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*

APPLICATION RECORD VOLUME 1 OF 2

January 10, 2025

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BETWEEN:

(Court Seal)

THE NEIGHBOURHOOD GROUP COMMUNITY SERVICES,
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APPLICATION UNDER Rule 14.05 of the *Rules of Civil Procedure*

NOTICE OF APPLICATION

TO THE RESPONDENT

A LEGAL PROCEEDING HAS BEEN COMMENCED by the Applicant. The claim made by the Applicant appears on the following page.

THIS APPLICATION will come on for a hearing *(choose one of the following)*

☐ In writing
☒ In person
☐ By telephone conference
☐ By video conference

at the following location:

330 University Avenue, Toronto ON M5G 1R on a date to be set by the Registrar.

IF YOU WISH TO OPPOSE THIS APPLICATION, to receive notice of any step in the application or to be served with any documents in the application, you or an Ontario lawyer acting for you must forthwith prepare a notice of appearance in Form 38A prescribed by the *Rules of Civil Procedure*, serve it on the Applicant's lawyer or, where the Applicant does not have a lawyer, serve it on the Applicant, and file it, with proof of service, in this court office, and you or your lawyer must appear at the hearing.

IF YOU WISH TO PRESENT AFFIDAVIT OR OTHER DOCUMENTARY EVIDENCE TO THE COURT OR TO EXAMINE OR CROSS-EXAMINE WITNESSES ON THE APPLICATION, you or your lawyer must, in addition to serving your notice of appearance, serve a copy of the evidence on the Applicant's lawyer or, where the Applicant does not have a lawyer, serve it on the Applicant, and file it, with proof of service, in the court office where the application is to be heard as soon as possible, but at least four days before the hearing.

IF YOU FAIL TO APPEAR AT THE HEARING, JUDGMENT MAY BE GIVEN IN YOUR ABSENCE AND WITHOUT FURTHER NOTICE TO YOU. IF YOU WISH TO OPPOSE THIS APPLICATION BUT ARE UNABLE TO PAY LEGAL FEES, LEGAL AID MAY BE AVAILABLE TO YOU BY CONTACTING A LOCAL LEGAL AID OFFICE.

Date Dec. 9th, 2024 Issued by Jueen Falcão "L. Falcão"
Local Registrar

Address of court office: Superior Court of Justice L.F
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APPLICATION

1. The Applicants make application for:

(a) an order declaring that sections 2 and 3 of the *Community Care and Recovery Act, 2024*, S.O. 2024, c. 27, Sch. 2, violate sections 7, 12 and 15 of the *Canadian Charter of Rights and Freedoms* in a manner that cannot be demonstrably justified in a free and democratic society under section 1 of the *Charter*;

(b) a declaration pursuant to section 52(1) of the *Constitution Act, 1982*, taking immediate effect, that sections 2 and 3 of the *Community Care and Recovery Act, 2024* are invalid and are of no force or effect;

(c) in the alternative to the relief sought at paragraph 1(b), an order pursuant to section 24(1) of the *Charter*, including but not limited to exempting the Kensington Market Overdose Prevention Site and the Supervised Consumption Site – Kitchener from the application of section 2 of the *Community Care and Recovery Act, 2024*;

(d) an order declaring that sections 2 and 3 of the *Community Care and Recovery Act, 2024*, are *ultra vires* because they encroach upon Canada's exclusive jurisdiction over criminal law under section 91(27) of the *Constitution Act, 1867*;

(e) in the alternative to the relief sought at paragraph 1(d), an order declaring that sections 2 and 3 of the *Community Care and Recovery Act, 2024* are constitutionally inoperative because they frustrate the purpose of the *Controlled Drugs and Substances Act*, S.C. 1996, c. 19;

(f) an interim and/or interlocutory injunction restraining the application and effect of sections 2 and 3 of the *Community Care and Recovery Act, 2024* until the final determination of this proceeding;

(g) their costs of this application on a full indemnity basis, plus taxes; and

(h) such further and other relief as this Honourable Court may deem just.

2. The grounds for the application are:

Overview

(a) The *Community Care and Recovery Act, 2024* ("***CCRA***" or the **"Act"**) will shutter supervised consumption sites across Ontario in a matter of months. The result will be that thousands of vulnerable Ontarians will be denied the medical care they need and will be exposed to an unnecessary risk of death and disease. The *CCRA* is unconstitutional and should be declared invalid;

(b) Supervised consumption sites are a response to a Canada-wide drug overdose crisis that kills thousands of people every year. In Ontario alone, drug overdoses have claimed the lives of over 26,000 people since 2016;

(c) The scientific data is clear and unambiguous: the consumption of drugs under the supervision of trained health professionals virtually eliminates the risk of death by overdose and substantially reduces the transmission of infectious diseases. For that reason, Canada enacted a regime that permitted the operation of supervised consumption sites notwithstanding the criminal prohibitions on controlled substances. Specifically, the *Controlled Drugs and Substances Act,* S.C. 1996, c. 19

("***CDSA***") allows the Federal Minister of Health to issue exemptions when "necessary for a medical purpose" or "in the public interest" to permit people to use drugs at a supervised consumption site without the threat of criminal prosecution or sanction;

(d) Ontario's first authorized supervised consumption sites opened in 2017, following a precipitous rise in overdose-related deaths across the province resulting from the emergence of fentanyl in the street drug supply. The Federal Minister of Health has issued 23 exemptions for supervised consumption sites in Ontario;

(e) The positive health outcomes achieved by supervised consumption services in Ontario are undeniable. Between 2020 and 2024, Ontario's supervised consumption sites served 178,253 people, reversed 21,979 overdoses, and made 533,624 service and substance use treatment referrals;

(f) Providing low-barrier, widespread access to supervised consumption services has achieved demonstrably positive health outcomes in Ontario. Despite this, Ontario enacted the *CCRA* and decided to treat supervised consumption as a social evil that causes increased crime and social disorder. There is no evidence to support the rationale for the approach taken by Ontario – to the contrary, experts in the field have unanimously concluded that supervised consumption sites actually decrease crime and social disorder in the communities they serve. Ignoring the objective evidence, Ontario has continued its attack on supervised consumption services through the *CCRA*;

(g) The *CCRA* is unconstitutional in violation of the *Charter*:

(i) it infringes the rights to life, liberty and security of the person under section 7 by arbitrarily denying or limiting access to services that save lives and reduce the transmission of infectious diseases;

(ii) it imposes cruel and unusual punishment contrary to section 12 by exposing people who use drugs to a substantially increased risk of death, disease, and a variety of other harms, in a manner that is degrading and dehumanizing and incompatible with basic conceptions of human dignity; and

(iii) it is discriminatory in violation of section 15 by denying people who suffer from a substance use disability, most of whom are already marginalized and disadvantaged, much-needed and proven medical treatment, thereby exacerbating existing disadvantages they face. It also reinforces the unjustified and unsubstantiated stereotype that people who use drugs and who suffer from substance use disabilities are a danger to society, and in particular to children, and are therefore not worthy of the care they need to survive;

(h) The *CCRA* is also unconstitutional as a result of the division of powers. It is in pith and substance a restriction on supervised consumption services as a socially undesirable practice which should be extinguished and is therefore a clear incursion into Canada's exclusive criminal law jurisdiction that is *ultra vires* Ontario;

(i) Even if the *CCRA* is not *ultra vires*, its purpose conflicts with the purpose of the *CDSA* and is therefore inoperative under the doctrine of federal paramountcy. The purpose of the *CDSA* is the promotion of health and public safety by regulating the

possession of controlled substances. The operation of the *CCRA* is incompatible with the *CDSA's* purpose because its object is to terminate supervised consumption services that are proven to save lives and preserve and promote health;

The Applicants

(j) The Neighbourhood Group Community Services ("**TNG**") is a social agency serving more than 40,000 low-income people and families across Toronto. It offers free programs and services to address a broad range of issues, including homelessness, mental health, unemployment, social isolation, treatment for substance use, conflict resolution, violence, youth alienation, and the settlement of newcomers. TNG is a charitable corporation under the Ontario *Not-for-Profit Corporations Act, 2010*, S.O. 2010, c. 15;

(k) As part of its programs and services, TNG operates the Kensington Market Overdose Prevention Site ("**KMOPS**"), located at 260 Augusta Avenue, Toronto. KMOPS offers supervised consumption services to people who use drugs, in addition to other harm reduction services such as drug checking and peer assistance;

(l) TNG operates KMOPS pursuant to an exemption from the federal government under section 56.1 of the *CDSA*. TNG has operated KMOPS since 2018. Its current exemption was approved on November 25, 2022 and expires on November 30, 2025;

(m) KMOPS is privately funded. TNG does not receive or use any public funding to operate KMOPS;

(n) Katharine Resendes is an individual living in Ontario. She is a person who suffers from a substance use disorder. She has used the supervised consumption services that TNG provides at the KMOPS to use drugs. She has also accessed the other services that TNG provides, including recovery services. In fact, she is a graduate of TNG's peer program. Ms. Resendes is currently in recovery for her substance use disorder. However, relapse is a recognized part of her medical condition, and Ms. Resendes has had to use TNG's supervised consumption services in order to consume in a safe manner;

(o) Jean-Pierre Aubry Forgues is an individual living in Ontario. He currently accesses supervised consumption services at the Kitchener CTS (defined below). Access to supervised consumption services stabilized Forgues' medical condition, allowing him to improve his health, secure housing and employment, and live a fuller life;

Supervised consumption services

(p) But for Canada granting an exemption for the possession and use of controlled substances, providing and accessing supervised consumption services would be criminal acts. They would violate provisions of the *CDSA* that prohibit the possession of Schedule I, II and III drugs. It is only pursuant to an exemption from the Minister of Health under the *CDSA* that service providers are able to provide supervised consumption services. A *CDSA* exemption permits people who use drugs at a particular site, and staff at that site, to use and/or handle drugs without facing the risk of criminal prosecution for the possession or trafficking of a controlled substance;

(q) Supervised consumption services save lives and benefit communities. They provide safe, clean, clinical spaces for people to bring their own drugs to use in the presence of trained health professionals. This supervision allows for immediate intervention in the event of an overdose. They also offer other harm reduction services such as providing safe supplies for substance consumption (*e.g.*, sterile injection equipment) and "drug checking" (*i.e.*, checking drugs for contaminants);

(r) Supervised consumption services also connect people who use drugs to other health and social services, including counselling, social services, and treatment for their underlying medical conditions;

(s) The exemption eliminating the threat of criminal prosecution enhances the likelihood that people who use drugs will use a supervised consumption site, rather than using drugs elsewhere in the community, and will therefore have the benefit of the supervision of health professionals and the other services offered by the site. Without an exemption, the threat of criminal prosecution would deter staff from providing supervised consumption services and deter people who use drugs from accessing those life-saving services;

(t) The discretion of whether to grant an exemption under the *CDSA* is solely the prerogative of Canada and the Minster of Health;

(u) For decades, supervised consumption services have been deployed as a primary form of medical intervention for combatting the risk of overdose death, the spread of infectious diseases, and improving the broader health outcomes of people who

use illegal, street-sourced substances. There are over 100 supervised consumption sites in more than 60 cities in 11 countries;

(v) There is a large body of scientific data and literature (including data and literature that Ontario has commissioned) evaluating the efficacy of supervised consumption services. The overwhelming consensus is that the provision of supervised consumption services has positive health effects. The scientific evidence demonstrates that supervised consumption services:

(i) reduce overdose morbidity and mortality;

(ii) reduce unsafe consumption behaviours (*i.e.*, needle sharing and reuse, improper disposal of consumption equipment, and poor hygienic practices);

(iii) reduce the risk of transmission of injection-related infections, such as HIV, hepatitis C, and bacterial infections;

(iv) reduce public drug consumption and improve the clean disposal of drug paraphernalia;

(v) promote access to health and social services, including wound care, treating blood-borne diseases, substance use treatment, and access to housing supports; and

(vi) reduce crime and social disorder in the neighbourhoods in which they are provided;

The toxic opioid epidemic and overdose crisis

(w) Beginning in 2016, overdose rates in Ontario, and particularly in Toronto, saw a precipitous rise. This was because the street opioid supply was becoming increasingly potent and dangerous as a result of toxic drug contamination, leading to unprecedented overdose-related deaths and hospitalizations across the province;

(x) In 2017, the opioid overdose mortality rate in Ontario increased by almost 50% compared to the previous year, from 867 deaths in 2016 to 1,294 deaths in 2017;

(y) In an effort to combat the escalating toxic opioid drug crisis, three supervised consumption sites were opened in Toronto between 2017 and 2018 under the *CDSA* exemption scheme. More sites opened across Ontario in subsequent years. The Minister of Health currently has issued 23 exemptions under section 56.1 for supervised consumption sites in Ontario;

(z) In 2018, in connection with the roll-out of supervised consumption services, Ontario commissioned an internal fact-finding investigation and expert study on supervised consumption services. The report coming out of that investigation was completed in September 2018. The report concluded that access to supervised consumption services:

(i) reduced overdose-related morbidity and mortality and can help reduce ambulance calls for overdose-related purposes;

(ii) improved access to health care services, such as treatment for injection-related infections, medical care, and harm reduction services;

(iii) improved referrals and uptake for addictions treatment; and

(iv) minimized social disorder resulting from illegal substance use by decreasing needle sharing, the incidence of public drug use, and the unsafe disposal of drug paraphernalia;

(aa) In other words, by September 2018, Ontario had expert advice, that it had itself commissioned, confirming that supervised consumption services are highly effective at preventing overdose-related deaths and reducing the spread of infectious diseases, and create additional health and social benefits for both people who use drugs and the broader community;

Supervised consumption has had overwhelmingly positive health effects in Ontario

(bb) The data and research regarding the efficacy of supervised consumption services in Ontario is clear that these services have unambiguously had positive effects not only for people who use drugs, but also for the communities in which those services are provided;

(cc) On November 13, 2024, the Centre on Drug Policy Evaluation published a report presenting data on the efficacy of supervised consumption services in Ontario. The report was prepared and published in response to the restrictions announced by the Ontario government that are the subject of this proceeding. As stated in the report, "The government announced this ban without presenting any supporting scientific, clinical, or public health evidence. This report, prepared by the Centre on Drug Policy Evaluation, is intended to fill this gap";

(dd) The report found, among other things, that:

(i) between 2020 and 2024, a total of 21,979 non-fatal overdoses were reversed at supervised consumption sites. Without supervised consumption services, nearly all of those overdoses would likely have resulted in death or grievous bodily injury;

(ii) Toronto neighbourhoods that implemented supervised consumption services experienced a 67% reduction in the overdose mortality rate, compared to no significant reductions for neighbourhoods that did not implement supervised consumption services;

(iii) site users who injected at a site that also offered Hepatitis C care were 12% more likely to have received Hepatitis C testing and 67% more likely to have been treated for Hepatitis C, compared to those who did not access supervised consumption services;

(iv) among those who are homeless or underhoused, recent supervised consumption was associated with a substantial reduction in public injecting;

(v) areas close to the supervised consumption sites in Toronto experienced significant reductions in the homicide rate, while areas further away experienced increases; and

(vi) the rate of major crimes in neighbourhoods with supervised consumption services generally *declined* after their implementation (whereas neighbourhoods with no such services saw no decline);

Ontario ignores expert reports and forces closure of supervised consumption sites

(ee) Despite the overwhelming data demonstrating the beneficial impacts of supervised consumption services, on August 20, 2024, Ontario announced that it would be imposing new restrictions on these services. Among other things, Ontario declared that it would be:

(i) "banning supervised drug consumption sites within 200 metres of schools and child care centres"; and

(ii) prohibiting "municipalities or any organization from standing up new consumption sites or participating in federal so-called 'safer' supply initiatives";

(ff) The announcement of these upcoming restrictions followed an audit that Ontario had commissioned to review a supervised consumption site operated by South Riverdale Community Health Centre ("**SRCHC**"). The audit was in response to the accidental shooting death of a person near the site in July 2023;

(gg) The audit consisted of two reports: one from Unity Health Toronto ("**Unity Health**"), and one undertaken by the government-appointed supervisor of SRCHC, who was appointed after the shooting incident, with the assistance of staff from the office of the Medical Officer of Health;

(hh) The Unity Health report recommended increasing funding to SRCHC. The supervisor's report recommended expanding the availability of supervised

consumption services at SRCHC. Neither report suggested closing supervised consumption services;

(ii) Ontario decided to impose the new restrictions, and announce that decision to the public, notwithstanding the findings and conclusions of the Unity Health and supervisor reports, which Ontario itself had commissioned;

The *CCRA* terminates supervised consumption services

(jj) The restrictions announced by Ontario in August 2024 were made into law on December 4, 2024, through the passage of the *CCRA*;

(kk) Section 2 of the Act prohibits the establishment or operation of a "supervised consumption site at a location that is less than 200 metres" from a school or child care centre. Section 2 comes into force on April 1, 2025;

(ll) KMOPS is located within 200 metres of a child care centre (which is also operated by TNG) and is therefore caught by section 2 of the *CCRA*. TNG has been notified by Ontario that it must close KMOPS by April 1, 2025;

(mm) The Applicant, Ms. Resendes has made use of the supervised consumption services at KMOPS. Relapse is a recognized part of recovery and so Ms. Resendes's continued recovery from her medical condition depends on her ability to make use of these services. If the KMOPS closes, she will no longer have ready access to this service;

(nn) Section 3(2) of the *CCRA* removes from "a municipality or local board" the power to apply for an exemption or a renewal of an exemption under the *CDSA* to operate

a supervised consumption site. A "local board" includes a "board of health". Some of Ontario's supervised consumption sites are operated by a municipality or board of health, and will therefore be prohibited from applying for a renewal of their exemptions when they expire;

(oo) One of the supervised consumption sites that are run by boards of health is the Supervised Consumption Site – Kitchener, which is operated by Region of Waterloo Public Health and Paramedic Services and Sanguen Health Centre and is located at 150 Duke St West, Kitchener (the **"Kitchener CTS"**);

(pp) The Applicant Mr. Forgues treats his condition through a safe supply treatment program that the Kitchener CTS connected him to in or around 2022. Mr. Forgues' condition is chronic and relapsing, and he requires access to supervised consumption services when that occurs. With the Kitchener CTS closing, he will no longer have access to this service;

(qq) In its August 2024 news release announcing the impending legislation, Ontario identified ten supervised consumption service facilities across Ontario (including KMOPS and the Kitchener CTS) that will close as a result of the *CCRA*. Five of these sites are located in Toronto. As Toronto only has ten supervised consumption service facilities in total, this means that ***half*** of Toronto's supervised consumption sites will close. Given the demographic data of the individuals that tend to use supervised consumption services, and their inability to travel easily, closing these sites effectively denies them the ability to obtain supervised consumption services,

thereby increasing the likelihood of death and grievous bodily injury and other health and social harms;

(rr) The other five supervised consumption sites that will be closed are located in Ottawa, Thunder Bay, Kitchener, Hamilton and Guelph. The closure of these facilities will have a similar, and likely even worse, adverse impact for users of supervised consumption services in those cities. In Thunder Bay, Kitchener, Hamilton and Guelph, the sites that are being closed are the only facilities where individuals can obtain supervised consumption services in those respective cities;

(ss) In fact, the supervised consumption site in Thunder Bay is the only site in the entirety of Northern Ontario. Its closure will effectively deprive all Northern Ontarians of supervised consumption services;

(tt) The closures compelled by the *CCRA* may be even more expansive than the ten sites identified by Ontario to date, as subsection 2(4) of the Act will compel any remaining supervised consumption sites to close within thirty days if a new private school or child care begins operating within a 200 metre radius;

The CCRA is unconstitutional

(i) Sections 2 and 3 of the CCRA violate section 7 of the Charter

(uu) The Supreme Court of Canada has already determined that the termination of supervised consumption services violates section 7 the *Charter*;

(vv) In *Canada (Attorney General) v. PHS Community Services Society*, the Supreme Court of Canada held that Canada's refusal to renew an exemption for a supervision

consumption site in Vancouver's Downtown East Side violated section 7 of the *Charter* in a manner that did not accord with the principles of fundamental justice and could not be saved by section 1;

(ww) Sections 2 and 3 of the *CCRA* effect the very same outcome that was challenged in *PHS Community Services Society*, namely the closure of supervised consumption sites and the termination of supervised consumption services for the sites' clients. The *CCRA* therefore also violates section 7 of the *Charter* in a manner that does not accord with principles of fundamental justice and that cannot be saved by section 1;

(xx) The termination of supervised consumption services infringes supervised consumption sites' clients' right to life. Supervised consumption services are a primary method of medical intervention for people who use drugs, and in particular people living with substance use disorder and who use street-sourced, illegal substances. Access to supervised consumption dramatically reduces the risk of death by overdose. Without meaningful access to supervised consumption services, people who use drugs will be forced to resort to unhealthy and unsafe consumption in environments where there is a significant risk of morbidity or death;

(yy) The termination of supervised consumption services infringes clients' liberty interests under section 7 of the *Charter*. Without access to supervised consumption site, which are protected by a *CDSA* exemption, these individuals will be exposed to a higher risk of potential criminal sanction as a result of their drug use disorders;

(zz) The termination of supervised consumption services infringes clients' security of the person interests under section 7 of the *Charter*. Denying or limiting access to supervised consumption exposes substance users to a higher risk of the transmission of infectious diseases, among other harms to their health, including their psychological health, and imposes a barrier to accessing health care;

(aaa) The threat to life, liberty and security of the person created by the *CCRA* is not in accordance with the principles of fundamental justice. Sections 2 and 3 of the *CCRA* are arbitrary, overbroad, and grossly disproportionate;

(ii) Sections 2 and 3 of the CCRA violate section 12 of the Charter

(bbb) Section 12 of the *Charter* protects the "right not to be subjected to any cruel and unusual treatment or punishment",

(ccc) People in Ontario who use drugs, and particularly those suffering from substance use disorder, have come to rely on supervised consumption services for their daily survival. Without supervised consumption services, people who use drugs will be exposed to a substantially increased risk of death, disease, and a variety of other harms, and will be left to face those risks alone and without sufficient medical or social support;

(ddd) When it passed the *CCRA*, Ontario was aware of the health and social benefits of supervised consumption, and the deleterious effects the *CCRA* will cause people who use supervised consumption services;

(eee) Ontario has thus knowingly increased the likelihood of death and grievous bodily injury for countless people in Ontario. The effects of the *CCRA* are grossly disproportionate, degrading and dehumanizing, and offend basic conceptions of human dignity. Accordingly, sections 2 and 3 of the Act give rise to cruel and unusual treatment that is prohibited under section 12 of the *Charter*;

(iii) Sections 2 and 3 of the CCRA violate section 15 of the Charter

(fff) Section 15 of the *Charter* guarantees the right to be free from discrimination;

(ggg) Sections 2 and 3 of the Act violate section 15:

(i) they impose differential treatment: people who access supervised consumption services will be denied access to those services or their access will be significantly impaired;

(ii) the differential treatment is based on an enumerated and analogous grounds: most people who access supervised consumption services suffer from substance use order, which is a mental and physical illness and a disability. Moreover, the closure of supervised consumption services will have a disproportionate and compounding effect on people from marginalized communities and who face disadvantage because of their race, gender, and other personal, immutable characteristics;

(iii) the differential treatment is discriminatory: termination of supervised consumption services exacerbates existing disadvantages faced by people who use those services. Many service users are marginalized and

disadvantaged, are subject to higher mortality and morbidity rates due to their medical condition, and have inequitable health care access. Impeding or outright denying service users access to these life-saving services will exacerbate their already vulnerable circumstances. The *CCRA* will also reinforce false stereotypes about people who suffer from substance use disorder, including that they are dangerous to children and to society more generally and that they are not worthy of medical care and attention;

(iv) The violations of the Charter cannot be saved by section 1

(hhh) The violations of sections 7, 12 and 15 cannot be justified in a free and democratic society and therefore cannot be saved by section 1. The *CCRA* does not have a pressing and substantial objective – the purported objectives of the legislation are not supported by evidence. Further, sections 2 and 3 of the *CCRA* are not proportionate to the infringements they impose – they are not minimally impairing and their salutary benefits do not outweigh their deleterious effects;

(v) The CCRA is ultra vires and therefore invalid

(iii) The *CCRA* is in pith and substance criminal law and therefore intrudes on Parliament's exclusive jurisdiction over this area. The purpose of the Act is to prohibit supervised consumption sites. This prohibition is not for the purpose of serving a health objective. It is fundamentally to serve a criminal law purpose, namely to suppress or extinguish the availability of supervised consumption services as a socially undesirable practice;

(jjj) The *CCRA* meets its criminal law objective by imposing requirements that make it nearly impossible for supervised consumption service providers to obtain the *CDSA* exemptions necessary to protect providers and users from penal sanction;

(kkk) Decisions about whether to criminalize certain conduct, and, conversely, when to *not* criminalize conduct, is exclusively the domain of Canada. It reflects and is consistent with Canada's responsibility over peace, order, security, health and morality. A myriad of factors affect these policy decisions, which are Canada's to make;

(lll) Ultimately, after consideration and study, Canada determined that allowing for exemptions from criminal sanction for supervised consumption services best served peace, order, security, health and morality;

(mmm) The *CCRA*, in pith and substance, prohibits supervised consumption services in Ontario. There is no valid health purpose for these prohibitions. Even reports that Ontario itself has commissioned show the individual and public health benefits of supervised consumption. The *CCRA* is Ontario's colourable effort to thwart Canada's approach to address the drug overdose health crisis by effectively recriminalizing what Canada has sought to decriminalize in certain circumstances;

(vi) Paramountcy renders sections 2 and 3 of the CCRA inoperative

(nnn) Even if the *CCRA* is *intra vires* Ontario, it is nonetheless unconstitutional and inoperative under the doctrine of federal paramountcy. Sections 2 and 3 of the

CCRA frustrate the purpose of the *CDSA*, namely the promotion of public health and safety by regulating the possession of controlled substances;

(ooo) By enacting the statutory exemption regime under section 56 of the *CDSA*, Canada has conferred on the Minister of Health the discretionary power to issue and refuse exemptions for the operation of supervised consumption sites. It is up to the Minister to decide when an exemption should be granted, in accordance with the *CDSA*'s purpose of promoting health and public safety;

(ppp) Sections 2 and 3 of the *CCRA* usurp the Minister's delegated role as gatekeeper of *CDSA* exemptions and directly interfere and conflict with the health and safety purpose of the *CDSA*. Sections 2 and 3 force the termination of supervised consumption services. Many service users will be unable to access supervised consumption services and suffer catastrophic health consequences because of these closures. The *CCRA* necessarily conflicts with the *CDSA's* promotion of health and safety, because its entire object is to bring to an end to life-saving and health-promoting services;

(qqq) Sections 2 and 3 should be declared inoperative for interfering with the purpose of the federally-enacted *CDSA*;

Other grounds

(rrr) sections 7, 12, 15(1), and 24(1) of the *Charter*;

(sss) section 52 of the *Constitution Act, 1982*;

(ttt) this Court's inherent jurisdiction;

(uuu) Rule 14.05 of the *Rules of Civil Procedure*; and

(vvv) such further and other grounds as the lawyers may advise.

3. The following documentary evidence will be used at the hearing of the application:

(a) the affidavit of Bill Sinclair, to be sworn; and

(b) such further and other evidence as the lawyers may advise and this Honourable Court may permit.

December 9, 2024

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THE NEIGHBOURHOOD GROUP COMMUNITY SERVICES et al.
Applicants

-and-

HIS MAJESTY THE KING IN RIGHT OF ONTARIO
Respondent

Court File No. CV-24-00732861-0000

ONTARIO
SUPERIOR COURT OF JUSTICE

PROCEEDING COMMENCED AT TORONTO

NOTICE OF APPLICATION

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TAB 2

TAB 3

26 TATION:

ONTARIO SUPERIOR COURT OF JUSTICE (TORONTO REGION)

CIVIL ENDORSEMENT FORM

(Rule 59.02(2)(c)(i))

BEFORE	**Judge/Associate Judge**	**Court File Number**:
	KOEHNEN	**CV-24-00732861-0000**

Title of Proceeding:

THE NEIGHBOURHOOD GROUP COMMUNITY SERVICES et al Applicant(s)

-v-

HIS MAJESTY THE KING IN RIGHT OF ONTARIO Respondent(s)

Case Management: ☐ **Yes** If so, by whom:	**No**

Participants and Non-Participants: *(Rule 59.02(2)((vii))*

Party	Counsel	E-mail Address	Phone #	Participant (Y/N)
1) **Applicant** (THE NEIGHBOURHOOD GROUP COMMUNITY SERVICES)	AGARWAL, RAHOOL	Ragarwal@lolg.ca		**Y**
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	DI CARLO, CARLO	carlodc@stockwoods.ca	(416) 593-2495	**Y**
2) **Applicant** (RESENDES, KATHARINE)				**Y**
3) **Applicant** (FORGUES, JEAN-PIERRE AUBRY)				
4) **Respondent** (HIS MAJESTY THE KING IN RIGHT OF ONTARIO)	OWENS, EMILY	Emily.owens@ontario.ca		**Y**
	BOLIEIRO, ANDREW	andrea.bolieiro@ontario.ca		**Y**

Date Heard: *(Rule 59.02(2)(c)(iii))* **December 12, 2024**

Nature of Hearing (mark with an "X"): *(Rule 59.02(2)(c)(iv))*

☐ Motion ☐ Appeal ☒ Case Conference ☐ Pre-Trial Conference ☐ Application

Format of Hearing (mark with an "X"): *(Rule 59.02(2)(c)(iv))*

☐ In Writing ☐ Telephone ☒ Videoconference ☐ In Person

If in person, indicate courthouse address:

Relief Requested: *(Rule. 59.02(2)(c)(v))*

Disposition made at hearing or conference (operative terms ordered): *(Rule 59.02(2)(c)(vi))*

This application shall proceed according to the following timetable:

1. Any party seeking to intervene in the proceeding shall advise the applicants and the respondent of their intention to do so by January 10, 2025.
2. A case conference will occur before me on January 15, 2025 at 8:30 AM to determine the process to be used to determine intervener status.
3. Applicants' record to be delivered by January 10, 2025.
4. Respondent's record to be delivered by January 24, 2025.
5. Reply record to be delivered by February 7, 2025.
6. Cross examinations to be completed by February 21, 2025.
7. Applicants' factum to be delivered by March 5, 2025.
8. Respondent's factum to be delivered by March 18, 2025.
9. Reply factum to be delivered March 21, 2025.
10. The court will advise of a hearing date in the immediate future.

Costs: On a indemnity basis, fixed at $ are payable by to [when]

Brief Reasons, if any: *(Rule 59.02(2)(b))*

Additional pages attached: ☐ Yes **X** No

December 12, 20 **24**
Date of Endorsement *(Rule 59.02(2)(c)(ii))*

Signature of Judge/Associate Judge *(Rule 59.02(2)(c)(i))*

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 BILL SINCLAIR

I, BILL SINCLAIR, of the City of Toronto, in the Province of Ontario, **MAKE OATH AND SAY:**

1. I am the President and Chief Executive Officer ("**CEO**") of The Neighbourhood Group Community Services ("**TNG**"), one of the applicants in this application, and as such have knowledge of the matters contained 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.

A. Overview of The Neighbourhood Group Community Services

2. TNG is a busy social agency that serves over 40,000 low-income people and families in Toronto, Ontario. It provides a diverse array of programs and services tackling pressing issues including poverty, homelessness, mental health, unemployment, social isolation, substance use, conflict resolution, violence, youth alienation, and the settlement of newcomers.

3. TNG is a charitable corporation under the Ontario *Not-for-Profit Corporations Act, 2010*, S.O., c. 15. It currently has over 1,000 employees, 900 volunteers, and an annual operating budget of approximately $75 million. It operates 34 locations across the city of Toronto, including (but not limited to):

(a) 11 childcare centres;

(b) 9 affordable housing locations, housing over 400 tenants;

(c) 2 employment centres;

(d) 5 locations providing newcomer services, including English classes;

(e) a drop-in centre for people experiencing homelessness; and

(f) the Kensington Market Overdose Prevention Site ("**KMOPS**").

4. TNG's operations are divided into ten programs: Homecare; Child Care; Urban Health & Homelessness; Housing; Employment & Skill Training; Newcomer Services; Seniors' Services; Children and Youth Services; Community Development; and Legal Services.

5. A copy of TNG's Annual Report for the 2023-2024 year setting out the programming we offer in greater detail is attached as **Exhibit "A"** to this affidavit.

6. TNG is funded through various sources. The breakdown is as follows:

(a) Approximately 80% of TNG's total funding comes from grants from the municipal, provincial, and federal governments. These grants are often program or service-specific. Although the proportions can vary from year to year, an approximate breakdown of our total government funding is as follows:

(i) roughly half is from the Government of Ontario;

(ii) one quarter is from the City of Toronto; and

(iii) one quarter is from the Government of Canada.

(b) Approximately 15% of TNG's total funding is derived from fees charged on services it operates, namely its childcare services, housing services (rent from tenants of its affordable housing), and programs like Meals on Wheels.

(c) The remaining 5% of TNG's funding comes from fundraising.

7. A copy of TNG's audited financial statements for our fiscal year ending March 31, 2024 are attached as **Exhibit "B"** to this affidavit.

8. TNG is also a United Way Anchor Agency and receives significant funding through United Way.

B. Personal Background

9. I obtained my Masters of Social Work from the University of Toronto in 1987.

10. I spent approximately 10 years working at York Community Services (now Unison Health & Community Services) in Toronto. I started as a Housing Coordinator in 1987, then became a Volunteer Coordinator and later a Program Coordinator.

11. In 1999, I joined an entity that was one of the predecessors to TNG, St. Stephen's Community House ("**St. Stephen's**") as Director of Community Services. One of my areas of responsibility was St. Stephen's homeless services. At that time, we ran a busy daytime drop-in for people experiencing homelessness that was open seven days a week. I hired and supervised the manager, who in turn supervised a team of staff and volunteers. I also managed relationships with funders, donors, neighbours, and our landlord.

12. Because we were open seven days a week, I worked some weekend shifts to learn about the program and interact with the many people who used the service. They were a mix of people who were completely homeless, people staying for long periods of time in nearby homeless shelters, and people living permanently in nearby rooming houses in the neighbourhood. People in all three situations often lacked access to kitchens and meals, and food was a key service we provided. For people who were homeless, access to washrooms and showers were vital. For all of these groups, access to counselling and crisis support was needed every day.

13. I became the Associate Executive Director of St. Stephen's in 2002, and the Executive Director in 2015. In these roles, I was the senior staff member in the organization reporting to the Board of Directors. Over this period, St. Stephen's operated from ten locations, all west of Yonge

Street, through which it delivered seven programs: Child Care; Urban Health & Homelessness; Employment Services; Newcomer Services; Seniors' Services; Youth Services; and Community Development. In this role, I would visit our location in the Kensington Market area each day, but I was not involved in providing direct services to program participants.

14. In 2020, I became the President and CEO of TNG (as will be described below, TNG was created through the merger of St. Stephen's and two other organizations). I have filled this role continuously since that time. I am the senior staff member reporting to the Board of Directors of a much larger combined agency with 34 locations, including all of the St. Stephen's locations and KMOPS. I remain connected with KMOPS through weekly visits and reports from staff in this service.

C. History of TNG

15. TNG was formed through the merger of three long-standing charitable organizations: Central Neighbourhood House, Neighbourhood Link Support Services, and St. Stephen's.

16. Central Neighbourhood House was founded in 1911 in Toronto with a mission of improving the conditions of people living in poverty, particularly newcomers to Canada. Central Neighbourhood House is the second oldest settlement house in Toronto, located a few blocks west of the Regent Park neighbourhood.

17. Neighbourhood Link Support Services was founded in 1975 by a group of Toronto residents seeking to address the isolation experienced by many seniors living in the city. The organization has expanded its programming and services over the years to provide supports to newcomers, youth, and people who are marginally housed.

18. St. Stephen's was founded in 1962 by the Anglican Diocese and operated a settlement house in Toronto providing community services, primarily to youth. St. Stephen's soon began offering services to newcomers to Canada, including English classes and job placement services.

19. In May 1974, St. Stephen's became independent of the Diocese and was incorporated as a not-for-profit charitable organization. A copy of St. Stephen's Letters Patent are attached as **Exhibit "C"** to this affidavit.

20. Over time, St. Stephen's has expanded to offer a variety of services to the community, including childcare services, newcomer services, and homelessness services. It provides these services based on what it perceives to be the needs of the community. Often, these perceptions are based on direct feedback received from community members.

21. St. Stephen's operates principally in the Kensington Market area of Toronto. In April 2018, St. Stephen's opened KMOPS, which is one the supervised consumption sites at issue in this application. As alluded to above, and as will be discussed in further detail below, we only opened KMOPS because we concluded that it was necessary to do so to provide the community—including people who use drugs, as well as people who do not but live or work in the area—with the services that it needed.

22. In April 2023, Kensington Bellwoods Community Legal Services ("**KBCLS**") joined TNG. KBCLS is a non-profit community legal clinic funded by Legal Aid Ontario. It provides free legal services to low-income residents of the Kensington Market and Trinity-Bellwoods neighbourhoods of Toronto in several areas, including Employment Insurance, housing,

immigration and refugee matters, income security, and social assistance (such as Ontario Works and the Ontario Disability Support Program).

23. St. Stephen's/TNG has traditionally provided a number of services to the Kensington Market area of Toronto. However, there are two that are of particular significance to this application: (i) the Bellevue Child Care centre, and (ii) the Corner Drop-In, with which KMOPS is now co-located. Below, I provide further history and detail of both services.

i. The Bellevue Child Care Centre

24. Upon its incorporation in 1974, St. Stephen's conducted a survey of local needs, which indicated a significant desire in the community for affordable childcare services. St. Stephen's began offering childcare services to the surrounding community in 1975, when it opened its first childcare centre, the Bellevue Child Care Centre, in the Kensington Market neighbourhood of Toronto (in a building that the Anglican Diocese of Toronto provided).

25. Childcare was, and remains, a core part of our mission at St. Stephen's/TNG to break the cycle of poverty. We see it as necessary to help people find and maintain stable employment and to provide children with a good start in life. Today, the Bellevue Child Care Centre is one of 11 childcare centres operated by TNG in the City of Toronto.

26. The Bellevue Child Care Centre has operated continuously since opening in 1975 at 91 Bellevue Avenue, where it remains today. Since 1962, St. Stephen's (now TNG) had operated newcomer services out of the same building, including after-school programs for teens and English Second Language classes for newcomers.

27. The building is a Victorian-style house with a playground in its front yard, and a small gymnasium connected to the back of the house. The property backs onto a public laneway. Directly across the laneway is the back of St. Stephen's other property at 260 Augusta Avenue. As described further below, 260 August Avenue is the property from which TNG operates KMOPS.

28. The Bellevue Child Care Centre provides daycare for 34 children: 10 toddlers as young as 18 months, and 24 preschool-aged children (between the ages of 3 and 5).

ii. The Corner Drop-In

29. In 1984, St. Stephen's was approached by a local hospital called Doctor's Hospital about the possibility of opening a service for people experiencing homelessness. The hospital—now closed and their services part of Kensington Foundation—was located in the Kensington Market neighbourhood, just one block away from St. Stephen's.

30. The hospital advised us that they had been having issues with adult men, who either had no homes or were marginally housed, occupying its emergency room and waiting rooms when they did not need to access the hospital's services. Some of those men routinely used alcohol and drugs.

31. The hospital provided St. Stephen's with financial support, allowing it to rent a storefront in the Kensington Market area and hire a staff to open a homeless drop-in program. In its early years, the drop-in provided a place where people could have a meal and get out of the cold in the winter, or get out of the heat in the summer. The drop-in gradually expanded to offer a host of additional services.

32. When I started at St. Stephen's in 1999, the organization was in the process of finding a new location for the drop-in centre, and I became directly involved in that process. It was extremely difficult for St. Stephen's to find landlords willing to allow us to operate our homeless services on the property. Landlords would make discriminatory comments against having people who are homeless in their buildings, and about the risk of wear and tear on the property. We also needed a large location with good facilities—including wheelchair accessibility and safe fire exits—to satisfy the requirements for the program. It was difficult to find suitable properties in Kensington Market.

33. Those challenges ultimately led to our decision in 2000 to purchase a building so that we could be our own landlord and ensure stable service provision. Later that year, St. Stephen's was able to purchase the building at 260 Augusta Avenue, which backs onto the same laneway as the Bellevue Child Care Centre.

34. Since purchasing 260 Augusta Avenue in 2000, the location has been home to both the drop-in centre, now called the Corner Drop-In, as well as program, health, and office spaces for St. Stephen's (now TNG). The building continues to bear the name of St. Stephen's Community House. 260 Augusta is where TNG also delivers its KMOPS services today.

35. The Corner Drop-In provides a place where people experiencing homelessness can come and have a nutritious meal, shelter from the elements, access facilities like mail delivery, telephone services, washrooms, showers, and laundry, and be connected to a host of other services. It serves as a safe space where people who do not have a home and face stigma and isolation in their day-

to-day lives can come to feel a sense of community and have a non-judgmental, human conversation.

36. The Corner Drop-In is also a place where people who do not have a home and are otherwise marginalized can develop relationships with TNG staff. These relationships, and their consistency, are important to us at TNG. Through regular contact, we can track how our clients are doing and whether they need direction to any of the particular services we offer. In this way, we can also develop the trust that is necessary for these clients to confide in us and be open to our suggestions regarding other services, including substance use treatment services.

37. The Corner Drop-In serves over 200 members of the community each day. It is open Monday to Friday from 7:30am to 11:30am, and from 12:00pm to 4:00pm, and on Sundays from 8:00am to 12:00pm. Amongst homeless drop-ins we are considered an "early morning" centre where people who have been outside at night or living in insecure shelter can access services early in the morning and before going to work. We are not open on Saturdays to accommodate the traditional Saturday shopping day of Kensington Market. This was based on feedback and consultation with the community and the Kensington Market BIA when we purchased 260 Augusta.

38. The Corner Drop-In is staffed by (among others) community workers, case managers, a mental health case manager, and a harm reduction case manager who can help people access health and addiction treatment services. A TNG legal worker attends at the Corner Drop-In once a week and provides legal information. A TNG identification worker attends as well to help people get government-issued identification (something that in turn helps people access other services, like

healthcare). Among other programs, TNG operates a financial trusteeship program through the drop-in centre to help people manage their money and pay rent to their landlords. Other organizations also have staff visit the drop-in to provide programming that helps people who are homeless. TNG has many volunteers on-site who help with food, laundry, recreation and art in the drop-in.

39. Four days a week, a nurse funded by Ontario Health Toronto Region attends at the Corner Drop-In to provide medical care. Once a week, a physician from Inner City Health Associates comes to the site to provide medical care. The physician also acts as our on-call clinician during the rest of the week and provides staff consultation. A psychiatrist also attends at the site once a week.

40. In addition to service provision on-site, the Corner Drop-In serves as a transition point where people are connected to longer-term services, such as harm reduction, primary and mental health care, crisis counselling, social support, and other social services. Many of the services offered at the Corner Drop-In seek to address upstream issues that may be driving problematic drug use, such as homelessness, trauma, social isolation, and lack of positive activities such as work or volunteering.

41. The Corner Drop-In has always operated as a “low threshold centre”, where people are allowed to access our services when they are under the influence of drugs or alcohol. This was part of the original request for help from the local hospital. Some other homeless drop-ins have ideological, faith-based, or practical limitations on serving people who are not sober. Those

practical limitations often relate to having insufficient staff or volunteers and insufficient training to support people who are not sober.

42. Our experience has been that restricting access for individuals who are not sober creates a barrier to accessing necessary services—barriers that are particularly acute for people with substance use disorder. For some of our clients who have or appear to have substance use disorder, we are effectively a place of last resort because they have been turned away from other services due to their substance use.

43. As a result of both our conscious efforts to reduce barriers to access and the prevalence of drug use in the Kensington Market area, we have long had a relatively high proportion of people using our services who use substances like drugs or alcohol and may live with substance use disorder. I do not purport to diagnose the people who use our services, and in our experience, trying to "medicalize" people's situations is not always well-received and can make it harder to build trust. However, many of the people who use our homeless drop-in services have spoken to us about having a physical and/or emotional dependence on substances like drugs or alcohol, and of continuing to use substances despite having a desire to stop and/or despite serious adverse impacts in their professional and personal lives.

44. When St. Stephen's first began offering its homeless drop-in services in the 1980s, alcohol use was particularly frequent. However, over the years (including since I started at St. Stephen's) we have been seeing a higher proportion of service users who use other substances and stimulants, like crystal meth and crack cocaine.

45. One of TNG's programs currently being run out of the Corner Drop-In is our Crystal Meth Project. This is a pilot project to provide health care, social supports, and case management to people using crystal meth, who are often excluded from other services. We have specific hours each week when people who use crystal meth use our drop-in space and the staff and volunteer team provide one-on-one and group supports just for these visitors. The team includes a case manager, the nurse and doctor, and peer workers and volunteers who can offer group meals, recreation and activities.

46. Working with these communities in the Kensington Market area over the past 40 years has given us direct insight into the barriers and dangers faced by people with substance use disorder, including the difficult and non-linear nature of recovery from addiction and the devastating and often fatal consequences of drug overdoses.

D. TNG's Kensington Market Overdose Prevention Site

i. Origins of KMOPS

47. As noted above, we have been working with people in the Kensington Market area who use drugs and who may suffer from substance use disorder long before the opening of KMOPS in 2018. We at St. Stephen's—and myself personally—have witnessed first-hand how our local community has been affected by the growing opioid crisis. We have also seen the positive, life-saving impacts of harm reduction efforts, including supervised consumption.

48. In or around the mid-2010s, various civil society groups in the downtown Toronto area began providing supervised consumption services, despite the fact that those activities were not sanctioned at any level of government.

49. We learned of the positive impacts that these supervised consumption services were having through our service users, who include people who may use drugs and who suffer from substance use disorder, as well as through some of our staff who volunteered in those community initiatives.

50. We were broadly supportive of these harm reduction efforts at St. Stephen's. At the time, however, we did not permit the use of illegal drugs on our own premises or otherwise provide any supervised consumption services. That said, given the high incidence of drug use and overdoses in our community, and among the individuals that we provided services to at that time, our staff were trained on overdose prevention, as well as on the use of naloxone (a medication which is used to temporarily reverse the effects of opioid overdoses). Many of our staff members and volunteers carried naloxone, and on multiple occasions had to administer naloxone in our building and out in the Kensington Market area to respond to a person overdosing. Sometimes St. Stephen's staff members would discover these overdoses; sometimes members of the community would call us to alert us of these incidents, and we would respond.

51. In short, even pre-KMOPS, overdose prevention methods, such as naloxone, were necessary services for us to provide to meet the needs of our community.

52. Before opening KMOPS in 2018, we had recurring issues with people using drugs in the washrooms, stairwells, and other areas at the St. Stephen's Community House. On multiple occasions, our staff members came upon people while they were overdosing and were able to intervene. When our staff and volunteers came upon people using drugs on our property, we had to ask them to leave the premises, as we could not allow our staff or our organization to be party

to illegal activity and we did not have systems in place to ensure the safety of either our staff or the person using drugs.

53. Asking people to leave our premises was detrimental to our mission in several respects. Making those people leave meant they were unable to access our services. As noted previously, many of our clients are unable to access the services of other similar organizations in the city that have rules restricting access to people who are under the influence of drugs or alcohol. Additionally, these interactions introduced an adversarial element to our relationships with the people using our services. This undermined the trust and relationship-building that is critical to our ability to effectively provide services.

54. In 2017, St. Stephen's was approached by various residents of our local community who were seriously concerned about the effects the drug overdose crisis was having in the Kensington Market area. These people wanted us to begin providing supervised consumption services. Some of them had been personally affected by the drug overdose crisis and had lost loved ones. Their concerns were spurred in part by fatal overdoses that had occurred in our immediate neighbourhood, including multiple fatal overdoses in the public washrooms at Bellevue Square Park, a public park down the street from our Bellevue Child Care Centre and St. Stephen's Community House. The body of another person who died from an overdose was discovered in Sonya's Park, a small parkette also a few blocks away from us.

55. The drug overdose crisis was also directly impacting our service users at St. Stephen's. One of the programs that we ran at St. Stephen's (now continued through TNG) was the Toronto Community Action Team ("**TCAT**"). This program involved going to hospitals and identifying

people with complex substance use issues who visited the hospital regularly (multiple times in a month) for issues related to their substance use. We provided them with supportive housing and case management, and saw a significant reduction in emergency room visits among our TCAT clients. However, in 2017 we began losing some of our TCAT clients to fatal overdoses, usually from fentanyl. Those experiences impressed on us the urgent need to take action to prevent more overdose deaths, and we started looking into the possibility of offering supervised consumption services.

56. In late 2017, the Government of Canada announced that the Government of Ontario ("**Ontario**") had formally requested and been granted a class exemption under the *Controlled Drugs and Substances Act,* S.C. 1996, c. 19 (the "***CDSA***") to enable Ontario to establish emergency overdose prevention sites in the province. A copy of a statement from the federal Minister of Health from December 7, 2017 is attached as **Exhibit "D"** to this affidavit.

57. Shortly thereafter, on or about January 10, 2018, Ontario announced a call for proposals for the establishment of temporary overdose prevention sites, which would operate under Ontario's *CDSA* exemption and receive funding from Ontario to operate. On or around January 11, 2018, Ontario released guidelines for the application process.

58. Our management team at St. Stephen's put together a presentation for our Board of Directors to seek approval to apply to Ontario to open an overdose prevention site. A copy of our supplementary Board materials for our January 18, 2018 Board meeting are attached as **Exhibit "E"** to this affidavit. Those materials include our proposal for the supervised consumption services we hoped to offer at St. Stephen's, and a copy of the application guidelines issued by Ontario.

59. Our proposal was approved by our Board, and St. Stephens applied to Ontario's program for overdose prevention sites, submitting that application in on or about February 6, 2018. A copy of our initial 2018 application is attached as **Exhibit "F"** to this affidavit.

60. St. Stephen's was accepted into the program and received funding from Ontario for our first year of operations in the amount of approximately $124,000. A copy of the letter we received from the Toronto Central Local Health Integration Network confirming we had been approved for funding is attached as **Exhibit "G"** to this affidavit.

ii. Early operations of KMOPS

61. KMOPS opened in April 2018, operating out of St. Stephen's Community House at 260 Augusta Avenue. We were among the first overdose prevention sites to open in Toronto.

62. In KMOPS' first 11 months of operation (between April 2018 and March 2019), KMOPS received over 1,300 visits, despite being open only 4 hours a day, six days a week. Over the course of that period, KMOPS reversed ten overdoses and distributed over 400 naloxone kits.

63. In the August 2018 to March 2019 period (when KMOPS began tracking this data), KMOPS provided over 130 referrals to medical care, detox services, housing/shelter support, case management, and training opportunities. KMOPS provided supportive counselling on 358 occasions, first aid on 114 occasions, health/medical counselling on 235 occasions, and provided 57 volunteer, training, and/or employment opportunities.

64. On or around September 26, 2018, we applied to the federal government directly for our own exemption under s. 56.1 of the *CDSA*. A copy of St. Stephen's September 2018 application is attached as **Exhibit "H"** to this affidavit.

65. On or around January 23, 2019, we were notified by Health Canada that our application for a s. 56.1 exemption had been approved, and would be valid until January 31, 2020. A copy of our exemption letter from Health Canada is attached as **Exhibit "I"** to this affidavit.

iii. Government of Ontario defunds KMOPS

66. In June 2018 there was a provincial election which resulted in a change in the government and a new premier. This election resulted in immediate changes for KMOPS.

67. In late 2018, Ontario announced that it was changing the funding model for overdose prevention sites, which would be called "Consumption and Treatment Sites" or "CTSs" under the new program.

68. On or around December 13, 2018, we applied to Ontario for CTS funding for KMOPS. As part of our application, we included letters of support from a number of individuals and groups in the community who were supportive of KMOPS and wanted us to keep operating. These included letters of support from the Kensington Community School Council. The Kensington Community School is an elementary school located two blocks away from KMOPS.

69. A copy of our December 2018 CTS application is attached as **Exhibit "J"** to this affidavit.

70. On or around March 29, 2019, Ontario advised us that our application for funding was denied, and it would no longer be funding KMOPS effective March 31, 2019. A copy of the letter

we received from Ontario's Ministry of Health and Long-Term Care is attached as **Exhibit "K"** to this affidavit.

71. We met with representatives of Ontario to try and understand why we had been denied funding. Although we did not receive a clear answer, an Ontario representative verbally suggested to us that we were too close to another funded site and that our community relations plan was inadequate.

72. On or around April 29, 2019, we resubmitted our application to Ontario for CTS funding. In our resubmitted application, we gathered even more letters of support from our local community. Those included a letter of support from the Harbord Village Residents' Association, who advised that they had not had any issues with our supervised consumption site and that having it there was improving conditions in the neighbourhood "by keeping drug usage safely away from laneways, parks and school yards, where discarded needles may pose a danger to children, pets, and adults". Another letter of support from the Kensington Market BIA echoed the same concerns that the closure of our supervised consumption site "will only send people into our parks and alleyways, where they may in fact become a problem for residents and visitors to Kensington Market".

73. A copy of our April 2019 CTS application is attached as **Exhibit "L"** to this affidavit. On or around May 31, 2019, Ontario advised that we were once again not being approved for funding and that "only CTS applications from new communities that do not yet have a CTS approved for provincial funding will be given priority for ministry review". A copy of the letter we received from the Ontario Ministry of Health and Long-Term Care is attached as **Exhibit "M"**.

74. We applied to Health Canada for 6 months' worth of transitional funding, which we received, and which allowed us to keep operating as we transitioned to relying on fundraising to support our supervised consumption site. A copy of our funding application to Health Canada is attached as **Exhibit "N"** to this affidavit.

75. Ever since we exhausted the six months of transitional funding, TNG has been privately funding the KMOPS. Following Ontario's withdrawal of funding from KMOPS and other supervised consumption sites in the province, Professor Gillian Kolla at Memorial University in St. John's Newfoundland conducted an evaluation of both KMOPS and Street Health to assess their service delivery model and the impacts of their potential closures. Among other impacts, many clients who participated in the study indicated that if the overdose prevention sites were to close, they would go back to using alone and in public places like alleys, washrooms, parks, and stairwells (p. 18). A copy of the November 2019 report is attached as **Exhibit "O"** to this affidavit.

iv. Current operations at KMOPS

76. KMOPS continues to operate out of St. Stephen's Community House at 260 Augusta Avenue in the Kensington Market neighbourhood, in the same building as the Corner Drop-In. KMOPS' current *CDSA* exemption was granted on November 25, 2022 and is valid until November 30, 2025. A copy of that exemption is attached as **Exhibit "P"** to this affidavit.

77. KMOPS is open six days a week from 8:00am to 2:00pm; it is closed on Saturdays. KMOPS is only open for these limited hours due to funding restrictions. We have set its opening hours to match the hours of the Corner Drop-In to the extent possible (including the Saturday closure, implemented following consultation with the Kensington Market BIA) to facilitate

KMOPS clients being able to access the additional services offered there, and to provide KMOPS clients with a safe, indoor place to wait if KMOPS is at capacity.

78. There continues to be significant need in the surrounding community for KMOPS' services outside of its opening hours, including at night and on Saturdays, however TNG lacks the resources to extend its hours.

79. As noted above, KMOPS does not receive any government funding and its services are entirely free. It is funded entirely by third-party donations. Attached as **Exhibit "Q"** to this affidavit is a high-level budget for KMOPS' operations for our Fiscal Year 2024-2025.

80. KMOPS is set up for supervised consumption through injection, intranasal consumption, and oral consumption. It does not provide supervised inhalation services (i.e. smoking).

81. KMOPS consists of an intake/assessment area, and a consumption area with three booths set up for supervised consumption and three comfortable chairs where people can wait under observation by staff after consuming drugs. Photographs of KMOPS taken by Barb Panter, our Senior Manager of Harm Reduction and Drop-In Services, in December 2024 are attached as **Exhibit "R"** to this affidavit.

82. Those photographs depict how KMOPS is set up as of the date of this affidavit.

83. During its hours of operation, St. Stephen's Community House has a staff member stationed at the front door of the building, equipped with a radio. When people come to the door, the doorperson determines what service they are there to access (i.e. whether they are seeking to use the Corner Drop-In, KMOPS or other services). If a person has come to use KMOPS, the

doorperson will check-in with KMOPS staff over the radio to confirm if there is currently space available.

84. If there is space in KMOPS, the doorperson will escort the client inside to the intake/assessment area. If KMOPS is at capacity, the doorperson will invite the client to make use of the Corner Drop-In, where they can wait comfortably and make use of the other services offered there if they choose to do so. The doorperson is otherwise responsible for monitoring the number of people inside the building, as well as the number of people in the immediate vicinity outside the building.

85. Once a client has been taken to the KMOPS intake/assessment area, they will be greeted by the staff there and will participate in an eligibility assessment. The eligibility assessment has three criteria: (1) the client must sign the KMOPS User Agreement, Release, and Consent Form; (2) the client must agree to adhere to the KMOPS Code of Conduct; and (3) the client must not be exhibiting overly aggressive behaviour.

86. A copy of the KMOPS User Agreement, Release, and Consent Form is attached as **Exhibit "S"**.

87. A copy of the KMOPS Code of Conduct is attached as **Exhibit "T"**.

88. If a client satisfies the eligibility criteria, KMOPS staff will issue them a unique numerical identifier at their first visit. At subsequent visits, clients are asked to provide their numerical identifier.

89. Clients are not asked to provide government-issued identification or otherwise provide identity verification to use the KMOPS. This is for several reasons, including that many of our clients are homeless and do not have documentation verifying their identity. Further, participant anonymity is a way to ensure that clients feel safe and comfortable accessing our services.

90. Clients are then taken into the supervised consumption room, and will be directed by staff to an injection table once one becomes available. Each client is provided with all necessary injection equipment (such as a tray, fresh syringe, alcohol swab, filters, sterile water, disposable cooker, lighter, tourniquet, gauze, and Band-Aid, as applicable). Clients are required to use only supplies provided by KMOPS.

91. When clients pick up drug equipment from KMOPS, our policy is to encourage them to have their drug use occur under the supervised conditions at our site. However, clients are permitted to collect drug equipment from us free of charge without using KMOPS to consume their drugs.

92. Clients self-inject their drugs (though it is permitted for other clients to assist them in doing so if necessary). KMOPS staff do not physically conduct injections, though where necessary they may advise clients on how to do so safely to avoid injury.

93. KMOPS clients are required to arrive at the site already in possession of their drugs in order to use our supervised consumption services. Selling, purchasing, sharing, or otherwise exchanging drugs on or in the vicinity of our property is expressly prohibited. Our doorperson specifically monitors the area surrounding our building for behaviour of that nature. Clients who

engage in this conduct are asked to leave our site for the day and to use a different service. If the conduct recurs, the client will be barred from KMOPS for a longer period of time.

94. However, in our experience it has been relatively rare for clients to attempt to sell or exchange drugs at KMOPS or in its direct vicinity. Our understanding based on our client interactions is that our clients are highly motivated to preserve their own access to our supervised consumption services, preserve the trust they have built with our staff members, and preserve the sense of safety and community they have at KMOPS and at the Corner Drop-In.

95. In addition to supervised consumption, KMOPS provides several other harm reduction services. These include: providing safe, sterile drug use equipment; providing safe disposal of drug use equipment; providing naloxone kits and education on their use; education on safe practices, including proper hygiene; and checking drugs for contaminants (including fentanyl and carfentanil). KMOPS also provides other health and wellness services to KMOPS clients, including wellness tips and coaching related to good sleep practices, hydration, and nutrition; peer support services; basic first aid; and supported access to healthcare.

96. In July 2024, KMOPS began participating in Toronto's Drug Checking Service ("**TCDS**"), which is an initiative coordinated by St. Michael's Hospital. Clients are able to bring drug samples (whether small quantities of drugs or used drug equipment) to KMOPS, which are transported to laboratories at the Centre for Addiction and Mental Health ("**CAMH**") or St. Michael's Hospital for analysis.

97. These drug checking services allow KMOPS clients to identify when their drugs are contaminated with other substances (including with other drugs). TNG's understanding is that

contaminated drugs can be more dangerous for our clients to consume. As such, the drug checking service allows our clients to make informed choices to protect their own health, including adjusting their planned dosage or choosing not to consume the drugs in question at all. In this way, these services directly empower people who use drugs to protect themselves against the risk of accidental overdose.

98. Since KMOPS began participating in TCDS in July 2024, it has collected and sent in 59 samples for testing, 59% (35) of which were expected to be (i.e. was obtained or bought as) fentanyl.

99. Even before KMOPS itself began offering drug checking services, the drug checking services provided at other sites in Toronto served as a valuable source of information for us about current and emerging dangers in Toronto's street drug supply. We often posted advisories at KMOPS to warn our clients about contaminated drugs that had been found circulating in the community so that they could take steps to stay safe.

100. As of November 29, 2024, KMOPS has reversed 397 drug overdoses. Between January and November 2024, KMOPS received 4,891 visits. Of those visits, 1,301 included drug consumption. In that period, KMOPS had 25 overdoses on site. On 11 occasions, KMOPS had to administer naloxone to reverse the overdose, and on 9 occasions, emergency medical services were called to respond.

101. Attached as **Exhibit "U"** to this affidavit are copies of the data tracking reports that we prepared and submitted to Health Canada each month between January and November 2024 pursuant to the requirements of our exemption.

v. KMOPS' client base

102. We have had 762 registered clients at KMOPS since we began operating in April 2018. (Because we do not require government-issued identification to use our service, it is possible that some of these are duplicates if a client forgot their identification number).

103. The majority of KMOPS' clients are white, male, and between the ages of 35-45 years old. Approximately 80% of KMOPS' clients are without permanent shelter.

104. As noted above, I am not in a position to formally diagnose our clients as having substance use disorder, nor do we require clients to obtain a diagnosis of substance use disorder to use our services. Our observations have been that the majority of our KMOPS clients are people who describe to us having a physical and/or emotional dependence on substances like drugs or alcohol. Many of our KMOPS clients have disclosed to our staff that they continue to use substances even when they wish they could stop, and/or even when their substance use has caused significant adverse effects in their life, such as losing their job or losing relationships with family and friends. Further, as part of the wraparound services we provide at St. Stephen's, we have assisted numerous KMOPS clients in applying for disability benefits where the client has indicated substance use disorder as their disability. We also regularly discuss treatment options for substance use disorder with KMOPS clients.

105. Many of our KMOPS clients also report to us that they struggle with anxiety, depression, and trauma. The significant majority of our KMOPS clients have accessed mental health supports through TNG, in addition to accessing our supervised consumption services. We have provided

supportive counselling and/or a referral to other programs (internal or external) to approximately 98% of our KMOPS clients.

106. A significant proportion of KMOPS clients live in the immediate neighbourhood. Very few of our clients travel more than 20-30 minutes walking distance to access KMOPS. There are homeless encampments in Bellevue Square Park, Alexandra Park, and in front of the St. Stephens-in-the-Field Church at Bellevue Avenue and College Street, and many of our clients are living in those encampments. As noted above, approximately 80% of our KMOPS clients are experiencing homelessness.

107. We do have a small number of clients who travel to access our site; many of those clients are people who are clients of other TNG services, such as people living in our supportive housing sites.

vi. KMOPS staff

108. KMOPS always has at least three staff members working at the site, two of whom remain in KMOPS at all times while the third (a supervisor) may be either directly inside KMOPS or nearby inside the St. Stephen's Community House.

109. KMOPS staff are trained on harm reduction, overdose prevention, and overdose response, including training on First Aid and CPR. We keep both naloxone and oxygen on-site, and KMOPS staff are trained on their use.

110. All KMOPS staff are required to have lived experience with drug use. In our experience as an agency that has been working in harm reduction and both training and employing people with

lived experience for many years, individuals who have their own lived experience with drug use are best-equipped to provide supervised consumption services. Substance use is highly stigmatized and drug use practices often occur in secret. We have heard from our clients, and have observed first-hand, that people without lived experience with drug use can be prone to unintentionally using language or engaging in behaviours that reinforce stigma. We have also observed that people without lived experience are often unaware of the specifics of drug use practices.

111. Conversely, our observation has been that people with lived experience with drug use are able to communicate with KMOPS clients in a shared language about drugs and drug use, which facilitates building relationships of trust with clients. Our staff with lived experience are also more familiar with drug use practices like "cooking" and injecting, which helps them deliver services to clients, including providing education on safe practices, managing substance use, treatment options, and recovery resources, in a more knowledgeable and non-judgmental manner.

112. We also choose staff who have lived experience because we find that they serve as powerful role models and mentors for our service users. They provide examples of people who have "been there" and can give hope to our clients that they will be able to make a positive change in their own lives.

vii. Impact on our other services

113. TNG operates several other services in the immediate vicinity of KMOPS, namely the Corner Drop-In (operating out of the same building), and the Bellevue Child Care Centre and some of its newcomer services, which operate directly across the laneway at 91 Bellevue Avenue, 30 metres away. TNG also has residential tenants in St. Stephen's Community House.

114. On the north side of College Street, a few blocks away from KMOPS, TNG operates two other childcare centres: the King Edward Child Care Centre at 112 Lippincott Street and the Lord Lansdowne Child Care Centre at 33 Robert Street. These childcare centres operate out of the King Edward Junior and Senior Public School and Lord Lansdowne Junior Public School, respectively.

115. TNG has never observed any level of disruption to our other services—including our three childcare centres in the area—stemming from KMOPS. In the six and a half years we have been operating KMOPS, we have never received a complaint from a parent or guardian of a child at our childcare centres about KMOPS, whether made to KMOPS/St. Stephen's Community House, or to the Bellevue Child Care Centre, King Edward Child Care Centre, or Lord Lansdowne Child Care Centre.

116. Further, the Bellevue Child Care Centre, King Edward Child Care Centre, and Lord Lansdowne Child Care Centre, as with all childcare centres, are highly regulated operations, subject to unscheduled inspections by the City of Toronto Children's Services, City of Toronto Public Health, and the Province of Ontario. These audits have never disclosed an issue that in any way relates to TNG's operation of the KMOPS.

117. In our capacity as the owner and operator of Bellevue and our two other childcare centres north of College, we do not have any concerns about the continued operation of KMOPS at its current location. Our ability to deliver those childcare services safely has been entirely unimpeded by the presence of KMOPS across the laneway from Bellevue. We have not had issues with discarded drug paraphernalia on our childcare centres' property, nor have we received reports of children or their families being exposed to public drug use.

118. TNG's Bellevue Child Care Centre was not consulted by Ontario at any point in respect of Bill 223, now the *CCRA*. To the best of our knowledge, Ontario did not consult with any of the parents whose children attend the childcare centre either.

119. Overall, our visitors at KMOPS have shown a very high degree of compliance with the rules and policies at our site, including our rules prohibiting the sale of drugs on or around the property, and prohibiting the use of drugs anywhere on or around the property except for the supervised consumption room. We have not experienced any issues with aggressive or disruptive behaviour from KMOPS clients.

120. In addition to our childcare centres in the Kensington Market area, TNG also owns and operates St. Stephen's Waterfront Childcare at 635 Queen's Quay West which is nearby (and just outside the 200 metre radius) to Homes-First, a homeless shelter from which Toronto Public Health operates an Urgent Public Health Needs Site ("**UPHNS**") where supervised consumption services are provided for shelter residents. We similarly have not experienced any disruption to our childcare services being delivered at that location stemming from the nearby UPHNS.

E. Public Health and Safety Benefits for the Community

121. TNG's relationship to our local community is deeply important to the organization. It is something that we are sensitive to and continuously monitor. We want to respond to the needs of our community. Ultimately, this is what led us to open the KMOPS. We conduct extensive and ongoing consultation with stakeholders in the Kensington Market area to ensure that our services—including KMOPS—are contributing to a safe and healthy community.

122. We work collaboratively with several groups in the area. For example, we have been working with the Kensington Community School for several years on strategies for reducing public drug use and the presence of used drug equipment on and around their property. Indeed, Kensington Community School was very supportive when KMOPS opened in 2018 in part because of its ability to respond to that problem. Staff at our Bellevue Child Care Centre regularly consult with parents and families there, and both staff and families were also very supportive of KMOPS opening.

123. KMOPS delivers many important benefits to the broader community beyond the specific benefits to our clients and direct service users.

124. We are able to provide immediate intervention when people overdose on or in the immediate vicinity of our site. Although we do call 911 where appropriate, because we have staff trained in recognizing and responding to overdoses and keep both oxygen and naloxone on-site, we are frequently able to reverse overdoses without having to call for emergency services. This reduced resort to emergency services frees them up to respond to calls elsewhere in the community.

125. Because KMOPS provides people in the area who use drugs with a secure indoor space to consume drugs, since the opening of KMOPS we have witnessed noticeable shifts from consumption of drugs in public areas in the Kensington Market neighbourhood (such as parks, alleys, and public washrooms) to the controlled environment inside our site. As a result, members of the community are less exposed to the public consumption of substances.

126. We also provide a readily accessible means for people who use drugs to dispose of their used drug equipment in a safe manner, rather than discarding it on the ground (or other unsafe

disposal methods). We often have people who use drugs coming to KMOPS in order to safely dispose of their used drug paraphernalia (such as needles) and to collect sterile equipment.

127. A TNG staff person searches for and collects drug paraphernalia (and litter) in the vicinity of KMOPS on a daily basis. We also have a memorandum of understanding with Kensington Community School pursuant to which TNG staff attend at their property regularly to look for discarded drug paraphernalia and safely dispose of it if found. (A copy of that memorandum of understanding is included as Appendix H to our December 2018 CTS application, at Exhibit J to this affidavit). We are also occasionally contacted by members of the community to come dispose of discarded drug paraphernalia they have found, though this is not particularly common. Since we began offering our supervised consumption services, we have observed a decline of improperly discarded drug paraphernalia in the vicinity of St. Stephen's.

F. Impact of Closure

i. Inability to relocate

128. On Tuesday, August 20, 2024, Ontario notified the media that it was introducing new legislation that would require KMOPS to close by April 1, 2025. A copy of Ontario's news release announcing the new legislation is attached as **Exhibit "V"** to this affidavit. A copy of Ontario's Backgrounder identifying the supervised consumption sites slated for closure is attached as **Exhibit "W"** to this affidavit.

