areas where SCS were opened. The authors also employed statistical weights to account for potential differences between the synthetic control areas and the affected areas to minimize the potential for bias. This study used complaint data from the New York City Police Department crime data warehouse. The authors then created two crime data sets. The first, for recorded property crime, included burglary, grand larceny, grand larceny of motor vehicle, and petit larceny (i.e., theft under \$1000). The second, for recorded violence, included robbery, felony assault, and assault and related offenses.

After assessing 257 weeks prior to the opening of the SCS and 65 weeks post-SCS opening, the authors observed a statistically significant increase in property crime within 1000 feet of the Washington Heights SCS, but no statistically significant increases in property crime proximal to the East Harlem SCS. Furthermore, there were no statistically significant

¹⁰ Hall JJ, Ratcliffe JH. Assessing the impact of safe consumption sites on neighborhood crime in New York City: a synthetic control approach. *Journal of Experimental Criminology* 2024: 1-16.

changes in violent crime within 1000 feet of either site after their implementation compared to the period before. The authors concluded that, “the local context is important in determining any local effects of consumption sites. The existing level of disorder in a location, how they are managed internally, how the local business community reacts, and how the environment is policed are all likely to determine whether drug consumption locations negatively impact neighborhoods.”¹¹

These results are largely consistent with a previous study of crime in New York City, published in the *Journal of the American Medical Association (JAMA) Network Open*, that compared crime trends prior to and after the opening of the two SCS across multiple areas. This study employed Poisson regression models (i.e., models that use count-based outcomes rather than rates, and which are able to adjust for variables that might potentially obscure the association between an exposure [e.g., SCS] and an outcome [e.g., the number of crimes committed]) to compare trends in the following outcomes: changes in the volume of crimes reported by the public or observed by police; arrests for drug possession and weapons; 911 calls and 311 calls regarding crime, public nuisances, and medical events; and summonses issued by police for criminal infractions in the immediate vicinity of the sites (i.e., an area spanning about 6 city blocks) and a wider area spanning about 18 city blocks in the vicinity of the sites. They then compared trends in these areas with those observed at areas around 17 other syringe service programs that did not offer

¹¹ Hall JJ, Ratcliffe JH. Assessing the impact of safe consumption sites on neighborhood crime in New York City: a synthetic control approach. *Journal of Experimental Criminology* 2024: 1-16.

SCS in New York City.¹² The authors observed no significant changes in violent crimes or property crimes, 911 calls for crime or medical incidents, or 311 calls regarding drug use or unsanitary conditions observed in the vicinity of the OPCs. They did, however, observe significant reductions in drug possession arrests and criminal court summonses in areas in the vicinity of the two SCS. They concluded that these reductions are likely reflective of changes in policing near SCS that were made to ensure that SCS clients were not deterred from attending the sites.

iii. Toronto Studies

Two studies of SCS and crime in Toronto have also been undertaken, though neither have yet been peer-reviewed. Both employed publicly available Toronto Police Services data. The first examined rates of assault, auto theft, break and enter, robbery, theft over \$5000, bicycle theft, and theft from motor vehicles, as well as mental health act apprehensions. In an initial analysis, the authors investigated trend changes in these crimes in areas within 100 meters, 200 meters, and 500 meters in areas with SCS, prior to and after their implementation . The total time period for the study was January 2014 to June 30 2024. This 10-year period provided years-long pre-SCS and post-SCS periods, which is a strength given that this allowed for a characterization of trends over a long period of time, which allowed for a better understanding of the potential impact of SCS on crime. It did so using interrupted time series analyses, which allow for the examination of trend changes before

¹² Chalfin A, Del Pozo B, Mitre-Becerril D. Overdose prevention centers, crime, and disorder in New York City. *JAMA Network Open* 2023; **6**(11): e2342228-e.

and after an event (i.e., the opening of an SCS).¹³ The authors also undertook a sensitivity analysis to determine whether any potential increases in crime in these areas might be attributable to crime displacement; that is, by looking at whether areas in other parts of neighbourhoods with SCS experienced reductions in crime, which would then suggest that SCS lead to a net neutral effect across neighbourhoods in which they are located.

The authors observed a range of level and trend differences for crimes at different distances from SCS. Within 100 meters of SCS, in absolute terms across the five years after sites opened, these level and trend differences translate to an estimated total of 5.96 more assaults over five years (slightly more than 1 additional assault per year), 2.72 fewer break and enters over five years, and 1.19 fewer robberies over five years, compared to what was expected based on crime trends in the period prior to the opening of SCS. Within 200 meters of SCS, in absolute terms across the five years after sites opened, there were an estimated 15.2 fewer assaults over five years (about 3 fewer assaults per year), 0.11 fewer break and enters over five years, 13.0 fewer robberies over five years (about 2 fewer robberies per year), and 6.7 fewer thefts from motor vehicles over five years (about 1 less theft from motor vehicles per year) compared to what was expected based on crime trends in the period prior to the opening of SCS. Within 500 meters of SCS, in absolute terms across the five years after sites opened, there were approximately 72.6 fewer assaults over five years (about 14 fewer assaults per year), 17.7 fewer break and enters over five years

¹³ Interrupted time series is an approach that characterizes the difference in trends of an outcome prior to and after an event (e.g., the opening of an SCS), to see whether this 'interruption' alters the trends.

(about 3 fewer break and enters per year), 34.8 fewer robberies over five years (about 7 fewer robberies per year), and 19.3 fewer thefts from motor vehicles over five years (about 4 fewer thefts from motor vehicles) compared to what was expected based on trends in the period prior to the opening of SCS.¹⁴

The authors also used interrupted time series analysis and segmented regression¹⁵ to compare pre-intervention and post-intervention trends in ‘treated’ neighbourhoods (i.e., those with SCS) and control neighbourhoods, while adjusting for potential confounders. After controlling for trend and level changes in synthetic control neighbourhoods, treated neighbourhoods did not experience a level increase for any rates of crime or mental health act apprehensions. Furthermore, rates of auto theft declined faster (0.99, 95% CI: 0.99 to 1.00; $p=0.038$), while rates of assault rose faster (1.01, 95% CI: 1.00 to 1.01; $p=0.003$) in treated compared with synthetic control neighbourhoods; both of these changes were minimal yet statistically significant.

The authors concluded that, “in aggregate, OPS/SCS did not contribute to increases in crimes. Further, these findings conflict with city-wide increases in the volume and severity

¹⁴ Panagiotoglou D, Lim J, Ingram G, et al. Evaluating the effects of Toronto's supervised consumption sites on crime: multiple baseline interrupted time series analyses with and without synthetic controls. *medRxiv* 2024: 2024.11.08.24316990.

¹⁵ Segmented regression is a complementary approach to interrupted time series that can better determine whether trend changes before or after an event are truly statistically significant or whether they are spurious.

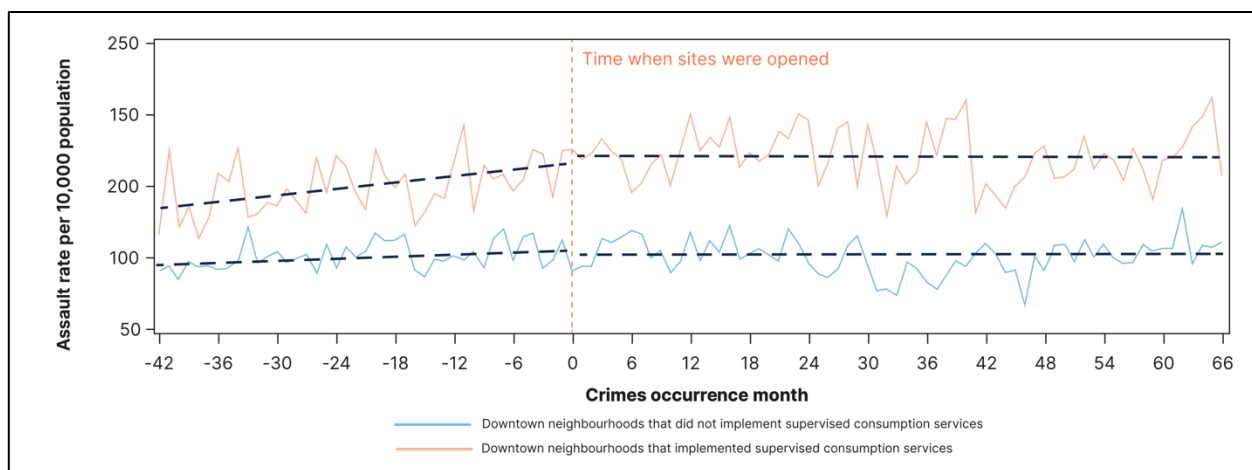
of police-reported crimes.”¹⁶ By this, the authors suggest that the lack of increases in crime detected in the areas near OPS/SCS areas was in contrast to city-wide increases in crime.

In a separate study that I and co-authors conducted, we undertook interrupted time series analyses of data from the Toronto Police Services Open Data Portal. This involved accessing nine years of crime data—from 2014 and 2023—and comparing changes in crime rates only in downtown neighbourhoods in Toronto that did and did not implement SCS in the periods prior to and after these sites were implemented. This was done to minimize potential spurious findings that could have arisen by comparing crime trends in neighbourhoods that opened SCS and crime trends in dissimilar neighbourhoods in Toronto (i.e. those not located in the city’s downtown core). Crimes included: assaults, robberies, break & enters, and thefts over \$5000.

When analyzing these crimes together, there was no statistically significant change ($p > 0.05$) in the overall crime rate after the implementation of supervised consumption services across downtown neighbourhoods in Toronto that did and did not implement SCS. We also analyzed each crime type separately to determine whether there were any significant changes before and after the implementation of supervised consumption services.

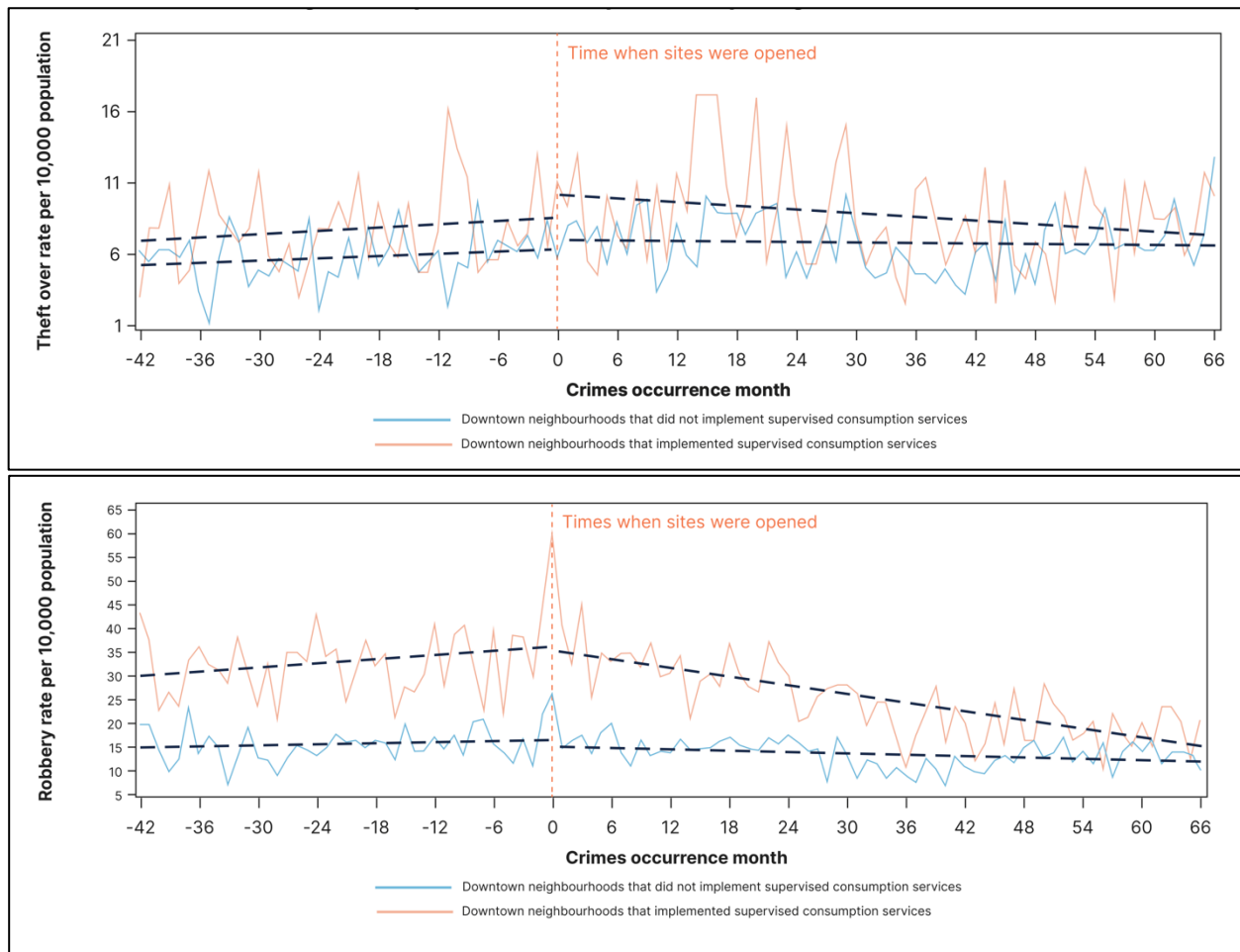
¹⁶ Panagiotoglou D, Lim J, Ingram G, et al. Evaluating the effects of Toronto's supervised consumption sites on crime: multiple baseline interrupted time series analyses with and without synthetic controls. *medRxiv* 2024: 2024.11. 08.24316990.

We found that neighbourhoods that implemented SCS did not experience a significant increase in the assault rate. Instead, neighbourhoods with SCS experienced a statistically significant downward shift in the assault rate in the period after the sites were implemented ($p < 0.05$). No statistically significant downwards trend was observed in downtown neighbourhoods that did not implement SCS. These findings are summarized in the below chart:



Neighbourhoods with SCS experienced a statistically significant downward shift in the robbery rate after the sites were implemented ($p < 0.01$). However, no statistically significant change in the robbery rate was observed in neighbourhoods that did not

implement SCS ($p > 0.05$). Similarly, there were no statistically significant changes in the rate of thefts over \$5000 in either neighbourhoods that did and did not implement SCS ($p > 0.05$). These findings regarding robbery and theft rates are summarized in the below charts:



Downtown neighbourhoods that did and did not implement SCS both experienced statistically significant level increases in the break & enter rate after the period immediately after SCS opened. Both sets of neighbourhoods, however, subsequently experienced statistically significant downward shifts in the trend of break & enters after SCS were opened ($p < 0.05$). This is reflected in the below chart:



B. Do SCS's affect homicide rates in the communities in which they are located? How so?

In my opinion, there is no evidence to suggest that SCS increase homicide rates in the communities in which they are located.

To my knowledge, only one scientific study has investigated this question, and it was conducted by myself and co-authors, and is currently in press at *The Lancet Regional Health – Americas*, a leading regional health peer-reviewed journal.¹⁷ This study conducted an ecological analysis to characterize trends in homicide in the City of Toronto prior to and after the opening of SCS. It used 13 years of data (2010-2023) from the Office of the Chief Coroner of Ontario to determine the geographic location of homicides and to provide a long lookback and post-SCS study period. We then organized homicides into three geographic 'buffer' zones. The first buffer zone ('near') was defined as an area within 500 meters of a location in which an SCS site was

¹⁷ Werb D, Sung HS, Na Y, et al. Investigating the Spatial Association between Supervised Consumption Services and Homicide Rates in Toronto, Canada, 2010-2023. *SSRN preprint* 2024.

implemented. The second buffer zone ('far') was defined as an area between 500 meters and 3 kilometers of a location in which an SCS site was implemented. The third buffer zone ('out') was defined as an area more than 3 kilometers from a location in which an SCS site was implemented. Monthly homicide trends were generated and analyzed using interrupted time series, which is a method that is used to detect significant changes in a trend (e.g., homicide rate) prior to and after a specified event (e.g., the implementation of an SCS site).

This study found no evidence that the monthly incidence of homicides increased in areas near SCS (<500 m). Specifically, we detected a minimal but statistically significant decrease in the monthly incidence of homicides near SCS (<500 m; $p < 0.01$), no significant change in areas between 500 meters and 3 kilometers, and a minimal but statistically significant increase in areas more than 3 km away from the sites ($p = 0.03$). This trend was consistent across different definitions of homicide: restricting to shootings and stabbings; or only shootings and stabbings that occurred outside; or including all homicides. This trend was also consistent across different time periods: 18 months, 3, 4, and 5 years before and after SCS were implemented.¹⁸

¹⁸ Werb D, Sung HS, Na Y, et al. Investigating the Spatial Association between Supervised Consumption Services and Homicide Rates in Toronto, Canada, 2010-2023. *SSRN preprint* 2024.

C. Do SCS's affect overdose-based mortality in the communities in which they are located? How so?

In my opinion, the evidence suggests that SCS are likely to lead to reductions in overdose mortality rates in the communities in which they are located.

Two peer-reviewed scientific studies have investigated this question: one study from Vancouver, British Columbia, published in 2011, and one study conducted in Toronto, Ontario, by myself and co-authors, published in 2024.

The Vancouver-based study employed overdose mortality data from the British Columbia provincial coroner service. It then compared the overdose mortality rate within 500 meters of Insite, the only sanctioned community SCS operating in Vancouver at the time, with the overdose mortality rate in the rest of the city, 21 months prior to, and 15 months after, Insite opened. The authors found that the fatal overdose rate in the area within 500 meters of Insite decreased by 35% after its opening, which was a statistically significant decrease. During the same period, the fatal overdose rate in the rest of the city decreased by 9.3%, which was not a statistically significant decrease.¹⁹

The Toronto-based study conducted by myself and co-authors was published in the *Lancet Public Health*, the world's leading peer-reviewed public health journal, in 2024.

This study used two and a half years of overdose mortality data collected by the Office

¹⁹ Marshall BDL, Milloy MJ, Wood E, Montaner JSG, Kerr T. Reduction in overdose mortality after the opening of North America's first medically supervised safer injecting facility: a retrospective population-based study. *The Lancet* 2011; **377**(9775): 1429-37.

of the Chief Coroner of Ontario to identify the location of fatal overdose events across the City of Toronto between May 1, 2017 and Dec 31, 2019, and to then generate overdose mortality rates across all Toronto neighbourhoods. First, we compared overdose mortality rates before and after the implementation of nine SCS in Toronto in 2017 across the following areas: those within 250 meters, 500 meters, 1 kilometer, 2.5 kilometers, and 5 kilometers of an SCS, and those further away from an SCS. We then assessed overdose incident data for global spatial autocorrelation and local clustering, and used geographically weighted regression to model the association between SCS proximity and overdose mortality incidence in 2018 and 2019. These techniques allow for the detection of spatial relationships between two location-based datasets (e.g., the location of SCS and the location of fatal overdoses) while adjusting for potential factors that could influence these relationships (e.g., neighbourhood level factors such as median income, availability of healthcare centers, etc.).