129. TNG lacks the financial ability to relocate its supervised consumption site to a location that is compliant with the *CCRA*. TNG (and before that, St. Stephen's) has owned the building currently housing KMOPS for 24 years. TNG is able to achieve substantial efficiencies by operating

KMOPS out of the same building as the Corner Drop-In. As it is, TNG is only able to keep KMOPS open for a few hours a day on its current budget, which does not include rent. TNG simply does not have the financial capacity to relocate KMOPS, and either purchase or rent a new building for that purpose.

130. Moreover, no matter where in the city KMOPS attempted to relocate to, we would never have any assurance that we could actually operate a supervised consumption site there for any length of time, because the *CCRA* would require our site to close within 30 days if a school or childcare centre opened within 200 metres of it.

131. The closure of KMOPS will at least for the foreseeable future mean that TNG will be unable to offer any supervised consumption services at all.

132. In any event, TNG operates KMOPS in the Kensington Market area because we directly observed a need for supervised consumption services in that particular neighbourhood. Kensington Market is a vibrant neighbourhood full of both schools and childcare centres, which will make relocating within the same area extraordinarily difficult. A copy of a map of schools within the Toronto District School Board is attached as **Exhibit "X"** to this affidavit. (This does not include Catholic schools, private schools, or childcare centres).

133. A screenshot of an interactive map of elementary schools within the Toronto Catholic District School Board, taken from that Board's website, is attached as **Exhibit "Y"** to this affidavit (this does not include Catholic secondary schools).

134. According to the City of Toronto's website, there are 1,097 licensed child care centres in Toronto.

135. KMOPS is an integrated service with all of our services at 260 Augusta Avenue and would not be nearly as effective unless all of the services were to relocate together. However, relocating everything to a new neighbourhood would deprive residents of the Kensington Market area (including residents who are homeless) of our services.

ii. Increased risk of death, disease, and other bodily harm

136. If KMOPS is closed, our belief is that our clients will lose access to our life-saving services. Most directly, our services will not be available to reverse drug overdoses when they occur, and people will die.

137. Each of the 397 overdoses that have been reversed at KMOPS represent a human life that may have been lost if that overdose had occurred somewhere other than in KMOPS' facility, under the direct supervision of trained staff, with immediate access to naloxone and oxygen.

138. A significant number of our clients describe a dependence on substances and may suffer from substance use disorder. My belief is that they will not stop using drugs merely because they will be unable to do so in the supervised environment provided by KMOPS. I fear that, just as happened before KMOPS existed, people will continue to overdose in our neighbourhood, and when they do, they will not have access to the supervision and immediate intervention that our services provide, including the immediate availability of medications like naloxone.

139. In addition to supervision, KMOPS offers a safe and secure environment where clients do not have to worry about detection by law enforcement, as their possession and use of drugs on our premises is lawful pursuant to our *CDSA* exemption. Our clients are able to take their time and be careful while consuming drugs at our site (for example, being able to take the time to properly

measure their dose), which in turn helps mitigate the risk of injury. With KMOPS' closure, our clients will have to turn back to public drug use where there is a risk of being found and arrested by law enforcement.

140. For our clients who do have housing, KMOPS' closure makes it more likely that they will consume drugs in their residence (rather than at a supervised consumption site), where they are alone and unsupervised. Toronto Public Health's Annual summary of opioid toxicity deaths in Toronto for 2023 (compiled based on data provided by the Office of the Chief Coroner for Ontario) indicates that the majority of opioid toxicity deaths in Toronto occurred in the individual's private dwelling (56%). A copy of that report is attached as **Exhibit "Z"** to this report.

141. In addition to the heightened risk of overdose, I fear that the closure of KMOPS will lead to a heightened risk of infection, disease, and other adverse health impacts for people who use drugs. Our clients who are homeless (who comprise a significant majority of our client base) are extremely limited in their ability to purchase new/clean drug equipment, keep drug equipment clean, and maintain their own hygiene due to lack of access to washrooms and shower facilities. KMOPS provides clients with safe, sterile equipment for their drug use, and a safe and clean environment in which to use them, reducing the risk of infection and disease.

142. Without access to safe equipment at our site, I believe that many of our clients—especially people who are homeless or marginally housed—will have no other option but to consume drugs in an unsafe and unhygienic manner, including sharing and/or re-using needles.

143. The closure will also mean that we will no longer be able to offer our drug checking services, depriving our clients of an important tool that they use to protect themselves. Over the

past few years, the information that we have been seeing coming out of Toronto Public Health and drug checking services has suggested to us that many drugs in Toronto's illegal drug supply are being cut or contaminated with other substances that the user did not expect to be there. This includes a variety of street drugs, including stimulants like crystal meth and crack cocaine, being cut with substances like fentanyl. Attached as **Exhibit "AA"** to this affidavit is a report from TCDS dated December 23, 2024, illustrating some of the kinds of information we get out of services like TCDS. Without the means to identify when their drugs have been contaminated with unexpected substances (including high-potency opioids like fentanyl and carfentanil), our clients will be at higher risk of overdose and other health harms.

144. The termination of drug checking services at KMOPS and the other Toronto supervised consumption sites that offer it and which are required to close by the *CCRA* (including Parkdale Queen West Community Health Centre, South Riverdale Community Health Centre, and The Works) also deprives us of an important source of real-time information about contaminants and other trends in Toronto's illegal drug supply. We routinely provide education to KMOPS clients on contaminants in the street drug supply using information gathered through the drug checking program so that our clients are able to take steps to protect themselves. Our ability to do so will be severely restricted by the closure of KMOPS and the other supervised consumption sites affected by the *CCRA.*

145. Given our relationships and experiences with our clients, our belief is that for those with substance use disorder, the closure of KMOPS will impair their access to services that have the potential to set them or keep them on the path to recovery. KMOPS serves as a first point of contact for many people who end up using our other services at TNG, including obtaining referrals for

treatment for substance use disorder. We frequently have people who come into St. Stephen's Community House from the surrounding area for the purpose of using our supervised consumption services, and in the course of that visit, they learn about and access some of the other services that TNG provides. This includes accessing the Corner Drop-In, counselling, seeing a nurse, and getting assistance with housing.

146. While some of our KMOPS clients are not ready to seek treatment for their substance use disorder directly, their use of KMOPS facilitates their access to other services that add stability to their lives and puts them in a better position to pursue recovery when they are ready to do so.

iii. Higher incidences of unsafe public drug use in the community

147. Our experience pre-KMOPS suggests that without a supervised consumption site, our clients who would otherwise use their drugs inside our facility will instead use drugs in unsafe conditions, including:

(a) in public parks in the surrounding area;

(b) in streets and laneways in the surrounding area;

(c) in or around the grounds of the nearby Kensington Community School and Westside Montessori School;

(d) in public washrooms in the surrounding area, including washrooms of local businesses;

(e) in the washrooms, stairwells, and other areas of St. Stephen's Community House, which was a recurring issue that we experienced before we opened KMOPS.

148. All of the above were places where we at St. Stephen's observed public drug use occurring, and were informed by members of the community of public drug use occurring, prior to the opening of KMOPS in 2018. We are in fact beginning contingency planning to deal with these circumstances in the event that the *CCRA* comes into effect. This is what we saw pre-KMOPS and there is no reason for us to expect any different now.

149. Many if not most of our KMOPS clients will realistically be unable to access supervised consumption services at the small number of sites that will remain open in Toronto after the *CCRA* comes into effect on April 1, 2025, meaning their drug use will instead shift to the above areas. Most of our KMOPS clients are homeless and living in the immediate area (within a 20-30 minute walk). Many of our clients lack access to any form of transportation other than walking.

150. When the *CCRA* comes into effect, the two supervised consumption sites that are closest to KMOPS will also be required to close. Those sites are PQWCHC at 168 Bathurst Street and The Works at 277 Victoria Street. (My understanding is that The Works would have to relocate from that address in any event because its lease is up, but that because of the *CCRA*, The Works will be unable to open a new site without provincial approval, which Minister of Health Sylvia Jones has publicly stated will not be given under any circumstances). PQWCHC is an approximately 18-minute walk from KMOPS. The Works is an approximately 32-minute walk from KMOPS. For many of our clients, both of these sites were already too far away for them to realistically or reliably access.

151. Upon the closure of KMOPS, PQWCHC, and The Works, the next closest supervised consumption site is Street Health, a site that is not funded by the provincial government, located at 338 Dundas Street East—an approximately 44-minute walk away. Travelling this distance to access supervised consumption services is simply not tenable for the majority of KMOPS clients.

iv. Other negative impacts on community health and safety

152. As part of KMOPS' supervised consumption services, we ensure that drug equipment (including but not limited to needles) is disposed of safely and securely. That includes not only disposing of the equipment used by KMOPS clients when they use drugs at our site, but also disposal of equipment that KMOPS clients—and other members of the community—bring into KMOPS from outside, and our staff's activities in going out into the areas around KMOPS on a daily basis to collect and dispose of used drug equipment. Our staff are provided with both training and safety equipment (such as gloves, tongs, and sharps containers) to perform those activities safely.

153. From both our own direct observations and from what we are told by members of the community, there has been a lower incidence of discarded drug paraphernalia in the area since we started operating in 2018. For example, in a letter she provided to us after the government's closure of KMOPS was announced, the priest at St. Stephen-in-the-Fields Church (on the same block as the Bellevue Child Care Centre) has told us of her observations of seeing fewer discarded needles in the area since we started operating. A copy of that letter is attached as **Exhibit "BB"** to this affidavit.

154. Collection and disposal of used drug equipment (which necessarily involves collecting small quantities of the drugs themselves) is activity that is covered by our s. 56.1 *CDSA* exemption from the federal government. When the *CCRA* comes into effect, we will no longer be able to provide this service, meaning the used drug equipment that we used to clean up from the surrounding areas will simply remain there, where it poses a health and safety risk to other community members, including children in the area.

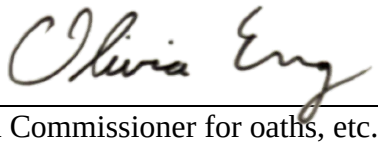
SWORN REMOTELY by Bill Sinclair of the City of Toronto, in the Province of Ontario, before me at the City of Toronto, in the Province of Ontario, on January 9, 2025, in accordance with O. Reg. 431/20, Administering Oath or Declaration Remotely.

Commissioner for Taking Affidavits
(or as may be)

Olivia Eng (84895P)

BILL SINCLAIR

This is **Exhibit "A"** to the Affidavit of Bill Sinclair,
sworn January 9, 2024



A Commissioner for oaths, etc.

ABOVE & BEYOND

2023-2024
Impact Report

TNG
Community Services

CENTRAL NEIGHBOURHOOD HOUSE
NEIGHBOURHOOD LINK
ST. STEPHEN'S COMMUNITY HOUSE

Our Mission

The Neighbourhood Group Community Services works with people at every stage of their lives, providing access to innovative and effective programs, and collaboratively building and advocating for an equitable, just, and vibrant community.

ABOVE & BEYOND

Jennifer Hartviksen
Board Chair

Bill Sinclair
President and Chief Executive Officer

The Neighbourhood Group Community Services is known to all as a place where staff and volunteers go above and beyond to provide care, support, and advocacy to meet the whole needs of people, families, and neighbourhoods!

Together we provide extraordinary support for people in need, but also tackle the big issues and crises that touch all of us everyday in a big urban city. Thank you for reading our Impact Report and the powerful stories of Andrew, Ella, Fatimot, Farzana, Luca, Masha, Wilbert and more.

There are many highlights from 2023/2024, but we especially want to welcome Kensington-Bellwoods Community Legal Services and Downsview Childcare into our group! The path to justice for many of our participants includes free community legal services, and the path to prosperity for many of our families includes affordable childcare. In addition to these Downsview and Kensington locations, we also opened three new offices in partner hubs in Scarborough this year, with the focus of providing holistic services to youth, women, and families. We are proud to be building successful and sustainable neighbourhoods in Toronto.

On behalf of the Board of Directors, we want to express our sincere appreciation for all of our incredible and dedicated staff, volunteers and peer leaders, our generous donors and funders, and our neighbours who fight for a better Toronto.

A YEAR IN PICTURES

Participants from the Youth Arcade Studio pose by the murals they painted in the alleyway between Belleuve Ave. and Augusta Ave.

Offering free haircuts in shelters is one of the added services we provide in SafeSpot, a peer-run harm reduction program.

Thanks to the generosity of companies like RBC Capital Markets, we shared healthy food and fun at events like the annual summer barbeque at our Norm Houghton supportive housing residence.

Volunteers served up nutritious meals and holiday cheer at one of our holiday dinners.

At our Repair Café, volunteers fixed broken items while teaching people, all with the goal of creating a more sustainable society.

Everyone got into the spirit to show our pride at the Toronto's annual Pride Parade.

The National Day for Truth and Reconciliation was recognized across the organization, with special events at our Corner Drop-in, and educational projects at our childcare centres.

Residents enjoyed their furry friends at Pet Palooza, a gathering of people in our supportive housing who receive assistance for their pets through Tango's Pet Fund, founded by Sonia Yung.

Services and Programs

In 2023-2024, The Neighbourhood Group Community Services' in-person and online programs helped improve the lives of **47,815** vulnerable people in priority Toronto neighbourhoods.

Childcare

11 provincially-licensed childcare centres provided safe and enriching childcare for **1,127** children, ages newborn to 12 years. Locations include:

- Bellevue Ave.
- Canoe Landing Centre
- Downsview Public School
- Harbourfront Centre
- King Edward Public School
- Lord Lansdowne Public School
- Ontario St.
- Our Lady of Lourdes Catholic School
- Waterfront Public School
- Winchester Public School
- Yonge & Sheppard Centre

Children & Youth Services

Drop-in, academic and employment support, mental health, arts, recreational, mentorship, advocacy and justice programs helped **3,849** children and youth transition through the teen years. Programs include:

- After School Programs
- Extra Judicial Sanctions/ Measures
- Game Changers Restorative Justice
- Integrated Model of Care
- Kick Start
- Kidz Klub
- Legacy
- Newcomer Youth Drop-in
- Steps2Success
- Summer Camps
- Youth Arcade Studio
- Youth Awoken
- Youth Outreach Workers
- Youth Recreation & Leadership

Community Development

Working alongside community members to address issues and build better neighbourhoods helped **4,616** people through advocacy, education, mediationand support. Programs include:

- Community Dinners
- Community Gardens
- Community Mediation
- Easy-Access Voicemail
- Financial Advocacy and Literacy
- Neighbourhood Pods – Mutual Aid
- Social Action
- Teesdale Food Bank

Employment Services

Programs, workshops, training, resource centres, individual counselling and job development helped **5,182** job seekers prepare for and find employment with specialized programs for newcomers, at-risk youth, and people with mental health challenges. Programs include:

- Better Jobs Ontario
- Carry On
- Connections
- Enhanced Services
- Employer Services
- Moving Forward
- New Knowledge, New Steps
- Opportunity Knocks
- Youth Job Connection
- Youth Works

Housing & Housing Development

Supportive housing, eviction prevention, case management and wraparound services helped **538** people maintain their independence. Locations include:

- Art Manuel House
- Cecelia Murphy Building
- Community Link House
- Dovercourt Place
- Jean Dudley House
- L.L. Odette Place
- Macey Place
- Norm Houghton Complex
- O'Connor House

Independent Living & Seniors

Personal Support Workers, nutritious food, recreational services and general assistance helped **5,492** seniors and adults living with physical and/or mental challenges live independently and with dignity. Programs include:

- Adult Day Services
- Cantonese, Korean and Mandarin Programs
- Case Management
- Congregate Dining
- Home at Last
- In-Home Services and Personal Support Workers
- Meals on Wheels
- Respite Care
- Seniors Active Living Centres
- Stroke Survivors
- Transitional Care
- Transportation and Toronto RIDE

Legal Services

Kensington-Bellwoods Community Legal Services helped **1,396** people living on low incomes resolve issues with tenant rights, immigration and refugee status, and income security (CPP, OAS, ODSP & OW). The clinic also provided public legal education workshops, shared information at community events, advocated for more equitable laws and policies from all levels of government and participated in community development initiatives in partnership with other agencies and non-profit organizations.

Newcomer Services

English classes, workshops and settlement support helped **4,745** newcomers successfully adapt to life in Canada. Programs include:

- Beginners Computer Skills Program
- English Conversation Circles
- Healthy Lifestyle Workshops
- LINC & ESL English Classes
- Perinatal Settlement Support Services
- Rainbow Connect
- Women's Program

Trustee Hub

Mentoring, financial and administrative assistance helped **108** community groups fulfill their mandates to improve social and economic justice. Some include:

- Alliance For Equality of Blind Canadians
- Crescent Community Service
- Emotionart
- Moss Park Women's Group
- South Asian Advisory Group
- Youth4Youth

Urban Health & Homelessness Services

Holistic case management, harm reduction and poverty reduction services improved the mental and physical health of **20,870** people who are living below the poverty line, including people who are homeless or marginally-housed, and those who have mental health and substance use challenges. Programs include:

- Clinical Care and Case Management Services
- Community Connect
- Corner Drop-in
- Crystal Meth Project
- Employment Program
- Eviction Prevention (EPIC)
- Harm Reduction Services
- HIV & AIDS Prevention
- Integrated Prevention and Harm Reduction (iPHARE)
- Kensington Market Overdose Prevention Site
- Mobile Shelter Support Program
- Partners for Access and Identification (PAID)
- Peers in Emergency Departments
- Peer and Park Outreach
- Peer Training and Development
- Safe Seniors Supported Housing
- SafeSpot
- Street Survivors
- Toronto Community Action Team (TCAT)
- UHN Stabilization Centre
- Voluntary Trustee Program

Defined by dreams

Farzana's Canadian journey continues as she helps other newcomer women

Farzana had high hopes for her life in Afghanistan, with a Public Administration and Policy degree and years of experience at a renowned non-profit. Unfortunately, the turmoil there shattered her dreams, leaving her with nothing but the clothes on her back and a heart full of hope yet to be abandoned.

After immigrating to Canada, her initial days were confusing and overwhelming as she faced the daunting task of starting a new life in a foreign land. However, Farzana found solace at The Neighbourhood Group Community Services, thanks to the shared experiences of fellow Afghan newcomers.

Programs for newcomers provided Farzana with the support and resources she needed to navigate her new environment, including settlement services, adult education, employment opportunities and a connection to her new community. This was most felt in the Women's Program, where newcomer women from all backgrounds gather to share their experiences and support each other.

"The essential services I accessed through the Women's Program helped me bridge the gap between my past experiences and my new life in Canada. What really helped me turn the corner was when I started volunteering. I found a new purpose and a way to give back. That led me to a summer job and a role as a Women's Outreach Assistant, and now as a Women's Program Outreach Worker.

"When I think about my journey, and the challenges I faced when I arrived, I know my life is no longer defined by what I lost, but by my new dreams and goals. I am committed to helping other newcomer women like myself, to empower them and help them navigate their new lives in Canada."

93%

of newcomer women found the Women's Program greatly helped them adapt to life in Canada

Shared vision

Through the Trustee Hub, neighbourhood organizations gain essential support and expertise to improve their communities

As Toronto continues to grow, so does the income gap. Caught in that gap are underserved populations in the city, like youth, newcomers and people who live in racialized communities. Grassroots organizations spring to life to help people like these who are in danger of falling through the cracks, much like how the Trustee Hub came to be. Leveraging mentorship, as well as fundraising and administrative resources of The Neighbourhood Group Community Services, the Hub empowers these grassroots groups to tackle the pressing issues within their communities. Together, we strive to improve the lives of people in our neighbourhoods, and strengthen the communities themselves.

108 **grassroots groups gained financial and organizational expertise to better serve local communities in 2023-2024**

MENTAL HEALTH MATTERS

Trustee Spotlight

Mental Health Matters truly follows its mandate to improve the mental health and well-being of marginalized youth in Regent Park. Led by youth for youth, this initiative offers free mental health services that help young people cope with the traumas and issues they face growing up in the city. By working with Mental Health Matters, youth better understand their behaviour, learn strategies to help them cope, and increase their sense of self-worth, all while reducing stigma and fostering community resilience.

Good fences make good neighbours

Evangeline used our free Community Mediation service to resolve an ongoing dispute with her neighbour

The broken fence was only the latest of many issues with Evangeline's neighbour. A major barrier to solving the problem was that the owner lived abroad. But after several emails went unanswered, Evangeline went looking for help.

"On the City of Toronto's website, I saw The Neighbourhood Group (TNG) as the organization the city uses to handle disputes between neighbours. I heard about TNG's Community Mediation before because someone I know got a mediation training certificate from them some years ago. The answer to my problems was obvious.

"Thankfully, the owner agreed to mediation. My husband said we should focus on the fence instead of other past issues, but when we were meeting, the owner was angry about the other things and especially that we sent him a letter some years ago. Part of the reason why mediation works is that you have to listen to the other side and we did just that. We appreciated how straightforward the process was and that it helped us better understand each other.

"In the end, the owner agreed to pay half the fence cost. And we agreed to communicate by email, and WhatsApp for emergencies. We're very happy with how things turned out."

300+

community mediations in the Greater Toronto Area reduced conflict and improved communication among participants last year

A hub of activity

Our youth wellness hub helps young people who struggle with poor mental health

The Taylor-Massey Oakridge neighbourhood has seen a dramatic increase in anxiety, depression, violence and the risk of suicide among youth since the pandemic. To alleviate the traumas faced by young people in the community, The Neighbourhood Group partnered with Access Alliance to create our youth wellness hub at the Access Point on Danforth.

Replicating our successful health clinic housed at the Youth Arcade in Kensington Market, the hub combines mental, physical and sexual health services in a safe space. This reduces barriers and stigma for young people struggling with poor health who now have a place to access nurses, therapists, social workers, youth workers, and referrals to employment and other essential services.

Soo is one of those youth.

"I used to be anti-social. I'd find everything boring and not talk to other people much. Someone told me about Youth Awoken at the hub because it's fun and everybody there is nice and understanding. I already knew about The Neighbourhood Group because I went to the Kickstart after school program, but Youth Awoken was new.

"I'm glad I tried it because Youth Awoken helped me with my mental health by offering inclusive activities where you don't do things all on your own. I made new friends and don't feel so alone. Life now has drastically changed to the better - my number one resource for support is Youth Awoken!"

Suicide is the 2nd leading cause of death among youth aged 15-24

Employment is knocking at your door

Andrew got his career on track through Opportunity Knocks

"I was trying to ease my way back into the workforce after a two-year recovery from a serious head injury. I really felt that I wasn't hirable or a good candidate due to the large gap in my work history. My confidence was shot and my appearance wasn't exactly polished. This made getting interviews and finding career direction difficult. I'm lucky my Employment Advisor suggested I try Opportunity Knocks, a training program for youth.

"Through the five-week training and 12-week work placement, I learned many things to help my career – interview and resume skills, financial literacy, legal advice, contacts, and professional training in first aid/CPR, conflict resolution and customer service. I improved practical life skills too, like teamwork and healthy eating on a budget. I also did a vocational assessment to better understand my strengths, aptitudes, temperament, work styles and areas for growth, which provided me with a basic road map for my work journey.

"Being part of Opportunity Knocks showed me I wasn't alone. My classmates helped take away my fear and rebuild my confidence.

And since we all shared the same goal of finding employment, we encouraged each other the whole way.

"Everything led me to land two jobs as a CPR instructor and as an extra-curricular instructor in a company called Extra Ed. That's all because of Opportunity Knocks."

99%

of at-risk youth completed their Opportunity Knocks training to further their employment goals

A lifeline to happiness

Services like our Adult Day Program and Client Intervention and Assistance help seniors like Mary live happily and independently

"When I first moved to my new seniors' apartment building, I felt lonely and isolated. I was employed but on sick leave and was not sure how I could pay my rent. The superintendent told me The Neighbourhood Group could help. Staff listened to me and were comforting. They explained the process and how they could help me until my apartment was adjusted for rent geared to income. Before my sick benefits ran out, they helped me apply for my private and senior's pensions and prepare my income taxes.

"Throughout that time, I wanted to keep busy and see people so I wouldn't be so lonely. The Neighbourhood Group already had a day program in my building, so I started going. It made me happy to meet new friends in my building, do chair exercises to stay fit, have homemade lunches and learn new things in the engaging programs. There's a painting class, yoga, holiday celebrations and day trips.

"I am very grateful to live in my seniors' building and be connected to the staff who are always helping me and supporting me. Time goes by fast every day and I am not lonely anymore. The Neighbourhood Group has truly been a lifeline that keeps me and many seniors happy and active. Thank you!"

50%+

of seniors in Toronto have incomes at or below the poverty line

Making a difference, one person at a time

As a peer worker, Masha helps people in shelters struggling with homelessness, substance use, and mental health issues

"Working at The Neighbourhood Group Community Services (TNGCS) has been life-changing for me. When I joined the organization in May 2023, I never imagined the profound impact it would have on my life. TNGCS didn't just offer me a job; they extended a hand of support and opportunity when I needed it most.

"The journey began when TNGCS visited the shelter where I was staying, offering peer positions to people with lived experience like myself. This gesture of inclusivity and empowerment spoke volumes about the organization's values and mission. I eagerly interviewed for the position, knowing that it was a chance to not only rebuild my life but also to make a difference in the lives of others.

"From day one, TNGCS welcomed me into a supportive and nurturing environment. They provided comprehensive training and guidance, equipping me with the skills and knowledge necessary to excel in my role. But more than that, they fostered a sense of belonging and purpose within me—a feeling that I had something valuable to contribute, despite the challenges I faced as a newcomer.

"As a peer at TNGCS, I've had the privilege of connecting with people who have faced similar struggles to my own. Whether it's providing emotional support, responding to overdoses, connecting clients to community resources, or simply lending an empathetic ear, every interaction has been meaningful and rewarding. Knowing that I can offer hope and encouragement to others going through tough times fills me with a profound sense of fulfillment.

"Moreover, my time at TNGCS has been instrumental in my personal and professional growth. I've honed my communication skills with the opportunity to be empathetic and compassionate, and learned the importance of resilience and perseverance. These skills are invaluable in my role as a Shift Lead and serve as a foundation for my future aspirations.

"Above all, working at TNGCS has shown me the transformative power of community and support. It reminded me that we are never alone no matter what challenges we face—and that by coming together, we can overcome even the greatest obstacles.

"I am immensely grateful for the opportunity to be part of the team because of the positive impact it has had on my life. As I look to the future, I am excited about the possibility of continuing to grow and evolve with TNGCS, changing lives and making a difference in the world, one person at a time."

27,343 **overdose prevention activities and harm reduction supports were provided by peer workers in shelters last year**

Better together

Gwen and Wilbert maintain their independence at Jean Dudley supportive housing

Finding supportive housing for one senior can be tough. For a couple, it can be impossible. Fortunately for Gwen and Wilbert, Jean Dudley House was the perfect spot.

After suffering a stroke three years ago, Wilbert needed the care only supportive housing could provide. At Jean Dudley House, personal support workers are available around the clock, and residents can access our other essential services like Meals on Wheels, transportation, and even our Adult Day Program.

"It was easy for Wilbert when he moved in to Jean Dudley House a few years ago and the staff could help care for him. Then when I had a heart attack, I couldn't live on my own. You have no idea how happy I was when I found I could move there too. It's exactly what I needed.

"The staff are amazing and always helpful. They know how everyone here needs something different. Being here with Wilbert lets us live independently with the support we need. And the other people here are so much fun. It's a lovely, homey place. There's even a garden here and I'm very excited for that. Honestly, as soon as I moved in, I felt like I've been here forever."

11,000

hours of care are given each year from personal support workers at Jean Dudley House

Legal lifeline

Ella found much-needed help for her legal issues at Kensington-Bellwoods Community Legal Services

For people struggling to find affordable help for complex legal issues, the search can be daunting. Fortunately for Ella, Kensington-Bellwoods Community Legal Services (KBCLS) was just around the corner.

Since 1982, KBCLS has been steadfast in its mission: to help people living on low incomes resolve issues with tenant rights, immigration and refugee status, and income security (CPP, OAS, ODSP & OW). They also promote public legal education, law reform initiatives and community development in our neighbourhood.

"One of my friends was in the same situation as me and went to KBCLS. She had nothing but good things to say about Lee, the immigration lawyer and the clinic, and highly recommended that I do the same. As a single mom with kids living in Canada without status, KBCLS was a blessing. They helped tremendously and walked me through everything. Lee worked very hard for me and I appreciate that so much. She was amazing!

"Now I have no worries about myself, my boys and our future. I am legally in Canada now and can visit my mom and family in Malaysia who I had not seen for 20 years. I love Lee! I love KBCLS! I love Canada! Thank you so much!"

Kensington-Bellwoods Community Legal Services resolves almost

600 **cases per year for people living around the poverty line**

Refuge from persecution

Fatimot found solace and acceptance in Rainbow Connect, a program for LGBTQ+ newcomers

Warning: The following story references sexual abuse and domestic violence.

"I grew up in Nigeria. At university, I became close with my roommate who then became my partner. She was a year older than me so she left a year before me. To hide my sexuality, I got a 'boy-friend'. Because of him, I was a rape victim, and couldn't get close to anyone for some time.

"After I graduated and started working, I fell in love with a man from France and got pregnant. We weren't married so to avoid the pressure of being an unmarried mother, I went to France to have my baby. Then I found out he was married with three kids and he abandoned me in a shelter. I didn't know anyone in France and returned to Nigeria.

"Four days after returning, my sister died. There was no one to look after her two children so I took care of them as my own. Eventually I got married and had another child. But there was no love in that marriage. My partner from university also wasn't happy in her marriage. So when her husband was away on business, I went to visit her. Her husband came home early and caught us. He was furious and started beating her. She was yelling at me to run. That was the last thing she said to me. I haven't heard from her since 2009.

"I got my kids and fled to France since my first child was French-born. I found out later that my partner gave her husband fake locations to buy me time to escape. And that he kept on harassing my family after I was gone. But being in France wasn't easy. We had no family here, and no money. I slept on the street with my kids. It was only when I got temporary papers that I could get a little cleaning work to support us. After a short time, I was told my papers weren't valid and had to leave within 30 days. I couldn't go back to Nigeria. It wasn't safe for me or my kids. Luckily with help, I was able to get to Canada.

"It was tough at the start. We were living in a shelter and we only had a few clothes. I was so lonely and depressed. But a friend told me about Rainbow Connect. When I came there, they didn't turn me away! Everywhere I'd been, people rejected me because of my kids, immigration status, or my sexual identity. But not here. Meeting people at Rainbow Connect, I saw there were so many people like me. They became my family, my sisters. In a few months, I felt strong enough to share my story with them, like I'm sharing now.

"A few years ago, staff at Rainbow Connect helped me get my official status in Canada. The hearing was supposed to be long but when I spoke, it was done in only 10 minutes. Today, I have a good job and a three-bedroom apartment. I want to give my kids a good life, especially with what they went through. I still come to Rainbow Connect today. They gave me back every-thing I lost. They gave me back my life."

95% **of people in Rainbow Connect fled their countries as refugees**

Priority child care

The Downsview Child Care Centre gives peace of mind to parents like Vince

As the population of Toronto grows, essential community services are not keeping pace. For families already struggling near the poverty line, those services are essential. This is truly the case in the Downsview neighbourhood.

Designated by the City as a Neighbourhood Improvement Area, Downsview is one of the poorest in Toronto and continues to lack support services. That makes the Downsview Child Care Centre a critical service for residents in the neighbourhood.

Opened in December 2023, the Centre is a lifeline for parents in the community. The Centre provides a nurturing, inclusive space where children thrive through social, emotional, cognitive, and perhaps most importantly, fun programs. For parents like Vince, the availability of local, quality child care is crucial.

“In Downsview, we couldn’t find any centre that had affordable before and after school care. The only ones were pretty far away. With it getting more and more expensive to live in Toronto, that made it very difficult to accommodate our work schedules with our son Luca’s school. And we weren’t comfortable with the child cares we did find.

Life is much easier for us at Downsview. We can go to work without the added stress of worrying about dropping Luca off and picking him up. We feel very good about this Centre because he really seems to enjoy it there. He’s in good hands and I know we can trust them to care for Luca. We are so relieved!”

37%

lower average household income in Downsview than Toronto average

Donor Roster 2023-24

Thank you for your generosity!

As visionary donors, partners and funders, you bring opportunity and possibility to life. Your kindness helps people improve their lives and the communities in which they live.

We are proud to be a United Way Greater Toronto Anchor Agency! Thank you to all our staff and supporters who donate to United Way Greater Toronto. We are also grateful to the many businesses and non-profits we work with annually through job and community service placements and joint initiatives.

Excellent Neighbours: $50,000+

1 Anonymous
Freedman Family
Rochelle Rubinstein - Emerald Foundation
Sonia Yung
The Ontario Trillium Foundation

Dedicated Neighbours: $10,000 - $49,999

2 Anonymous
Aston Family Foundation
BrookField Asset Management Inc. - Jack Cockwell
Charitable Impact Foundation
Charities Aid Foundation Canada
Deltera Inc.
ECHO Foundation
Estate of Josephine Jenkinson
Intact Insurance
J.P. Bickell Foundation
Jane and Oliver Lennox-King
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Lynda Hamilton - Edper Investments Limited
Patricia Lepage
RBC Foundation
Sprott Foundation
The Catherine and Maxwell Meighen Foundation
The Lawrason Foundation
Toronto Arts Council
Toronto Star Children's Charities
Vinny Bhathal

Friendly Neighbours: $1,000 - $9,999

2 Anonymous
Akler Browning LLP
Alisha Kaplan
Alterna Savings and Credit Union Ltd.
Andrea Boctor
Andrea Rosen
Anna Binswanger-Healy
Anthony Mancini
B & B Hamilton Fund at Toronto Foundation
Beekay Foundation
Bell Let's Talk Community Fund
Bill Sinclair
Blackbaud
Bob & Mary Gore
Bob Cronin
Brian Maxwell
Canadian Online Giving Foundation
Care Management Solutions
Carla Brown
Chi Chiu Yau
Chris Makris
Clayton Gyotoku Fund at Toronto Foundation
Connie & Theodore Marras
CP24 CHUM Christmas Wish
Cynthia Bliss
Danforth Morningside Mennonite Church
Daniels HR Corporation
David C. Rich
David Crawford & Julia Holland
David Reed
Donna Dasko
Edward Stephen
Elizabeth R. Redelmeier
Emily Winsor
Erion Insurance Group
Francis Low
Gloria Jean Thomas
Gordon Hamilton
Harold Durnford Fund at The United Church of Canada Foundation
Helen Thorpe
Hitesh & Kimberley A. Patel
Jacqueline Solway
Jane M. Wilson
Jean Reeves
Jennifer Hartviksen
Jennifer Rae
Jennifer Rigney
Joe C. K. Kwok
Jonathan Medline
Kate McMurray
Kevin Fisher
Kevin Fretz
Kin-Fan Young-Tai
Kyle Gossen
Lynn Eakin & David Young
Marc Savoie
Matt Broadbent
Michael Craig
Miriam Newhouse
Mitchell Rose Professional Corporation (o/a Rose Dispute Resolution)
Music Performance Trust Fund
Nicolette Agnew-Ogg
Pam Oiye
Pat McNamara
Phoenix Kunsel
Rachel Barkley
Rachel Harding
Randall Boyd
RBC Capital Markets
Reid Rusonik
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Rotary Club Of East York
RP Investment Advisors
Samira Viswanathan
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Shannon Stanojevic
Sheri Ellis
Shona Godwin
Signatures Shows Ltd.
Steve Hirshfeld
Susan Loube
Thomas Chon
Thomas Keane
Tracy Cooper
WeirFoulds LLP
Yanny Chi Yan Lee
Zou Xue Fu

Caring Neighbours: $100 - $999

10 Anonymous
10475793 Canada Inc. - Matthew Ma
Abbas Sabur
Adam Beatty
Adam Starkman
Adam Vanderlip
Adrian Pel
Ahmad Goudarzi
Ai Len Kwan
Aimee Jessop
Akua Delfish
Alan Kwok
Alana Dobbs
Alda Neves
Alexandra Conliffe
Aline Tso
Allan W. & Nadia Hawkins
Alphonse Barikage
Amana Manori
Amber Daugherty
Amina Yassin-Omar
Andrew Duncan
Andrew Haisley
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Anne Marie Guchardi
Annette Dreidger
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Anthony Van Leeuwen
Arturo Aster
Ash & Danae MacLeod
Asha Chiba
Ashley Thompson
Atin Bhattacharya
Avery Krisman
Avneet Sidhu
Barbara Fischer
Barbara Hall
Barbara Titherington
Bernard Johnpulle
Beth Kesselman
Bette Walker
Beverley Koven
Bevonie Brown
Bi Rui Yu
Biju Sebastian
Bik Fung Nye
Birinder Sidhu
Bloor Street United Church
Bo Sing Lee
Bob Smith
Brendan Maher
Brent Lawson
Brent Vickar
Brett Wolfson-Stofko
Bruce A. Weber
Bruce Cooper
Bryant Ramdoo
Bryna Levitin
Canada Tour System Inc.
Candida Garcia
Carol A. Thompson
Catherine Hennessey
Catherine McVitty
Catherine Siemens
Catherine Tallerico
Celia Denov
Celina Marchese
Charles Andrew Barclay
Charles B. Gordon
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Ching Chu Wong
Chris Chong
Chris Janson
Christina M. Cameron
Christina Robinson
Christopher Augello
Christopher Gilbert
Christopher M. & Mary L. Bailey
Cindy Chan
Cindy Phung
Colette Snyder
Colin Hardman
Colin R.C. Dobell
Craig Donovan
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Dan Scrimger
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Dorothy Ellis
Douglas Campbell
Douglas Hay
Edith Galinaitis
Edna Bampton
Edward Hall
Edward Thorne
Eileen M. Barbeau
Eileen Rochon
Eleanor Connie Munson
Eleanor K. Latta
Elisabeth Evans
Elisha Gore
Elisheva Adina Gamse
Elizabeth Carveth
Elizabeth Gordon
Elizabeth Hanson
Elizabeth Silva
Ellen Kung
Enos Malcolm
Eon Guy & Bok Sil Shin

Erika Chandler
Ernest McNee
Estelita Ugbinada
Eugenie Parker
Eva Chow
Florence Barwell
Frances Hamill
Francis Muli
Francois Villeneuve
Frank Duong
Frank Pagliarello
Fu Zhen Zhou
Gail Robinson
Gary Hopkins
Gavin Belgrave
Gay Brema
Gay Thomson
Geoff Horton
George & Jane Werniuk
George Yamazaki
Georges Dube
Gerald Sears
Geraldine Ambas
Geraldine Penni
Giles Osborne
Gina Lee
Glenn Gibson
Gordon Hamilton
Grace Olds
Gregg Paisley
Gregory Fisher
Guo Zhen Wen
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Hanna Heger
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Heather Kwak
Heather MacDonald
Heather Menzies
Heather Wolfe
Helen Chung
Helen J. Breslauer
Helen Orr
Helena Friesen
Helena Webster
Hermina Goor
Hilary Francis
Hong Y. Lee
Honghua Yan
Howard Green
Hsi Hsien Huang
Hue Nghi Chau
Huen Wai Kwok
Hun Kuen Fong
Hunter Thompson
Huu Thi Lam
Huu Tran-Nguyen
I.O. Promo
Ian Mallov
Ian McCombe & Elizabeth Ritchie
Ian Muirhead
Ian Robinson
Ihor G. Taraschuk
Iivi Campbell
Imran Ilahi
Ione Williams
Irene Nham
Ivan Martellino
J.E. & Barbara Tangney
Jaanus Marley
Jacquline Trieu
James Cockfield
James Devlan Nicholson
James T. Fisher
Janani Mahendran
Jane Jung
Jane Lowbeer
Janelle Estwick
Janet Sinclair
Janet Winhall
Janine Kinch
Jean Dempsey
Jeff Rogers
Jeff Thomas
Jeffrey Levitt
Jenessa Dworet
Jennifer Cruickshank
Jennifer M. Ross
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Jessica Wolfe
Jill Kelsall
Jing Tian Wei
Joachim Schmidt
Joan Danard
Joan Dullege
Joan Mceachern
Joe Sawada
John & Sue Wissent
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John Gregory
John Hassell
John Marshall
John Reid
John Sutton
John Todd
John Walker
John Wilkinson
John Williams
Jon Walls
Jonathan Tsang
Jordan Zale
Jose Diaz
Joselen Liguori
Joyce Barrass
Judith C. Campbell
Judith Friedl
Julia Low
Julia Song
Julie Richardson
Kan Hoi Kwan
Karen Kaplan
Karen Matsumoto
Karen Stephenson
Kate Richardson
Katharine Bates
Katherine Chau
Kathleen McMorrow
Kathleen Scardellato
Kathleen Schneider
Kathryn Woods
Kathy McKenna
Kathy Narraway
Kelly Read
Kenneth & Dawn Michael Martin
Kenneth Fisher
Kenneth Walley
Kersti Kahar
Ket Lu
Kevin Godin
Kevin Taylor
Khue Lu
Kim Le Chau Lieu
Kim Maxwell
Kim Patel
King Ching Chau
Kirsten Monaghan
Kirsti Luoma
Krizsia Praznik
Krysta Lombardi
Ky Phu Phung
Laina Gibson
Lan Fang Mao
Lan Fong Chiu
Lap Khac Huynh
Laura Lane
Laura Norris
Laurie Brema
Laurie Taniguchi
Leah Tussman
Lei Ken Cheung
Leonard Shirchenko
Leonard Sussman
Levi Cooperman
Li Yun Chen
Li Yun Zhang
Lilian Thong
Linda English
Linda Grearson
Linda MacKeigan
Linda Pace
Lorraine Ulett
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Loucas Gousopoulos
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Lyndsey Gallant
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Mamoon Khan
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Maria Cheung
Maria Cristina Hernaez
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Maria Santos-Findlay
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Mary Ann Bulosan
Mary Bull
Mary Ellen Mahoney
Mary Kay Sonier
Mary Low
Mary McGowan
Mary Walsh
Massimiliano Perrone
Matthew Valic
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Meeley Chan
Meng Choi
Michael Charles
Michael Friesen
Michael Gallacher
Michael Marrin
Michael Maugeri
Michelle Hyland
Michelle Mawhinney
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Microsoft
Miko Yu
Ms. Mairs
Mui Tran
Nadia Gouveia
Nadia Sahadeo
Nancy Laverne
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Nero Persaud
Nicholas Volk III
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Paul Patterson
Pauline Mazumdar
Peggy Tseung
Peter Borsellino
Peter Brydon
Peter Nurse
Phebe Pang
Philip F. Jones
Philip Unrau
Pierre Nadeau
Pol & Wybogina Maenhaut
Qi Dao Chen
Rachel Vickerson
Raffaela Di Paola
Ralph Thomson
Rebecca Lee
Rebecca Lock
Rebecca Smart
Regan Watts
Rei M.
Reinhart & Marina Wieland
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Richard Frank
Richard Konopada
Richard Rose
Richard Sugarman
Robert Butler
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Robert Tomovski
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Roger Beech
Ron & Gay Gibson
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Ronald Andersen
Ronald Morrish
Rosemary Shipton
Rosemary Vandierendonck
Ryk Cameron
Sabah Hassan
Samuel & Sunday Rizzo
Samuel Kolber
Sandra A. Dalziel
Sandy M. Smith
Sarah Murdoch
Sarah Richardson
Sarah Turnbull
Serena Nudel
Shadi Farshadfar
Shannon McCauley
Sharon & Glenn Griffin
Shaun Smith
Shawnee Hardware
Shea & Matea Hurley
Shing Kwong Lee
Shing Wah Lee
Shirley Goldenberg
Shun Yi Wu
Simone Lehmann
Sinh Hue Khiem
Sonia Stanojevic
Sooi Cheng Yee
Sook Ja Cho
Sophie McCormack
Stanislav Kirschbaum
Stefan Senyk
Stephanie Rutherford
Stephen Paterson
Steve Bujouves
Steven Bartlett
Sui Har Annie Leung
Sui Yong Leong
Susan E. Kiil
Susan Griffin
Susan Min
Suzanne Bond
Suzie Wong
Suzy Jeronimo
Sylvia Soyka
T.C. Chan
Tang Qiu Li
Tatjana Rumjanseva
Terrence Choo-Kang
Terry Sinclair
Thao Nguyen
The UK Online Giving Foundation
Theresa Hall
Therese Edwards
Thiago M. Oshida
Thomas Freeman
Thomas Roberts
Tim Grant
Tim Utting
Tom Edwards
Tony Redmond
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Tracey Rees
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Wai Lin Der
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Wendy L. Dicker
Wendy Rothwell
Whitney French
Willima Joseph Stone
William MacKay
William Sheehan
Winter Auger

Xiem Huong Huynh
Yan Ying Weng
Yee Hing Lee
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Ying Kwan Lam
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Yuet Ling Ellen Kung
Yuk Hing Leong
Yuko Sorano
Yun Chuen Lee
Yvonne Chan
Yvonne John
Yvonne Lee
Zaher Dadelahi
Zahra Ebrahim
Zahra Jamal
Zizina Estevens

Giving Neighbours:
$1 - $99

4 Anonymous
A. Xiang Lin
A. Anne Evans
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Ada Yip
Adam Smith
Adel Majd
Adnahn Batson
Adriana Peralta
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Kaydeen Bankasingh
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Kimathi Kimami
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Kit Tse
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Raymond Tam
Raymond Yuen
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Robert Drummond
Robert Sitarski
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Roney Pinuela
Rong Xiang Tang
Rosalind Cooper
Roy Merrens
Ru Jin Xie
Rui Jin Huang
Russell Janzen
Ruth Elaine Axler
S. Molloy
Sally Vickers
Sally Wong
Sam Chiu
Samantha Lynn
Sansan Chow
Sapana Banskota
Sarah Milton-Lomax
Sarah Pengelly
Selma Shearer
Seta Shamoun
Shari McKee
Sharon Flynn
Sharon Graham
Sharyn Chandik
Shehinaz Manori
Shei Lu Chuen
Sheikh Mohammed
Sheila Doherty
Sheila Gilbert
Sheila Kapcsos
Sheila Maxwell
Sheila Slattery-Ford
Sheng Yi Wang
Shennell Joseph
Shirley Roberts
Shirley Tang
Shirley Thompson
Shuk Yee Yick
Shyue Fen Wang
Silvina Rosa
Sin Li
Sip Han Sue
Sirpa Ruotsalainen
Siu Chun Chan
Slavotinka Nikolova
Snehlata Ghose
So Ching & Chun Kow Chan
Sofia Berehanu
Soojinn Jang
Sophia Purmal
Stanko Stankov
Stanny Shen
Stavros Argyropoulos
Stella Fan
Stephanie Donalds
Steven Chan
Steven Lewis
Steven Spencer
Su Lan Chen
Suk Han Ho
Summer Nudel
Sun Nghi Chau
Sunil Meher
Susan Henry
Susan Kuskelin
Susan Laffier-Fraser
Susan Machado
Susan Porter
Susan Selby
Susan Shipton
Susan Smith
Susan Warden
Sushant Koul
Suzanne Sutcliffe
Suzy Duong
Takwan Tawshik
Tammy Knowlton
Tan Tran
Tania Nguyen
Thelma Sookman
Theodora Lamshoeft
Theresa Florence Corbett
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Tin Lo
Ting Chung Cheung
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Tom Pang
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Tony McAlinden
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Vincent Ka Hang Fok
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Wai King Wong
Wai Ting Lee
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Wei Zhen Li
Wei Zhu Wang
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Wendy Wong
William Bradley
Wilma Voskamp
Wing Chan
Wing Yee Quan
Winona Magno
Winston Nugent
Woon Hin Chow
Wun Choy Lau
Xiang Qiong Ren
Xiu Chuang Yu
Xiu Fang Xia
Xu Ting Mei
Xue Hua Zhou
Ya Ping Bian
Yang Yang
Yee Mee Joyce Leung
Yee Shew Kwan
Yick Ping Cheung
Yie Ling Lee
Yim Chun Lee
Ying Suet Leung
Yong Shan Shi
Youheng Chen
Yu Hai Hu
Yue Qing Feng
Yuet-Oi Lee
Yumna Mohamed
Zenira Lopes
Zeporah Green
Zhao Feng Chen
Zhen Shi

Neighbours
Helping Neighbours
Giving Circle

2 Anonymous
Agnes Van 'T Bosch
Alphonse Barikage
Amber Daugherty
Andrew Milne-Allan
Andrew Pruss
Ann Graham
Ann Steer
Anna Dodd
Annette Dreidger
Bill Sinclair
Bob & Mary Gore
Caeli Mazara
Carol A. Thompson
Celia Denov
Charities Aid Foundation Canada
Charles B. Gordon
Christopher Gilbert
Christopher M. & Mary L. Bailey
Craig Donovan
Cynthia Bliss
David Crawford & Julia Holland
David Guttman
Debra Scanlon
Diane Granfield
Donna Jones
Dorothy Ellis
Douglas Campbell
Douglas Hay
Eileen Rochon
Eleanor Connie Munson
Elisabeth Evans
Elizabeth Hanson
Erika Chandler
Francois Villeneuve
Frank Pagliarello
Gay Thomson
Geoff Horton
Gloria Jean Thomas
Helen Orr
Hitesh & Kimberley A. Patel
Ian Mallov
Ian McCombe & Elizabeth Ritchie
James Devlan Nicholson
Janani Mahendran
Jennifer Rae
Jill Kelsall
Julia Song
Karen Marzocco
Karen Stephenson
Kathleen McMorrow
Kathleen Scardellato
Kathleen Schneider
Kelly Read
Kenneth Walley
Kersti Kahar
Kevin Fisher
Laina Gibson
Laura Norris
Leighton Taylor
Louise T. Guillemette
Lyndsey Gallant
Manuel & Lucila

Granados
Marc Francoeur
Margaret Oldfield
Maria Podorojansky
Marie Glass
Marilyn Vasilevich
Mary Ellen Mahoney
Mary McGowan
Mary Walsh
Matthew Valic
Maureen & David Carter-Whitney
Michelle Mawhinney
Ned Stewart
Nicholas Volk III
Nicolette Agnew-Ogg
Norman Gillanders
Patricia Kishino
Patrick Lacroix
Patrick Riesterer
Paul Palen
Pauline Mazumdar
Pierre Nadeau
Rebecca Lock
Reid Rusonik
Rhona Zitney
Sarah Murdoch
Shannon Stanojevic
Sheri Ellis
Shirley Goldenberg
Sophie McCormack
Stephanie Donalds
Thiago M. Oshida
Tim Grant
Tom Edwards
Utpala Gupta
Valerie March
Vasu Srinivasan
Victoria Lee
Wendy L. Dicker
Wendy Rothwell
Whitney French
William Bradley
Yvonne Chan
Zahra Ebrahim

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XYZ Storage
Yorkshire Rose Quilters' Guild

We apologize for any errors or omissions in our Donor Roster and respect the wishes of donors requesting anonymity. Please direct any inquiries to 647.458.1649.

Board of Directors

Thank you to our Board of Directors from 2023-2024. Their compassion and commitment are instrumental to help guide the overall health of The Neighbourhood Group Community Services by defining the goals of the organization, establishing the strategic plan and setting governance policies. The Board truly makes an impact on the lives of people in our community.

Jennifer Hartviksen
Chair

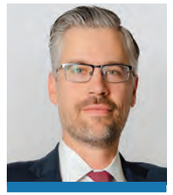
Josh Kleiman
Vice-Chair

Vinny Bhathal
Treasurer

Shannon McCauley
Secretary

Levi Cooperman

Shadi Farshadfar



Kevin Fisher

Craig Knowles

Nero Persaud

Alena Ravestein

Shannon Stanojevic

Chana Weinstein

Gregory Wilson

Sonia Yung

A special thank you to departing Board Members: Craig Knowles and Sonia Yung

Craig's dedication and desire to improve the lives of people in our community was strongly felt on the Advocacy committee and as Chair of the Quality Committee. Sonia started volunteering on the Quality Committee before joining the Board in 2017. Her leadership and kindness were evident throughout her tenure as Chair and Co-Chair of the Board, as well as the Chair of the Quality and Governance Committees. Sonia's generosity shone through with her funding of Tango's Pet Fund, a program that helps support pets of people living in our supportive housing.

Thank you to our dedicated volunteers!

Last year, over **730** of our dedicated volunteers delivered more than **38,167** hours of essential support to our community!

Whether it's helping at our Corner Drop-in and Food Bank, giving time as a Board member, acting as a community mediator, doing community outreach, helping at income tax clinics, tutoring, or mentoring, our volunteers make a huge difference in the lives of vulnerable people in Toronto.

Volunteer Spotlight

Mauricia Harvey, Meals on Wheels and Teesdale Food Bank volunteer

Meals on Wheels

"I choose to volunteer because I want to make an impact in the lives of people who need these types of services in Toronto and reciprocally, helping myself as well by engaging with the community.

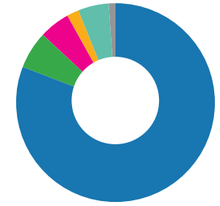
"Meals on Wheels is a great opportunity to help others who are isolated and struggle with food insecurity. But the food we deliver is just the introduction to a greater story. As human beings, we're not meant to be isolated. We're meant to connect and help each other in whatever capacity we can. With Meals on Wheels, we can interact with people one-on-one and give them a connection with other people. I've heard some people say volunteers are like their family. We give them the warmth of a friendly smile, and check in with them to see if they need any help. We give them respect and dignity.

"I absolutely love volunteering here and I'll continue to do it for a very long time."

Statement of Operations and Changes in Fund Balances

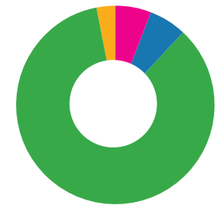
Year ending March 31, 2024

	2023-24	2022-23
Revenues		
Fees		
Home and Community Care Support Services	$ 7,368,108	$ 5,552,367
Fees from Users	4,619,408	5,082,063
City of Toronto	3,558,526	3,341,320
Grants		
Province of Ontario	$ 24,414,794	$ 23,006,048
City of Toronto	14,980,263	12,526,826
Government of Canada	10,411,883	9,174,078
United Way	1,317,271	1,553,631
Other		
Partner Agencies	$ 4,028,602	$ 2,858,045
Trustee Funds	2,687,677	3,175,573
Donations and Fundraising Events	1,179,115	1,075,837
Investment	718,756	314,328
Amortization of Deferred Capital	209,076	–
Total Revenues	$75,493,479	67,876,662
Expenditures		
Wages	$ 46,939,319	$ 40,586,605
Benefits	10,327,423	8,500,033
Program Expenses	6,491,176	6,213,134
Occupancy Costs	4,961,544	4,202,959
Purchased Services	2,763,426	2,996,585
Food Services	1,794,039	1,601,835
Office and General	1,617,491	1,271,506
Employer Wage Subsidy and Participant Support	1,170,494	1,385,967
Amortization	817,570	725,402
Promotion and Publicity	234,189	396,686
Travel	161,885	460,792
Total Expenditures	77,278,556	68,341,504
(Deficiency) excess of revenues over expenditures for the year	$ (1,785,077)	$ (464,842)



Revenue

- **81%** Government
- **6%** Fees
- **5%** Donations
- **2%** United Way
- **5%** Partner Agencies
- **1%** Investment & Amortization



Expenditures

- **6%** Building Costs
- **6%** Administration
- **84%** Direct Program Costs
- **4%** Purchased Services

The 2023-2024 financial results reflect several factors, including 11% overall growth, retroactive payments and salary harmonization, rising inflation, higher demand for services, the merger with Kensington-Bellwoods Community Legal Services, and the addition of Downsview Childcare.

TNG Community Services

CENTRAL NEIGHBOURHOOD HOUSE
NEIGHBOURHOOD LINK
ST. STEPHEN'S COMMUNITY HOUSE

United Way Greater Toronto

GOOD FOOD ORGANIZATION
In alliance with Community Food Centres Canada 2022

@TNGcommunityTO

349 Ontario Street | Toronto, ON M5A 2V8 | 416.925.2103 | info@TNGCS.org

www.TNGcommunityTO.org

Charitable Registration: 106887284RR0002

This is **Exhibit "B"** to the Affidavit of Bill Sinclair,
sworn January 9, 2024

A Commissioner for oaths, etc.

THE NEIGHBOURHOOD GROUP COMMUNITY SERVICES
FINANCIAL STATEMENTS
FOR THE YEAR ENDED
MARCH 31, 2024

THE NEIGHBOURHOOD GROUP COMMUNITY SERVICES
Financial Statements
March 31, 2024

Index	**Page**

AKLER BROWNING LLP
CHARTERED PROFESSIONAL ACCOUNTANTS

INDEPENDENT AUDITOR'S REPORT

To the Directors of The Neighbourhood Group Community Services

Qualified Opinion
We have audited the financial statements of The Neighbourhood Group Community Services, which comprise the statement of financial position as at March 31, 2024, and the statements of changes in fund balances, operations and cash flows for the year then ended, and notes to the financial statements, including a summary of significant accounting policies.

In our opinion, except for the effects of the matter described in the Basis for Qualified Opinion section of our report, the accompanying financial statements present fairly, in all material respects, the financial position of The Neighbourhood Group Community Services as at March 31, 2024, and its results of operations and its cash flows for the year then ended in accordance with Canadian accounting standards for not-for-profit organization.

Basis for Qualified Opinion
In common with many charitable organizations, The Neighbourhood Group Community Services derives revenue from donations and fundraising activities the completeness of which is not susceptible to satisfactory audit verification. Accordingly, our verification of these revenues was limited to the amounts recorded in the records of The Neighbourhood Group Community Services and we were not able to determine whether any adjustments might be necessary to donation and fundraising revenue, excess of revenues over expenditures, and cash flows from operations for the year ended March 31, 2024, current assets and net assets as at March 31, 2024.

We conducted our audit in accordance with Canadian generally accepted auditing standards. Our responsibilities under those standards are further described in the Auditor's Responsibilities for the Audit of the Financial Statements section of our report. We are independent of the organization in accordance with the ethical requirements that are relevant to our audit of the financial statements in Canada, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our qualified opinion.

Emphasis of Matter
We draw attention to note 2 to the financial statements regarding a change in accounting policy.

Responsibilities of Management and Those Charged with Governance for the Financial Statements
Management is responsible for the preparation and fair presentation of the financial statements in accordance with Canadian accounting standards for not-for-profit organizations, and for such internal control as management determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, management is responsible for assessing the organization's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless management either intends to liquidate the organization or to cease operations, or has no realistic alternative but to do so.

Those charged with governance are responsible for overseeing the organization's financial reporting process.

5255 Yonge Street, Suite 700, Toronto, Ontario, M2N 6P4 Tel: (416) 221-7000 Fax: (416) 221-7005 Website: www.aklerbrowning.com

INDEPENDENT AUDITOR'S REPORT, continued

Auditor's Responsibilities for the Audit of the Financial Statements
Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with Canadian generally accepted auditing standards will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements. As part of an audit in accordance with Canadian generally accepted auditing standards, we exercise professional judgment and maintain professional skepticism throughout the audit. We also:

- Identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, design and perform audit procedures responsive to those risks, and obtain audit evidence that is sufficient and appropriate to provide a basis for our opinion. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control.

- Obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the organization's internal control.

- Evaluate the appropriateness of accounting policies used and the reasonableness of accounting estimates and related disclosures made by management.

- Conclude on the appropriateness of management's use of the going concern basis of accounting and, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast significant doubt on the organization's ability to continue as a going concern. If we conclude that a material uncertainty exists, we are required to draw attention in our auditor's report to the related disclosures in the financial statements or, if such disclosures are inadequate, to modify our opinion. Our conclusions are based on the audit evidence obtained up to the date of our auditor's report. However, future events or conditions may cause the organization to cease to continue as a going concern.

- Evaluate the overall presentation, structure and content of the financial statements, including the disclosures, and whether the financial statements represent the underlying transactions and events in a manner that achieves fair presentation.

We communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit and significant audit findings, including any significant deficiencies in internal control that we identify during our audit.

Akler Browning LLP

Chartered Professional Accountants
Licensed Public Accountants
Toronto, Canada
September 10, 2024

5255 Yonge Street, Suite 700, Toronto, Ontario, M2N 6P4 Tel: (416) 221-7000 Fax: (416) 221-7005 Website: www.aklerbrowning.com

THE NEIGHBOURHOOD GROUP COMMUNITY SERVICES
Statement of Financial Position
March 31, 2024

	2024	2023
Assets		
Current		
Cash	$ 9,069,852	$ 12,097,357
Cash in trust (note 3)	350,489	263,218
Marketable securities (note 4)	7,151,209	7,173,987
Accounts receivable (note 10)	5,529,150	4,161,589
Grants receivable	1,225,784	1,995,181
HST rebate receivable	531,313	1,588,916
Prepaids	355,937	225,491
Total Current	24,213,734	27,505,739
Property and equipment (note 5)	3,401,510	3,330,488
Total Assets	$ 27,615,244	$ 30,836,227
Liabilities		
Current		
Accounts payable and accrued liabilities (note 10)	$ 8,226,086	$ 6,720,234
Due to trustee participants	350,489	263,218
Deferred contributions (note 6)	10,881,112	13,711,651
Total Current	19,457,687	20,695,103
Deferred capital contributions (note 7)	291,248	489,738
Total Liabilities	19,748,935	21,184,841
Fund Balances		
Unrestricted fund	7,866,309	9,651,386
Total Liabilities and Fund Balances	$ 27,615,244	$ 30,836,227

Approved on behalf of the Board:

Director

Director

September 10, 2024
Date

THE NEIGHBOURHOOD GROUP COMMUNITY SERVICES
Statement of Changes in Fund Balances
Year ended March 31, 2024

	2024	2023
Fund balance, as previously stated	$ 9,651,386	$ 10,816,700
Prior period adjustment (note 2)	-	(700,472)
Fund balance, beginning of year, as restated	9,651,386	10,116,228
Deficiency of revenues over expenditures for the year	(1,785,077)	(464,842)
Fund balance, end of year	$ 7,866,309	$ 9,651,386

THE NEIGHBOURHOOD GROUP COMMUNITY SERVICES
Statement of Operations
Year ended March 31, 2024

	2024	2023
Revenues		
Fees		
Home and Community Care Support Services	$ 7,368,108	$ 5,552,367
Fees from users	4,619,408	5,082,063
City of Toronto	3,558,526	3,341,320
Grants		
Province of Ontario	24,414,794	23,006,048
City of Toronto	14,980,263	12,526,826
Government of Canada	10,411,883	9,174,078
United Way	1,317,271	1,553,631
Other		
Partner agencies	4,028,602	2,858,045
Trustee funds	2,687,677	3,175,573
Donations and fundraising events (note 10)	1,179,115	1,075,837
Investment	718,756	314,328
Amortization of deferred capital contributions (note 7)	209,076	216,546
Total revenues	75,493,479	67,876,662
Expenditures		
Wages	46,939,319	40,586,605
Benefits (note 12)	10,327,423	8,500,033
Program expenses	6,491,176	6,213,134
Occupancy costs (note 10)	4,961,544	4,202,959
Purchased services	2,763,426	2,996,585
Food services	1,794,039	1,601,835
Office and general	1,617,491	1,271,506
Employer wage subsidy and participant support	1,170,494	1,385,967
Amortization	817,570	725,402
Promotion and publicity	234,189	396,686
Travel	161,885	460,792
Total expenditures	77,278,556	68,341,504
Deficiency of revenues over expenditures for the year	$ (1,785,077)	$ (464,842)

THE NEIGHBOURHOOD GROUP COMMUNITY SERVICES
Statement of Cash Flows
Year ended March 31, 2024

	2024	2023
CASH FLOWS FROM OPERATING ACTIVITIES		
Deficiency of revenues over expenditures for the year	$ (1,785,077)	$ (464,842)
Adjustments for non-cash items		
Amortization	817,570	725,402
Amortization of deferred capital contributions	(209,076)	(216,546)
	(1,176,583)	44,014
Net change in non-cash working capital items		
Cash in trust	(87,271)	97,405
Accounts receivable	(1,367,561)	530,492
Grants receivable	769,397	(418,912)
HST rebate receivable	1,057,603	(767,215)
Prepaids	(130,446)	(113,070)
Accounts payable and accrued liabilities	1,505,852	1,088,422
Due to trustee participants	87,271	31,414
Deferred contributions	(2,830,539)	(5,142,007)
	(995,694)	(4,693,471)
Cash Used in Operating Activities	(2,172,277)	(4,649,457)
CASH FLOWS FROM INVESTING ACTIVITIES		
Marketable securities	22,778	(5,716,202)
Purchase of property and equipment	(888,592)	(866,547)
Cash Used in Investing Activities	(865,814)	(6,582,749)
CASH FLOWS FROM FINANCING ACTIVITIES		
Deferred capital contributions	10,586	5,813
Cash Provided by Financing Activities	10,586	5,813
Net decrease in cash	(3,027,505)	(11,226,393)
Cash, beginning of year	12,097,357	23,323,750
Cash, end of year	$ 9,069,852	$ 12,097,357

NATURE OF OPERATIONS

The mission of the organization is to work with individuals and communities in the City of Toronto to identify, prevent and eliminate social and economic inequality by creating and providing a range of effective and innovative programs. Existing programs aim to assist the most vulnerable members of our community: children, youth, seniors, newcomers to Canada, people who are homeless, people who are unemployed, people living in poverty, and people needing harm reduction supports.

The organization was incorporated as a non-profit corporation without share capital, is a registered charity and as such, is exempt from income taxation under Section 149(1)(f) of the Canadian Income Tax Act.

1. SIGNIFICANT ACCOUNTING POLICIES

These financial statements are prepared in accordance with Canadian accounting standards for not-for-profit organizations. The significant accounting policies are detailed as follows:

(a) Property and equipment

Property and equipment are accounted for at cost and amortized on a straight-line basis over their estimated useful life using the following durations:

Buildings	20 years
Leasehold improvements	5 - 45 years
Computer equipment	3 years
Equipment	5 years
Vehicles	3 years

(b) Impairment of long-lived assets

Property and equipment subject to amortization are tested for recoverability whenever events or changes in circumstances indicate that their carrying amount may not be recoverable. An impairment loss is recognized when the carrying amount of the asset exceeds the sum of the undiscounted cash flows resulting from its use and eventual disposition. The impairment loss is measured as the amount by which the carrying amount of the long-lived asset exceeds its fair value.

(c) Funds held in trust

The organization receives funds which it holds in trust to be disbursed in accordance with the terms of the underlying trust arrangement. In addition, the organization acts as administrator of funds for projects undertaken jointly with other agencies. The unexpended balances of such funds are shown as an asset and liability on the statement of financial position.

1. SIGNIFICANT ACCOUNTING POLICIES, continued

(d) Revenue recognition

The organization uses the deferral method of accounting for its revenue contributions in which restricted contributions related to expenditures of future periods are deferred and recognized as revenue in the period in which the related expenditures are incurred.

Fees, investment income and other revenues are recognized on the accrual basis.

The organization manages and mentors other not-for-profit organizations which includes signing agreements on the behalf of the organizations, receiving and disbursing funds to these organizations. The related revenue and expenditures including the fees earned to provide this service is recognized as revenue and expenditures of the unrestricted fund.

(e) Deferred capital contributions

Deferred contributions related to property and equipment represent restricted contributions for the purchase of buildings, leasehold improvements, equipment and vehicles. Deferred capital contributions are recognized as revenue on the same basis as the related property and equipment is being amortized.

(f) Government assistance

The organization was entitled to the Canada Emergency Wage Subsidy and the Canada Emergency Rent Subsidy, which are accounted for using the income approach. Under this approach, government subsidies are recognized as revenue in the period in which those expenses are incurred.

(g) Contributed materials and services

The organization would not be able to carry out its activities without the services of the many volunteers who donate a considerable number of hours. Due to the difficulty of compiling these hours, contributed services are not recognized in the financial statements. The fair market value of donated property and equipment is recognized as donation revenue in the year the property and equipment are donated, if the fair market value can be reasonably estimated.

(h) Use of estimates

The preparation of financial statements requires management to make estimates and assumptions that affect the reported amount of assets and liabilities and the reported amounts of revenues and expenditures for the periods covered. The main estimates relate to the estimated useful lives of the property and equipment and the impairment of financial assets.

1. SIGNIFICANT ACCOUNTING POLICIES, continued

(i) Financial instruments

Measurement of financial instruments

The organization initially measures its financial assets and liabilities at fair value, except for certain related party transactions that are measured at the carrying amount or exchange amount, as appropriate.

The organization subsequently measures all its financial assets and financial liabilities at amortized cost, except for investments in equity instruments that are quoted in an active market, which are measured at fair value. Changes in fair value are recognized in excess of revenues over expenditures in the period incurred.

Financial assets measured at amortized cost include cash, cash in trust, guaranteed investment certificate, accounts receivable, grants receivable and HST rebate receivable.

Financial liabilities measured at amortized cost include accounts payable and accrued liabilities and due to trustee participants.

Financial assets measured at fair value include investments in marketable securities, excluding guaranteed investment certificate.

Impairment

For financial assets measured at amortized cost, the organization determines whether there are indications of possible impairment. When there is an indication of impairment, and the organization determines that a significant adverse change has occurred during the period in the expected timing or amount of future cash flows, a write-down is recognized in excess of revenues over expenditures. A previously recognized impairment loss may be reversed to the extent of the improvement. The carrying amount of the financial asset may not be greater than the amount that would have been reported at the date of the reversal had the impairment not been recognized previously. The amount of the reversal is recognized in net excess of revenues over expenditures.

(j) Allocated expenses

The organization engages in various programs and services. The costs of each program includes the cost of personnel and other expenditures that are directly related to providing the services. The organization also incurs other expenditures that are common to the management and operations of the organization and each of its programs.

The organization allocates certain of its administration expenditures by identifying the appropriate basis of allocating each component expenditure, and applies the basis consistently each year according to contracts with the Federal, Provincial and Municipal governments.

2. CHANGE IN ACCOUNTING POLICY

The organization has elected to use the deferral method of revenue recognition which is one of the options available to not-for-profit organizations. This reporting option change has been retroactively applied to the organization's financial statements. As a result, total fund balances as at March 31, 2023 have been decreased by $489,738 and excess of revenues over expenditures as at March 31, 2023 have been increased by $210,734.