Our analyses found that areas within 250 meters, 500 meters, and 1 kilometer of SCS experienced statistically significant 67% reductions in the population-level overdose mortality rate in the period after SCS were opened compared to the same time period prior to their opening; areas within 2.5 kilometers experienced a 60% reduction in the population-level overdose mortality rate, and areas within 5 kilometers experienced a 59% reduction; these were all statistically significant decreases ($p < 0.05$). There were no statistically significant reductions in the population-level overdose mortality rate in neighbourhoods that did not implement SCS.

The two maps in the figure below show that neighbourhood overdose fatality counts decreased from 2018 to 2019 in the areas with SCS. The figure also shows that the protective neighbourhood-level association between SCS and overdose mortality—that is, that overdose deaths were less likely to occur in neighbourhoods near SCS after they were opened—more than doubled between 2018 and 2019. This suggests that the overdose prevention benefits of SCS in Toronto may have increased over time such that areas located nearer to SCS experienced relatively fewer fatal overdoses, and that the reduction in fatal overdoses increased the longer the sites were open.²⁰ The figure below also highlights, with yellow circles, the SCS that are slated to be closed as a result of the *Community Care and Recovery Act*.

²⁰ Rammohan I, Gaines T, Scheim A, Bayoumi A, Werb D. Overdose mortality incidence and supervised consumption services in Toronto, Canada: An ecological study and spatial analysis. *The Lancet Public Health* 2024; 9(2): e79-e87.

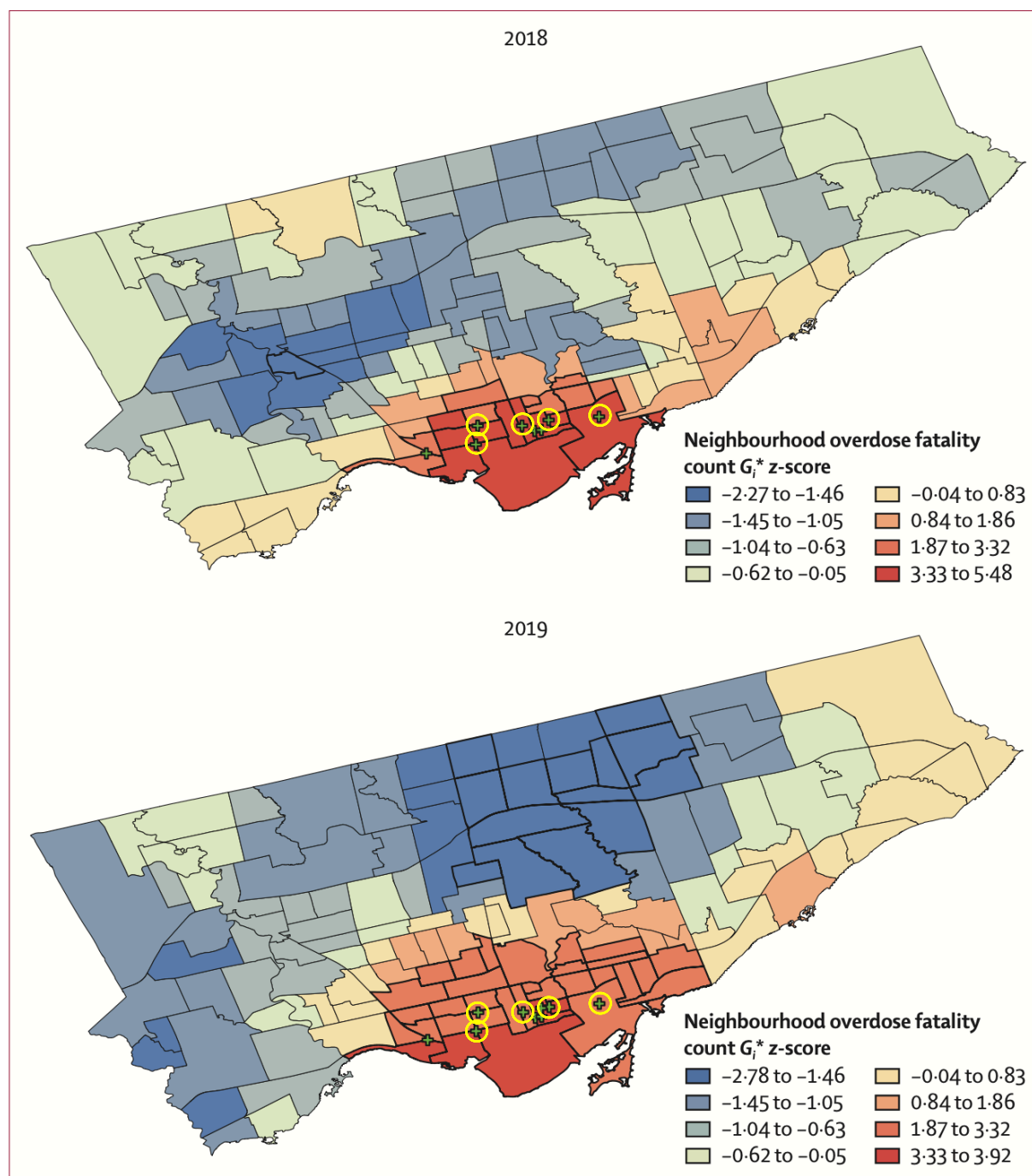


Figure 1: Hot spot and cold spot neighbourhoods in 2018 and 2019

Increasingly negative G_i^* z-scores indicate neighbourhoods with fewer overdose deaths than all other neighbourhoods (ie, cold spots), whereas increasingly positive G_i^* z-scores indicate neighbourhoods with more overdose deaths than other neighbourhoods. Neighbourhoods outlined in bold are significant hot and cold spots (surrounded by neighbourhoods with similar G_i^* z-scores). The green crosses indicate supervised consumption services and overdose prevention sites.

D. Who accesses SCS? What are the socio-demographic characteristics of individuals who are most likely to use these facilities?

SCS in Ontario have been visited over one million times over the past four years, and those that visit SCS are frequently homeless, precariously housed, at high risk of both fatal and non-fatal overdose, and more likely to inject in public in the absence of these services.

i. General Discussion of the Available Data

Between March 2020 and May 2024, 1.12 million visits were made to SCS in Ontario, according to Health Canada's Supervised Consumption Service Dashboard (41% of all SCS visits across Canada).²¹ These visits were by more than 178,000 unique registered clients (44% of all SCS clients across Canada), though given that SCS use is anonymous and that clients may choose multiple usernames, the true number of individual clients is likely lower than the total number of unique registered clients. Overall, 21,979 overdoses were attended to onsite by SCS staff (50% of all overdoses across Canada), and none were fatal. Finally, there were more than 533,000 referrals of clients to other services while visiting an SCS in Ontario during this time (40% of all referrals made across SCS in Canada). This suggests that while the proportion of visits, clients, and referrals in Ontario SCS are all approximately equivalent to the province's proportion of Canada's population, Ontario SCS are overrepresented with respect to the

²¹ Government of Canada, Health InfoBase (2024, Aug 22). Supervised consumption sites: Dashboard. Health InfoBase. Retrieved 2024-09-10 from <https://health-infobase.canada.ca/supervised-consumption-sites/>.

proportion of overdoses to which they have responded compared to SCS in the rest of Canada.

The breakdown of specific service referrals made at SCS for clients is not provided by Health Canada's Supervised Consumption Service Dashboard at the provincial level. However, across Canada, 22% of all referrals are to services not offered at the SCS itself (e.g., sterile syringe distribution, naloxone dispensation), and include the following: primary health care (including treatment for drug dependence), testing for sexually transmitted and blood-borne infections, wound care, mental health care (including treatment for drug dependence), food and shelter services, legal aid, and employment assistance.

ii. Demographic Data Available Regarding People Who Use SCS

National surveillance data demonstrate that, between March 2020 and August 2024, 53% of all SCS clients across Canada were under the age of 40. Additionally, 24% were women, 69% were men, and 7% had a non-binary or unknown gender. These data are noteworthy because people under 40 have consistently made up the largest proportion of overdose mortality victims in Canada (and Ontario) since 2016 (between 44% and 49% annually), while men have made up 70% or more of all overdose mortality victims during this time.²² As such, SCS appear to be effective at serving Canadians at highest risk.

²² Government of Canada. Opioid- and Stimulant-related Harms in Canada. 2023-12-15. <https://health-infobase.canada.ca/substance-related-harms/opioids-stimulants/>.

Further, the data suggests that the overwhelming majority of the individuals who use SCS are homeless or unstably housed. An initial profile of the OiSIS cohort (a Canadian Institutes of Health Research-funded observational cohort of people who use drugs in Toronto that I lead as Principal Investigator) used cross-sectional baseline data of 701 people who inject drugs who were recruited into the study from areas in downtown Toronto, including both frontline service providers and informal areas where people who use drugs congregate. For this initial profile, participants were surveyed between November 2018 and March 2020. Of these individuals, 9 out of 10 (91%) were homeless or housed in unstable situations, while over one-third (38%) had been incarcerated in the past six months. While the cohort sample of participants is not generalizable to the broader population of people who use drugs in Toronto, it represents a highly vulnerable group of people that are highly reliant on SCS and other health services to avoid overdose and other harms.

The data from the OiSIS cohort also suggests that the majority of individuals who use SCS are people who repetitively rely on SCS sites. Among participants, 86% reported using an SCS in the past six months.²³ Approximately a quarter of participants used a site for more than 75% of their injections. This demonstrates that clients of these sites in Toronto are among those that face the greatest difficulties in accessing substance use treatment, as housing precarity and incarceration are well-documented barriers to

²³ Scheim, A. I., R. Sniderman, R. Wang, Z. Bouck, E. McLean, K. Mason, G. Bardwell, S. Mitra, Z. R. Greenwald, K. Thavorn, G. Garber, S. D. Baral, S. B. Rourke and D. Werb (2021). "The Ontario Integrated Supervised Injection Services Cohort Study of People Who Inject Drugs in Toronto, Canada (OiSIS-Toronto): Cohort Profile." *Journal of Urban Health*: 1-13.

treatment enrolment and retention,^{24,25,26,27} as well as key risk factors for overdose.^{28,29,30} Nevertheless, a statistically significantly higher proportion of participants—almost twice the proportion—who accessed SCS for all or most of their injections also reported currently being enrolled in treatment for drug dependence compared to those that did not access SCS (37% vs. 19%).³¹ As this is a cross-sectional study, we cannot assume that accessing SCS causally led to increased treatment enrolment, though this is a possible explanation. However, these results suggest that SCS access in Toronto is, at minimum, complementary to treatment enrolment, which is consistent with best practices regarding comprehensive approaches to reducing substance-related harms and improving short- and long-term outcomes among people who use drugs. Given that SCS are equipped to refer people to treatment, it is also highly likely that at least some participants were provided access via their visits to SCS. While the exact number of people with substance use disorders who

²⁴ McLaughlin MF, Li R, Carrero ND, Bain PA, Chatterjee A. Opioid use disorder treatment for people experiencing homelessness: A scoping review. *Drug and Alcohol Dependence* 2021; **224**: 108717.

²⁵ Krausz RM, Clarkson AF, Strehlau V, Torchalla I, Li K, Schuetz CG. Mental disorder, service use, and barriers to care among 500 homeless people in 3 different urban settings. *Social psychiatry and psychiatric epidemiology* 2013; **48**: 1235-43.

²⁶ Biondi BE, Vander Wyk B, Schlossberg EF, Shaw A, Springer SA. Factors associated with retention on medications for opioid use disorder among a cohort of adults seeking treatment in the community. *Addiction Science & Clinical Practice* 2022; **17**(1): 15.

²⁷ Gazzola MG, Carmichael ID, Madden LM, et al. A cohort study examining the relationship among housing status, patient characteristics, and retention among individuals enrolled in low-barrier-to-treatment-access methadone maintenance treatment. *Journal of Substance Abuse Treatment* 2022; **138**: 108753.

²⁸ Lyons RM, Yule AM, Schiff D, Bagley SM, Wilens TE. Risk factors for drug overdose in young people: a systematic review of the literature. *Journal of Child and Adolescent Psychopharmacology* 2019; **29**(7): 487-97.

²⁹ Macdonald C, Macpherson G, Leppan O, et al. Interventions to reduce harms related to drug use among people who experience incarceration: systematic review and meta-analysis. *The Lancet Public Health* 2024; **9**(9): e684-e99.

³⁰ Mital S, Wolff J, Carroll JJ. The relationship between incarceration history and overdose in North America: A scoping review of the evidence. *Drug and alcohol dependence* 2020; **213**: 108088.

³¹ Scheim, A. I., R. Sniderman, R. Wang, Z. Bouck, E. McLean, K. Mason, G. Bardwell, S. Mitra, Z. R. Greenwald, K. Thavorn, G. Garber, S. D. Baral, S. B. Rourke and D. Werb (2021). "The Ontario Integrated Supervised Injection Services Cohort Study of People Who Inject Drugs in Toronto, Canada (OiSIS-Toronto): Cohort Profile." *Journal of Urban Health*: 1-13.

access SCS is unknown, it is noteworthy that 29% of people who reported using SCS enrolled in the OiSIS observational cohort study in Toronto were also currently receiving an opioid agonist treatment such as methadone or buprenorphine,³² which requires a diagnosis of a substance use disorder. Within this cohort, 29% should therefore be considered the lowest potential proportion of people with substance use disorders who access SCS, given that many people who have substance use disorders do not receive treatment, particularly those that face challenges such as homelessness, and economic and social precarity.

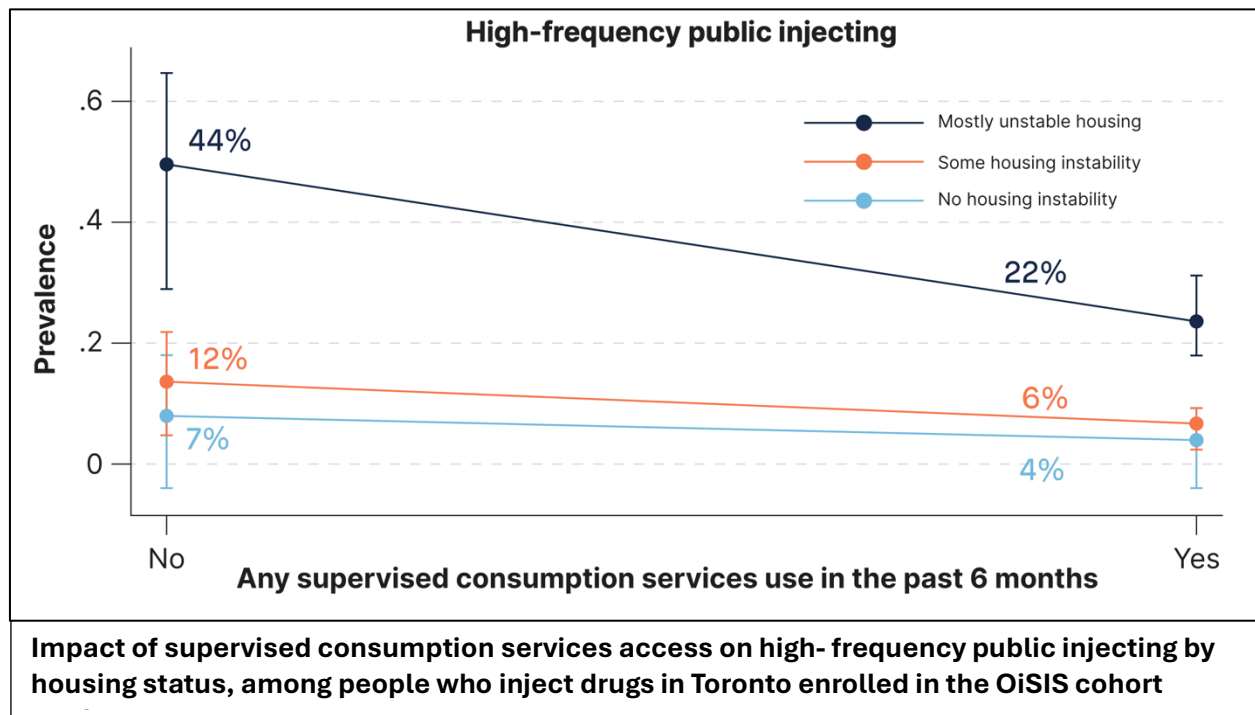
iii. The Availability of SCS and the Reduction of Public Consumption of Substances

Recent research conducted by myself and co-authors demonstrates that SCS in Toronto are implicated in reduced public injecting. Specifically, data drawn from the previously described OiSIS study demonstrate that people who inject in public in Toronto are more likely to be homeless and/or experience housing instability. Furthermore, and as shown in the figure below, among those who are homeless and/ or unstably housed, recently accessing SCS (i.e., accessing an SCS in the past 6 months) was associated with a 50% reduction in the prevalence of high-frequency public injecting, from 44% to 22%.³³ This suggests that SCS use among the people most likely to inject in public (i.e., those

³² Scheim AI, Sniderman R, Wang R, et al. The Ontario Integrated Supervised Injection Services Cohort Study of People Who Inject Drugs in Toronto, Canada (OiSIS-Toronto): Cohort Profile. *Journal of Urban Health* 2021: 1-13.

³³ Greenwald Z, Bouck Z, Eeuwes J, et al. "Exploring the impact of supervised consumption service use on public injecting in Toronto, Canada." 12th International Conference on Health and Hepatitis in Substance Users. Athens; 2024.

without stable housing) leads to reduced public injecting, even when people only access SCS occasionally.



E. What are, in your opinion, the likely ramifications for users of SCS services and the communities in which they are located if the Community Care and Recovery Act goes into effect?

In my opinion, the likely ramifications of the closure of SCS is a higher overdose mortality rate in neighbourhoods in which they are located, along with a higher prevalence of public injecting, fewer referrals for users of SCS services to social services and clinical care, and the potential for increased transmission of infectious diseases such as HIV and hepatitis C given bans on the distribution of sterile syringes by frontline service providers selected as HART hub locations.

There are a range of factors that drive substance-related outcomes, and the evidence to date on the likely effects of SCS cannot capture all factors that may influence these outcomes. However, given the robustness of the data collected and analyses undertaken, there are some outcomes that can be reasonably assumed to occur.