March 31, 2023	Previously reported	Adjustments	Restated
	$	$	$
Statement of Financial Position:			
Deferred capital contributions	-	489,738	489,738
Unrestricted fund	6,347,499	3,303,887	9,651,386
Property fund	3,793,625	(3,793,625)	-
Statement of Changes in Fund Balances:			
Total fund balances, beginning of year	10,816,700	(700,472)	10,116,228
Deficiency of revenues over expenditures for the year	(675,576)	210,734	(464,842)
Total fund balances, end of year	10,141,124	(489,738)	9,651,386
Statement of Operations:			
Amortization of deferred capital contributions	-	216,546	216,546
Partner agencies revenue	2,861,265	(3,220)	2,858,045
Grants - City of Toronto	12,529,418	(2,592)	12,526,826
Deficiency of revenues over expenditures for the year	(675,576)	210,734	(464,842)

3. CASH IN TRUST

As of March 31, 2024, the organization held funds in trust in the amount of $350,489 (2023 - $263,218) on behalf of its trustee clients.

4. MARKETABLE SECURITIES

	2024	2023
Measured at amortized cost		
Guaranteed investment certificate	$ 42,079	$ 406,463
Measured at fair value		
Money market funds	-	2,748,518
Canadian fixed income funds	3,302,477	1,969,393
Foreign fixed income funds	1,097,494	499,776
Canadian equities funds	1,277,290	868,157
Foreign equities funds	1,431,869	681,680
	$ 7,151,209	$ 7,173,987

5. PROPERTY AND EQUIPMENT

			2024	2023
	Cost	Accumulated amortization	Net	Net
Land	$ 600,000	$ -	$ 600,000	$ 600,000
Buildings	2,915,745	2,915,744	1	1
Leasehold improvements	4,571,732	2,485,126	2,086,606	1,812,197
Computer equipment	1,497,642	980,078	517,564	603,118
Equipment	1,041,552	889,427	152,125	237,645
Vehicles	264,814	219,600	45,214	77,527
	$ 10,891,485	$ 7,489,975	$ 3,401,510	$ 3,330,488

6. DEFERRED CONTRIBUTIONS

	2024	2023
City of Toronto	$ 4,872,024	$ 2,893,457
Government of Canada	4,828,011	9,530,541
Foundations and other	916,486	901,716
Province of Ontario	264,591	385,937
	$ 10,881,112	$ 13,711,651

7. DEFERRED CAPITAL CONTRIBUTIONS

	2024	2023
Balance, beginning of year	$ 489,738	$ 703,692
Additions	10,586	2,592
Amortization of deferred capital contributions	(209,076)	(216,546)
Balance, end of year	$ 291,248	$ 489,738

8. GOVERNMENT ASSISTANCE

Included in Government of Canada revenue and deferred contributions respectively, is $4,445,080 (2023 - $4,047,682) and $4,828,011 (2023 - $9,273,091) of government assistance related to subsidies received in prior years under the Canada Emergency Wage Subsidy and Canada Emergency Rent Subsidy programs.

9. CONTRACTUAL OBLIGATIONS

The organization's total obligations, under property lease agreements for its existing premises and for software under an operating lease are summarized as follows:

Leased Premises
The organization is obligated under various property lease agreements, exclusive of occupancy costs as follows:

2025	$ 1,614,673
2026	1,553,709
2027	1,473,897
2028	1,033,134
2029	994,510
Subsequent years	3,357,885
	$ 10,027,808

Software
The organization is obligated to minimum subscription fees under a payroll software agreement as follows:

2025	$ 348,909
2026	186,682
	$ 535,591

10. ORGANIZATIONS UNDER SIGNIFICANT INFLUENCE

The organization exercises significant influence over The Neighbourhood Group Foundation and Neighbourhood Link Homes by sharing management and administrative resources. Transactions with The Neighbourhood Group Foundation and Neighbourhood Link Homes are in the normal course of operations and are measured at the exchange amount, which is the amount of consideration established and agreed to by the parties.

The Neighbourhood Group Foundation was incorporated with a general object to undertake charitable work within Canada, and is a registered charity under the Income Tax Act. Included in donations and fundraising events is $344,349 (2023 - $405,041) received from The Neighbourhood Group Foundation. Included in accounts receivable is $Nil (2023 - $270,316) owing from The Neighbourhood Group Foundation. Included in accounts payable is $44,813 (2023 - $Nil) owing to The Neighbourhood Group Foundation.

Neighbourhood Link Homes, was incorporated with the object to deal in residential property to provide adequate living accommodation for elderly persons, to provide social and recreational facilities for elderly persons and to promote understanding and undertake problems of the elderly, and is a registered charity under the Income Tax Act. Included in occupancy costs are amounts paid to Neighbourhood Link Homes of $250,785 (2023 - $252,668). Included in accounts receivable is $2,849,332 (2023 - $2,178,967) owing from Neighbourhood Link Homes.

11. CREDIT FACILITIES

A revolving line of credit to a maximum of $650,000 is available to the organization. The line of credit bears interest at the bank's prime lending rate plus 0.5%, is due on demand and is secured by a general security agreement covering all assets of the organization and a collateral mortgage on the property located at 260 Augusta Avenue. As at March 31, 2024, the credit balance amounted to $Nil (2023 - $Nil).

12. PENSION PLAN

The organization participates in a multi-employer defined contribution pension plan, which includes certain full time and part time employees. The organization also contributes to a defined contribution plan which was established for its remaining full time and part time employees. Participation in these plans is mandatory. Contributions made by the organization are recognized as benefits expense in the Statement of Operations.

13. FINANCIAL INSTRUMENTS

Transactions in financial instruments may result in an entity assuming or transferring to another party one or more of the financial risks described below. The required disclosures provide information that assists users of financial statements in assessing the extent of risk related to financial instruments.

(a) Liquidity risk

Liquidity risk is the risk that the organization will encounter difficulty in meeting obligations associated with financial liabilities. The organization is exposed to this risk mainly in respect to its trade accounts payable and accrued liabilities. The organization expects to meet these obligations as they come due by generating sufficient cash flow from operations combined with the receipt of fees and grants from its funders.

13. FINANCIAL INSTRUMENTS, continued

(b) Credit risk

Credit risk is the risk that one party to a financial transaction will cause a financial loss for the other party by failing to discharge an obligation. The organization's main credit risk relates to accounts and grants receivable and HST rebate receivable.

(c) Market risk

Market risk is the risk that the fair value or future cash flows of a financial instrument will fluctuate because of changes in market prices. Market risk comprises three types of risk: currency risk, interest rate risk and other price risk. The organization has exposure to interest rate and other price risk.

(i) Interest rate risk

Interest rate risk is the risk that the fair value or future cash flows of a financial instrument will fluctuate because of changes in market interest rates. Fixed rate instruments subject the organization to a fair value risk while the floating rate instruments subject the organization to cash flow risk. The organization is exposed to this type of risk as a result of its variable rate credit facility and investments in fixed income funds and guarantee investment certificates. The exposure to these risks also fluctuates as the debts and investments change from year to year.

(ii) Other price risk

Other price risk is the risk that the fair value or future cash flows of a financial instrument will fluctuate because of changes in market prices (other than those arising from interest rate risk or currency risk), whether those changes are caused by factors specific to the individual financial instrument or its issuer, or factors affecting all similar financial instruments traded in the market. The organization is exposed to other price risk through its investments in marketable securities for which the value fluctuates with the quoted market price.

14. COMPARATIVE AMOUNTS

The financial statements have been reclassified, where applicable, to conform to the presentation used in the current year. The changes do not affect prior year earnings.

This is **Exhibit "C"** to the Affidavit of Bill Sinclair,
sworn January 9, 2024

A Commissioner for oaths, etc.

Province of ONTARIO

By the Honourable JOHN T. CLEMENT,

MINISTER OF CONSUMER AND COMMERCIAL RELATIONS

To all to whom these Presents shall come

Greeting

Whereas *The Corporations Act provides that with the exceptions therein mentioned the Lieutenant Governor may in his discretion, by Letters Patent, issue a Charter to any number of persons, not fewer than three, of* eighteen ~~twenty-one~~ *or more years of age, who apply therefor, constituting them and any others who become shareholders or members of the corporation thereby created a corporation for any of the objects to which the authority of the Legislature extends;*

And Whereas *by the said Act it is further provided that the member of the Executive Council to whom the administration of this Act is assigned may in his discretion and under the Seal of his office have, use, exercise and enjoy any power, right or authority conferred by the said Act on the Lieutenant Governor;*

And Whereas *it has been made to appear that the persons herein named have complied with the conditions precedent to the issue of the desired Charter and that the said undertaking is within the scope of the said Act;*

Now Therefore Know Ye *that, being the member of the Executive Council to whom the administration of this Act is assigned,*
I do by these Letters Patent *issue a Charter to the Persons hereinafter named that is to say:*

Arthur Hilton Peacock, Retired Administrator; Lorne Brown, School Principal; Douglas Ball, Verger; Campbell Alexander Russell, Priest; Leslie Leone Oliveira, Social Worker; and Richard Brian Lawrie, Research Assistant; all of The Municipality of Metropolitan Toronto, in the Province of Ontario; constituting them and any others who become members of the Corporation hereby created a corporation without share capital under the name of

ST. STEPHEN'S COMMUNITY HOUSE

for the following objects, that is to say:

(a) TO operate a community house in the said The Municipality of Metropolitan Toronto and to carry on such charitable services as would promote the physical, social and spiritual needs of the community, either in connection or not in connection with the operation of such house as may from time to time be deemed advisable by the board of directors; (b) TO do all such things as are incidental or conducive to the attainment of the above objects and in particular subject to The Charitable Gifts Act and The Mortmain and Charitable Uses Act: 1. TO receive and maintain property either real or personal and to apply from time to time all or part thereof and/or the income therefrom for such objects; 2. TO use,

apply, give, devote or distribute from time to time all or part of the said property and/or the income therfrom for such objects by such means as may from time to time seem expedient to its directors; 3. For the further attainment of the above objects, to acquire, accept, solicit or receive, by purchase, lease, contract, donation, legacy, gift, grant, bequest or otherwise, any kind of real or personal property, and to enter into and carry out agreements, contracts and undertakings incidental thereto; 4. For the further attainment of the above objects, to hold, manage, sell, lease, mortgage or convert any of the real or personal property from time to time owned by the Corporation and to invest and re-invest moneys in such investments as the directors in their absolute discretion may deem advisable without being limited to investments authorized by law for the investment of trust funds and to retain any real or personal property in the form in which it may be when received by the Corporation for such length of time as may be deemed best; 5. For the further attainment of the above objects, to draw, make, accept, endorse, execute and issue cheques, promissory notes, bills of exchange and other negotiable or transferable instruments; 6. For the further attainment of the above objects, to demand, receive, sue for, recover and compel the payment of all sums of money that may become due and payable to the Corporation, and to apply the said sums for the objects of the Corporation and generally to sue and be sued; and 7. For the further attainment of the above objects, to employ and pay such social workers, assistants, agents,

representatives and employees, and to procure, equip and maintain such offices and other facilities and to incur such expenses, as may be necessary; and

(c) For the objects aforesaid, to acquire and take over as a going concern the undertaking heretofore carried on in the said The Municipality of Metropolitan Toronto and elsewhere of the unincorporated association known as St. Stephen's Community House;

PROVIDED, however, that it shall not be lawful for the Corporation hereby incorporated directly or indirectly to transact or undertake any business within the meaning of The Loan and Trust Corporations Act;

THE HEAD OFFICE of the Corporation to be situate at the City of Toronto, in the said The Municipality of Metropolitan Toronto; and

THE FIRST DIRECTORS of the Corporation to be Arthur Hilton Peacock, Lorne Brown, Douglas Ball, Campbell Alexander Russell, Leslie Leone Oliveira and Richard Brian Lawrie, hereinbefore mentioned;

AND IT IS HEREBY ORDAINED AND DECLARED that the Corporation shall be carried on without the purpose of gain for its members and any profits or other accretions to the Corporation

shall be used in promoting its objects;

AND IT IS HEREBY FURTHER ORDAINED AND DECLARED that, upon the dissolution of the Corporation and after the payment of all debts and liabilities, its remaining property shall be distributed or disposed of to charitable organizations which carry on their work solely in Ontario;

AND IT IS HEREBY FURTHER ORDAINED AND DECLARED that the directors shall serve as such without remuneration, and no director shall directly or indirectly receive any profit from his position as such; provided that a director may be paid reasonable expenses incurred by him in the performance of his duties.

Given *under my hand and Seal of office at the City of Toronto in the said Province of Ontario this* eighteenth *day of* March *in the year of Our Lord one thousand nine hundred and* seventy-four.

Minister of Consumer and
Commercial Relations

Dated March 18, *A.D.* 1974

Province of ONTARIO

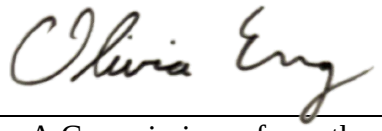
Letters Patent

Incorporating

ST. STEPHEN'S COMMUNITY HOUSE

Recorded *this* 23RD.
day of MAY *A.D.* 1974
as Number 288925

This is **Exhibit "D"** to the Affidavit of Bill Sinclair,
sworn January 9, 2024



A Commissioner for oaths, etc.

Statement from the Minister of Health Regarding the Opioid Crisis

From: Health Canada

Statements

Today, the Honourable Ginette Petitpas Taylor, Minister of Health, issued the following statement:

"I am concerned and saddened by the latest data on opioid-related overdose deaths from Ontario.

"Each opioid-related death is a lost family member, friend, community member and Canadian. We must all take a moment to acknowledge the immense loss for the communities and families impacted by this crisis across this country.

"These numbers confirm that the current crisis is worsening despite our collective efforts to date. Every day, individual Canadians from all walks of life and all parts of the country are losing their lives to this crisis. And the numbers continue to climb. I believe this crisis requires a comprehensive whole-of-government response. It is absolutely critical that we address both the immediate crisis and the longer-term factors at the roots of problematic substance use.

"As Canadians may be aware, last month I announced that Health Canada would authorize emergency overdose prevention sites for those provinces and territories that request them. These facilities are meant as an immediate short-term response to save lives. Today, the Government of Ontario formally requested approval for overdose prevention facilities in the province. I have already spoken with Ontario Health Minister Dr. Eric Hoskins to discuss the situation. I am pleased to say that Health Canada has now received all of the documentation from Ontario and has granted its request for a class exemption. This emergency measure echoes the efforts taken in British Columbia to address the crisis in that province.

"These overdose prevention sites are one step in what has been and will continue to be a concerted and urgent response to this crisis.

"This crisis is unlike any other public health crisis we have experienced in recent years. For that reason, I am committed to moving quickly on my mandate to review Canada's framework for dealing with public health emergencies in collaboration with the Minister of Public Safety and Emergency Preparedness. Through this review, I have asked Health Canada and the Public Health Agency of Canada to identify any additional measures or powers that would help me, as Minister of Health, address the current crisis and any similar crisis in future.

"I am committed to making sure that we have the appropriate resources and tools needed to address this crisis. Whether it is increasing access to treatment services for all Canadians, reducing systemic barriers like stigma that prevent people from receiving help, or expanding the evidence base to inform and evaluate our response, the Government of Canada will continue to work hand-in-hand with the provinces and territories, health professionals, front-line workers and people with lived and living experience to reverse the trend of opioid overdoses and deaths in Canada."

Contacts

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Office of the Honourable Ginette Petitpas Taylor
Minister of Health
613-957-0200

Media Relations

Health Canada
613-957-2983

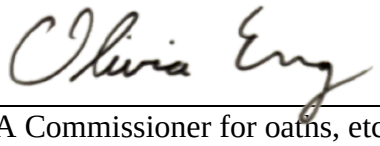
Public Inquiries:

- 613-957-2991
- 1-866-225-0709

Search for related information by keyword: Drug use | Health Canada | Ontario | Healthy living | general public | media | statements | Hon. Ginette Petitpas Taylor

Date modified:
2017-12-07

This is **Exhibit "E"** to the Affidavit of Bill Sinclair,
sworn January 9, 2024



A Commissioner for oaths, etc.

St. Stephen's Community House

BOARD OF DIRECTORS

Date: Thursday, January 18, 2018
Time: **6:00 – 8:00 p.m.**
Location: 1415 Bathurst Street
2nd Floor Workshop Room

REVISED AGENDA

6:00 p.m.	**1. Welcome & Announcements**	Howard Green
6:05 p.m.	**2. Consent Agenda** 2.1. Minutes of December 14, 2017 Meeting and Business Arising 2.2. Motion: Expression of Interest – Lansing Child Care Site	Howard Green
6:20 p.m.	**3.** Request to apply to province for **Overdose Prevention Site** 3.1. Discussion and motion	Lidia Monaco/ Lorie Steer
7:00 p.m.	**4. Committee Reports** 4.1. Quality Committee 4.1.1. Youth Program Audit 4.1.2. Quality Committee Strategic Plan Directions 4.2. HR Committee 4.2.1. Bill 148 Implications 4.3. Strategic Planning Working Group 4.3.1. Update on January Innovation Training 4.4. Advocacy Committee 4.4.1. City Budget Deputations 4.4.2. Shelter Crisis Reveals Health Crisis Press Release	Sonia Yung/ Sarah Doyle Cathy Hennessey Zahra Ebrahim Yuko Sorano
7:40 p.m.	**5. Executive Director Report** 5.1. Update on Management Compensation Review 5.2. Short Term Action Plan on the Budget 5.3. Contingency Plan for 1415 Bathurst Leases	Bill Sinclair
7:50 p.m.	**6. Other Business** 6.1. Directors & Officers Insurance 6.2. Anti-Harassment Policy	Bill Sinclair
8:00 p.m.	**7. Adjournment**	Howard Green

Next Meeting: February 15, 2018

Memo January 15, 2018

To: The Board of Directors From: Senior Management

St. Stephen's Community House has been engaged in the overdose crisis in Toronto for several years. We have lost many program participants to overdose, and even more of our tenants and participants have lost friends and family.

As an organization we have been supportive of our sister organizations such as *Queen West Community Health Centre* opening Safe Injection Sites. We have also supported the emergency overdose prevention site in Moss Park through volunteers and supplies. Our site is now a harm reduction site where people who use drugs can get support & information, clean, free supplies, and help in an overdose crisis (health care and Naloxone).

As the crisis has grown, the Board has discussed applying to become a **Safe Injection Site** as well. We have been following the efforts of *Fred Victor Centre* in downtown east Toronto as they have worked for 'fast-track' permission and funding.

On Thursday, January 11th, the Province of Ontario has released a clear, funded and legal application process for creating **Temporary Overdose Prevention Sites** (**OPS**) for periods of up to 6 months. This is the legal and provincially supported pathway we have been waiting for. The provincial legal approval and funding answer two of our four concerns identified by the Board. The other two were worker safety, and neighbourhood response. We will address all four in the Board presentation.

In this package are the provincial guidelines for OPS and a FAQ prepared by the Housing & Homeless Staff Team. Staff are seeking approval to apply to be a **temporary overdose prevention site** at 260 Augusta Avenue to supplement the three safe injection sites (Toronto Public Health 277 Victoria Street, Queen West Community Health Centre 168 Bathurst Street, South Riverdale Community Health Centre 955 Queen Street East) in terms of hours and location. Subject to government approval and the resolution of worker safety and neighbourhood consultations, SSCH services would be open March 1st in our existing space, four hours a day, six days a week (*7:30 – 11:30 am, Sunday to Friday*). Although it is hard to predict, we estimate 3-10 users of the service per day.

We hope at the Board meeting to identify and answer concerns.

Thank you.

St. Stephen's Community House

Overdose Prevention Service

FAQ

(image from the OPS in Moss Park)

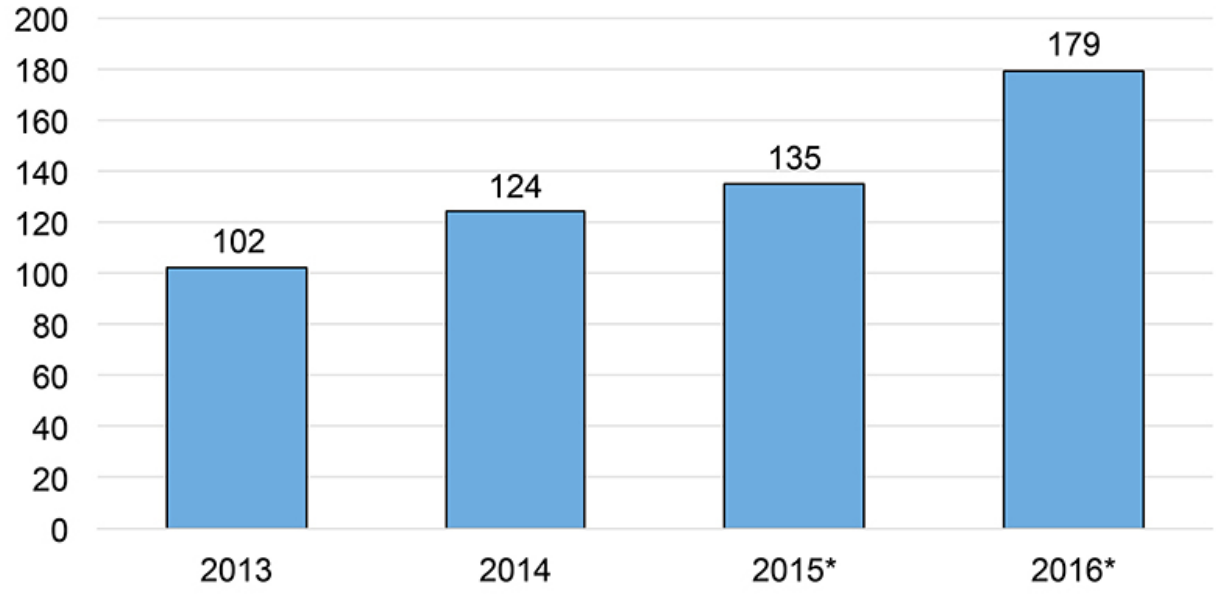
What is an overdose prevention service (OPS)?

Overdose prevention services are health services that provide a safer and hygienic environment for people to inject pre-obtained drugs under the supervision of staff. In addition to supervised injection, individuals are provided with sterile injection supplies, education on safer injection, overdose prevention and intervention, and referrals to drug treatment, housing, income support and other services. An OPS differs from Supervised Injection Sites (SIS) in that they are **a temporary, interim measure** to deal with emergency situations. An OPS, like an SIS, obtains an exemption from existing Canadian laws around illegal drugs in order to legally provide these services.

Why do we need overdose prevention services in Toronto?

Research has concluded that Toronto would benefit from multiple supervised injection services that are integrated into services already working with people who inject drugs. There is a high demand for harm reduction services in Toronto. In 2015, there were over 100,000 client visits to harm reduction services, and almost 1.9 million needles were distributed.

Overdoses in Toronto are on the rise. Total overdose deaths in Toronto reached an all-time high in 2014, increasing 77 per cent over a decade to 258 deaths. Of those, 131 were opioid-related (e.g. heroin and fentanyl), according to a new provincial data-tracking site. That number rose again to 135 opioid deaths in 2015, and rose again in 2016 (see below).



Annual number of accidental opioid toxicity deaths, Toronto, 2013 to 2016* * Data are preliminary. Source: Office of the Chief Coroner for Ontario. Number of Toxicity Deaths in Toronto – Accidental Manners of Death. 2013 to 2016. Received September 2017.

Preliminary data shows that the death toll for 2017 will surpass previous years. From May to July 2017, there were 336 opioid-related deaths in Ontario, compared with 201 during the same time period in 2016, representing a 68 per cent increase. From July to September 2017, there were 2,449 emergency department visits related to opioid overdoses, compared with 1,896 in the three months prior, representing a 29 per cent increase.[1] Rates of HIV (11%) and hepatitis C (66%) infection[2] among people who inject drugs are much higher than for the general population. In addition, a Toronto study found 54% of people who use drugs reported injecting in public places such as washrooms and alleyways.[3]

What is the new service being proposed at our 260 Augusta site?

SSCH is planning to add a small-scale, legal, fully-funded OPS to its existing drop-in services for people who inject drugs. This is a different model than Vancouver's InSite. The service will be located on the below ground floor within the agency's existing program space. The funding offered by the Ministry of Health includes only small amounts for capital costs so there will be no changes to the floor plan of the drop-in. With the opening of the new Peer Training Centre at 258 Augusta office space has been freed up that we can easily transform in to an Overdose Prevention Service. The space for the service will include an intake/assessment area, an injection room with 2 supervised injection booths and an adjoining post-injection area. The services will be open 6 days per week and hours will be aligned with drop-in hours. It will be staffed by a coordinator, who will be the Designated Person responsible for overseeing all operations at the OPS as per the funding requirements, and part time harm reduction peer workers. We already have a nurse on site for the hours the OPS will be operating. The funding for

[1] http://www.health.gov.on.ca/en/news/bulletin/2018/hb_20180111.aspx
[2] https://www.canada.ca/en/public-health/services/diseases/hiv-aids/surveillance-hiv-aids/itrack-enhanced-surveillance-hiv-hepatitis-associated-risk-behaviours-people-who-inject-drugs-canada-phase-3.html
[3] http://www.stmichaelshospital.com/pdf/research/SMH-TOSCA-report.pdf

these staff positions will be provided by the Ministry of Health.[4] Staff at the drop-in will also provide support for the clients who use the service. Most of the people using the service will be existing clients.

Clients will arrive at the service with pre-obtained drugs. Clients will be assessed to ensure they are eligible for the service. Upon each visit, clients will undergo a pre-injection assessment to determine their current health status, individual needs, safer injection knowledge and ability, risk of drug overdose or other harm and the type/amount of drug they intend to use. Upon completion of the assessment they will be given sterile injecting equipment and instruction on safer injecting practices if needed. OPS staff will then supervise their injection in a room dedicated for this purpose (i.e. injection room), and intervene in the case of any medical emergencies. Once the individual has injected their drugs they will be directed to a post injection space, for users of the services only, where they will continue to be observed for any negative drug reactions.

Clients of the service will have direct referral access to the Centre's housing, case management, primary care and wellness programs and will also receive information and referrals to external health, social and drug treatment supports/services and will be engaged about accessing those resources by OPS staff.

We do not anticipate the need for any safety protocols beyond the ones already in place in the drop-in. Staff at H&H are trained to handle incidents of escalated client behaviour, and we have policies and procedures in place to address needle stick injuries, debriefing incidents, and when to call 911. OPS staff would have additional training in administering naloxone, and monitoring overdose. The Ministry also provides an Overdose Prevention Site (OPS) Policies and Procedures Toolkit that we would follow. If necessary, we can also call on our community partners at Parkdale Queen West CHC to ensure appropriate infection prevention and control practices are in place.

Where will the money come from?

The information we have received from the Ministry of Health is that they will fully fund this expansion of service. They have created a funding guideline (see footnote #4) and we are in touch with staff there to determine how those guideline might work for SSCH. As we already provide naloxone and harm reduction supplies, provided for free through the City of Toronto, the only addition to our service is the space for supervised injection. We would apply for staffing costs (one full time coordinator and some part time peer workers), admin, and overhead costs, and a small start-up grant to purchase stainless steel injecting booths. As far as we are aware at this time, there will be no changes to our insurance policy due to this expansion of service.

Will the OPS increase crime in our neighbourhood?

No. Supervised injection services do not contribute to more crime. They are located in neighbourhoods where there is a demonstrated need, usually where drug use is already having an impact on the community. There is considerable research on this subject. For example, in the neighbourhood around InSite in Vancouver, there has been no increase in crime, and actual decreases in vehicle break-ins and thefts.[5] It is also our expectation that we will receive fewer complaints from our neighbours as drug users in our community will be using our service instead of using their drugs in public places.

[4] http://www.health.gov.on.ca/en/news/bulletin/2018/docs/hb_20180111_ops_user_guide.pdf
[5] http://www.communityinsite.ca/pdf/impact-on-drug-related-crime.pdf

Will the supervised injection encourage drug use?

No. There is no evidence that the provision of supervised injection services encourages increased drug use or initiates new users. There is little evidence that by providing better conditions for drug consumption they perpetuate drug use in clients who would otherwise discontinue consuming drugs such as heroin or cocaine, nor that they undermine treatment goals. In fact, research at InSite in Vancouver has indicated that services such as these can often lead to a decrease in drug use by service users.[6] Research in Europe and Vancouver identifies that when managed in consultation and cooperation with local authorities and police, they do not increase public order problems by increasing local drug scenes or attracting drug users and dealers from other areas.[7]

Is there an opportunity for community input? What is our Communication Strategy?

In the spring of 2016, the three Toronto SIS sites hired an independent consulting company (MASS LBP) to conduct community consultations. The report on their combined consultation activities and findings can be found in the June 16, 2016 *Board of Health Report – Implementing Supervised Injection Services in Toronto* (https://www.toronto.ca/legdocs/mmis/2016/hl/bgrd/backgroundfile-94548.pdf) SSCH will, in part, be using this feedback to help inform the development of an OPS at our Augusta site. We will also expand on it and be soliciting feedback from local residents and businesses. We have already met with our local councilor, Joe Cressy, and secured his unqualified support for our initiative. He has also confirmed he will use his knowledge from the Queen West process to ensure our process is just as smooth.

SSCH wants to continue to be a good neighbour and build on the strong community relationships we have now. Engaging with the local community is an important part of the process of expanding this existing service. We want to ensure people have accurate information about the service, and an opportunity to raise any issues or concerns that need to be addressed. To that end we'll be communicating these program changes with the local BIA and other groups, many of whom have already received overdose prevention training and have expressed concern about escalating rates of overdose in the city.

In addition, SSCH will have a designated contact person, the Manager of Housing and Drop-in Services, who community members can call with concerns and who would be available to facilitate a response. The Centre will also regularly reach out and engage the community in a planned and thoughtful way to ensure they are provided with updates and that concerns are addressed quickly. A variety of methods, including sharing information via SSCH web site and display boards within the centre, attending meetings of the Community Policing Liaison Committee, the BIAs, local Residents Associations, etc., will be utilized to share implementation and operational information and gather input.

What is the process/timeline for this service at St. Stephen's?

On January 10, 2018 the Ministry of Health released the application form and guidelines for applying for an OPS exemption for agencies already providing harm reduction services to add an

[6] http://www.communityinsite.ca/pdf/Injection%20cessation%20and%20insite_in%20press%20article%202010.pdf
[7] http://www.communityinsite.ca/pdf/changes-in-public-order.pdf

OPS. We have already been considering an application to the more permanent SIS exemption and so are very well placed to submit an OPS exemption to the province very shortly after Board approval. We already have a great deal of experienced staff at SSCH who have volunteered their time at the OPS in Moss Park and therefore expect that staff recruitment could be done very quickly.

The Ministry has committed to responding to applicants within 14 days of the application submission. Providing we are not required to amend our application, we expect we could begin providing this new service by March 1 of this year, depending on how quickly the money flows from the province.

How would our service compliment the SISs already in place in the city?

Three sites in Toronto already have federal exemption from Health Canada and funding from the province to open an SIS, and two of them, the Works and South Riverdale Community Health centre, already has. Parkdale – Queen West Community Health Centre is the third agency to obtain an exemption and will be opening in the near future. There are also other agencies that are working on submitting an application for an exemption, for example Fred Victor Centre and Regent Park CHC.

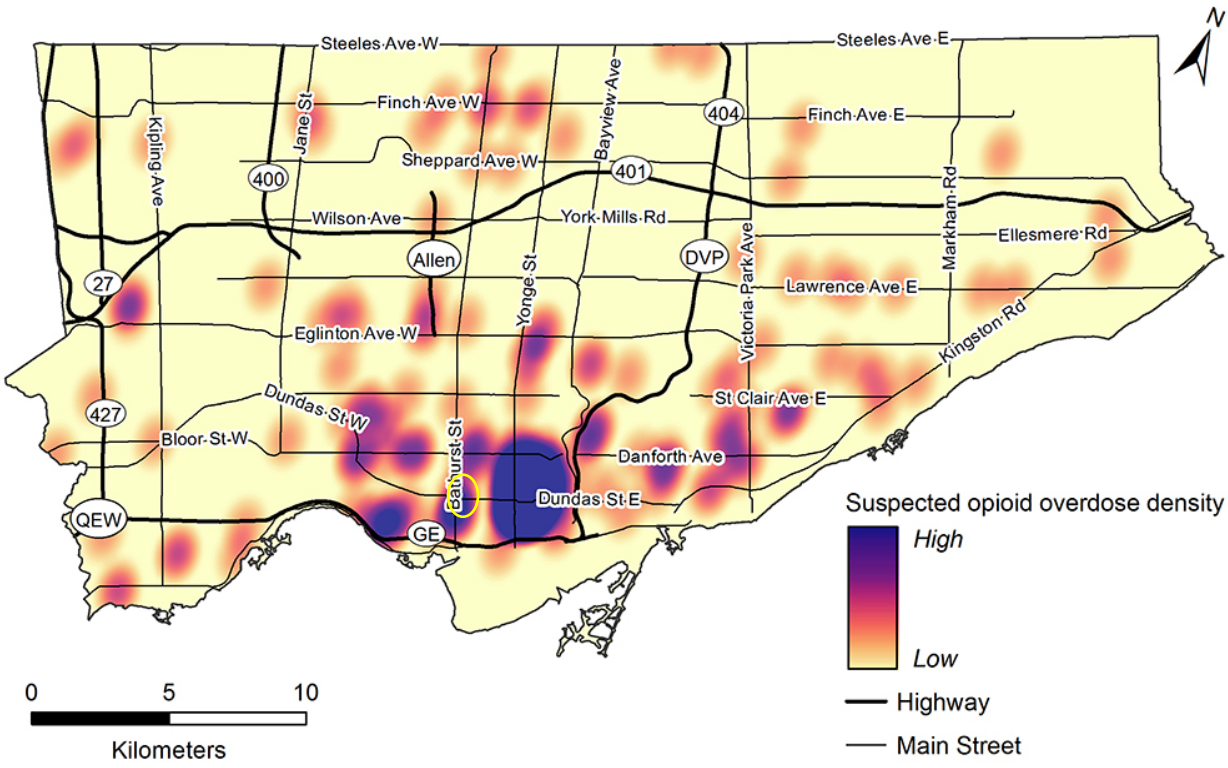
A service at SSCH would fill a need as we are open in the morning before most other services. We are also the only service of this kind in the Kensington Market area. City data (see below) shows us that we are in a moderately high drug using area of the city and expect that this service would be well used.

Are there any benefits to these services?

International and Canadian research shows that supervised injections services have benefits both for individuals using the services and for 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;
- Reducing the amount of publicly discarded needles;
- Cost-effectiveness; and,
- Not contributing to crime or increased drug use in the local community

Map of suspected opioid overdose calls received by Toronto Paramedic Services, Toronto, November 1 to 30, 2017



Prepared by Surveillance & Epidemiology Unit, Toronto Public Health.
Source: Toronto Paramedic Services. Electronic Patient Care Record. November 1 to 30, 2017. Extracted December 5, 2017.

Overdose Prevention Sites: User Guide for Applicants

Population and Public Health Division
Ministry of Health and Long-Term Care

January 2018

Ontario

INTRODUCTION

On November 15, 2017, the federal Minister of Health announced the federal government's new strategy to address the opioid crisis, which includes working with provinces and territories to establish a streamlined protocol for temporary exemptions under Section 56(1) of the *Controlled Drugs and Substances Act (CDSA)* for overdose prevention sites.

On December 7, 2017, Health Canada issued an exemption to the Minister of Health and Long-Term Care to establish temporary Urgent Public Health Need Sites (referred to as Overdose Prevention Sites) in Ontario. As such, the Ministry of Health and Long-Term Care (MOHLTC) will establish Overdose Prevention Sites (OPS) on a time limited basis (3 to 6 months), with the possibility of extension. **OPS are intended as low barrier, life-saving, time-limited services. OPS offer targeted services in order to address the crisis in opioid related overdoses.**

Successful OPS applicants will enter into a legal agreement with the MOHLTC or a Local Health Integration Network (LHIN) that will cover the required terms and conditions, including the services permitted at the OPS.

Overdose prevention sites **will** provide the following services:

- Supervised injection;
- Naloxone; and
- Provision of harm reduction supplies including, but not limited to needles, syringes and other safe drug use equipment, and the disposal of used harm reduction supplies.

OPS **can** provide or permit the following services based on local need and capacity:

- Peer to peer assisted injection;
- Supervised oral and intranasal drug consumption; and/or
- Fentanyl test strips as a drug checking service.

The OPS exemption does not cover supervised inhalation services.

The *Overdose Prevention Sites: User Guide for Applicants* provides an overview of the process involved to receive provincial approval and funding to establish OPS. The guide also provides information on program delivery requirements under the Health Canada exemption and the provincial criteria used to assess each applicant's ability to address these requirements.

The *OPS Application Form* assists applicants with the necessary information to facilitate the application review process. Note that applicants do not need to apply for a federal exemption.

THE APPLICATION PROCESS

Stage One: Program Application Review and Approval

Program Model Minimum Requirements

Applications must demonstrate the following minimum requirements:

a) Site is led by an incorporated healthcare or community based organization, or partners with one (referred to as a co-applicant)[1], that works with individuals who use drugs. Preference will be given to those who currently offer harm reduction services.
   - If there is a co-applicant:
     - The relationship between the applicant and co-applicant must be provided;
     - A letter from the co-applicant which describes how they will support the overdose prevention site must be submitted with the application[2].

b) Site must have a Designated Person[2] who is responsible for overseeing all operations, including staff members at the OPS

c) Evidence demonstrating local need:
   - Opioid-related morbidity and mortality data (may be obtained from Coroner's data, Public Health Ontario's Opioid Tracker, and/or other data sources);
   - Approximate number of expected clients visiting the OPS per day;
   - Other data to indicate local need for the OPS (as determined by the applicant)

d) Letter of permission from the land/property owner to operate an OPS on-site if the applicant does not own the property;

e) Applicant has the space to operate an OPS with minimal or no capital start-up costs required[3]:
   - Floor plan is provided with the application
   - Please indicate if there is access to washroom facilities and a sink.

f) Site meets municipal bylaws and provincial regulations for accessibility;

g) Physical safety and security measures are in place to ensure client, staff and community safety:

[1] If the applicant is not an incorporated health care or community based organization (i.e. a legal entity capable of entering into contracts) that works with individuals who use drugs and offers harm reduction services, it will require a co-applicant for the overdose prevention site. The co-applicant must be willing to enter into a legal agreement and assume accountability for OPS operations, including funding, etc.
[2] The Designated Person must, before the OPS is operational, provide: a résumé including relevant education and training; a criminal record check issued by a Canadian police force; and, a document(s) issued by a police force of another country, if the person has lived outside of Canada within the preceding 10 years.
[3] The space can be a permanent building or a mobile site such as a trailer.

- Meets provincial and municipal safety requirements
- Fire safety plan is in place
- EMS, first responders, and fire service have access to and within the site

h) Minimum of two employees, with CPR and naloxone training, are required to be on-site at all times, with one designated health professional available as determined by the applicant (e.g. on-call or onsite);

i) Applicant has established relationships with other service providers that can provide staff or other support to the OPS as needed.

Successful applicants must also comply with the terms and conditions set out by Health Canada in exemptions under Section 56(1) of the *Controlled Drugs and Substances Act* (CDSA) in relation to overdose prevention sites in Ontario[4] (see Appendix A).

Provincial Funding for OPS

As part of the application process, applicants will identify the duration of the OPS they are applying for (3 or 6 months) and the site's proposed days/hours of operation. This will vary for each OPS based on local need and capacity.

To support applicants develop their OPS model of service, the ministry developed an OPS Funding Guide (see Table 1). While the table presents three potential OPS models, the ministry will consider OPS with less days/different hours of operation. Funding allocations for an approved OPS will, however, fall within the parameters outlined in the OPS Program Funding Guide (excluding minimal capital start-up costs, if applicable).

Table 1: OPS Program Funding Guide

Length	7 hours / day 7 days / week	12 hours / day 7 days / week	24 hours / day 7 days / week
3 months	$61,100	$97,350	$184,350
6 months	$122,200	$194,700	$368,700

Funds provided for OPS will support direct service delivery and may include:

- Salaries
- Medical Supplies
- Program, Administrative, Phone, Data Management and IT Expenses.

Applicants will be required to submit a budget as part of entering into a legal agreement with MOHLTC or a LHIN.

Funding must not be used for physician funding to deliver clinical services.

[4] See the Ministry of Health and Long-Term Care's *Overdose Prevention Site Policies and Procedures Toolkit* for sample policies and procedures that will assist an OPS in meeting the terms and conditions of the exemption.

Additional Funding Requests for Minimal Capital Start-Up Costs

Applicants may request additional funding for minimal start-up costs that are required to launch services. Requests for additional funding of this nature must include a detailed description of work to be done or item needed, including the rationale and a cost estimate. Requests for additional funding for minimal capital start-up costs will be made on a case-by-case basis.

Approval

The applicant (and co-applicant, if applicable) will be notified within 14 days from the date a completed application, including any supporting documentation, is received by the Ministry (through the Ministry Emergency Operations Centre (MEOC)). Applicants will be notified as follows:

- Approved as submitted;
- Approved with revisions;
  - Ministry staff will notify applicants if revisions are required, and a summary of the revisions, within 14 days from the date the application was received.
  - Applicants are encouraged to re-submit the application with the required revisions in a timely manner.
  - Resubmissions should be sent to EOCLogistics.moh@ontario.ca with the subject "Revised Application for OPS: <Name of Applicant Organization>"
  - The revised application will be reviewed by ministry staff and applicants will be notified of the ministry's final decision. This may exceed 14 days if the applicant is delayed in sending any follow-up material.
- Rejected (rationale provided).

Stage Two: Operationalize OPS

Approved applicants (and co-applicants, if applicable) will receive a letter confirming funding subject to signing an agreement with the MOHLTC or a LHIN.

The funding agreement sets out the minimum program requirements, terms and conditions, funding allocation and outlines reporting requirements for monitoring purposes. Applicants will be required to develop site-specific policies/procedures in order to comply with the terms and conditions in the OPS exemption provided under Section 56(1) of the *Controlled Drugs and Substances Act*. To support applicants, the ministry will provide an *Overdose Prevention Site (OPS) Policies and Procedures Toolkit*[5] that can be adapted for this purpose. OPS will be required to ensure all polices and/or procedures are adhered to.

Applicants will also ensure appropriate infection prevention and control practices are in place. Public Health Units (PHUs) will be able to support this work, upon request.

An inspection of the site may be conducted to ensure that provincial program requirements are met.

[5] To be provided to overdose prevention sites by the Ministry of Health and Long-Term Care.

Stage Three: Monitoring, Reporting and Evaluation

As part of the monitoring and reporting requirements, monthly reporting from any OPS to the MOHLTC will be required for the following variables:

- # of client visits (including an average number of clients per day)
- # of overdoses
- # of clients administered naloxone
- # of calls to EMS
- # of deaths
- General demographics of clients served

All OPS providers will also be required to meet financial reporting requirements as defined by a LHIN or ministry. A standardized reporting template will be provided to facilitate reporting.

To ensure that the OPS programs are cost effective and are achieving provincial objectives, the MOHLTC will complete an evaluation of all provincially funded OPS operations.

Data and other information related to overdose prevention sites may be provided to the federal Minister of Health upon request.

Stage Four: Submitting an Application

Completed OPS application forms and accompanying documents should be submitted to the Ministry Emergency Operations Centre (MEOC) with the subject “Application for OPS: <Name of Applicant Organization>” at EOCLogistics.moh@ontario.ca.

Upon submission, MEOC will forward application to local municipality. The local municipality will have up to 4 days to provide feedback and/or comment on the application to the MEOC. Applicants will be notified of the decision to approve or decline the application within 14 days of submission to the MEOC.

Questions about the application process may be forwarded to EOCLogistics.moh@ontario.ca or 1.866.212.2272.

Appendix A: Summary of Health Canada Terms and Conditions for Overdose Prevention Sites

General

- The Overdose Prevention Site (OPS) is, and continues to be, in compliance with other applicable federal, provincial and municipal legislation to maintain public health and safety.
- Staff members are trained on their roles and responsibilities.
- The OPS must provide to the Ministry of Health and Long-Term Care, upon request, access to any records, information or any relevant data gathered or collected at the UPHN-Site.
    - Relevant data includes, but is not limited to:
        - Average number of visits per day
        - General demographics of the clients served
        - Number of overdoses/drug emergencies
        - Number of deaths related to activities involving illicit substances

  This information may be shared with Health Canada upon request.

Policies and Procedures[6]

- Each Overdose Prevention Site must have policies and procedures in place:
    - regarding the possession, production, administration and transferring of illicit substances at the OPS;
    - that will take necessary precautions to prevent drug trafficking activities that are not otherwise authorized under this exemption within the OPS; and
    - to address any amount of “unidentified substance” that may be an illicit substance that has been left at the UPHN-Sites, including notifying local law enforcement within 24 hours of the occurrence for them to pick up the unidentified substance for disposal.

[6] See the Ministry of Health and Long-Term Care’s Overdose Prevention Site Policies and Procedures Toolkit for sample policies and procedures that will assist an OPS in meeting the terms and conditions of the exemption.

Designated Persons, Staff Members and Clients

- Designated persons and staff members may only produce an illicit substance if the production of the illicit substance is for the purpose of drug checking, or administering or transferring an illicit substance, as allowed by this exemption.
- Designated persons may only administer and transfer an illicit substance if the administration and transfer is for the purpose of assisting a client with the consumption of an illicit substance. The administration and transfer of illicit substances cannot involve any exchanges for financial compensation, goods, or services.
- Clients may only produce an illicit substance if the production of the illicit substance is for the purpose of self-consumption, or the administering or transferring of an illicit substance, as allowed by this exemption.
- Clients may only transfer an illicit substance if the transfer is for the purpose of:
  - Assisting another client with the consumption of an illicit substance; or
  - Drug checking by a designated person or staff member.

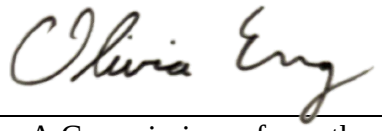
  The administration and transfer of illicit substances cannot involve any exchanges for financial compensation, goods, or services.
- Clients may only administer an illicit substance if the administration is for the purpose of assisting another client with the consumption of an illicit substance. The administration of illicit substances cannot involve any exchanges for financial compensation, goods or services.

This is **Exhibit "F"** to the Affidavit of Bill Sinclair,
sworn January 9, 2024

A Commissioner for oaths, etc.

A copy of Exhibit "F" to the Affidavit of Bill Sinclair, sworn January 9, 2025 can be found at this Link

This is **Exhibit "G"** to the Affidavit of Bill Sinclair,
sworn January 9, 2024



A Commissioner for oaths, etc.

MA137 2018

Toronto Central **LHIN**

425 Bloor Street East, Suite 201
Toronto, ON M4W 3R4
Tel: 416 921-7453 • Fax: 416 921-0117
Toll Free: 1 866 383-5446
www.torontocentrallhin.on.ca

Funding Letter # 0008497

May 08, 2018

Mr. Bill Sinclair
Executive Director
St. Stephen's Community House
91 Bellevue Avenue,
Toronto, ON M5T 2N8

Dear Mr. Sinclair,

Re: 2017-19 Support a time limited overdose prevention Site

The Toronto Central Local Health Integration Network (the "LHIN") is pleased to advise you that St. Stephen's Community House (the "HSP") has been approved to receive $12,000 in one-time funding for the fiscal year 2017-18 up to $112,000 for the 2018-19 funding year (the "Funding") to support the above-named project/program. Details of the Funding and the terms and conditions on which it will be provided (the "Terms and Conditions") are set out in Appendix A and Schedule A.

In accordance with the Local Health System Integration Act, 2006 the LHIN hereby gives notice that, subject to the Multi-Sector Service Accountability Agreement (the "M-SAA"), it proposes to amend the M-SAA between the HSP and the LHIN with effect as of the date of this letter.

Please indicate the HSP's acceptance of the Funding on the Terms and Conditions as well as the HSP's agreement to the amendment of the M-SAA by signing below and returning one copy of this letter to Beatriz Chavez (the "LHIN Contact") within one (1) week of receipt of this letter.

If you have any questions or concerns please contact Beatriz Chavez at (416) 217-3820 ext 3380 or by email at tcfunding.coordinator@tc.lhins.on.ca.

Sincerely,

Per

Susan Fitzpatrick
Chief Executive Officer

Encls: Appendix A and Schedule A

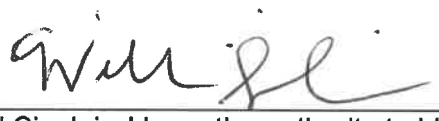
Ontario
Local Health Integration Network

Funding Letter # 0008497
Admin Letter Ref. # 2018-00451
St. Stephen's Community House
Re: 2017-19 Support a time limited overdose prevention Site
May 08, 2018

cc: Howard Green, Chair, St. Stephen's Community House
Vivek Goel, Chair, Toronto Central LHIN
Han Dong, MPP, Trinity-Spadina
Raj Krishnapillai, VP, Finance & IT, Chief Financial Officer, Toronto Central LHIN
Chris Sulway, Vice President, Quality, Performance and Accountability, Toronto Central LHIN

AGREED TO AND ACCEPTED BY:

St. Stephen's Community House



Bill Sinclair, I have the authority to bind St. Stephen's Community House

Funding Letter # 0008497
St. Stephen's Community House
Re: 2017-19 Support a time limited overdose prevention Site
May 08, 2018

Appendix A

1. **HSP:** St. Stephen's Community House

2. **Program:** 2017-19 Support a time limited overdose prevention Site

3. **Funding:**

Purpose/Deliverables	One-Time 2017-18	One-Time 2018-19
To support a time-limited overdose prevention site at St.Stephen's Community House site at 260 Augusta Avenue in Toronto, Ontario.	$12,000	$112,000

4. **Terms and Conditions of Funding** (the "Terms and Conditions")

The HSP acknowledges and agrees that:

(i) The Funding is provided pursuant to the terms and conditions of the Multi-Sector Service Accountability Agreement (the "M-SAA"). To the extent that there are any conflicts between what is in the M-SAA and what is added to the M-SAA by this letter in respect of the Funding, the Terms and Conditions will govern. All other terms and conditions in the M-SAA will remain the same.

(ii) Funding will flow subject to obtaining all necessary approval and may be re-allocated. The HSP should work with the LHIN to obtain detailed deliverables before using the funding.

(iii) It will use the Funding only for the program/initiatives indicated in this letter.

(iv) It will maintain financial records for the Funding for the fiscal year.

(v) Further expectation including deliverables, milestones and performance indicators for this project may be outlined in the Project Charter, if any.

(vi) Financial/Expenditure report and/or progress report confirming funding spent and objectives achieved to be provided at fiscal year-end or upon request.

(vii) Unspent funds and funds not used for the intended and approved purposes, are subject to recovery by the LHIN in accordance with the Ministry's year-end reconciliation policy.

Furthermore, the government remains committed to eliminating the deficit while focusing on priorities in healthcare, education and job creation. That commitment includes moving forward to transform public services by changing the way programs and services are delivered. The Broader Public Service (BPS) plays a critical role in providing services to the people of Ontario and the government has always valued, and will continue to value that work.

a. Compensation costs account for over 50 per cent of Ontario funded program spending. To meet the government's fiscal targets, all compensation costs must be addressed within Ontario's existing fiscal framework which includes no funding for incremental compensation increases for new collective agreements.

b. Ontario is expecting all public sector partners, including employers and bargaining agents to work together to control current and future compensation costs including wages, benefits and pension. Employers and bargaining agents should look to mechanisms such as productivity improvements as a way to achieve fiscal and service delivery goals.

c. The *Broader Public Sector Accountability Act, 2010*, implements compensation restraint measures for designated executives at hospitals, universities, colleges, school boards and designated organizations. The restraint measures are effective March 31, 2012, and are in place until the deficit is eliminated.

d. Decisions related to compensation for non-executives who are not governed by collective agreements should live within fiscal targets.

SCHEDULE A

RELATED PROGRAM POLICIES AND GUIDELINES

Overdose Prevention Site (100%)

This one-time funding is to support the provision of a time-limited overdose prevention site (OPS) from May 1, 2018 to October 31, 2018 by St. Stephen's Community House at 260 Augusta Avenue in Toronto, Ontario. The one-time funding is subject to the Ontario Minister of Health and Long-Term Care continuing to have an exemption under section 56(1) of the *Controlled Drugs and Substances Act* to operate overdose prevention sites. The Toronto Central Local Health Integration Network (TCLHIN) and St. Stephen's Community House (SSCH) agree that if the Ontario Minister of Health and Long-Term Care does not have an exemption under section 56(1) of the *Controlled Drugs and Substances Act*, this one-time funding will be terminated immediately.

Service Provision Requirements

- The OPS will provide clients with the following services:
  - Supervised injection;
  - Distribution of harm reduction supplies and disposal of used harm reduction supplies; and
  - Provision of naloxone[1].
- The OPS may also provide the following services based on local need/capacity:
  - Peer to peer assisted injection;
  - Supervised oral and intranasal drug consumption; and/or
  - Fentanyl test strips as a drug checking service.

Where these optional services are provided based on local need/capacity, the OPS (SSCH) shall notify the TCLHIN and Ministry of Health and Long-Term Care that these services are being provided. The TCLHIN and SSCH will also provide any other information as may be requested by the ministry.

Program Requirements

St. Stephen's Community House must ensure they comply with the following minimum federal[2] and provincial requirements to operate an OPS. Specifically, the OPS must:

- Maintain a Designated Person(s) who is identified to the Minister of Health and Long-Term Care and is the person responsible for operations of the OPS, and staff members at the OPS;
- Receive and maintain permission from the land/property owner to establish and operate an

[1] As per O. Reg. 474/07: Needle Safety under the *Occupational Health and Safety Act*, an employer whose staff administer the injectable form of naloxone must be provided with, and use, hollow bore/safety engineered needles.

[2] As identified by Health Canada in Subsection 56.1 of the *Controlled Drugs and Substances Act Class Exemption in Relation to the UPHN Sites in Ontario* in relation to urgent overdose prevention sites.

SCHEDULE A

RELATED PROGRAM POLICIES AND GUIDELINES

OPS on-site throughout the duration of this Agreement (if SSCH does not own the property);

- Maintain a safe and adequate space for operations:
  - Ensure that all clients and persons visiting the site are in direct line of sight of staff at all times
- Meet all federal, provincial and municipal laws, regulations and bylaws, including regulations respecting accessibility;
- Maintain physical safety and security measures to ensure client, staff and community safety, including:
  - provincial and municipal safety requirements, including applicable regulations and by-laws for operating a health services site as well as the *Occupational Health and Safety Act*;
  - having a fire safety plan;
  - security measures, including controlled access to the site; and,
  - ensuring that EMS, first responders, and fire service can readily access the site in case of emergency.
- Develop and ensure appropriate infection prevention and control policies and procedures are in place including a sharps handling and disposal policy and/or procedure;
- Have a minimum of two employees, both with CPR and naloxone training on-site at all times during hours of operation, with one designated health professional available as determined by St. Stephen's Community House (e.g. on-call or onsite);
- Ensure OPS staff members are fully informed and trained on their roles and responsibilities;
- Have the following policies and procedures in place, at a minimum and ensure they are followed by all staff, clients and visitors[3]:
  - policy to address the possession, production, administration and transferring of illicit substances within the OPS;
  - policy to identify precautions that prevent drug trafficking activities within the OPS that are not otherwise authorized under this exemption;
  - policy to address any amount of "unidentified substance" (that may be a controlled substance) that has been left behind at the OPS, which includes placing the substance in a sealed dated envelope that is signed by the Designated Person(s) and put in secure storage, notifying local law enforcement within 24 hours of the occurrence for them to pick up the unidentified substance for disposal;
  - policies and procedures for all services offered at the site;
  - policy for ensuring all staff members are adequately trained on their roles and responsibilities; and
  - policies related to occupational health and safety.
- Ensure provision of locked and anchored storage security for controlled substances left behind;

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[3] Refer to the Ministry of Health and Long Term-Care's *Guidance to Assist and Inform Overdose Prevention Site Service Delivery* document for more information.

SCHEDULE A

RELATED PROGRAM POLICIES AND GUIDELINES

- Ensure the Designated Person(s) and all staff members are only permitted to produce an illicit substance if the production of the illicit substance is for the purpose of:
  - Drug checking; or
  - Transferring an illicit substance;
- Ensure clients only produce an illicit substance if the production of the illicit substance is for the purpose of self-consumption, or the administering or transferring of an illicit substance;
- Ensure clients only transfer an illicit substance if the transfer is for the purpose of:
  - Assisting another client with the consumption of an illicit substance; or
  - Drug checking by the Designated Person(s) or staff member.
- Ensure the administration and transfer of illicit substances does not involve any exchanges for financial compensation, goods, or services.
- Ensure clients may only produce or administer an illicit substance if the administration is for the purpose of assisting another client with the consumption of an illicit substance.
- Ensure the Designated Person(s) notify the Ministry of Health and Long-Term Care of the following and keep the Ministry of Health and Long-Term Care updated as to any changes in the below noted information:
  - The name of the Designated Person(s) for the OPS.
  - The types of services in relation to illicit substances being offered at the request.
  - The date of intended closure or actual closure of the OPS no later than 10 days after the closure.
  - Any death at the OPS immediately, and no later than 24 hours after the death.

Program Audit Requirements

The Province or any other entity designated by the Province may require the OPS at St. Stephen's Community House to undergo program audits.

Upon request, the Designated Person(s) will be required to submit to the Province, and the TCLHIN if applicable, any records, information or data collected at the OPS relevant to the provincial program and/or federal exemption requirements. The Province may also share this information, including the results of any audits with the federal Minister of Health and Health Canada upon request. Information requested may include, but would not be limited to:

- Valid criminal record check for Designated Person(s)
- All OPS' policies and procedures
- Staff training log
- Client intake and site access log
- Incident log (illicit substances left behind, calls to local law enforcement, calls to EMS)
- Fire safety plan
- Infection prevention and control policies and procedures

SCHEDULE A

RELATED PROGRAM POLICIES AND GUIDELINES

Failure to adequately meet audit requirements may result in immediate termination of the Agreement.

All program documents that provide proof that program requirements have been met must be retained for two years after site closure.

Reporting Requirements

The OPS at St. Stephen's Community House shall submit monthly program activity reports directly to the MOHLTC using the supplied provincial template. Reporting should be submitted no later than one week after month's end (e.g. Feb. 7 for January data) by emailing the completed template to EOCLogistics.moh@ontario.ca, by verbally reporting the data to the Ministry Emergency Operations Centre at 1-866-212-2272, or via fax at 416-212-4466.

The following mandatory indicators are included in the provincial reporting template:

- # of client visits (including an average number of clients per day), and by time of day
- # of overdoses occurring in the OPS
- # of clients administered naloxone
- # of calls to EMS related to an overdose
- # of transfers to emergency department related to an overdose
- # of deaths occurring in the OPS
- Age of clients (under 25, 25 – 64, over 65)
- Drugs being used within the OPS
- # of peer assisted injections, if service being provided

Optional Indicators

- General demographics of clients served (e.g. gender; no personal information or personal health information should be provided)
- Any other indicators collected by the organization

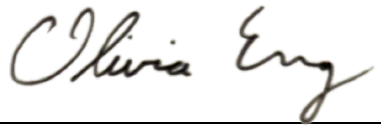
Additional indicators may be requested by the ministry as required.

SSCH will also be required to provide quarterly financial reports directly to the MOHLTC using a template supplied by the Province, and is required to continue meeting any other regular reporting requirements as identified by TCLHIN and/or the MOHLTC.

To ensure that the OPS programs are cost effective and are achieving provincial objectives, the ministry will complete an evaluation of all provincially funded OPS operations.

Data and other information related to overdose prevention sites may be provided to the federal Minister of Health upon request.

This is **Exhibit "H"** to the Affidavit of Bill Sinclair,
sworn January 9, 2024



A Commissioner for oaths, etc.

A copy of Exhibit "H1" to the Affidavit of Bill Sinclair, sworn January 9, 2025 can be found at this Link

A copy of Exhibit "H2" to the Affidavit of Bill Sinclair, sworn January 9, 2025 can be found at this Link

This is **Exhibit "I"** to the Affidavit of Bill Sinclair,
sworn January 9, 2024

A Commissioner for oaths, etc.

Health Canada / Santé Canada

Address Locator 0300B
Ottawa ON K1A 0K9

2019-01-23

Your file *Votre référence*

Our file *Notre référence*
HC6-53-139-59
18-120802-6

Lorie Steer
Director, Housing and Homeless Services
St. Stephen's Community House
260 Augusta Ave
Toronto ON M5T 2L9

Dear Ms. Steer:

Please find attached the exemption from the *Controlled Drugs and Substances Act* (CDSA) to operate a supervised consumption site at the St. Stephen's Community House. The exemption has been granted pursuant to section 56.1 of the CDSA and is valid for a one year period.

Please carefully review this initial exemption and all terms and conditions that are included. In particular, please note that you are required to provide the Office of Controlled Substances with written confirmation of funding prior to opening as a supervised consumption site. In addition, please be advised that a site visit may be required prior to opening as a supervised consumption site, and that the site may also be subject to subsequent regular visits during the validity period of the exemption. Failure to comply with the terms and conditions of the exemption may result in your exemption being suspended or revoked.

Health Canada is available to discuss the exemption and its terms and conditions with you at any time.

Sincerely,

for Michelle Boudreau
Director General
Controlled Substances Directorate
Health Canada

Attachments

Canada

Health Canada / Santé Canada

Address Locator 0300B
Ottawa ON K1A 0K9

2019-01-23

Your file *Votre référence*

Our file *Notre référence*
HC6-53-139-59
18-120802-6

Lorie Steer
Director, Housing and Homeless Services
St. Stephen's Community House
260 Augusta Ave
Toronto ON M5T 2L9

Dear Ms. Steer:

In response to your request for an exemption to the *Controlled Drugs and Substances Act* (CDSA) to operate a supervised consumption site at the St. Stephen's Community House, I would like to inform you that an exemption is being granted to you pursuant to section 56.1 of the CDSA. This letter authorizes the exemption for the St. Stephen's Community House to operate as a supervised consumption site, and sets out the terms and conditions that must be followed.

The following definitions apply to this exemption:

"Alternate responsible person in charge" means any person designated by the applicant who is responsible, when the responsible person in charge is absent from the supervised consumption site, for ensuring that every person or class of persons who is exempted for a medical purpose under subsection 56.1(1) from the application of all or any of the provisions of the CDSA complies with the terms and conditions specified by the Minister in the exemption when they are at the Site.

"Clients" means an individual who is at the Site to consume substances by self-injection, oral or intranasal means and/or to receive other services;

"Designated criminal offence" means

(a) an offence involving the financing of terrorism against any of sections 83.02 to 83.04 of the *Criminal Code*;
(b) an offence involving fraud against any of sections 380 to 382 of the *Criminal Code*;
(c) the offence of laundering proceeds of crime against section 462.31 of the *Criminal Code*;

(d) an offence involving a criminal organization against any of sections 467.11 to 467.13 of the *Criminal Code*; or
(e) a conspiracy or an attempt to commit, being accessory after the fact in relation to, or any counselling in relation to an offence referred to in any of paragraphs (a) to (d);

"Designated substance offence" means
(a) an offence under part I of the CDSA, except subsection 4(1), or
(b) a conspiracy or an attempt to commit, being an accessory after the fact in relation to, or any counselling in relation to, an offence referred to in paragraph (a);

"Illegal substance" means a controlled substance or precursor that is obtained in a manner not authorized under the CDSA;

"Key staff members" means the persons designated by the applicant who are responsible for the direct supervision, at the supervised consumption site, of the consumption of an illegal substance by a client;

"OCS" means the Office of Controlled Substances, Controlled Substances Directorate, Health Canada;

"Responsible person in charge" means the person, designated by the applicant, who is responsible, when the person is at the supervised consumption site, for ensuring that every person or class of persons who is exempted for a medical purpose under subsection 56.1(1) from the application of all or any of the provisions of the CDSA complies with the terms and conditions specified by the Minister in the exemption when they are at the Site;

"Site" means the premises located on the main floor but limited to the supervised consumption services within the building located at 260 Augusta Avenue, Toronto, Ontario;

"SSCH" means the St. Stephen's Community House; and

"Staff member" means an individual employed by or under contract with the SSCH to work at the Site.

Scope

This authority is being exercised under section 56.1 of the CDSA. The following classes of persons are hereby exempted for a medical purpose as set out below to engage in certain activities in relation to an illegal substance within a supervised and controlled environment as specified below:

- All staff members are exempted while they are within the interior boundaries of the Site from the application of subsection 4(1) of the CDSA with respect to any illegal substance in the possession of a client or that is left behind by a client within the interior boundaries of the Site, if such possession is to fulfill their functions and duties in connection with the operation of the Site; and

- Clients are exempted, while they are within the interior boundaries of the Site from the application of subsection 4(1) of the CDSA with respect to an illegal substance, if possession of the illegal substance is for the purpose of self-injection, oral or intranasal consumption by the client.

Suspension Without Notice

A suspension without prior notice may be ordered if the Minister or her designate under section 56.1 deems that such a suspension is necessary to protect public health, safety or security including, without limiting the generality of the foregoing, to prevent controlled substances from being trafficked or otherwise diverted within or from the Site for illegal purposes

Revocation

This authorization may be revoked if the SSCH or any staff member of the Site has contravened any of the terms and conditions set out in this document (please note that such a contravention may, in some cases, also constitute an offence under the CDSA).

Duration

This exemption is issued for a period of one year. The authorization expires on the earliest of the following dates:

- January 31, 2020; or
- the date on which the exemption is revoked.

Other Terms and Conditions

(1) Prior to opening to the public as a supervised consumption site, you must provide the OCS with written confirmation of funding;

(2) A Site visit of the SSCH Site may be required prior to opening to the public as a supervised consumption site. Health Canada will contact you to schedule a Site visit when and if necessary. If major deficiencies are found during the Site visit that could be a risk to public health and safety, you will be asked to provide appropriate corrective measures and the Site may not be allowed to open as a supervised consumption site until Health Canada has approved the corrective measures;

(3) The SSCH must inform and train the Responsible Person In Charge (RPIC), Alternate Responsible Person in Charge (A/RPIC), key staff members and all staff members on their roles and responsibilities;

(4) The RPIC, A/RPIC, key staff members and all staff members must follow the Site's policies and procedures;

(5) Only clients who are properly enrolled may have access to the areas of the Site where supervised consumption services occur;

(6) The RPIC, or in his or her absence an A/RPIC, must be present on site at all times to oversee the operation of the supervised consumption site services;

(7) The RPIC must have a valid criminal record check. The criminal record check must be a document issued by a Canadian police force in relation to the RPIC, stating whether, in the 10 years before the day on which the application was made, the person was convicted as an adult in respect of a designated substance offence or designated criminal offence. If the RPIC has ordinarily resided in a country other than Canada in the 10 years before the day on which the application was made, a document issued by a police force of that country stating whether in that period the person was convicted as an adult for an offence committed in that country that, if committed in Canada, would have constituted a designated substance offence or a designated criminal offence must be submitted;

(8) A new RPIC may not work at the Site without the SSCH having obtained and submitted a valid criminal record check to the OCS;

(9) Where the RPIC is found guilty of a "designated substance offence" or "designated criminal offence", the SSCH must advise the OCS, and that person will no longer be covered by the exemption;

(10) The RPIC, or in his or her absence the A/RPIC, must take necessary precautions to prevent drug trafficking within the Site, including having staff members draw to the attention of clients the *User Agreement, Release and Consent Form*, which prohibits the dealing, exchanging or passing of controlled substances, and must remove from the Site any client caught attempting to traffic or trafficking a controlled substance;

(11) The RPIC, or in his or her absence the A/RPIC, must be notified of an incident of any amount of 'unidentified substance' that may be an illegal substance that has been left behind by clients. The substance must be placed in an envelope that is sealed, dated and initialled by a staff member. The RPIC or A/RPIC must then place the envelope in a *lock box*, and log tracking information in the Site's *Unknown Substance Left Behind* form. The RPIC, or in his or her absence the A/RPIC, must notify the Toronto Police Service (TPS) within 24 hours of the occurrence. When the envelope containing the substance is picked up for disposal by the TPS, it must be logged out by the police officer;

(12) In the event of theft of illegal substances left behind by clients, the RPIC, or in his or her absence the A/RPIC, must notify the TPS immediately and the OCS within 24 hours of the occurrence. The RPIC must maintain a record of losses and thefts of illegal substances left behind by clients;

(13) The return of used or contaminated syringes must be supervised by the RPIC, A/RPIC or a key staff member and managed safely as per Site procedures;

(14) The security system intended to provide physical security at the Site must be operational at all times, and access to the Site must be controlled, as submitted in your application. The RPIC, or in his or her absence the A/RPIC, must ensure that a record of entry and exit from the Site is maintained;

(15) The SSCH must notify the OCS of amendments to any security measures or policies and procedures that could lead to an increased risk to public safety and security and provide the OCS with a description of the revised security measures and a copy of the revised policies and procedures no later than 10 working days following the effective date of the amendments;

(16) All records or other information required to be kept under this exemption must be maintained at the Site for the duration of the exemption and made available to the Health Canada upon request;

(17) The SSCH must notify the OCS within 24 hours in the event of a death related to activities involving illegal substances at the Site;

(18) The SSCH must notify the OCS within 48 hours should the Site be closed;

(19) In accordance with any applicable privacy laws, the SSCH will provide the Minister, upon request, with access to any relevant data gathered or collected related to the Site; and

.../6

(20) The SSCH must provide a report to the OCS before November 30, 2019 summarizing the activities undertaken and clients served at the Site, the impact of the services on the clients and the community and any other information related to the services offered. The report should include, but is not limited to:

- the average number of visits per day;
- the number of unique visitors per month;
- the general demographics of the clients served;
- the number of referrals to other health care facilities including treatment and rehabilitation services;
- the number of referrals to other health and social services;
- the number of overdoses/drug emergencies at the Site per year; and
- the percentage of the most prevalent drugs used at the Site according to the user.

Should it be necessary to change the terms and conditions, you will be informed in writing and a reason for the change will be provided.

Please note that it is recommended that you establish a mechanism to collect information required for subsequent applications, as set out in subsection 56.1(3) of the CDSA, including any information related to the public health impacts of the activities at the Site, and as described in subsection 56.1(3).

It is your responsibility to verify that the operation of the supervised consumption services at the Site is, and continues to be, in compliance with other applicable federal, provincial and municipal legislation to maintain public health and public safety.

Finally, the OCS welcomes receiving any information you feel pertinent to your exemption throughout its validity period. We are available to answer questions on any aspect of your exemption, and look forward to working with you to assist in the continued legal operation of your endeavour.

Sincerely,

for Michelle Boudreau
Director General
Controlled Substances Directorate
Health Canada

Attachment

List of approved personnel on date of January 23, 2019
St. Stephen's Community House

RPIC (Responsible Person in Charge)

Tyler Watt

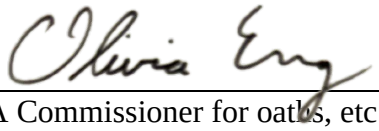
This is **Exhibit "J"** to the Affidavit of Bill Sinclair,
sworn January 9, 2024

A Commissioner for oaths, etc.

A copy of Exhibit "J1" to the Affidavit of Bill Sinclair, sworn January 9, 2025 can be found at this Link.

A copy of Exhibit "J2" to the Affidavit of Bill Sinclair, sworn January 9, 2025 can be found at this Link.

This is **Exhibit "K"** to the Affidavit of Bill Sinclair,
sworn January 9, 2024



A Commissioner for oaths, etc.

Ontario

Ministry of Health and Long-Term Care

Office of Chief Medical Officer of Health, Public Health
393 University Avenue, 21st Floor
Toronto ON M5G 2M2

Telephone: (416) 212-3831
Facsimile: (416) 325-8412

Ministère de la Santé et des Soins de longue durée

Bureau du médecin hygiéniste en chef, santé public
393 avenue University, 21e étage
Toronto ON M5G 2M2

Téléphone: (416) 212-3831
Télécopieur: (416) 325-8412

HLTC6605IT-2019-42

MAR 29 2019

Mr. Bill Sinclair
Executive Director
St. Stephen's Community House
260 Augusta Avenue
Toronto ON M5T 2L9

Dear Mr. Sinclair:

I am writing to you regarding St Stephen's Community House application to the Ministry of Health and Long-Term Care's ("ministry's" Consumption and Treatment Services (CTS) funding program.

The ministry has carefully reviewed all applications to assess which applications meet all CTS funding requirements. St Stephen's Community House's application has not been approved for the CTS provincial funding program.

As indicated in the ministry's Overdose Prevention Site agreement with St. Stephen's Community House, funding expires on March 31st, 2019.

We thank you for your interest in applying to the CTS funding program, and for St. Stephen's continued commitment to harm reduction programs and services. If you have any questions regarding your application you may contact Laura Pisko, Director, Health Improvement Policy and Programs, at laura.pisko@ontario.ca or 416-327-7445 or Chris Harold, Manager, Addiction and Substances Policy and Programs, at chris.harold@ontario.ca or 416-326-5253.

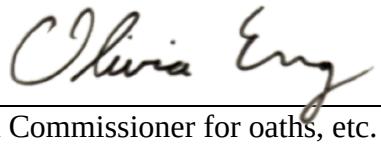
Sincerely,

David C. Williams, MD, MHSc, FRCPC
Chief Medical Officer of Health, Public Health

Enclosure

c: Laura Pisko, Director, Health Improvement Policy and Programs
Chris Harold, Manager, Addiction and Substances Policy and Programs

This is **Exhibit "L"** to the Affidavit of Bill Sinclair,
sworn January 9, 2024



A Commissioner for oaths, etc.

A copy of Exhibit "L" to the Affidavit of Bill Sinclair, sworn January 9, 2025 can be found at this Link

This is **Exhibit "M"** to the Affidavit of Bill Sinclair,
sworn January 9, 2024

A Commissioner for oaths, etc.

Ministry of Health and Long-Term Care

Office of Chief Medical Officer of Health, Public Health
393 University Avenue, 21st Floor
Toronto ON M5G 2M2

Telephone: (416) 212-3831
Facsimile: (416) 325-8412

Ministère de la Santé et des Soins de longue durée

Bureau du médecin hygiéniste en chef, santé publique
393 avenue University, 21e étage
Toronto ON M5G 2M2

Téléphone: (416) 212-3831
Télécopieur: (416) 325-84

Ontario

MAY 3 1 2019

Mr. Bill Sinclair
Executive Director
St. Stephen's Community House
260 Augusta Avenue
Toronto ON M5T 2L9

Dear Mr. Sinclair:

I am writing to acknowledge receipt of St. Stephen's Community House's (SSCH) revised Consumption and Treatment Services (CTS) application submitted on April 29, 2019. This is in follow-up to SSCH's first application, which as communicated on March 29, 2019, was not approved for funding.

The ministry completed a careful review of all CTS funding applications, including the first application from SSCH. SSCH's first application was assessed, like all applications, against communicated program criteria which were made publicly available in November 2018. Applications were also assessed to ensure that funding decisions reflected the province-wide nature of the opioid crisis. Based on this review, SSCH's application was not approved for CTS program funding.

There are communities across Ontario that have indicated a need for a CTS. Please note only CTS applications from new communities that do not yet have a CTS approved for provincial funding will be given priority for ministry review. As such, the ministry is not accepting re-submitted applications.

We thank you for St. Stephen's continued commitment to harm reduction programs and services.

Sincerely,

BLyaffe pes

David C. Williams, MD, MHSc, FRCPC
Chief Medical Officer of Health, Public Health

c: Lorie Steer, Director of Urban Health and Homelessness Services, SSCH
Laura Pisko, Director, Health Improvement Policy and Programs Branch, MOHLTC
Chris Harold, Manager, Addiction and Substances Policy and Programs, MOHLTC

This is **Exhibit "N"** to the Affidavit of Bill Sinclair,
sworn January 9, 2024

A Commissioner for oaths, etc.

St. Stephen's Community House

April 28, 2019

Substance Use and Addictions Division
Controlled Substances and Cannabis Branch
Health Canada

Re: Supervised Consumption Site Application
Agency: St. Stephen's Community House,

St. Stephen's Community House (SSCH) is a non-profit, community-based social service agency that has been serving the needs of Kensington Market and other neighbourhoods in Toronto since 1962. We are dedicated to making our communities stronger, happier and healthier. With more than 200 staff, our 12 locations offer services for more than 27,000 people a year and address the most pressing issues in our community: poverty, hunger, homelessness, unemployment, HIV and AIDS, youth alienation and the integration of immigrants.

The Mission of SSCH is to work with individuals and communities in the City of Toronto to identify, prevent and eliminate social and economic inequality by creating and providing a range of effective and innovative programs and services.

The SSCH Supervised Consumption Site (SCS) has operated for one year as an Overdose Prevention Site, within the department of Urban Health and Homelessness Services (UHHS). We serve approximately 5000 individuals each year and support approximately 350 visits to our UHHS site each day. With a committed and multi-disciplinary staff team of 47 and a supportive community, we are able to provide comprehensive, integrated services that meet immediate needs and provide longer term, transformative interventions that support sustained wellness for individuals living with complex issues, including substance use, mental health issues, poverty and isolation.

The UHHS department has worked extensively with people who use drugs within a harm reduction framework. Along with the SCS, we provide safer drug use education, supplies, peer training and support, overdose prevention training and Naloxone. We also work closely with people who use drugs to identify and respond to emerging needs. Most recently we have worked with people who use drugs to develop our Crystal Methamphetamine strategy and we implemented a series of individual and group services including an innovative amphetamine replacement therapy service.

SSCH receives and successfully manages funding from all levels of Government including a federal SUAP grant in our Youth Services department. Along with our extensive experience managing similar grants, we have a strong infrastructure to ensure our success including a finance department, a human resource department and a senior management team led by our Associate Executive Director, an Executive Director and Board of Directors.

/ .. 2

Enclosed is our application for transition funding for our SCS. We are confident that we have the knowledge, experience, infrastructure and community support to successfully manage the SUAP grant for our SCS.

Sincerely,

Lorie Steer
Director of Urban Health and Homelessness Services
St. Stephen's Community House

Cathy Hennessey
President, Board of Directors
St. Stephen's Community House

Substance Use and Addictions Program (SUAP)

Streamlined Funding Application Template for Supervised Consumption Sites

INSTRUCTIONS:

This template must be completed in full.

- □ Complete the template and submit document in Microsoft Word.
- □ **Maximum** length is 6 pages inclusive of existing template contents, singled spaced, in size 12 font.
- □ A cover letter is required to accompany the LOI.
- □ Refer to the Assessment Criteria in the submission.
- □ Submit the LOI via email to: **SUAP-PUDS@hc-sc.gc.ca**

Cover Letter

Assessment Criteria:

- Degree to with the organization has the **capacity** to undertake the proposed project.

Section 1 – Project at a Glance

a) Name of Applicant:

St. Stephen's Community House

b) Project Title:

SSCH - SCS

c) Primary Contact (include name and title, mailing address, telephone number and e-mail address):

Lorie Steer, Director of Urban Health and Homelessness Services, 260 Augusta Avenue, Toronto, Ontario, M5T 2L9, slorie@sschto.ca, 647 678 7026

d) Project Duration (in months):

6 Months

e) Funding amount requested from Health Canada (per year and total):

$149,880

Section 2 –Evidence of need

Assessment criteria:

- Degree to which the **reasons that led to the proposed intervention** are described.

Supervised consumption sites remain controversial in some communities. A number of sites in Ontario are facing closure due to a lack of funding under Ontario's Consumption and Treatment Services (CTS) program. St. Stephen's Community House (SSCH) is one such organization. As a result, SSCH is well-placed to gather data and document the needs of our clients during our transition process to a new funding model or closure. In particular, this would be done with a focus on the following vulnerable communities: people who are 35 and under, poly-drug users and people who use crystal methamphetamine. Furthermore, SSCH will gather data on the benefits of providing a smaller SCS that is integrated into a larger set of health and social services on site. This information would then disseminated to other supervised consumption sites (SCS) and overdose prevention sites (OPS) operating across Canada.

Section 3 – Description of the intervention

1. PROJECT SUMMARY

SSCH will operate a supervised consumption site for a period of 6 months and document the unique integrated model of care and the needs of poly drug users, people who use crystal methamphetamine and people under 35, during a transition to a new funding model or closure. A report of recommendations and best practices will be shared with decision makers and other supervised consumption sites and overdose prevention sites operating across Canada.

2. KEY ACTIVITIES AND DELIVERABLES

Fiscal Year 2019-20	
Key Activities	**Key Deliverables/Outputs**
Operate full SCS service and extend SCS hours of service from 4 to 6 hrs per day, 6 days per week	Data tracking tools Service usage data
Development a collaborative evaluation plan	Evaluation plan and resulting tools for both Street Health and SSCH

Conduct interviews with staff and managers and run focus groups with service users	Summary of interviews and focus group results
Analysis of site usage data	Data on the OPS model and service usage
Complete final report and knowledge exchange documents	-1-2 page graphic summary of major findings and full evaluation report

3. OUTCOMES

Program outcomes

This project contributes to the following SUAP outcomes:

- Targeted stakeholders and Canadians access evidence-informed information on substance use;
- Targeted stakeholders and Canadians are equipped with the capacity (knowledge, skills and supports) to inform their decisions and actions related to substance use;
- Targeted stakeholders use evidence-informed information on substance use to change policies, programs, and practice;
- Canadians have access to quality, evidence informed health promotion, prevention, treatment and harm reduction programs and services; and
- Canadians have better health outcomes.

- Project outcomes
- SCS and OPS operators have a better understanding of their clients, and the specific risks and vulnerabilities associated with specific sub-populations during times of transition, such as when moving or closing sites.
- SCS and OPS operators integrate this evidence into programming decisions and, if necessary, transition plans.
- Decision makers are better placed to advise on the locations and considerations of establishing SCS and OPS services for specific vulnerable sub-populations.

4. TARGET GROUPS

The primary target to be reached through this project are people who use drugs within the GTA, with specific emphasis on poly drug users, people who use crystal methamphetamine and individuals under 35. This target group will be reached through outreach at St. Stephen's Community House supervised consumption site.

Another target is SCS/OPS program operators and other decision makers who will be reached through dissemination of a report on best practices and recommendations.

5. PARTNERSHIPS

Name of Partner Organization	Partner's Role
Toronto Overdose Prevention Society (TOPS)	To provide evaluation support, connection to other SCS providers and service use data for GTA
Toronto Public Health, The Works	Supplies all safe use equipment , provides overdose data, service usage data for comparison purposes and evaluation support
Inner City Health Associates	Provide primary and psychiatric care to SCS service users and medical oversight
Toronto Central LHIN- Home and Community Care	Nursing care, 4 days per week

Section 4 – Other considerations

Assessment criteria:

- Other considerations are adequately described

1. SEX AND GENDER

From the inception of the initiative, gender and gender disparities will be considered in different aspects of this program. For example, in the hiring process we will seek diverse candidates from a range of gender identities. In recognition of the known contribution of sex and gender in influencing drug-related harms, this project will include investigations of the role of sex and gender in influencing the capacity of individuals to access services.
The initiative will also take a gender-specific approach in its programming. In particular the initiative will focus on the needs of younger people using crystal methamphetamine and explore how sex and gender impact drug use, risks and access to services. Sex and gender informed data will inform best practices and recommendations to be included in the final report.

Describe how key activities and outputs will take into account, or will be tailored to, differences in groups of targeted men/women. E.g. Is accessibility the same for men /women*? Are outputs, such as reports or training materials, reflective of sex and gendered considerations?*

Among the target population of marginalized individuals who use substances, this project will recognize and respond to the dimensions of sex and gender to maximize benefits and impacts. Sex workers and members of the LGBTQI communities are two of its sub-populations; and the project will recognize sex- and gender-related needs among members of all sub-populations.

Their equitable and appropriate access to services will be enabled by social service professionals, most of whom have lived experience of drug use and/or housing insecurity.

Describe the impact that sex and gender considerations are expected to have in achieving equitable outcomes.

The approach outlined above is expected to achieve more effective and equitable service outcomes. Project design takes account of the fact that sex and/or gender is relevant to prevalence and patterns of substance use, types and physiological impacts of substances used, sub-populations affected, social context of use, and access to and outcomes of substance-targeted programs. Risk factors related to sex and gender will be addressed.

Describe how knowledge translation and exchange (KTE) strategies have been/will be developed to include all sub-groups being targeted, and to maximize uptake by men/women. Consider if content/messages/products will need to vary by sex and gender.*

We propose collaborating on the project evaluation with Street Health. Both Street Health and St. Stephen's operate small OPS that are integrated into larger agencies offering a broad array of health and social services to marginalized and street-involved population of people who use drugs, and are at high risk of overdose. The focus of the evaluation will be on examining the benefits of offering supervised consumption as part of an integrated service model, particularly for service users who may be at high risk of overdose and other health harms due to their gender, poly-substance use, crystal methamphetamine use, and experience of homelessness. Evaluation and analysis will include considerations related to age, ethnicity and interactions of these factors with sex and gender. A final report will evaluate the impacts of overdose prevention service models at Street Health and St. Stephen's Community House, and provide recommendations – including from service users – for service improvement. We expect to be able to document, explore and share insights on the differing experiences and outcomes for women, men and gender-diverse individuals. We believe that this collaboration will support KTE that bridges the gap between research and practice, and contributes to more effective responses to the overdose crisis. This project will complement our community-based initiatives to contribute to evidence-informed prevention efforts while promoting community capacity and the benefits of harm reduction in high-risk populations.

Describe how sex and gender-disaggregated data will be collected and used.

Two focus groups (4 in total) will be conducted with services users at each site. The evaluator will work with each agency to ensure targeted recruitment so that poly-substance users and women and people experiencing homelessness are represented. Analysis and reporting will include sex- and gender-disaggregated data. An infographic summary of major findings will be produced for easy dissemination to project partners, funders and other key stakeholders.

2. OFFICIAL LANGUAGES

This initiative is not offering services in both official languages, although we can access translation services when needed. It has been determined that French is not the spoken language in the regions and cultural communities of the Kensington-Chinatown community,

however St. Stephen's Community House is committed to access and inclusion. We have several bi-lingual staff who can attend the SCS if a service user requires service in French.

Section 5 – Budget

Assessment criteria:

3. BUDGET NARRATIVE

Personnel Salaries & Benefits - $107,714
Staffing includes:

Salaries for 6 months - $ 89,020; Benefits (21%) $18,694

.20 Manager for program oversight, 1 FT Coordinator to complete scheduling, supervision and work in the SCS; 1 FTE SCS Program Worker; 2 FTE Peer Workers to work as SCS staff and work as Doorperson for SCS entry

Travel & Accommodations - $1,205
Staff Transportation - mileage and TTC to attend related community meetings and taxi funds to accompany service users to urgent appointments
Client and Volunteer Travel - 122 individuals x $6.22 (two trips for TTC)

Materials & Supplies
Supplies- medical and hygiene (first aid supplies, vein finder, diagnostic supplies, soap, toothpaste, feminine hygiene products) - $1,500
Oxygen - $ 645
Staff Training & Development - 4.2 FTE - $630

Rent & Utilities
Hydro, Gas, Water and property tax - $ 8,793

Performance Measurement
Each Street Health and SSCH to contribute $10,000 to hire Gillian Kolla for evaluation and knowledge sharing activities

Other
Building maintenance, supplies, repairs and insurance - $8,197
Administration – (portion of finance, human resource, board costs, ED, audit) $11,196

CASH FLOW FORECAST AND RECORD OF EXPENDITURES

Period: Semi-Annual

Part 1

Arrangement Number:	Initiative Title:	Organization Name:	Health Canada Program Name:	Fiscal Year:
	Overdose Prevention Site	St. Stephen's Community House	Substance Use and Addictions Program	2019-2020

Part 2

Budget Items	First Period 05/15/19 - 09/30/19 Forecast	Actual	Difference $	Difference %	Second Period 10/01/19 - 11/15/19 Forecast	Actual	Difference $	Difference %	Baseline Approved Budget	Actuals to date plus future Forecasts	Variance % between Baseline & Forecasted Expenses	Total Actual Expenses	Total Funding Remaining	Variance % between Baseline & Actual Expenses
Personnel Salaries & Benefits	80,785		0	0%	26,928		0	0%		107,714	0%	0	0	0%
Contractual Personnel			0	0%			0	0%		0	0%	0	0	0%
Travel & Accommodations	803		0	0%	402		0	0%		1,205	0%	0	0	0%
Materials & Supplies	1,850		0	0%	925		0	0%		2,775	0%	0	0	0%
Equipment			0	0%			0	0%		0	0%	0	0	0%
Rent & Utilities	5,862		0	0%	2,931		0	0%		8,793	0%	0	0	0%
Performance Measurement			0	0%	10,000		0	0%		10,000	0%	0	0	0%
			0	0%			0	0%		0	0%	0	0	0%
			0	0%			0	0%		0	0%	0	0	0%
			0	0%			0	0%		0	0%	0	0	0%
Other Costs (Administration)	12,929		0	0%	6,464		0	0%		19,393	0%	0	0	0%
TOTAL	$102,229	$0	$0	0%	$47,650	$0	$0	0%	$0	$149,880	0%	$0	$0	0%

Budget Item "Other Costs", Please Specify:

Description	Total Forecast	Total Actual
**		
**		
**		
**		
**		
**		
**		
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**		
**		
SUBTOTAL	$0	$0

Part 3

	April	May	June	July	August	September	Subtotal	October	November	December	January	February	March	Subtotal	Total
Monthly Forecast / Monthly Actual			$25,557	$25,557	$25,557	$25,557	$102,228	$18,825	$28,825	$0	$0	$0	$0	$47,650	$149,878

Part 4

	2019-20	20XX-XX	20XX-XX	20XX-XX	20XX-XX	Total
Annual Forecast	$0	$0	$0	$0	$0	$0
Annual Actual	$0	$0	$0	$0	$0	$0

Part 4.5 ***(Contact the Office of Gs&Cs to unlock)*** *Complete Part 4.5 only if a carry-forward from the previous fiscal year has been approved by Health Canada.* ***NOTE:*** *This is not permitted under most funding agreements.*

Part 5

AUTHORIZED SIGNATURE

I certify that the amounts indicated accurately reflect the initiative forecasts and expenditures for the period specified and that Health Canada may at any time request supporting documents for audit purposes.

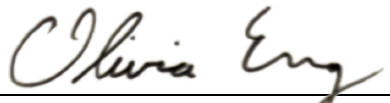
Authorized Signature	Print Name	Date
	BILL SINCLAIR	APRIL 30/19

HEALTH CANADA

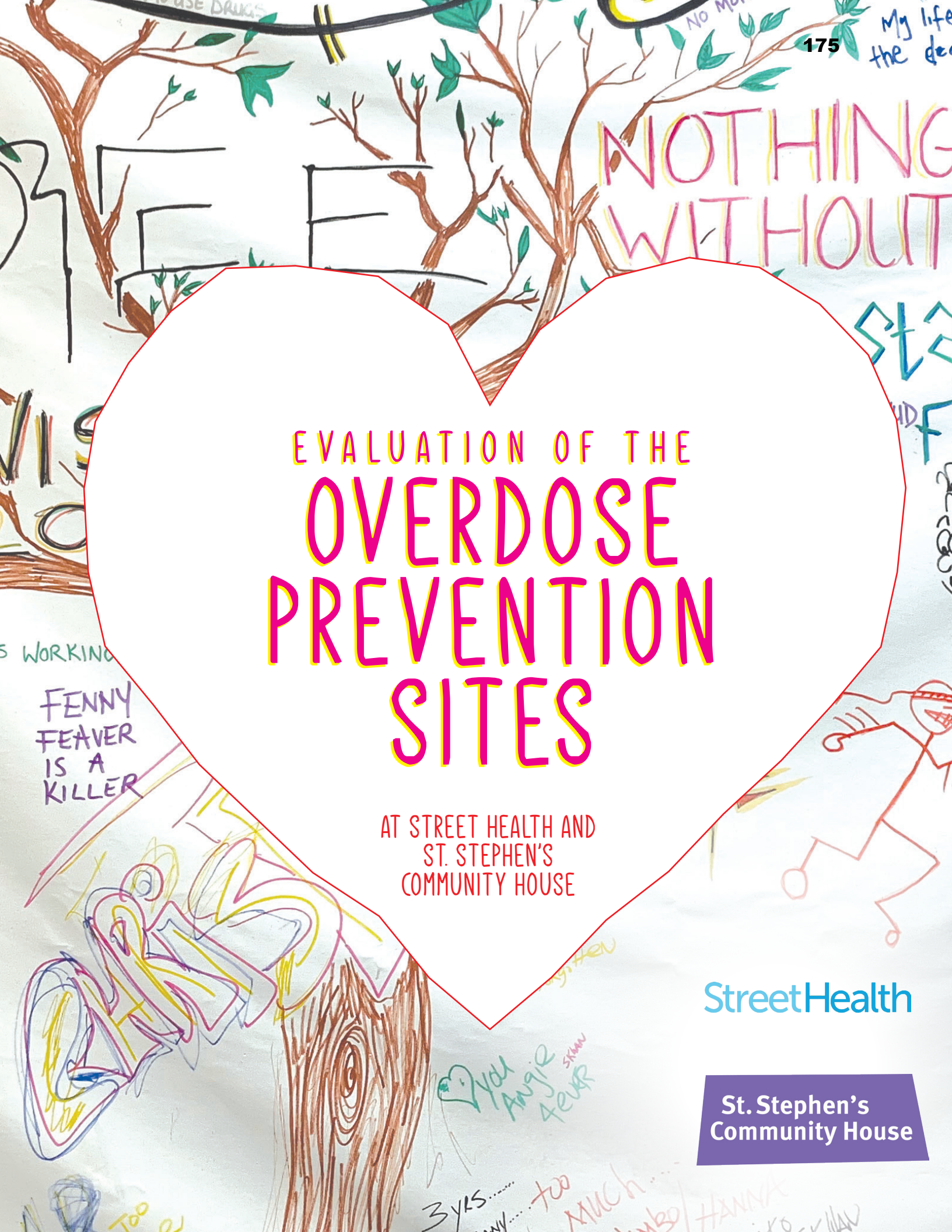
Document verified by:

Signature	Date
Print Name	

This is **Exhibit "O"** to the Affidavit of Bill Sinclair,
sworn January 9, 2024



A Commissioner for oaths, etc.



EVALUATION OF THE OVERDOSE PREVENTION SITES

AT STREET HEALTH AND ST. STEPHEN'S COMMUNITY HOUSE

StreetHealth

St. Stephen's Community House

ACKNOWLEDGEMENTS

PROJECT PARTICIPANTS

We would like to thank the people who participated in the interviews and focus groups for this evaluation, and who generously shared their thoughts, experiences and time with us. This includes the substantial contribution of people who use drugs and use the overdose prevention sites, the staff at Street Health and St. Stephen's Overdose Prevention Sites, and their supervisors and managers. Their contribution is gratefully acknowledged.

PROJECT TEAM

Gillian Kolla developed the facilitation guide with input from staff at Street Health and St. Stephen's Community House, and conducted the focus groups and interviews with staff members and people who use OPS services. Gillian Kolla, Rebecca Penn, and Cathy Long conducted analysis of the data, and contributed to writing and editing this report. Graphic design by Ryan White, R.G.D.

FUNDING

Production of this evaluation has been made possible through a financial contribution from Health Canada. The views expressed herein do not necessarily represent the views of Health Canada.

SUGGESTED CITATION

Gillian Kolla, Rebecca Penn & Cathy Long (2019). *Evaluation of the Overdose Prevention Sites at Street Health and St. Stephen's Community House.* Toronto: Street Health and St. Stephen's Community House.

November 2019

StreetHealth

St. Stephen's Community House

TABLE OF CONTENTS

SECTION 1: EXECUTIVE SUMMARY

Street Health and St. Stephen's Community House have long histories of providing services to marginalized people in their neighbourhoods who use drugs and are experiencing homelessness. Both agencies recognized the need to address the risk of overdose and related harms that their clients were facing in the context of a worsening opioid overdose crisis. In 2018, each organization received funding under the Ontario provincial government's Overdose Prevention Site program to open a small overdose prevention site (OPS) onsite.

This evaluation was undertaken to examine the provision of services within these two OPS, focused primarily on the impacts on clients using the OPS. In the context of the withdrawal of funding by the provincial government, this evaluation also sought to explore the potential impacts if the OPS at Street Health and St. Stephen's were forced to close. Furthermore, the report examines the implementation process, as well as the service delivery model to identify what worked well, and the challenges encountered. The ways in which both OPS work with priority populations such as people experiencing homelessness, women and members of the LGBTQI2S population, and people who inject stimulants like crystal methamphetamine is examined. Finally, staffing considerations are explored.

STREET HEALTH'S OVERDOSE PREVENTION SITE

Street Health's OPS opened on June 27th, 2018. The Dundas-Sherbourne intersection, where Street Health is located, is the epicentre of the overdose crisis in Toronto. It sees the 2nd highest rate of overdose calls to paramedics in the City of Toronto for suspected overdoses, which often occur in alleyways, building stairwells, and in shelters and drop-in centres. It is a small OPS, with only 2 spaces for injection. The OPS is open from 9:30am - 4pm, Monday to Friday, except on Tuesday when they open from 11am - 4pm.

3,134 total visits

56% clients identifying as women

+

43.5% clients identifying as men

+

0.5% clients identifying as trans, gender non-conforming or non-binary

Number of overdoses successfully reversed: 50

Average number of visits per month:[1] 272

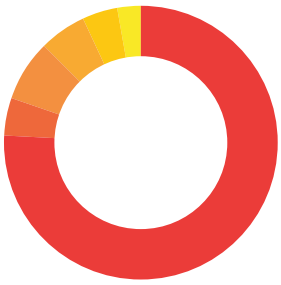
Average number of referrals per month to healthcare including substance treatment:[2] 53

Average age of clients: 36 years old

Peer-to-peer assisted injections: 12.9%

[1] Average number of visits per month from January – August 2019
[2] Average number of referrals per month from April – August 2019

PRIMARY DRUG CONSUMED



- Fentanyl **76.1%**
- Heroin **4.4%**
- Other opioids* **7.3%**
- Crystal methamphetamine **5.5%**
- Crack cocaine **4.2%**
- Other drugs **2.6%**

* oxycodone, hydromorphone, etc.

ST. STEPHEN'S OVERDOSE PREVENTION SITE

St. Stephen's OPS opened on April 25th, 2018. St. Stephen's is in the Kensington Market area, a neighbourhood that sees the 5th highest rate of overdose calls to paramedics in the City of Toronto for suspected opioid overdoses. The opening of an OPS there filled a service-gap in the west end of downtown Toronto. The OPS is open from 8am - 2pm, Monday to Friday, and Sunday and offers 3 spaces for injection.

2,357
total visits

36%
clients identifying as women

+

64%
clients identifying as men

+

0%
clients identifying as trans, gender non-conforming or non-binary

Number of overdoses successfully reversed: 17

Average number of visits per month:[1] 154

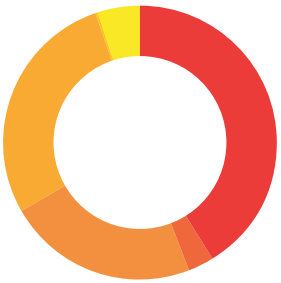
Average number of referrals per month to healthcare including substance treatment:[2] 37

Average age of clients: 37 years old

Peer-to-peer assisted injections: 8.1%

[1] Average number of visits per month from January – August 2019
[2] Average number of referrals per month from April – August 2019

PRIMARY DRUG CONSUMED



- Fentanyl **41.3%**
- Heroin **3.1%**
- Other opioids* **22.5%**
- Crystal methamphetamine **27.9%**
- Crack cocaine **0.3%**
- Other drugs **4.9%**

* oxycodone, hydromorphone, etc.

HEALTH AND SOCIAL IMPACTS ON CLIENTS USING THE OPS

Using at the OPS at Street Health and St. Stephen's has led to several positive health and social impacts for OPS clients, including:

- **Reduced overdose-related harms:** Staff are onsite and immediately able to intervene to reverse overdoses.
- **Increased safer drug use:** Clients using the OPS are able to consume drugs slowly, and use sterile equipment and safer consumption practices. Additional safety comes from not having to use drugs in public locations like alleys and stairwells, or in the washrooms of agencies or local businesses.
- **Improved engagement in wrap-around care:** Provision of OPS services for clients facilitates access to other healthcare and social services, both on-site and through referrals to community partners.

POTENTIAL IMPACTS OF OPS CLOSURE

Study participants anticipated the following potential outcomes of OPS closures:

- **Increased drug use and overdoses in public spaces:** This includes the potential for increased need for overdose response in public spaces such as alleys, stairwells, alcoves, and washrooms within businesses and other agencies in the community. Clients said that they would return to using drugs in public spaces, as well as agency and public washrooms, as they did prior to the opening of the OPS.
- **Increased risk of overdose and related harms, including death:** Risks associated with overdose are increased when people use alone and/or in spaces where they are unable to get help. Risk of harm increases in the absence of immediate intervention.
- **Loss of accessible overdose prevention options for people who use drugs:** Clients expressed a strong preference for the small, quiet OPS located at St. Stephen's and Street Health. The noise and high-impact of other SCS would dissuade them from using those sites. This is particularly relevant for people who use stimulants, women, and members of the LGBTQI2S community.
- **Interruption of connections to wrap-around care:** The OPS provides an entry point and connection to other health care and social services. Without the OPS, clients may not frequent the agencies and will lose connection to wrap-around services.
- **Loss of a safe space with a supportive community:** Staff worried that closing the OPS would feel like rejection and abandonment for the vulnerable people using the OPS, who they had worked hard to build relationships with.
- **Loss of jobs and income for people working in the OPS:** Staff with lived experience feared that they will have difficulty securing other employment and will face financial and personal insecurity. In addition to income, OPS jobs also provide people with lived experience with a sense of purpose, pride, and way to help members of their community reduce drug-related harms.

IMPLEMENTATION OF OPS

The implementation of OPS within both agencies was facilitated by several factors:

- **Extended harm reduction services and filled a service gap:** The OPS at Street Health and St. Stephen's are an extension of and complement to existing harm reduction services offered by both agencies. The addition of an OPS filled a service gap and responded to a need voiced by clients, staff members, and some members of the community.
- **Built on established relationships with people who use drugs:** Both agencies have well established relationships with people who use drugs in their communities, and they built on these relationships to encourage existing clients to use the OPS, and to attract people who use drugs in the community who were unconnected to health and social services.
- **OPS as low-threshold and safe spaces:** The OPS were designed to be safe and welcoming spaces located onsite in agencies where people who use drugs were already receiving services and supports.
- **Increased options for supervised drug use:** In both agencies, the opening of an OPS allowed staff members to divert people from using in public spaces in the community, in public washrooms and in agency washrooms.

OPS SERVICE DELIVERY MODEL

There are several key elements of the OPS service delivery model at Street Health and St. Stephen's that are notable:

- **Integrated:** Both OPS are small sites integrated into a larger, multi-service agency, providing a wide array of health and social services. This facilitates OPS client access to comprehensive wrap-around services including access to on-site health and social services, and external referrals to other agencies in the community. Supports for clients interested in treatment and detox services are also facilitated by this model.
- **Accessible:** The design of the OPS space and operational policies emphasized accessibility through the development of a low-threshold model of service delivery. A significant finding of this evaluation was learning that clients prefer the small, calm, and non-clinical environment in these two OPS, in comparison to other larger OPS and SCS in the city. This finding highlights the importance of multiple models of OPS/SCS – larger, busier sites as well as smaller sites integrated into agencies offering a wide range of services. A range of models is critical for meeting the diverse needs of people who use drugs.
- **Staffed by people with lived experience:** OPS staff members are primarily people with lived experience of drug use. Having staff with lived experience of drug use reduced barriers to services, and ensured that services were relevant and responsive to client needs.

Challenges in service delivery

- **Lack of shelter beds or treatment/detox space:** Central to the OPS model at both sites is the provision of wrap-around care through onsite or community partner services to address the wider health and psychosocial needs of their clients. However, OPS staff reported frustration about the lack of essential services requested by OPS clients, particularly shelter beds, and detox or treatment beds.
- **Lack of supervised smoking facilities:** Lack of supervised spaces for people who smoke their drugs is a health equity issue. Smoking is a common mode of consumption of opioids and stimulants that the OPS are currently not able to accommodate.
- **Funding insecurity:** The major organizational challenge affecting service delivery was the uncertainty around long-term funding. Efforts to keep the programs operating required balancing service delivery with the considerable time and human resource demands dedicated to securing funding and developing contingency plans if the sites were to close.
- **Community response:** Street Health faced an additional challenge from the community reaction to their OPS, even prior to its opening. Street Health has worked with community groups to respond to longstanding concerns in the neighbourhood, including loitering and public drug use. The lack of shelter space and drop-ins aimed at people experiencing homelessness is exacerbating this issue.

Potential areas for improvement

- Offering bereavement counseling for clients dealing with grief and trauma from overdose-related losses.
- Providing Safer Supply programs to divert people from the illegal drug supply.
- Adding supervised smoking services to current OPS services.
- Extending hours of operation to include access seven days per week and in the evenings.
- Expanding the OPS spaces to include larger waiting and chill out areas.
- Need for additional small, low-barrier OPS located directly in neighbouring Toronto Community Housing buildings, in shelters, respite centres, and drop-in centres in the Sherbourne/Dundas area.

WORKING WITH SPECIFIC POPULATION GROUPS

The service delivery model of the OPS at Street Health and St. Stephen's is designed to be low-threshold and accessible to the diverse population of people who use drugs.

Working with people experiencing homelessness

- **Providing a safe space and services for people experiencing homelessness:** The addition of an OPS at both agencies provides people who are homeless with supervision and support with safer substance use practices and access to additional wrap-around services.
- **Lack of shelter and respite space:** A major external challenge to working with people experiencing homelessness is the current extreme lack of services for this group, exacerbated by a lack of space in shelters and respite centres. OPS staff spend a significant amount of time attempting to secure space in shelters/respites for clients.

Working with women and members of LGBTQI2S communities

- **Creating welcoming environments that reduced barriers to access for women and members of LGBTQI2S communities:** While both agencies recognize that this is a priority, a majority of the clients at Street Health's OPS are women (56% of all client visits). This gender breakdown is notably higher than many other harm reduction programs and OPS/SCS in the city of Toronto. Participants credited the non-clinical character of the Street Health OPS, complete with magazines, plants, and art, as contributing to making it a welcoming space. Participants also highlighted that much of the OPS staff team are women with lived experience of drug use.
- **Addressing gendered harassment, homophobia and transphobia:** Staff members at both agencies noted the need to proactively address issues that may keep women and members of the LGBTQI2S communities from using the site, such as gendered harassment, and homophobic and transphobic comments.

Addressing the needs of people who use stimulants

- **Focus on the unique needs of people using stimulants:** St. Stephen's OPS sees a high proportion of people who inject crystal methamphetamine (used in 27.9% of all OPS visits). Participants highlighted the work that St. Stephen's has accomplished in developing programs and services directly for people who use crystal methamphetamine.
- **Providing calm environments and programs adapted to meet stimulant users' needs:** Clients described the positive impacts of having a quieter OPS with smaller capacities at both Street Health and St. Stephen's for people who inject stimulants. More dedicated programming for people who use stimulants, like the Crystal Meth project at St. Stephen's, is necessary.

STAFFING AN OPS

There are several key aspects of the staffing model at both Street Health and St. Stephen's that are notable:

- **Privileging of lived experience of drug use:** Staff and managers at both agencies described the staffing model where frontline staff have lived experience of drug use and play a central role in the operation of the OPS as a key strength.
- **Non-hierarchical staffing structure:** Street Health established a non-hierarchical staffing structure where all OPS staff are given the same job title and are evenly compensated.
- **Support for front-line staff:** Staff at both agencies reported that they feel well supported by their team and managers. However, given the emotional demands of front-line work in an OPS, the need for ongoing specialized supports was identified as a key priority.
- **High levels of competence at overdose response among front-line staff:** Many OPS staff at both agencies received extensive training prior to their hiring as volunteers at the Moss Park Overdose Prevention Site. They also received extensive training from their agency upon hiring. Ongoing training opportunities such as those offered by the Moss Park Skill-Share were appreciated.

Challenges

- **Need for ongoing training and support:** Participants emphasized the need for ongoing training and support for staff members, particularly training for staff on addressing gendered harassment, homophobic, transphobic, and inappropriate behaviours and fostering a safe space. Training in trauma-informed care, conflict resolution and restorative justice would be useful. Adequate training opportunities should be available to all staff including part-time and relief staff. Funding for on-going training is a key difficulty.
- **Ensuring adequate pay and benefits for all staff:** Participants stressed the importance of providing compensation that reflects the high level of skill and expertise required for the difficult and intense work in the OPS. Adequate sick and vacation days were identified as being crucial. While full-time staff at both Street Health and St. Stephens receive benefits, part-time or relief staff may not. The particular needs of part-time or relief workers who are receiving social assistance must also be considered in decisions around pay and benefits.

SECTION 2: BACKGROUND

CANADA'S OVERDOSE CRISIS AND THE DEVELOPMENT OF THE OVERDOSE PREVENTION SITE MODEL

Canada is facing a devastating overdose crisis; over 12,800 people have died from opioid-related overdose between January 2016-March 20191. The overdose crisis is driven primarily by illicitly produced fentanyl (and fentanyl analogues) that now predominate the illicit opioid supply in many parts of the country, including Ontario. In 2018, the presence of fentanyl was detected in 74% of opioid-related deaths in Ontario; however as of early 2019, fentanyl was detected in fully 86% of opioid-related deaths in the province[1].

The Overdose Prevention Site (OPS) model was developed in direct response to the rising number of overdose deaths. In response to government inaction and bureaucratic delays in mounting an effective public health response to the mounting crisis[2-6], OPS emerged in the Canadian provinces of British Columbia (B.C.) in 2016 and Ontario in 2017. They began as unsanctioned, low-threshold services run by volunteers and community members and in makeshift environments, such as tents and trailers. It is important to note that when the first unsanctioned OPS was launched in September 2016 in B.C., there were only two supervised consumption sites (SCS) in Canada (both in Vancouver) that had received an exemption from Health Canada to operate. The process for receiving an exemption to operate from federal authorities and subsequent funding from provincial health officials had been repeatedly criticized as too onerous[3], which led to the opening of unsanctioned OPS.

Municipal and criminal justice actors did not intervene to shut down the unsanctioned sites in BC and Ontario. Instead, health authorities in both provinces quickly introduced provincially sanctioned OPS program models, although their methods differed. In B.C., the provincial government had declared a state of public health emergency in relation to the overdose crisis on April 14, 2016. Frustrated by the lack of government action on the overdose crisis, an unsanctioned OPS was opened by activists from the Overdose Prevention Society in September 2016. The public health emergency was then used to sanction the opening of additional OPS at organizations already providing frontline services to people who use drugs in December 2016[2,3].

In Ontario, the first unsanctioned OPS opened in August 2017 by volunteers from the Toronto Harm Reduction Alliance and the Toronto Overdose Prevention Society[4,5]. In January 2018, the Ontario government announced a program model for OPS within the province, after obtaining a class exemption from federal health authorities to approve OPS within the province[7]. It is important to note that in both B.C. and Ontario, government and public health authorities sought to formalize an OPS program model that had already been functioning as an unsanctioned service by volunteers and community members, with integral input and leadership from people who use drugs. The involvement of people with lived experience in the development of OPS has been documented as a strength of such services, promoting safety and engagement among clients[8,9]. Significant input from the frontlines of the overdose crisis was incorporated into the Opioid Emergency Task Force that designed the OPS model, through the presence of front-line harm reduction workers (including organizers who had been running the unsanctioned OPS in Moss Park) and people with lived experience of drug use on the task force.

The original OPS model developed by the province of Ontario privileged a low-threshold approach to operations, and was designed to allow agencies providing services to people who use drugs to quickly apply for and receive funding from the provincial Ministry of Health to open a new service, with a response to OPS applications provided within two weeks of application submission7. The OPS model that was announced in January 2018 provided no funding for capital expenses, outlining a model where existing agencies would open bare-bones supervised drug consumption sites within existing facilities, with limited funding designed to pay primarily for staffing costs. One advantage of the model was that there was considerable flexibility in the ways that agencies could choose to operationalize the model; this allowed individual agencies leeway to develop service models adapted to the needs, resources, and values of their organization. Models included those that utilized a registered healthcare provider (such as a registered nurse) to supervise drug consumption; alternately, many agencies chose not to have a nurse within the injection space and utilized people with lived experience of drug use as program staff. In practice, and compared to the federal SCS model, this process resulted in greater flexibility of the model and an approach that was more strongly shaped by the needs and practices of the people who would be using these sites.

Following an election in the summer of 2018 that led to a change in government, the new Minister of Health, Christine Elliott, announced a review of the evidence on SCS and OPS in August 2018[10]. In October 2018, this review culminated with the announcement of a 'Consumption and Treatment Services' (CTS) model, which dismantled the previous OPS model, and replaced it with an approach that allowed supervised injection services to continue only if they implemented a 'comprehensive enforcement and audit protocol' and a 'new focus on connecting people with treatment and rehabilitation services'[11]. The new model also included an arbitrary cap of 21 on the maximum number of sites allowed to function in the province, and required all CTS applicants to also apply to the federal government for an exemption as an SCS[12]. After having completed a burdensome application process for the new CTS model in December 2018, and operating on precarious month-to-month extensions from October 2018 to March 2019, the Ontario government announced on March 29, 2019 that 15 existing OPS/SCS had been approved as CTS. One SCS in Ottawa was denied funding, along with two OPS in the city of Toronto also being denied funding – the Street Health OPS and St. Stephen's Community House OPS[13-15]. Since March 2019, the Street Health OPS and St. Stephen's Community House OPS have been able to remain open after receiving a Section 56 exemption from the federal government, and through generous donations from community members.

INTRODUCTION TO THE AGENCIES: STREET HEALTH AND ST. STEPHEN'S COMMUNITY HOUSE

Street Health

Street Health Community Nursing Foundation has been operating for over 30 years as a non-profit community agency, focused on the health of homeless and under-housed people in the neighbourhood surrounding the corner of Sherbourne and Dundas streets in Toronto. This area is estimated to have a poverty rate double the City of Toronto average, and has one of the largest concentrations of homeless shelters and drop-in centres for street-involved people in Toronto; for example, a 24-hour emergency respite and a large drop-in for people experiencing homelessness and extreme poverty are both located directly across the street from Street Health. As a multi-service agency that emphasizes low-threshold service delivery, Street Health provides mental and physical health programs and services, including access to nurse practitioners and registered nurses, as well as social services (intensive case management, street outreach, harm reduction programs, mail services, and ID storage and replacement) to a population experiencing high levels of extreme poverty, chronic unemployment, trauma, homelessness, and food and income insecurity.

According to data from Toronto Public Health on calls for paramedics for cases of suspected opioid overdose from January 1, 2018 – June 30, 2019, the intersection of Dundas and Sherbourne was the intersection with 2nd highest level of overdose calls in the entire City of Toronto[16].

Street Health's OPS opened on June 27th, 2018. The OPS operates out of a coach house that is located in a courtyard immediately behind Street Health's main building on Dundas Street East (close to the corner of Sherbourne). It is a small OPS, with only 2 spaces for injection. There is no nurse within the OPS, with trained overdose prevention site workers staffing the OPS. It was originally open from 11am-4pm, from Monday to Friday, due to funding limitations, and to match the hours of operation of the larger agency and allow for easy referrals to other services provided within the agency. Since May 27th, 2019, the OPS is open from 9:30am - 4pm, Monday to Friday, except on Tuesday when they open from 11am - 4pm.

St. Stephen's Community House

St. Stephen's Community House has been operating since 1962 as a non-profit, community-based social service agency, serving the needs of the Kensington Market area adjacent to downtown Toronto. St. Stephen's works with individuals and communities in the city of Toronto to identify, prevent and alleviate social and economic inequality by creating and providing a range of effective and innovative programs and services. They aim to address the most pressing issues in their community, including poverty, hunger, homelessness, unemployment, HIV and AIDS, youth alienation and the integration of immigrants. The Overdose Prevention Site at St. Stephen's operates within the department of Urban Health and Homelessness Services, which serves approximately 5000 individuals each year and supports approximately 350 visits every day through a range of services, including: a drop-in program that provides nutritious hot food, showers, laundry or socializing 6 days per week; primary health care services from on-site nurses, doctors and psychiatrists; information and support finding affordable housing, HIV/AIDS and Hep C prevention and education services, mental health support; voluntary financial trusteeship; peer training and development programs, and substance use counselling and access to harm reduction services. The Urban Health and Homeless Service focuses on the provision of comprehensive, integrated services that meet immediate and sustained wellness needs for individuals living with complex issues, including substance use, mental health issues, poverty and isolation. Most recently, St. Stephen's Community House worked with people who use drugs to develop a Crystal Methamphetamine strategy, involving the implementation of a series of individual and group services including an innovative amphetamine replacement therapy service.

According to data from Toronto Public Health on calls for paramedics for cases of suspected opioid overdose from January 1, 2018 – June 30, 2019, the Kensington-Chinatown neighbourhood received the 5th highest number of overdose calls in the entire City of Toronto[16].

St. Stephen's OPS opened on April 25th, 2018. The OPS was originally operating in a small room off the main drop-in space in the basement of the building on Augusta Avenue in Kensington Market. It is also a small OPS: the original OPS space only had 2 spaces for injection, with a small space leading into the injection room that functioned as the entry and post-consumption chill space. There is no nurse within the OPS, and trained overdose prevention site workers staff the OPS. It was originally open from 8am - 11:30am, Monday to Friday and Sunday, to match the hours of operation of the drop-in. In June 2019, the OPS moved upstairs to a larger room adjacent to the main entry for the agency. Due to the increased size of the new space, a 3rd consumption space was added. The hours also shifted to opening from 8am - 2pm, Monday to Friday, and Sunday.

SECTION 3: IMPACTS OF THE OPS

PROGRAM USAGE STATISTICS

Street Health Overdose Prevention Site:
Visits and client demographics, June 27th, 2018 to August 31st, 2019

3,134 total visits

56% clients identifying as women

+

43.5% clients identifying as men

+

0.5% clients identifying as trans, gender non-conforming or non-binary

Number of overdoses successfully reversed: **50**

Average number of visits per month:[1] **272**

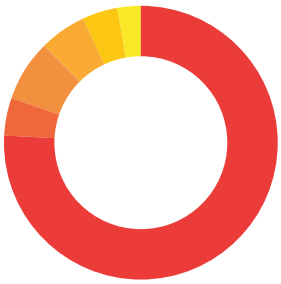
Average number of referrals per month to healthcare including substance treatment:[2] **53**

Average age of clients: **36 years old**

Peer-to-peer assisted injections: **12.9%**

[1] Average number of visits per month from January – August 2019
[2] Average number of referrals per month from April – August 2019

PRIMARY DRUG CONSUMED



- Fentanyl **76.1%**
- Heroin **4.4%**
- Other opioids* **7.3%**
- Crystal methamphetamine **5.5%**
- Crack cocaine **4.2%**
- Other drugs **2.6%**

* oxycodone, hydromorphone, etc.

St Stephen's Community House Overdose Prevention Site:
Visits and client demographics, April 24th, 2018 to August 31st, 2019

2,357 total visits

36% clients identifying as women

+

64% clients identifying as men

+

0% clients identifying as trans, gender non-conforming or non-binary

Number of overdoses successfully reversed: **17**

Average number of visits per month:[1] **154**

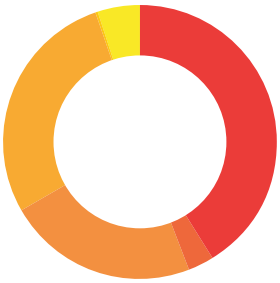
Average number of referrals per month to healthcare including substance treatment:[2] **37**

Average age of clients: **37 years old**

Peer-to-peer assisted injections: **8.1%**

[1] Average number of visits per month from January – August 2019
[2] Average number of referrals per month from April – August 2019

PRIMARY DRUG CONSUMED



- Fentanyl **41.3%**
- Heroin **3.1%**
- Other opioids* **22.5%**
- Crystal methamphetamine **27.9%**
- Crack cocaine **0.3%**
- Other drugs **4.9%**

* oxycodone, hydromorphone, etc.

HEALTH AND SOCIAL IMPACTS ON CLIENTS USING THE OPS

Easy intervention when overdose occurs

The major health impact of using an OPS is when an overdose occurs. Because trained staff are available to immediately intervene, an overdose that may have otherwise been deadly in a public location, in the community, or in a private residence are able to be quickly reversed. As one client remarked on their own overdose that occurred in an OPS:

> *"I'm alive today because of it."*
> (FOCUS GROUP WITH CLIENTS, STREET HEALTH)

Staff members in the OPS also frequently remarked on the impacts they have observed from overdoses reversed within the OPS:

> *"Well one of the big things that people have told me is that they're very fortunate that we are here and... most of them have had friends that have overdosed and some of them have friends that have died so they say they're very fortunate to have this place so we can keep an eye on them and make sure."*
> (INTERVIEW WITH STAFF, ST. STEPHEN'S)

> *"We've had lots of overdoses here, but they haven't been big crises, because the staff are calm and confident. It's really just been easy. It's been a simple, nice addition. It's been quite amazing."* (INTERVIEW WITH MANAGEMENT, ST. STEPHEN'S)

Reductions in public drug use

In addition to the impacts from having quick intervention by trained staff available in case of overdose, participants also spoke of how having access to an OPS impacted their use of drugs in public spaces; most importantly, participants frequently described how they reduced using drugs in public spaces like washrooms, parks, and public stairwells due to having access to the OPS at Street Health and St. Stephen's:

> *"It hasn't affected if you're talking about amount wise, no, it hasn't affected that. But it has affected it positive, where it gives me a safe place to use and not have to do it in a washroom."* (FOCUS GROUP WITH CLIENTS, STREET HEALTH)

> *"I think it's a good service; it'll help get people out of washrooms and stuff like that. Cause like, imagine you take your kid to the subway and you come into the washroom and you find someone dead. Well, instead, now they have these places to use, somewhere safe, right?"* (FOCUS GROUP WITH CLIENTS, ST. STEPHEN'S)

> *"I'm awfully happy they're here, because I haven't had to use in these washrooms for a while. I just find one of these places. Cause they're all, conveniently in the places where people use a lot, right? So, my drugs are usually in the areas of these sites, so, it makes it pretty good that way."* (FOCUS GROUP WITH CLIENTS, ST. STEPHEN'S)

Reducing the impacts of overdose among people who have recently been housed

According to the Public Health Ontario and the Office of the Chief Coroner of Ontario[17], a very high proportion of fatal overdoses occur in private residences, when other people are not present and able to intervene if an overdose occurs following drug use. Staff in the OPS recognized that people who were recently housed following periods of homelessness were at high risk of overdose, and that by offering OPS services, they could address this risk:

> *"We know that people are dying in their units soon after they get housed, we know that people are at high risk for overdose when they are housed and using alone. I think that there is a proportion of our folks who recognize that risk of using alone in their space, so even if they're housed, they'll come and used a supervised consumption site, which is great." (Interview with management, St. Stephen's)*

Impacts on drug use and broader injection-related health behaviours

While quick intervention in case of overdose is a major health benefit of using OPS, there are other impacts on drug use and health-related behaviours. Participants described how being able to use in safer conditions allowed them to go slower, and use practices to decrease their risk of overdose, particularly when compared to using alone or in public:

> *"It decreases the risk of criminalization. It decreases the risk of overdose that people face because they have access to different tools that help them dose. They don't have to rush their dose, they can split it up into 2, 3, however many shots they want to do. They can test their drugs. They can get access to information. If people do overdose, we have access to all of the equipment that we need to reverse an opioid overdose. We have access to healthcare, so people have much more direct [access] to detox, to treatment, as best as we can get in the city, we have that."* (INTERVIEW WITH STAFF, STREET HEALTH)

"To be honest, my using has slowed down. I've learned to use around people more. And if, cause, I watched people overdose in front of me now, like, at the site, and, but then I've seen the help that they get while being at the site. So, if it just, makes me want to, if I was to ever go down, to be here while it happened."
(FOCUS GROUP WITH CLIENTS, STREET HEALTH)

Additionally, having access to sterile injection equipment and trained staff within the OPS improved both injection-related education and behaviours, which could impact on HIV and hepatitis C risk:

"I'm more educated [on HIV and hepatitis C] because of it." (FOCUS GROUP WITH CLIENTS, STREET HEALTH)

Impacts of experiencing non-judgmental and accepting provision of care

The experience of stigma and discrimination among people who use drugs is well-documented, particularly within healthcare settings. The experience of stigma and discrimination when receiving health and social services can be profound, and previous negative experiences can influence people's willingness to access services. Experiencing welcoming and non-judgmental services can have substantial positive impacts for people who use drugs. Participants in this evaluation spoke frequently of their positive experiences accessing care in both OPS:

"Everybody here cares. Once you start at reception and talk to the ladies behind the counter, very peaceful, nice people, very welcoming, encouraging and then you get through all the staff and everybody's very positive." (FOCUS GROUP WITH CLIENTS, ST. STEPHEN'S)

"They're very friendly and welcoming. They're not judgmental. They're like, I feel more they're friends than staff. And this is more at this site. When I come in this site, I don't look at this guys as staff. I look at them as associates or acquaintances. Or even friends, like, [staff member] is definitely my friend."
(FOCUS GROUP WITH CLIENTS, ST. STEPHEN'S)

The provision of non-judgmental OPS services within multi-service agencies that were already providing a wide variety of services to people experiencing marginalization had an unexpected impact of bringing people who were not open about their drug use into the OPS, and allowing staff to make connections with them. This was an important step in beginning to counter the impacts of stigma, and work on connecting them with appropriate services:

"I think there are a number of people, people who've been coming here a long time, and we didn't know they were injecting drugs."
(INTERVIEW WITH MANAGEMENT, ST. STEPHEN'S)

"The OPS staff were able to make that connection with them, because in the drop-in it's like, well, what do you need? I don't need anything. I've got my coffee, I'm good. But what they did need was some real harm reduction support and space to use and be accepted for what they were using, and because of stigma, they didn't want to talk about it in the drop-in, which is totally understandable, but having the OPS meant that now they have a place that's theirs and then they can start to get connected to other services." (INTERVIEW WITH MANAGEMENT, ST. STEPHEN'S)

Help connecting to other services

These positive connections and experiences of receiving care and support within the OPS can facilitate the ability of staff to connect clients to services, both within the agency, and in partner agencies in the community. According to clients:

"They're good providing other services...like housing or treatment, stuff like that."
(FOCUS GROUP WITH CLIENTS, STREET HEALTH)

"I think it's a good location because of the services. If you come in here and you're struggling you have somebody to talk to. If you want to seek out treatment they have programs for that. If you need housing you can get housing. If you need a meal you can get something to eat. They have washers and dryers. Everything you could possibly need is all in one location unlike some of the other sites is just a site."
(FOCUS GROUP WITH CLIENTS, ST. STEPHENS'S)

In the focus groups, participants described how the implementation of an OPS provided a new and critical service to existing clients. Equally, people who were not previously clients of Street Health or St. Stephen's came to the agency first to use the OPS, and then they began to access other services. In this way, offering an OPS onsite can be a way to connect with people who are not otherwise connected to services or care:

Participant 1: "Yeah. I started to use Street Health before the injection site.

Participant 2: I found out about the injection site first, and then Street Health."

(FOCUS GROUP WITH CLIENTS, STREET HEALTH)

IMPACTS ON STAFF MEMBERS WORKING IN THE OPS

Staff members from the OPS also reported strong impacts from their work in the OPS. These impacts are notable because both Street Health's OPS and St. Stephen's OPS privilege lived experience of drug use as a key criteria and area of expertise when hiring staff members. There are three major areas of impact on staff members working in the OPS identified: ability to make a difference in the midst of a crisis, personal growth and fulfillment from their job, and having access to job opportunities that recognize their expertise.

Making a difference in the midst of a crisis

While participants underlined how difficult working in the OPS could be (for more information, see Section 7), another theme identified in the narratives of the front-line staff working in the OPS was that they felt that they were making a difference in the middle of a major public health crisis. This is particularly notable because of how common an experience of having lost family, friends, co-workers and clients to the overdose crisis is for people.

> *"Yeah, I've saved somebody's life. That's the feeling I go home with that day. Even right now it affects me. I'm starting to choke up a little bit... I've gone through so much stuff in my life and if I can help one person to not go through what I went through it's worth it to me."* (INTERVIEW WITH STAFF, ST. STEPHEN'S)

Personal growth and fulfillment

The feeling of making a difference through their work was complemented by a feeling of personal growth and fulfillment. Participants noted that one of the major impacts of their work was on their own personal growth and development:

> *"I have learned so much about life. Not even just about working in an OPS, but so much about life and my life has changed drastically, and my thinking. Being loving and accepting, and non-judgmental. I've met so many beautiful people. The stories that I hear in there from participants that come in there, and oh my god. They're so beautiful. I've learned so much."* (INTERVIEW WITH STAFF, ST. STEPHEN'S)

> *"The whole thing has been a positive experience. It's just helped me all around. To just try and help people on the same journey as I am, support people where they're at, advocate for this movement, I guess, to keep going. I've always felt like I didn't really have much of a purpose or a passion in life. So, since finding social services work, I just love it. You know? I enjoy going to work. And without this, I don't think that I would be off of substances, I feel like it does give me a purpose and it gives me a reason to want to keep moving forward"* (INTERVIEW WITH STAFF, STREET HEALTH)

Job opportunities

It is important to note that for many people who use drugs, their experience of drug use can be extremely detrimental to their ability to find rewarding and well-remunerated employment. The expansion of OPS and supervised consumption services more generally has provided employment opportunities for people with lived experience of drug use within community-based agencies that value their expertise:

> *"One great thing with having injection sites around the city is that there have been more opportunities for folks to use their personal experience as a way to get them a job. So that has been really great, actually, for some of our clients. You know, injection spaces have not only given them a space to use safely, but for some people, it's also given them opportunities to start a career."* (INTERVIEW WITH STAFF, STREET HEALTH)

SECTION 4: POTENTIAL IMPACTS OF CLOSING THE OPS

On March 29, 2019, St. Stephen's Community House and Street Health received news that the Ontario Ministry of Health and Long-Term Care denied their application to transition to a Consumption and Treatment Service (CTS). Both agencies were informed late on a Friday afternoon that they were expected to not open again, with no ability to give notice to clients or develop a transition plan for clients that had been using these life-saving services:

> *"It was four pm. It was hard. I was like, 'Okay, what do we do?' It was scramble. The service was already closed. We couldn't tell anybody. We were supposed to be open on Sunday."* (INTERVIEW WITH MANAGEMENT, ST. STEPHEN'S)

> *"Our application to the province for consumption treatment service was not accepted. They told us on Friday and expected us to close on Monday. And we were not prepared to do that. That's unethical. We have people who count on this service, and it's a lifesaving service, so to simply say 'Now we're closed'? We just weren't able to do that."* (INTERVIEW WITH MANAGEMENT, STREET HEALTH)

In response to this news, the agencies scrambled to figure out how to continue these life-saving services for people who were at high risk of overdose related harms, including death. This was particularly hard as both agencies provided services to a marginalized group of people with whom they had worked hard to build trusting relationships. While the federal government provided St. Stephen's and Street Health an emergency exemption that allowed them to continue providing overdose prevention services, they were left without stable, long-term funding. Both agencies have been forced to rely on donations from community members and a small amount of short-term federal funding to continue operating this essential health service. Despite the pressures of not knowing if they would have a job the next day, staff sprang into action to work on fundraising and on applications for alternative funding opportunities.

> *"We have a fantastic fundraiser...I think it's very, very tough on people's psyche to have to fundraise for a health care service that should just be a core operation."* (INTERVIEW WITH MANAGEMENT, STREET HEALTH)

The clear need for OPS services and the huge impact these services have on community members who use them is most evident in the way that even clients of the sites – frequently people living in intractable poverty – were attempting to make donations to keep the sites open:

> *"[We are] honest with clients about what we're dealing with, with government and all the stuff that we're going through with. Clients try to offer whatever support they have, even if it's like, their last $5, wanting to donate. Something sweet. Beautiful moments with clients. That's my favourite."* (INTERVIEW WITH STAFF, ST. STEPHEN'S)

Luckily, both agencies were able to stay open and mitigate the potentially disastrous effects that an abrupt closure would have had on their clients:

> *"I also think a real commitment, at that point, as well, to find a way to make it work. I was really thankful that our executive director and our board felt the same way. We couldn't shut the service down now. The community wanted it, our service users wanted it, people needed it, were relying on it, so we had to keep it open."* (INTERVIEW WITH MANAGEMENT, ST. STEPHEN'S)

Unsure how much longer they will be able to stay open, the OPS staff members have been engaging in contingency planning. This has included talking to clients about what they can do and places that they can go to use as safely as possible should the OPS close given the context of a highly toxic and unpredictable drug supply and overdose crisis.

> *"We're starting to have conversations with people, like, 'If we're not here, what are we going to do? Like, let's make a plan. Have you used other sites? Like, let's integrate you into other spaces where you can start to feel comfortable there.'"* (INTERVIEW WITH MANAGEMENT, ST. STEPHEN'S)

Despite this planning with clients, there remains considerable concern among staff members around the potential impacts on clients if the OPS at Street Health and St. Stephen's are forced to close. Major areas of concern will be explored below, including the fear that not all clients will transition to other sites, that clients will begin using in public again, that clients will start using in bathrooms within the agency again, and that the trust that was built with clients will be destroyed.

POTENTIAL IMPACTS OF CLOSING THE OPS ON CLIENTS

Increase in overdose and overdose-related deaths

> *"I wouldn't have a safe place to use and I could overdose."* (FOCUS GROUP WITH CLIENTS, ST. STEPHEN'S)

The primary concern of all study participants is that the closure of the OPS at Street Health and St. Stephen's will result in an increase in overdoses and the harms that stem from unsupervised overdoses, including death. Without access to a reliable and regulated pharmaceutical alternative, people who use drugs are vulnerable to harm stemming from the increasingly unpredictable and toxic illegal drug supply. OPS staff monitor clients so that they can respond to overdoses that result from the contaminated drug supply.

> *"These places save lives. They are a necessity and a staple to our community and we need them. People will die if these places close. These places literally are what keeps, like, we're all here right now, because the site is open."* (FOCUS GROUP WITH CLIENTS, STREET HEALTH)

> *"They're going to go back to doing what they did before, they're gonna use in the washrooms or in the alleyways which opens up more chances of overdosing and dying."* (INTERVIEW WITH STAFF, ST. STEPHEN'S)

> *"People don't even care if we die. That's how this society views us. They won't even fund the service that literally saves our lives."* (INTERVIEW WITH MANAGEMENT, ST. STEPHEN'S)

Difficulty in transitioning clients to other SCS or OPS

Clients of both OPS know about other sites in the city, and most have used at least one other site. However, staff members who participated in this study voiced concerns that many clients would not go to other sites regularly and that clients do not have the relationships with other agency OPS that they have with the OPS staff at Street Health and St. Stephen's.

> *"Yes, there's other sites, but it's not their site. We can take people over to Queen West. It's a great site, but different, right? We have people who walk across the city to use this site. They just like it, you know?"* (INTERVIEW WITH MANAGEMENT, ST. STEPHEN'S)

> *"They know about all of the supervised consumption sites in the city, because we share that information with them, all the time. So if they're not already going there, it's because they choose not to."* (INTERVIEW WITH MANAGEMENT, ST. STEPHEN'S)

Many clients highlighted how much they preferred the quiet environment within the smaller sites at Street Health and St. Stephen's, and the feeling of safety and security they had there. OPS staff also highlighted that the other OPS tend to be busier, and that larger sites that may not appeal to clients who sought out the small, safer and secure atmosphere at the small OPS.

> *"We have a better opportunity to connect with the people here than at some of the other sites that are a bit more busy."* (INTERVIEW WITH MANAGEMENT, ST. STEPHEN'S)

Study participants also noted the importance of location of an OPS for clients, with many preferring to stay within certain areas or needing to avoid other areas. Location is also important regarding proximity to other services, including shelters, respites, drop-ins, and other community-based services.

> *"Some of our clients use Moss Park already so it's not like they'll never use Moss Park. But we have a subset of clients that only go to our site."* (INTERVIEW WITH MANAGEMENT, STREET HEALTH)

> *"I know when I picked up my drugs, if there wasn't an OPS very close by, I would just use in a stairwell. So, to go to the trouble of finding another OPS and becoming comfortable there, is like a whole other issue, let alone travelling there."* (INTERVIEW WITH STAFF, ST. STEPHEN'S)

Increase in public drug use and unsupervised use within agency bathrooms

Clients who participated in this study said that if the OPS were to close, they would go back to using alone and in places where they used prior to the opening of overdose prevention services, such as public spaces such as in alleys, washrooms, parks, and stairwells.

> *Participant 1: Go to another site maybe. Most likely I'd go down the hall in the bathroom.*
>
> *Participant 2: I'd be out in the woods or in the alley when it's dark and no one is there.*
>
> (FOCUS GROUP WITH CLIENTS, ST. STEPHEN'S)

It is important to note that Participant 1 above stated that they would simply return to using drugs in the bathroom of the agency that houses the OPS currently. This was a common sentiment among participants in the focus groups – they noted that prior to the OPS opening, they would use (and occasionally overdose) in the bathrooms within agencies. Many agencies decided to open OPS because clients were already using drugs within their bathrooms and quiet areas (such as stairwells and alcoves) – despite rules against this. Many clients would simply return to using in the bathrooms and other unsupervised areas if the OPS were to close, increasing their risk of harm (both from using in unsanitary conditions and from unsupervised overdose). In addition to the harms to clients, the reversion to concealed

drug use within agencies has detrimental effects on staff (such as having to respond to unwitnessed overdoses in suboptimal conditions such as bathrooms) and increase the potential for an overdose death to occur within agencies.

Increased criminalization

In addition to returning to use in public spaces (e.g. stairwells, parks, and alleyways) in the case of OPS closure, clients reported that they would also be spending more time in public spaces because there would be fewer places available for them to go to spend time off of the street. This would increase their chances of arrest for offenses such as drug possession, loitering, trespassing, and mischief, amongst others.

> *"There's this push right now to clean up the neighbourhood, and that just means more criminalization of people. So, you're waking up from overdose to getting arrested for trespassing for overdosing in an alleyway. So, people will be at risk of both things, overdose and criminalization."* (INTERVIEW WITH STAFF, STREET HEALTH)

Severing connections and reducing opportunities for connections to health and social services

The OPS have provided a space for staff members to nurture and build trusting relationships with clients. Participants identified the closure of the OPS as potentially damaging to those relationships.

> *"Clients would see it as another example of society shitting on them. It would be a real blow to the relationships that we've built, because they'd see us as complicit in taking away this service, so that trust that we have built up would be, for some people, that'd be it. We would be done."* (INTERVIEW WITH MANAGEMENT, ST. STEPHEN'S)

> *"We are very concerned with the idea of abandoning people who have come to depend on us."* (INTERVIEW WITH MANAGEMENT, STREET HEALTH)

> *"I think it would feel like a rejection for our clients. I think it could potentially lead to people taking more risks."* (INTERVIEW WITH MANAGEMENT, ST. STEPHEN'S)

> *"They'd feel shit on again because here they've got something, it's established, it's working for them, and our government is taking it away."* (INTERVIEW WITH MANAGEMENT, STREET HEALTH)

Study participants were concerned that the closure of their OPS would reduce client access to other healthcare and social services at the agencies, including just offering clients a safe place to be off the street.

> *"Shutting this down, you're severing the opportunity of people that potentially can go forward. If you sever good programs like this and shut them down, then people's opportunities are never gonna be realized."* (FOCUS GROUP WITH CLIENTS, ST. STEPHEN'S)

> *"I think a lot of the folks that we see in other programs that are coming through our OPS wouldn't come here anymore. The trust would be broken."* (INTERVIEW WITH MANAGEMENT, STREET HEALTH)

> *"I'd be very worried about their healthcare. Because this is an access point for a lot of people's healthcare."* (INTERVIEW WITH STAFF, STREET HEALTH)

POTENTIAL IMPACTS OF OPS CLOSING ON STAFF MEMBERS

Impacts of job loss from OPS closures

For many staff members, working at the OPS is more than 'just a job'. They care passionately about their work and their clients, and are committed to providing accessible and compassionate services to people who use drugs.