First, it is likely that neighbourhoods that currently have SCS slated for closures will experience increases in overdose mortality if these services are closed. This increase may extend across areas as much as 5 kilometers from SCS. I base this on data from the study published in the *Lancet Public Health* earlier this year demonstrating 67% reductions in population-level overdose mortality rates in areas within 1 kilometer of SCS in Toronto, with significant reductions in overdose mortality of 59% as far as 5 kilometers away. It is very important to state that this was an ecological analysis, and cannot therefore identify a causal association between SCS and overdose mortality across surrounding areas. However, I know of no plausible reason why areas close to SCS in Toronto would have experienced significant reductions in the overdose mortality rate after their opening, and why other neighbourhoods would not have, other than because SCS were opened. As such, it is my opinion that the most likely reason for this significant reduction in overdose mortality is because of the implementation of SCS, which provide a range of overdose prevention services that may be used by clients in community settings, such as naloxone dispensation, drug checking information, safer drug use education, and referrals to treatment.

It is also likely that the closure of SCS will lead to a higher incidence of public drug use in surrounding areas. This is because, as identified in Toronto, SCS use was associated with a 50% lower prevalence of public injecting among people experiencing housing precarity and who engaged in high-frequency public injecting. In other words, SCS use was most highly associated with reduced public injecting among the people who injected in public the most. It is very likely, then that SCS closures would lead to increases in public injecting among the group that injects in public the most frequently.

Additionally, the SCS slated for closure across Ontario have collectively, between March 2020 and May 2024, had over 380,000 visits from about 75,000 unique clients, and made over 200,000 referrals to other services including social services, clinical care, and addiction treatment. They have also attended to about 8,500 overdoses onsite. As such, it is reasonable to assume that these closures will lead to increases in public injection and fatal overdoses, as well as reductions in the number of people who are referred to services that they require to manage their drug use and related health and social concerns. It is noteworthy that HART hubs will likely be established at some sites currently offering SCS at some point in 2025. However, these are designed to provide intensive services for a small number of clients, and are therefore unlikely to fill the gap for the large number of people who use drugs that currently rely on SCS.

Additionally, the potential exists that the closure of SCS may lead to a growing epidemic of blood-borne diseases, including HIV and hepatitis C, among people who inject drugs. This is because injecting in public is a key risk factor for infectious disease

transmission,³⁴ and because HART hubs are restricted from distributing sterile syringes to clients.

Dr. Dan Werb

³⁴ Arum C, Fraser H, Artenie AA, et al. Homelessness, unstable housing, and risk of HIV and hepatitis C virus acquisition among people who inject drugs: a systematic review and meta-analysis. *The Lancet public health* 2021; **6**(5): e309-e23.

V. LITERATURE REVIEWED

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3. Magwood, O., G. Salvalaggio, M. Beder, C. Kendall, V. Kpade, W. Daghmach, G. Habonimana, Z. Marshall, E. Snyder and T. O'Shea. (2020). "The effectiveness of substance use interventions for homeless and vulnerably housed persons: a systematic review of systematic reviews on supervised consumption facilities, managed alcohol programs, and pharmacological agents for opioid use disorder." *PloS One* 15(1): e0227298.
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22. Macdonald C, Macpherson G, Leppan O, et al. Interventions to reduce harms related to drug use among people who experience incarceration: systematic review and meta-analysis. *The Lancet Public Health* 2024; **9**(9): e684-e99.
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26. Arum C, Fraser H, Artenie AA, et al. Homelessness, unstable housing, and risk of HIV and hepatitis C virus acquisition among people who inject drugs: a systematic review and meta-analysis. *The Lancet Public Health* 2021; **6**(5): e309-e23.

DAN WERB, PhD

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BIOSKETCH

Dan Werb, PhD, is an epidemiologist and policy analyst with expertise in overdose, drug policy, and the continuum of care for people with substance use disorders and psychiatric comorbidities. Dr. Werb is the St. Michael's Hospital/University of Toronto Chair in Mental Health and Substance Use Disorders. He is an Associate Professor with dual appointments at the Institute of Health Policy, Management & Evaluation at the University of Toronto and in the Division of Infectious Diseases & Global Public Health at the University of California San Diego. He is Director of the Centre on Drug Policy Evaluation (CDPE; www.cdpe.org), which conducts high-impact implementation science and observational research to improve the measurement and execution of policies and interventions to respond to substance-related harms. Dr. Werb is an inaugural winner of the U.S. National Institute on Drug Abuse Avenir Award (2015), awarded to creative new investigators proposing highly innovative research at the intersection of HIV and substance use, a recipient of a Traiblazer Award (2017) from the Canadian Institutes of Health Research, and is the winner of a Pandemic Preparedness and Health Emergencies: Early Career Investigator Prize (2022) from the Centre for Research on Pandemic Preparedness and Health Emergencies at the Canadian Institutes of Health Research.

Dr. Werb has published >135 studies on issues related to substance use, overdose, drug policy, infectious disease, and mental health, with a focus on overdose prevention, implementation science, understanding the initiation of injection drug use, and identifying the impact of policy and public health interventions on marginalized drug-using populations experiencing psychiatric comorbidities. Dr. Werb meets regularly with decision makers and has been featured in media stories in every global hemisphere.

Dr. Werb conducts extensive knowledge translation on drug policy and public health, through print and radio journalism, and is the winner of a 2014 Canadian National Magazine Award for his popular science writing, with work published in *The New York Times*, *TIME*, *Salon*, *The Globe & Mail*, *Buzzfeed*, and other outlets. His first book, which tracks his investigation of Tijuana's femicide, *City of Omens: A Search for the Missing Women of the Borderlands*, was published in

June 2019, was selected by the *New York Times Book Review* as a 2019 Summer Read, and was named one of five finalists for the 2019 Canadian Governor-General's Award in Non-Fiction. Most recently, he is the author of *The Invisible Siege: The Rise of Coronaviruses and the Search for a Cure* (March 2022), which chronicles the development of coronavirus science. Among other honours the book was selected as one of the Top 10 Science Books of the Season by *Publishers Weekly*. It is the winner of the 2022 Hilary Weston Writer's Trust Nonfiction Prize and the 2022 Science Writers and Communicators of Canada Book Award.

EDUCATION

Ph.D. Population and Public Health

2010-2013

School of Population and Public Health, University of British Columbia
Vancouver, BC, Canada

Title: Injection career trajectories among a cohort of illicit drug users in Vancouver, Canada
Supervisors: Drs. Evan Wood & Jane Buxton

M.Sc. Population and Public Health

2008-

2010

School of Population and Public Health, University of British Columbia
Vancouver, BC, Canada

Title: Initiation of illicit drug use among youth: determinants and responses
Supervisors: Drs. Thomas Kerr & Jane Buxton

B.A. Philosophy/English Literature

1998-

2002

Department of English & Department of Philosophy, McGill University
Montreal, QC, Canada

CURRENT AFFILIATIONS

Chair in Mental Health and Substance Use Disorders
St. Michael's Hospital/University of Toronto

March 2024 - Present

Associate Professor
Institute of Health Policy, Management & Evaluation
University of Toronto

July 2022 - Present

Associate Professor
Division of Infectious Diseases & Global Public Health
University of California San Diego, CA

July 2022 - Present

Executive Director Present Centre on Drug Policy Evaluation, Toronto, ON	January	2015	–
Chief Executive Officer Present DoseCheck Technologies, Ltd., Toronto, ON	February	2024	–

INDIVIDUAL AWARDS & RECOGNITIONS

2022 Science Writers and Communicators of Canada Book Award 2023

- Awarded for the best book of science writing by a Canadian for *The Invisible Siege: The Rise of Coronaviruses and the Search for a Cure* (Crown, 2022).

2023 Spring Writer in Residence

2023

Toronto Public Library

- Invitation in recognition of excellence in literary nonfiction writing

Research and Creation Award

Canada Council for the Arts

2023

- Awarded \$48,500 to support the research and creation of a non-fiction popular science book on coral reef resilience

Innovation in Laboratory Medicine Award

2023

Canadian Society for Clinical Chemistry

- Awarded to Toronto's Drug Checking Service (PI: Werb) for excellence in innovation and strategic planning and implementation, development of new laboratory programs

Hilary Weston Writer's Trust Nonfiction Prize

2022

Writer's Trust of Canada

- Awarded \$60,000 for excellence in the category of literary nonfiction

Pandemic Preparedness and Health Emergencies: Early Career Investigator Prize

2022

Centre for Research on Pandemic Preparedness and Health Emergencies, Canadian Institutes of Health Research

- Awarded \$100,000; award is for early career investigators with the highest ranking projects in the Fall Project Grant competition that are relevant to the mission of the Centre for Research on Pandemic Preparedness and Health Emergencies

Research and Creation Award

Canada Council for the Arts

2020

- Awarded \$25,000 to support the research and creation of *The Invisible Siege*, a non-fiction popular science book on the development of coronavirus science (Crown, March 2022)

Research and Creation Award

Canada Council for the Arts

2018

- Awarded \$35,000 to support the research and creation of *City of Omens*, a non-fiction popular science book about sex workers in Tijuana, Mexico (Bloomsbury US, 2019)

Canadian Institutes of Health Research Trailblazer Award (Early Career Investigator) 2017

- Awarded \$12,500 in recognition of having made an exceptional contribution in the area of population health and for leadership, mentorship, and innovation

Canadian Institutes of Health New Investigator Award 2016-2021

- Awarded \$300,000 in recognition of exceptional contribution to the area of population health

Ontario Ministry of Research, Innovation and Science Early Research Award 2017-

2022

- Awarded \$190,000 in recognition of exceptional contribution to the area of population health for an early career investigator

National Institute on Drug Abuse Avenir Award 2015-2020

- USD\$1.5 million Director's Project Award by the National Institute on Drug Abuse for creative new investigators proposing highly innovative research on HIV and substance abuse

Writer's Trust of Canada Magazine Award 2014

- Awarded \$6,000 to support the publication of a unique and important article

National Magazine Award (Canada) 2014

- Awarded Gold in the Society (\$1,000) category for '*The Fix*'

Canadian Institutes of Health Research Fellowship 2013-

2016

- Awarded \$150,000 for research achievement, productivity, and potential

Pierre Elliott Trudeau Foundation Scholarship 2012-2015

- Awarded \$180,000 for leadership potential and research achievement

Frederick Banting and Charles Best Canada Graduate Scholarship 2010-2013

- Awarded \$105,000 for research achievement, productivity, and potential

Canadian Institutes of Health Research Canada Graduate Scholarship (Masters) 2008-2010

- Awarded \$17,500 for exceptional academic achievement and research potential

Michael Smith Foundation for Health Research Trainee Award 2008-2010

- Awarded \$45,000 for outstanding research activity and potential

McGill University Faculty of Arts Clark Lewis Prize 2002

- Awarded annually for the best play written by a McGill University student

ACTIVE PI FUNDING

Title:	Development and validation of a novel point-of-care technology for rapid non-targeted identification of emerging opioid and other drug threats
PI:	Dan Werb/Drew Hall
Funding:	HEAL Initiative: Rapidly Assessing the Public Health Impact of Emerging Opioid Threats (UG1): USD\$2M
Summary:	Development and validation of r, an electrochemical point-of-care drug detection platform that uses machine learning to identify opiates, stimulants, and other drugs associated with drug overdose in clinical specimens.
Status:	Funded: December 1, 2023 – November 30, 2027
Title:	Preventing morbidity and mortality among people who inject drugs in the post-pandemic era: Modelling the impact of service restrictions during COVID-19 across three North American countries
PI:	Dan Werb
Funding:	New Frontiers in Research Fund – Special Call: \$500,000
Summary:	Longitudinal cohort study of three cohorts of people (Toronto and Vancouver, Canada; San Diego, USA; and Tijuana, Mexico) who inject drugs in settings impacted by overdose during COVID-19.
Status:	Funded: February 1, 2023 – January 1, 2025

- Title:** The Toronto Disparities, Overdose, and Treatment (T-DOT) study: Investigating clinical outcomes among people who inject drugs during a period of rapid programmatic and policy change
- PI:** Dan Werb
- Funding:** Canadian Institutes of Health Research Project Grant: \$1,560,600
- Summary:** Longitudinal cohort study of people who inject drugs with linked administrative health data to assess the impact of health and social disparities on overdose and access to treatment.
- Status:** Funded: October 1, 2022 – September 30, 2027
-
- Title:** A National Evaluation of Safer Supply Pilot Programs in Canada
- PI:** Dan Werb
- Funding:** Canadian Institutes of Health Research Operating Grant: \$2,096,316
- Summary:** Support an evaluation to assess the program implementation and short-term impact of Health Canada's Substance Use and Addictions Program's Safer Supply Pilot Projects.
- Status:** Funded: January 1, 2021 – December 31, 2024
-
- Title:** Preventing Injecting and Overdose by Disrupting Injection Drug Use Transitions: The PRIMER II Study
- PI:** Dan Werb
- Funding:** Canadian Institutes of Health Research Project Grant: \$761,175
- Summary:** Expand a multi-cohort consortium of existing cohort studies of people who inject drugs, thereby leveraging independent, longitudinally funded observational studies to address a key aim: designing a scalable and adaptable strategy to prevent incident cases of injection drug use initiation.
- Status:** Funded: April 1, 2021 - March 31, 2026
-
- Title:** Rapidly assessing the impact of the COVID-19 pandemic and response on clinical and social outcomes, service utilization, and the unregulated drug supply experienced by people who use drugs in Toronto
- PI:** Dan Werb
- Funding:** Canadian Institutes of Health Research Operating Grant: \$206,760
- Summary:** To understand the direct population-level impact of the pandemic on PWID in Toronto, this study will identify those at highest risk of both COVID-19 and overdose and track how distancing restrictions are impacting the use of services to prevent overdose across the city, including addiction treatment access, supervised injection services, and street drug checking.
- Status:** Funded: June 1, 2020 - May 31, 2021

- Title:** The Ontario Integrated Supervised Injection Services Research Program: Examining Uptake and Impacts in Different Community Settings and Models of Care
- PI:** Dan Werb
- Funding:** Canadian Institutes of Health Research Project Grant: \$644,399.
- Summary:** Evaluation of the effectiveness and impacts of integrated supervised injection service models implemented in four community health agencies in Ontario.
- Status:** Funded: February 7, 2018 - March 31, 2022
-
- Title:** A Multi-Site Drug Checking Pilot Project to Prevent Overdose in Toronto, Ontario
- PI:** Dan Werb
- Funding:** Health Canada & St. Michael's Hospital Foundation: \$2,442,115.
- Summary:** Implementation and evaluation of the impact of drug checking services co-located with supervised consumption services at three frontline harm reduction agencies and in partnership with clinical laboratories in Toronto.
- Status:** Funded: February 1, 2018 - January 31, 2023
-
- Title:** 'Addiction Treatment as Prevention': An Innovative Global Strategy To End the Opioid Overdose Epidemic
- PI:** Dan Werb
- Funding:** St. Michael's Hospital Foundation: \$2,100,000.
- Summary:** Development and evaluation of a community-based program to implement an addictions care continuum between harm reduction agencies and hospital, piloting injectable opioid agonist therapy (iOAT) and ancillary supports.
- Status:** Funded, 2019-2024
-
- Title:** The Implementation of Drug Checking Services for People Who Use Drugs: A Systematic Review
- PI:** Dan Werb
- Funding:** Canadian Research Initiative in Substance Misuse (CRISM), CIHR: \$50,000.
- Summary:** Systematic review of the influence of drug checking services on people who use drugs, including behaviour, drug market surveillance & service delivery models.
- Status:** Funded: April 1, 2018 – March 31, 2022
-
- Title:** A Smartphone-Based Drug Checking Technology and Data Dissemination Tool
- PI:** Dan Werb
- Funding:** Health Canada Drug Checking Technology Challenge: \$191,497
- Summary:** Development of a smartphone-based drug checking and data dissemination technology that uses energy pulses and specialized sensors to detect toxic adulterants in street drugs. *One of three finalists for a \$1 million prize selected in Spring 2021.

Status: Funded, 2019-2020

Title: **Centre on Drug Policy Evaluation (Policy Impact Unit)**

PI: Dan Werb

Funding: Open Societies Foundation: \$30,000 USD

Summary: Research and outreach to support the development of evidence-based policies for people who use drugs internationally.

Status: Funded: November 1, 2020 – October 31, 2021

CO-INVESTIGATOR FUNDING

Title: **Evaluation of the British Columbia Exemption to Allow for Personal Possession of Small Amounts of Illegal Drugs**

PI: Dr. Jürgen Rehm

Funding: Canadian Research Initiative in Substance Misuse

Summary: A mixed methods evaluation of the health and social impact of drug decriminalization in the province of British Columbia, Canada.

Status: Funded:

Title: **Identifying Intersectional Stigma Intervention Targets for People Who Inject Drugs in a High-Risk International Setting**

PI: Laramie Smith

Funding: Fogarty International Center/National Institute on Drug Abuse

Summary: Use a longitudinal observational data collection approach and robust advanced quantitative methods to identify which stigmas are most optimal to intervene on to optimize engagement in HIV prevention services among urban and rural PWID in Kyrgyzstan.

Status: Funded: March 1, 2021 – February 28, 2022

Title: **We the People: An HIV Policy Research Center that Works for All of California**

PI: Orlando Harris, Laramie Smith

Funding: California HIV/AIDS Policy Research Centers

Summary: One of three participating center within the California HIV/AIDS Policy Research Centers

Status: Funded: February 1, 2021 – January 31, 2025

Title: **Marijuana legalization policy: Impact on prevalence and risk behaviours among youth and young adults in Canada. International Cannabis Policy Study (ICPS)**

PI: Dr. David Hammond

Funding: Canadian Institutes of Health Research Project Bridge Grant: \$1,514,700

Summary: Prospective cohort study to evaluate the impact of cannabis policies in Canada and the United States at the national and provincial/state levels.

Status: Funded, 2018-2023

INACTIVE PI FUNDING

Title: **DoseCheck: Final validation and field pilot testing of a consumer-priced, networked, and analytically sophisticated drug checking technology**

PI: Dan Werb

Funding: Health Canada Substance Use and Addictions Program: \$854,439

Summary: The DoseCheck device has the goal of radically expanding access to overdose prevention technology in underserved settings and among structurally vulnerable populations who use drugs.

Status: Funded: January 27, 2022 – March 31, 2024

Title: **DoseCheck: Final validation and field pilot testing of a consumer-priced, networked, and analytically sophisticated drug checking technology**

PI: Dan Werb

Funding: St Michael's Hospital Foundation: \$257,000

Summary: The DoseCheck device has the goal of radically expanding access to overdose prevention technology in underserved settings and among structurally vulnerable populations who use drugs.

Status: Funded: January 1, 2022 – March 31, 2024

Title: **Identifying Intersectional Stigma Intervention Targets for People Who Inject Drugs in a High-Risk International Setting**

PI: Dan Werb

Funding: Canadian Institutes of Health Research Project Grant - Priority Announcement (HIV/AIDS and STBBI): \$100,000

Summary: Use a longitudinal observational data collection approach and robust advanced quantitative methods to identify which stigmas are most optimal to intervene on to optimize engagement in HIV prevention services among urban and rural PWID in Kyrgyzstan.

Status: Funded: March 1, 2021 – February 28, 2022

Title: ***PReventing Injecting by Modifying Existing Responses (PRIMER)***

PI: Dan Werb

Funding: US National Institute on Drug Abuse: USD\$2.3M.
 Summary: Development of a cohort consortium to identify and evaluate the impact of harm reduction and addiction treatment interventions on preventing the transition of injection-naïve individuals into drug injecting.
 Status: Funded, 2015-2020.

Title: **Centre on Drug Policy Evaluation**
 PI: Dan Werb
 Funding: MAC AIDS Fund: \$65,000.
 Summary: Research and outreach to support the development of evidence-based policies for people who inject drugs in Canada.
 Status: Funded, 2019-2020.

Title: **Centre on Drug Policy Evaluation – Policy Impact Unit**
 PI: Dan Werb
 Funding: Open Societies Foundation: \$50,000 USD
 Summary: Research and outreach to support the development of evidence-based policies for people who use drugs internationally.
 Status: Funded, 2019-2020.

Title: **A Framework to Evaluate Drug Policy in Canada**
 PI: Dan Werb
 Funding: Health Canada Canadian Drugs and Substances Strategy: \$22,000.
 Summary: Development of an evaluation framework for the Canadian Drugs and Substances Strategy (CDSS), including theoretical foundation, specific indicators and data sources, and methodologies.
 Status: Funded, 2018-2019.

INACTIVE CO-I FUNDING

Title: **Supervised Consumption and COVID-19 in ON: An Evaluation (SCCONE)**
 PI: Dr. Ahmed Bayoumi
 Funding: Health Canada: \$250,000 CAD
 Summary: Examine the best models for supervised injection sites, how these sites can be sustained over time, and how to address barriers to using sites for specific groups, including people who are racialized and Indigenous, women, and people who use stimulants.
 Status: Funded: 2020 - 2021

Title: **Alterations in Prescribing of Opioid Agonist Therapy due to the Pandemic (ALT-POP) Study**

PI: Dr. Ahmed Bayoumi, Dr. Sam Young
 Funding: Canadian Institutes of Health Research Operating Grant: \$184,446 CAD
 Summary: Evaluate how the changes in prescribing of medications for opioid use disorder as a result of COVID-19 impacted the clients who take them.
 Status: Funded: September 2020 - August 2021

Title: **The Effects of the COVID-19 Pandemic Response for People who are Marginalized**
 PI: Dr. Ahmed Bayoumi
 Funding: University of Toronto, Toronto COVID-19 Action Initiative: \$325,000 CAD
 Summary: This collaborative, mixed-methods, community-engaged study will examine the myriad negative effects of physical distancing policies on marginalized populations in Toronto, and will develop immediate, effective, on-the-ground solutions.
 Status: Funded: September 2020 - August 2021

Title: **The Effects of the COVID-19 Pandemic Response for People who are Marginalized**
 PI: Dr. Ahmed Bayoumi
 Funding: St. Michael's Hospital Foundation. COVID Fund Related: \$125,000 CAD
 Summary: This collaborative, mixed-methods, community-engaged study will examine the myriad negative effects of physical distancing policies on marginalized populations in Toronto, and will develop immediate, effective, on-the-ground solutions.
 Status: Funded: September 2020 - August 2021

Title: **Securing Safe Supply during COVID-19 and Beyond: Scoping Review and Knowledge Mobilization**
 PI: Dr. Matthew Herder
 Funding: Canadian Institutes of Health Research Operating Grant: \$49,952 CAD
 Summary: Identify ways to facilitate access to a safe supply of drugs in the context of COVID-19 and develop recommendations and strategies to encourage the uptake of safe supply across Canada.
 Status: Funded: May - October, 2020

Title: **CRISM Urgent Guideline Activities Related to COVID-19**
 PI: Evan Wood, Cameron Wild, Jürgen Rehm, Julie Bruneau
 Funding: Canadian Institutes of Health Research Operating Grant: \$1.0M CAD
 Summary: Rapidly develop guidelines for provision of care and services for people who use drugs in Canada.
 Status: Funded: June 1, 2020 - March 31, 2022

PUBLICATIONS

Peer-Reviewed Publications

1. Martignetti L, Knight R, Nafeh F, Atkinson K, Laurence G, Johnson CH, **Verb D**, Karamouzian M. Motivations for and perspectives of medication diversion among clients of a safer opioid supply program in Toronto, Canada. *International Journal of Drug Policy*. 2024. In Press.
2. Scheim AI, Bouck Z, Greenwald ZR, Ling V, Hopkins S, Johnson M, Bayoumi A, Gomes T, **Verb D**. Frequency of supervised consumption service use and acute care utilization in people who inject drugs. *Drug and Alcohol Dependence*. Accepted October 23, 2024.
3. Russell. C., Ali F., Imtiaz S., Butler A., Greer A., Rehm J. and the Decriminalization Evaluation Research Group*. (2024). The Decriminalization of Illicit Drugs in British Columbia: A National Evaluation Protocol. *BMC Public Health* (in press). *Group co-author.
4. Killion JA, Jegede OS, **Verb D**, Davidson PJ, Smith LR, Gaines T, Graff Zivin T, Zuniga ML, Pines HA, Garfein RS, Strathdee SA, Rivera Saldana C, Martin NK. (2024). Modeling the impact of a supervised consumption site on HIV and HCV transmission among people who inject drugs in three counties in California, USA. *International Journal of Drug Policy*, 132, 104557.
5. Kennedy, R; Bouck, Z; **Verb, D**; Kurmanalieva, A; Blyum,A; Shumskaya, N; Patterson, TL; Cepeda, J; Smith LR. A cross-sectional assessment of injection of 'salts' and HIV transmission-related behaviours among a cohort of people who inject drugs in Kyrgyzstan. *Journal of the International AIDS Society*. 2024. In press.
6. Mitra S., Bouck Z., Larney S., Zolopa C., Hoj S., Minoyan N., Upham K., Rammohan I., Mok WY., Hayashi K., Milloy M-J., DeBeck K., Scheim., **Verb D**. The impact of the COVID-19 pandemic on people who use drugs in three Canadian cities: A cross-sectional analysis. *Harm Reduction Journal*. 2024. In press.
7. Greenwald ZR, **Verb D**, Feld JJ, Austin P, Fridman D, Bayoumi AM, Gomes T, Kendall C, Lapointe-Shaw L, Scheim AI, Bartlett S, Benchimol EI, Bouck Z, Boucher L, Greenaway C, Janjua NZ, Leece P, Wong WWL, Sander B, Kwong JC. Validation of case-ascertainment algorithms using health administrative data to identify people who inject drugs in Ontario, Canada. *Journal of Clinical Epidemiology*. 2024. In Press.
8. Rammohan I, Gaines T, Scheim A, Bayoumi A, **Verb D**. Overdose mortality incidence and supervised consumption services in Toronto, Canada: an ecological study and spatial analysis. *The Lancet Public Health*. 2024;9(2).

9. Salvalaggio G, Brooks H, Caine V, Gagnon M, Godley J, Houston S, Kennedy M.C, Kosteniuk B, Livingston J, Saah R, Speed K, Urbanoski K, Werb D & Hyshka E. Flawed reports can harm: the case of supervised consumption services in Alberta. *Canadian Journal of Public Health*. (2023). <https://doi.org/10.17269/s41997-023-00825-x>
10. Bowles, J.M., Mansoor, M., Werb D, Kerr, T., Bardwell, G., (2023). A qualitative assessment of tablet injectable opioid agonist therapy (TiOAT) in rural and smaller urban British Columbia, Canada: Motivations and initial impacts. *Journal of Substance Use and Addiction Treatment*. In press.
11. Rammohan I, Jain S, Sun S, Marks C, Milloy MJ, Hayashi K, DeBeck K, González-Zúñiga P, Strathdee S, Werb D. Latent polydrug use patterns and the provision of injection initiation assistance among people who inject drugs in three North American settings. *Drug Alcohol Rev*. 2023;42(6):1504-16.
2. Ondocsin J, Ciccarone D, Moran L, Outram S, Werb D, Thomas L, Arnold EA. Insights from Drug Checking Programs: Practicing Bootstrap Public Health Whilst Tailoring to Local Drug User Needs. *Int J Environ Res Public Health*. 2023;20(11).
3. Nafeh F, Werb D, Karamouzian M. The ups and downs of harm reduction in Afghanistan. *Lancet Reg Health Southeast Asia*. 2023;13:100186.
4. Karamouzian M, Rafat B, Kolla G, Urbanoski K, Atkinson K, Bardwell G, Bonn M, Touesnard N, Henderson N, Bowles J, Boyd J, Brunelle C, Eeuwes J, Fikowski J, Gomes T, Guta A, Hyshka E, Ivsins A, Kennedy MC, Laurence G, Martignetti L, Nafeh F, Salters K, Tu D, Strike C, Pauly B, Werb D. Challenges of implementing safer supply programs in Canada during the COVID-19 pandemic: A qualitative analysis. *Int J Drug Policy*. 2023;120:104157.
5. Guise A, Harris M, McCusker M, McNeil R, Werb D. Stigma is stopping an evidence based response to drug overdose deaths in the UK. *Bmj*. 2023;382:e074934.
6. Greenwald ZR, Bouck Z, McLean E, Mason K, Lettner B, Broad J, Dodd Z, Nassau T, Scheim AI, Werb D. Integrated supervised consumption services and hepatitis C testing and treatment among people who inject drugs in Toronto, Canada: A cross-sectional analysis. *J Viral Hepat*. 2023;30(2):160-71.
7. Gicquelais RE, Astemborski J, Werb D, Kirk GD, Mehta SH, Genberg BL. Context and correlates of providing assistance with someone's first injection in the AIDS linked to the IntraVenous Experience cohort, Baltimore, MD. *Drug Alcohol Depend*. 2023;250:110909.
8. Delaney SR, Konforte D, Stefan C, Palaty J, Sun D, McDonald K, Thompson H, Werb D, Beriault DR. Drug checking services as a surveillance tool for clinical laboratories:

Examining trends in the unregulated fentanyl supply. Clin Biochem. 2023;111:11-6.

9. Bowles JM, Kolla G, Smith LR, Scheim A, Dodd Z, Verb D. Disease-related stigma among people who inject drugs in Toronto amidst the COVID-19 pandemic. Drug Alcohol Depend Rep. 2023;7:100167. **Editor's Pick*
10. Bouck Z, Tricco AC, Rosella LC, Banack HR, Fox MP, Platt RW, Milloy MJ, DeBeck K, Hayashi K, Verb D. First-line opioid agonist treatment as prevention against assisting others in initiating injection drug use: A longitudinal cohort study of people who inject drugs in Vancouver, Canada. Drug Alcohol Depend Rep. 2023;7:100168.
11. Bardwell G, Bowles JM, Mansoor M, Verb D, Kerr T. Access to tablet injectable opioid agonist therapy in rural and smaller urban settings in British Columbia, Canada: a qualitative study. Subst Abuse Treat Prev Policy. 2023;18(1):14.
12. Ali F, Russell C, Greer A, Bonn M, Verb D, Rehm J. "2.5 g, I could do that before noon": a qualitative study on people who use drugs' perspectives on the impacts of British Columbia's decriminalization of illegal drugs threshold limit. Subst Abuse Treat Prev Policy. 2023;18(1):32.
13. Algarin AB, Verb D, Shumskaya N, Kurmanalieva A, Blyum A, Cepeda J, Patterson TL, Baral S, Smith LR. Financial Vulnerability and Its Association with HIV Transmission Risk Behaviors Among People Who Inject Drugs in Kyrgyzstan. AIDS Behav. 2023.
14. Verb D, Scheim AI, Soipe A, Aeby S, Rammohan I, Fischer B, Hadland SE, Marshall BDL. Health harms of non-medical prescription opioid use: A systematic review. Drug Alcohol Rev. 2022;41(4):941-52.
15. Smith LR, Shumskaya N, Kurmanalieva A, Patterson TL, Verb D, Blyum A, Algarin AB, Yeager S, Cepeda J. Cohort profile: the Kyrgyzstan InterSectional Stigma (KISS) injection drug use cohort study. Harm Reduct J. 2022;19(1):53.
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20. Persaud N, Woods H, Workentin A, Adekoya I, Dunn JR, Hwang SW, Maguire J, Pinto AD, O'Campo P, Rourke SB, Verb D. Recommendations for equitable COVID-19 pandemic recovery in Canada. *CMAJ*. 2022;194(2):E60-e72.
21. Nassau T, Kolla G, Mason K, Hopkins S, Tookey P, McLean E, Verb D, Scheim A. Service utilization patterns and characteristics among clients of integrated supervised consumption sites in Toronto, Canada. *Harm Reduct J*. 2022;19(1):33.
22. Mitra S, Kolla G, Bardwell G, Wang R, Sniderman R, Mason K, Verb D, Scheim A. Requiring help injecting among people who inject drugs in Toronto, Canada: Characterising the need to address sociodemographic disparities and substance-use specific patterns. *Drug Alcohol Rev*. 2022;41(5):1062-70.
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27. Lazor T, Blondal E, Scheim A, Cubillos P, Verb D, Milloy MJ, Bonato S, Maghsoudi N, Rueda S. Measurement of public health impacts of cannabis legalization in Canada to reflect policy maker priorities: A rapid scoping review of instruments and content

domains. *Drug Alcohol Depend.* 2022;236:109463.

28. Kitchen SA, Campbell TJ, Men S, Bozinoff N, Tadrous M, Antoniou T, Wyman J, Verb D, Munro C, Gomes T. Impact of the COVID-19 pandemic on the provision of take-home doses of opioid agonist therapy in Ontario, Canada: A population-based time-series analysis. *Int J Drug Policy.* 2022;103:103644.
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35. Scheim AI, Bouck Z, Tookey P, Hopkins S, Sniderman R, McLean E, Garber G, Baral S, Rourke SB, Verb D. Supervised consumption service use and recent non-fatal overdose among people who inject drugs in Toronto, Canada. *Int J Drug Policy.* 2021;87:102993.
36. Persaud N, Woods H, Workentin A, Adekoya I, Dunn JR, Hwang SW, Maguire J, Pinto AD, O'Campo P, Rourke SB, Verb D. Recommendations for equitable COVID-19 pandemic recovery in Canada. *Cmaj.* 2021;193(49):E1878-e88.

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Book Chapters

1. **Werb D**, Maghsoudi N. "The search for new drug policy metrics". In: *Research handbook on international drug policy*. Cheltenham, UK: Edward Elgar Publishing, 2020 (forthcoming).
2. Fischer B, Kuganesan S, Burnett C, Gallassi A, **Werb D**. "Crack: Global epidemiology, key characteristics and consequences of use, and current interventions". In: *Roadmaps to regulation: Coca, cocaine and derivatives*. London: Beckley Foundation, 2016.

Selected Professional Publications

1. **Werb D.** Supervised Consumption Services in Toronto: Evidence and Recommendations. Toronto: Centre on Drug Policy Evaluation. November 2024.
2. Maghsoudi N, Owusu-Bempah A, **Werb D.** A Roadmap for Cannabis Equity in Canada to Inform the Legislated Review of the Cannabis Act. Toronto: Centre on Drug Policy Evaluation, 2023.
3. McDonald K, Thompson H, **Werb D.** 10 key findings related to the impact of Toronto's Drug Checking Service. Toronto: Centre on Drug Policy Evaluation. May 31, 2023.
4. Thompson H, McDonald K, Maghsoudi N, **Werb D.** Toronto's increasingly unpredictable and toxic unregulated opioid supply. Results from samples checked by Toronto's Drug Checking Service: January 1st, December 31, 2022. Toronto: Centre on Drug Policy Evaluation. April 30, 2023.
5. Maghsoudi N, Rammohan I, Bowra A, Sniderman R, Tanguay J, Bouck Z, Scheim A, **Werb D.** Owusu-Bempah A. How Diverse is Canada's Legal Cannabis Industry? Examining Race and Gender of its Executives and Directors. Toronto: Centre on Drug Policy Evaluation, 2022.
6. Thompson H, McDonald K, Maghsoudi N, **Werb D.** What's Contaminating Toronto's Drug Supply? Insights from Samples Checked by Toronto's Drug Checking Service: January 1 - December 31, 2021. Toronto: Centre on Drug Policy Evaluation. August 16, 2022.
7. Beletsky L, **Werb D.** Scheim A, Bowles J, Lucas D, Maghsoudi N, and Owusu-Bempah A. Redressing Inequities in America's Drug Policies: An Evidence-Grounded Call for Bold Action. Cambridge: Harvard Law - Petrie-Flom Center; April 2021.
8. Gomes T, Kitchen S, Martins D, Tadrous M, Murray R, Bansal S, Leece P, McKinnon L, **Werb D.** Preliminary Patterns in Circumstances Surrounding Opioid-Related Deaths in Ontario during the COVID-19 Pandemic. Toronto, ON: Ontario Drug Policy Research Network; 2020.
9. McDonald K, Maghsoudi N, Thompson H, **Werb D.** What's in Toronto's Drug Supply? Results from Samples Checked by Toronto's Drug Checking Service: October 10, 2019 - March 31, 2020. Toronto: Centre on Drug Policy Evaluation. April 14, 2020.
10. Bewley-Taylor D, Horsfield N, Maghsoudi N, Meza O, Noia C, Pol L, Rolles S, Sagredo J, Stein S, **Werb D.** International Expert Group on Drug Policy Metrics, "Aligning Agendas:

Drugs, Sustainable Development, and the Drive for Policy Coherence,” New York: International Peace Institute, February 2018.