> *"I know that our staff are very committed and invested in the site, so I think it would be pretty devastating for them."* (INTERVIEW WITH MANAGEMENT, ST. STEPHEN'S)

The majority of OPS staff members are people with lived experience of drug use, including those who currently use drugs. For many, the work is very personal: they are providing a service that saves the lives of other people who use drugs, and they know that without these services, members of their community are at higher risk of overdose related harms, including death.

> *"It would be a real blow. I think they would see it as one more example of how society doesn't care about them and the people that they care about. That would really be the biggest psychological blow."* (INTERVIEW WITH MANAGEMENT, ST. STEPHEN'S)

> *"I'm just so tired of losing people and not having anything I can do about it, and being able to do something is really so important. I've brought a lot of friends through this space, too, to access services as well. It's really nice to be able to do that."* (INTERVIEW WITH STAFF, STREET HEALTH)

Loss of social support

Study participants voiced their fears that with the closure of the OPS, they would lose the sense of family and community that they had found amongst their OPS team.

"Aside from the practical pieces around money, and there was also, like, the team had also become a family, right? And so, the threat of breaking up the group, that felt really rough." (INTERVIEW WITH MANAGEMENT, ST. STEPHEN'S)

"Finding a whole new job is just stressful. Like, I love St Stephen's. I love their philosophy. I love their values. I love my team. I love how we support each other." (INTERVIEW WITH STAFF, ST. STEPHEN'S)

Others feared that with the loss of their job, they would lose an important stabilizing factor in their lives that gave them a sense of purpose and helped them feel like a productive member of society.

"The OPS isn't just helping clients. It's giving people that have lived experience an opportunity to work and an opportunity to be members of society, and you know, pay taxes and all that stuff that the government wants us to do. So like, now you're going to want to take that away from us?" (INTERVIEW WITH STAFF, STREET HEALTH)

"I really love my job, and I put a lot of myself into it. I think that without my job, I would fall deeper and deeper into drug use that I don't want for myself." (INTERVIEW WITH STAFF, STREET HEALTH)

Loss of income

Many of the OPS staff members have faced barriers to accessing and retaining employment. Their job as front-line staff in the OPS, which values their lived experience, would be difficult to replace. They also worried about how they would get by without income.

"It would be extremely stressful, not only from the point of being unemployed, but also from having lost something that we worked really hard to build up." (INTERVIEW WITH STAFF, STREET HEALTH)

"I would probably freak out about not having a job, not having any money." (INTERVIEW WITH STAFF, STREET HEALTH)

IMPACTS OF OPS SITES CLOSING ON THE AGENCIES RUNNING THE OPS

There were three main concerns that participants had about how the closure of the OPS would affect the agencies.

A return to unsupervised drug use within agencies

The major concern for agencies was, as mentioned above, that drug use would simply return to bathrooms and unsupervised areas of the agency. Agencies had long histories of attempting to prohibit drug use within their walls prior to opening an OPS. They also had long histories of being forced to respond to overdose in their bathrooms and other quiet areas of their agencies – a stressful situation for staff and a dangerous situation for clients. The potential for closure of the onsite OPS raised the concern that they would have to return to the sub-optimal state of attempting to prohibit drug use that they knew would occur anyway:

"If it closed, people will still see this as a place where people use drugs, so they'll use in the washroom, in our parking lot, and then we'd start having these more adversarial relationships with them saying, 'You can't use in our washroom. This is illegal, you're going to get us in trouble, plus you might die in here.' We'll lose all of that good stuff that we've built up with people." (INTERVIEW WITH MANAGEMENT, ST. STEPHEN'S)

This quote also highlights a second concern for agencies – that conflict between staff and clients will result from the closure of the OPS, as staff will be forced to return to enforcing rules that prohibit drug use on site. There is concern that this would be particularly detrimental to the trust and relationship-building that occurred within the OPS, where staff were able to meet clients where they were at in their drug use.

Negative impacts on relationships with people who use drugs

The third concern that was raised was that the closure of the OPS would have a negative impact on the reputation of the agency as a provider of harm reduction services and as being responsive to the needs of their community members. Study participants also discussed their concerns that the closure of the OPS might also lead to further program cuts.

"I think we'd have an influx of clients who would be angry and frustrated and disappointed and discouraged. We'd have to devote a lot of time and energy and resources to reestablishing trust with clients. Because this organization made a promise to the community." (INTERVIEW WITH STAFF, ST. STEPHEN'S)

"I worry that the agency, slowly, will start to fold more and more to doing things like changing and making compromises, and in the end, it would be the clients who are suffering due to that." (INTERVIEW WITH STAFF, STREET HEALTH)

POTENTIAL IMPACT OF THE OPS CLOSING ON COMMUNITIES

Potential for increases in deaths in the community

Study participants stated that the most significant impact of OPS site closures would be the potential for an increase in deaths of community members, and in businesses and other areas of the community, from overdoses:

"The community's terrified. We've had some deaths in the neighbourhood... A lot of our clients go into the businesses around here, and for the most part, they're welcomed, so they get to know them. They're part of the community. You don't want to put those lives at risk and lose people." (INTERVIEW WITH MANAGEMENT, ST. STEPHEN'S)

"I don't even think we're at the tip of this, quote unquote 'overdose crisis.' And, you know, without huge reform, I can't see it getting better fast. And so, closing these spaces, and specifically this space, will be pretty devastating for everybody." (INTERVIEW WITH MANAGEMENT, ST. STEPHEN'S)

Potential for increases in public drug use

Study participants were unanimous in the view that closing the OPS at Street Health and St. Stephen's would result in an increase in public drug use. Additionally, participants commented that the loss of the OPS would result in the loss of a safe place for people to be off the street. With public drug use comes additional concerns, such as increases in public disorder, loitering, and discarded paraphernalia.

"There's just going to be increased public use.... And what do you think is going to happen when we no longer have access to this bathroom for eight hours a day? More public defecating. Like, there is no one else to go. People aren't doing it for fun...There's just nowhere to go." (INTERVIEW WITH STAFF, STREET HEALTH)

"We'll see more drug use in the community, on the streets and in the alleyway. There will be more discarded works. The businesses in the area will be dealing with people in their washrooms again, which was an issue in the past." (INTERVIEW WITH MANAGEMENT, ST. STEPHEN'S)

"This neighbourhood, there's people using all the time, and we're just going to see more of it, unsafely in the alleys and the buildings and the other services. They would not have a safe place to be, not just to necessarily use, they would not have a safe place to be." (INTERVIEW WITH STAFF, STREET HEALTH)

Despite being asked about potential positive impacts from OPS closure, none of the participants in this evaluation were able to produce a single example of a positive impact that may come about from the closure of the OPS at Street Health or St. Stephen's. The overwhelming view was that these potential closures would have a devastating and potentially deadly effect on clients due to the loss of supervised spaces to use drugs, the loss of access to a crucial entry point to health and social services, and the severing of relationships of trust that had been built with clients. Additionally, the potential for negative impacts on staff members who would be losing their jobs was noted, as well as the negative impacts on agencies due to conflicts with clients stemming from a return to having to prohibit drug use within their agencies, and monitor their bathrooms for drug use and potential overdose. Finally, closure of the OPS would provoke negative impacts in the surrounding community due to increases in public drug use, drug use in neighbourhood businesses, and the increased potential for overdose deaths in the community from unsupervised drug use.

SECTION 5: THE IMPLEMENTATION PROCESS

In this section, the implementation process will be explored, including an examination of aspects of the implementation process that worked well, what some of the implementation challenges have been, and areas of improvement.

IDENTIFYING THE NEED FOR AN OPS AT EACH AGENCY

What worked well

Extends harm reduction services and fills a service gap

In addition to the positive impacts on clients and staff in the OPS detailed in the previous section, participants in the evaluation also identified positive impacts for agencies as they began offering OPS to clients. Both Street Health and St. Stephen's were eager to provide a safe space for supervised consumption and overdose response to reduce the risks of death and harms faced by their clients. As both agencies were already offering harm reduction-focused services for people who use drugs, the addition of an OPS within both agencies responded to community needs. It enabled both agencies to divert clients from using in public spaces (e.g., alleyways, parks, stairwells), and for St. Stephen's, to more effectively respond to drug use already happening on site (primarily in bathrooms). In this way, offering an OPS was a natural evolution and complement to the services already being provided:

> *"It just rounds out our package of services that we can offer. It felt like something was missing before. Because we've had this history of growing our harm reduction base here, it wasn't always a strong harm reduction agency, that's really taken time, and this just feel like such an important part of that in terms of welcoming people here who use drugs and growing our own knowledge."* (INTERVIEW WITH MANAGEMENT, ST. STEPHEN'S)

Located in areas of high rates of overdose, as well as high concentrations of homeless and marginalized people

Both Street Health and St. Stephen's have long histories of providing services to marginalized people in their neighbourhoods who use drugs and who are experiencing homelessness. Street Health is located in an area known to be the epicentre of the overdose crisis in Toronto. The Dundas-Sherbourne intersection has amongst Toronto's highest volume of calls to Paramedics for suspected overdoses, which often occur in alleyways, building stairwells, and in shelters and drop-in centres.

> *"This neighbourhood has the highest density of residences and shelters and services for homeless people in the city and because Street Health has been operating in this context for so long, we were very much aware that our clients were being affected by the poisoned drug supply and experiencing overdoses."* (INTERVIEW WITH MANAGEMENT, STREET HEALTH)

> *"It's absolutely essential that Sherbourne and Dundas have an OPS. We know that people are using and experiencing overdoses in the shelters and the buildings and alleys that surround us so, yeah, I think it's key that we be right where we are."* (INTERVIEW WITH MANAGEMENT, STREET HEALTH)

St. Stephen's is located in Kensington Market, a neighbourhood for which there was a high volume of calls to Toronto Paramedic Services for suspected opioid overdoses in 2017-2018. The opening of an OPS there filled a service-gap in the west end of downtown Toronto.

> *"We have our finger on the pulse here in the market. Lots of things go on in the alleyways here right behind us, people sleep there, people live in the alleyways and in the parks so I think it's an ideal setting."* (INTERVIEW WITH STAFF, ST. STEPHEN'S)

Community support for an OPS in the neighbourhood

Neighbours, businesses, and the community school in Kensington Market embraced the opening of an OPS at St. Stephen's, recognizing the potential benefits to the community in terms of reduced public drug use and overdoses, as well as reduced drug use related litter (e.g., used needles).

> *"We're in a really unique position here in that the community loves us, they love our site. They are mostly socially-minded businesses, but also they're concerned about people using in their washrooms and in the alleys and discarded supplies, so they've been really happy to have the site."* (INTERVIEW WITH MANAGEMENT, ST. STEPHEN'S)

> *"Friends of Kensington Market [a citizen's group] set up a YIMBY rally, saying 'Yes In Our Backyard', saying we want this service here."* (INTERVIEW WITH MANAGEMENT, ST. STEPHEN'S)

> *"The principal at the local school has also been amazingly supportive, has said that they saw a real decline in the number of discarded needles since they opened their site. That's pretty amazing, really."* (INTERVIEW WITH MANAGEMENT, ST. STEPHEN'S)

Challenges

Community reaction

For almost a century, Dundas and Sherbourne has been a hub of social services. In recent years, this neighbourhood has experienced considerable gentrification, accompanied by the development of a vocal residents' association that expressed their opposition to the very idea of an OPS at Street Health before the service opened. This organization has continued to advocate for the closure of the OPS, despite it being the same size and having the same level of service usage as the OPS at St. Stephen's.

> *"There's been a fair amount of push back from a small group of very vocal neighbours who have focused their attention on the OPS as a cause of crime and disorder and social unrest and all these sorts of things. It's pretty clear that it's visible poverty that they have the real issue with and that their ultimate goal is to gentrify this neighbourhood."* (INTERVIEW WITH MANAGEMENT, STREET HEALTH)

Street Health has been participating in community meetings and working to address community concerns, such as by establishing a gate to reduce loitering at the front of the agency.

Potential areas of improvement

The opening of more OPS in the neighbourhood, including sites with smoking facilities, may address community concerns about loitering, public drug use, discarded drug use equipment, and public disorder. More OPS would also address concerns from clients about waiting times and having quiet, safe spaces to use drugs.

> *"The problem isn't that there is one site at Dundas and Sherbourne, the problem is that there's only one site."* (INTERVIEW WITH STAFF, STREET HEALTH)

> *"The biggest issue that this intersection is that there isn't any place for people to go. If there were many sites at this intersection, a lot of those 'problems' that people are pointing at and are saying are there because of us would actually be vastly diminished."* (INTERVIEW WITH STAFF, STREET HEALTH)

DEVELOPING THE OPS AND OPENING ITS DOORS

What worked well

Program design process

OPS program design was a team effort at both agencies. Staff members participated in the development of OPS policies and the determination of how the programs would work. Emphasis was placed on creating a low-threshold, accessible, and welcoming service (further details are available in section 5, Service Delivery Model). Staff members appreciated the autonomy that they had in designing and implementing the programs, and acknowledged the importance of getting –and responding to – input from clients.

> *"We've had a lot of autonomy in creating the space, what it looks like, how it feels. Being able to take a lot of feedback from folks who are coming in to use the space and incorporate that as we see fit... being able to take that feedback from people and try to create a space where people feel comfortable."* (INTERVIEW WITH STAFF, STREET HEALTH)

Established relationships with people who use drugs

Both Street Health and St. Stephen's have well-established programs and services for people who use drugs. Adding the OPS filled a service gap for their existing clients. St. Stephen's is a community centre in which clients already come to access services such as the drop-in centre, trustee program, mental health services, case management, and meals. Street Health provides a wide array of low-barrier health services, as well as mental health supports, intensive case management, and ID replacement and storage services. When commenting on the implementation of OPS services within their agencies, several participants noted how 'easy' the implementation process was, as part of a natural fit within the services already being provided by these multi-service agencies. Provision of OPS services was also an acknowledgement of the fact that clients were already using inside of the agency prior to the OPS being open, and sent a strong message to clients that they did not have to hide or be ashamed of their drug use:

> *"I think we were all amazed with just how easy it was to implement it. It just fit in with the drop in. I think it did work well, having it attached to the drop in, because it was just another service we were offering, it was no big deal, it was a space where people were already coming in and some people were using in the washrooms. That worked really well."* (INTERVIEW WITH MANAGEMENT, ST. STEPHEN'S)

Addressing public drug use

Finally, offering OPS services was also a way for agencies to assist with addressing injection drug use within the community. By opening an OPS, both agencies were able to proactively offer a place within their communities for people injecting drugs in public to do so in a supervised environment, thereby reducing public drug use. Additionally, they were able to work with community members – in this example, a local school, to address discarded injection equipment:

> *"Yes, I definitely. I think it's been positive. Like I said, a lot of the clients were … before the OPS was here I mean a lot of their clients they still were using. I mean they didn't start using when we opened up. They were using a long time before we got here … and using and needles were all over the neighbourhood. We've helped that so much. We even went to the school over here and we teach the janitors how to use tongs because they were finding needles on the grounds. The first people on the scene in the morning is the janitors."* (INTERVIEW WITH STAFF, ST. STEPHEN'S)

Challenges

Opening the doors to the services was mostly seamless, however there were challenges.

Overcoming fear of stigma and criminalization of drug use

Experiences of discrimination and criminalization have led to distrust and fear about injecting around other people. Staff found that for some people, it took some time to dispel myths and build trust that would enable people to feel more comfortable using the service, and to not hide their substance use.

> *"A big challenge was getting clients comfortable using the site. We still struggle with building trust with folks that are like, 'I don't trust any regulated space.' There's zero trust with the law and that sort of thing."* (INTERVIEW WITH MANAGEMENT, ST. STEPHEN'S)

> *"Everybody's so used to having to hide their drug use and be on the lookout, watching for the cops and everything like that. And it's so hard for people to get their head around that idea, right?"*
> (INTERVIEW WITH STAFF, STREET HEALTH)

When the OPS first opened at Street Health, the police demonstrated support and understanding for the need of an OPS.

> *"When the cops were parked outside, we'd go out and talk to them, and say, by parking out here, you're scaring people away, and they're potentially dying. And they'd be like, 'Oh, you're right!' and they'd move away."* (INTERVIEW WITH STAFF, STREET HEALTH)

However, this support was short lived. A recent study[18] in Toronto found that police presence near SCS and OPS impacts clients' access to sites. This finding was illustrated in the concerns expressed by this study's participants. They commented on the seemingly 'antagonistic' approach that the police have towards the site, the OPS staff, and clients, which scares clients away:

> *"They came and took pictures of our entranceway a few months back, and wouldn't stop when we asked them to. They're always coming into sites, refusing to wait outside, and they won't move from being parked out front. They're just not working with us anymore. I don't know what that's about, but it's really shitty."* (INTERVIEW WITH STAFF, STREET HEALTH)

Insecure funding

The major organizational challenge affecting OPS service delivery at Street Health and St. Stephen's is the uncertainty around long-term funding for the OPS. Participants spoke of how stressful the precarity of the funding situation is for clients, staff, and management at both agencies. Staff members described the tension that arises while building relationships with clients and working to bring them into the OPS, yet knowing that it could be closed. Efforts to keep the programs operating required balancing service delivery with the considerable time and human resource demands dedicated to securing funding and developing contingency plans if the site were to close.

"It's a tough balance between creating this service that people feel a part of, and that they feel connected to, and also knowing that this could go away, you know, in any minute. It's really stressful." (INTERVIEW WITH MANAGEMENT, ST. STEPHEN'S)

"The political structure we are functioning under has been amazingly stressful. We kind of knew as we were opening that the service was precarious. We opened knowing we only had six months of funding, generally speaking, so even as we started out, we put a lot of ourselves into this space, and that's a lot to do personally and professionally in a space that you know and a service you know might be short-lived. You're building relationships with people, setting up services that might not exist in a very short period of time. Again, building those relationships and offering those services in and of itself can be stressful, but it's a different kind of stress than offering those things while at the same time trying to, I guess reconcile how things are going to be in the medium to long term, when these services might go on indefinitely, they might end next month, they might end tomorrow... that's been very challenging." (INTERVIEW WITH STAFF, STREET HEALTH)

Repeated applications to multiple levels of government

Participants highlighted how the continuous application process was stressful and increasingly convoluted. First, an application to Ontario Ministry of Health and Long-term Care as part of the original OPS model in early 2017 was required. And then later that same year, a much more cumbersome application was necessary as part of the application process for the Consumption and Treatment Services (CTS) model in late 2017, which included the need to also apply to Health Canada at the federal level for a SCS exemption. As one participant noted:

"It just felt like jumping through a lot of hoops that kept getting higher." (INTERVIEW WITH MANAGEMENT, ST. STEPHEN'S)

"I wrote three applications in the space of nine months. We had to write, I had to write, the OPS application, and then we decided that it would be smart to also get the SCS exemption, not rely on the province, so we did that, I wrote the SCS exemption, and then the CTS application came through. That was really all-consuming for that nine months, it was all OPS all the time." (INTERVIEW WITH MANAGEMENT, ST. STEPHEN'S)

Potential areas for improvement

- Sufficient and secure funding was cited as the most important resource for improving the implementation of the OPS.
- SCS and OPS in Toronto, including Street Health and St. Stephen's provide information and education about overdose prevention services to Toronto Police Services to reduce barriers for their clients.
- Decriminalization of drugs is a structural change needed to reduce barriers to health and social services for people who use drugs.

SECTION 6: OPS SERVICE DELIVERY MODEL

This section outlines the OPS service delivery model, including its strengths, challenges, and potential areas of improvement. There are three key characteristics of the OPS model at St. Stephen's and at Street Health:

1. **Integrated:** they are small sites that are integrated into a larger, multi-service agency;
2. **Accessible:** they emphasize accessibility through the provision of low-threshold services that are well-integrated into the agency;
3. **Staffed by people with lived experience:** the OPS staff members are primarily people with lived experience of drug use.

INTEGRATING OPS INTO MULTI-SERVICE COMMUNITY AGENCIES PROVIDING WRAP-AROUND SERVICES

What works well

Having OPS onsite, but separate from busy spaces

Having the OPS integrated into St. Stephen's has facilitated both introducing the OPS to existing clients, and introducing additional agency services to new clients. In the beginning, the OPS at St. Stephens was in a small room in the basement, located right next to the drop-in program, which made it easy to connect with people coming in for food and other services. It was later moved to a bigger space upstairs, adjacent to the front entrance, with the drop-in still easily accessible.

At Street Health, the OPS is located in a coach house that is just behind the main building where service provision occurs. A backyard, described as 'an oasis', separates the coach house from the main building. This calm spot is an area used by both clients and staff members, and place where they are able to connect.

The ability to provide wrap-around care

While using the OPS, clients build relationships with staff and begin to discuss their needs and goals and learn about resources and services, both onsite and in the community. Having services onsite creates a 'one-stop shop' for clients. In addition to OPS services (which include the provision of harm reduction supplies and education; drug testing services; observed injection, oral and intranasal consumption; and overdose response using oxygen and naloxone), Street Health and St. Stephen's provide access to a wide range of healthcare and psychosocial services, both onsite and through community partners.

> *"I think it's a really easy catch-all service for any issues that come up as a drug user, too, that wasn't there before. Like my abscess from injecting, I can just walk in, or I need someone to call detox with me, whether I get in or not, and someone to talk with me... I can just walk in. So many things can fit under the umbrella, and you know it's all going to be judgement-free."*
> (INTERVIEW WITH STAFF, STREET HEALTH)

> *"People come here to use drugs but it's like a one stop shop where we'll try to get all of their social and health needs met. So I think just knowing we'll kind of be here and we'll kinda like jump through the hoops and are willing to do that work for them is really key."* (INTERVIEW WITH MANAGEMENT, STREET HEALTH)

Both agencies also have healthcare providers on staff to provide quick and easy access to healthcare, which is crucial since the population accessing the OPS often lack access to primary care:

> *"We're very lucky in that we have a nurse four days a week, and then a doctor here one day a week, so if we have people come in who need some wound care or something, we just take them to see the nurse."*
> (INTERVIEW WITH MANAGEMENT, ST. STEPHEN'S)

> *"Street Health really does embody the low threshold, low barrier model or spirit of delivering health care. I can think of many situations where someone came in initially to consume substances, they had a pressing health issue. We have a nurse practitioner on site, we have registered nurses on site. Those people also have connections in the broader health care system and the broader hospital system."*
> (INTERVIEW WITH MANAGEMENT, STREET HEALTH)

Additionally, both agencies provide access to substance use treatment either onsite by their healthcare providers, or through referral pathways to agencies in the community providing these services:

> *"Our nurse practitioner can also prescribe methadone and Suboxone. People are occasionally interested in that. Many of the people we see have already had long experiences with methadone and Suboxone but just in terms of having that treatment available right here I think that's very key."*
> (INTERVIEW WITH MANAGEMENT, STREET HEALTH)

Examples of onsite programs and services include:

- Primary care
- Drop-in program
- Foot care
- Laundry and shower programs
- Hepatitis C / HIV rapid testing
- Clothing and basic needs
- Mental health services
- Peer programs
- Methadone and Suboxone prescribing
- Housing help
- Toronto Community Addiction Team
- Financial trustee programs
- Case management
- ID and health card clinics
- Counselling and support
- Computers, telephones, and mail registries

Referrals to external agencies

At both the Street Health OPS and St. Stephen's Community House OPS, OPS services are very low-threshold, with minimal intake process and many clients leaving with multiple referrals to services that address the wide variety of health and social needs faced by clients, including homelessness, entrenched poverty, need for access to health and social services, and desire for supports around substance use. Both agencies work closely with community partners and agencies in the community to ensure that clients are linked up to available health services, social services, and drug treatment and detox services when desired.

> *"Methadone and Suboxone, that kind of thing, we have a lot of connections in the community to places that provide that. Like both kind of more traditional, high volume methadone clinics and some of more connected to primary care, rapid access addiction medicine clinics in hospitals. We have pretty strong connections to Anishnawbe Health. They offer an indigenous focused opioid treatment program so that's helpful."* (INTERVIEW WITH MANAGEMENT, STREET HEALTH)

Staff members also link clients to services in the community, such as addictions treatment (e.g. to detox services, rapid access addictions medicine clinics), shelter beds, and culturally specific programs. They facilitate urgent health care for needs that cannot be met on site. Referral success is based on building trust over time and connecting clients to access existing resources within the agency and the larger community.

> *"We're looking at, like all of the elements that contribute to a successful referral from point A to point B and really trying to find all the supports and ways to make those referrals successful."*
> (INTERVIEW WITH STAFF, STREET HEALTH)

Examples of services provided through referrals:

- Healthcare – primary care
- Dental care
- Healthcare – specialists
- Food Security/food banks
- Sexual health
- Shelters/respites
- HIV/hepatitis C specialized care
- Support finding housing
- Mental health care
- Landlord/tenant relations
- Crisis intervention/crisis centres
- Immigration services
- Treatment – detox
- Education and employment services
- Treatment – opioid agonist treatment
- Skills training
- Treatment – rehab
- Volunteer opportunities

Challenges

OPS staff members reported frustration in trying to secure shelter beds and detox beds, stating that they frequently spend many hours trying to find available beds for clients desperate for these essential services.

> *"When it comes to detox and treatment, it's rare that there's a bed or a program ready when that person is ready. It's often the case of spending the whole day on the phone waiting for a cancellation or for a space to open up."* (INTERVIEW WITH MANAGEMENT, STREET HEALTH)

> *"I'll spend hours calling for a shelter bed, no shelter bed, try to get an assaulted women's bed, can't get that, try to get a detox bed, can't get that, try to get a crisis bed, can't get that... It was just constantly having to be, sorry, there's nothing, there's nothing, there's nothing."* (INTERVIEW WITH STAFF, STREET HEALTH)

The lack of availability of treatment or detox services for clients who would like to access them is a major difficulty given the current emphasis on access to treatment services in the new CTS model. Participants repeatedly emphasized the total dearth of available services for people wishing to access treatment or detox beds, and the difficulty in coordinating access to these services:

> *"I regularly call for detox beds for people. Once, this summer, I called and got a bed for a woman. Every time that I've called, the automated message has always said, if you're calling for a detox bed for a male-identified person, we do not have any."* (INTERVIEW WITH STAFF, STREET HEALTH)

> *"It's impossible to line up detox with treatment plans on people's chosen timelines. If we're asking people to wait a day, a week, even an hour, to go to detox or treatment, we're losing people. People need those things when they need them, not some time that is convenient for the system."* (INTERVIEW WITH STAFF, STREET HEALTH)

Study participants recognized that the OPS are vital services that have prevented harms, including death. But they also pointed out that an OPS cannot completely protect people who use drugs from the poisoned illegal drug supply the way an integrated Safer Supply program would.

> *"The drug supply is very unpredictable and toxic and it's hard for people to know what to use to just maintain themselves and not kill themselves. So yeah, I think a major need for our clientele is a safer supply program."* (INTERVIEW WITH MANAGEMENT, STREET HEALTH)

Potential areas for improvement

- Offering bereavement counseling for clients dealing with grief and trauma
- Providing Safer Supply programs to divert people from the poisoned illegal drug supply

OPS ARE ACCESSIBLE & PROVIDE LOW THRESHOLD SERVICES

The OPS program model is 'low-threshold'; that is, it is delivered within existing spaces and hours of operation of the agencies offering the service, without excess 'hoops' to jump through for access to services. The policies and procedures, as well as the staff approach to working with clients are designed to reduce barriers to services as much as possible for the diverse groups of people who use drugs. The goals of low-threshold services are to open doors to services for marginalized people, to provide a safe, non-judgmental, welcoming space that encourages clients to come back, to work with clients on their self-defined needs and goals, and to meet them 'where they are at'. Some of the ways that accessibility is addressed in this model is through the design of the OPS space, hours of operation, wait times, and staff approach to working with clients.

What's working well

A bright, airy space, non-clinical space

At Street Health, the OPS is located in the coach house, a space people described as 'bright' and 'homey', complete with skylights, artwork, plants, and access to an 'oasis-like' backyard that provided relief from the bustle on the street.

> *"Being a very cozy, comfy homey space, that has been really useful, to break away from the more institutional clinical vibe. It's just much more casual and accommodating. Yeah, so I just think people feel comfortable."* (INTERVIEW WITH MANAGEMENT, STREET HEALTH)

Study participants from both agencies felt that the comfortable spaces were critical for welcoming in clients and for facilitating relationship-building between staff and clients, which helped staff connect clients with additional services onsite and in the community.

> *"I really think that it has to do with how at ease people feel in this space. I think anxiety and stress and just being someone who experiences oppression in your daily life, I think that those things contribute to your potential to overdose."* (INTERVIEW WITH STAFF, STREET HEALTH)

"And because it's a quieter space, you have more time and opportunity to think things through, to connect and talk to staff, figure out what you need, what you want." (INTERVIEW WITH STAFF, STREET HEALTH)

Client participants talked about having spent much time using drugs in dark basement-like places, and felt that having the OPS at St. Stephen's move from the basement to above ground made it feel less stigmatizing and more welcoming.

"Yeah, it's just like, more light and airy. Like it has a better energy. I feel like coming upstairs, where there's an office and people, it's more like, normalized, and less shame, less stigma, all that stuff." (INTERVIEW WITH STAFF, ST. STEPHEN'S)

A small, quieter space

Smaller, less-busy spaces were discussed as an important alternative for people, and an option that needs to be available throughout the city in locations where people who use drugs go and where they live.

"Ontario's going in the direction of very large, centralized services and I think for the people we see, they'd benefit much more from decentralized smaller services spread around the city." (INTERVIEW WITH MANAGEMENT, STREET HEALTH)

"A person who uses drugs has to use throughout the day, they're gonna be in various places through the day. They need access to a very simple low threshold booth in their building, shelter, drop-in, wherever." (INTERVIEW WITH MANAGEMENT, STREET HEALTH)

Study participants discussed the merits of having a small space, such as the ability for staff to better manage the space and connect with clients. They described the 'rock and roll' environment of some of the larger and busier OPS as something that some clients wished to avoid – even at the expense of having to use alone or in public spaces such as alleyways. Due to much higher volumes of clients needing services, some participants had the impression that larger sites sometimes tended to hurry people along, leaving clients feeling rushed when doing their drugs and forced to leave before they are ready – a particular issue for people who were homeless and had no place to go.

At the Street Health and St. Stephen's OPS, clients are able to take their time when consuming drugs, and 'chill out' for more than 20 minutes. This longer time at the site let them interact more with staff and feel comfortable in a safe space instead of having to be out on the street.

"What clients tell me most is that the coziness of the space and the quietness of the space is what draws them. Like, people, women identified folks in particular, will come in and say 'Oh my god, this is the first quiet moment I've had all day. I cherish this. I value this.'" (INTERVIEW WITH STAFF, STREET HEALTH)

"The small space, it's good for, like, attention wise, the staff are able to focus on them and like, overdoses, things don't go missing...." (FOCUS GROUP WITH CLIENTS, STREET HEALTH)

Easy access to the OPS and to services

The OPS at St. Stephens was previously in the basement next to the drop-in but has since moved upstairs, to a room at the front of the building. The drop-in and all related services are steps away, but far enough to provide greater privacy and ease of access to the OPS. For some clients, accessing the OPS through the drop-in was a problem: it was too crowded and chaotic, and made them feel too visible. Staff also found the OPS space was too small, making it difficult for clients to move around (if needed post-consumption) and for staff members to work.

"There was benefits to having it with the drop-in, but some people struggled walking into a busy, noisy environment. And, hard to be anonymous. Here, you just walk right in. You don't need to go to reception, just go right into the site. It's very private. And the drop-in and everything else is still right there." (INTERVIEW WITH MANAGEMENT, ST. STEPHEN'S)

"Come right in the front door and come right in! It's right there, it's more accessible for people to see, know that we're up here." (INTERVIEW WITH STAFF, ST. STEPHEN'S)

Accessible for people requiring mobility assistance devices

Study respondents from Street Health and St. Stephen's reported that the OPS in both agencies are accessible for those who use mobility devices and they the OPS have accommodated clients in wheelchairs and using walkers.

Short wait times

Critical to creating a low-threshold and accessible space is ensuring that clients have access to services when they need them. The small OPS at Street Health and St. Stephen's are able to keep wait times at a minimum. They do not have time limits for how long someone can be at a consumption booth or in the OPS. They work with people to move them along when a booth is needed, moving them from the booth to another space in the OPS to be monitored and for the client to 'chill' for a bit.

> *"Yeah, this one is very accessible. I've never, ever came here once before and had to wait so that's a good thing."* (FOCUS GROUP WITH CLIENTS, ST. STEPHEN'S)

> *"I like this site better too, because when you come in, you get a booth right away. At other sites, you go in, you're sitting in the waiting room for ten, fifteen minutes and then that's when I resort to using a washroom again, because I'm not going to sit there forever with drugs in my pocket while I'm dope sick."* (FOCUS GROUP WITH CLIENTS, ST. STEPHEN'S)

Challenges

Lack of smoking facilities

Lack of supervised smoking facilities for people seeking to smoke their drugs is a health equity issue. Smoking is a common mode of consumption of opioids and stimulants, and the OPS are currently not able to accommodate this. Certain groups are also more likely to smoke as opposed to inject drugs. For example, study participants reported that in their neighbourhoods, Indigenous community members prefer smoking drugs and drinking alcohol, neither of which are permitted in the OPS. Clients are forced to smoke outside in public spaces, placing them at risk of criminalization, conflict with neighbours, and harms related to the toxic drug supply, and creating barriers to access to the wide range of services that the agencies offer.

> *"We can't keep them safe, from the law, from overdose, when they want to smoke. Lots of people are like, 'I want to stop injecting and I want to smoke.' And it's impossible to help with that, when we can't offer a space, even with opiates."* (INTERVIEW WITH MANAGEMENT, ST. STEPHEN'S)

> *"We need an inhalation site desperately. When folks are on the street, they are at risk of criminalization, but also they're not gaining that streamlined access to all these other services – medical, housing, food. It's unfair."* (INTERVIEW WITH STAFF, STREET HEALTH)

> *"There isn't an equivalent for people who smoke, and I think that's a disservice. What this community needs is a safer inhalation space. It'd make a big difference both to the community opposition and to the clients who we're looking to serve."* (INTERVIEW WITH MANAGEMENT, STREET HEALTH)

> *"Injection users get special treatment. They get safe sites. What about us? We got no choice but just sit right there in front of that business, and everyone knows that's not a good place to smoke crack!"* (FOCUS GROUP WITH CLIENTS, STREET HEALTH)

Reaching people who use drugs who are reticent to access health and social services

While efforts to create welcoming inclusive environments have resulted in existing clients feeling very comfortable accessing OPS, participants acknowledged that there are still people using drugs in community settings who would benefit from overdose prevention services – particularly those using in 'trap houses' or social housing apartment buildings in the community – that the OPS is having difficulty reaching.

> *"There are a number of spaces in the neighbourhood, like trap houses that people have been there for years and years. So, part of our challenge is to reach those people."* (INTERVIEW WITH MANAGEMENT, ST. STEPHEN'S)

> *"There's a lot of people we're not reaching even in that one building over there where there are still people dying from overdose, like, constantly. And overdosing in the stairwells, people who don't live there even. I wish that there was a better way to infiltrate that. Really, they need an OPS right in there."* (INTERVIEW WITH STAFF, STREET HEALTH)

Additionally, the roll-out of SCS and OPS into all locations where they are needed has stalled. Notably, many drop-ins, shelters and respites centres continue to experience drug use and overdoses in their bathrooms, and clients hesitate to travel even short distances to access formal OPS rather than using onsite in agencies that lack OPS services.

> *"It might seem really simple for people to just run across the street here, but if they've never gone here before, they don't know what they're walking into, they might just stick to the comfort of the All Saints' bathroom, you know?"* (INTERVIEW WITH STAFF, STREET HEALTH)

Hours of operation

All study participants agreed that the hours of operation are insufficient and do not meet the needs of people who use drugs. They discussed the need for hours every day of the week, and for clients to have access to an OPS 24 hours per day. Specifically, there are very few OPS options for people at night or on the weekends. Night hours are particularly needed for people who use stimulants: they are often up for long hours and do not have options for safe places to be at night.

> *"I feel like the hours are like, the staff hours, not the drug user hours. I feel like, yeah, drug user hours are night."* (INTERVIEW WITH STAFF, ST. STEPHEN'S)

> *"Gotta have hours open during the middle of the night, cause people who use stimulants are usually up for a long time. And then, all the sites are usually closed at night."* (FOCUS GROUP WITH CLIENTS, ST. STEPHEN'S)

> *"Most of the times overdoses happen is at night, because the places are closed. So, they're resorting to using on the streets, the bathrooms, whatever. And they don't have somebody there to say 'Hey, are you okay?' or check on them or reverse anything."* (FOCUS GROUP WITH CLIENTS, STREET HEALTH)

Enough space for clients pre- and post-consumption

Staff discussed the potential benefit of adding more consumption booths, but felt that the more pressing need was for space for clients to be before and after using the OPS. This problem is linked to the lack of spaces in the community for people who use drugs and who are experiencing homelessness to hang out and just 'be'. At St. Stephen's, the new OPS has more room and both staff and client participants acknowledged that this larger space was an improvement and was working well. At Street Health, the CTS application had contained a request for funding for renovations to create a 'chill' space. In the absence of capital funds to address this issue, a 'chill' space remains major need.

> *"It'd be really great to have a waiting room, or a chill space for people to spend time in. We're not a drop-in, but we do have a lot of folks who are hanging out because they can't move along right away, or aren't comfortable to move."* (INTERVIEW WITH STAFF, STREET HEALTH)

> *"We use the backyard as a chill out space. People get monitored back there and that's good, but it's very weather dependent. It would be excellent to have a separate room where people could just spend time. This neighbourhood really suffers from a lack of spaces for people to just be."* (INTERVIEW WITH MANAGEMENT, STREET HEALTH)

Entry into the OPS at Street Health

Street Health has succeeded in creating a very comfortable OPS space, but there are concerns about how the OPS must be accessed. Participants described that there were several steps necessary to enter the OPS. Due to the current design and lack of funding for renovations, clients have to enter the main building and request that the receptionist ring them through the gate into the courtyard, and then must buzz again to get into the coach house building (though frequently, OPS staff will greet them at the door as they are alerted by the receptionist that someone is coming through). As one client explained:

> *"I dislike that I have to go upstairs, ask the lady to buzz me in, then I have to wait five minutes to get buzzed in. Then I have to wait another five minutes to get in the door. Like, what– am I in jail?"* (FOCUS GROUP WITH CLIENTS, STREET HEALTH)

Staff members acknowledged the need for 'traffic control' and for locked doors, but felt that clients experience these as barriers.

> *"There's too many barriers that could lead to people never coming back. Too many locked doors."* (INTERVIEW WITH STAFF, STREET HEALTH)

Street Health respondents are interested in finding a way to streamline the entry access process to the OPS. One suggestion that was repeatedly made was accessing the OPS from the back alley.

Potential areas for improvement

- Adding supervised smoking services to current OPS services
- Need for small, low-barrier OPS located directly in neighbouring Toronto Community Housing buildings, in shelters, respite centres, and drop-in centres
- Extend hours of operation to include access seven days per week and in the evening
- Expanding the OPS spaces to include larger waiting and chill out areas
- Examine alternate entrance options for clients to facilitate site access

EMPLOYMENT OF PEOPLE WITH LIVED EXPERIENCE OF DRUG USE

The employment of people with lived experience of drug use is an important characteristic of the OPS service delivery model, and a necessary component to the successful design and delivery of overdose prevention services.

What's working well

Participants described the following ways that programs and clients benefit from having people with lived experience as staff members:

Reduces barriers to services

Participants referred to the presence of staff with lived experience as a key feature of the OPS that made it a welcoming and comfortable space. Clients felt that because staff have used or do use illegal drugs, the staff are able to understand their experiences of withdrawal, drug use, homelessness, poverty, and other related challenges.

> *"I've just always felt so much more comfortable talking to people that have been on the same path as me. Like, people that haven't been there won't get it, as much as they might try to. So, yeah, having people with lived experience, we can connect with the clients, in a way that maybe other people won't be able to. And even if the other people think they would be able to, like the clients might not feel like that, so."* (INTERVIEW WITH WORKER, ST. STEPHEN'S)

> *"So it's a little easier to open up to them. Like when I went in there, and someone's going to see me, like shooting up fentanyl and stuff, I thought they're all going to be fascinated and want to watch. But they didn't care because they've all done it before. So yeah, it's just another place to use. You know? And I'm very comfortable and stuff."* (FOCUS GROUP WITH CLIENTS, ST. STEPHEN'S)

Ensures relevance of services

Staff who currently use drugs that are procured from the illegal market are well tuned to what is happening in the local drug scene. They can provide information to both clients and the agency to make sure that the services are relevant and responsive to what is happening in the drug market.

> *"The drug supply is also always changing, so if you want an up to date understanding of that, you really need to be using drugs. Someone who is fully abstinent is not going to understand the state of fentanyl in the city right now, and what that means for things like trying to stop or getting on methadone or even just your daily life and the things you're going through."* (INTERVIEW WITH STAFF, STREET HEALTH)

> *"People who have lived experience of drug use are able to offer a lot more relevant information to people who are maybe struggling with different pieces of injecting, the knowledge of drugs that are currently on the street or are injectable is a lot more relevant than say, a nurse who either doesn't have that knowledge because they haven't had that experience, or can't share that knowledge, because they are limited by their college."* (INTERVIEW WITH STAFF, STREET HEALTH)

Demonstrates organizational commitment to addressing stigma and discrimination and to meaningfully involving people with lived experience

Community healthcare and social service providers often profess to involve people with lived experience and subscribe to the ideals of 'nothing about us, without us', yet they do not always have opportunities for people with lived experience to engage meaningfully and equitably. As described in Section 7: Staffing, St. Stephen's and Street Health determined that lived experience is one form of expertise required for the role of OPS worker – a formal employment position (as opposed to a peer, volunteer or intern/job training position). This demonstrates their commitment to meaningful engagement of people with lived experience, and to countering the stigma and discrimination that people have experienced in previous interactions with other healthcare and social service providers.

> *"The folks coming in will see that we value the expertise in their community."* (INTERVIEW WITH MANAGEMENT, ST. STEPHEN'S)

> *"We primarily serve people who are homeless or heavily street involved and a lot of those people have had horribly traumatic and negative experiences with like formal health care. I think the fact that the vast majority of staff are people who use drugs or did use drugs has really informed the character of the site and the way we do things here. We make them feel comfortable, safe."* (INTERVIEW WITH MANAGEMENT, STREET HEALTH)

Provides role models for other clients

Study participants referred to OPS staff with lived experience as providing a role model for clients.

> *"I think there's value in showing clients that you can be an injection drug user and still have all these things that you're told you can only get once you've reached abstinence and recovery. You can have an apartment, and keep that apartment, and pay your rent. You can have a good job and you can have stability. There isn't only one way to be."* (INTERVIEW WITH STAFF, STREET HEALTH)

> *"And so many people, when they hear your lived experience, they're like, 'Oh! So, you used to use drugs, and now you're clean and you've got your life together', and 'you used to be one of us', and I'm like, 'No. I use drugs now. I'm able to manage my drug use alongside my lifestyle, and my work', and people are just like, What? Wow!"* (INTERVIEW WITH STAFF, STREET HEALTH)

SECTION 7: WORKING WITH SPECIFIC POPULATION GROUPS

The service delivery model of the OPS at Street Health and St. Stephen's is designed to be low-threshold and accessible to the diverse population of people who use drugs. To enhance accessibility, the unique needs of specific population groups who make up the client population of each agency have been considered. In this section, we discuss how Street Health and St. Stephen's OPS have worked to facilitate access to their services for people experiencing homelessness, for women and members of LGBTQI2S communities, and for people who use stimulants.

WORKING WITH PEOPLE EXPERIENCING HOMELESSNESS

Street Health and St. Stephen's have long histories of providing services to people experiencing homelessness, and they offer multiple services for this vulnerable population. Most clients that use both St. Stephen's and Street Health's OPS are experiencing homelessness, and as such, their service delivery model has been designed with the needs of people who are homeless in mind.

What's working well

Providing a safe space for homeless people

People who are experiencing homelessness are at high risk of criminalization. When using drugs outside or in public spaces people are forced to rush, which compromises their ability to use safer injection practices and puts them at higher risk for harms including overdose. The addition of an OPS at both agencies provides people who are homeless protection from criminalization, as well as providing them with supervision and support with safer substance use practices, access to additional wrap-around services, and simply a safe place to be.

> *"People who are homeless know that Street Health is here. It's trusted in the community and people have experiences getting other services here so it's great to have an OPS connected because there's already that trust that people have with Street Health."* (INTERVIEW WITH MANAGEMENT, STREET HEALTH)

> *"For folks on the street, it's huge. It's a calm, safe space. Often people come in, they use, and then just flake out for the rest of the morning, and that's the only sleep that they're going to have that's actually restful, because the rest of the time, they're outside moving around or camped out but having to be alert."* (INTERVIEW WITH MANAGEMENT, ST, STEPHEN'S)

> *"We try to have food and anticipate what people might be needing. We try to have food and toiletries and even makeup, like nice little treats for people when we can get them."* (INTERVIEW WITH MANAGEMENT, STREET HEALTH)

Challenges

Lack of housing, shelter beds, respite centres, and drop-in programs

Overwhelmingly, study participants were frustrated by the lack of services available for people who are homeless. In particular, they report that there are very few places for homeless people to spend time – day or night. This forces people to pass time on the streets, in alleyways, public spaces, businesses, and in building stairwells. This makes them vulnerable to criminalization, and creates tensions with community members. It also exposes them to multiple health harms, Participants highlighted how the homelessness crisis is so bad that even access to basic amenities like bathrooms is lacking and that people are forced to toilet in public. While the provision of basic amenities was not originally in their scope of service, it has been a key advantage:

> *"It's shocking to me in this neighbourhood that there are not enough washrooms. People are forced to use the washroom in public, which in a city like Toronto is ludicrous. We try to have food and anticipate what people might be needing... toiletries and even makeup, like nice little treats for people when we can get them."* (INTERVIEW WITH MANAGEMENT, STREET HEALTH)

Staff members report that a large part of their job is finding places for their clients to go, but their efforts to secure a spot in a shelter or respite centre were often not successful due to the lack of shelter beds to accommodate the homeless population. In the face of insufficient resources and services, the OPS attempt to provide de-facto respite services, though they are not resourced or recognized as such.

> *"We're doing work that we're not meant to be doing. The loss of something like several hundred shelter beds massively impacts us. People stay for hours because they don't have anyplace else to go. It's heartbreaking to have to send people out when there isn't any place for them to go."* (INTERVIEW WITH STAFF, STREET HEALTH)

"This year especially, access to shelter beds and detox beds has been atrocious. It was one thing in the winter when we expected that based on past experience, but this summer, to still not be able to get a shelter bed for someone at 2 pm, or even a mat on the floor or respite or something, anything, is really difficult and taxing." (INTERVIEW WITH STAFF, STREET HEALTH)

Potential areas for improvement

- Additional spaces for OPS clients to spend time pre- and post-consumption
- Expanding hours to include OPS opening hours on weekends and at night

WORKING WITH WOMEN AND MEMBERS OF LGBTQI2S COMMUNITIES

Establishing a safe space for women and transgender people has been a priority, particularly for Street Health – an agency where the OPS is largely staffed by people who identify as women. It is exceptionally notable that the majority of clients at Street Health's OPS are women (56% of all client visits), as harm reduction programs typically have a difficult time reaching women who use drugs, and often have difficulty reaching 35-40% usage by women who use drugs. The success of Street Health at creating a space with high usage rates among women is exceptional and deserving of further research to document and ascertain the factors contributing to this success. The experience of Street Health's OPS in creating safe spaces for women and LGBT folks can be applied to other organizations.

Study participants described how the OPS was designed to facilitate access for women and members of LGBTQI2S communities. This included the recognition that environments with high frequencies of gendered comments and insults (including sexist, homophobic and transphobic comments) create barriers to services. The following are examples staff provided of how to reduce barriers:

"I think just prioritizing women's interests and women's needs and like taking them seriously and shutting down the things that they think are serious threats to their well-being. Yeah, I tend to think that having a service that's open to everybody but just like explicitly anti-oppression, anti-sexist is the way to go." (INTERVIEW WITH STAFF, STREET HEALTH)

"Something that's been very valuable is giving women a space away from men. We know that more women use our space than other spaces and I think it's because they feel safer here. They probably aren't gonna run into somebody that they're trying to avoid. They can take their time. We're here to support them." (INTERVIEW WITH STAFF, STREET HEALTH)

"Women are exceptionally stigmatized for their drug use for a lot of reasons. For women to come into a space where they feel safe, they aren't being criminalized, they have people to talk to, to connect them with services who aren't going to judge them... it's incredibly important." (INTERVIEW WITH STAFF, STREET HEALTH)

What's working well

Creating welcoming spaces

The non-clinical character of the Street Health OPS, complete with magazines, plants, and art, was identified by participants as one aspect of the OPS, which made it a welcoming space. Participants also appreciated that the majority of the OPS staff team are women with lived experience of drug use.

"The character of the space is warm and friendly and doesn't look like a health care service. The vast majority of our staff are women. The vast majority of our staff are women who use drugs or have used drugs. We share a lot of common experiences with our clients just for that reason." (INTERVIEW WITH STAFF, STREET HEALTH)

An important part of establishing a safe and welcoming space is to have clear policies that prohibit inappropriate conduct, including sexual harassment, gender-based, homophobic or transphobic comments, and other forms of gender-based violence.

"We are staffed by women who share a lot of the same experiences. We have a very explicit like anti-oppression policy. When people are behaving badly we shut it down right away so women are seeing we're on it and that that matters to us as a rule just as much as any of the other rules and I think they appreciate that" (INTERVIEW WITH STAFF MEMBER, STREET HEALTH)

Clients also noted the impacts of having staff quickly address gender-based comments and harassment:

"There was a client here once hitting on a staff and making sexual comments and I don't work here, I was just coming in to use, and I said shut your fuckin' mouth, you're here to do drugs, not flirt, not make sexual comments, if you wanna do that get out the door and the staff backed me up." (FOCUS GROUP WITH CLIENTS, ST. STEPHEN'S)

Challenges

Addressing gendered harassment, homophobia and transphobia

St. Stephen's OPS sees fewer women; although their proportion of women clients is lower than at Street Health's OPS, they are nonetheless in line with many other harm reduction programs in the city. Staff members from St. Stephen's OPS noted that they are also proactively attempting to address issues that may keep women and members of the LGBTQI2S communities from using the site, such as gendered harassment, and homophobic and transphobic comments. Staff members recognize this is an issue and are focused on addressing inappropriate behaviours and fostering a safe space.

> *"Well a lot of the women don't feel comfortable because it's a majority of men that use the site and they try to hit on them. And I've seen it happen and we have to step up."* (INTERVIEW WITH STAFF MEMBER, ST. STEPHEN'S)

> *"We have a lot of work to do around curbing a lot of the sexism and stuff like that, that happens in our spaces. I'm constantly reminding folks in the OPS that, you know, 'This is not a locker room. You know, we don't want to be hearing about these things! Like, keep it -' And that's an ongoing accessibility piece for sure, that I think is going to take a lot more work."* (INTERVIEW WITH MANAGEMENT – ST. STEPHEN'S)

Potential areas for improvement

- Explore the potential for establishing spaces or hours targeted at women and transgender people
- Provide training to ensure all staff members are equipped with strong tools for intervening when gendered, homophobic and/or transphobic comments are made. Training should focus on ensuring that staff are equipped with tools in trauma-informed care, conflict resolution and restorative justice.

ADDRESSING THE NEEDS OF PEOPLE WHO USE STIMULANTS

Much attention has been paid to the opioid overdose crisis, and research confirms the importance of SCS and OPS in working with people who use opioids to provide quick response to overdose when it occurs. Less attention has been paid to the role of SCS and OPS in working with people who use stimulants, particularly crystal methamphetamine. As seen in the program usage statistics in Section 3, St. Stephen's Community House OPS sees a notably high proportion of people who inject crystal methamphetamine, with crystal methamphetamine being the primary drug used in 27.9% of all OPS visits. This is likely due to the work that St. Stephen's has accomplished in developing programs and services directly for people who use crystal methamphetamine:

> *"Overall, stimulant users really like us. (laughs) They come back and come back and come back. Which isn't always the case for the opiate users. I think because there is an established community of stimulant users in the market. But also, we've done a lot of work at St. Stephen's recently, around crystal meth use. We had a pilot project for crystal meth users in particular, to have access to dedicated case management, as well as our doctor is quite well informed... We have the AMP group which is just for folks that use crystal meth to kind of gather and talk and that's been really great. We had the bike group, having folks fixing bikes, and taking bikes apart, which they were already doing outside, on the sidewalk, but you know, with real tools and with a bike expert and things like that, that was really great. So I think there's opportunity here for people who use crystal meth, to engage further than just using the OPS.* (INTERVIEW WITH MANAGEMENT, ST. STEPHEN'S)

What's working well

Providing a calm environment

Clients in focus groups spoke of the unique needs of people who inject stimulants when accessing OPS. In particular, people who injected stimulants spoke of the necessity of having calm and quiet spaces. They highlighted how the smaller capacity at both Street Health and St. Stephen's, as well as the fact that they were quieter sites overall, had positive impacts on people who were injecting stimulants. One participant spoke of a negative experience 'over-amping' at another site, which prompted them to leave due to the noise and excess of activity, and how they would have preferred to have a quiet space to go to:

> *"I want a quiet room, instead of going out on the street and seeing twenty people. If it was there, I would have done that. If I knew there was a quiet room. It's actually a good idea."* (FOCUS GROUP WITH CLIENTS, ST. STEPHEN'S)

Another client spoke of letting people who inject stimulants know that a quiet space was available pro-actively, in case over-amping occurred, and staff members were well-versed in how to engage with people who needed a calmer environment when using stimulants:

> *"Maybe just like a quiet, maybe before I go in there, have it known that there's a quiet space you go to."* (FOCUS GROUP WITH CLIENTS, ST. STEPHEN'S)

> *"We're able to bring them into this nice, quiet space, where we can dim the lights, and so you're able to better connect with people, offer support, and build those relationships."* (INTERVIEW WITH MANAGEMENT, ST. STEPHEN'S)

Challenges

Managing different reactions and needs in a limited space

Study participants shared their experiences with stimulants and with people who use stimulants, and commented on the difference in reactions that different drugs can bring on. For example, one participant talked about how they can become very sociable and chatty when using stimulants, whereas other people become paranoid, anxious, and 'twitchy' and want to be in a 'bubble', undisturbed by others. This can be difficult to manage in a small space and with time limits.

> *"Some people feel great on cocaine and meth, would socialize, but I get very paranoid, very racy and twitchy and I don't want to be around people. You know? That'd make me feel awkward and nervous, if there's a lot going on in the room, and yeah, I would rather just do it on my own."* (INTERVIEW WITH STAFF, ST. STEPHEN'S)

> *"I used stimulants at a site, and it's like: 'Okay, you gotta go.' And I'm like: 'I'm all fucked up. I can't rush on'. So, to use an OPS, it'd have to be a booth or something, to be in my own little bubble. And extra time, so not rushed in and out."* (FOCUS GROUP WITH CLIENTS, ST. STEPHEN'S)

Clients identified that having medication available for clients who were experiencing over-amping would be useful:

> *"Valium. No, seriously. That saved me, when I did a big smash of coke. All serious, the hospital gave me Valium. And in twenty minutes, my heart felt fine. I felt good. They let me go in a couple of hours. If I hadn't had that Valium, I could have died. So, seriously, if you're going to save someone's life, you give them that, it's pretty quick too. And it's only like, serious cases, not like, 'Oh, I feel bad'."* (FOCUS GROUP WITH CLIENTS, ST. STEPHEN'S)

Potential areas for improvement

- Availability of different spaces, including a private, quiet room or booth that could act as a 'bubble' for people who are using stimulants.
- Provision of medication for clients who are experiencing over-amping.

SECTION 8: STAFFING AN OVERDOSE PREVENTION SITE

STAFFING MODEL

Privileging of lived experience of drug use

The OPS at Street Health and St. Stephen's share similar staffing structures; and in both, lived experience of drug use is prioritized as a key area of expertise for front-line OPS staff. Staff and managers at both agencies described this staffing model - where frontline staff have lived experience of drug use and play a central role in the operation of the OPS - as a key strength of their model.

> *"It was best to run it as a site kind of where people who use drugs had the biggest role, had the most agency in determining how things would look."*
> (INTERVIEW WITH STAFF MEMBER, STREET HEALTH)

> *"When we were hiring, we looked at lived experience as another asset. As much as educational experience or work experience would be an asset, lived experience with drug use was considered an asset."*
> (INTERVIEW WITH MANAGEMENT, STREET HEALTH)

Staff roles requiring lived experience are distinct from peer worker roles, which are also available at St. Stephen's OPS (but not at Street Health's OPS). At St. Stephen's, the existence of a peer worker training programs allows for integration of peer workers into various roles in the organization, as a means of acquiring job experience. This is distinct from full staff roles, where lived experience is privileged as an area of expertise, particularly for staff working at the OPS.

Non-hierarchical staffing structure

In particular, the Street Health OPS follows a non-hierarchical staffing structure where all OPS staff are given the same job title and are evenly compensated. Participants felt this was important in preventing divisions between staff and fostering more comfortable interpersonal relationships.

> *"I've really enjoyed the fact that our staffing structure is very equitable, we all have the same job title despite our different experiences coming into the job, there isn't a hierarchy or pay discrepancy between any of the staff, which makes for a much more comfortable interpersonal experience and I think it helps us focus on the service that we are delivering."*
> (INTERVIEW WITH STAFF MEMBER, STREET HEALTH)

> *"When we created the staffing model and hired people we were very keen on not having a division between sort of a professional tier of staff and a peer tier of staff."* (INTERVIEW WITH MANAGEMENT, STREET HEALTH)

Unlike many of the other SCS in Toronto, neither OPS at Street Health nor St. Stephen's has a nurse inside the injection room. However, both have access to medical staff (a combination of nurses, nurse practitioners or doctors) within the agency during their hours of operation, who is available to provide additional medical support when necessary. Consistently, participants felt the absence of a nurse within the OPS did not compromise client safety, but rather provided an advantage to creating a more comfortable and less clinical environment.

> *"I don't think there should be nurses inside an overdose prevention site. Or at least, you know, that's just how it's worked for us and it's worked phenomenally. We don't have that clinical person in the room, who might then make you feel like you are in this very official clinical space."* (INTERVIEW WITH STAFF MEMBER, STREET HEALTH)

Pay and benefits for staff

Participants emphasized the importance of ensuring adequate pay and benefits for OPS workers because front-line workers, and in particular front-line workers with lived experience, are often underpaid and under-recognized for their crucial work in responding to the overdose crisis. Participants stressed the importance of providing compensation that reflects the high level of skill and expertise required for the difficult and intense work of supporting OPS clients and responding to overdoses. Furthermore, and as one participant reflected, a fair wage also gives a sense of validation for staff who are taking on the difficult work.

> *"When we were starting the OPS there was just no friggin' way that we were going to have people there saving people's lives being paid $15 an hour. It's ridiculous. It's very challenging that the sector expects people who are already struggling with their own issues to take on this kind of work and not be compensated appropriately."* (INTERVIEW WITH MANAGEMENT, STREET HEALTH)

> *"People need a lot of skills and a lot of expertise to work in spaces like this. They are high stress. They are intense a lot of the time, and require a lot of skill to keep people safe, to keep each other safe, so offering a wage that is reflective of that, that honours the fact that people have worked really hard to get to this point where they can work in spaces like this effectively and successfully, I think is really validating."* (INTERVIEW WITH STAFF MEMBER, STREET HEALTH)

Given the complex and high demands of working in an OPS, employment benefits and protections, including sick and vacation days, were identified as being crucial to ensuring staff have adequate rest time. While full-time staff at both Street Health and St. Stephens receive benefits, part-time or relief staff do not. Furthermore, participants described how the lack of mental health leave can create barriers for staff who may need a longer period of leave to work on personal goals.

> *"Also, mental health leaves and stuff, I want to go to detox. I want to stop using fentanyl. And if I do that, I have to basically choose between paying my rent and getting better. I've just been stuck for like two years being like, nope, have to go to work, and that's not great, either."* (INTERVIEW WITH STAFF MEMBER)

Safeguarding adequate pay and benefits is particularly difficult for part-time or relief workers who are receiving social assistance. Participants commented on the challenges of navigating social assistance policies, which limit the number of hours staff can work before their social assistance benefits are taken away.

> *"What we're seeing is this dance with ODSP around income and benefits. Folks are on medications that they need coverage for and so they're pulling back on working, so they can stay on ODSP, but they want to work."* (INTERVIEW WITH MANAGEMENT, ST STEPHEN'S)

TRAINING FOR FRONT-LINE OPS STAFF

Overall, prior to the OPS opening (or when new staff are hired), OPS staff receive training on:

- Overdose prevention and response
- Naloxone adminstration
- CPR/First Aid
- Crisis Intervention and de-escalation

Staff also received training on OPS policies and procedures, including when to call EMS and how to handle substances left behind. Several participants commented that they found it very helpful to run drills of challenging or unique scenario that could arise. Trainings also focused on how to respond to situations in the specific space of the OPS, and ways of communicating and supporting one another.

> *"The biggest part of it was, 'Okay, what does our space look like? How do we navigate situations in this space? You know, how many people do we need and who's going to be doing crowd control? And how do we communicate that with each other?' A lot of it was about, 'How do we communicate with each other? How do we support each other in those moments?'"* (INTERVIEW WITH MANAGEMENT, ST STEPHEN'S)

In addition to training received at Street Health and St. Stephen's, the vast majority of staff members had previous experience volunteering at the Moss Park Overdose Prevention Site (during its existence as an unsanctioned site, run out of tents and a trailer) and commented that the experience and training gained there was valuable to their role.

> *"Like, the volunteering in Moss Park was the absolute best training. That two-week period before we opened, I don't know what that would have been like without all of us having worked in the tent and trailer situation at Moss Park. Like that was the best way to get into this I could ever imagine."* (INTERVIEW WITH STAFF MEMBER, STREET HEALTH)

Other OPS workers had previous involvement in preventing and reversing overdoses in their personal lives before joining the OPS, which they found helped their capacity to respond to overdoses.

> *"When I did the interview, they did ask me what I already knew. So my boyfriend had overdosed many times. So I already had a lot of experience with naloxone and all that."* (INTERVIEW WITH STAFF MEMBER - ST. STEPHEN'S)

Ongoing training opportunities

Overall, participants felt that more ongoing training would be beneficial. For example, participants highlighted training opportunities that were developed among the community of SCS and OPS workers in Toronto (for example, the "Skillshare" run by the Moss Park OPS in summer of 2019) as being particularly useful:

> *"They all came back raving about what an important experience it was for them, to meet people who were also doing the work and to get new information. They just raved about that." (Interview with management, St Stephen's)*

> *"I think we could do more ongoing training. I was really pleased that Moss Park and South Riverdale put together the training that they did, because I think that's necessary, and I don't think we necessarily have the capacity to do that, especially with our funding the way it is, and our belief that people need to be paid for the time they're working, including training time." (Interview with management, St Stephen's)*

Participants stressed the importance of ensuring that part-time and relief staff were also provided with training opportunities.

> *"I would like to ensure that the relief staff who cover on an occasional basis also have that training and have it open to them if they feel they need it and refreshers if they feel they need it."* (INTERVIEW WITH MANAGEMENT, STREET HEALTH)

Specifically, participants felt training session that would be helpful were:

- Training on anti-oppression and trauma-informed approaches
- Additional first aid and medical training (e.g. to respond to over-amping or medical issues related to stimulant use)
- Training on addressing gendered, sexist, homophobic and transphobic comments
- Training on coping with grief and loss
- Training on how to provide grief counselling

CHALLENGES FACED BY STAFF

Isolation of OPS staff

Staff at both the Street Health and St. Stephen's OPS expressed feeling isolated from the rest of the agency. As one participant explained, lack of funding can be one barrier to the full integration of OPS staff with agency staff, as OPS staff are often unable to attend agency staff meetings due to lack of funding for relief coverage.

> *"They [OPS staff] feel a bit isolated from the rest of the organization and I think that there has been at times that feeling of the OPS staff is separate. And part of that was a function of when we first started is we didn't have the hours to enable those staff to attend staff meetings, for example. Because the hours were so restrictive you had to come in and do your work. You couldn't come in for two hours extra on a Tuesday morning when we had a staff meeting because we didn't have the [funding for] staffing"* (INTERVIEW WITH MANAGEMENT, STREET HEALTH)

Stigma and discrimination

Stigma and discrimination were another challenge many staff faced. Stigma and discrimination can manifest in many ways and can be particularly harmful to staff who use drugs. Staff described encountering stigma and discrimination from other staff from within the agency as well as from clients. While lived experience is privileged when hiring OPS staff, staff who actively use are particularly vulnerable to difficult encounters, such as hateful comments. This was also noted by participants in managerial positions who spoke about the importance of ongoing training for staff and supervisors across the agency on how to support staff with lived experience.

> *"I think that people with lived experience, and especially people who are current drug users, are more vulnerable to a lot of the shit that comes with this job, such as hateful messages from ignorant people."* (INTERVIEW WITH STAFF MEMBER, STREET HEALTH)

> *"Another big piece that we do is training all of the staff and supervisors how to work with peer workers, to supervise and how to work alongside peers. That can be a challenge, we've had all sorts of issues come up. Discriminatory comments, or...everyone needs to build some understanding and awareness, and that's really key, for an agency."* (INTERVIEW WITH MANAGEMENT, ST. STEPHEN'S)

Stress and provision of supports for OPS staff

As well as having to manage challenges related to the workplace, staff also spoke about the difficulties of working in the high stress setting of an OPS which requires a lot of emotional energy. Staff spoke about the emotional toll of responding to overdoses and overdose losses. Namely, participants described that responding to overdoses could be very difficult.

> *"When I had the first overdose, it actually kind of brought up a lot of emotions, from my, like, triggering emotion from my boyfriend overdosing that I didn't really anticipate. But, the staff are really, like, my team is really amazing. Afterwards, and even during, they were checking in with me, because they knew it was my first time."* (INTERVIEW WITH STAFF MEMBER, ST. STEPHEN'S)

> *"An actual overdose is challenging. It's very draining. No matter how much training you have, until you go through it, it's... it's scary."* (INTERVIEW WITH STAFF, ST. STEPHEN'S)

Given the stressful nature of the work of responding to overdoses, adequate support for frontline OPS staff is essential. As illustrated in the first quote above, the OPS teams provide crucial support for each other that they value and have come to rely on. Both staff and managers discussed how management has worked to respond to the articulated needs of staff. In one example, staff requested a debrief space to connect with other staff without the presence of supervisors, which was implemented.

> *"People have been asking for a sort of peer debrief space, where they can get together without supervision, without supervisors being there, to just talk to each other. So that's going to be starting next month. We set aside paid time, where people can come in and connect with peers and talk to each other and have that kind of support."* (INTERVIEW WITH MANAGEMENT, ST. STEPHEN'S)

Uncertainty regarding the future of the OPS

The stressful nature of responding to overdoses and the emotional impacts of this work were exacerbated by the instability of the funding situation of the OPS at Street Health and St. Stephen's, and the strain of not knowing if they were going to lose their jobs:

> *"People weren't sure how they were going to pay their rent. People weren't sure, you know, and aside from sort of the practical pieces around money, and there was also, like, the team had also become a family, right? And so, there was a lot of like, breaking up the group, that felt like really rough, especially going through the things that they go through together."* (INTERVIEW WITH MANAGEMENT, ST. STEPHEN'S)

> *"The biggest challenge is just the day-to-day not knowing what tomorrow will bring sort of thing. Like I said, we've developed in many cases these ongoing intense relationships and to have to let those go would be quite devastating for everybody."* (INTERVIEW WITH MANAGEMENT, STREET HEALTH)

Ensuring that emotional supports are available for staff members is extremely important for the long-term health of workers and their ability to continue to do this crucial work. Additionally, the instability surrounding the future of the sites and their long-term viability was clearly impacting the stress that front-line workers were feeling, and must be addressed as soon as possible.

Support for staff with lived experience of drug use

From the perspective of frontline staff, participants reported feeling well supported by supervisors overall. In addition to receiving support on the job, staff also provided examples of support they received from supervisors outside of the work setting. Shows of support for staff members' overall wellbeing beyond the job were expressly appreciated by participants.

> *"I tell everybody that my boss is the most amazing person I've ever met in my life. They're so compassionate, caring, loving, non-judgmental. They came to my house to pick me up for an appointment to take me to my doctor's. They asked me when I'm sick if they can bring me Gatorade and I said I don't want you to see me right now, so they dropped off outside my house Gatorade and something sweet because they knew I would need sugar."* (INTERVIEW WITH STAFF MEMBER- ST. STEPHEN'S)

Lived experience of drug use is an important area of expertise, which both Street Health and St. Stephen's privilege and recognize as a core strength of the two OPS teams. Accompanying this recognition was the acknowledgement by participants of the importance of providing support to staff members to do this difficult work.

> *"This is one of the tough things about this particular job, because you still have people that are actively using and things happen, they fall down and things happen. And St. Stephen's supports them."* (INTERVIEW WITH STAFF MEMBER- ST. STEPHEN'S)

Managers also recognized the importance of providing flexibility to staff, including lateness and missed shifts, while also upholding professional expectations of staff.

> *"We talk about that up front, that you guys are professionals, this is the job, this is what we expect from you, and we also recognize that because people, they're still living in poverty, they're living with lots of health concerns and their own stuff, so there's lots of flexibility, and they're not fired the first time they show up late, or, we don't have a three strikes you're out policy. There's a lot of flexibility in our expectations of what professionalism looks like for the team."* (INTERVIEW WITH MANAGEMENT- ST. STEPHEN'S)

POTENTIAL AREAS FOR IMPROVEMENT

Overall, participants felt there was a need for additional formal resources, such as ongoing counselling opportunities, to ensure the long-term well-being of staff. Participants pointed out that while they receive support from fellow front-line OPS workers as well as program managers, there was a lack of formal resources given the high demand and emotional toll of the job:

> *"It's not adequate, the baseline. We have a lot of support between front line staff supporting each other, which is really nice, and debriefing and understanding each other, and we can talk about things in really caring ways, but aside from that, there isn't really anything formal offered."* (INTERVIEW WITH STAFF MEMBER, STREET HEALTH)

> *"I'm not going to get traumatized by every overdose that I respond to now, but it builds up a lot, and there are some really rough ones, and there's a lot of stuff that happens on the job that affects me physically and I'm exhausted."* (INTERVIEW WITH STAFF MEMBER, STREET HEALTH)

Finally, participants asked for more opportunities to spend time with other staff for professional development and team building:

> *"But we don't have extra time to take and do team building projects. I think it's important in addition to serving clients, that you have time away from service provision to be with your team and whether it be professional development or team building or you know, staff meetings and debriefs, bereavement and grief work, like, all of that."* (INTERVIEW WITH STAFF MEMBER, STREET HEALTH)

Lack of and precarious funding were identified as key barriers to providing further training:

> *"We haven't had a lot of ability to say, you know, we're doing a half day training with this external facilitator, and they're going to train you up on this really important and cool thing, because we don't know what our money is going to look like next year, so. It's really hard to budget and plan"* (INTERVIEW WITH MANAGEMENT, ST STEPHEN'S)

METHODS APPENDIX

An evaluation plan was developed in consultation with representatives from Street Health and St. Stephen's OPS, including both staff who were responsible for front-line service delivery, and management from both organizations. An evaluation framework was developed and key areas to investigate in the evaluation were identified:

1. Who is using the OPS?
2. What are the advantages and challenges during service delivery?
3. How can services be improved?
4. What are the lessons learned from the first year of offering OPS services?
5. What are the impacts (positive and negative) of the OPS on clients using the service?
6. What are the impacts (positive and negative) of the OPS on staff and the organization offering OPS services?
7. What would be the impacts (positive and negative) of the OPS closing on clients and service users?

The main priority in the evaluation process was to ensure that the perspectives of people who use drugs and access the OPS (clients) were reflected and centralized. Additionally, service providers involved in the delivery of front-line services in the OPS were prioritized for engagement. These two groups were specifically prioritized to draw upon the first-hand, experiential knowledge and expertise that they possess, and to have this reflected this in the evaluation. Finally, managers responsible for overseeing the operation of the OPS were also interviewed as part of the evaluation process.

DATA COLLECTION

Data collection included:

1) Focus groups with 24 OPS clients (4 focus groups, 2 at each OPS):
   - Conducted in August & September 2019
   - 2 focus groups were held at Street Health: One group with people who identified as women and trans, and one group open to all OPS clients
   - 2 focus groups were held at St. Stephen's: One group with people who identified as primarily people who injected stimulants, and one group open to all OPS clients
2) Interviews with 6 front-line OPS staff (3 at each OPS):
   - Conducted in August & September 2019
   - 3 targeted one-on-one interviews with front-line staff involved in OPS service provision were conducted at each agency, for a total of 6 interviews
3) Interviews with 6 staff in coordinator or management roles at each agency (3 at each agency):
   - Conducted in August & September 2019
   - 3 targeted one-on-one interviews with coordinators or managers involved in supervision of OPS service provision or program management at each agency, for a total of 6 interviews
4) Review of program statistics
   - Program statistics from the date of opening until August 30th, 2019 were reviewed

ANALYSIS & SYNTHESIS

With the consent of participants, the focus groups and one-on-one interviews were audio-recorded and transcribed. Iterative and thematic analytic methods were used to identify key themes that emerged in the discussions in the consultation groups and key informant interview. The project team coded and analysed all transcripts, and themes were mapped onto the key areas that were identified in the evaluation framework. Once initial themes were identified, they were compared (between the different groups of participants) to identify consistent themes. A preliminary version of the evaluation report was provided to each agency for comment.

Demographic characteristics of participants in focus groups (Total number of participants = 24)

Gender	
Women	11 (46%)
Men	12 (50%)
Trans	1 (4%)
Age	
Average age of women	39 years old
Average age of men	37 years old
Drug of choice (injection)	
Fentanyl	13 (54%)
Other opioid (heroin, hydromorphone)	3 (12.5%)
Crystal Meth	5 (21%)
Cocaine/crack cocaine	3 (12.5%)

REFERENCES

1. Special Advisory Committee on the Epidemic of Opioid Overdoses (September 2019). *National report: Apparent opioid-related deaths in Canada (January 2016 to March 2019).* Web Based Report. Ottawa: Public Health Agency of Canada. Retrieved from: https://health-infobase.canada.ca/datalab/national-surveillance-opioid-mortality.html

2. Collins, A. B., Bluthenthal, R. N., Boyd, J., & McNeil, R. (2018). Harnessing the language of overdose prevention to advance evidence-based responses to the opioid crisis. *International Journal of Drug Policy,* 55, 77-79.

3. Kerr, T., Mitra, S., Kennedy, M. C., & McNeil, R. (2017). Supervised injection facilities in Canada: Past, present, and future. *Harm Reduction Journal,* 14, 28.

4. Kolla, G., Dodd, Z., Ko, J., Boyce, N., & Ovens, S. (2019). The major lesson from Canada's overdose crisis: Government and public health authorities are not acting fast enough. *Lancet Public Health, 4*(4), e180. http://doi.org/10.1016/S2468-2667(19)30040-4

5. Lupick, T. (2017, August 26). How activists across Canada are subverting the law to establish safe spaces for people to use drugs. *The Georgia Straight.* Retrieved from http://www.straight.com/news/956056/how-activists-across-canada-are-subverting-law-establish-safe-spaces-people-use-drugs

6. Wallace, B., Pagan, F., & Pauly, B. (2019). The implementation of overdose prevention sites as a novel and nimble response during an illegal drug overdose public health emergency. *International Journal of Drug Policy, 66,* 64-72.

7. Ministry of Health and Long-Term Care (2018a). *Overdose Prevention Sites: User guide for applicants.* Ontario Ministry of Health and Long-Term Care. Retrieved from http://www.health.gov.on.ca/en/news/bulletin/2018/docs/hb_20180111_ops_user_guide.pdf

8. Boyd, J., Collins, A., Mayer, S., Maher, L., Kerr, T., & McNeil, R. (2018). Gendered violence and overdose prevention sites: A rapid ethnographic study during an overdose epidemic in Vancouver, Canada. *Addiction, 113*(12), 2261-2270.

9. Kennedy, M. C., Boyd, J., Mayer, S., Collins, A., Kerr, T., & McNeil, R. (2019). Peer worker involvement in low-threshold supervised consumption facilities in the context of an overdose epidemic in Vancouver, Canada. *Social Science and Medicine, 225,* 60–68. http://doi.org/10.1016/j.socscimed.2019.02.014

10. Rushowy, K. (2018, October 1). Recommendation on safe-injection sites postponed. *The Star.* Retrieved from http://www.thestar.com/news/queenspark/2018/10/01/recommendation-on-safe-injection-sites-postponed.html

11. Ministry of Health and Long-Term Care. (2018b). News release: *Ontario Government connecting people with addictions to treatment and rehabilitation. Ontario Ministry of Health and Long-Term Care.* Retrieved from http://news.ontario.ca/mohltc/en/2018/10/ontario-government-connecting-people-with-addictions-to-treatment-and-rehabilitation.html

12. Ministry of Health and Long-Term Care. (2018c). *Consumption and Treatment Services: Application Guide.* Ontario Ministry of Health and Long-Term Care. Retrieved from http://health.gov.on.ca/en/pro/programs/opioids/docs/CTS_application_guide_en.pdf

13. HIV & AIDS Legal Clinic Ontario. (2018). *Ontario's new "Consumption and Treatment Services" plan – open letter from HALCO and other organizations.* Retrieved from http://www.halco.org/2018/news/cts-ont-plan

14. Ministry of Health and Long-Term Care. (2019). *Backgrounder: Consumption and Treatment Services Sites.* Ontario Ministry of Health and Long-Term Care. Retrieved from http://news.ontario.ca/mohltc/en/2019/03/consumption-and-treatment-services-sites-1.html

15. Stone, L. (2019, April 5). Trudeau says Ford government putting lives at risk by closing supervised drug-use sites. *Globe and Mail.* Retrieved from http://www.theglobeandmail.com/canada/article-trudeau-says-ford-government-putting-lives-at-risk-by-closing/

16. City of Toronto (2019, September). *Calls to Paramedic Services for Suspected Opioid Overdoses Geographic Information: July 1, 2018 to June 30, 2019.* Retrieved from: https://www.toronto.ca/wp-content/uploads/2019/09/8e6e-CallsforSuspectedOpioidOverdoses_GeographicInformation_Sep2019.pdf

17. Public Health Ontario; Office of the Chief Coroner; Ontario Forensic Pathology Service; Ontario Drug Policy Research Network (2019). Opioid mortality surveillance report: analysis of opioid-related deaths in Ontario July 2017-June 2018. Toronto, ON: Queen's Printer for Ontario. Retrieved from: https://www.publichealthontario.ca/-/media/documents/opioid-mortality-surveillance-report.pdf?la=en

18. Bardwell, G., Strike, C., Altenberg, J., Barnaby, L., & Kerr, T. (2019). Implementation contexts and the impact of policing on access to supervised consumption services in Toronto, Canada: a qualitative comparative analysis, 1–9. http://doi.org/10.1186/s12954-019-0302-x

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As does

OPS

NO MORE NEEDLESS DEATHS!

these guys Saved My life. Back from the dead. Bless You

NOTHING ABOUT US WITHOUT US

A HOUSE DIVIDED WILL NOT STAND!

RENDER UNTO CEASAR WHAT IS CEASARS AND RENDER UNTO GOD WHAT IS GOD'S!

LAUGH AND THE WORLD LAUGHS. WITH YOU! BUT WEEP AND YOU WEEP ALONE

PROB. FROM

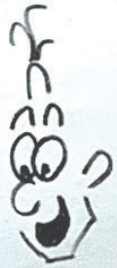
Do Not Share Me

STAY SAFE

I ♡ PWUD FAM ♡

I'm ALL YOURS

The High of Life



StreetHealth

St. Stephen's Community House

This is **Exhibit "P"** to the Affidavit of Bill Sinclair,
sworn January 9, 2024

A Commissioner for oaths, etc.

Health Canada
Santé Canada

Address Locator 0300B
Ottawa ON K1A 0K9

2022-11-25

22-111410-483
HC6-53-139-59

Lorie Steer
Vice President
Urban Health and Homelessness Services
The Neighbourhood Group
260 Augusta Ave
Toronto ON M5T 2L9

Lorie Steer:

In response to your request for an exemption from the *Controlled Drugs and Substances Act* (CDSA) to operate a supervised consumption site at the Kensington Market Overdose Prevention Service, we would like to inform you an exemption is being granted to you pursuant to section 56.1 of the CDSA. This letter authorizes the exemption for the Kensington Market Overdose Prevention Service Site, and sets out the terms and conditions that must be followed. This exemption replaces the one that was issued to you on November 26, 2021.

The following definitions apply to this exemption:

"Alternate responsible person in charge" means any person designated by the applicant who is responsible, when the responsible person in charge is absent from the supervised consumption site, for ensuring that every person or class of persons who is exempted for a medical purpose under subsection 56.1(1) from the application of all or any of the provisions of the CDSA complies with the terms and conditions specified by the Minister in the exemption when they are at the Site.

"Client" means an individual who is at the Site to consume illegal substances by self-injection, oral or intranasal means, to have substances administered by a peer and/or to receive other services;

"Designated criminal offence" means

(a) an offence involving the financing of terrorism against any of sections 83.02 to 83.04 of the *Criminal Code*;
(b) an offence involving fraud against any of sections 380 to 382 of the *Criminal Code*;
(c) the offence of laundering proceeds of crime against section 462.31 of the *Criminal Code*;
(d) an offence involving a criminal organization against any of sections 467.11 to 467.13 of the *Criminal Code*; or
(e) a conspiracy or an attempt to commit, being accessory after the fact in relation to, or any counselling in relation to an offence referred to in any of paragraphs (a) to (d);

…/2

“Designated substance offence” means

(a) an offence under part I of the CDSA, except subsection 4(1), or

(b) a conspiracy or an attempt to commit, being an accessory after the fact in relation to, or any counselling in relation to, an offence referred to in paragraph (a);

“Illegal substance” means a controlled substance or precursor that is obtained in a manner not authorized under the CDSA or its regulations;

“Key staff members” means any person designated by the applicant who is responsible for the direct supervision, at the supervised consumption site, of the consumption of an illegal substance by a client;

“Minister” means the federal Minister of Mental Health and Addictions and Associate Minister of Health;

“OCS” means the Office of Controlled Substances, Controlled Substances Directorate, Health Canada;

“Peer” means an individual who is not the responsible person in charge, an alternate responsible person in charge, a key staff member or a staff member, and is identified by a client to provide said client with peer assistance at the Site;

“Peer assistance” means the activities of a peer preparing illegal substances for a client and the administration of illegal substances by a peer to a client;

“Responsible person in charge” means the person, designated by the applicant, who is responsible, when the person is at the supervised consumption site, for ensuring that every person or class of persons who is exempted for a medical purpose under subsection 56.1(1) from the application of all or any of the provisions of the CDSA complies with the terms and conditions specified by the Minister in the exemption when they are at the Site;

“Site” means the premises located on the first floor but limited to the supervised consumption services within the building located at 260 Augusta Avenue, Toronto, Ontario;

“Staff member” means an individual employed by or under contract with The Neighbourhood Group to work at the Site; and

“TNG” means The Neighbourhood Group.

Scope

This authority is being exercised pursuant to section 56.1 of the CDSA. The following classes of persons are hereby exempted for a medical purpose as set out below to engage in certain activities in relation to an illegal substance within a supervised and controlled environment as specified below:

- The Responsible Person in Charge (RPIC), Alternate Responsible Persons in Charge (A/RPICs), key staff members and all staff members are exempted, while they are within the interior boundaries of the Site, from the application of subsection 4(1) of the CDSA with respect to any illegal substance in the possession of a client or a peer, or that is left behind by a client or a peer within the interior boundaries of the Site, if such possession is to fulfill their functions and duties in connection with the operation of the Site;

- The RPIC, A/RPICs, key staff members and all staff members are exempted, while they are within the interior boundaries of the Site, from the following provisions of the CDSA and its regulations when possessing or transferring for the purposes of disposal, any illegal substance in the possession of a client or a peer, or that is left behind by a client or a peer within the interior boundaries of the Site:

    a. subsections 4(1), 5(1) and 5(2) of the CDSA, and
    b. subsections 6(1) and 6(2) of the *Precursor Control Regulations* (PCR);

- Clients are exempted, while they are within the interior boundaries of the Site, from the application of subsections 4(1) and 7(1) of the CDSA with respect to an illegal substance, if possession or production of the illegal substance is for the purposes of self-injection, oral or intranasal consumption by the client, or for the purposes of preparing substances for inhalation;

- Clients are exempted, while they are within the interior boundaries of the Site, from the following provisions of the CDSA and its regulations when possessing or transferring an illegal substance for the purposes of disposal or peer assistance:

    a. subsections 4(1), 5(1) and 5(2) of the CDSA, and
    b. subsections 6(1) and 6(2) of the PCR;

- Peers are exempted, while they are within the interior boundaries of the Site, from the following provisions of the CDSA and its regulations when possessing, producing, transferring or administering an illegal substance for the purposes of disposal or peer assistance:

    a. subsections 4(1), 5(1), 5(2) and 7(1) of the CDSA, and
    b. subsections 6(1) and 6(2) of the PCR.

Suspension Without Notice

A suspension without prior notice may be ordered if the Minister or their designate under section 56.1 deems that such a suspension is necessary to protect public health, safety or security including, without limiting the generality of the foregoing, to prevent controlled substances from being trafficked or otherwise diverted within or from the Site for illegal purposes.

Revocation

This exemption may be revoked if TNG or any staff member of the Site has contravened any of the terms and conditions set out in this document. Please note that such a contravention may, in some cases, also constitute an offence under the CDSA.

Duration

This exemption is issued for a period of three years. The exemption expires on the earliest of the following dates:

- November 30, 2025; or
- the date on which the exemption is revoked.

Other Terms and Conditions

(1) TNG must inform and train the RPIC, A/RPICs, key staff members and all staff members on their roles and responsibilities;

(2) The RPIC, A/RPICs, key staff members and all staff members must follow the Site's policies and procedures, including those regarding peer assistance;

(3) The RPIC, A/RPICs, key staff members and all staff members may only possess or transfer illegal substances for the purposes of disposal;

(4) The RPIC, A/RPICs, key staff members and all staff members may only transfer an illegal substance for the purposes of disposal to the RPIC, an A/RPIC, a key staff member or other staff member of the Site;

(5) Only clients who are properly enrolled, or peers who have been identified as per the Site's policies and procedures with respect to peer assistance, may have access to the areas of the Site where supervised consumption services occur;

(6) Only clients who are properly enrolled, or peers who have been identified as per the Site's policies and procedures with respect to peer assistance, may possess or transfer illegal substances for the purposes of disposal or peer assistance;

…/5

(7) Clients or peers may only transfer an illegal substance for the purposes of disposal to the RPIC, an A/RPIC, a key staff member or other staff member of the Site;

(8) Clients may only transfer an illegal substance to the individual identified as their peer, and the transfer may only be for the purposes of peer assistance;

(9) Peers may only transfer an illegal substance to a client who has identified them as their peer, and the transfer may only be for the purposes of peer assistance;

(10) Only peers may administer an illegal substance for the purposes of peer assistance;

(11) Peer assistance within the Site cannot involve any exchanges for financial compensation, goods, or services;

(12) The RPIC, or in their absence an A/RPIC, must be present at the Site at all times to oversee the operation of the supervised consumption site services;

(13) The RPIC must have a valid criminal record check. The criminal record check must be a document issued by a Canadian police force in relation to the RPIC, stating whether, in the 10 years before the day on which the application was made, the person was convicted as an adult in respect of a designated substance offence or designated criminal offence. If the RPIC has ordinarily resided in a country other than Canada in the 10 years before the day on which the application was made, a document issued by a police force of that country stating whether in that period the person was convicted as an adult for an offence committed in that country that, if committed in Canada, would have constituted a designated substance offence or a designated criminal offence must be submitted;

(14) A new RPIC may not work at the Site without TNG having obtained and submitted a valid criminal record check to the OCS;

(15) Where the RPIC is found guilty of a designated substance offence or a designated criminal offence, TNG must advise the OCS, and that person will no longer be covered by the exemption;

(16) The RPIC, or in their absence an A/RPIC, must take necessary precautions to prevent drug trafficking within the Site, including having staff members draw to the attention of clients the *User Agreement, Release and Consent Form*, which prohibits the dealing, exchanging or passing of controlled substances, unless for the purposes of disposal or peer assistance as authorized under this exemption, and must remove from the Site any client caught attempting to traffic or trafficking a controlled substance;

(17) The RPIC, or in their absence an A/RPIC, must be notified of an incident of any amount of 'unidentified substance' that may be an illegal substance that has been left behind by clients or peers. The substance must be placed in an envelope that is sealed, dated and initialled by a staff member. The RPIC or an A/RPIC must then place the envelope in a lock box, and log tracking information in the Site's *Unknown Substance Left Behind Form*. The RPIC, or in their absence an A/RPIC, must notify the Toronto Police Service (TPS) within 24 hours of the occurrence. When the envelope containing the substance is picked up for disposal by the TPS, it must be logged out by the police officer;

…/6

(18) In the event of theft of illegal substances left behind by clients or peers, the RPIC, or in their absence an A/RPIC, must notify the TPS immediately and the OCS within 24 hours of the occurrence. The RPIC, or in their absence an A/RPIC, must maintain a record of losses and thefts of illegal substances left behind by clients or peers;

(19) The return of used or contaminated syringes, needles and other consumption equipment and supplies must be supervised by the RPIC, an A/RPIC or a key staff member and managed safely as per TNG procedures;

(20) The security system intended to provide physical security at the Site must be operational at all times, and access to the Site must be controlled, as submitted in your application. The RPIC, or in their absence an A/RPIC, must ensure that a record of entry and exit from the consumption area is maintained for all clients and visitors;

(21) TNG must notify the OCS of changes affecting the security, physical layout of the Site or resources available to support the maintenance of the Site, and provide the OCS with a copy of the revised policies and procedures no later than 10 working days following the effective date of the changes;

(22) All records or other information required to be kept under this exemption must be maintained at the Site for the duration of the exemption and made available to Health Canada upon request;

(23) TNG must notify the OCS within 24 hours in the event of a death related to activities involving illegal substances at the Site;

(24) TNG must notify the OCS within 48 hours should the Site be closed permanently, or for longer than 24 hours;

(25) TNG must notify the OCS within 48 hours should the Site no longer allow for peer assistance;

(26) TNG should continue to maintain engagement with the community and other service providers impacted by the Site. This engagement could include outreach to organizations such as school boards, childcare providers, business associations and other local community groups. Any concerns raised should be documented and where appropriate, TNG should implement relevant mitigation strategies in response to concerns raised;

(27) In accordance with any applicable privacy laws, TNG will provide the Minister, upon request, with access to any relevant data gathered or collected related to the Site, including data regarding peer assistance; and

(28) TNG must provide a report every month to the OCS summarizing the activities undertaken and clients served at the Site, the impact of the services on the clients and the community, and any other information related to the services offered. The report must be submitted monthly (by the 15th of each month) to exemption@hc-sc.gc.ca and should include, but is not limited to:

- the total number of visits and total number of consumption visits;
- the number of total visits that involved peer assistance;
- the number of total visits that involved preparing substances for inhalation;
- the number of unique clients and number of new clients per month;
- the number of unique clients that received peer assistance per month;
- the general demographics of the clients and peers served, such as age and gender;
- the number of referrals to other health and social services, within the Site, onsite and offsite;
- the number of overdoses/drug emergencies (fatal, non-fatal, and requiring naloxone administration) at the Site per month;
- the number of overdoses/drug emergencies that occurred following peer assistance;
- the number of service calls made to law enforcement and to emergency medical services; and
- the percentage of the most prevalent drugs used at the Site according to the client.

Should it be necessary to change the terms and conditions, you will be informed in writing and a reason for the change will be provided.

Please note that it is recommended that you establish a mechanism to collect information required for subsequent applications, as set out in subsection 56.1(3) of the CDSA, including any information related to the public health impacts of the activities at the Site, and as described in subsection 56.1(3).

It is your responsibility to verify that the operation of the supervised consumption services at the Site is, and continues to be, in compliance with other applicable federal, provincial and municipal legislation to maintain public health and public safety.

Finally, the OCS welcomes receiving any information you feel pertinent to your exemption throughout its validity period. We are available to answer questions on any aspect of your exemption, and look forward to working with you to assist in the continued legal operation of your endeavour.

Sincerely,

Jennifer Saxe
Director General
Controlled Substances Directorate
Health Canada

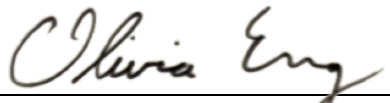
Attachment

Record of Approved RPIC on date of November 25, 2022
Kensington Market Overdose Prevention Service

RPIC (Responsible Person in Charge)

Barbara Panter

This is **Exhibit "Q"** to the Affidavit of Bill Sinclair,
sworn January 9, 2024



A Commissioner for oaths, etc.

The Neighbourhood Group Community Services
KMOPS
Year: 2024-2025 (12 months)

KMOPS	Amounts
Revenue	
Donations and Fundraising	393,900
Total Income	**393,900**
Expenses	
Salaries & Benefits: • Manager 0.75 FTE • Receptionist 0.15 FTE • OPS Worker Team 2.5 FTE • Doorperson 0.5 FTE • Total 3.9 FTE	300,200
Share of Building Costs • 5% of taxes, utilities, cleaning services	40,000
Staff Training and Travel	3,000
Health/Medical Supplies	12,000
Share of Administration • Finance, HR, Audit, Insurance, Fundraising	38,700
Total Expenses	**393,900**

This is **Exhibit "R"** to the Affidavit of Bill Sinclair,
sworn January 9, 2024

A Commissioner for oaths, etc.

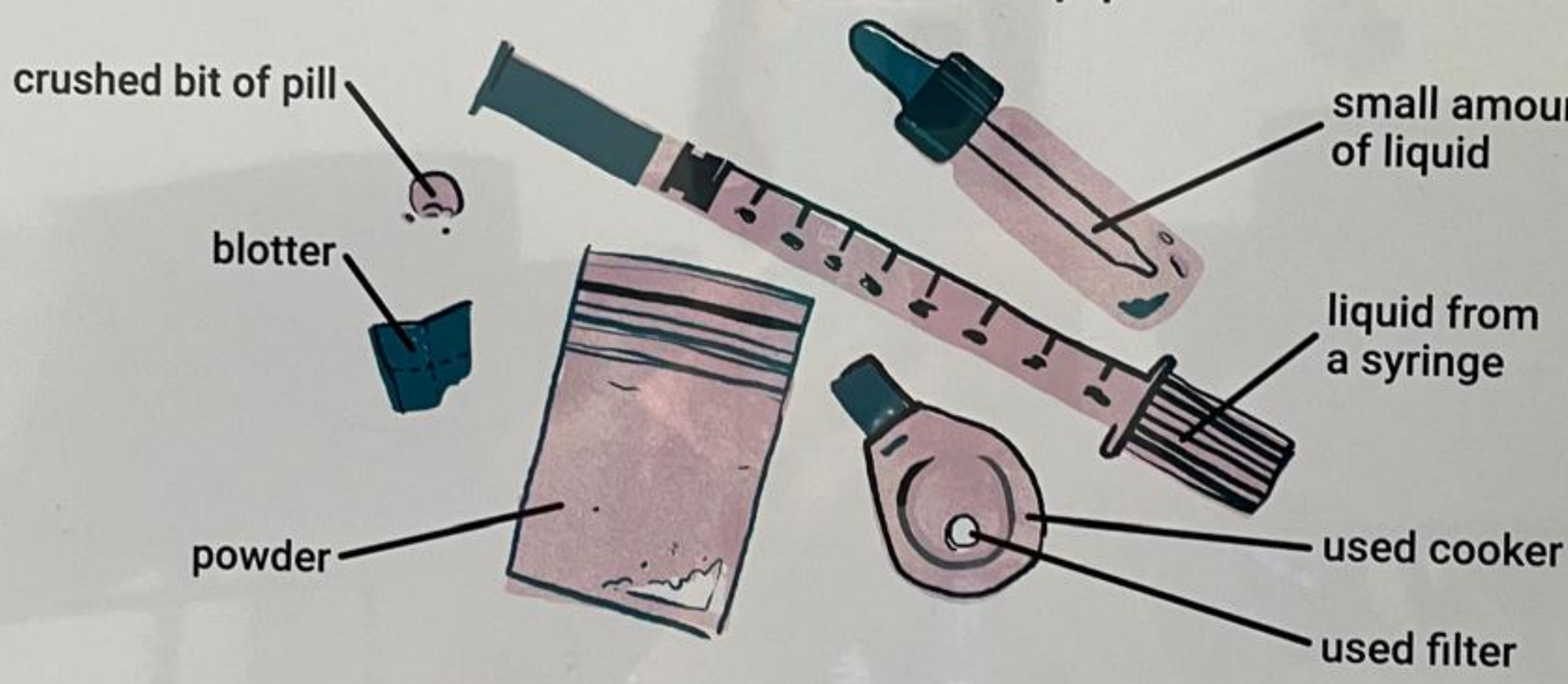

SAVE OUR SIS
S.S.C.H. OPS SMALL BUT MIGHTY
FRAGRANCE FREE SPACE
IN YOUR COMMUNITY

Find out what's in your drugs

Free and anonymous drug checking is available!

What you give...

A 10mg drug sample or used equipment:



What you get...

A breakdown of what's in your sample AND tailored harm reduction strategies

• Results from various drug checking technologies, including mass spectrometry, Fourier transform infrared spectroscopy (FTIR), and/or test strips • Results are typically available within a business day •

Talk to a staff member about dropping off a sample!

QUESTIONS OR COMMENTS?

You can reach us at hello@drugchecking.community
www.drugchecking.community @drugchecking @drugcheckingTO

Participating collection sites: Casey House | Parkdale Queen West Community Health Centre (Parkdale and Queen West sites) | Regent Park Community Health Centre | South Riverdale Community Health Centre (KeepSix and Moss Park sites) | Street Health | The Neighbourhood Group (Kensington Market Overdose Prevention Site) | The Works at Toronto Public Health | Toronto Shelter and Support Services (Seaton House Overdose Prevention Site)

Participating analysis sites: Centre for Addiction and Mental Health (Clinical Laboratory and Diagnostic Services) | St. Michael's Hospital (Department of Laboratory Medicine and Drug Checking Unit)

Toronto's Drug Checking Service is coordinated by a small central team that operates from within the Drug Checking Unit at St. Michael's Hospital.


SSCH OPS
NISH 2019
SAFE SUPPLY = LIFE
DIZZY
NOTHING ABOUT US WITHOUT US
WONTON
Toronto UNITED!
StaySafe Fam
You are Enough
NISH 2019
"SAVING EVEN ONE LIFE MEANS IT'S WORKING WE WILL FIGHT"
FENNY FENTER IS A KILLER
I'M GOING TO LOVE MYSELF THE WAY I WANT YOU TO LOVE ME
Hope u stay open
Love and respect
Marco Gypsy
Sinten
Judge tenderly, if you must. There is usually a side you have not heard, a story you know not of. Think about and a battle waged that you are not having to fight!
28/14
21/10

OPS Client Overdose Response Report

_Male __Female __Trans Male __Trans Female __Other

: _ _ _ _ _ _ _ _ _ Staff Responding: ______________________

Date: ______________________

Drug Identified: ______________________

Time	Skin Colour	LOC	Adverse Reaction	Respirations	O2 Sat	Pulse	O2 Admin'd	Naloxone	Airway	911
	○ Normal ○ Pale ○ Blue/Grey	○ Alert ○ Verbal ○ Pain ○ Unresponsive	○ Flailing ○ Overamp	○ >10 ○ 8-10 ○ 4-8 ○ <4 ○ 0			○ NC ○ NRB ○ BVM _____L/min	○ IM .2 mg (bump) ○ IM .4 mg ○ IM .8 mg ○ Nasal	○ Oral ○ Nasal ○ CPR ○ AED	○
	○ Normal ○ Pale ○ Blue/Grey	○ Alert ○ Verbal ○ Pain ○ Unresponsive	○ Flailing ○ Overamp	○ >10 ○ 8-10 ○ 4-8 ○ <4 ○ 0			○ NC ○ NRB ○ BVM _____L/min	○ IM .2 mg (bump) ○ IM .4 mg ○ IM .8 mg ○ Nasal	○ Oral ○ Nasal ○ CPR ○ AED	○
	○ Normal ○ Pale ○ Blue/Grey	○ Alert ○ Verbal ○ Pain ○ Unresponsive	○ Flailing ○ Overamp	○ >10 ○ 8-10 ○ 4-8 ○ <4 ○ 0			○ NC ○ NRB ○ BVM _____L/min	○ IM .2 mg (bump) ○ IM .4 mg ○ IM .8 mg ○ Nasal	○ Oral ○ Nasal ○ CPR ○ AED	○
	○ Normal ○ Pale ○ Blue/Grey	○ Alert ○ Verbal ○ Pain ○ Unresponsive	○ Flailing ○ Overamp	○ >10 ○ 8-10 ○ 4-8 ○ <4 ○ 0			○ NC ○ NRB ○ BVM _____L/min	○ IM .2 mg (bump) ○ IM .4 mg ○ IM .8 mg ○ Nasal	○ Oral ○ Nasal ○ CPR ○ AED	○
	○ Normal ○ Pale ○ Blue/Grey	○ Alert ○ Verbal ○ Pain ○ Unresponsive	○ Flailing ○ Overamp	○ >10 ○ 8-10 ○ 4-8 ○ <4 ○ 0			○ NC ○ NRB ○ BVM _____L/min	○ IM .2 mg (bump) ○ IM .4 mg ○ IM .8 mg ○ Nasal	○ Oral ○ Nasal ○ CPR ○ AED	○
	○ Normal ○ Pale ○ Blue/Grey	○ Alert ○ Verbal ○ Pain ○ Unresponsive	○ Flailing ○ Overamp	○ >10 ○ 8-10 ○ 4-8 ○ <4 ○ 0			○ NC ○ NRB ○ BVM _____L/min	○ IM .2 mg (bump) ○ IM .4 mg ○ IM .8 mg ○ Nasal	○ Oral ○ Nasal ○ CPR ○ AED	○
	○ Normal ○ Pale ○ Blue/Grey	○ Alert ○ Verbal ○ Pain ○ Unresponsive	○ Flailing ○ Overamp	○ >10 ○ 8-10 ○ 4-8 ○ <4 ○ 0			○ NC ○ NRB ○ BVM _____L/min	○ IM .2 mg (bump) ○ IM .4 mg ○ IM .8 mg ○ Nasal	○ Oral ○ Nasal ○ CPR ○ AED	○
	○ Normal ○ Pale ○ Blue/Grey	○ Alert ○ Verbal ○ Pain ○ Unresponsive	○ Flailing ○ Overamp	○ >10 ○ 8-10 ○ 4-8 ○ <4 ○ 0			○ NC ○ NRB ○ BVM _____L/min	○ IM .2 mg (bump) ○ IM .4 mg ○ IM .8 mg ○ Nasal	○ Oral ○ Nasal ○ CPR ○ AED	○

If Cyanosis is a clinical sign of hypoxia, franc cyanosis which corresponds to SaO2 of about 66% (in patients with normal hemoglobin and lighter skin complexion).

Client Refuses Transfer to Hospital:

- If staff recommend a transfer to hospital and client refuses transfer – document on the "EMERGENCY MEDICAL RESPONSE: Client refuses Transfer to Hospital"
- Ensure a full set of vitals are done at least once before the client leaves the CTS, if not going to hospital.

Oxygen check list

Days checking	DATE	TIME	STAFF INITIALS
1	Sept 1	7:30 PM	MM
2	Sept 2	7:	MM
3	Sept 3	7:15	MM
2	Sept 6	8:50	AB
1		9:50	AB
		7:50	AB
3	Sept 17		JE
3	Sept 18		TE

tank when
finished using

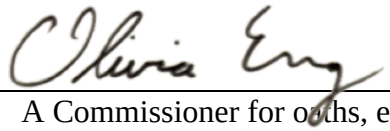
Safer
Crack
Smoking

Bad Date Coalition

OFF
L/min
Grab 'n Go.
PRAXAIR


Toronto Overdose Prevention Society
April 18, 2019
St. Stephen Overdose Prevention Site
Twenty thousand and 00/100
OPS core fund
Waiting to inhale
MESSAGE BOARD
DRUG CHECKING AVAILABLE AT KMOPS
How Does it work?
Get trained to save lives
PLEASE DON'T DO COKE IN THE BATHROOM ALONE
Take NORS With You
LONGS
SHORTS
BLACK SHARE CAT
G ZERO

This is **Exhibit "S"** to the Affidavit of Bill Sinclair,
sworn January 9, 2024



A Commissioner for oaths, etc.

TNG Community Services

CENTRAL NEIGHBOURHOOD HOUSE
NEIGHBOURHOOD LINK
ST. STEPHEN'S COMMUNITY HOUSE

User Agreement, Release and Consent Form: Supervised Consumption Site (SCS)

Prior to using the SCS, I agree to the following:

- I have injected drugs in the past, am in this facility for the purpose of using injection drugs, and I intend to inject them regardless of any risks to my health.
- I will follow the direction of SCS staff and any Code of Conduct.
- I will remain in possession of my own drugs for injection at all times.
- I authorize SCS staff to provide emergency medical services if necessary.
- I am aware of the harmful effects of drug use and accept full responsibility for all risks to myself, including my death, and on behalf of myself and my heirs, hereby release the Supervised Consumption Site, St. Stephen's Community House and their employees, partners and agents from any and all liability for any loss, injury or damage I may suffer as a result of my use of this facility.
- I agree that any substances left behind after I leave will NOT be returned to me

I understand the above and am able to give consent.

Name: _____ (must include first & last initials)

Date of Birth: _____ (D/M/Y)

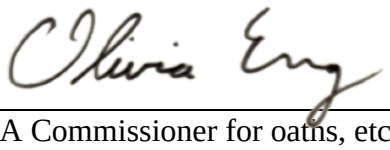
Completed by: _____

Date: _____ (D/M/Y)

Signature: _____

Number: _____

This is **Exhibit "T"** to the Affidavit of Bill Sinclair,
sworn January 9, 2024



A Commissioner for oaths, etc.

SSCH OPS GUIDELINES

CAPACITY

Injection space: 3 people (ONE per table)
Chill space: 3 people
Max 6 participants in the OPS at one time.

INJECTION

Please only inject in the injection space. Please keep your rig capped when not in use. We suggest you safely put away your drugs before you do your shot so that they don't get lost.

TIME LIMIT

There is a 20min time limit at the tables. You may also be asked to free up space in the chill area if needed. We are not a drop-in, help us keep things flowing!

CLOTHING

Please keep your clothing on while in the OPS.

BELONGINGS

Please keep your belongings together. We cannot hold, store or keep an eye on your belongings, including cellphones, they are your responsibility! Belongings left behind will be disposed of every Friday.

BIKES

Please don't bring bikes into the OPS. We're just a wee space, it's not safe.

NO DEALING

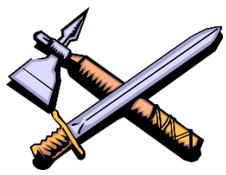
Please do not buy / sell / exchange drugs in the OPS, drop-in or outside the door. No monetary exchanges in the OPS.

HAVE YOUR DRUGS

Please have your drugs before you go into the injection room.

NO VIOLENCE or THREATS

Please do not engage in any violent behavior including threats of violence or bullying. No roughhousing.



NO WEAPONS

Please do not bring weapons to the OPS. You will be asked to leave.

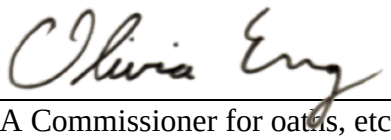
NO OPRESSIVE LANGUAGE

Please be respectful to everyone, regardless of gender, sexuality, race & social class. Absolutely no sexual, racist and oppressive comments in the OPS.

COMMUNITY

We want you to feel safe, supported and respected here. Please respect other services users' privacy and confidentiality. What happens in here stays in here. If you have feedback or concerns please let us know!

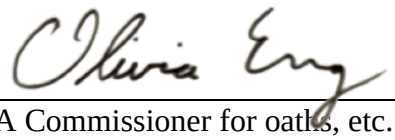
This is **Exhibit "U"** to the Affidavit of Bill Sinclair,
sworn January 9, 2024



A Commissioner for oaths, etc.

A copy of Exhibit "U" to the Affidavit of Bill Sinclair, sworn January 9, 2025 can be found at this Link

This is **Exhibit "V"** to the Affidavit of Bill Sinclair,
sworn January 9, 2024



A Commissioner for oaths, etc.

NEWS RELEASE

Ontario Protecting Communities and Supporting Addiction Recovery with New Treatment Hubs

Province banning consumption sites near schools and daycares while investing $378 million more in 19 new treatment hubs

August 20, 2024

Health

OTTAWA — 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.

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."

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
- Mental health services
- Addiction care and support
- Social services and employment support
- 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
- More than $19 million over three years to create 10 new Youth Wellness Hubs that the government is adding to the network of 22 hubs already opened since 2020, 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.
- While HART Hubs will not be allowed to deliver needle exchange programs, needle return or collection services may be considered during the application process.
- 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

"Today’s announcement by the provincial government will deliver safer streets for the residents of Ontario through increased funding for mental health and addiction supports 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 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

Additional Resources

- Protecting Community Safety and Connecting More People to Addiction Recovery Care
- Your Health: A Plan for Connected and Convenient Care
- 2024 Ontario Budget: Building a Better Ontario
- Roadmap to Wellness: A Plan to Build Ontario’s Mental Health and Addictions System
- Find out how you can access mental health support

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

Media Contacts

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Media.moh@ontario.ca

This is **Exhibit "W"** to the Affidavit of Bill Sinclair,
sworn January 9, 2024

A Commissioner for oaths, etc.

BACKGROUNDER

Protecting Community Safety and Connecting More People to Addiction Recovery Care

August 20, 2024

Health

As a result of the ban on the operation of consumption sites within 200 metres of a school or child care centre, the provincially-funded consumption sites slated for closure include:

- 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
- Parkdale Queen West Community Health Centre (Bathurst) – 168 Bathurst Street, Toronto
- Regent Park Community Health Centre – 465 Dundas Street East, Toronto
- Region of Waterloo Public Health and Emergency Services – 150 Duke Street West, Kitchener
- Somerset West Community Health Centre – 55 Eccles Street, Ottawa
- South Riverdale Community Health Centre (Queen) – 955 Queen Street East, Toronto
- Toronto Public Health (The Works) – 277 Victoria Street, Toronto

Self-funded sites slated for closure include:

- Kensington Market Overdose Prevention Site, The Neighbourhood Group – 260 Augusta Avenue, Toronto

The government is also proposing to mandate additional measures to increase community safety and security at the remaining sites, including:

- Requiring CTS sites to work with their local police service to undertake a crime prevention through environmental design assessment every three years, and to update their safety and security policies and procedures
- New policies for reporting complaints and serious incidents, discouraging loitering, de-escalation, and service restriction

- Enhanced reporting to enable greater ministry oversight of any safety and security concerns

Additional measures for enhanced compliance and enforcement include:

- Clear public health unit roles and responsibilities, including implementing timelines for starting investigations into complaints and requiring public health units to report all complaints regardless of whether or not they are substantiated
- Improving the Ministry of Health's awareness of community concerns by mandating the reporting of all complaints to the ministry regardless of substantiation or scope
- Transparent posting of compliance and enforcement results for community awareness and confidence

Additional measures for improved community engagement include:

- Increased accountability for community engagement, routine reporting on key indicators, such as total unique clients for wraparound services and number of complaints received, and ability to monitor performance
- New Consumption and Treatment Service (CTS) complaints reporting and escalation policy
- New ability for the ministry to measure responsiveness to complaints

Additional measures to strengthen oversight and responsiveness include:

- Annual requirements for risk assessment and mitigation plans
- Sites will be held to greater accountability requirements, including transparency and community responsiveness, improving site performance monitoring
- Increased reporting requirements mean the ministry will have greater situational awareness and be able to quickly identify trends and make improvements to the overall CTS program requirements

Homelessness and Addiction Recovery Treatment (HART) Hubs

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.

View the new HART Hub Client Journey here.

Download the HART Hub Call for Proposals (PDF)

Additional Resources

- Ontario Protecting Communities and Supporting Addiction Recovery with New Treatment Hubs

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

Media Contacts

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Communications Division
416-314-6197
media.moh@ontario.ca

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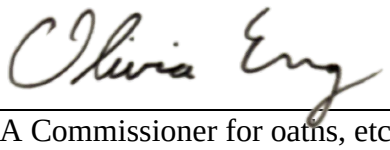


A Commissioner for oaths, etc.

A copy of Exhibit "X" to the Affidavit of Bill Sinclair, sworn January 9, 2025 can be found at this Link

This is **Exhibit "Y"** to the Affidavit of Bill Sinclair,
sworn January 9, 2024

A Commissioner for oaths, etc.

Elementary School Locator

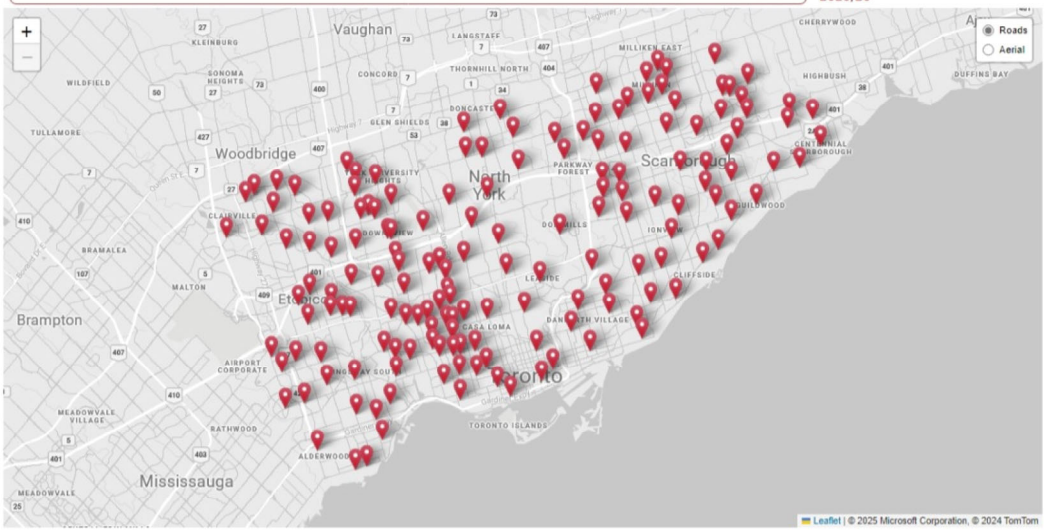
Use our school locator to find your local Toronto Catholic District School Board (TCDSB) elementary schools.

Important Information +

Please enter a home address (100 Main St) or a School Name

School Year: 2025/26

+ Advanced Search



Back to Kindergarten Registration | Back to Elementary Registration

In God's Image: Growing in Knowledge, with Justice and Hope.

Contact Us

This is **Exhibit "Z"** to the Affidavit of Bill Sinclair,
sworn January 9, 2024

A Commissioner for oaths, etc.

Annual summary of opioid toxicity deaths in Toronto

Background

Toronto has been facing a drug toxicity crisis for the past decade, with an escalation seen after 2015. Starting May 2017, the Office of the Chief Coroner for Ontario (OCCO) made available preliminary additional detailed information on opioid toxicity deaths. This included socio-demographic characteristics of the deceased, circumstances surrounding their deaths, substances present following death and any resuscitation interventions performed.

This document is produced annually by Toronto Public Health as a part of the Toronto Overdose Information System (TOIS). It presents preliminary findings for confirmed accidental opioid-related deaths in Toronto in the most recent one-year period with available data **(January 1, 2023 to December 31, 2023)**, with comparisons to earlier periods and the rest of Ontario where possible.

Please note, when the data on additional details are received, details might be missing on some of the confirmed deaths that are reported on TOIS. Additionally, most details are only available for confirmed deaths that have been deemed to be accidental in nature.

Overall Summary and Key Findings

Based on preliminary data, there were 525 confirmed and probable opioid toxicity deaths among Toronto residents in 2023.[1] These include confirmed and probable deaths with an accidental or intentional manner of death, as well as deaths with undetermined intent. The preliminary number of opioid toxicity deaths in 2023 is comparable to 2022 (N=510) but remains high when compared to pre-pandemic years.

As of July 23, 2024, there were 497 confirmed opioid toxicity deaths among Toronto residents in 2023 and 506 deaths in 2022 for which detailed circumstantial information was available. This means additional information was not available on the remaining deaths, for all manners of death (accidental, intentional or deaths with undetermined intent).

There were 476 deaths with detailed circumstantial information that were deemed to be accidental in 2023 and they are the primary focus of this report (Table 1).[1] Accidental deaths represented 96% of Toronto's opioid toxicity deaths and are comparable to the percentage of accidental opioid deaths in the rest of Ontario (95%).

[1] Numbers are expected to change as the coroner completes their investigations.

Table 1: Confirmed opioid toxicity deaths with detailed circumstantial information by manner of death, Toronto and the rest of Ontario, 2022 and 2023[1]

Year	Manner of death	Toronto	Rest of Ontario
2023	Accidental	476 (96%)	1,910 (95%)
	Intentional	13 (3%)	58 (3%)
	Undetermined Intent	8 (2%)	36 (2%)
2022	Accidental	478 (94%)	1,882 (94%)
	Intentional	18 (4%)	85 (4%)
	Undetermined Intent	10 (2%)	45 (2%)

Additional highlights include:

- Accidental opioid toxicity deaths in Toronto were higher among males (78% of all accidental deaths) in 2023.
- The highest proportion of accidental opioid toxicity deaths have been reported among individuals aged 25 to 44 years (48%), followed by 45 to 64 years (41%). This was comparable to the 2022 reports for these age groups.
- Where known, private dwellings were the most common living arrangement of those who died from an accidental opioid toxicity in Toronto in 2023, representing more than 50% of deaths.
    - The share of accidental opioid deaths among people experiencing homelessness in Toronto was more than 10% in 2023. Please note that some deaths with unknown living arrangements may include those experiencing homelessness or those with no otherwise indicated living arrangement.
- Private residences were the location of overdose incident with the highest proportion of accidental opioid toxicity deaths in Toronto (56%) and the rest of the province (69%) in 2023. When comparing the two regions, deaths with overdose incidents at private residences were higher in the rest of Ontario, while they were higher in Toronto at outdoor, shelter or public building locations.
    - Across Toronto, deaths with outdoors, congregate living and hospital/clinic incident locations also increased between 2022 and 2023, while private residences decreased.
- Fentanyl continued to be the highest direct contributor to accidental opioid toxicity deaths between 2019 and 2023 in Toronto, at 86% in the most recent year.
- Cocaine remained the highest direct contributing non-opioid, accounting for 56% of accidental deaths in 2023. This was a slight increase compared to 2022 (53%).
    - Benzodiazepines were the second highest contributor at 39% in 2023, an increase from 11% in 2022.

Detailed Breakdown for Accidental Opioid Toxicity Deaths

Socio-demographic characteristics

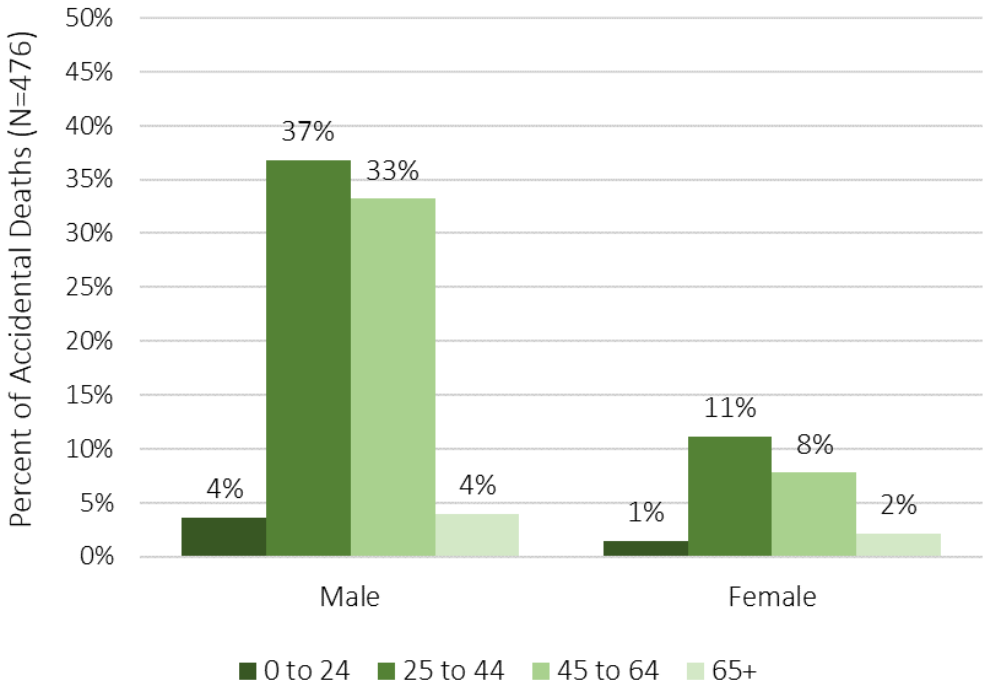
Forty-eight (48%) of all accidental deaths in 2023 occurred among individuals aged 25 to 44 years, followed by 41% in the 45 to 64 year age group (Table 2).[1] The age-specific distribution of opioid toxicity deaths in 2023 remains comparable to the distribution in 2022.

Table 2: Accidental opioid toxicity deaths by age group (years), Toronto, 2022 and 2023[1]

Age group (Years)	2023 (N=476)	2022 (N=478)
0 to 24	24 (5%)	27 (6%)
25 to 44	228 (48%)	232 (49%)
45 to 64	195 (41%)	197 (41%)
65+	29 (6%)	22 (5%)

In 2023, 78% (N=369) of all accidental opioid toxicity deaths in Toronto occurred among males, while 22% (n=107) were among females (Figure 1).[1] The age distribution of opioid toxicity deaths among males and females were similar, with the highest proportion being among males aged 25 to 44 years at 37%, followed by males aged 45 to 64 years (33%).

Figure 1: Accidental opioid toxicity deaths by age group (years) and gender, Toronto, 2023[1,2]



[2] Please note that the maximum value of the y-axis for this figure shown is not 100%.

Racial identity was unknown or missing in 35% of 2023 deaths, and in 51% of 2022 deaths. For accidental deaths due to opioid toxicity where information on racial identity was available in 2023, 73% of deaths occurred among White individuals in Toronto, followed by 10% in Black individuals (Table 3).[1,3] This was comparable to 2022.

Table 3: Accidental opioid toxicity deaths by racial identity, Toronto, 2022 and 2023[1,3,4]

Race	2023 (N=311)	2022 (N=234)
White	73%	72%
Black	10%	13%
Middle Eastern	5%	4%
South Asian	5%	3%
Latin American	4%	4%
East or Southeast Asian	3%	5%

Note: Accidental deaths with unknown or missing racial identity were excluded from the denominator.

Living arrangement

Information on living arrangement of the deceased at the time of death was unknown or missing in 28% of all accidental deaths for Toronto in 2023. For accidental opioid toxicity deaths where the living arrangement of the deceased was known, more than 50% of individuals residing in Toronto lived in a private dwelling at the time of their death in 2023.[1,5,6] In addition, more than 10% of individuals who died from accidental opioid toxicity in Toronto were experiencing homelessness. Please note that some unknown living arrangements may include those experiencing homelessness or those with no otherwise indicated living arrangement.

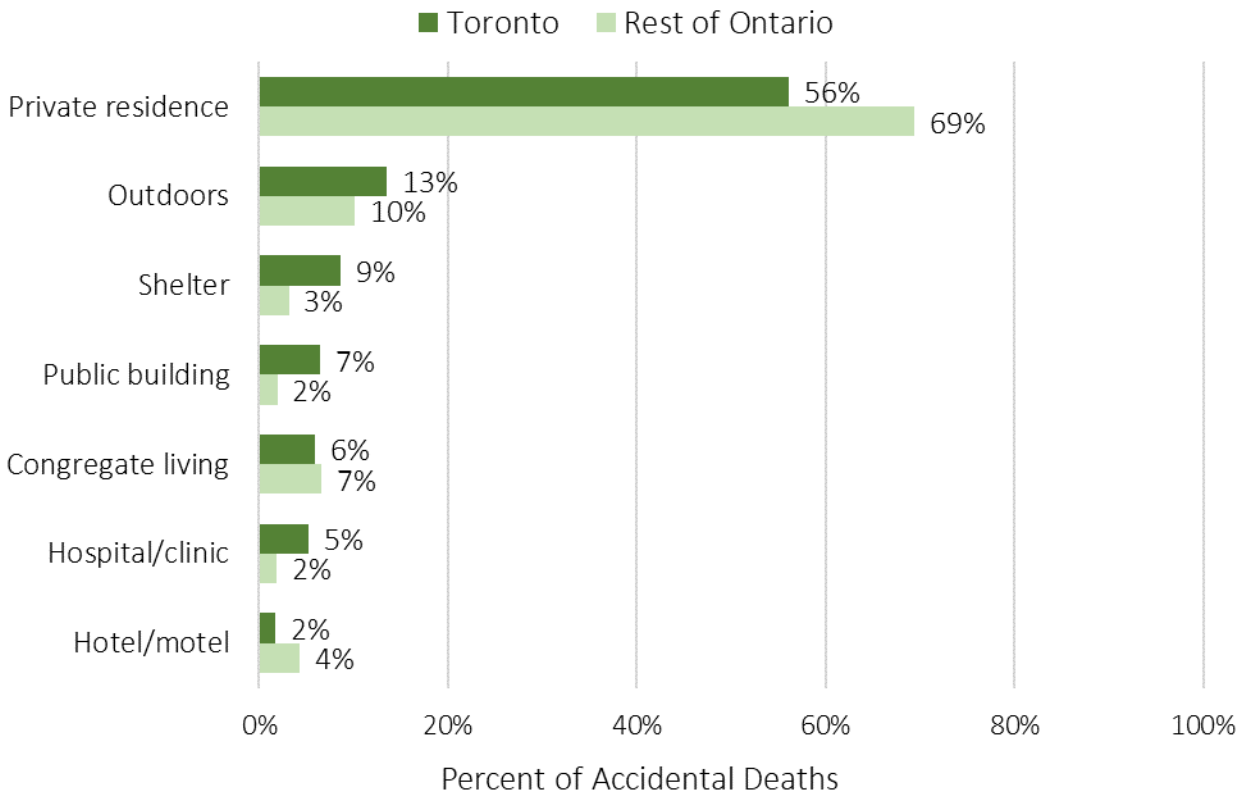
Location of overdose incident

The overdose incident occurred indoors in a private residence for more than half of all accidental opioid toxicity deaths in Toronto (56%) and in the rest of the province (69%) (Figure 2).[1] A higher proportion of opioid toxicity deaths occurred in Toronto shelters (9%), public buildings (7%) and outdoors (13%) compared to the rest of Ontario (3%, 2% and 10%, respectively). In two percent (2%) of accidental opioid toxicity deaths in Toronto and four percent (4%) in the rest of Ontario, the incident occurred in a hotel or motel. For Toronto, hotels may also include temporary hotel shelters implemented for COVID-19 response. Please refer to the Definitions section of the report for more information on the different locations of the overdose incident.

[3] Accidental deaths with unknown or missing information on racial identity were excluded from the denominator.
[4] Data for Indigenous identity continues to be unavailable as the OCC continues to consult with stakeholders.
[5] Accidental deaths with unknown or missing information on living arrangement were excluded from the denominator. Data is shown for 342 deaths in Toronto for 2023.
[6] Living arrangement of the deceased at the time of death may be different from the location of overdose incident or the location of death.

The proportion of deaths where the overdose incident was a private residence was lower in 2023 compared to 2022 (64%). In contrast, incidents associated with opioid toxicity deaths were slightly higher at other locations such as outdoors, congregate living and hospital/clinic in 2023 compared to 2022 (10%, 3% and 2%, respectively). This indicates a possible shift in 2023 from private residences to other locations in the city.

Figure 2: Accidental opioid toxicity deaths by location of overdose incident leading to death, Toronto compared to the rest of Ontario, 2023[1]



Conditions surrounding death

For 40% of all accidental opioid toxicity deaths in Toronto, the individual was reported to be at home in 2023, which is a decrease from 2022 at 48%.[1] Information on other indicators describing conditions surrounding opioid toxicity deaths in Toronto are provided below.

Recent release from a correctional facility

Information on whether the deceased was released from a correctional facility in the past four weeks was unknown or missing for a large number of accidental opioid toxicity deaths among Toronto residents in 2023 (N=399 out of 476).[1] The high number of deaths with unknown or missing information on recent incarceration is possibly because of the difficulty associated with tracking information on incarceration status of the affected individual.

In 2023, there were 11 opioid toxicity deaths where the individual was released from a correctional facility in the past four weeks (Table 4).[1] The number of opioid toxicity deaths where the deceased was not recently incarcerated was lower in 2023 compared to previous years.

Table 4: Number of accidental opioid toxicity deaths by recent release from a correctional facility, Toronto, 2019 to 2023[1]

Recent release from correctional facility	2019 (N=278)	2020 (N=508)	2021 (N=557)	2022 (N=478)	2023 (N=476)
Yes	6	15	16	12	11
No	167	259	290	133	66
Unknown or Missing	105	234	251	333	399

Someone was Present During Time of Death Who Could Intervene

Information on whether someone else was present at the time of incident who could have intervened was unknown or missing for more than half of all accidental deaths in 2023. For deaths where this information was known, 78% occurred without the presence of another individual who could have intervened at the time of overdose in 2023 (Table 5).[1,7] Additionally, there appears to be a slight increase in deaths in the recent years where the deceased was alone at the time the incident occurred.

Table 5: Accidental opioid toxicity deaths by presence of someone else who could intervene, Toronto, 2019 to 2023[1,7]

Someone present during time of death	2019 (N=207)	2020 (N=341)	2021 (N=374)	2022 (N=290)	2023 (N=199)
Yes	26%	29%	27%	19%	22%
No	74%	71%	73%	81%	78%

Note: Accidental deaths with unknown or missing information on someone else being present were excluded from the denominator.

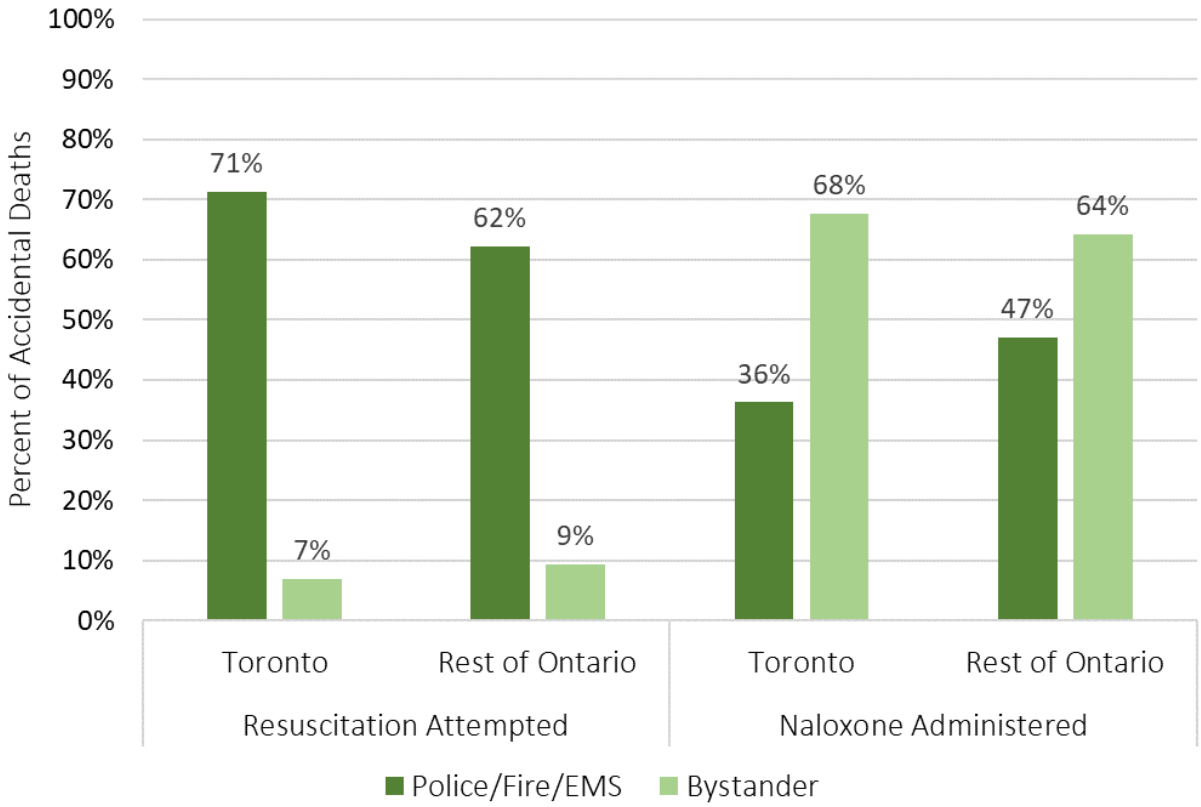
Attempt to resuscitate and naloxone administration

Information was unknown or missing on resuscitation attempt for almost half of all accidental opioid toxicity deaths in Toronto (48%) in 2023, and for 33% of all deaths when it came to naloxone use. Where known, there was an attempt to resuscitate the deceased individual in 47% (N=115) of accidental deaths in Toronto in 2023.[1,8] For accidental opioid toxicity deaths where information on naloxone use was available, naloxone was administered in 32% (N=102) of deaths in 2023.[9]

[7] Accidental deaths with unknown or missing information on whether or not another individual was present at time of incident who could intervene were excluded from the denominator.
[8] Accidental deaths with unknown or missing information on resuscitation attempt were excluded from the denominator. Data is shown for 246 deaths in 2023 for whether or not there was a resuscitation attempt in Toronto.
[9] Accidental deaths with unknown or missing information naloxone administration were excluded from the denominator. Data is shown for 320 deaths in 2023 for whether or not naloxone use was reported in Toronto.

For opioid toxicity deaths where resuscitation was attempted, first responders (police/fire/EMS) attempted resuscitation for more than half of the deaths in Toronto (71%) and the rest of the province (62%) in 2023 (Figure 3).[10,11] However, where used, naloxone was administered more commonly by bystanders in Toronto (68%) and the rest of the province (64%) in 2023.[12]

Figure 3: Accidental opioid toxicity deaths with resuscitation attempt and naloxone use by who attempted or used, Toronto compared to the rest of Ontario, 2023[1,10,11,12]

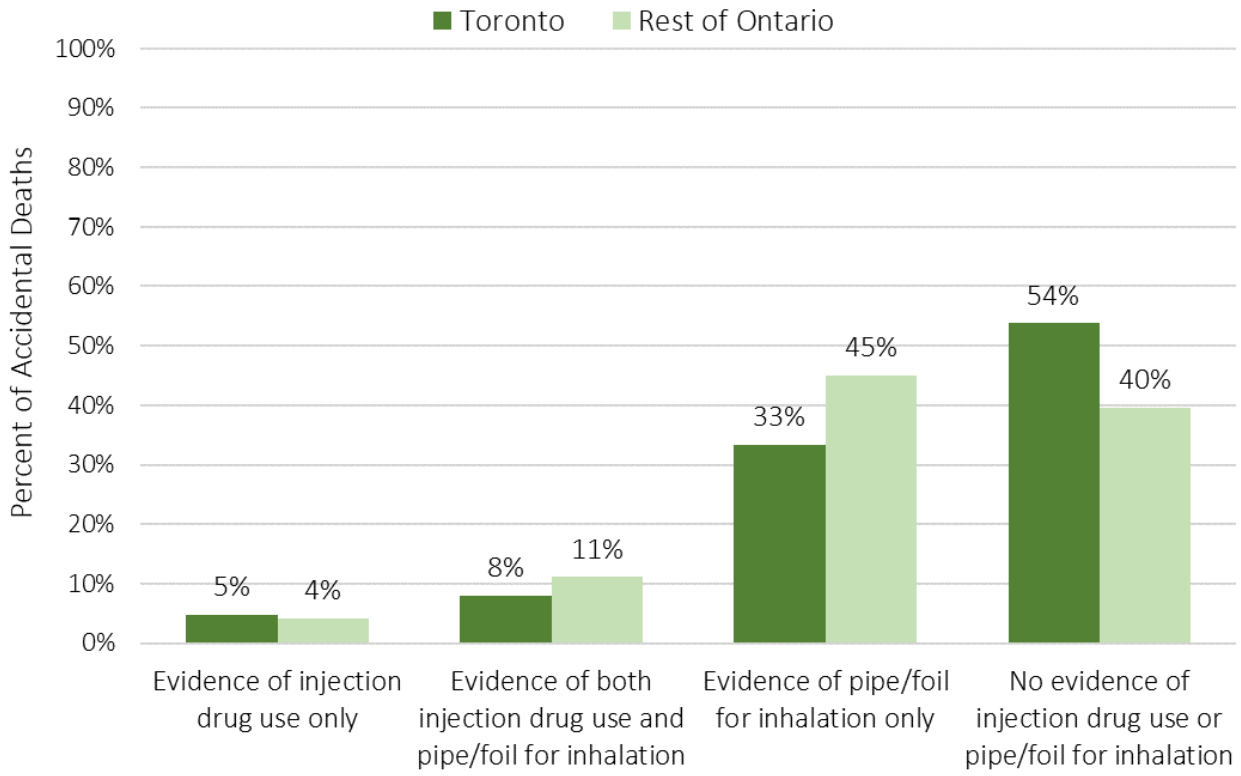


Mode of use

Although the investigating coroner found no evidence of injection drug use or pipe/foil use in more than half of the accidental deaths in Toronto, there was evidence of only pipe/foil use for inhalation in 33% of all accidental opioid toxicity deaths among Toronto residents in 2023, while this was true for 45% of the deaths in the rest of Ontario (Figure 4).[1] Please note, no evidence of injection drug use or pipe/foil use does not indicate that any of these modes were not used, but that there was no evidence found by the coroner of their use for an accidental death. This may indicate oral, nasal, transdermal, other, or unknown modes of drug use.

[10] Attempt of resuscitation or administration of naloxone can be done by bystander, hospital, Police/Fire/EMS or can be unknown/missing. These categories are not mutually exclusive; some deaths can have multiple attempts of resuscitation or naloxone administration and can fall under more than one of these categories.
[11] Resuscitation was attempted for 115 accidental deaths in Toronto in 2023, and for 725 deaths in the rest of Ontario.
[12] Naloxone was administered for 102 accidental deaths in Toronto in 2023, and for 511 deaths in the rest of Ontario.