11. Werb D, Wood E, Strathdee S, Kazatchkine M, Des Jarlais D, Hankins C, Nutt D, Montaner J, Kerr T, Hayashi K. A call for the reprioritization of metrics used to evaluate illicit drug policies. Toronto: International Centre for Science in Drug Policy, 2016.
12. Werb D, Maghsoudi NM. Using evidence to talk about cannabis. Toronto: International Centre for Science in Drug Policy, 2016.
13. Werb D, Watson TM, Maghsoudi NM. State of the evidence: Cannabis use and regulation. Toronto: International Centre for Science in Drug Policy, 2015.
14. Ti L, Wood E, Kerr T, Werb D, DeBeck K, Graham D, Vann P. Drug situation in Vancouver, 2nd ed. Vancouver: Urban Health Research Initiative, 2013.
15. Wood E, Werb D. How not to protect community safety: What the government’s own data say about the effects of cannabis prohibition. Vancouver: Stop the Violence BC, 2012.
16. Wood E, Werb D. Breaking the silence: Cannabis prohibition, organized crime and gang violence in BC. Vancouver: Stop the Violence BC, 2012.
17. Wood E, Werb D, Fischer B, Hart C, Wodak A, Bastos FI, Montaner J, Kerr T. Tools for debate: US federal government data on cannabis prohibition. Vancouver: International Centre for Science in Drug Policy, 2012.
18. Werb D, Rowell G, Guyatt G, Kerr T, Montaner J, Wood E. Effect of drug law enforcement on drug-related violence: Evidence from a scientific review. Vancouver: International Centre for Science in Drug Policy, 2010.
19. Werb D, Quayle K, Wood E, Macklin R, Shalev C, Osmanov S, Gutnick R, Hankins C. Ethical participation of people who inject drugs in HIV prevention trials. Geneva: World Health Organization, 2010.
20. Wood E, Kerr T, Werb D, Lai C, Li K, Zhang R, Marshall BD, Montaner J. Drug situation in Vancouver, 1st ed. Vancouver: Urban Health Research Initiative, 2009.
21. Wood E, Kerr T, Werb D, DeBeck K, Graham D, Tyndall M, Montaner J. Findings from the evaluation of Vancouver’s pilot medically supervised safer injecting facility – Insite. Vancouver: Urban Health Research Initiative, 2009.

Selected Popular Publications

1. **Werb D.** "Ending the overdose crisis is not at odds with keeping our communities safe from violence". *Toronto Star*. August 29, 2023.
2. **Werb D.** "The U.S. Scientist at the Heart of COVID Lab Leak Conspiracies". *TIME Magazine*, June 6th, 2023.
3. **Werb D.** "For-Profit Science Can't Save Us From the Next Pandemic". *The Daily Beast*, June 2, 2022.
4. **Werb D.** "A Nineteenth-Century Pandemic May Be a Window into Coronaviruses". *The Walrus*, March 17, 2022.
5. **Werb D.** "To End COVID-19, We Have to Admit That We've Failed". *TIME Magazine*, March 16, 2022.
6. **Werb D.** *The Invisible Siege: The Rise of Coronaviruses and the Search for a Cure*. New York: Crown Publishing, Inc. March 2022.
7. **Werb D.** "Seven Important Things to Know About Coronaviruses". *New York Times*, March 20, 2020.
8. **Werb D.** "Resist the Authoritarian Response to the Coronavirus". *Buzzfeed News*. March 5, 2020.
9. **Werb D.** "To Understand the Wuhan Coronavirus, Look to the Epidemic Triangle". *New York Times*, January 30, 2020.
10. **Werb D.** "What happens when a border city's lifeline is brutally severed". *Salon*. June 9, 2019.
11. **Werb D.** "Life on the Margins in a Kingdom of Cartels – On the Rise and Fall of Mexico's Narco Empire". *Literary Hub*. June 5, 2019.
12. **Werb D.** *City of Omens: A search for the missing women of the borderlands*. New York: Bloomsbury Publishing, Inc. June 2019.
13. **Werb D.** "How doctors discovered the true causes of drug addiction". *The Globe and Mail*. December 13, 2019.

14. **Werb D.** "How North America found itself in the grips of an opioid crisis." *VICE.com*, October 31, 2016.
15. **Werb D.** "Is media coverage of the opioid crisis making it worse?" *VICE.com*, October 11, 2016.
16. **Werb D.** "Epidemic in the Borderland". *The Believer Magazine* (McSweeney's Publishing), November 2015.
17. **Werb D.** "Oxy Town: Prescription opioids, a small Ontario community, and the failure of the war on drugs". *The Walrus Magazine*, December 2014. *Nominated for a 2015 Canadian National Magazine Award.*
18. **Werb D.** "Weeding out organized crime". *The Walrus Magazine*, May 2014.
19. **Werb D.** "The fix: A new way of thinking about the intractable problem of injection drug use". *The Walrus Magazine*, September 2013. *Winner of a 2014 Canadian National Magazine Award.*
20. Montaner M, **Werb D.** "Let Cory Monteith's overdose death be a loud wake-up call". *Huffington Post*, July 16th, 2013.
21. **Werb D.** "Canada's addiction to the war on drugs has ugly side effects". *Huffington Post*, July 6th, 2012.
22. **Werb D.** "Who do we blame for bath salts?" *Huffington Post*, June 22nd, 2012.
23. **Werb D.** "Should taxpayers support drug users?" *Huffington Post*, June 14th, 2012.
24. **Werb D.** "Health and Social Programs" in *Drug Policy Guide*. 2nd Ed. London: International Drug Policy Consortium, March 2012.
25. **Werb D.** "The Legalization of Pot". *Montreal Gazette*, January 19th, 2012.
26. **Werb D.** "Local long-term study leads HIV/AIDS fight". *The Georgia Straight*, August 24th, 2006.
27. **Werb D.** "Scientific Data Backs Insite". *The Georgia Straight*, August 17th, 2006.
28. **Werb D.** "Pillars of support: Against all odds, housing support workers keep homes steady". *Crosscurrents Journal of Mental Health and Addiction*, May 2006.

29. **Werb D.** "Breaking Out: Why do Canadian Prisons still not have needle-exchange programs?" *Crosscurrents Journal of Mental Health and Addiction*, February 2006.
30. **Werb D.** "Afghanistan: Narco-state or the future of pain treatment?" *Crosscurrents Journal of Mental Health and Addiction*, December 2006.
31. **Werb D.** "Canada's Attack on Afghan Smack". *Globe and Mail*, January 21st, 2006.

CONFERENCE PRESENTATIONS

1. Kolla G, Upham K, Bowles J, Ali H, Pinch S, Majid H, Bellony L, **Werb D**, Mitra S. *The impact of the COVID-19 pandemic on access to harm reduction and treatment services among people who inject drugs in Toronto, Ontario: A qualitative investigation*. 2024 CRISM Atlantic Symposium. Halifax, Nova Scotia (November 4–5, 2024). Poster presentation. *2nd place, best poster competition.
2. Greenwald ZR, Feld JJ, **Werb D**, Austin PC, Drover S, Fridman D, Bayoumi A, Gomes T, Kendall CE, Lapointe-Shaw L, Scheim AI, Bartlett SR, Benchimol EI, Bouck Z, Greenaway C, Janjua NZ, Leece P, Wong WW, Sander B, and Kwong JC. "Enhancing population-level research among people who inject drugs: a validation and retrospective cohort study using health administrative data in Ontario, Canada", *International Population Data Linkage Network 2024 Conference*. Chicago, USA (Sept 16-18, 2024).
3. Martignetti, L., Knight, R., Atkinson, K., **Werb, D.**, & Karamouzian, M. (October 8-11, 2024). *A Qualitative Assessment of Medication Diversion in a Safer Supply Program in Toronto*. 12th International Conference on Health and Hepatitis in Substance Users, Athens, Greece. Oral presentation.
4. Greenwald ZR, Bouck Z, Eeuwes J, Clark R, Atkinson K, Hopkins S, Tookey P, Greig S, Bonn M, Scheim AI, **Werb D**. Exploring the impact of supervised consumption service use on public injecting in Toronto, Canada. *12th International Conference on Health and Hepatitis in Substance Users*. Athens, Greece. 8-11, October 2024. Poster presentation.
5. Sung HS, Rammohan I, Bayoumi A, Karamouzian M, **Werb D**. Investigating the spatial association between supervised consumption services and fatal shootings and stabbings in Toronto. *AIDS 2024*. Munich, Germany. July 22-26, 2024. Poster presentation.
6. ZR Greenwald, Z Bouck, J Eeuwes, R Clarke, K Atkinson, S Hopkins, P Tookey, S Greig, MA Bonn, AI Scheim, **D Werb**. Public injecting and supervised consumption service use among people who inject drugs in Toronto, Canada during the fentanyl era. *AIDS 2024*. Munich, Germany. July 22-26, 2024. Poster presentation (withdrawn).

7. Scheim AI, Bouck Z, Greenwald ZR, Ling V, Hopkins S, Johnson M, Bayoumi A, Gomes T, **Werb D**. Frequency of supervised consumption service use and acute care utilization in people who inject drugs. *Annual Meeting of the Society for Epidemiologic Research*, June 18-21, 2024. Oral presentation.
8. **Werb D**, Karamouzian M. A roadmap to end the overdose epidemic in Canada. *17th annual conference of the International Society for the Study of Drug Policy*. June 19-21 2024; Oral presentation.
9. Rolle V., Na Y., Mason K., Atkinson K., Burke O., **Werb D**, Mitra S. Changes in opioid toxicity deaths after the implementation of COVID-19 emergency measures in Ontario, Canada: An interrupted time series. *17th annual conference of the International Society for the Study of Drug Policy*. June 19-21 2024; Oral presentation.
10. Martignetti, L., Maghsoudi, N., Ziegler, C., Fusigboye, S., Rammohan, I., Saposnik, F., Karamouzian, M., Owusu-Bempah, A., & **Werb, D**. (June 24-29, 2023). *A Scoping Review on Cannabis Equity Initiatives in Jurisdictions with Regulated Cannabis Markets*. 33rd Annual International Cannabinoid Research Society Symposium on the Cannabinoids, Toronto, Canada. Oral presentation.
11. Karamouzian M, Mbichila T, Mitra S, Martignetti L, Nafeh F, Rafat B, Brown C, Gomes T, Bayoumi A, **Werb D**. Short-term social and substance use-related outcomes among clients of safer opioid supply programs in Toronto, Canada. *INHSU 2023*, 17-20 October 2023; Poster presentation.
12. Hall D, Beriault D, **Werb D**. Development and validation of a novel point-of-care technology for rapid non-targeted identification of emerging threats in North American drug markets. Accepted for oral presentation at the *2023 American Chemical Society Annual Meeting*. San Francisco, CA. August 17th-19th, 2023.
13. **Werb D**, Fowler B, Cepeda J, Yeager S, Algarin A, Shumskaya N, Kurmanalieva A, Blyum A, Patterson TL, Smith LR. Treatment, policing, and fear among people who inject drugs in Kyrgyzstan. Accepted for oral presentation at the *2023 Conference of the International Society for the Study of Drug Policy*. Leuven, Belgium. May 30th-June 2nd, 2023.
14. Karamouzian M, Mbichila T, Bouck Z, Bayoumi A, Rafat B, Brown C, Hopkins S, Scheim A, **Werb D**. Reduction in Substance Use-Related Harms among a Cohort of People Receiving Injectable Opioid Agonist Treatment in Ontario, Canada. (Poster presentation). The College on Problems of Drug Dependence (CPDD) 85th Annual Scientific Meeting; Denver, Colorado, USA, June 17–21, 2023.

15. Bardwell G, Bowles J, Mansoor M, Werb D, Kerr T. Access to Tablet Injectable Opioid Agonist Therapy in Rural and Smaller Urban Settings in British Columbia: A Qualitative Study. College on Problems of Drug Dependence Annual Scientific Meeting, Denver, USA, June 17-21, 2023. Poster presentation.
16. Greenwald ZR, Feld JJ, Werb D, Austin PC, Mendlowitz A, Fridman D, Bartlett S, Janjua NZ, Greenaway C, Sander B, Kwong J. Measuring disparities in the Hepatitis C care cascade among people who inject drugs in Ontario: a population-based retrospective cohort study. Society for Epidemiologic Research 2023 Meeting. Portland, USA. June 13-16, 2023 (Submitted/Under Review)
17. Maghsoudi N, Werb D, Owusu-Bempah A. Equity in Canada's Legal Cannabis Industry: Research Findings and Policy Recommendations. 27th Harm Reduction International Conference, Melbourne, Australia, April 2023.
18. Karamouzian M, Rafat B, Werb D. Challenges of implementing safer supply initiatives in Canada: A qualitative analysis. Harm Reduction International Conference 2023; 16-19 April 2023; Melbourne, Australia.
19. Greenwald ZR, Feld JJ, Werb D, Austin PC, Mendlowitz A, Fridman D, Bartlett S, Janjua NZ, Greenaway C, Sander B, Kwong J. The population-level Hepatitis C care cascade among people who inject drugs in Ontario before and after the introduction of direct-acting antiviral therapy. Joint Canadian Digestive Diseases Week™ and Canadian Liver Meeting Conference 2023. Halifax, Canada. February 28 – March 5, 2023 (Oral Presentation)
20. Scarfone KM, Maghsoudi N, Thompson H, Stefan C, Beriault DR, Werb D, Bowles JM. Detection of Potent "Nitazene" Synthetic Opioids by a networked drug checking service in Toronto, Ontario, Canada. In: *Lisbon Addictions 2022 European Conference on Addictive Behaviours and Dependencies*, 23-25 November 2022; Lisbon, Portugal.
21. McDonald K, Matthews J, Tobias S, Werb D, Ti L. Drug checking in supervised drug consumption rooms: Rationale, methods and results. *Lisbon Addictions 2022 European Conference on Addictive Behaviours and Dependencies*, 23-25 November 2022; Lisbon, Portugal.
22. Bowles J, Kolla G, Smith LR, Scheim A, Dodd Z, Werb D. Disease-related stigma among people who inject drugs in Toronto amidst the COVID-19 pandemic. Oral Presentation. *13th National Harm Reduction Coalition Conference*. San Juan, Puerto Rico, October 13th, 2022.

23. Kolla G, Bowles J, Werb D. The impact of the COVID-19 pandemic on access to treatment and harm reduction services among people who inject drugs in Toronto: A qualitative investigation. Oral Presentation. *13th National Harm Reduction Coalition Conference*. San Juan, Puerto Rico, October 13th, 2022.
24. Bouck Z, Tricco AC, Rosella LC, Banack HB, Platt RW, Fox MP, Milloy M-J, DeBeck K, Hayashi K, Werb D. First-line opioid agonist treatment as prevention against assisting others in initiating injection drug use: a longitudinal cohort study of people who inject drugs in Vancouver, Canada. *Society for Epidemiological Research (SER) Annual Meeting*, Chicago, IL, USA, June 16th, 2022 (Poster Presentation).
25. Gicquelais RE, Astemborski J, Werb D, Collins EA, Kirk GD, Mehta SH, Genberg BL. Circumstances and Correlates of Providing Assistance with Someone's First Injection in the AIDS Linked the IntraVenous Experience Cohort, Baltimore, MD. *College on Problems of Drug Dependence Annual Scientific Meeting*, June 2022.
26. Yeager, S., Shumskaya, N., Kurmanalieva, A., Blyum, A., Patterson, T. L., Werb, D., Cepeda, J., & Smith, L. R. (2022, July). Differences in Drug Use and HIV Stigma among People Who Inject Drugs in Kyrgyzstan. Poster presentation at the *24th Annual Conference for the International AIDS Society*, Montreal, Canada.
27. Werb D. The Long Tail of Warp Speed: The politics of HIV science and the role of the AIDS pandemic in generating the COVID-19 scientific response. To be presented as an e-poster at *AIDS 2022* (Jul 29 - Aug 2) in Montreal, Canada.
28. Algarin AB, Werb D, Kurmanalieva A, Shumskaya N, Blyum A, Cepeda J, Patterson TL, Smith LR. Examining the association of financial vulnerability on injection and sexual HIV transmission risk among people who inject drugs in Kyrgyzstan: Implications for intervention and policy. To be presented as an e-poster at *AIDS 2022* (Jul 29 - Aug 2) in Montreal, Canada.
29. Werb D. The Limits and Opportunities of Drug Policy: Ending the Crisis Cycle. *Public Health Approaches to Drug Policy in Canada (CPHA)*. October 6-8, 2021; Ottawa, Canada; Virtual.
30. Bonn M, Touesnard N, Cheng B, Pugliese M, Comeau E, Bodkin C, Brothers TD, Genge L, Lepage C, Scheim A, Werb D, Wildeman S, Herder M. Securing "Safe Supply" during COVID-19 and beyond: scoping review and knowledge mobilization. [Poster presentation.] *International Network on Health and Hepatitis in Substance Users (INHSU) Annual Conference*. October 13-15, 2021 at Sydney, Australia; Virtual.

31. Rammohan I, Fusigboye S, Bouck Z, McDonald K, Maghsoudi N, Verb D. Correlates of interest in drug checking use among a cohort of people who inject drugs in Toronto, Canada. Poster submitted at the *2021 NIDA International Forum*, June 22-24, 2021; Virtual.
32. Mitra S., Bardwell G., Wang R., Sniderman R., Verb D, Scheim A. Prevalence and correlates of assisted injection among people who inject drugs in Toronto, Canada. *The 83rd College of Problems on Drug Dependence Annual Scientific Meeting*. June 21-24, 2021.
33. Maghsoudi N, Tanguay J, Scarfone K, Rammohan I, Ziegler C, Verb D, Scheim A. The Implementation of Drug Checking Services for People Who Use Drugs: A Systematic Review. *14th Annual International Society for the Study of Drug Policy (ISSDP) Conference*, Aguascalientes, Mexico. June 2021.
34. Verb, D. The current state of drug overdoses and a pilot drug checking program in Toronto, Ontario. *American Association for Clinical Chemistry 2021 Annual Conference*. May 13th, 2021.
35. Maghsoudi N, Tanguay J, Scarfone K, Rammohan I, Ziegler C, Verb D, Scheim A. The Implementation of Drug Checking Services for People Who Use Drugs: A Systematic Review. *30th Annual Canadian Conference on HIV/AIDS Research*, May 2021.
36. Marks, C., Pearson, J., Martin, N., Verb, D. Changes in income predict subsequent initiation and cessation of cigarette use but not e-cigarette use in the United States. *The Society for Research on Nicotine & Tobacco Conference 2021 Annual Meeting - Virtual*.
37. Rammohan I, Jain S, Sun S, Marks C, Milloy MJ, Hayashi K, DeBeck K, Strathdee S, González-Zúñiga P, Verb D. Polydrug use patterns and the provision of injection initiation assistance in Vancouver, Canada and Tijuana, Mexico: A latent profile analysis. Poster accepted at the 2020 NIDA International Forum; June 2020; Florida, USA. *Canceled due to COVID-19 pandemic*
38. Meyers, S., Jain, S., Sun, X., Marks, C., Milloy, M-J, DeBeck, K., Hayashi, K., Strathdee, S. A., & Verb, D. Gender and Time to the First Provision of Injection Initiation Assistance among People Who Inject Drugs across Two Distinct North American Contexts: Tijuana, Mexico and Vancouver, Canada. Poster accepted at the 2020 NIDA International Forum; June 2020; Hollywood, FL. *Canceled due to COVID-19 pandemic*
39. Maghsoudi N, Tanguay J, Scarfone K, Rammohan I, Ziegler C, Verb D, Scheim A. The Implementation of Drug Checking Services for People Who Use Drugs: A Systematic Review. *14th Annual International Society for the Study of Drug Policy (ISSDP) Conference*, Aguascalientes, Mexico, May 2020. *Canceled due to COVID-19 pandemic*

40. Meyers S., Earnshaw, V., Verb, D., & Smith, L. R. (April, 2020). The Intersection of Gender and Substance Use-Related Stigma: A Systematic Review of the Literature. Poster accepted at the 41st Annual Meeting & Scientific Sessions of the Society for Behavioral Medicine, San Francisco, CA. **Annual meeting canceled due to COVID-19 pandemic*
41. Maghsoudi N, Beriault D, Watson TM, Beletsky L, Verb D. Building an addiction care continuum model in North America. *Annual Meeting of the College on Problems of Drug Dependence*. San Antonio, Texas, USA. June 14-17, 2019.
42. Verb D. Jain S, Sun S, Debeck K, Rafful C, Hayashi K. Assessing the risk of incarceration on time to first injection initiation assistance provision among a cohort of people who use drugs in Vancouver, Canada. *10th International AIDS Conference (IAS 2019)*, 21-24 July 2019, Mexico City, Mexico.
43. Mittal ML, Jain S, Sun X, Hayashi K, Milloy M-J, Fairbairn N, Verb D. The association between opioid agonist treatment and injection initiation assistance among persons who inject different types of drugs in Vancouver, Canada. *10th International AIDS Conference (IAS 2019)*, 21-24 July 2019, Mexico City, Mexico.
44. Tirado-Muñoz J, Jain S, Sun X, Hayashi K, DeBeck K, Mittal ML, Verb D. Rafful C. Association between mental health and risk of initiating others into drug injecting in Vancouver, Canada. *2019 NIDA International Forum, Annual Meeting of the College on Problems of Drug Dependence*. San Antonio, Texas, USA. June 14-17, 2019.
45. Scheim A, Maghsoudi N, Churchill S, Ghaderi G, Marshall Z, Verb D. What matters and what has been measured? A systematic review of research on the impacts of implementing drug decriminalization or regulation. *Annual Conference of the International Society for the Study of Drug Policy*, Paris, France. May 22-24, 2019.
46. Maghsoudi N, Boudreau M, Mattison K, Elliott R, MacPherson D, Verb D. Negotiating a United Nations Resolution on Stigma Against People Who Inject Drugs: Reflections on Process and Implications. *28th Annual Canadian Conference on HIV/AIDS Research*, Saskatoon, Canada. May 2019.
47. Sniderman R, Maghsoudi N, Barnaby L, Coburn F, Hopkins S, Kallio N, Scheim A, Verb D. Integrating Frontline Harm Reduction Services to Better Meet People Where They're At: Experiences from Toronto, Ontario, Canada During A National Opioid Overdose Crisis. *Harm Reduction International Conference 2019*. Porto, Portugal. April 28th–May 1st, 2019.
48. Olding M, Guise A, Verb D. McNeil R. Injection initiation assistance as harm reduction during a fentanyl-driven overdose crisis: Injection drug users' experiences and

- implications for structural interventions. *Harm Reduction International Conference 2019*. Porto, Portugal. April 28th–May 1st, 2019.
49. Scheim AI, Maghsoudi N, Churchill C, Marshall Z, **Werb D**. Health and social impacts of implementing drug decriminalization or regulation: A systematic review. *Harm Reduction International Conference 2019*. Porto, Portugal. April 28th–May 1st, 2019.
 50. Mittal ML, Rafful C, Jain S, Sun S, Guise A, Gonzalez-Zuñiga P, Strathdee SA, **Werb D**. Reforming medication-assisted treatment to achieve harm reduction goals and address injection initiation assistance in Tijuana, Mexico. *Harm Reduction International Conference 2019*. Porto, Portugal. April 28th–May 1st, 2019.
 51. Maghsoudi N, **Werb D**. Emergence of Drug Checking Services (DCS) in Canada: Implementing a Multi-site DCS Network in Toronto, Ontario for a Marginalized Population of People Who Use Drugs. *reduse2018: International Multidisciplinary Conference on "New Aspects and Developments in Recreational Drug Use,"* Vienna, Austria. September 2018.
 52. West BS, Abramovitz D, Gonzalez-Zuniga P, Rangel G, **Werb D**, Cepeda J, Beletsky L, Strathdee SA. Drugs, Discipline and Death: Causes and Predictors of Mortality among People who Inject Drugs in Tijuana, 2011-2018. *22nd International AIDS Conference*, Amsterdam, Netherlands. July 23-27, 2018.
 53. Lake S, Kerr T, **Werb D**, Haines-Saah R, Fischer B, Thomas G, Walsh Z, Ware MA, Wood E, and Milloy, M-J. Guidelines for public health and safety metrics to evaluate the potential harms and benefits of cannabis regulation in Canada. *Cannabinoids in Clinical Practice*, Toronto, Canada. April 4-5, 2018.
 54. Lake S, Kerr T, **Werb D**, Haines-Saah R, Fischer B, Thomas G, Walsh Z, Ware MA, Wood E, and Milloy, M-J. Guidelines for public health and safety metrics to evaluate the potential harms and benefits of cannabis regulation in Canada. *12th International Society for the Study of Drug Policy Conference*, Vancouver, BC, Canada. May 16-18, 2018.
 55. Lake S, Kerr T, **Werb D**, Haines-Saah R, Fischer B, Thomas G, Walsh Z, Ware MA, Wood E, and Milloy, M-J. Guidelines for public health and safety metrics to evaluate the potential harms and benefits of cannabis regulation in Canada. *Public Health 2018 (Canadian Public Health Association)*, Montreal, PQ, Canada. May 29-31, 2018.
 56. Lake S, Kerr T, **Werb D**, Haines-Saah R, Fischer B, Thomas G, Walsh Z, Ware MA, Wood E, and Milloy, M-J. Guidelines for public health and safety metrics to evaluate the potential harms and benefits of cannabis regulation in Canada. *International Cannabinoid Research Society 2018*, Leiden, Netherlands. July 1-4, 2018.

57. Ospina-Escobar A, Juárez F, Magis C, Strathdee SA, Werb D. Trajectories of injection drug use and related risks among people who inject drugs in Northern Mexico. *NIDA International Forum, The College on Problems of Drug Dependence 2018 Annual Meeting*. San Diego, CA. June 9-14, 2018.
58. Mittal ML, Jain S, Hayashi K, Milloy M-J, DeBeck K, Sun S, Werb D. Enrolment in Medication-Assisted Treatment and its Association with Injection Initiation Assistance in Vancouver, Canada. *The College on Problems of Drug Dependence 2018 Annual Meeting*. San Diego, CA. June 9-14, 2018.
59. Meyers S, Scheim A, Jain S, Sun X, Milloy MJ, DeBeck K, Hayashi K, Garfein R, Strathdee SA, Werb D. Gender Differences in the Provision of Injection Initiation Assistance: A Comparison of Three North American Settings. *The College on Problems of Drug Dependence 2018 Annual Meeting*. San Diego, CA. June 9-14, 2018.
60. Maghsoudi N, Scheim A, Tupper K, Werb D. Protocol and rationale for evaluation of a multi-site drug checking pilot project in Toronto, Canada. *27th Annual Canadian Conference on HIV/AIDS Research*. Vancouver, Canada. April 26-29, 2018.
61. Hapsari AP, Werb D, Oviedo-Joekes E, Richardson CG. Exploring the role of cannabis use expectancies in optimizing health promotion programming to prevent or delay the initiation of cannabis use among Canadian adolescents. *Issues of Substance 2017: Addiction Matters*. Ottawa, Canada. November 13-15, 2017.
62. Vashishtha D, Mittal ML, Garfein R, Hayashi K, Milloy MJ, Cuevas-Mota J, Sun S, Jain S, Strathdee SA, Werb D. Public injection and providing injection initiation assistance among people who inject drugs in two North American countries. *NIDA International Forum, College on Problems of Drug Dependence Annual Meeting*. Montreal, Canada. June 19, 2017.
63. Melo JS, Garfein RS, Hayashi K, Milloy MJ, DeBeck K, Sun S, Jain S, Strathdee S, Werb D. The impact of law enforcement on risk for injection drug use initiation assistance in North America. *NIDA International Forum, College on Problems of Drug Dependence Annual Meeting*. Montreal, Canada. June 19, 2017.
64. Mittal ML, Rafful C, Vashishtha D, Gonzalez P, Davidson P, Werb D, Guise A. Drug policy implications of pathways to initiation of injection drug use facilitated by people who inject drugs in Tijuana, Mexico. Conference Paper. *11th Annual Conference of the International Society for the Study of Drug Policy (ISSDP)*, Aarhus, Denmark. May 17th-19th, 2017.
65. Rafful C, Orozco R, Rangel G, Davidson P, Gonzalez-Zuniga P, Werb D, Beletsky L, Strathdee SA. Increased overdose risk Associated with involuntary drug treatment in a

- longitudinal study with people who inject drugs in Tijuana, Mexico. Conference Paper. *11th Annual Conference of the International Society for the Study of Drug Policy* (ISSDP), Aarhus, Denmark. May 17th-19th, 2017.
66. Guise A, Hamida A, Mittal ML, Rafful C, Davidson P, **Verb D**. Harm reduction, choice and pleasure in structural responses to injecting initiation; insights from qualitative research in the Mexico-U.S. border region. Conference Paper. *11th Annual Conference of the International Society for the Study of Drug Policy* (ISSDP), Aarhus, Denmark. May 17th-19th, 2017.
 67. Rafful C, Garfein RS, Cuevas-Mota J, Sun S, Jain S, Strathdee SA, **Verb D**. HIV risk behaviors and providing injection initiation assistance among people who inject drugs in the San Diego – Tijuana border region. *2017 International Harm Reduction Conference*, Montreal, Canada, May 14th - 17th, 2017.
 68. Mittal ML, Gonzalez P, Sun S, Jain S, Strathdee SA, **Verb D**. Pathways and contexts for initiation of others into injection drug use in Tijuana, Mexico. *2017 International Harm Reduction Conference*, Montreal, Canada, May 14th - 17th, 2017.
 69. Beletsky L, **Verb D**. Police Innovations: The Future of Harm Reduction or a Source of Harm? *2017 International Harm Reduction Conference*, Montreal, Canada, May 14th - 17th, 2017.
 70. Mittal ML, Vashishtha D, Sun X, Jain S, Garfein R, Strathdee SA, **Verb D**. Opioid substitution therapy and initiation into injection drug use in San Diego, CA. *2017 Conference on Retroviruses and Opportunistic Infections (CROI)*, Seattle, USA, February 13th - 16th, 2017.
 71. Maghsoudi NM, **Verb D**. Emerging policy options for cannabis in Canada. *2016 American Society of Criminology Annual Conference*, New Orleans, USA, November 18th, 2016.
 72. Rafful C., Melo J., Medina-Mora M.E., Rangel G., Sun S., Jain S., **Verb D**. Cross-Border Migration and Initiation into Drug Injecting in Tijuana, Mexico. *6th Binational Conference*, Tijuana/San Diego, Mexico/USA, November 17th-18th, 2016.
 73. Rafful C, Mittal ML, Melo J, **Verb D**, Guise A. Initiation into injection drug use and cross-border migration among people who inject drugs in Tijuana, Mexico. *38th Annual Meeting and Scientific Sessions of the Society of Behavioral Medicine*, San Diego, USA, March 29th - April 1st, 2017.
 74. **Verb D**, Guise A, Jauffret-Roustide M, Garfein R, Strathdee SA. A socio-structural approach to preventing injection drug use initiation: Rationale for the PRIMER study. *2016 U.S. Harm Reduction Conference*, San Diego, USA, November 3rd-6th, 2016.

75. Vashishtha D, Mittal ML, Murphy JD, Werb D. Incorporating injection initiation into a cost-effectiveness model of methadone for heroin users. *California Medical Association 2016 House of Delegates Conference*, Sacramento, USA, October 15th-16th, 2016.
76. Werb D, Meacham M, Rafful C. The effectiveness of compulsory addiction treatment: A systematic review. *2015 International AIDS Conference*, Vancouver, Canada, July 19th – 22nd, 2015.
77. Werb D, Fast D. Defining public disorder: Conceptual implications for HIV prevention efforts. *2015 International AIDS Conference*, Vancouver, Canada, July 19th – 22nd, 2015.
78. Gaines T, Werb D, Arredondo J, Alaniz VM, Beletsky L. The spatial-temporal relationship of policing in areas with high drug activity in Tijuana. *College on Problems of Drug Dependence 77th Annual Meeting*, Phoenix, Arizona, USA, June 13th – 18th, 2015.
79. Vera A, Ojeda AV, Strathdee S, Werb D, Wagner K. Factores asociados con percepción de violencia en usuarios de drogas inyectables en centros de rehabilitación. *16 Congreso de Investigación en Salud Publica*, Cuernacava, Mexico, March 6th, 2015.
80. Werb D, Strathdee S, Gaines T. Spatial analysis of police encounters and addiction treatment center locations in Tijuana, Mexico. *2014 International AIDS Conference*, Melbourne, Australia, July 20th – 26th, 2014.
81. Werb D. Estimating the number of HIV and hepatitis C cases averted through the implementation of federal prison-based needle exchange programs in Canada. *2014 International AIDS Conference*, Melbourne, Australia, July 20th – 26th, 2014.
82. Werb D, McNeil R, Montaner M, Wood E. The need for social scientist involvement in evidence-based drug policy reform. Presented at the *9th International Conference on Interdisciplinary Social Sciences*, Vancouver, Canada, June 11th – June 13th, 2014.
83. Werb D, Wagner KD, Beletsky L, Strathdee S. Police bribery and access to methadone maintenance therapy within the context of drug policy reform in Tijuana, Mexico. *NIDA International Forum of the College on Problems of Drug Dependence Annual Conference*, San Juan, Puerto Rico, June 13th – June 16th, 2014.
84. Werb D, Richardson C, Buxton J, Shoveller J, Wood E, Kerr T. Development of a sensation seeking scale for use among vulnerable drug-using populations. Presented at the *7th International AIDS Society Conference on HIV Pathogenesis, Treatment and Prevention*, Kuala Lumpur, Malaysia, June 30th – July 3rd, 2013.

85. **Werb D**, Montaner M, Wood E. The need for social scientist involvement in evidence-based drug policy reform. Presented at the *2nd International HIV Social Sciences and Humanities Conference*, Paris, France, July 7th – 10th, 2013.
86. **Werb D**, Kerr T, Buxton J, Shoveller J, Richardson C, Montaner J, Wood E. Does sterile needle distribution prolong injection drug using careers? Presented at the *22nd Annual Canadian Conference on HIV/AIDS Research*, Vancouver, Canada, April 11th – 14th, 2013.
87. **Werb D**, Kerr T, Nosyk B, Strathdee S, Montaner J, Wood E. Patterns of drug price, purity and seizures: A review of government surveillance systems. Presented at the *23rd Conference of the International Harm Reduction Association*, Vilnius, Lithuania, June 9th – 12th, 2013.
88. **Werb D**, Kerr T, Feng C, Montaner J, Wood E. HIV antiretroviral therapy enrolment and cannabis use among a cohort of HIV-positive injection drug users in a Canadian setting. Presented at the *19th International AIDS Conference*, Washington, DC, July 21st – 27th, 2012.
89. **Werb D**, Kerr T, Montaner J, Wood E. Crystal methamphetamine and injection drug use initiation among street-involved youth in a Canadian setting. Presented at the *21st Annual Canadian Conference on HIV/AIDS Research*, Montreal, Canada, April 19th – 22nd, 2012.
90. **Werb D**, Montaner M, Tapp C, Wood E. The Vienna Declaration: Building international consensus for drug policy reform. Presented at the *22nd International Conference of the International Harm Reduction Association*, Beirut, Lebanon, April 3rd – 8th, 2011.
91. **Werb D**, Zhang R, Montaner J, Wood E. Injection drug use and antiretroviral therapy discontinuation among a cohort of illicit drug users. Presented at the *22nd International Conference of the International Harm Reduction Association*, Beirut, Lebanon, April 3rd – 8th, 2011.
92. **Werb D**, Bouchard M, Kerr T, Qi J, Montaner JSG, Wood E. Determinants of cessation of drug trade involvement among a cohort of injection drug users in Vancouver. Presented at the *9th International Conference on Urban Health*, New York City, New York, October 27th – 29th, 2010.
93. **Werb D**, Rowell G, Guyatt G, Kerr T, Montaner J, Wood E. The effect of drug law enforcement on drug-related violence: A systematic review. Presented at the *9th International Conference on Urban Health*, New York City, New York, October 27th – 29th, 2010.
94. **Werb D**, Mills E, Montaner J, Wood E. Risk of resistance to HIV antiretroviral therapy among patients with and without a history of injection drug use: A meta-analysis.

Presented at the *5th International AIDS Society Conference on HIV Pathogenesis, Treatment and Prevention*, Cape Town, South Africa, July 19th – 22nd, 2009.