Figure 4: Accidental opioid toxicity deaths by evidence of injection drug use or pipe/foil for inhalation, Toronto compared to the rest of Ontario, 2023[1]

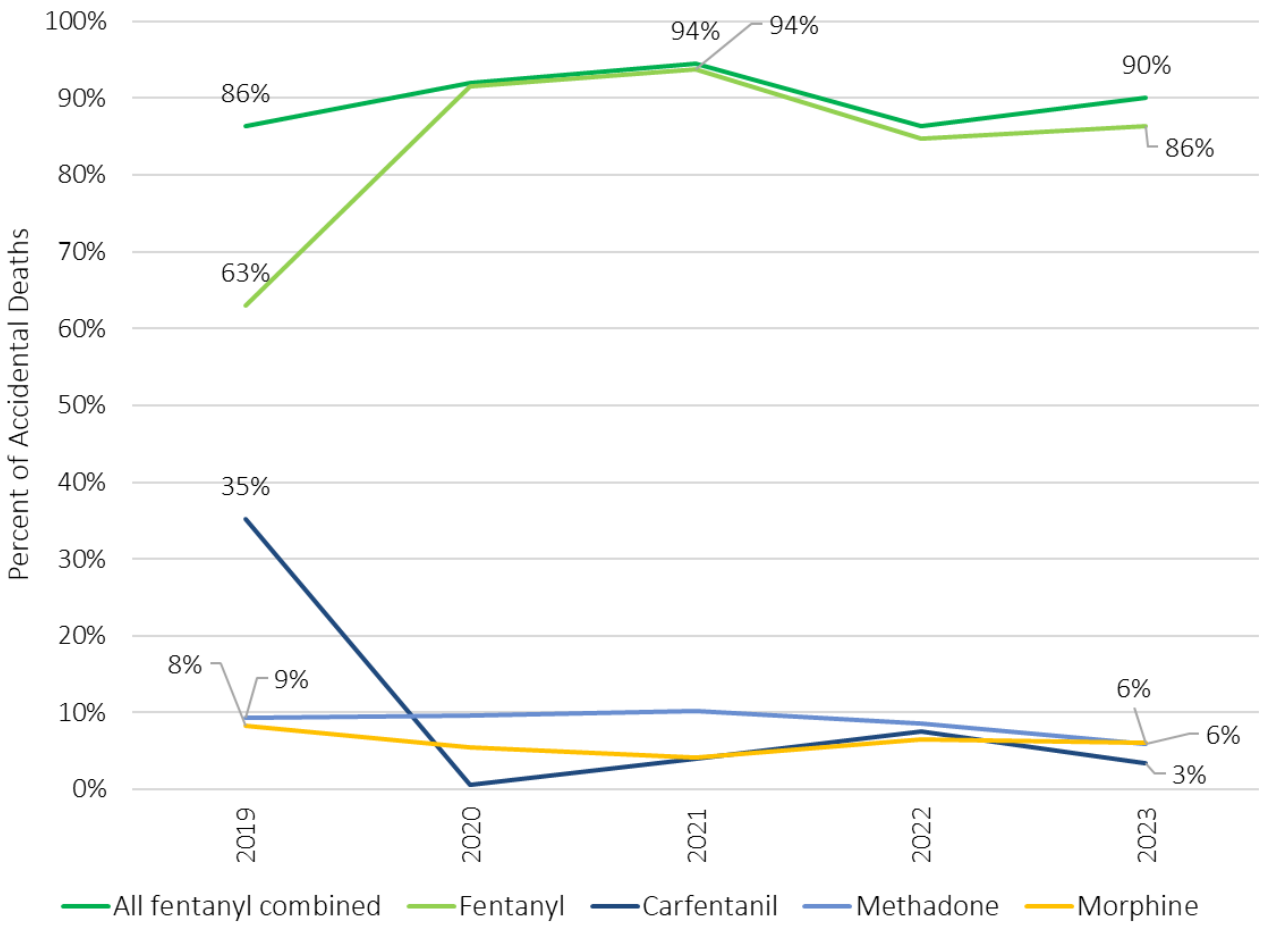


Type and origin of substances contributing to death

Between 2019 and 2023, fentanyl has continued to be the highest direct contributor to accidental opioid toxicity deaths in Toronto, with a peak of 94% in 2021 (Figure 5).[1,13] Notably, carfentanil contributed to 35% of deaths in 2019, with a decrease in the following years and ending at 3% in 2023.

[13] Drug categories are not mutually exclusive; some deaths are attributed to multi-drug toxicity where a death can be caused by more than one drug.

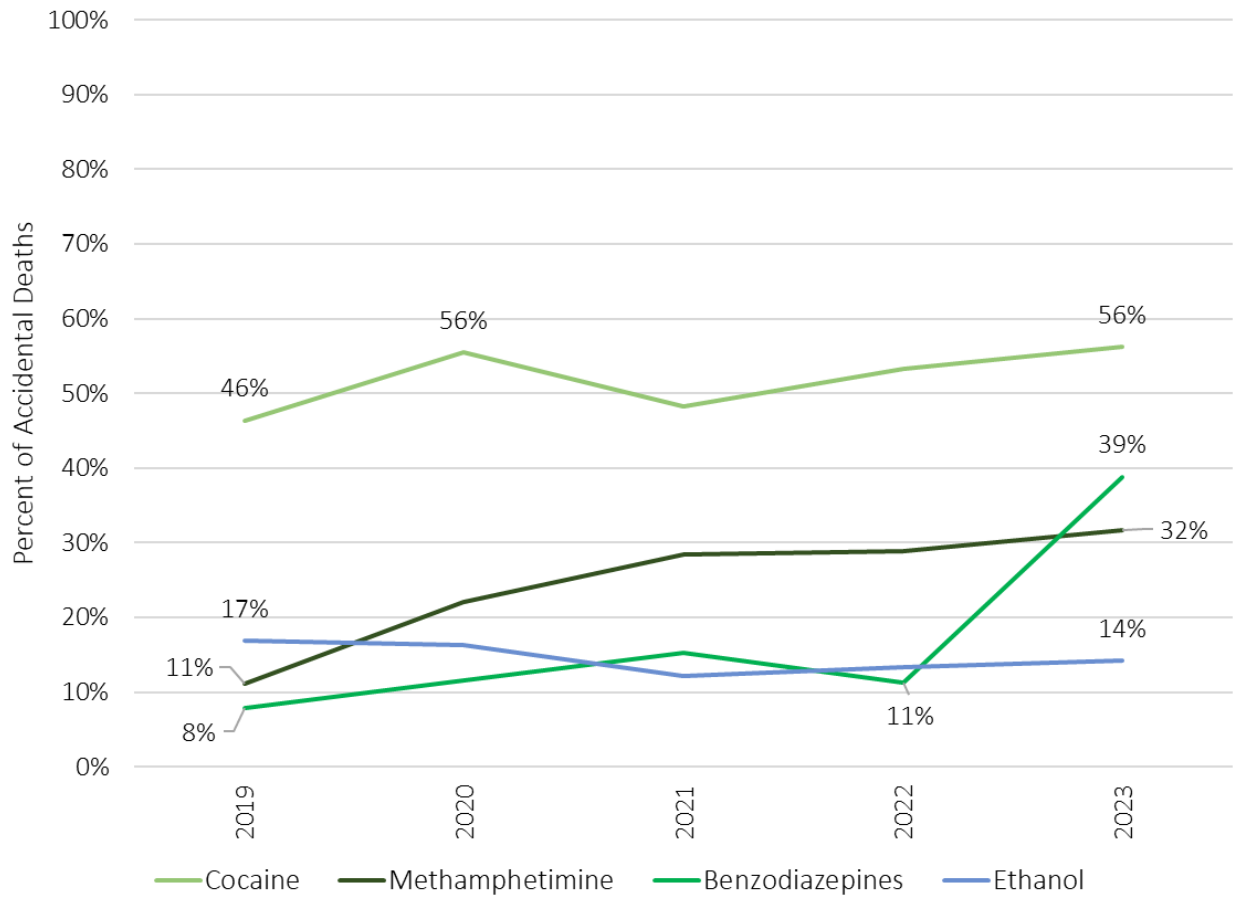
Figure 5: Accidental opioid toxicity deaths by select type of opioid directly contributing to death, Toronto, 2023[1,13,14,15]



Cocaine has remained the non-opioid substance directly contributing to the highest percentage of accidental opioid toxicity deaths in Toronto from 2019 to 2023, contributing to 56% of deaths in 2023 (Figure 6).[1,13] Other notable non-opioids include methamphetamine and benzodiazepines, where the contribution of both have increased in the recent years since 2019 from 11% and 8% (2019) to 32% and 39% (2023), respectively.

[14] The "All fentanyl combined" category includes fentanyl, carfentanil and fentanyl analogues.
[15] Only select substances are presented in this figure: all fentanyl combined, carfentanil, fentanyl, methadone and morphine. Other substances not shown include heroin, hydromorphone, buprenorphine, codeine, hydrocodone, other fentanyl analogues, oxymorphone, tramadol, U47700 and oxycodone.

Figure 6: Accidental opioid toxicity deaths by select type of non-opioid directly contributing to death, Toronto, 2023[1,13]



In 84% of accidental opioid toxicity deaths that occurred in Toronto in 2023, the opioids contributing to death were exclusively non-pharmaceutical in origin (Table 6).[1] This was slightly higher than the rest of the province at 79%. Other origins for the contributing opioids included pharmaceutical and mixed. The origin of the opioids was unclassified in 3% of accidental opioid-related toxicity deaths in both regions.

Table 6: Origin of opioids contributing to accidental opioid toxicity deaths in Toronto, compared to the rest of Ontario, 2023[1]

Origin of contributing opioid	Percentage of accidental deaths	
	Toronto (N=476)	Rest of Ontario (N=1,910)
Non-pharmaceutical	84%	79%
Pharmaceutical	6%	9%
Both pharmaceutical and non-pharmaceutical	7%	10%
Unclassified	3%	3%

Data Sources

Office of the Chief Coroner for Ontario, January 2019 to December 2023.

- Yearly counts extracted August 2024.
- Detailed socio-demographic characteristics and nature and origin of substances received via September 5, 2024 Public Health Ontario Quarterly Public Health Unit Opioid-related Death Report, extracted on July 23, 2024.

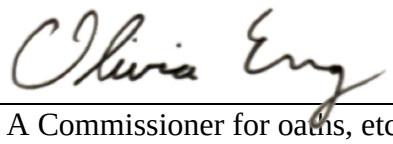
Data Notes

- 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 supressed.
- Deaths have been assigned to Toronto based on the six-digit postal code of the residence of the deceased individual. If the postal code of the residence was not available, the postal code of the incident location was used. If this information was not available, the postal code of the death location was used. In cases where postal code is unavailable, other geographic information such as city of residence/incident/death may be used to assign PHU.
- An individual is considered to have died at home if the location of death address is the same as their home address.
- Emergency responders refer to EMS, Police and Fire.
- Living arrangement categories include private dwelling, homeless, collective dwelling, correctional facility, residential care facility, hospital or long-term care home, other, and unknown.
    - In Q3 2021, the OCCO transitioned to a new case management system, which may have contributed to an increase in “Unknown” living arrangements. Some unknown living arrangements may include those experiencing homelessness or those with no otherwise indicated living arrangement.
- Incident location categories include private residence, public building, hotel/motel, congregate living, shelter, hospital/clinic, correctional facility, in a vehicle, and outdoors.
- Origin of contributing opioid include non-pharmaceutical, pharmaceutical and unclassified.
- Gender is based on gender identity at time of death.
- Information on recent release from a correctional facility is collected by the coroner from next of kin or witnesses.
- Information on someone being present during time of death who could intervene is collected by the coroner. If the coroner attends the scene, they collect this information from witnesses or other first responders (i.e., EMS).
- The substances reported in the data are not reflective of all contributing substances for a death. The cases reflect confirmed opioid toxicity deaths with at least one opioid contributing to death, but the record-level data indicates presence (i.e., detection at post-mortem).

Definitions

Term	*Definition*
Living Arrangement	
Private dwelling	A separate set of living quarters designed for or converted for human habitation. Must include a source of heat or power and must be an enclosed space that provides shelter/protection from the elements. In Toronto, this includes community housing units.
Homeless	Without stable, permanent, appropriate housing, or the immediate prospect, means and ability of acquiring it; includes no fixed address and those temporarily residing in shelters.
Collective dwelling	Lodging and rooming houses, hotels, motels, tourist establishments, campgrounds and parks, sober living facilities, school residences and training centre residences, work camps, religious establishments, military bases, commercial vessels.
Correctional facility	May include federal correctional institutions, provincial and territorial custodial facilities, young offenders' facilities, jails and police lock-up facilities.
Residential care facility (including group homes)	Institutions or establishments that provide accommodation, and potentially treatment, to various groups (e.g., physically handicapped, children/youth, persons with psychiatric disorders or developmental disabilities).
Hospital or long-term care home	An institution or establishment providing medical care (short term or continuous).
Incident Location	
Private residence	Apartment/Condominium, Single-detached house, Rowhouse/townhouse, Semi-detached house, Private residence, Trailer/Mobile home, Private Residence, Rural/Agricultural: Residential, Shed, Community Housing, Barn
Public building	Airport, Recreational building, Commercial, Commercial/retail building, Other public building
Hotel/motel	This may also include deaths in temporary hotel shelters implemented for COVID-19 response
Congregate living	Long-term care home, Supported living, Rooming house
Outdoors	Urban/Suburban, Recreational space, Railroad: On tracks, Forest/Park/Conservation area
Origin of Contributing Opioid	
Non-pharmaceutical	• Heroin, fentanyl analogues (including carfentanil), U-47700 • Fentanyl without evidence of patch, vial or other pharmaceutical formulation or prescription is determined to be of suspected non-pharmaceutical origin. • Morphine without or unknown evidence of a prescription, with or without 6-monoacetylmorphine (6-MAM) and with evidence suggesting non-pharmaceutical heroin use (e.g., other non-pharmaceutical opioids detected on toxicology such as carfentanil or history of consuming or seeking heroin). • Codeine without or unknown evidence of a prescription, with 6-MAM, or without 6-MAM but with morphine (without a prescription) and with evidence suggesting non-pharmaceutical heroin use.
Pharmaceutical	• Buprenorphine/naloxone, codeine without 6-MAM or 6-MAM and evidence suggesting non-pharmaceutical heroin use, dextromethorphan, fentanyl (with evidence of patch, vial or other pharmaceutical formulation), hydrocodone, hydromorphone, loperamide, meperidine, methadone, morphine with evidence of a morphine or codeine prescription, oxycodone, oxymorphone or tramadol. • May include opioids that were prescribed to the deceased person or that were prescribed to someone else (i.e., diverted).
Unclassified	Opioid could not be clearly categorized as non-pharmaceutical or pharmaceutical

This is **Exhibit "AA"** to the Affidavit of Bill Sinclair,
sworn January 9, 2024



A Commissioner for oaths, etc.

Contamination of Toronto's Unregulated Fentanyl Supply: Reported by Toronto's Drug Checking Service

October 10, 2019 – November 30, 2024

The Neighbourhood Group's Kensington Market Overdose Prevention Site (KMOPS) joined **Toronto's Drug Checking Service** in July 2024. Since launching, 59 samples collected by KMOPS have been checked by the program – 59% (35) of these samples were expected to be (i.e., got or bought as) fentanyl. Given the number of samples and amount of time since launch at KMOPS (59 over 5 months) compared to the total number of samples collected in Toronto and checked by the program since it launched (15,000 over 5 years), the included summary is comprised of data from expected fentanyl samples checked across the program's 10 **collection site members**. It is reasonable to believe the composition of fentanyl KMOPS service users have access to is consistent with fentanyl being used by others in Toronto's downtown core.

Since launching in 2019, Toronto's Drug Checking Service has checked over 15,000 drug samples from the city's unregulated drug supply and identified over 450 unique drugs – many of which can be directly linked to overdose. The service allows people to anonymously submit a sample of their drug to be tested and receive results about what's in it, along with tailored strategies to reduce harm and referrals to drug-related, health, and social services. Approximately half of the samples submitted to the program are expected to be fentanyl, which is important as **the contamination of the unregulated fentanyl supply is what is driving our country's toxic drug supply crisis**.

Between October 10, 2019 – November 30, 2024, 4,157 fentanyl drug samples were checked by Toronto's Drug Checking Service. Of these:

- 4% **met service user's expectations** (meaning fentanyl was the only drug found)
- 96% did not **meet service user's expectations**:
    - 85% were contaminated with other drugs
    - 15% contained no drugs (i.e., it is likely only non-drug filler was in the sample)

By comparison, expected ketamine drug samples **met service user's expectations** 90% of the time and methamphetamine 82% of time, respectively. Our data demonstrates that expected fentanyl drug samples almost never meet service user's expectations, that fentanyl is far more contaminated than other drugs (often with central nervous system and respiratory depressants that increase the risk of overdose and dangerous suppression of the vitals), and that these factors make it disproportionately difficult for fentanyl users to be able to reduce the harms associated with their drug use.

Other key findings related to the composition and contamination of the 4,157 fentanyl drug samples checked by Toronto's Drug Checking Service between October 10, 2019 – November 30, 2024, include:

- 8% were known to be associated with an overdose
- 44% contained a benzodiazepine-related drug – 6% of these samples contained multiple benzodiazepine-related drugs.
- 32% contained multiple high-potency opioids, including fentanyl, fluorofentanyl, carfentanil, methylfentanyl-related drugs, and/or nitazene opioids
- 31% contained fluorofentanyl (up to 2 times stronger than fentanyl)
- 16% contained a veterinary tranquilizer
- 13% contained a methylfentanyl-related drug (which is roughly as strong as fentanyl)
- 6% contained a nitazene opioid (up to 25 times stronger than fentanyl)
- 1% contained carfentanil (up to 100 times stronger than fentanyl)

Having monitored the composition of the unregulated drug supply since October 2019, Toronto's Drug Service has noted a few key trends related to contamination of the fentanyl supply:

1. **High-potency opioids are increasingly being found in combination**, increasing the risk of overdose and requiring greater than normal doses of naloxone to rouse individuals experiencing an overdose
2. **Other central nervous system and respiratory depressants are often found**, increasing the risk of dangerous suppression of vitals (e.g., slowing down of breathing, blood pressure, heart rate)
3. **Inconsistent amounts of fentanyl and other central nervous system and respiratory depressants are found**, making it impossible for people who use fentanyl to make informed dosing decisions
4. There has been **significant volatility in the specific central nervous system and respiratory depressants presenting in the fentanyl supply**, resulting in the continual need to change and adapt overdose response management and best practice

At the root of the toxic drug supply crisis is a fentanyl supply that is contaminated and unpredictable – that is what is killing people. KMOPS offering essential harm reduction services – including supervised consumption – to people who use drugs in Toronto's downtown core is vital given the composition of the unregulated fentanyl supply, as made clear by data generated by Toronto's Drug Checking Service.

About Toronto's Drug Checking Service: Comprised of a group of members, and the flagship program of Ontario's Drug Checking Community, Toronto's Drug Checking Service is a public health service that aims to reduce the harms associated with substance use and, specifically, to prevent overdose by offering people who use drugs timely and detailed information on the contents of their drugs. Beyond educating individual service users, results for all samples are combined and analyzed to perform unregulated drug market monitoring, then translated and **publicly disseminated every other week** to communicate drug market trends and education to those who cannot directly access the service, as well as to inform care for people who use drugs, advocacy, policy, and research.

Collection site members: Casey House | Parkdale Queen West Community Health Centre: Parkdale and Queen West sites | Regent Park Community Health Centre | South Riverdale Community Health Centre: KeepSix and Moss Park sites | Street Health | The Neighbourhood Group: Kensington Market Overdose Prevention Site | The Works at Toronto Public Health | Toronto Shelter and Support Services: Seaton House Overdose Prevention Site

Analysis site members: Centre for Addiction and Mental Health (Clinical Laboratory and Diagnostic Services) | St. Michael's Hospital (Department of Laboratory Medicine and Drug Checking Unit)

Central operating team: Ontario's Drug Checking Community is coordinated by a small central team that operates from within the Drug Checking Unit at St. Michael's Hospital. The central operating team is also responsible for conducting unregulated drug market monitoring, developing and disseminating relevant drug information, and building community related to drug checking service provision.

Our work would not be possible if people who use drugs did not access our service and, as a result, advocate for themselves and help develop solutions that impact them. We thank the community of people who use drugs across Ontario for their trust and leadership.

(website) **www.drugchecking.community** | (email) **hello@drugchecking.community** | (X) **@drugcheckingTO** | (IG) **@drugchecking**

This is **Exhibit "BB"** to the Affidavit of Bill Sinclair,
sworn January 9, 2024

A Commissioner for oaths, etc.

January 9, 2025

I have been the priest at the Anglican church of St Stephen-in-the-Fields since May 2013. My work includes leading worship services, providing pastoral conversation and support, providing end-of-life care at hospitals, hospices, and long-term care homes, and coordinating the parish's active program of support for people in the community who are unhoused or marginally housed. The parish serves free breakfasts on weekends, and a drop-in dinner on Friday evenings; at this time, we serve over 500 meals every week. I have served on the boards of Friends of Kensington Market and the Kensington Market Land Trust. I also live nearby, in the Alexandra Park neighbourhood. I walk through Kensington Market every day, and talk to people from all social backgrounds and walks of life.

I am very aware that many people in Kensington Market and Alexandra Park use street drugs. I've also seen drug dealing in the area since I lived in the Market in the early 90s, at that time primarily crack cocaine. When I began my work as the priest at St Stephen's, most people who sought to talk to me about substance use problems were abusing alcohol. Crystal meth became a large factor within a few years, and now co-exists, as a major issue, with street opiates, especially fentanyl. I am aware that this street supply is routinely contaminated, and that people do not in any real sense know what they are using or in what amounts.

I observed large numbers of discarded needles in the streets and alleyways, and in the church yard and garden, from the time that I began working at the church. Staff and volunteers could not work in, or clean up, any of our grounds without wearing protective gloves and closed shoes (I had a possible needle-stick incident when I carelessly went into the garden in sandals). This was the case at least from 2013, and was probably the case long before I was the priest here.

From about 2016 onwards, I began to see that more and more of the people we served were dying from overdoses or contaminated drug supply. I remember some of these people vividly, people who attended our Friday dinner every week, kind and gentle souls, some people with obvious learning difficulties, others who were artists or musicians, my friends. The level of grief and trauma among our regular guests was constantly increasing, and the intense unresolved mourning was obviously making it even harder for people to function well or to get their lives more organized. For these reasons, I strongly supported the Kensington Market Overdose Prevention Site from the time it was first proposed.

Although we do not keep count, it was my strong impression that, as soon as the site opened, there was a marked decrease in discarded needles on our grounds. I am aware that staff from the site regularly walk the neighbourhood picking up discarded needles, and, of course, if people have a safe area to use drugs and to leave their used needles, it makes sense that there would be fewer needles in the street.

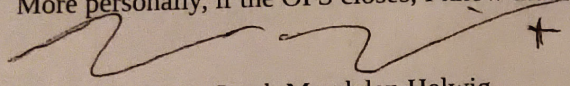
As we are all aware that the toxic drug crisis is escalating, and intersecting with the continuously worsening housing situation, it's impossible to compare overdose deaths with the situation years ago, but I know personally a number of people whose lives have been saved at the Overdose Prevention Site. I also know that staff from the site have acted as a mobile unit when needed, and I have seen them responding to overdoses in the streets, and indeed have sometimes worked alongside them to reverse overdoses in the church yard. In the last year, there have been two overdose deaths on the grounds of the church itself. Both occurred during the night, when the Overdose Prevention Site is closed. My greatest wish would be that the site could have enough funding to operate round the clock.

I hear many people experiencing homelessness talking about the OPS as a place they value, and a place where they feel valued. It is much more than a space where they can use drugs more safely; it is a space

where they feel more safe in general, where they don't face stigma or judgement, where they have a respite from the constant stress and anxiety of life on the street. It helps them to stabilize emotionally and psychologically. It is also a place where people can grieve in community, and be supported in mourning the friends they have lost, resulting in less ongoing trauma. These are the necessary preconditions for people to be willing to explore reducing their substance use. I know that some people who use the site have reduced their use of street drugs, and sometimes stopped using entirely. Others have not, but they are no less deserving of safety and care.

I am convinced that if the OPS is closed, we will see:
-- more discarded needles around the neighbourhood
-- more visible drug use in public
-- more overdose deaths, many of them in public locations, including parks and schoolyards
-- a greater burden on EMS as they need to respond to many more overdose calls

More personally, if the OPS closes, I know that more of my friends will die.



Reverend Canon Sarah Magdalen Helwig
Church of St Stephen-in-the-Fields
103 Bellevue Avenue

THE NEIGHBOURHOOD GROUP COMMUNITY SERVICES et al.
Applicants

-and-

HIS MAJESTY THE KING IN RIGHT OF ONTARIO

Respondents

Court File No. CV-24-00732861

ONTARIO
SUPERIOR COURT OF JUSTICE

PROCEEDING COMMENCED AT TORONTO

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TAB 4

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 KATHARINE RESENDES

I, KATHARINE RESENDES, of the City of Toronto, in the Province of Ontario, MAKE OATH AND SAY:

1. I am one of the applicants in this application and as such have knowledge of the matters contained 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.

A. Personal Background and Introduction to Drugs

2. I was born on April 1, 1988, in Toronto, Ontario.

3. I have lived in Toronto my entire life.

4. After graduating high school, I began an undergraduate degree at university. It was at university that I began using cocaine. In my later years of high school, I had smoked marijuana and drank alcohol recreationally from time to time, but it was only as an adult that I became introduced to harder drugs.

5. My cocaine use began recreationally, but I soon began to develop a dependence on it. However, the cocaine also gave me negative side effects, including feelings of paranoia and anxiety.

6. When I was 20 years old, I was introduced to heroin by a friend of mine who used it. I used it for a few days consecutively and became addicted to it almost immediately. The heroin did not come with the same side effects for me as the cocaine did. I stopped using cocaine, and heroin became my drug of choice. I began using heroin every day. I dropped out of university shortly afterward, having completed two years of my degree.

7. I was struggling with my mental health at the time, and I used drugs to self-medicate at a time when I was not yet accessing formal mental health treatment.

B. My Experiences with Substance Use Treatment and the Healthcare System

8. Approximately 8 months to a year after I started using heroin, I had reached a point where I needed to use heroin every day in order to avoid withdrawal symptoms. Withdrawal for me would start with flu-like symptoms like a runny nose, sneezing, and muscle aches all over my body. It would progress to cramps, pain, vomiting, diarrhea, and shivering, like I was experiencing the worst flu imaginable. I would be anxious and unable to sleep. I would think about how I knew the heroin would instantly take the pain and other symptoms away.

9. However, my addiction to heroin had become extremely expensive and I was no longer financially able to afford to purchase that amount of heroin. At the same time, I was unable to tolerate the withdrawal symptoms when I would try to reduce my heroin use. The pain and the cravings of withdrawal were too overwhelming for me stop. I was also unable to cope with the withdrawal symptoms while also maintaining my employment.

10. Those circumstances led to my decision to pursue a methadone program. Methadone is an opioid that is sometimes prescribed by doctors to treat opioid addiction by preventing physical withdrawal symptoms and reducing drug cravings without the person getting high.

11. The person who had introduced me to heroin was also on methadone at the time and connected me to their methadone clinic. I have been on methadone ever since. My methadone treatment regimen requires me to take a dose of methadone every single day (which I consume orally). As part of my treatment regimen, I have an appointment with my doctor once a month and must go to my doctor's office once a week to give a urine sample. I am currently on a very high dose of methadone (155 mg per day) and have been on a high dose of methadone for many years.

12. Methadone allowed me to significantly decrease my consumption of heroin. The methadone helps suppress my physical withdrawal symptoms without me actually getting high, which allowed me to function in my day-to-day life. However, I continued (and still continue) to experience psychological withdrawal symptoms and cravings for opioids.

13. While I was able to stop using heroin every day, I still obtained and injected heroin regularly. When I did not consume heroin, I would feel highly emotional and anxious. Everything felt overwhelming. These symptoms were too severe for me to discontinue heroin altogether.

14. While I was not able to stop relying on street drugs, my methadone treatment has allowed me to maintain a degree of stability in my life. I have been diagnosed with substance use disorder and lived with it for approximately 16 years now. I would describe myself as being a very high-functioning addict throughout most of that time.

15. I have been able to maintain largely steady employment and housing throughout my addiction (which I attribute in part to my methadone treatment). Even though it has not eliminated my dependence on opioids, the methadone controlled my physical dependence enough that I was able to go back to school in 2012. After completing my diploma I spent the next 11 years working in the legal field.

16. Aside from methadone, I have also accessed other treatment for my substance use disorder and other mental health needs, including residential drug treatment programs. When I was around 25 years old, I sought counselling at the Jean Tweed Centre, which is an organization that provides mental health services for women. I was driven to seek treatment over the implications my drug use had on my personal life.

17. Through the Jean Tweed Centre, I learned about a 3-month residential treatment program for women with substance use issues offered by The Salvation Army. I attended a detox program first and then began the 3-month treatment program. At the time, I was not ready for treatment. I ended up leaving the treatment facility on multiple occasions over the course of the treatment programs during our free time to obtain and use heroin. This was eventually detected through the program's random urine tests and I had to go back to detox before I could return and complete the program.

18. A couple of months after completing the 3-month program, I did a second inpatient residential treatment program for 21 days. I again used drugs while in treatment.

19. At the time, I was not fully ready to quit using drugs. Although I wanted to stop using, my need to self-medicate through drugs was stronger. I also had not yet unpacked the underlying mental issues and trauma I struggle with that contribute to my continued drug use.

20. While I did learn some useful tools in those treatment programs, like approaches to dealing with panic attacks, there were negative aspects to the experience as well and I did not find the programs to be effective for me overall. Both programs were heavily based in a twelve-step type of approach (the approach used by Alcoholics Anonymous) where there is a focus on complete abstinence from all substances. Because I was on methadone at the time (and still am), complete abstinence was not an option for me. Quitting methadone 'cold turkey' is dangerous and stopping methadone requires being weaned off over a period of time under the direction of your doctor. The abstinence-based programming delivered by the treatment centre did not really account for my particular needs. I also felt a lot of judgment in those programs for my methadone use from staff and other participants.

21. The judgment I experienced, going to treatment before I was ready, and the incompatibility of a fully abstinence-based approach with my situation (including my methadone treatment), made those treatment options less effective for me. I do not think that I would not seek out an abstinence-based treatment program again.

22. Beyond drug treatment specifically, I have frequently had negative experiences within the healthcare system more generally where I have felt judged and stigmatized for my drug use. When

I do seek treatment at a hospital, I always identify myself as an intravenous drug user because I know that there are health implications that flow from that.

23. My experience has been that as soon as I disclose my drug use to hospital staff, the way I am treated changes immediately and significantly. Nurses and doctors speak to me more harshly and I am taken less seriously. I have frequently experienced negative and judgmental comments from healthcare professionals relating to my drug use, such as comments that I am "destroying my body" (referring to my track marks and wounds from my intravenous drug use).

24. Because of the judgment I feel when I try to access healthcare services, I often avoid seeking treatment or wait longer than I realistically should, until the issue I am experiencing becomes severe enough that I cannot wait any longer.

C. Drug Use Practices and Impacts on My Health

25. I have lived with substance use disorder for approximately 16 years. For nearly all of that time, I have consumed drugs intravenously, through injection.

26. I started injecting fentanyl approximately 5 or 6 years ago. At the time, I had not deliberately sought out fentanyl. Instead, fentanyl seemed to suddenly explode into Toronto's street drug supply and it became very difficult for me to obtain heroin. The dealers from whom I had been buying heroin now no longer had it and were only selling fentanyl. It felt like overnight, heroin just ceased to be available and fentanyl was everywhere. As a result, I switched to using fentanyl and have been injecting fentanyl since then.

27. Fentanyl delivers a different high than heroin, one that is more powerful. Although I know that fentanyl is extremely dangerous, I have not yet been able to stop using it. I have known many

people who have died from opioid overdoses—most from heroin, but in recent years it has been as a result of fentanyl.

28. Those losses devastated me. I am also afraid for my own life. Getting off opioids is a long-term goal of mine, but I do not feel ready yet to start that process again.

29. Before I started using supervised consumption sites, I would typically inject drugs at home either alone, or together with my boyfriend who also had a dependence on heroin. When I would inject with my boyfriend, we would take turns so that we could monitor each other for a possible overdose or other bad reaction to the drugs.

30. I have overdosed multiple times. On several occasions, my boyfriend was with me when I overdosed and he used naloxone to reverse it. The experience is extremely frightening. I am not aware when it is happening, and when I come out of it, I do not remember what happened or that I was administered naloxone. Waking up to that reality is very unsettling. It has made me aware of how easily life can slip away without warning.

31. One time, my overdose was so serious that my boyfriend had to call an ambulance. I was hospitalized and put on a naloxone drip. It was a terrifying experience. If my boyfriend did not happen to be with me as my overdose was happening—and willing to call 911 for me—I do not know if I would still be alive.

32. Before I started using the services at supervised consumption sites, I engaged in several drug use practices that I now understand were unsafe. I would buy needles at the pharmacy and use household supplies like a kitchen spoon and Q-Tips.

33. Using the cotton from Q-Tips as a filter sometimes gave me something that I understand is referred to as “cotton fever”. My understanding is that this is the term for a reaction when bacteria from the cotton or small pieces of the cotton get into your bloodstream. For me, cotton fever would last a couple of hours and be extremely intense. I would get a severe headache and have other intense flu-like symptoms, such as vomiting and chills. While it was happening, it would feel like the worst two hours of my life.

34. I would usually use the same needle multiple times so as not to go through them as quickly. (Although I was steadily employed during that time and able to afford to buy new needles from time to time, doing so was still expensive.) Using the same needle multiple times blunts it and makes it harder to catch a vein. Sometimes I would miss or only partially catch a vein. When that would happen, I would accidentally inject the drugs into the muscle. That would create a big lump at the injection site. Those sites would sometimes get infected and turn into an abscess, which is incredibly painful. I have had abscesses several times from injecting, mainly on my arms and hands.

35. As I did not have ready access to a safe disposal method for my used needles, I would usually discard them in an unsafe manner.

D. My Experience with Supervised Consumption Sites

36. Approximately 6 years ago, I heard about supervised consumption sites opening up in Toronto and was curious about the services being offered there. I started going to The Works at Victoria Street and Dundas Street East in order to pick up clean supplies, which I would bring home with me. Through using The Works’ needle exchange program, I learned about their other services, including their supervised consumption services, which I also began using.

37. I had a very positive experience at The Works. Their supervised consumption services made me feel safe, as I knew that if something were to happen to me (such as an overdose) the staff there could intervene and save me. I found an incredible sense of community there with both the staff and the other clients. The environment was very non-judgmental, which is incredibly important to me. As an intravenous drug user, I have experienced a lot of judgment and stigma from not just the healthcare system and people generally, but other (non-intravenous) drug users as well. The feeling of safety the site gave me, the non-judgmental approach of the staff, and the kindness that the people there showed me, were significant factors in why I continued to go back.

38. The Works also offered a drug checking service where I could bring in drugs and get them tested to see what substances were in them. I would use the drug checking service sometimes, if I had something new that I had not tried before or if I had had a bad experience after using certain drugs to see if the drugs were the issue. Sometimes the results would come back indicating that the contents of the drugs were not what I had expected. On multiple occasions, animal tranquilizers and other drugs, such as benzodiazepines were detected in samples I originally thought to contain fentanyl. When an unexpected drug was detected in a sample that I provided for testing, I would not purchase that same batch of substances again. That means that I would be forced to purchase fentanyl from a different source. On these occasions I would try to use in a supervised consumption site, rather than on my own at home to mitigate the chance of overdose from an unknown batch of drugs.

39. Although I had a good experience using the site itself, it was challenging for me to physically access it because it was very far away from where I was living. I do not drive, and it would take me approximately 60 minutes on the subway to get to The Works. Although I was scared for my safety when I would use alone at home, oftentimes I just could not wait long enough

to actually get myself to the supervised consumption site to inject in the supervised environment and I would end up injecting my drugs alone at home.

40. Approximately two or three years ago, I was in the Kensington Market area and happened to discover the Kensington Market Overdose Prevention Site ("**KMOPS**"). I met some of the staff there, who I found to be very welcoming. As it was a somewhat shorter travel time for me to get to KMOPS compared to The Works, I started going to KMOPS instead. I feel like KMOPS is a more intimate environment compared to The Works (there are a smaller number of booths at KMOPS) and it is easier for me to connect with the people around me, including the other clients.

41. Like with The Works, KMOPS is a very non-judgmental atmosphere and I feel a strong sense of community there. I have had a lot of meaningful conversations with staff and clients, sharing our experiences. I have learned a great deal through those conversations about different substance use treatment options, mental health supports, harm reduction methods, and other information to keep myself safe (like being warned about particularly dangerous/potent substances circulating and what they look like). For example, through using KMOPS I learned about a medication called SUBLOCADE, which is an opioid agonist treatment option that you take once a month (unlike methadone, which I have to take every single day). This was something I did not know existed. Although I do not know if that option would be right for me, I appreciate knowing about the alternatives that are out there.

42. A lot of the staff at KMOPS have their own lived experience with drug use, which I have found helpful. It has been beneficial for me to hear about various resources and treatment options from people who have lived it (both staff and clients) and were able to give their own insights and share their own personal experiences. I have also personally found it healing to hear from and get

to know other people who have been through some of what I have been through. Being able to visit KMOPS regularly and make connections with people I can relate to (and who I can be open with about my drug use without judgment) has been very beneficial to my mental health.

43. Although KMOPS is closer to me than The Works, it is still far enough away that I cannot walk to get there and have to take public transit. I would prefer to use in the supervised environment at KMOPS rather than at home because it makes me feel so much safer, but KMOPS is still far enough away from where I live that I am often unable to wait and will inject drugs at home, even though I am afraid of overdosing, and possibly dying, in that setting.

44. I also regularly visit KMOPS to access its other harm reduction services without actually consuming drugs on-site. I frequently collect sterile supplies from KMOPS to use off-site, which has allowed me to stop my previous practice of re-using the same needle over and over again. I also gather up the needles I have used at home into a plastic container (a repurposed plastic cat litter container) and bring them to KMOPS to dispose of them safely in the dedicated sharps container at the site, rather than just throwing them away in regular garbage bags.

45. Beyond harm reduction services, I am also seeking assistance through KMOPS to try and find a new psychiatrist. My current psychiatrist has advised me that she is changing her practice area and will no longer be able to treat me, but she has not been able to provide me with a referral to another psychiatrist. From using KMOPS for its supervised consumption services and speaking regularly with the staff there, I learned that this was something KMOPS could possibly help me with.

46. I learned through KMOPS about TNG's peer program. I applied and was selected for the program last year. The peer program is a 10-week training program for people with lived

experience with drug use and trains you on skills like mentoring and harm reduction. The program has a strong focus on empathy and how to assist people who are using substances and/or who are homeless.

47. I have now graduated from the peer program and am doing a paid placement with TNG as a peer worker. In that role, I help out at the Corner Drop-In at reception, welcoming people, handing out supplies like clothing and hygiene products, and monitoring and operating the laundry facilities, among other tasks. Many of the people who use the Corner Drop-In use substances like drugs or alcohol, and I have found that my own lived experience with drug use helps me relate to them (although I do not always expressly disclose that I am a drug user).

48. I found the program to be very informative and meaningful, and I am hoping to take the skills that I have learned through it with me in my personal life and my career. In the longer term, I am planning to pursue a career in social work.

E. Impact On Me If KMOPS Closes

49. I am afraid of what will happen to me if KMOPS closes.

50. Since I started using supervised consumption sites, I have been able to reduce my drug consumption and I feel that I am on my way to the road to recovery. However, I am not quite there yet. Although I want to stop using drugs, I do not feel ready to stop using at this time. Going to abstinence-based treatment before I was ready did not work for me, and in some ways was actually a negative experience. For me, it is important that I first work through my past trauma and mental health difficulties. I know that I have a long journey ahead of me before I will be able stop using drugs fully. Using supervised consumption sites is a way that I protect myself from accidentally overdosing and dying in the meantime.

51. I know that if I were to no longer have access to KMOPS, I would continue to inject drugs. I want to live, and I am afraid of overdosing and dying when I use drugs alone. However, I do still sometimes have to use alone because I cannot always make it to KMOPS. With the closure of KMOPS (and other supervised consumption sites in Toronto), it is going to be harder and harder for me to find safe locations. I am afraid that when these sites close, I am going to have to use alone more and more, where I am at greater risk of dying from an overdose.

52. I also do not know where I will go to access sterile supplies. This was a challenge for me before I learned about supervised consumption sites, and I often re-used needles and used unsterile equipment, which both caused me to injure myself and make myself sick. If I am no longer able to access these things from KMOPS, and my access in the city generally is more limited, I will likely return to many of those unsafe practices that I used to engage in, even though I do not want to and know that they pose health risks to me. Even knowing the dangers, the compulsion that I feel to use drugs still overwhelms me sometimes.

53. The closure of KMOPS and other supervised consumption sites also likely means that I will have to return to my previous practice of disposing of needles unsafely, as I will no longer be able to bring my used needles to KMOPS for safe disposal.

54. If KMOPS were to close, I would also lose the community I have found there. It has been hugely beneficial to me and my mental health to find and connect with people at KMOPS who do not judge me for being a drug user. I also learn so much from the KMOPS staff and other clients at the site about treatment options and measures I can take to keep myself safe, which I will no longer have access to once these sites close.

SWORN by Katharine Resendes 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**.**

Olivia Eng

Commissioner for Taking Affidavits
(or as may be)

OLIVIA ENG (84895P)

Katharine Resendes

KATHARINE RESENDES

THE NEIGHBOURHOOD GROUP COMMUNITY SERVICES et al.	and	HIS MAJESTY THE KING IN RIGHT OF ONTARIO	Court File No. CV-24-00732861-0000

ONTARIO
SUPERIOR COURT OF JUSTICE

Proceeding commenced at TORONTO

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TAB 5

Court File No.

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 JEAN-PIERRE AUBRY FORGUES

1. I am one of the applicants in this proceeding, and as such have knowledge of the matters contained 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. I was born on August 21, 1988 and raised in Aylmer, Quebec, which is now part of the National Capital Region in Ontario and Quebec that includes Ottawa and Gatineau.

3. My earliest memories are being mentally and physically abused by my stepdad. I remember spending most of my time hiding and trying to avoid my stepdad, especially when he was drunk.

4. Around eight years old, I started drinking alcohol. I would take alcohol from my parents. I started drinking because it helped escape the pain and isolation I felt. Alcohol numbed my feelings and blanked out my thoughts. It provided me relief from what I was experiencing at home.

5. As I grew older, my reliance on alcohol increased. By the time I was twelve years old, I was drunk about three to four times a week. At age 14, I was drinking every day to the point that I was drunk. Drinking, and drinking to the point where I could no longer remember anything, was a regular part of my childhood.

6. At 14 or 15 years old, I tried harder drugs for the first time. I started with ecstasy and cocaine, and then crack cocaine a few years later. These drugs replaced my reliance on alcohol. I came to consume them daily. Eventually, my life centered around using them, and I turned to crime to support my substance use. I ended up dropping out of high school because of my substance use.

7. When I was 27, I started injecting opioids such as heroin. Opioids provided me with a belonging, a sense of relief I never felt before. I liked how they made me feel. It eventually became my substance of choice. I would spend most of my days finding money to buy opioids, often through criminal acts like theft or panhandling, and then spent my remaining time high from whatever opioids I was able to buy on the street. This led me to be unstably housed, where I would move frequently, stay at friends' places, and often sleep outside or in shelters because I would prioritize spending money on opioids over paying rent or my other expenses. This was the

start of what I now know to be opioid use disorder, the chronic, relapsing medical condition that I live with to this day.

8. I would also inject opioids in unsafe conditions, including alone and in alleys and stairwells. I did this because I did not want to get caught by the police while consuming substances, which meant I could be arrested and put in jail. I also injected without proper, sanitized equipment, often reusing or sharing syringes. This is how I acquired hepatitis C and other diseases and injuries, like body wounds from injecting street-sourced opioids. These illnesses and injuries were preventable and treatable but are common for street-sourced substance users like me. They made me very sick and have had a lasting impact on my health.

9. Substance users also disengage from the health care system once their consumption becomes regular. Personally, I felt like I did not get adequate health care supports, that my medical needs were not a priority, and that I was judged because I was a substance user and received worse medical care. Hospitals and clinics were not safe spaces for me to access medical care. I would only end up in the hospital in extreme cases, for instance if I had a serious overdose, lost consciousness, and was rushed to the emergency department by an ambulance. Aside from rare instances, I completely disengaged from the formal medical system. This made the illnesses and wounds I endured due to my substance use worse. But, I did not trust the system because I felt like I would not be respected as a substance user and would receive worse medical care. I felt I was better off on my own.

10. In or around 2018, I remember that I tried fentanyl for the first time. It was not by choice, but because it was in some heroin I bought. I was not expecting it. Fentanyl was very different

than heroin. Heroin provided a gradual high, while fentanyl was instant. Fentanyl hit you like a train; it was more powerful than anything I had ever tried. It scared me because I knew it could easily kill people if they did not know how much they were using.

11. Eventually, fentanyl was found in all opioids you bought on the streets. It was mixed into all drugs that were sold, including non-opioids like street-sourced stimulants such as crystal meth, which I would sometimes try. This made it even more dangerous. You would be taking a substance and not know you were consuming fentanyl and at what levels. This was alarming because even a small amount of fentanyl could cause you to overdose and die.

12. The emergence of fentanyl in the street-supply of opioids changed everything. I started overdosing regularly. By my late twenties, I was injecting opioids multiple times a day, and I was afraid that every dose would be my last. That is how powerful fentanyl was and how you did not know how much you were consuming if you bought opioids on the street. It was everywhere and you did not know the quantities or concentrations of it in the opioids you bought on the street.

13. But I could not stop buying and consuming opioids. My withdrawal symptoms were so strong that I felt like I would die if I did not consume opioids, which I knew could also kill me. The symptoms included severe physical pain, like my skin was being ripped off my body and constant severe migraines. I would be sick for days, unable to talk and move. I would sweat and hallucinate for hours. I would want to die and ask others to kill me to relieve the pain. I would not wish what I was enduring on my worst enemies, particularly as the street opioid supply became increasingly contaminated with substances like carfentanyl (a more potent synthetic

opioid) and benzodiazepines (a depressant), which would intensify my cravings and withdrawal symptoms. I was stuck in this vicious cycle.

14. I overdosed and nearly died so many times that it is impossible to provide a total number. I also saw so many of my friends die due to an accidental overdose. It became a part of our lives. I did not know if the next time I would use would be my last.

15. I did not want to live like this. I tried to stop many times. I would quit for three to four days only to relapse and fall deep into opioid use. I even went to detox during my attempts to quit opioid use. My usage would only go up when I inevitably relapsed, and I would take greater risks. The most dangerous time in my substance use was when I would return to using street-sourced opioids after stopping them for a period. I would overdose more regularly and seriously because my body was not used to the dosages and I would frequently misjudge the amount of fentanyl, carfentanyl, or benzodiazepines in opioids I would buy on the street. When you are consuming street-sourced opioids daily, multiple times each day, you acquire a rhythm and awareness of risk around dosages and amounts, including from what you had tried previously and in communicating with other substance users. That went away when I would abstain from opioid use for a few days, placing me at greater risk of overdose death.

16. Abstaining from using substances was not a solution for my condition and it only increased my risk of harm. It could not be the first way for me to stop using opioids.

17. Around 2019, I was living in Ottawa and community groups started to offer supervised consumption services. Essentially, groups would test your drugs and have nurses or other

medical professionals monitor you while you were consuming substances. I am not sure if these services were licensed, but this is the first time that I accessed supervised consumption services.

18. Immediately, I knew that supervised consumption services could transform my life. They provided a safe, monitored space for me to use substances, along with clean, sterile equipment to consume them. Having this all in a single location where I was not rushed to use or constantly looking over my back ensured I was taking measures to protect my health. This included wound care, blood tests, treatment of diseases, and therapy, which I accessed while receiving supervised consumption services in Ottawa. There were also medical professionals present to assess and intervene if something happened to me. They also recommended care to address other aspects of my health and treated me like a real person. I did not feel the judgment that I had received from other medical providers for being a substance user. It felt like they just wanted me to improve my health and I wanted to work with them to do it.

19. The experience inspired me to get involved in community organizing around harm reduction and ensuring that people who used substances accessed the health care they needed. It showed me that we could change our lives and take control over our situations, and live a better, longer life.

20. I later visited other supervised consumption sites in Ottawa, including the Sheperds of Good Hope, Sandy Hill Community Health Centre, and the Somerset West Community Health Centre. I started to regularly attend the sites in Ottawa and became more involved in harm reduction organizing. I stopped injecting substances publicly and in unsafe settings, and used clean equipment.

21. My health improved significantly during this period, all due to the support I was receiving from the supervised consumption services I was accessing. I started to gain weight, received treatment for my injecting wounds (which also became significantly less frequent), stopped reusing and sharing needles (which helped with the injection wounds), and took other measures to improve my health. Accessing supervised consumption services provided stability to my life, and allowed me access health care on a regular basis. This caused me to decrease the amount of overdoses I had, and when I had them, I was under supervision from medical professionals who quickly administered naloxone and oxygen to revive and keep me safe.

22. In and around 2021, I moved to Kitchener and started attending the Kitchener Consumption and Treatment Services ("**Kitchener CTS**") regularly to consume substances. The support I received from the Kitchener CTS accelerated my journey of taking control back over my condition.

23. At the Kitchener CTS, I received medical monitoring while consuming substances, where they reversed countless overdoses and near deaths. I also accessed other support services to help address the health and social aspects of my substance use. I received wound care to treat serious abscess that developed from injecting substances into my body for so long and treatment for my hepatitis C. I also decreased my street-sourced substance use dramatically and was encouraged to address the underlying reasons for my substance use. I ended up securing housing through my recovery efforts and landing a job. The Kitchener CTS stabilized my opioid use and health and put me in a position to access housing and obtain employment.

24. I felt like those at the Kitchener CTS wanted me to get better, which encouraged me to take control over my substance use and health. It was the non-judgmental, holistic support they provided me that was essential. On some days, I just wanted to use substances and not think about my broader recovery journey. Other days, we were developing plans to treat my hepatitis C and reduce the rate of my injections. They met me where I was at and encouraged me towards my goal of no longer being reliant on street-sourced opioids.

25. The most profound impact the Kitchener CTS had on my life was that through my commitment to overcoming my condition, the Kitchener CTS ended up referring me to a safe supply treatment option for my substance use. I was connected with a physician who prescribed me daily medication for my opioid use disorder. The treatment means that I am no longer dependent on street-sourced opioids to self-medicate my condition, which are mixed with fentanyl, carfentanyl, benzodiazepines, and other extremely toxic substances. I know the opioid medication I am prescribed is safe and how much I need to take to live a functioning life where I can work and maintain strong social relationships. I no longer interact with the criminal justice system because I stopped doing crimes to support my substance use. I live for much more than I did before.

26. The only reason that I am still living and am so far along in my journey of recovery is because I accessed the supervised consumption services offered by the Kitchener CTS. Supervised consumption services stabilized my condition, allowing me to gradually access other treatments at my own pace and when I was ready. I now have control over my opioid use disorder, rather than it controlling me.

27. My aim now is to eventually stop using substances all together. My current treatment regime has put me on that path, though I know it will take time and a lot of effort to reach my goal.

28. However, my journey is not a straight line, and I do have challenges along the way. Opioid use disorder is a chronic, relapsing condition, like any form of substance use disorder. I have relapsed along the way, where I have reverted to using street-sourced opioids. There are a lot of reasons why, including having intense withdrawal episodes that I need to address immediately, causing me to buy opioids on the street to inject. Or something else takes a hold of my brain, compelling me to use street-sourced opioids. I do not have a clear explanation of why or when these urges occur; I try my best not to succumb to them, but I am not always successful.

29. In those instances when I have relapsed, I attended the Kitchener CTS to use street-sourced opioids. I did because it is the only way to reduce my risk of overdose death to basically zero. If I were to use alone, or with others outside the Kitchener CTS, I could easily overdose and die. I know this because so many people are dying of overdoses after consuming street-sourced opioids in unsupervised settings; I know many who have died and have seen the statistics for overdose deaths in the Kitchener-Waterloo over the past few years. It is a very dangerous time to consume street sourced substances in this area.

30. Over the past year, I have used the Kitchener CTS to consume street-sourced opioids a few times, with the most recent use sometime in June or July 2024. I know that in the future, when another relapse occurs, I will attend the Kitchener CTS, so that I can safely consume substances and not die.

31. The Kitchener CTS is the only supervised consumption service provider in the Kitchener-Waterloo region. There is no other way me or other substance users to consume street-sourced substances safely in the entire region if it is closed. I worry that means that people not as far in their recovery journey as me will be deprived of lifesaving, sustaining, and enhancing medical care in the form of supervised consumption services. I worry that means more people will die preventable overdose deaths and suffer a range of other social and health harms associated with street-sourced substance use. Many of my friends are in this situation. I know that they will die or suffer significant harms if the Kitchener CTS no longer offers supervised consumption services. I am concerned about my own safety and well-being if supervised consumption services are no longer provided in Kitchener-Waterloo, but also the safety and well-being of my friends.

32. Personally, the closure of the Kitchener CTS will mean that I will no longer have access to the medical services I need when I relapse and require supervised consumption services to ensure I do not die of an overdose or suffer other health harms associated with injecting street-sourced opioids. It is not feasible for me to travel to a different city to access supervised consumption services when I relapse, as the urges that hit me are too strong and immediate to delay obtaining and consuming opioids for any significant length of time. The only reason I am still alive, medically stable, and on a path to recovery is because of my access to supervised consumption services. If I relapse and consume street-sourced opioids without access to supervised consumption services, which occurs a few times each year, there is a strong likelihood of me overdosing and dying.

33. I do not want to die. I want to continue to see what I can do and achieve in my life. I want to continue on my path to recovery and one day live a life where I do not use drugs. I do not

want to return to a situation where I do not know if I will live to see the next day because of an overdose. I do not want to be forced back to consuming opioids in dangerous conditions and circumstances. I want access to supervised consumption services when I relapse to ensure that I can continue to live.

34. I want my medical condition to be treated the same as other medical conditions. The government usually encourages people to access essential health treatment for medical conditions that can be fatal. To me, that is what supervised consumption services are. However, restricting access to supervised consumption services, and categorically denying people in the Kitchener-Waterloo region access to them in any capacity means that government is denying me and other people like me critical and essential medical care.

35. Cutting access to supervised consumption services to an entire region makes me feel like the government considers my life and the lives of people living with substance use disorder as not being worth anything. It makes me feel like my life is disposable; that it does not matter if I live or die. That is the only way that I can understand why the government is cutting access to supervised consumption services in Ontario and specifically in the Kitchener-Waterloo region, where no service provider will remain. If our lives meant something, the government would not be stopping access to the only form of medical treatment that ensures we do not die, particularly in the current overdose crisis. The decision could cost my life and the life of so many others who rely on supervised consumption services to live.

36. I am a harm reduction outreach worker with the Waterloo Public Health and Paramedic Services and Sanguen Health Centre, which operates the Kitchener CTS. I am not aware if the

Kitchener CTS no longer offering supervised consumption services will impact my employment. Even if it did, it would not impact the evidence I have set out above on the history of my substance use, the efforts I have taken to treat it, and the impact of denying access to supervised consumption services in the Kitchener-Waterloo region will have on me and other substance users.

SWORN BEFORE ME at the City of Kitchener, in the Province of Ontario on January 3, 2025.

Commissioner for Taking Affidavits
(or as may be)

JEAN-PIERRE AUBRY FORGUES

)

Ashley Elizabeth Schuitema
A Commissioner etc.
Province of Ontario
while a Barrister and Solicitor
LSO # 68257G

***
Applicants

-and-

HIS MAJESTY THE KING IN RIGHT OF ONTARIO
Respondents

Court File No.

ONTARIO
SUPERIOR COURT OF JUSTICE

PROCEEDING COMMENCED AT TORONTO

AFFIDAVIT OF BILL SINCLAIR

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[AVNISH]
Lawyers for the Applicants

TAB 6

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 NICOLE HORSFORD

I, NICOLE HORSFORD, of the City of Toronto, in the Province of Ontario, **MAKE OATH AND SAY:**

1. I am the parent of a child who attended the Bellevue Child Care Centre, in the Kensington Market neighbourhood of Toronto (**"Bellevue"**). The Neighbourhood Group Community Services ("**TNG**"), one of the applicants in this application, operated Bellevue at the time my child attended, and my understanding is that it still does.

2. As such have knowledge of the matters contained 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.

3. My son is currently six years old and attends senior kindergarten at his local public school. However, from ages two to four (*i.e.*, 2020 to 2022), he attended Bellevue. During this time, assuming he was healthy, he attended the centre five days a week, from approximately 9am in the morning until 5pm in the evening. On the overwhelming majority of these days, I would drop my son off in the morning and pick him up in the evening. I would periodically attend the facility at other times to either watch performances or to pick up my son when he became ill or was injured.

4. From 2020 to 2022, I was in regular communication with Bellevue early childhood education staff. We would have short discussions during drop offs and pick ups about my son or events at the facility. They would also email me if anything happened at the facility (for example, if my son got hurt or felt ill) and would send incident reports if there were ever accidents where my son was injured (detailing the nature of the accident and injury).

5. The entire time that my son was at Bellevue, I understood that TNG also operated the Kensington Market Overdose Prevention Service (**"KMOPS"**) out of a building that is directly behind Bellevue. From my perspective, TNG's operation of the KMOPS had no impact on its ability to provide child care services at all. The entire time my son attended Bellevue, I never:

(a) saw any drug paraphernalia on the premises of the child care facility;

(b) saw anyone publicly consume drugs on the premises of the child care facility;

(c) saw a person who appeared to be under the influence of any substance on the premises of the child care facility; or

(d) received a report from Bellevue staff to advise of any of the above occurring.

6. The entire time my son attend attended Bellevue, I never had any concerns for his safety or well-being in general, nor did I have any such concerns particularly because of TNG's operation of the KMOPS. In fact, during my drop offs and pick ups of my son, I had no contact at all with the KMOPS or with people who appeared to be going to or coming from the KMOPS. But for the fact that I was a member of the community and otherwise knew about the KMOPS, I would not have even known it existed.

7. In addition to my son attending Bellevue, two years ago TNG offered me job to work at Bellevue. Because of a serious illness that afflicts my son, I have not been able to commence my employment there yet. I have not worked a single shift, and I do not believe I am on TNG's payroll. This fact has not affected the evidence that I provided in this affidavit.

SWORN REMOTELY by Nicole Horsford 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.

DocuSigned by:
115121625407489...

Commissioner for Taking Affidavits
(or as may be)

Carlo Di Carlo

Partner

Signed by:
Nicole Horsford
7BD3258DB1F2436...

NICOLE HORSFORD

THE NEIGHBOURHOOD GROUP COMMUNITY SERVICES et al.	and	HIS MAJESTY THE KING IN RIGHT OF ONTARIO	Court File No. CV-24-00732861-0000
Applicants		Respondent	

ONTARIO
SUPERIOR COURT OF JUSTICE

Proceeding commenced at TORONTO

AFFIDAVIT OF NICOLE HORSFORD

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Lawyers for the Applicants

TAB 7

Court File No. CV-24-00732861

ONTARIO
SUPERIOR COURT OF JUSTICE

B E T W E E N:

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 ELLA BAKKER-MOFFITT

I, ELLA BAKKER-MOFFITT, of the City of Toronto, in the Province of Ontario,

MAKE OATH AND SAY:

1. I am the parent of a child who attends the Bellevue Child Care Centre, in the Kensington Market neighbourhood of Toronto (**"Bellevue"**). The Neighbourhood Group Community Services ("**TNG**"), one of the applicants in this application, operates Bellevue.

2. As such have knowledge of the matters contained 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.

3. My child is currently three years old. She has attended Bellevue since April of 2024 when she was two years old. She attends the centre five days a week, from approximately 8am in the morning until 4pm in the evening. For the most part, I drop my daughter off in the morning and pick her up in the evening. I also, from time-to-time, enter into the daycare at other times watch performances or to pick up my daughter when he is sick or is injured.

4. I am in regular communication with Bellevue early childhood education (**"ECE"**) staff. This is important to me, as I want to know what is going on in my daughter's life and know that she is safe. I usually will have short discussions with ECE staff during drop offs and pick ups about my daughter or what is going on at the daycare. They will also let me know if anything has happened (for example, if my daughter got hurt or felt ill) and would send incident reports if there were ever accidents where my daughter was injured (detailing the nature of the accident and injury).

5. I have only recently learned, in the last month or so, that in addition to operating Bellevue, TNG also operates the Kensington Market Overdose Prevention Service (**"KMOPS"**) out of a building that is directly behind Bellevue. I only learned about the existence of the KMOPS because of this court application related to the government's efforts to close the KMOPS down. Prior to learning this fact, I had no idea that the KMOPS even existed.

6. From my perspective, TNG's operation of the KMOPS had no impact on its ability to provide child care services at all. The entire time my daughter has attended Bellevue, I never:

(a) saw any drug paraphernalia on the premises of the child care facility;

(b) saw anyone publicly consume drugs on the premises of the child care facility;

(c) saw a person who appeared to be under the influence of any substance on the premises of the child care facility; or

(d) received a report from Bellevue staff to advise of any of the above occurring.

7. The entire time my daughter has attend attended Bellevue, I never had any concerns for her safety or well-being in general. Given that I did not even know that the KMOPS existed, I obviously had no because of TNG's operation of the KMOPS. In fact, during my drop offs and pick ups of my daughter, I had no contact at all with the KMOPS or with people who appeared to be going to or coming from the KMOPS.

8. In addition to my daughter attending Bellevue, I have lived across the street from Bellevue for essentially my entire life, approximately thirty years. I was born and raised in this neighbourhood. Although I left for university, I continued to periodically visit to see my mom and I returned to spend summer holidays there. I lived in the neighbourhood from September 2021 to October 2022 and then returned to live last May (2024).

9. I lived across from Bellevue before the KMOPS opened. For as long as I can remember, there have always been people using drugs in the Kensington Market and this was not different pre-KMOPS. The only difference in the pre-KMOPS era was that it was far more frequent to see improperly discarded drug paraphernalia throughout the neighbourhood, and including in the park at the end of the market (Bellevue Square Park).

10. I want the KMOPS to remain open. I am concerned that if it closes down there will be increased amounts of drug paraphernalia that is improperly discarded in the neighbourhood. I also fear that the effects of drug use will become more prevalent in the neighbourhood.

SWORN REMOTELY by Ella Bakker-Moffitt 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

ELLA BAKKER-MOFFITT

THE NEIGHBOURHOOD GROUP COMMUNITY SERVICES et al.	and	HIS MAJESTY THE KING IN RIGHT OF ONTARIO	Court File No. CV-24-00732861-0000
Applicants		Respondent	

ONTARIO
SUPERIOR COURT OF JUSTICE

Proceeding commenced at TORONTO

AFFIDAVIT OF ELLA BAKKER-MOFFITT

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Lawyers for the Applicants

TAB 8

Court File No. CV-24-00732861

ONTARIO
SUPERIOR COURT OF JUSTICE

B E T W E E N:

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 HOLLY GAUVIN

I, HOLLY GAUVIN, of the City of Thunder Bay, in the Province of Ontario, **MAKE OATH AND SAY:**

1. I am the Executive Director of AIDS Committee Thunder Bay, operating as Elevate NWO (**"Elevate"**), a non-profit, community-based organization working to improve the health and wellbeing of those living with HIV, HEPC and responding through harm reduction supports to those who are at highest risk to harms related to substance use including overdose. Additionally for the last five years we have been the primary responders to the homeless encampments within Thunder Bay, we run a drop in centre that acts as a life line for those experiencing homeless and under-housed population in Thunder Bay. As such have knowledge of the matters contained 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.

A. Background Information about Elevate

2. Elevate is a registered charitable organization bearing registration number 10668 0947 RR0001. It was established in 1987. It is a not-for-profit community-based organization based in Northwestern Ontario dedicated to improving the quality of life for individuals and communities affected by HIV, Hepatitis C, and substance use related health and social issues. The organization consistently responds to the social determinants of health while focusing its efforts on harm reduction, equitable health care for marginalized populations, outreach, harm reduction housing, and advocacy for priority populations, including those who use drugs, experience homelessness, or belong to marginalized communities. The organization aims to reduce stigma, promote inclusion, and provide practical support to enhance health outcomes and social equity for those it serves.

3. Elevate currently operates out of a facility that is located at 102-106 Cumberland Street North, Thunder Bay. Out of this location, it delivers a number of services. These services include (but are not limited to):

(a) **HIV and Hepatitis C Prevention, Testing, and Treatment Support**: Offering education, service coordination, treatment and practical supports.

(b) **Harm Reduction Programs**: Distributing tools like sterile drug use equipment to reduce the risk of infections and overdoses, as well as reversing overdoses including by administering Naloxone.

(c) **Homelessness and Housing Support**: Providing 10 Harm Reduction Housing Units to people who are actively using substances. Assisting individuals in finding and maintaining safe housing through outreach, case management, and system navigation.

(d) **Education and Advocacy**: Raising awareness about health and social issues while advocating for systemic change.

4. Our staff consists of 23 dedicated individuals including Nurses, a Nurse Practitioner, an Indigenous Elder, Social Workers and People with Lived Experience.

5. As I noted above, I am the Executive Director at Elevate. I have held this position since 2013. Before that I held the following positions: of Director of Client Services. In total, I have worked at Elevate for 14 years and in Health & Social Services in Thunder Bay since 1996 focusing my efforts on working with marginalized populations.

B. Elevate's Clients

6. Elevate provides services to approximately 1,100 clients a month. Based on my and my staff's interactions with these clients, I would estimate that approximately 65% of these clients appear to have substance use disorders (**"SUDs"**). To be clear, Elevate has not received formal diagnoses that any of its clients have SUDs. However, we came to this conclusion based on interactions we have had with our clients, including (but not limited to):

(a) our clients' self-reporting to us (of their SUDs);

(b) situations where we have treated clients that we perceived to be intoxicated;

(c) scenarios where we have had to reverse overdoses at our site; and

(d) the fact that a large number of our clients utilize our harm reduction program.

7. Also based on our interactions with our clients, I would estimate that approximately 70% of them are indigenous and that 70% are experiencing homelessness or have precarious housing.

8. To be clear (and as is likely implied above), there are many intersecting identities between these three marginalized groups. For example, there are many Elevate clients that are indigenous and have SUDs and are homeless. In fact, the majority of our clients have intersectional identities. Again, from our experience and observations, these individuals with intersectional identities are disproportionately affected by the impact of their SUDs. We have tragically had several clients die of overdose; the majority of these individuals were indigenous.

C. The Relationship Between Elevate and Path 525

9. In 2018, the NorWest Community Health Centre (**"NorWest"**), another community-based organization in Thunder Bay, established Path 525. Path 525 provides supervised consumption and treatment services. Path 525 is not only the only supervised consumption site in Thunder Bay; it is the only such site in all of Northwestern Ontario. Path 525 clients have access to safer consumption education, harm reduction supplies, overdose response, and connections to community resources such as housing, mental health, and addiction services.

10. NorWest (through its operation of Path 525) and Elevate have a number of relationships and synergies. Both groups share a mutual focus on supporting individuals who are impacted by homelessness, substance use, and health vulnerabilities. Elevate refers its clients who use drugs to Path 525's supervised consumption services. Conversely, Path 525, which offers screening

services for HIV and Hepatitis C, refers its clients who have tested positive for either illness to Elevate for treatment or to participate in our drop in centre programming.

11. This partnership between Elevate and Path 525 transforms service delivery by uniting Elevate's specialized expertise in harm reduction and HIV/Hepatitis C prevention and treatment navigation with Path 525's lifesaving consumption and treatment services. Together, they create a network of care that significantly improves the quality of life and long-term outcomes for vulnerable populations in Thunder Bay. For example, NorWest Staff identify clients who have HIV and Hep C and Navigate them to Elevate services where treatment is started immediately. Elevate coordinates services through NorWest's Rapid Addiction Management Clinic for those seeking support with the substance use.

12. As a result, there significant overlap in the clients that each organization services. I have person knowledge of several of our clients whom I know also use (and/or have used) Path 525's supervised consumption services.

D. Effect of the Closure of Path 525

13. Elevate understands that the *Community Care and Recovery Act* (the **"CCRA"**) will require the closure of Path 525's supervised consumption services. The closure of Path 525 in Thunder Bay will leave a significant gap in harm reduction services for the community. The nearest supervised consumption sites are located in southern Ontario, with the closest being in Guelph, approximately 1,200 kilometers away, translating to a drive of about 13 hours under normal conditions. The nearest supervised consumption site is in Winnipeg, situated roughly 700 kilometers from Thunder Bay, equating to a drive of approximately 8 hours.

14. These substantial distances make it impractical for individuals in Thunder Bay to access supervised consumption services elsewhere.

15. The sudden deprival of supervised consumption services in Thunder Bay has forced Elevate to quickly mobilize to adopt contingency plans in order address what it expects will be a health crisis. In fact, my understanding is that this is the largest, most rapid mobilization Elevate has engaged in since the HIV/AIDs epidemic in the 1980s. We are expecting that Thunder Bay will witness not only a rise in overdoses but also a rise in overdose-caused mortality. Our view on this is informed by, among other things, data published by the Office of the Chief Coroner that routinely shows that Thunder Bay has the highest opioid mortality rate. Attached as **Exhibit "A"** are examples of these reports.

16. In order to address these issues, we are in the midst of adopting the following contingency plans:

(a) We are providing our staff with advanced level training on responding to and (hopefully) reversing overdoses. To be clear, this goes beyond merely providing Naloxone (which our staff is already trained to administer).

(b) We have taken (and are taking) measure to secure storage of oxygen on site. This is in order to provide oxygen to individuals who are overdosing in order to minimize brain damage.

(c) We are scaling up our training with our clients to treat overdoses (*i.e.*, in other clients or simply individuals that they encounter). For example, we are providing

them with access to and training on how to administer, Naloxone. This will hopefully allow our clients to support one another.

(d) We are planning workshops and supports for staff related to resiliency in the face of multiple loss, given that our staff are already experiencing a high amount of compassion fatigue, burnout and stress due to drug toxicity crisis.

(e) We are preparing for grief and loss services not only to family members and fellow services users who have lost loved ones to overdose, but also for our staff.

17. All of these steps require considerable resources (both financial and otherwise). Given Elevate's limited financial resources, these sudden expenditures have stretched our budget thin and I can not be sure for how long we will be able to provide these services. Further, we do not expect that any of these steps will completely address for the gap in services caused by the sudden removal of Path 525.

SWORN REMOTELY by Holly Gauvin of the City of Thunder Bay, 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

Holly Gauvin

HOLLY GAUVIN

This is **Exhibit "A"**
to the Affidavit of Holly Gauvin
sworn before me this 8th day of January, 2025.