95. Werb D, Wood E, Kerr T, Hershfield N, Palmer R, Remis R. Treatment costs of hepatitis C infection among drug users in Canada, 2006 – 2007. Presented at the *18th Annual Canadian Conference on HIV Research*, Vancouver, British Columbia, April 23rd – 26th, 2009.
96. Werb D, Mills E, DeBeck K, Kerr T, Montaner J, Wood E. The effectiveness of anti-illicit drug public service announcements: A meta-analysis and systematic review. Presented at the *18th Annual Canadian Conference on HIV Research*, Vancouver, British Columbia, April 23rd – 26th, 2009.
97. Werb D, Mills E, DeBeck K, Kerr T, Montaner J, Wood E. The effectiveness of anti-illicit drug public service announcements: A meta-analysis and systematic review. Presented at the *20th International Conference of the International Harm Reduction Association*, Bangkok, Thailand, April 20th – 23rd, 2009.
98. Werb D, Kerr T, Fast D, Qi J, Montaner JSG, Wood E. Displacement of a concentrated drug market among a cohort of street youth in Vancouver. Presented at the *8th International Conference on Urban Health*, Nairobi, Kenya, October 18th – 23rd, 2008.
99. Werb D, Kerr T, Zhang R, Montaner J, Wood E. Crystal methamphetamine and risk of malnutrition. Presented at the *8th International Conference on Urban Health*, Nairobi, Kenya, October 18th – 23rd, 2008.
100. Werb D, Kerr T, Marsh D, Li K, Montaner J, Wood E. Effect of methadone treatment on incarceration rates among injection drug users. Presented at the *27th Annual AIDS Conference*, Mexico City, Mexico, August 3rd – 8th, 2008.
101. Werb D, Kerr T, Lai C, Montaner J, Wood E. Non-fatal overdose among a cohort of street-involved youth. Presented at the *17th Annual Canadian Conference on HIV Research*, Montreal, Quebec, April 24th – 27th, 2008.
102. Werb D, Kerr T, Wood E, Small W, Strathdee S, Montaner J. Effects of police confiscation of illicit drugs and syringes among injection drug users in Vancouver. Presented at the *16th Annual Canadian Conference on HIV Research*, Toronto, Ontario, April 26th – April 29th, 2007.
103. Werb D, Kerr T, Small W, Li K, Montaner J, Wood E. Factors associated with incarceration and drug use in prison among injection drug users. Presented at the *16th Annual Canadian Conference on HIV Research*, Toronto, Ontario, April 26th – April 29th, 2007.

104. **Werb D.** Kerr T, Li K, Montaner J, Wood E. HIV risks associated with incarceration among injection drug users: Implications for Canada's new drug strategy. Presented at the *16th Annual Canadian Conference on HIV/AIDS Research*, Toronto, April 26th – April 29th, 2007.

INVITED TALKS

1. **Werb D.** Emerging research on the public health and public safety impacts of supervised consumption services. *Drug Strategy Network of Ontario seminar series*. November 27th, 2024.
2. **Werb D.** **Canada's overdose crisis:** How we got here, where we are now, and the challenges ahead. *Canadian Centre on Substance Use and Addiction Annual Summit*. September 5th, Timmins, Ontario. *Keynote.
3. **Werb D.** Prescribed safer supply. *6th Annual BC Substance Use Conference*. Friday May 31 until Saturday June 1st, 2024. Vancouver, Canada.
4. **Werb D.** Presentation to the Standing Committee on Health, Canadian House of Commons, Ottawa. December 11th, 2023.
5. **Werb D.** DoseCheck: A novel harm reduction tool for drug checking and drug market monitoring. U.S. National Institute on Drug Abuse Leadership Group. December 7th, 2023.
6. **Werb D.** DoseCheck: A mobile drug checking technology for use in Northern, rural, and remote communities. Northern Centre for Advanced Technology, Sudbury. August 23, 2023.
7. **Werb D.** Update from the National Safer Supply Evaluation for Federal Minister of Mental Health and Addictions Carolyn Bennett. May 10th, 2023.
8. **Werb D.** The long tail of Warp Speed: HIV science, pandemic prescience, and the role of the market in generating the COVID-19 scientific response. *Dr. Peter Centre COVID-19 community of practice seminar*. January 17th, 2023 (Zoom).
9. **Werb D.** Session #1: Building and sharing the evidence on current models of safer supply. *Health Canada Knowledge Exchange Series on Safer Supply Optimizing approaches to safer supply in Canada – Evidence and innovations*, October 27, 2022 (Zoom).

10. **Werb, D.** A tale of two futures. *PREPARE Institute Seminar*. October 18th, 2022 (Zoom).
11. **Werb, D.** A tale of two futures (*keynote). *Cutting Edge / Te toka tū moana; New Zealand Addiction Practitioners Association Annual Meeting 2022*. Christchurch, New Zealand. September 1st, 2022.
12. **Werb D.** The long tail of Warp Speed: HIV science, pandemic prescience, and the role of politics in generating the COVID-19 scientific response. *UC San Diego Department of Medicine Grand Rounds*. June 10th, 2022 (Zoom).
13. **Werb, D.** The current state of drug overdose and a pilot drug checking program in Toronto. *New York Upstate Local Section Spring Virtual Meeting hosted by the American Association for Clinical Chemistry*. May 13 – 14, 2021.
14. **Werb, D.** Preventing injection drug use: The state of the evidence, the promise and the perils. *Improving Prevention: Prioritizing Effective Approaches and Secondary Prevention*. Presented at The New Zealand Drug Foundation's Side Event of the 64th Commission on Narcotic Drugs. April 13th, 2021.
15. **Werb, D.,** Simmons, E. The effect of COVID on individuals suffering from addiction (Panel Session). *Annual Centre for Clinical Ethics Conference: Learning through the Storm: Ethical issues raised during COVID-19*. Virtual. November 26, 2020.
16. **Werb, D.,** Rai, N., Maser, B., Pavlovic, M. (Panel Session). *Accountability and Transparency in Opioid Access and Use in the Context of COVID-19: A Multi-Stakeholder Webinar Series. Session 2 - Opioid Practices and Policies: Benefits, Harms, and Opportunities*. Virtual. November 5, 2020.
17. **Werb D.** Improving drug policy metrics to achieve the Sustainable Development Goal Agenda: The Drug Policy Metrics Map. *The Role of Civil Society in Supporting UN System Wide Coordination: Research, Data Collection & Analysis in Drug Policy (Hosted by Governments of Mexico and Luxembourg)*. United Nations Headquarters, New York City. November 12th, 2019.
18. **Werb D.** Understanding the limits of drug policy: A pathway to better integration with HIV treatment, prevention and care. *The International AIDS Society—Lancet Commission on the Future of Global Health and the HIV Response: Eastern Europe Central Asia Regional Launch*. Lake Issyk-Kul, Kyrgyzstan, April 23rd-25th, 2019.
19. **Werb D.** Drug control interventions: Systematic findings on effectiveness. *Drugs Do Not = Death Conference*. Columbia University, New York, April 12th, 2019.

20. Maghsoudi N, Coburn F, Hyshka E, Tupper K W, Wilson D, Scheim A, Werb D. Integrating frontline harm reduction services to respond to the opioid overdose crisis and beyond (Panel Session). *Stimulus 2018: Drugs, Policy and Practice in Canada*. Edmonton, Canada, October 2018.
21. Katsivas TF, Mittal ML, Rafful C, Werb D. Disrupting the process of entry into injection drug use: Findings from the PRIMER study. *U.S. National Institute of Drug Abuse Cutting Edge Science Meeting to End the Opioid Crisis*. Washington, DC. March 5-6, 2018.
22. Werb D. Moving beyond the crisis cycle: A drug policy future. *Department of Public Safety Roundtable on the Opioid Crisis Agenda*. Ottawa, March 19th, 2018.
23. Werb D. Moving beyond the crisis cycle: A drug policy future. *Pacific Aids Network Annual Conference*. Vancouver, October 25th, 2017. (*Keynote)
24. Werb D. The prevention of injection drug use: Emerging responses. *Centre for AIDS Research, UC Los Angeles* (Grand Rounds). October 13th, 2017.
25. Werb D. Options for recreational cannabis regulation in Canada. *Law Union of Ontario Annual Conference 2016*. Toronto, May 13th, 2016.
26. Maghsoudi N, Werb D. Getting better results: Aligning drug policy objectives within the wider UN system. *Governments of Brazil, New Zealand, Switzerland and Canada, International Centre for Science in Drug Policy*, New York City (UN Headquarters), April 18th, 2016.
27. Werb D. The global context for cannabis policy. *Cannabinoids in Clinical Practice*, Toronto, April 8th, 2016.
28. Werb D. The future of injection drug use prevention: Preliminary evidence from an international multisite study. *St. Michael's Hospital Clinical and Population Research Rounds*, Toronto, March 31st, 2016.
29. Werb D. Preventing socially communicable conditions through policy-level approaches: An emerging research agenda. *Institute for Health Policy, Management & Evaluation, University of Toronto*, March 8th, 2016.
30. Werb D. Establishing a law enforcement-public health research partnership to respond to emerging questions on cannabis policy in Canada. *2016 Meeting of the Canadian Association of Chiefs of Police*, Halifax, Canada, March 1st, 2016.

31. **Werb D.** From research to action: How to translate research into policy change. *5th Canadian Symposium on HCV*, Montreal, Canada, February 26th, 2016.
32. **Werb D.** A call for the reprioritization of metrics used to evaluate illicit drug policies. Special panel session on 'Identifying Common Ground for the United Nations General Assembly Special Session on the World Drug Problem,' *United Nations University/International Centre for Science in Drug Policy*, New York City (UN Headquarters), January 21st, 2016.
33. **Werb D.** Addictions issues in Canada. *4th Annual Pain Alberta Health Services Awareness Education Day*, Calgary, Alberta, November 4th, 2015.
34. **Werb D.** Evaluating the impact of North American regional cannabis policies on illegal drug markets in British Columbia. *2015 Meeting of the Canadian Association of Chiefs of Police*, Halifax, Canada, November 3rd, 2015.
35. **Werb D.** The value of experimentation with innovative practices in drug policy. *Briefing of the Permanent Mission of Switzerland to the United Nations: Preparing for UNGASS 2016: Examining complex drug policy issues*, New York City (UN Headquarters), October 14th, 2015.
36. **Werb D.**, Maghsoudi N. Scientists and the 2016 UNGASS on Drugs. *2015 International AIDS Conference*, Vancouver, Canada, July 19th – 22nd, 2015.
37. **Werb D.** The role of drug policy in the HCV epidemic. Presented at the *2nd International HIV/Viral Hepatitis Co-Infection Satellite Meeting (IAS 2015 Conference)*. Vancouver, Canada, July 17th-18th, 2015.
38. **Werb D.**, O'Campo P. Developing indicators to better respond to drug-related violence in Toronto. Presented at the *Inaugural Global Health Equity & Innovation Summit*, Dalla Lana School of Public Health, Toronto, November 4th, 2014.
39. Collins J, Bewley-Taylor D, **Werb D.** Current drug policies: Evaluating indicators, examining future options. Presented at the *Government of Finland side event at the 2014 Commission on Narcotic Drugs*, Vienna, Austria, March 19th, 2014.
40. **Werb D.** Evaluating the impact of drug policy reform on people who inject drugs in Tijuana, Mexico. Presented at the *St. Michael's Hospital Clinical and Population Research Rounds*, Toronto, April 17th, 2014.
41. **Werb D.**, Montaner M. Working with researchers. Presented at the *2013 International Drug Policy Reform Conference*, Denver, Colorado, October 26th, 2013.

42. Werb D, Denning P, Discepola M, Galloway G, Kellogg S. Roundtable: How to end problematic drug use – what works and why? Presented at the *2013 International Drug Policy Reform Conference*, Denver, Colorado, October 26th, 2013.
43. Werb D. Heroin Prescription, HIV, and drug policy: Emerging regulatory frameworks. Presented at the *University of Oregon Law Review Drug Policy Symposium*, Eugene, Oregon, April 10th, 2013.
44. Hadland S, Werb D, Kerr T, Fu E, Wang H, Montaner J, Wood E. Childhood sexual abuse and risk for initiating injection drug use: A prospective cohort study. Presented at the *2013 Lost In Translation Conference*, Vancouver, Canada, March 25th – 26th, 2013.
45. Werb D. Harm reduction and religious values: Cause for conflict? Presented at the *"Whose Conviction? Religion and the (de)criminalization of drugs"* Symposium, University of Toronto, Canada, March 20th, 2013.
46. Werb D. A template for drug policy reform in Latin America. Presented at the *MUCD/Transform Latin America Drug Policy Symposium*, Mexico City, Mexico, November 21st – 24th, 2012.
47. Werb D. Infectious diseases and psychiatric disorders related to the use of illicit drugs. Presented at the Autonomous University of Mexico's *International Forum on the Regulation of Illicit Drugs*, Mexico City, Mexico, March 23rd – 27th, 2012.
48. Werb D, Montaner M, Wood E. A template for change: Research and policy change in British Columbia. Presented at the *CSSDP Progress Not Prisons Conference*, Calgary, Alberta, March 4th, 2012.
49. Werb D, Wood E. The failure of supply reduction strategies. Presented at the *Urban Health Research Initiative Community Forum*, Vancouver, February 20th, 2012.
50. Werb D. Romance and the multiverse. *Trampoline Hall*. Toronto, February 6th, 2012.
51. Werb D, Wood E. The impact of supply reduction strategies on illicit drug availability and violence. Presented at the *3rd Latin American and 1st Mexican Conference on Drug Policy*, Mexico City, September 12th – 14th, 2011.
52. Werb D, Kerr T. Clinical trials involving injection drug users: Experiences from a community-based research project in Bangkok, Thailand. Presented at the *Society for Clinical Trials 32nd Annual Meeting*, Vancouver, Canada, May 15th – 18th, 2011.

53. **Werb D**, Kerr T, Wood E. Harm reduction, drug policy, and the prevention and treatment of drug-related harms. Presented at the *NARSF Harm Reduction Symposium*, Nanaimo, British Columbia, December 6th, 2010.
54. **Werb D**, Wood E. Barriers to the incorporation of scientific evidence into illicit drug policy. Presented at the *Hepatitis C Council of British Columbia Conference*, Abbotsford, British Columbia, November 4th, 2010.
55. **Werb D**, Wood E. **Plenary**: Barriers to the incorporation of scientific evidence into illicit drug policy. Presented at the *21st International Conference of the International Harm Reduction Association*, Liverpool, United Kingdom, April 25th – 29th, 2010.
56. **Werb D**, Wood E. A history of harm reduction in Vancouver. Presented at the *Open Society Institute Drug Policy Reform Symposium*, New York City, New York, December 7th, 2009.
57. **Werb D**, Johnston CL. The Vancouver Injection Drug Users Study: Reflections on 10 years of studying HIV/AIDS in Vancouver. Presented at the *2009 World AIDS Day Symposium*, Vancouver, British Columbia, December 1st, 2009.
58. **Werb D**, Mills E, DeBeck K, Kerr T, Montaner J, Wood E. The effectiveness of anti-illicit drug public service announcements: A meta-analysis and systematic review. Presented at the *Drug Policy Alliance Reform Conference*, Albuquerque, New Mexico, November 2nd – 5th, 2009.
59. **Werb D**, DeBeck K, Kerr T, Li K, Montaner J, Wood E. Massive increase in crack use in a Canadian setting. Presented at the *International Society for the Study of Drug Policy's Drug Policy Modeling Workshop*, Vienna, Austria, March 2nd – 3rd, 2009.
60. **Werb D**, DeBeck K, Kerr T, Li K, Montaner J, Wood E. Massive increase in crack use in a Canadian setting. Presented at *Learning from Cross Canadian Experience: Harm Reduction in the Context of Crack Cocaine Smoking*, Toronto, Canada, March 31st, 2009.
61. **Werb D**, DeBeck K, Kerr T, Li K, Montaner J, Wood E. Massive increase in crack use in a Canadian setting. Presented at the *Cracked But Not Broken Conference*, Vancouver Canada, April 18th – 20th, 2008.

TEACHING

Mentorship & Supervision (N = 46)

Trainee Name	Type/Training Period	Thesis/Project Title	Funding	Year(s)
<i>Postdoctoral trainees (N = 11)</i>				
Sanjana Mitra	Postdoctoral Fellow, St. Michael's Hospital	Evaluating the impact of drug decriminalization on people who use drugs in Toronto	Canadian Institutes of Health Research/St. Michael's Hospital Foundation	2022-2025
Gillian Kolla	Postdoctoral Fellow, St. Michael's Hospital	Evaluating the impact of COVID-19 on structurally vulnerable people who inject drugs in Toronto	Canadian Institutes of Health Research	2020-21
Jeannette Bowles	Postdoctoral Fellow, St. Michael's Hospital	Evaluating an addiction care cascade in Toronto	St. Michael's Hospital Foundation	2019-2022
Ayden Scheim	Postdoctoral Fellow, University of California San Diego (Supervisor)	Investigating the risk of injection initiation among gender and sexual minorities in Vancouver, Canada; San Diego, USA; and Tijuana, Mexico	Canadian Institutes of Health Research	2017-2020
Claudia Rafful	Postdoctoral Fellow, St. Michael's Hospital (Supervisor)	Identifying the role of health service utilization on the risk that people who inject initiate others into injecting	Canadian Institutes of Health Research	2017-2020
Judit Tirado-Munoz	Postdoctoral trainee, University of California San Diego (Supervisor)	Assessing the role of intimate partner violence and psychiatric comorbidities in the risk of injection initiation assistance provision	National Institute on Drug Abuse INVEST program	2018-2019
Andrew Guise	Postdoctoral trainee, University of California San Diego (Supervisor)	Exploring injection drug use initiation pathways among participants in the San Diego-Tijuana region	U.S. National Institute on Drug Abuse	2014 – 2021
Maria Luisa Mittal	Postdoctoral trainee, University of California San Diego (Supervisor)	Migration and risk of injecting: A mixed-methods investigation of the Tijuana-San Diego border	U.S. National Institute on Drug Abuse	2014 – 2020
Meredith Meacham	Postdoctoral Fellow, University of California San Diego (Research Supervisor)	Effectiveness of compulsory addiction treatment	National Institutes of Health T32 award	2014 - 2016
Danielle Horyniak	Postdoctoral trainee, University of California San Diego (Research Supervisor)	Pathways to injection initiation: A qualitative synthesis	U.S. National Institute on Drug Abuse	2014 - 2017
Alicia Vera	Postdoctoral Fellow, Universidad Autonoma de Baja California (Research Supervisor)	HIV prevention among drug treatment programs in Tijuana, Mexico	AITRP fellowship, Fogarty International Program	2014 - 2015

Trainee Name	Type/Training Period	Thesis/Project Title	Funding	Year(s)
<i>Doctoral trainees (N = 12)</i>				
Kate Roberts	PhD trainee, Bryn Mawr College, Boston	The experience of women who use drugs in the initiation of injection drug use	Bryn Mawr College	2022-
Frishta Nafeh	PhD trainee, University of Toronto (PhD Supervisor)	Evaluation of novel opioid agonist treatment modalities to reduce overdose in Canada	Institute of Health Policy, Management & Evaluation, University of Toronto	2023-
Alexandra Almeida	PhD trainee, UCSD/SDSU (PhD Supervisor)	The syndemic of crack use, HIV, and HCV in Brazil: the role of gender and the open drug scenes	UC San Diego-San Diego State University Joint Doctoral Program on Interdisciplinary Research on Substance Use	2020-2023
Nazlee Maghsoudi	PhD trainee, University of Toronto (Thesis Co-Supervisor)	Evaluating the impact of street drug checking on overdose risk behaviors among people who use drugs in two Canadian cities	Institute of Health Policy, Management & Evaluation, University of Toronto	2017-
Zachary Bouck	PhD trainee, University of Toronto (Research Supervisor/Committee Member)	Longitudinal trends in injection initiation assistance	Health Canada/CIHR	2018-2023
Zoë Greenwald	PhD trainee, University of Toronto (Committee Member)	Measuring Hepatitis C treatment uptake and impact among key risk groups in Ontario	Canadian Institutes of Health Research	2020-
Jacob Morgan	PhD trainee, University of Toronto (Research Supervisor)	Assessing the impact of supervised consumption services on emergency department presentations of overdose in Toronto, Ontario	Health Canada/CIHR	2019-2020
Charles Marks	PhD trainee, UCSD/SDSU (PhD Supervisor)	Mathematical modeling of injection drug use initiation in three North American settings	UC San Diego-San Diego State University Joint Doctoral Program on Interdisciplinary Research on Substance Use	2017-2021
Stephanie Meyers	PhD trainee, UCSD/SDSU (PhD Supervisor)	Investigating the impact of stigma on pathways to the initiation of individuals into injection among people who inject drugs in North America	UC San Diego-San Diego State University Joint Doctoral Program on Interdisciplinary	2016-2020

Trainee Name	Type/Training Period	Thesis/Project Title	Funding	Year(s)
			Research on Substance Use	
Brittnie Bloom	PhD trainee, UCSD/SDSU (Research Supervisor)	The effect of childhood sexual assault on the risk of initiating individuals into injecting: a multi-site investigation	UC San Diego-San Diego State University Joint Doctoral Program on Global Health	2017-2018
Angelica Ospina	Visiting Doctoral Student, University of California San Diego (Research Supervisor)	Comparing access to harm reduction services in Tijuana, Ciudad Juarez, and Hermosillo, Mexico	National Council of Science and Technology, Mexico (CONACYT)	2014 - 2016
Jaime Arredondo	PhD trainee, Global Health track, University of California San Diego/San Diego State University (Research Supervisor)	Aligning law enforcement with HIV prevention in Mexico	AITRP fellowship, Fogarty International Program	2014 - 2015
<i>Master's-level trainees (N = 15)</i>				
Seneka Krishnakumar	Practicum trainee, St. Michael's Hospital (Practicum Director)	Investigating racial equity in access of supervised consumption services in Toronto, Canada	Lakehead University	2023
Sarah Clarke	MSc trainee, St. Michael's Hospital (Committee Member)	Experiences of non-prescribed opioid use during opioid agonist therapy: An interpretative phenomenological study	St. Michael's Hospital	2022-2024
Sufiat Fusigboye	MSc Trainee, Unity Health Toronto (Research Supervisor)	The impact of COVID-19 on people who use drugs in Toronto, Ontario	CIHR COVID-19 Rapid Project Grant	2020-2022
Indhu Rammohan	MSc Trainee, University of Toronto (Thesis Supervisor)	The health impacts of non-medical prescription opioid use: A systematic review	CIHR Canadian Research Initiative in Substance Misuse (CRISM), Ontario node	2018-
Monika Roerig	MA trainee (External Thesis Committee Member)	Exploring hepatitis C testing and treatment barriers among people who inject drugs	Wilfrid Laurier University	2016-2017
Amen Ben Hamida	MSc student, University of California San Diego (Research Supervisor)	Injection drug use among migrants to Europe from the Middle East and North Africa region	U.S. National Institute on Drug Abuse/Fulbright Scholarship	2016 - 2017
Pinky Hapsari	MSc trainee (Thesis Committee Member)	Exploring expectancies and intention to use as potential determinants of cannabis initiation among adolescents	University of British Columbia, School of Population and Public Health	2016

Trainee Name	Type/Training Period	Thesis/Project Title	Funding	Year(s)
Keikhosrow Zamaninoor	Masters capstone project trainee, Munk School of Global Affairs, University of Toronto	Recreational cannabis regulation and Canada's international obligations: Findings from a transformational scenario planning process	Munk School of Global Affairs, University of Toronto	2016
Virginia Arsenault	Masters capstone project trainee, Munk School of Global Affairs, University of Toronto (Research Supervisor)	Recreational cannabis regulation and Canada's international obligations: Findings from a transformational scenario planning process	Munk School of Global Affairs, University of Toronto	2016
Joy Rogers	Masters capstone project trainee, Munk School of Global Affairs, University of Toronto (Research Supervisor)	Recreational cannabis regulation and Canada's international obligations: Findings from a transformational scenario planning process	Munk School of Global Affairs, University of Toronto	2016
Yun Lin	Masters capstone project trainee, Munk School of Global Affairs, University of Toronto (Research Supervisor)	Recreational cannabis regulation and Canada's international obligations: Findings from a transformational scenario planning process	Munk School of Global Affairs, University of Toronto	2016
Ayorinde Soipe	MSc student, Brown University (Research Supervisor)	The health impacts of non-medical prescription opioid use: A systematic review	CIHR Canadian Research Initiative in Substance Misuse (CRISM), Ontario node	2015 - 2016
Danielle Smith	MSc Summer Student, University of California San Diego (Research Supervisor)	Barriers to needle exchange program access among people who inject drugs in Tijuana	Simon Fraser University	2014 - 2015
Samantha Aeby	MSc student, University of Toronto (Research Supervisor)	The health impacts of non-medical prescription opioid use: A systematic review	CIHR Canadian Research Initiative in Substance Misuse (CRISM), Ontario node	2013 - 2014
Michaela Montaner	Master's student in Interdisciplinary studies, University of British Columbia	Effectiveness of knowledge translation activities for the Vienna Declaration	Canadian Institutes of Health Research	2010 - 2014
<i>Clinical trainees (N = 6)</i>				
Saadia Sediqzadah	Clinical Fellow	Estimating the cost-effectiveness of injectable opioid agonist treatment in Toronto, ON	Health Canada	2019-2020
Devesh Vashishtha	Master's of Advanced Studies in Clinical	The impact of methadone maintenance therapy	NIH TL-1 grant	2016-2017

Trainee Name	Type/Training Period	Thesis/Project Title	Funding	Year(s)
	Research (MAS Supervisor)/Medical Resident	enrollment on injection initiation in Tijuana, Mexico and San Diego, California		
Matthew To	Medical Student, Research Practicum, Li Ka Shing Knowledge Institute (Research Supervisor)	The impact of incarceration on housing stability in Canadian settings	Li Ka Shing Knowledge Institute, St. Michael's Hospital	2014 - 2016
Dipinder Keer	Medical Resident, University of British Columbia/St. Paul's Hospital (Research Supervisor)	Topiramate for cocaine dependence	Addiction Medicine Fellowship, St. Paul's Hospital	2014 - 2016
Mohit Singh	Medical Resident, University of British Columbia/St. Paul's Hospital (Research Supervisor)	Topiramate for cocaine dependence	Addiction Medicine Fellowship, St. Paul's Hospital	2014 - 2016
Goldis Chami	Medical Resident, University of British Columbia/St. Paul's Hospital (Research Supervisor)	Neighborhood of residence and risk of initiation into injection drug use among street-involved youth in a Canadian setting	Addiction Medicine Fellowship, St. Paul's Hospital	2012 - 2013
<i>Pregraduate trainees (N = 3)</i>				
Kristy Scarfone	Pregraduate trainee, St. Michael's Hospital	Assessing the impact of street drug checking on drug market trends	Substance Use and Addictions Program, Health Canada	2019-
Jason Melo	Pregraduate trainee, University of California San Diego (Research Supervisor)	The role of migration in heightening risk of injection drug use initiation	U.S. National Institute on Drug Abuse	2015 - 2018
Justine Tanguay	Pregraduate trainee, Queen's University (Research supervisor)	The drug policy metrics map.	Open Society Foundations	2017- 2019

Course Instruction & Creation

1. Canada's Health Care System (HAD5011; University of Toronto). Fall 2019 & 2020.
2. Applied HIV and Substance Seminar (MED258; University of California, San Diego), Winter 2017 and ongoing. ****Course Created by Dan Werb.***

3. Global Health (PHTH 5230/LAW 7630; Northeastern University, Bouvé College of Health Sciences), Winter 2015 (co-instructor with Leo Beletsky, JD).

Guest Lectures

1. "Emerging research on the public health and public safety impacts of supervised consumption services." University of California San Diego Centre for AIDS Research seminar. November 13th, 2024.
2. "Why I Write." University of King's College Master of Fine Arts in Fiction, Closing Lecture, Halifax, June 9th, 2024.
3. "DoseCheck: A novel harm reduction tool for drug checking and drug market monitoring". HIV & Substance Use Research Seminar, Division of Infectious Diseases & Global Public Health, UC San Diego, April 11th, 2024.
4. "Transforming Research Into a 'City of Omens': The U.S.-Mexico Border, an HIV Epidemic, and Turning Epidemiologic Research Into Popular Science Writing." Canadian Centre on Health Economics, University of Toronto, November 29th, 2019.
5. "From HIV Research to True Crime Literature: Dan Werb discusses *City of Omens: A Search for the Missing Women of the Borderlands*." MED258, UC San Diego, October 17th, 2019.
6. "Socio-structural barriers to drug-related treatment and care in Tijuana, Mexico". McMaster University (Health Inequalities), 2018.
7. "Monitoring Drug Policies". University of Geneva (Drugs, Drug use, Drug policy and Health; Massive Open Online Course), 2018.
8. "Epidemiology, substance use and HIV". University of California San Diego MS1 (Introduction to Global Health Research), 2018.
9. "Epidemiology, substance use and HIV". University of California San Diego MS1 (Introduction to Global Health Research), 2017.
10. "Epidemiology, substance use and HIV". University of California San Diego MS1 (Introduction to Global Health Research), 2016.
11. "Barriers to the incorporation of scientific evidence into addictions policy". University of British Columbia SPPH 502 (Introduction to Epidemiologic Methods), 2014.

12. "Mixed methods research: An introduction to multiple approaches". University of California San Diego MED 123 (Introduction to Mixed Methods Research), 2014.
13. "Implementation barriers to drug policy reform: Mexico as a case study". University of British Columbia Law 343C.002 (Civil Liberties), 2014.
14. "It's never too early: Publishing research at every stage of your project". University of British Columbia SPPH 607 (Research in Progress), 2013.
15. "Barriers to the incorporation of scientific evidence into drug laws". University of British Columbia Law 343C.002 (Civil Liberties), 2013.
16. "The boomerang effect in interventions to control HIV and illicit drug use". University of British Columbia SPPH 527 (Social Determinants of Health), 2011.
17. Werb D, Shoveller J. "Mixed methods research: The how & the when". University of British Columbia SPPH 607 (Research in Progress), 2009.

MEMBERSHIP, COMMITTEE & BOARD PARTICIPATION

- Member, Health Canada's Federal Expert Task Force on Substance Use (2021)
- Member, Toronto Cannabis and Cannabinoid Research Consortium (2020)
- Member, CIHR HIV/AIDS & STBBI Strategic Planning Focus Group (2019)
- Investigator, Canadian HIV/AIDS Trial Network, Prevention Core (2019)
- Official Country Representative (Canada), United Nations Office on Drugs & Crime (UNODC) expert working group on improving drug statistics and strengthening the Annual Report Questionnaire (2018)
- Member, Scientific Committee, Annual Conference of the International Society of the Study of Drug Policy (2017-2019)
- Member, Toronto Public Health Steering Committee for Community Dialogue on Drug Policy Reform (2017-ongoing)
- Member, Steering Committee for Municipal Drug Strategies Coordinators Network of Ontario Evaluation Framework, University of Toronto (2017-2018)
- Chair, Conference Committee, Drug Futures Forum, Ottawa, April 4th - 5th, 2017 (2015-2017)
- Associate Director, San Diego State University-University of California Joint Doctoral Program in Interdisciplinary Research on Substance Use (2017-2020)
- Member, External Scientific Advisory Board, NIH Collaborating Consortium of Cohorts NIDA Producing Opportunities (C3NPO), (2017-2022)
- Member, Society for Epidemiologic Research (2019-)
- Member, Canadian Association of HIV Research (2010-)

- Member, International AIDS Society (2010-)
- Member, Advisory Board, International Core of the UC San Diego Center for AIDS Research (2015-2019)
- Member, Pierre Elliott Trudeau Foundation Media Network Project (2017)
- Member, Executive & Scientific Committees, International Harm Reduction Conference, (2016-2019)
- Member, Admissions Committee, San Diego State University-University of California Joint Doctoral Program in Interdisciplinary Research on Substance Use (2015-2019)
- Associate, International Drug Policy Project, London School of Economics (2015-)
- Advisory Board Member, Harm Reduction Supplies Knowledge Hub (2013-2015)

CONSULTANCY

Region of Peel, 2024

City of Toronto, 2022

Health Canada, 2018-2020

Pierre Elliott Trudeau Foundation, 2014-2015, 2018

Canadian HIV/AIDS Legal Network, 2013-2015

Global Commission on Drug Policy, 2011

Joint United Nations Programme on HIV/AIDS, 2010

SELECTED REVIEW WORK

As Editor:

Associate Editor, *International Journal of Drug Policy* (2016-)

Associate Editor, *Harm Reduction Journal* (2014-2017)

Guest Assistant Editor, *PloS Medicine* (2019)

As Journal Reviewer:

1) *Canadian Journal of Addiction* (2024)

2) *The Lancet Psychiatry* (2023)

3) *Scientific Reports* (2020-2021)

4) *The Lancet HIV* (2020)

5) *AIDS & Behavior* (2020)

6) *Medical Anthropology* (2019)

7) *Translational Psychiatry* (2019)

8) *Addiction* (2014-2020)

9) *Substance Use & Misuse* (2016-2019)

- 10) *Addictive Behaviors* (2018)
- 11) *Preventing Chronic Disease* (CDC journal; 2018)
- 12) *International Journal of Drug Policy* (2009-2023)
- 13) *American Journal of Public Health* (2014, 2018)
- 14) *Drug and Alcohol Dependence* (2011-2019)
- 15) *PLOS One* (2017)
- 16) *Drug and Alcohol Review* (2017)
- 17) *Journal of Drug Issues* (2017)
- 18) *Journal of Urban Health* (2013-2019)
- 19) *Public Health Reports* (2016)
- 20) *Journal of Infectious Diseases* (2016)
- 21) *Contemporary Drug Problems* (2016)
- 22) *Cochrane Database of Systematic Reviews* (2010; 2013-2015)
- 23) *Journal of Paediatrics and Child Health* (2014)
- 24) *Journal of Acquired Immune Deficiency Syndromes* (2012-2014)
- 25) *Harm Reduction Journal* (2013-2015)
- 26) *American Journal of Drug & Alcohol Abuse* (2013)
- 27) *HIV/AIDS Policy and Law Review* (2011-2012)
- 28) *The Lancet* (2010)

As External Report Peer Reviewer:

- 1) *U.S. National Academy of Medicine* (2019-2020; 2022)
- 2) *Institute for Clinical and Economic Review, New England Comparative Effectiveness Public Advisory Council* (2020)

As Grant Reviewer:

- 1) *U.K. Wellcome Trust* (2024)
- 2) *U.S. Centers for Disease Control and Prevention – Injury Prevention Center Grant* (2023)
- 3) *UC San Diego Centre for AIDS Research* (2017-2021)
 - a. *Development Grant Review*
 - b. *International Pilot Grant Review*
 - c. *OK Review*
- 3) *Government of Canada New Frontiers in Research Fund - Exploration Grant* (2019-2020)
- 4) *U.S. Centers for AIDS Research (UC San Diego)* (2015-2019)
- 5) *Canadian Institutes of Health Research* (2016-2022)
 - d. *Longitudinal Cannabis Research* (2022)
 - e. *Cannabis Team Grant* (2019-2020)
 - f. *Trailblazer Award* (2018-2019)
 - g. *Cannabis Research in Urgent Priority Areas* (2018-2019)

h. *Planning and Dissemination Awards* (2016-2019)

As Conference Abstract Reviewer:

- 1) *Canadian Association of HIV Research Annual Conference* (2018)
- 2) *International Society for the Study of Drug Policy Annual Conference* (2018-2020)
- 3) *Harm Reduction International Conference* (2017-2018)

TAB B

This is Exhibit “B” referred to in the Affidavit
of Dan Werb sworn January 9, 2025.

Carlo Di Carlo

Commissioner for Taking Affidavits

Court File No. CV-24-00732861-0000

**ONTARIO
SUPERIOR COURT OF JUSTICE**

IN THE MATTER OF

B E T W E E N:

THE NEIGHBOURHOOD GROUP COMMUNITY SERVICES, KATHARINE
RESENDES and JEAN-PIERRE AUBRY FORGUES

Applicants

and

HIS MAJESTY THE KING IN RIGHT OF ONTARIO

Respondent

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

ACKNOWLEDGMENT OF EXPERT'S DUTY

1. My name is Dan Werb. I live at Toronto, in the Province of Ontario.
2. I have been engaged by or on behalf of Stockwoods LLP, Lax O'Sullivan Lisus Gottlieb LLP and Nanda and Company to provide evidence in relation to the above-noted court proceeding.
3. I acknowledge that it is my duty to provide evidence in relation to this proceeding as follows:
 - (a) to provide opinion evidence that is fair, objective and non-partisan;
 - (b) to provide opinion evidence that is related only to matters that are within my area of expertise; and
 - (c) to provide such additional assistance as the Court may reasonably require, to determine a matter in issue.

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4. I acknowledge that the duty referred to above prevails over any obligation which I may owe to any party by whom or on whose behalf I am engaged.

5. I certify that I am satisfied as to the authenticity of every authority or other document or record to which I have referred in the expert report accompanying this form, other than:

- (a) documents and records provided to me by or on behalf of the party intending to call me as a witness and consisting of evidence or potential evidence in the court proceeding that I have analysed or interpreted in my report;
- (b) authorities and other documents and records to which I have referred in my report only in order to address how another expert witness in the same court proceeding has used them in their report; and
- (c) the following authorities, documents and records, for which I have doubts as to their authenticity as detailed within my report:

[list authorities, documents and records]

Note: Under the Rules of Civil Procedure, an authority or other document or record that is published on a government website or otherwise by a government printer, in a scholarly journal or by a commercial publisher of research on the subject of the report is presumed to be authentic, absent evidence to the contrary. If you are aware of evidence to the contrary, list the authority, document or record under 5.c. and provide further details in the accompanying report.

None.

Date January 9, 2025

Dan Werb

Signature

DAN WERB

ONTARIO
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THE NEIGHBOURHOOD GROUP
COMMUNITY SERVICES et al.

and HIS MAJESTY THE KING IN RIGHT
OF ONTARIO

Court File No. CV-24-00732861-0000

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APPLICATION RECORD VOL. 2 OF 2

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