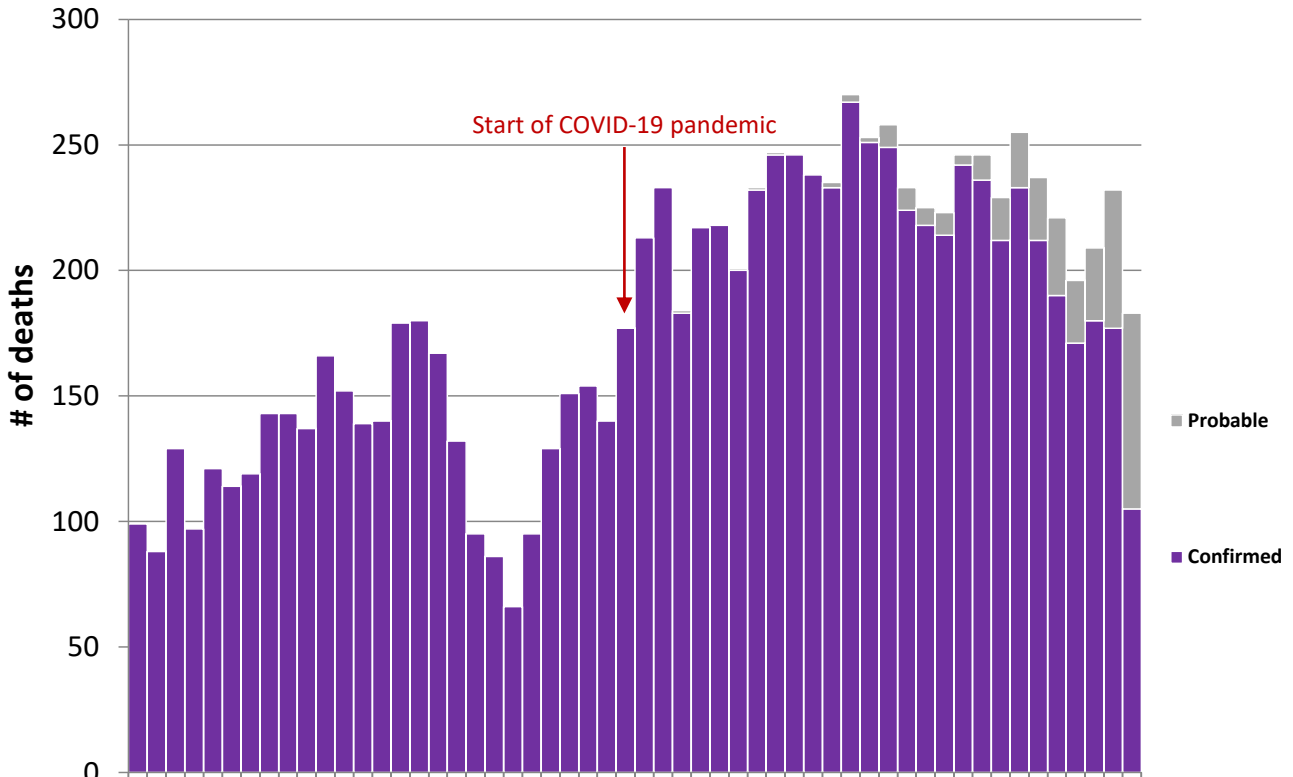
Carlo Di Carlo

A Commissioner for oaths, etc.

Quarterly Update from the Office of the Chief Coroner

Opioid-related Deaths in Ontario

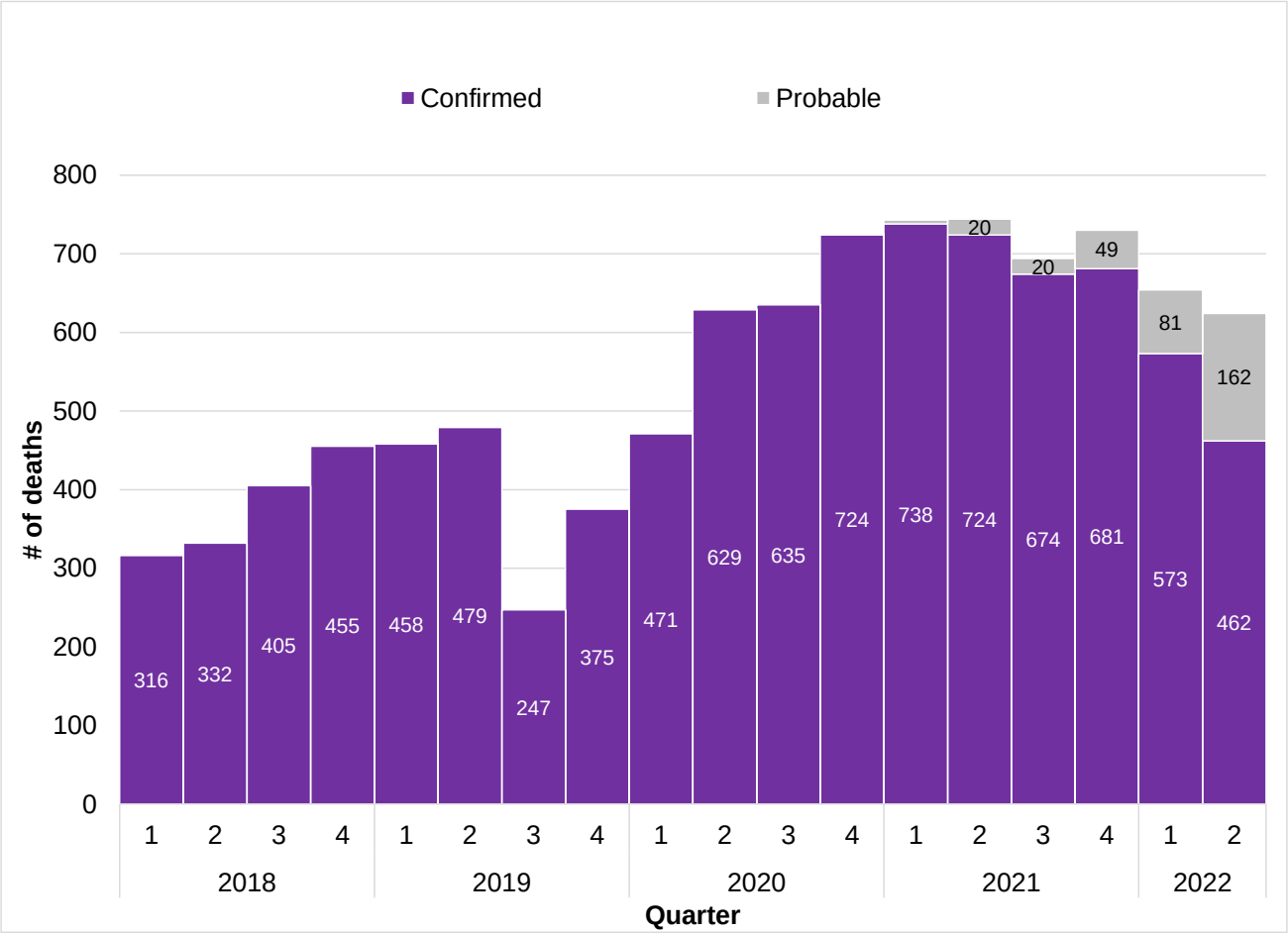
Opioid-related deaths in Ontario by month, Jan 2018-Jun 2022



	2018	2019	2020	2021	2022
Average deaths per month*	126	130	205	243	213
Average deaths per day*	4	4	7	8	7

Source: Office of Chief Coroner (OCC) - Data effective Nov 1, 2022
*includes both confirmed and probable opioid-related deaths, preliminary and subject to change

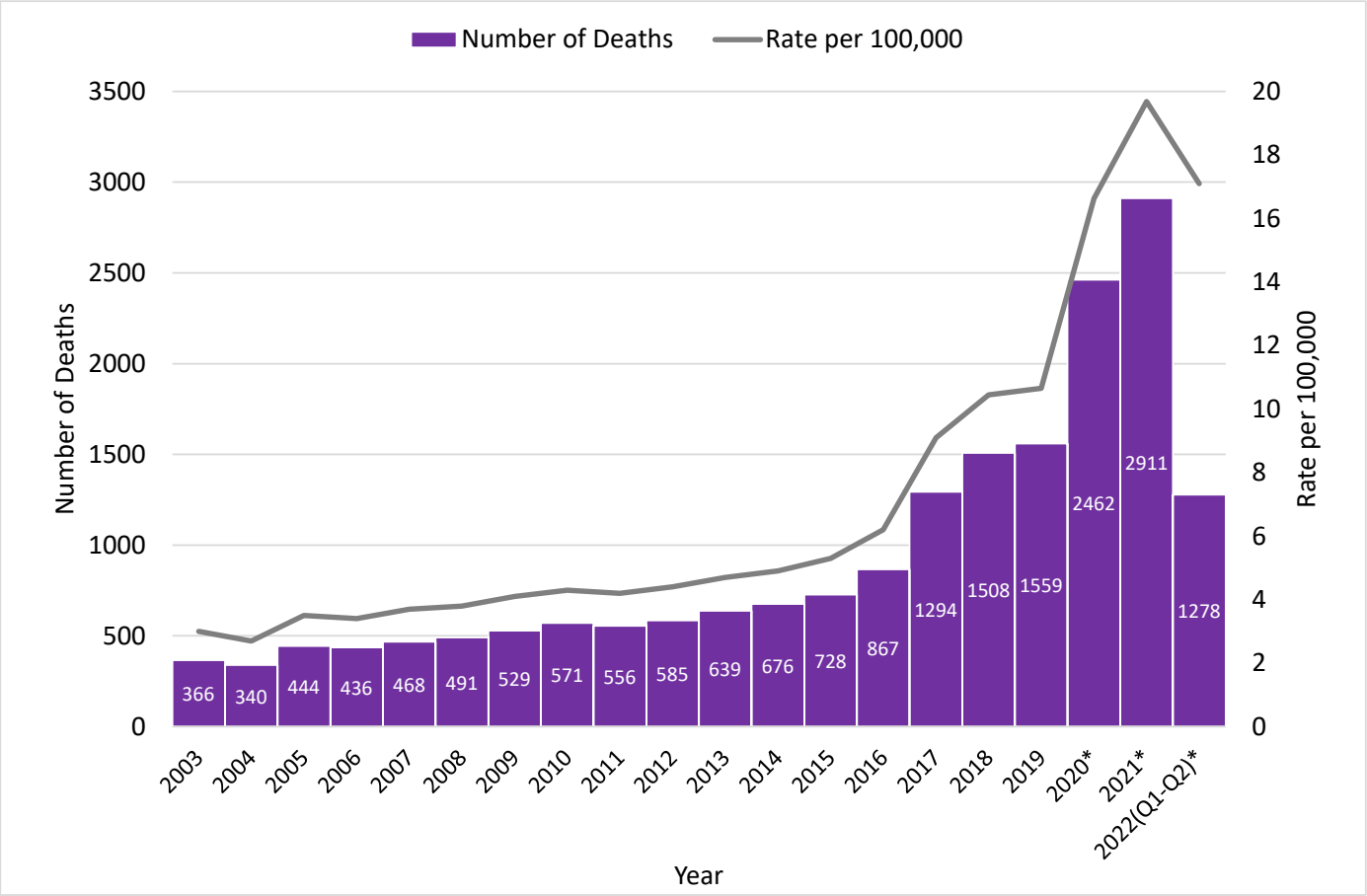
Opioid-related deaths in Ontario by quarter, 2018-2022(Q2)



There was a **5% decrease** in the number of opioid-related deaths* in the most recent quarter (Q2 2022; 624 deaths) compared to the quarter prior (Q1 2022; 654 deaths) (preliminary).

Source: Office of Chief Coroner (OCC) - Data effective Nov 1, 2022
*includes both confirmed and probable opioid-related deaths, preliminary and subject to change

Opioid-related deaths in Ontario by year, 2003-2022(Q2)

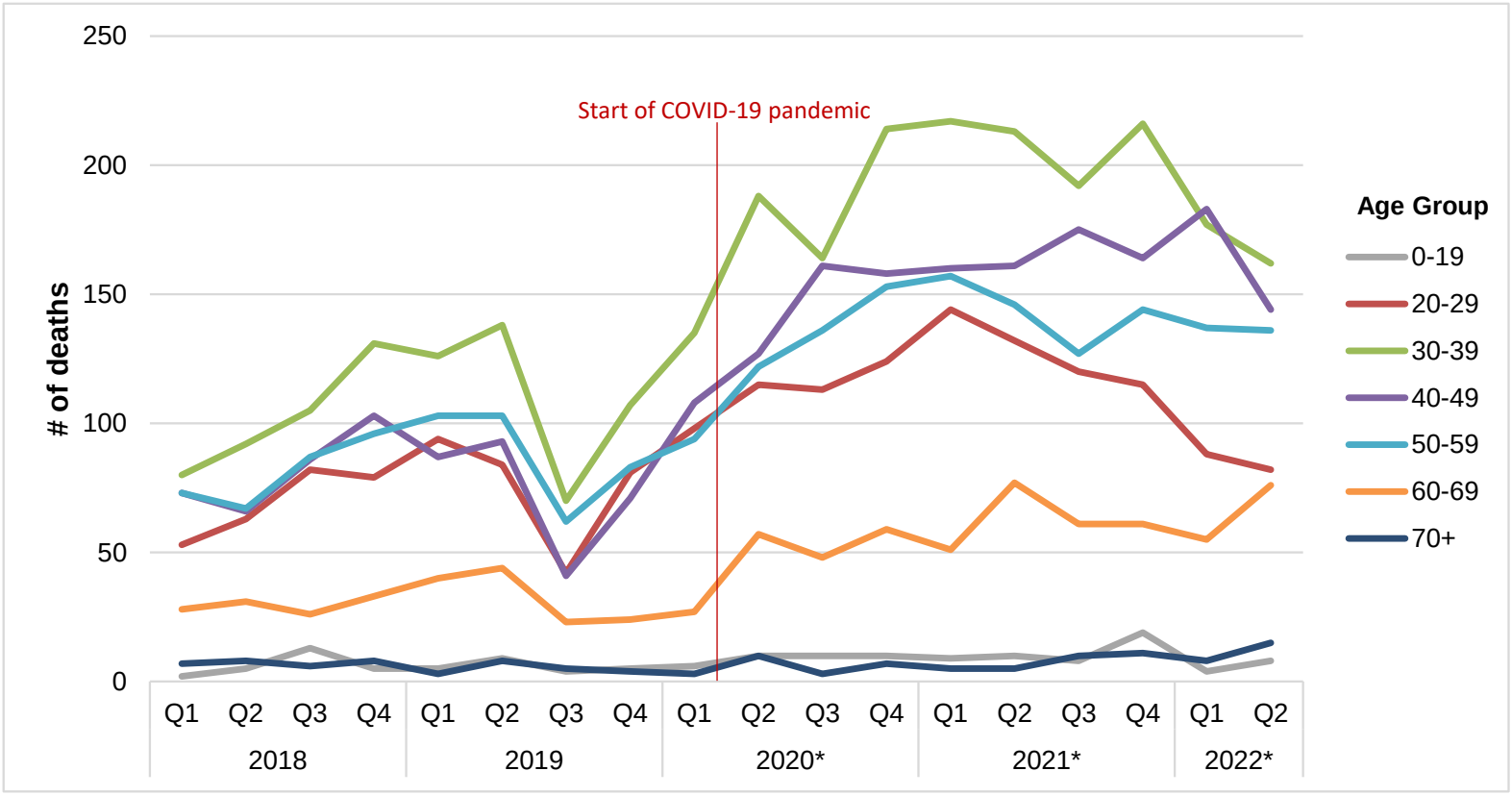


In **2021**, the mortality rate for opioid toxicity in Ontario was 19.7 per 100,000 population; **more than double** the rate in 2017 (9.1).

In **2022** (up to Q2), the mortality rate **decreased by 13%** compared to 2021 (preliminary), however remains **55% higher** than the mortality rate in 2019 (pre-pandemic).

Source: Office of Chief Coroner (OCC) - Data effective Nov 1, 2022
*includes both confirmed and probable opioid-related deaths, preliminary and subject to change.

Opioid-related deaths in Ontario by age group, 2018-2022(Q2)[331]

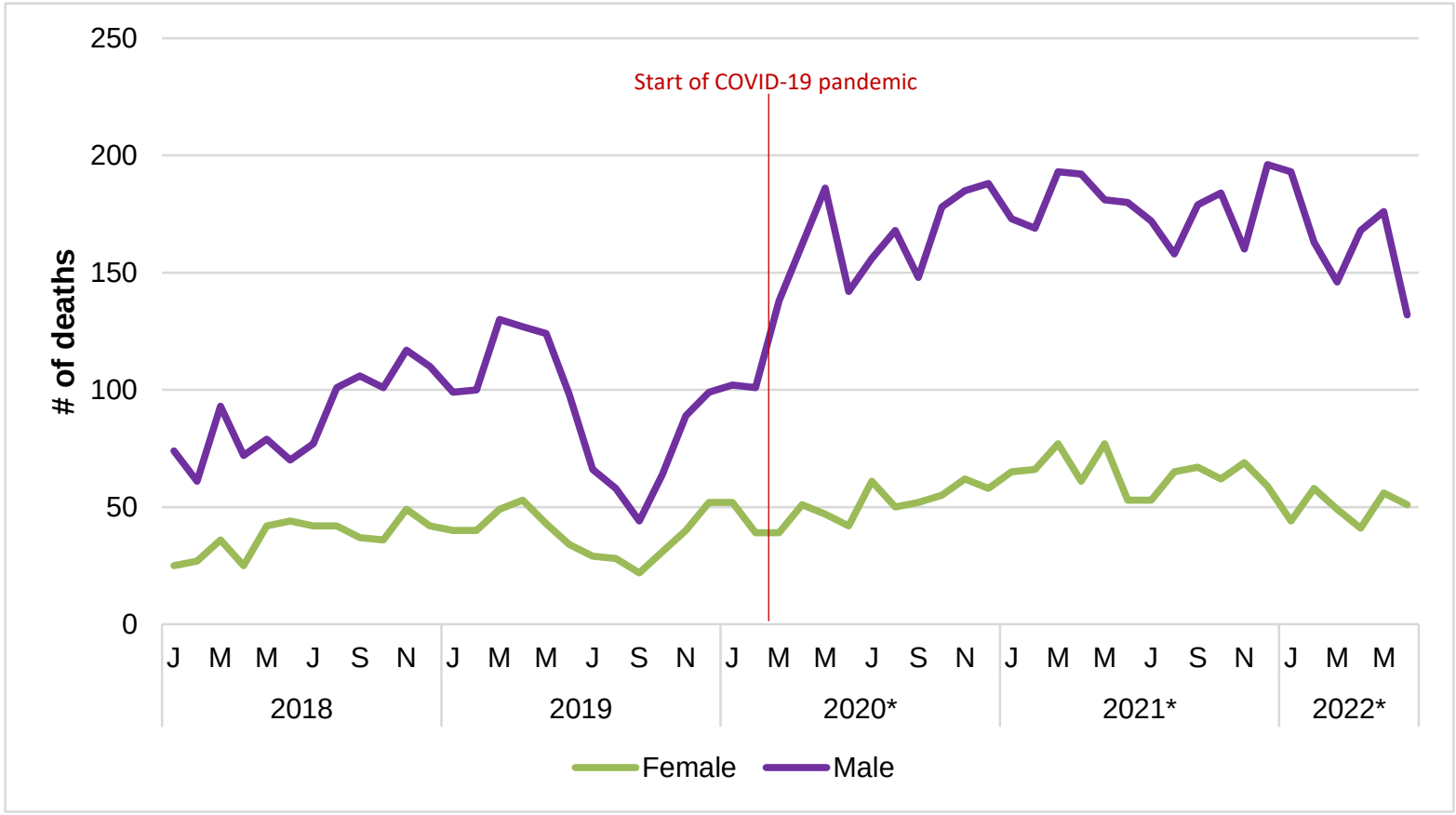


Age groups **30-59** continue to be **most impacted**, accounting for 71% of deaths in Q2 2022.

Relative to Q1, deaths during Q2 **decreased** among **ages 20-49** (-13%) and **increased** among **ages 60+** (+44%).

Source: Office of Chief Coroner (OCC) - Data effective Jul 18th, 2022
*includes both confirmed and probable opioid-related deaths, preliminary and subject to change

Opioid-related deaths in Ontario by month & sex, Jan 2018-Jun 2022



3 in 4 deaths have been among **males** since the start of the pandemic.

Source: Office of Chief Coroner (OCC) - Data effective Nov 1, 2022
*includes both confirmed and probable opioid-related deaths, preliminary and subject to change

Substances involved in opioid toxicity deaths [333] in Ontario, 2018-2022(Q2)

	2018 (N=1508)		2019 (N=1559)		2020* (N=2459)		2021* (N=2817)		2022(Q1-Q2)* (N=1035)	
	n	%	n	%	n	%	n	%	n	%
Non-Pharmaceutical Opioids										
Total Fentanyl/Fentanyl Analogues	1023	68%	1170	75%	2108	86%	2504	89%	880	85%
Fentanyl	969	64%	833	53%	2102	85%	2479	88%	877	85%
Carfentanil	96	6%	490	31%	12	0%	120	4%	50	5%
Nitazenes	0	0%	0	0%	0	0%	5	0%	12	1%
Heroin	108	7%	64	4%	43	2%	22	1%	4	0%
Opioids Indicated for Pain										
Hydromorphone	163	11%	158	10%	148	6%	164	6%	73	7%
Oxycodone	167	11%	142	9%	121	5%	105	4%	59	6%
Morphine***	161	11%	124	8%	128	5%	110	4%	47	5%
Codeine	69	5%	40	3%	45	2%	38	1%	9	1%
Tramadol	17	1%	10	1%	11	0%	5	0%	3	0%
Opioid Agonist Treatment										
Methadone	195	13%	201	13%	255	10%	289	10%	112	11%
Buprenorphine	1	0%	4	0%	7	0%	3	0%	1	0%
Other Substances										
Stimulants	653	43%	751	48%	1399	57%	1673	59%	615	59%
Cocaine	485	32%	536	34%	1022	42%	1135	40%	393	38%
Methamphetamine	245	16%	320	21%	634	26%	848	30%	328	32%
Alcohol	207	14%	196	13%	314	13%	297	11%	111	11%
Benzodiazepines	179	12%	131	8%	225	9%	305	11%	74	7%
*Detection of non-pharmaceutical benzodiazepines****	493	33%	464	30%	1108	45%	1809	64%	593	57%

Fentanyl continues to contribute to the majority (85%) of opioid toxicity deaths.
Stimulants are involved in 3 in 5 opioid toxicity deaths.

***Preliminary and subject to change** – does not include 340 probable cases pending conclusion on cause of death (3 in 2020; 94 in 2021; 243 in 2022).*

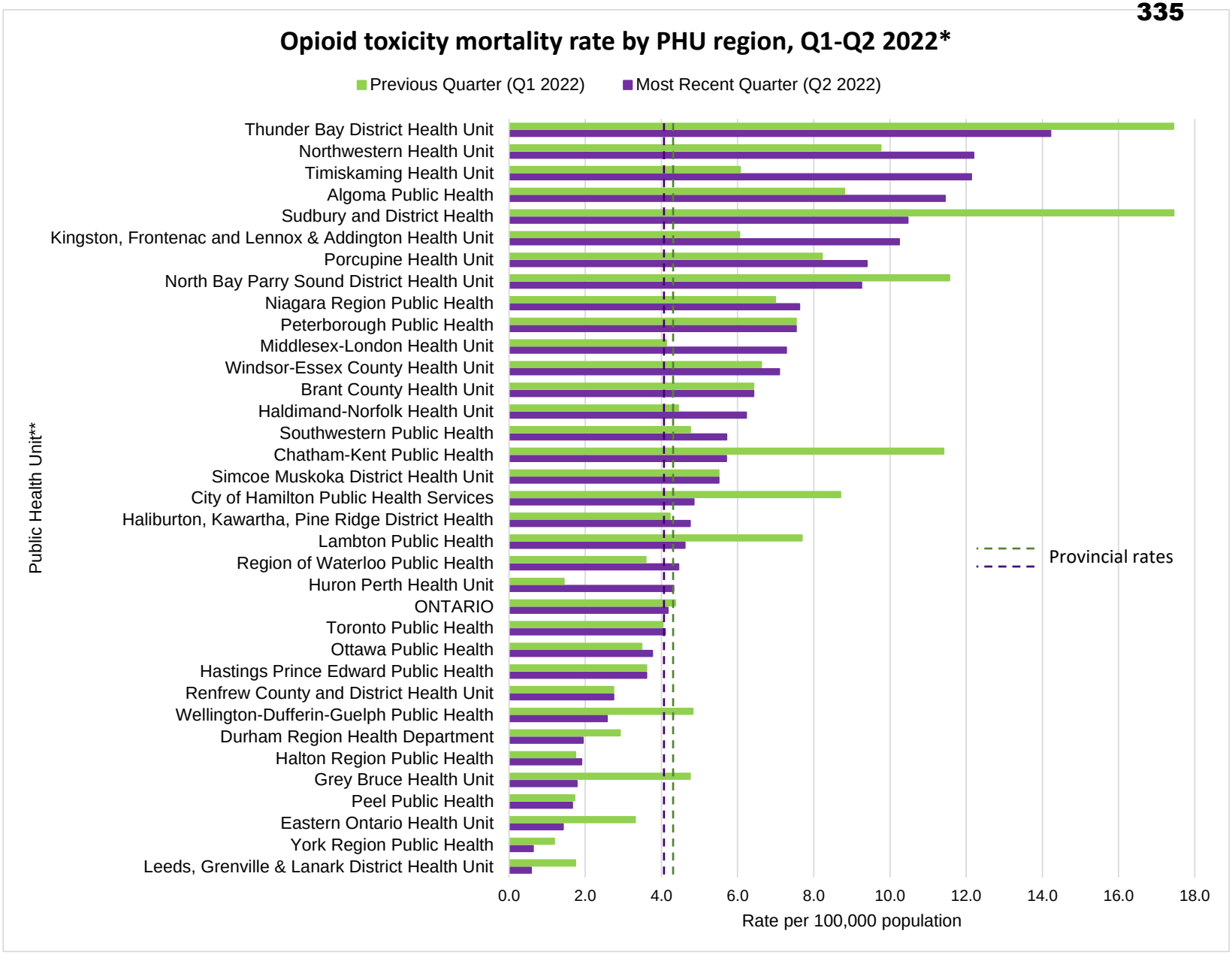
***Nitazenes include isotonitazene, metonitazene and protonitazene. Due to evolving toxicology methods and best practices around quantifying and defining toxic levels of nitazenes, these substances may not be consistently characterized in the cause of death. Nitazenes have been detected in an additional 54 deaths (31 in 2021; 23 in 2022) where they were either not attributed or conclusion on cause of death is pending.*

****Some deaths where morphine was identified as a direct contributor may reflect metabolism of heroin or codeine into morphine.*

*****Non-pharmaceutical benzodiazepines include etizolam, flualprazolam, flubromazolam, and bromazolam. Due to evolving toxicology methods and best practices around quantifying and defining toxic levels of non-pharmaceutical benzodiazepines, these substances may not be consistently characterized in the cause of death.*

Opioid-Related Deaths by Public Health Unit (PHU) Region

PHU BY QUARTER

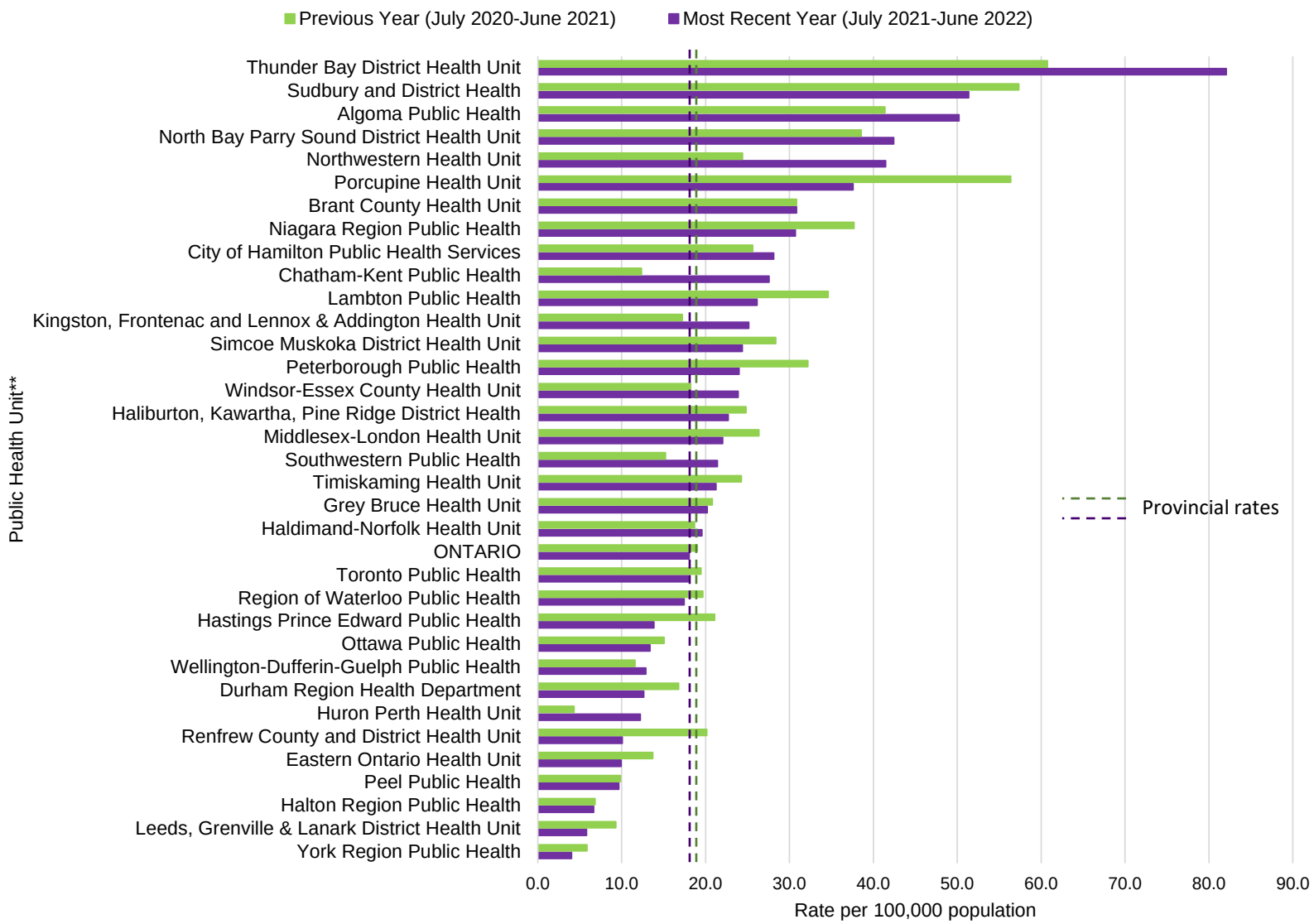


Source: Office of Chief Coroner (OCC) - Data effective Nov 1, 2022
*includes both confirmed and probable opioid-related deaths, preliminary and subject to change
**based on location of incident

PHU BY YEAR

Opioid toxicity mortality rate by PHU region

Most recent two years of data available*



Source: Office of Chief Coroner (OCC) - Data effective Nov 1, 2022

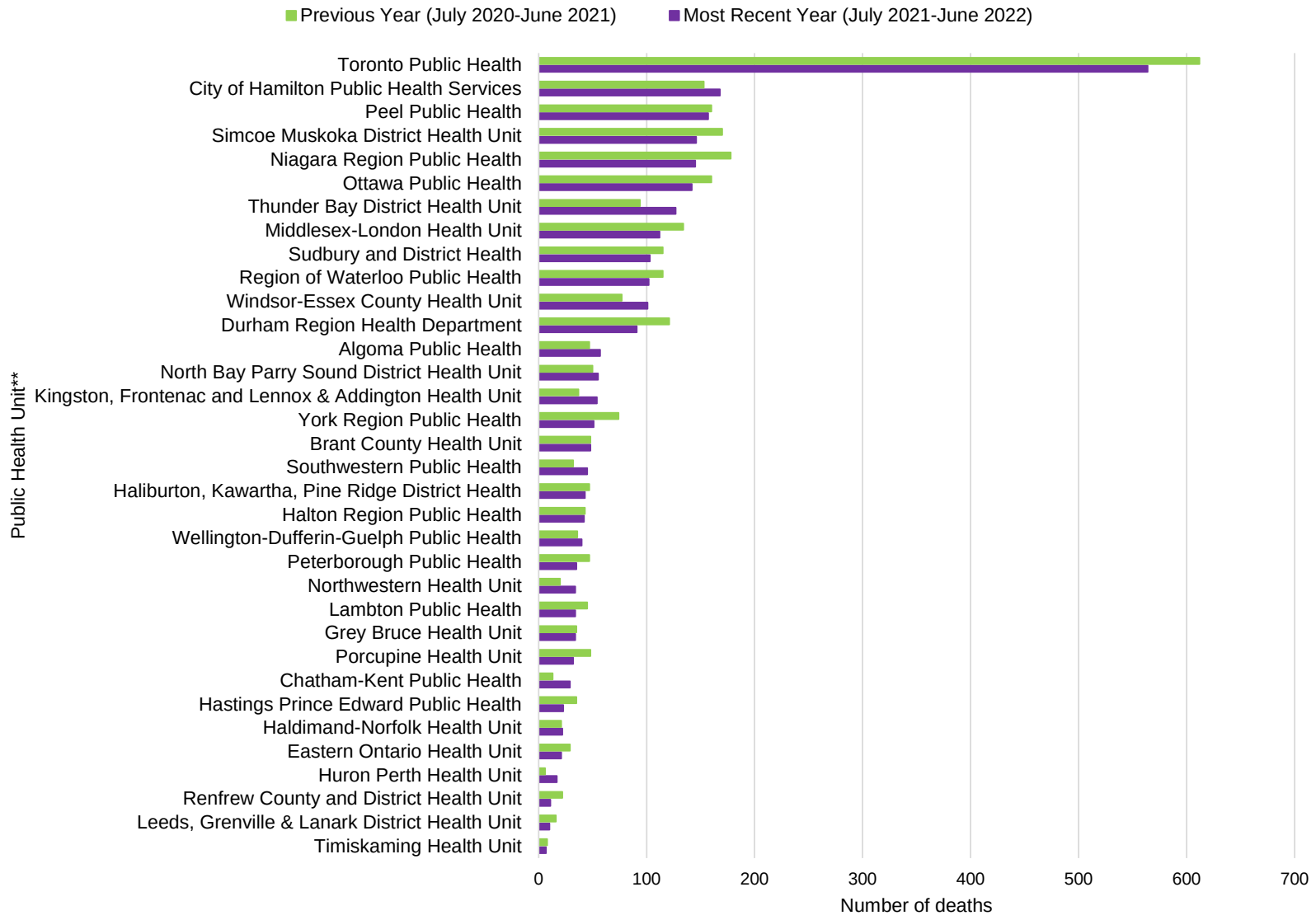
*includes both confirmed and probable opioid-related deaths, preliminary and subject to change

**based on location of incident

PHU BY YEAR

Number of opioid toxicity deaths by PHU region

Most recent two years of data available*



Source: Office of Chief Coroner (OCC) - Data effective Nov 1, 2022
*includes both confirmed and probable opioid-related deaths, preliminary and subject to change
**based on location of incident

Opioid Toxicity Mortality Rate in 2022(Q1-Q2)* by Census Subdivision (CSD)**

Ten (10) CSDs with the highest mortality rates during the first half of 2022(Q1-Q2):

Census Subdivision	Opioid toxicity* mortality rate per 100,000 population
Thunder Bay	42.4
Greater Sudbury	29.0
Timmins	28.6
North Bay	25.8
Peterborough	25.7
Sault Ste. Marie	24.1
Kingston	22.9
Niagara Falls	21.8
St. Thomas	20.8
Windsor	20.8
Ontario (for reference)	*8.5*

Source: Office of Chief Coroner (OCC) - Data effective Nov 1, 2022
*Includes both confirmed and probable opioid-related deaths; **preliminary and subject to change.**
**Based on location of incident. Among CSDs with >30,000 population.

Appendix 1: Opioid-related deaths in Ontario, 2022

Year	Quarter	Confirmed	Probable	Combined (Confirmed + Probable)
2018	Q1	316	0	316
	Q2	332	0	332
	Q3	405	0	405
	Q4	455	0	455
2019	Q1	458	0	458
	Q2	479	0	479
	Q3	247	0	247
	Q4	375	0	375
2020	Q1	471	0	471
	Q2	629	1	630
	Q3	635	0	635
	Q4	724	2	726
2021	Q1	738	5	743
	Q2	724	20	744
	Q3	674	20	694
	Q4	681	49	730
2022	Q1	573	81	654
	Q2	462	162	624

Source: Office of Chief Coroner (OCC) - Data effective Nov 1, 2022
Data are preliminary and subject to change.

Opioid toxicity deaths (confirmed + probable) in Ontario by public health unit (PHU) region and census subdivision (CSD), annual

Source: Office of the Chief Coroner

Data effective May 2, 2023

		Year				
PHU Region**	**CSD****	2018	2019	2020*	2021*	2022*
Thunder Bay District Health Unit	**DORION**	0	0	0	1	0
	FORT WILLIAM 52	1	0	1	0	0
	GREENSTONE	3	1	2	0	0
	MANITOUWADGE	1	0	0	0	0
	MARATHON	0	1	0	0	0
	NESKANTAGA	0	0	0	1	0
	NIPIGON	0	1	1	0	0
	OLIVER PAIPOONGE	2	1	0	0	2
	RED ROCK	0	0	1	0	0
	ROCKY BAY 1	0	0	0	1	0
	SHUNIAH	1	0	0	0	0
	THUNDER BAY	40	38	62	123	84
	THUNDER BAY, UNORGANIZED	0	1	1	0	0
Timiskaming Health Unit	**CHARLTON AND DACK**	0	0	0	0	1
	COLEMAN	0	0	2	1	0
	KIRKLAND LAKE	1	4	4	2	1
	LATCHFORD	1	0	0	0	1
	TEMISKAMING SHORES	1	1	1	1	3
	TIMISKAMING, UNORGANIZED, WEST PART	0	1	0	0	1
Toronto Public Health	**TORONTO**	312	301	551	592	499
Wellington-Dufferin-Guelph Public Health	**CENTRE WELLINGTON**	1	2	2	4	0
	EAST GARAFRAXA	0	1	0	0	0
	ERIN	1	1	0	1	0
	GRAND VALLEY	0	0	0	0	1
	GUELPH	14	18	22	26	29
	GUELPH/ERAMOSA	1	1	1	1	1
	MINTO	1	0	0	0	0
	MONO	1	2	0	0	1
	MULMUR	1	0	0	0	0
	ORANGEVILLE	3	10	1	3	2
	PUSLINCH	2	0	0	1	1
	SHELBURNE	0	0	0	2	0
	WELLINGTON NORTH	1	2	0	1	3
Windsor-Essex County Health Unit	**AMHERSTBURG**	3	1	2	2	2
	ESSEX	2	1	1	0	1
	KINGSVILLE	1	0	0	1	3
	LAKESHORE	1	3	2	3	2
	LASALLE	0	3	3	4	1
	LEAMINGTON	2	2	1	4	3
	TECUMSEH	2	1	3	0	2
	WINDSOR	45	40	58	71	90
York Region Public Health	**AURORA**	5	1	2	5	3
	EAST GWILLIMBURY	1	2	0	0	2
	GEORGINA	4	7	11	9	9
	KING	1	4	3	1	1
	MARKHAM	4	15	14	7	9
	NEWMARKET	8	9	9	12	14
	RICHMOND HILL	7	15	10	9	6
	VAUGHAN	6	7	12	20	12
	WHITCHURCH-STOUFFVILLE	2	2	3	2	3

*Data are preliminary and subject to change. Includes confirmed and probable cases.

**PHU and CSD are based primarily on location of incident.

Note:

- If a CSD is not listed, there were no opioid toxicity deaths recorded in that region over the years reported.
- Probable cases are pending conclusion on cause of death, but suspected to be drug-related and toxicology positive for opioids.

Opioid toxicity deaths (confirmed + probable) in Ontario by public health unit (PHU) region and census subdivision (CSD), annual

Source: Office of the Chief Coroner
Data effective October 28, 2024

		Year						
PHU Region**	**CSD****	2018	2019	2020	2021	2022*	2023*	2024(Q1 &Q2)*
Algoma Public Health	**ALGOMA, UNORGANIZED, NORTH PART**	0	0	4	3	0	3	0
	BLIND RIVER	0	1	0	1	2	1	1
	DUBREUILVILLE	0	0	1	0	0	0	0
	ELLIOT LAKE	1	0	5	3	2	7	1
	GARDEN RIVER 14	0	0	2	2	2	0	1
	MACDONALD, MEREDITH AND ABERDEEN ADDITIONAL	0	0	1	1	1	0	0
	RANKIN LOCATION 15D	0	0	0	0	1	0	0
	SAGAMOK	0	0	0	0	1	0	0
	SAULT STE. MARIE	26	16	33	48	43	36	24
	SERPENT RIVER 7	0	0	1	0	0	0	0
	SPANISH	0	0	2	0	0	0	0
	THE NORTH SHORE	1	0	0	0	0	0	0
	THESSALON	0	0	0	0	1	0	0
	WAWA	0	0	2	1	0	0	0
	WHITE RIVER	0	0	0	0	1	1	0
Brant County Health Unit	**BRANT**	1	2	4	4	1	4	1
	BRANTFORD	17	35	32	46	43	42	22
	NEW CREDIT (PART) 40A	3	2	0	0	0	0	0
	SIX NATIONS (PART) 40	3	3	5	3	3	4	2
Chatham-Kent Public Health	**CHATHAM-KENT**	5	7	15	19	37	16	13
City of Hamilton Public Health Services	**HAMILTON**	124	107	129	163	167	148	72
Durham Region Health Department	**AJAX**	5	7	7	14	7	6	3
	BOWMANVILLE	0	0	1	0	0	0	0
	BROCK	0	1	1	0	1	0	2
	CLARINGTON	5	11	6	20	5	8	3
	OSHAWA	37	43	61	67	41	47	29
	PICKERING	3	4	5	9	10	4	4
	SCUGOG	3	0	2	3	2	1	2
	UXBRIDGE	0	1	0	2	0	4	1
	WHITBY	3	8	8	13	8	8	4
Eastern Ontario Health Unit	**ALFRED AND PLANTAGENET**	0	0	1	0	0	1	0
	CASSELMAN	0	0	0	1	1	1	0
	CLARENCE-ROCKLAND	1	1	1	0	0	0	0
	CORNWALL	3	1	11	18	18	21	7
	HAWKESBURY	0	2	2	3	0	1	1
	NORTH DUNDAS	0	0	1	0	0	1	0
	NORTH GLENGARRY	0	0	0	0	1	1	0
	NORTH STORMONT	0	0	0	1	0	1	1
	RUSSELL	1	0	0	0	1	0	0
	SOUTH DUNDAS	0	1	1	1	0	0	1
	SOUTH GLENGARRY	0	1	1	0	0	0	0
	SOUTH STORMONT	1	0	0	1	2	1	0
	THE NATION / LA NATION	0	1	0	0	0	0	1
Grey Bruce Health Unit	**ARRAN-ELDERSLIE**	0	3	3	1	1	0	0
	BROCKTON	1	0	1	0	1	0	0
	CHATSWORTH	1	0	1	2	0	1	0
	GEORGIAN BLUFFS	2	0	4	5	1	0	0
	GREY HIGHLANDS	0	0	0	2	1	1	0
	HANOVER	0	2	3	1	1	1	0
	HURON-KINLOSS	1	0	1	1	1	0	0
	KINCARDINE	0	1	1	1	0	0	0
	MEAFORD	0	1	0	0	1	3	1
	NORTHERN BRUCE PENINSULA	1	0	0	1	0	1	0
	OWEN SOUND	1	6	10	15	6	15	10
	SAUGEEN SHORES	0	0	0	3	8	5	3
	SOUTH BRUCE	0	0	0	1	0	0	0
	SOUTH BRUCE PENINSULA	0	0	0	2	3	6	1
	SOUTHGATE	0	0	0	2	1	0	0
	THE BLUE MOUNTAINS	0	0	0	1	1	1	0
	WEST GREY	0	1	2	1	0	2	1
Haldimand-Norfolk Health Unit	**HALDIMAND COUNTY**	5	4	3	7	9	6	5
	NORFOLK COUNTY	7	9	13	17	10	5	4
	SIMCOE	0	0	1	0	0	0	0
Haliburton, Kawartha, Pine Ridge District Health Unit	**ALGONQUIN HIGHLANDS**	0	0	0	3	1	0	0
	ALNWICK/HALDIMAND	1	0	1	0	1	2	0
	BRIGHTON	0	0	0	0	1	1	0
	COBOURG	9	4	4	12	1	6	3
	CRAMAHE	1	2	1	1	1	0	0
	DYSART ET AL	0	0	0	3	1	0	1
	HAMILTON	1	0	2	0	2	1	0
	HIGHLANDS EAST	0	0	1	0	2	0	0
	KAWARTHA LAKES	13	10	20	23	22	29	10
	MINDEN HILLS	0	1	2	2	0	0	0
	PORT HOPE	1	2	2	3	4	3	2
	TRENT HILLS	2	0	4	4	0	0	0
Halton Region Public Health	**BURLINGTON**	17	13	12	13	17	16	4
	HALTON HILLS	6	4	6	2	2	0	4
	MILTON	6	5	9	4	7	8	3
	OAKVILLE	12	9	14	17	10	8	4
Hastings Prince Edward Public Health	**BANCROFT**	0	0	0	4	6	2	1
	BELLEVILLE	8	6	13	8	12	17	9
	CENTRE HASTINGS	0	0	1	1	1	1	0
	DESERONTO	0	0	0	0	1	1	0
	FARADAY	0	1	1	2	0	0	0
	HASTINGS HIGHLANDS	0	0	0	1	0	1	0
	MADOC	1	1	0	0	0	0	0
	MARMORA AND LAKE	0	1	0	1	0	1	0
	PRINCE EDWARD COUNTY	0	2	2	5	1	0	1
	QUINTE WEST	8	4	10	5	6	7	3
	TWEED	0	0	0	1	0	0	0
	TYENDINAGA	3	1	1	1	0	0	0
	WOLLASTON	1	0	1	1	0	0	0
Huron Perth Health Unit	**BLUEWATER**	0	0	0	2	0	0	0
	CENTRAL HURON	1	1	0	2	0	2	0
	GODERICH	0	0	1	1	1	2	0
	HOWICK	0	0	0	1	0	1	0
	HURON EAST	1	0	1	1	0	0	0
	MORRIS-TURNBERRY	0	0	1	0	0	0	0
	NORTH HURON	0	0	0	0	0	2	1
	NORTH PERTH	0	0	1	0	1	2	0
	PERTH EAST	0	0	0	0	0	0	1
	PERTH SOUTH	0	0	0	0	1	0	0
	SOUTH HURON	0	0	3	1	1	2	0
	ST. MARYS	1	0	1	0	1	1	0
	STRATFORD	6	0	1	4	6	4	1
Kingston, Frontenac and Lennox & Addington Health Unit	**ADDINGTON HIGHLANDS**	0	0	0	1	1	0	0
	CENTRAL FRONTENAC	0	1	0	0	0	0	1
	GREATER NAPANEE	3	2	1	1	1	2	0
	KINGSTON	19	31	39	28	46	43	13
	LOYALIST	0	2	0	1	1	2	2
	SOUTH FRONTENAC	1	0	1	3	2	1	0
	STONE MILLS	1	1	0	0	1	2	2
Lambton Public Health	**BROOKE-ALVINSTON**	1	1	0	0	0	0	0
	DAWN-EUPHEMIA	0	0	1	0	0	0	0
	ENNISKILLEN	1	0	3	1	0	0	0
	KETTLE POINT 44	0	1	2	4	1	1	1
	LAMBTON SHORES	0	1	0	1	1	4	1
	PETROLIA	0	0	0	0	0	1	1
	PLYMPTON-WYOMING	0	0	0	1	0	0	0
	POINT EDWARD	1	0	0	3	0	0	0
	SARNIA	8	16	33	26	30	30	21
	ST. CLAIR	2	2	3	2	0	0	0
	WARWICK	0	0	1	0	0	0	0
Leeds, Grenville & Lanark District Health Unit	**ATHENS**	0	0	0	0	0	0	1
	AUGUSTA	2	0	3	0	1	0	0
	BROCKVILLE	1	1	3	2	4	8	3
	CARLETON PLACE	1	0	0	2	0	1	1
	DRUMMOND/NORTH ELMSLEY	1	0	0	0	0	0	0
	EDWARDSBURGH/CARDINAL	1	0	0	1	0	2	0
	ELIZABETHTOWN-KITLEY	1	1	3	1	0	0	0
	FRONT OF YONGE	0	0	0	0	0	0	1
	GANANOQUE	0	1	0	0	1	1	1
	LANARK HIGHLANDS	0	0	0	1	0	0	0
	LEEDS AND THE THOUSAND	0	0	0	1	0	0	0
	MISSISSIPPI MILLS	0	0	1	1	0	0	0
	MONTAGUE	0	1	1	0	0	0	0

	NORTH GRENVILLE	0	1	1	2	1	0	0
	PERTH	0	0	2	0	1	4	0
	PRESCOTT	0	0	0	0	2	2	0
	RIDEAU LAKES	1	0	0	0	0	0	0
	SMITHS FALLS	1	2	0	3	1	1	1
Middlesex-London Health Unit	LONDON	57	61	101	122	112	105	35
	LUCAN BIDDULPH	2	0	0	0	1	0	0
	MIDDLESEX CENTRE	1	0	1	2	4	0	0
	SOUTHWEST MIDDLESEX	1	0	0	0	1	1	0
	STRATHROY-CARADOC	0	1	3	7	3	2	0
	THAMES CENTRE	2	0	0	0	0	0	0
Niagara Region Public Health	FORT ERIE	5	8	2	10	7	9	5
	GRIMSBY	3	2	4	6	2	2	0
	LINCOLN	0	1	2	6	1	4	1
	NIAGARA FALLS	18	21	52	41	35	28	13
	NIAGARA-ON-THE-LAKE	1	2	2	2	0	2	1
	PELHAM	1	0	1	1	0	3	1
	PORT COLBORNE	4	7	6	5	4	8	3
	ST. CATHARINES	38	40	48	63	46	51	26
	THOROLD	7	3	9	5	11	5	4
	WAINFLEET	1	0	0	2	0	1	0
	WELLAND	12	11	24	24	17	20	7
	WEST LINCOLN	1	0	2	1	2	2	1
North Bay Parry Sound District Health Unit	ARMOUR	0	2	1	0	0	0	1
	BONFIELD	0	1	0	1	1	1	0
	BURK'S FALLS	0	0	0	0	0	4	0
	CALLANDER	0	0	0	0	1	0	0
	CALVIN	0	0	1	1	0	0	0
	EAST FERRIS	1	2	0	0	0	0	0
	FRENCH RIVER 13	0	0	0	0	0	1	0
	MAGNETAWAN	0	0	0	0	2	0	0
	MATTAWA	0	0	0	1	1	2	1
	MCDOUGALL	1	1	0	1	0	0	0
	MCKELLAR	0	0	0	1	0	0	0
	MCMURRICH/MONTEITH	0	0	0	0	0	1	0
	NIPISSING	0	0	2	0	0	0	0
	NIPISSING 10	0	0	1	1	0	0	0
	NIPISSING, UNORGANIZED	0	0	1	0	0	0	0
	NORTH BAY	7	7	36	28	28	34	13
	PARRY SOUND	0	0	1	7	4	3	0
	PARRY SOUND, UNORGANIZED	0	1	0	3	0	0	0
	PERRY	0	0	1	1	0	1	0
	POWASSAN	0	0	0	0	0	1	0
	SEGUIN	0	0	1	0	0	0	0
	SOUTH RIVER	0	0	0	1	1	0	0
	SUNDRIDGE	0	0	0	0	1	1	0
	THE ARCHIPELAGO	0	1	0	0	0	0	0
	WEST NIPISSING / NIPISSING OUEST	3	6	5	3	1	0	1
	WHITESTONE	1	0	0	0	0	0	0
Northwestern Health Unit	ATIKOKAN	1	0	1	2	1	1	0
	CAT LAKE 63C	0	0	0	0	1	0	0
	CHAPPLE	0	0	2	1	0	0	1
	DAWSON	0	0	0	0	0	1	0
	DRYDEN	0	2	1	5	5	0	2
	EAGLE LAKE 27	0	0	0	1	0	0	0
	EAR FALLS	0	0	0	1	1	0	0
	EMO	0	0	0	1	2	0	0
	FORT FRANCES	1	1	5	12	8	9	2
	IGNACE	0	1	0	0	1	0	0
	KENORA	2	0	2	1	4	4	2
	KENORA, UNORGANIZED	1	3	1	0	0	2	0
	LA VALLEE	0	0	0	0	1	3	0
	LAC SEUL 28	0	0	1	0	2	0	0
	LAKE OF THE WOODS	1	0	0	0	0	1	0
	MUSKRAT DAM LAKE	0	0	0	1	0	0	0
	NORTH SPIRIT LAKE	0	0	0	0	0	1	0
	OSNABURGH 63B	1	0	0	0	0	0	0
	PIKANGIKUM 14	0	0	0	0	0	0	1
	RAT PORTAGE FIRST NATION	0	0	0	0	0	0	1
	SACHIGO LAKE 1	0	0	0	0	0	0	1
	SANDY LAKE 88	0	0	0	0	0	1	0
	SIOUX LOOKOUT	1	0	3	0	4	1	1
	SIOUX NARROWS-NESTOR FALLS	0	0	0	0	1	0	1
	WHITEFISH BAY 32A	0	2	0	0	0	0	0
Ottawa Public Health	OTTAWA	83	65	127	145	173	218	96
Peel Public Health	BRAMPTON	53	56	73	81	48	65	19
	CALEDON	4	1	4	5	5	5	1
	MISSISSAUGA	56	53	79	99	58	77	18
Peterborough Public Health	ASPHODEL-NORWOOD	1	0	0	0	2	1	0
	CAVAN MONAGHAN	0	0	0	1	1	0	1
	CURVE LAKE FIRST NATION	0	0	0	0	0	1	0
	DOURO-DUMMER	0	1	1	0	0	1	0
	HAVELOCK-BELMONT-METHUEN	0	0	0	1	1	0	0
	NORTH KAWARTHA	0	1	0	0	0	0	1
	OTONABEE-SOUTH MONAGHAN	3	0	1	1	1	2	2
	PETERBOROUGH	18	27	39	34	43	45	22
	SELWYN	3	1	2	0	1	2	0
	TRENT LAKES	1	0	0	0	0	0	0
Porcupine Health Unit	BLACK RIVER-MATHESON	2	1	1	0	1	1	0
	COCHRANE	0	2	2	0	1	1	1
	COCHRANE, UNORGANIZED,	1	0	0	0	0	0	2
	CONSTANCE LAKE 92	0	0	0	0	0	1	0
	FACTORY ISLAND 1	0	0	0	1	1	2	3
	FAUQUIER-STRICKLAND	0	1	0	0	0	0	0
	HEARST	0	0	2	0	0	1	1
	IROQUOIS FALLS	0	0	2	2	2	1	2
	KAPUSKASING	1	0	1	3	1	5	4
	MOOSONEE	0	0	1	1	2	2	3
	SMOOTH ROCK FALLS	0	0	0	0	0	1	0
	TIMMINS	10	19	31	33	22	26	11
Region of Waterloo Public Health	CAMBRIDGE	24	15	27	32	26	21	8
	KITCHENER	30	38	63	61	42	42	32
	NORTH DUMFRIES	1	1	1	1	1	0	0
	WATERLOO	8	9	13	14	17	7	9
	WELLESLEY	0	0	0	1	1	1	0
	WILMOT	0	1	1	1	1	1	1
	WOOLWICH	1	0	2	1	1	1	0
Renfrew County and District Health Unit	ARNPRIOR	0	0	1	2	0	0	0
	BONNECHERE VALLEY	0	0	2	0	3	0	0
	DEEP RIVER	1	0	0	0	2	1	0
	GREATER MADAWASKA	0	0	1	1	0	1	0
	HORTON	0	0	0	0	1	0	0
	KILLALOE, HAGARTY AND RICHARDS	0	1	0	0	2	0	3
	LAURENTIAN HILLS	0	0	1	0	0	0	0
	LAURENTIAN VALLEY	0	0	0	2	0	2	2
	MADAWASKA VALLEY	0	0	0	1	0	0	0
	MCNAB/BRAESIDE	0	0	1	0	0	1	0
	PEMBROKE	4	2	4	9	2	11	7
	PETAWAWA	1	0	1	2	0	3	1
	PIKWAKANAGAN (GOLDEN LAKE 39)	0	0	0	1	0	1	0
	RENFREW	0	1	0	1	0	3	1
	WHITEWATER REGION	0	0	0	0	0	2	0
Simcoe Muskoka District Health Unit	ADJALA-TOSORONTIO	0	1	0	2	0	0	0
	BARRIE	31	27	59	75	62	55	28
	BRACEBRIDGE	4	4	3	7	4	2	0
	BRADFORD WEST GWILLIMBURY	2	2	3	4	2	8	1
	CHIPPEWAS OF RAMA FIRST NATION	1	0	1	0	0	0	0
	CHRISTIAN ISLAND 30A	0	0	0	0	1	0	1
	CLEARVIEW	1	0	3	2	0	1	0
	COLLINGWOOD	3	7	2	5	2	5	0
	ESSA	2	3	2	0	4	6	1
	GEORGIAN BAY	0	1	0	0	1	2	1
	GRAVENHURST	4	5	3	4	4	6	4
	HUNTSVILLE	2	8	2	7	4	4	2
	INNISFIL	7	3	4	3	11	3	2
	LAKE OF BAYS	1	1	0	0	0	0	0
	MIDLAND	3	3	11	6	8	8	6
	MUSKOKA LAKES	1	0	1	1	1	0	1
	NEW TECUMSETH	0	2	2	5	4	5	1
	ORILLIA	10	10	14	21	9	17	8
	ORO-MEDONTE	1	1	1	2	2	2	0
	PENETANGUISHENE	1	3	2	2	1	4	3

	RAMARA	0	0	2	3	2	0	1
	SEVERN	1	2	1	3	7	1	1
	SPRINGWATER	0	3	1	4	1	1	2
	TAY	0	0	1	2	1	7	2
	TINY	2	1	0	4	2	2	0
	WASAGA BEACH	1	3	14	10	5	5	2
Southwestern Public Health Unit	AYLMER	0	0	0	1	0	2	0
	BAYHAM	1	0	0	1	2	0	1
	BLANDFORD-BLENHEIM	0	1	0	0	0	0	0
	CENTRAL ELGIN	2	0	0	2	1	1	0
	DUTTON/DUNWICH	1	0	0	0	0	0	0
	EAST ZORRA-TAVISTOCK	0	0	1	0	1	0	0
	INGERSOLL	2	0	2	3	2	1	1
	MALAHIDE	0	0	1	2	0	0	0
	NORWICH	2	0	1	2	0	1	1
	SOUTH-WEST OXFORD	1	0	3	1	1	0	0
	ST. THOMAS	8	6	7	10	11	2	3
	TILLSONBURG	3	2	3	3	7	3	2
	WEST ELGIN	1	0	0	1	1	2	0
	WOODSTOCK	3	8	8	17	11	9	6
	ZORRA	0	0	0	0	1	0	0
Sudbury and District Health	ASSIGINACK	0	0	0	1	0	0	0
	BURPEE AND MILLS	0	0	1	0	0	0	0
	CENTRAL MANITOULIN	0	0	0	0	1	0	2
	CHAPLEAU	0	0	0	2	2	1	1
	ESPANOLA	0	0	0	4	6	0	1
	FRENCH RIVER / RIVIÈRE	0	0	0	1	0	0	0
	GREATER SUDBURY	32	52	95	78	94	90	38
	M'CHIGEENG 22	0	0	0	1	0	0	1
	M'CHIGEENG 22 (WEST BAY 22)	0	0	3	2	0	0	0
	MANITOULIN, UNORGANIZED	0	0	0	0	0	1	0
	MARKSTAY-WARREN	0	0	0	0	0	1	0
	NORTHEASTERN MANITOULIN AND THE ISLANDS	1	0	1	0	1	1	1
	SABLES-SPANISH RIVERS	1	0	4	4	3	1	2
	ST.-CHARLES	0	0	0	0	0	0	1
	SUDBURY	0	0	1	0	0	0	0
	SUDBURY, UNORGANIZED, NORTH PART	0	1	1	0	2	0	2
	TEHKUMMAH	0	0	0	0	0	1	0
	WHITEFISH RIVER 4	0	0	0	0	1	0	1
	WIKWEMIKONG UNCEDED	0	2	1	5	3	4	2
Thunder Bay District Health Unit	FORT WILLIAM 52	1	0	1	0	0	1	1
	GREENSTONE	3	1	2	1	0	2	0
	MANITOUWADGE	1	0	0	0	0	1	0
	MARATHON	0	1	0	0	0	0	0
	NEEBING	0	0	0	0	0	2	0
	NESKANTAGA	0	0	0	1	0	0	0
	NIPIGON	0	1	1	0	0	0	0
	OLIVER PAIPOONGE	2	1	0	0	2	0	0
	RED ROCK	0	0	1	0	0	0	0
	SHUNIAH	1	0	0	1	0	0	1
	THUNDER BAY	40	38	62	124	83	79	33
	THUNDER BAY, UNORGANIZED	0	1	1	1	0	1	1
Timiskaming Health Unit	ARMSTRONG	0	0	0	0	0	1	0
	COBALT	0	0	0	0	0	0	1
	COLEMAN	0	0	2	1	0	0	0
	ENGLEHART	0	0	0	0	1	2	0
	KIRKLAND LAKE	1	4	4	2	1	1	3
	LATCHFORD	1	0	0	0	1	0	0
	TEMISKAMING SHORES	1	1	1	1	4	5	3
	TIMISKAMING, UNORGANIZED, WEST PART	0	1	0	0	0	0	0
Toronto Public Health	TORONTO	312	301	552	592	510	526	283
Wellington-Dufferin-Guelph Public Health	AMARANTH	0	0	0	0	0	1	0
	CENTRE WELLINGTON	1	2	2	4	1	1	0
	EAST GARAFRAXA	0	1	0	0	0	0	0
	ERIN	1	1	0	1	0	0	0
	GRAND VALLEY	0	0	0	0	1	0	0
	GUELPH	14	18	22	25	30	31	13
	GUELPH/ERAMOSA	1	1	1	1	1	1	0
	MAPLETON	0	0	0	0	1	0	0
	MELANCTHON	0	0	0	0	1	0	0
	MINTO	1	0	0	0	0	0	1
	MONO	1	2	0	0	0	1	0
	MULMUR	1	0	0	0	0	0	0
	ORANGEVILLE	3	10	1	3	2	4	1
	PUSLINCH	2	0	0	1	1	2	0
	SHELBURNE	0	0	0	2	0	0	1
	WELLINGTON NORTH	1	2	0	1	2	0	0
Windsor-Essex County Health Unit	AMHERSTBURG	3	1	2	2	1	3	0
	ESSEX	2	1	1	0	2	4	0
	KINGSVILLE	1	0	0	1	3	0	4
	LAKESHORE	1	3	2	3	3	5	3
	LASALLE	0	3	3	4	1	0	0
	LEAMINGTON	2	2	1	4	3	7	2
	TECUMSEH	2	1	3	0	3	1	0
	WINDSOR	45	40	58	70	96	109	48
York Region Public Health	AURORA	5	1	2	5	3	8	1
	EAST GWILLIMBURY	1	2	0	0	2	5	0
	GEORGINA	4	7	11	9	10	8	3
	KING	1	4	3	1	1	1	0
	MARKHAM	4	15	14	7	9	12	4
	NEWMARKET	8	9	9	12	14	15	9
	RICHMOND HILL	7	15	10	9	6	18	9
	VAUGHAN	6	7	12	21	12	15	5
	WHITCHURCH-STOUFFVILLE	2	2	3	2	3	0	0

*Data are preliminary and subject to change. Includes confirmed and probable cases.
**PHU and CSD are based primarily on location of incident.

Note:

- A CSD is a municipality or an area treated as an equivalent to a municipality for statistical purposes, assigned based on postal code.
- If a CSD is not listed, there were no opioid toxicity deaths recorded in that region over the years reported.
- Probable cases are pending conclusion on cause of death, but suspected to be drug-related and toxicology positive for opioids.

Opioid toxicity deaths (confirmed + probable) in Ontario by public health unit (PHU) region and census subdivision (CSD), annual

Source: Office of the Chief Coroner
Data effective April 29, 2024

		Year					
PHU Region**	**CSD****	2018	2019	2020	2021	2022*	2023*
Algoma Public Health	**ALGOMA, UNORGANIZED, NORTH PART**	0	0	4	3	0	1
	BLIND RIVER	0	1	0	1	2	1
	DUBREUILVILLE	0	0	1	0	0	0
	ELLIOT LAKE	1	0	5	3	2	7
	GARDEN RIVER 14	0	0	2	2	2	0
	MACDONALD, MEREDITH AND ABERDEEN ADDITIONAL	0	0	1	1	1	0
	RANKIN LOCATION 15D	0	0	0	0	1	0
	SAGAMOK	0	0	0	0	1	0
	SAULT STE. MARIE	26	16	33	48	43	37
	SERPENT RIVER 7	0	0	1	0	0	0
	SPANISH	0	0	2	0	0	0
	THE NORTH SHORE	1	0	0	0	0	0
	THESSALON	0	0	0	0	1	0
	WAWA	0	0	2	1	0	0
	WHITE RIVER	0	0	0	0	1	1
Brant County Health Unit	**BRANT**	1	2	4	4	1	4
	BRANTFORD	17	35	32	46	43	41
	NEW CREDIT (PART) 40A	3	2	0	0	0	0
	SIX NATIONS (PART) 40	3	3	5	3	3	4
Chatham-Kent Public Health	**CHATHAM-KENT**	5	7	15	20	37	17
City of Hamilton Public Health Services	**HAMILTON**	124	107	129	163	167	145
Durham Region Health Department	**AJAX**	5	7	7	14	7	7
	BOWMANVILLE	0	0	1	0	0	0
	BROCK	0	1	1	0	1	0
	CLARINGTON	5	11	6	20	5	7
	OSHAWA	37	43	61	67	41	44
	PICKERING	3	4	5	9	10	4
	SCUGOG	3	0	2	3	2	1
	UXBRIDGE	0	1	0	2	0	4
	WHITBY	3	8	8	13	8	8
Eastern Ontario Health Unit	**ALFRED AND PLANTAGENET**	0	0	1	0	0	1
	CASSELMAN	0	0	0	1	1	1
	CLARENCE-ROCKLAND	1	1	1	0	0	0
	CORNWALL	3	1	11	18	18	21
	HAWKESBURY	0	2	2	3	0	1
	NORTH DUNDAS	0	0	1	0	0	1
	NORTH GLENGARRY	0	0	0	0	1	1
	NORTH STORMONT	0	0	0	1	0	1
	RUSSELL	1	0	0	0	1	0
	SOUTH DUNDAS	0	1	1	1	0	0
	SOUTH GLENGARRY	0	1	1	0	0	0
	SOUTH STORMONT	1	0	0	1	2	1
	THE NATION / LA NATION	0	1	0	0	0	0
Grey Bruce Health Unit	**ARRAN-ELDERSLIE**	0	3	3	1	1	0
	BROCKTON	1	0	1	0	1	0
	CHATSWORTH	1	0	1	2	0	1
	GEORGIAN BLUFFS	2	0	4	5	1	3
	GREY HIGHLANDS	0	0	0	2	1	1
	HANOVER	0	2	3	1	1	1
	HURON-KINLOSS	1	0	1	1	1	0
	KINCARDINE	0	1	1	1	0	0
	MEAFORD	0	1	0	0	1	2
	NORTHERN BRUCE PENINSULA	1	0	0	1	0	1
	OWEN SOUND	1	6	10	15	6	12
	SAUGEEN SHORES	0	0	0	3	8	4
	SOUTH BRUCE	0	0	0	1	0	0
	SOUTH BRUCE PENINSULA	0	0	0	2	3	6
	SOUTHGATE	0	0	0	2	1	2
	THE BLUE MOUNTAINS	0	0	0	1	1	1
	WEST GREY	0	1	2	1	0	0
Haldimand-Norfolk Health Unit	**HALDIMAND COUNTY**	5	4	3	7	10	7
	NORFOLK COUNTY	7	9	13	17	10	7
	SIMCOE	0	0	1	0	0	0
Haliburton, Kawartha, Pine Ridge District Health Unit	**ALGONQUIN HIGHLANDS**	0	0	0	3	0	0
	ALNWICK/HALDIMAND	1	0	1	0	1	2
	BRIGHTON	0	0	0	0	1	1
	COBOURG	9	4	4	12	1	6
	CRAMAHE	1	2	1	1	1	0
	DYSART ET AL	0	0	0	3	1	0
	HAMILTON	1	0	2	0	2	0
	HIGHLANDS EAST	0	0	1	0	2	0
	KAWARTHA LAKES	13	10	20	22	22	24
	MINDEN HILLS	0	1	2	2	0	0
	PORT HOPE	1	2	2	3	4	3
	TRENT HILLS	2	0	4	4	0	0
Halton Region Public Health	**BURLINGTON**	17	13	12	13	17	15
	HALTON HILLS	6	4	6	2	2	0
	MILTON	6	5	9	4	7	7
	OAKVILLE	12	9	14	17	10	7
Hastings Prince Edward Public Health	**BANCROFT**	0	0	0	4	6	2
	BELLEVILLE	8	6	13	8	12	17
	CENTRE HASTINGS	0	0	1	1	1	0
	DESERONTO	0	0	0	0	1	2
	FARADAY	0	1	1	2	0	0
	HASTINGS HIGHLANDS	0	0	0	1	0	1
	MADOC	1	1	0	0	0	0
	MARMORA AND LAKE	0	1	0	1	0	1
	PRINCE EDWARD COUNTY	0	2	2	5	1	0
	QUINTE WEST	8	4	10	5	6	7
	TWEED	0	0	0	1	0	0
	TYENDINAGA	3	1	1	1	0	0
	WOLLASTON	1	0	1	1	0	0
Huron Perth Health Unit	**BLUEWATER**	0	0	0	2	0	0
	CENTRAL HURON	1	1	0	2	0	2
	GODERICH	0	0	1	1	1	2
	HOWICK	0	0	0	1	0	1
	HURON EAST	1	0	1	1	0	0
	MORRIS-TURNBERRY	0	0	1	0	0	0
	NORTH HURON	0	0	0	0	0	2
	NORTH PERTH	0	0	1	0	1	2
	PERTH SOUTH	0	0	0	0	1	0
	SOUTH HURON	0	0	3	1	1	4
	ST. MARYS	1	0	1	0	1	1
	STRATFORD	6	0	1	4	6	4
Kingston, Frontenac and Lennox &	**ADDINGTON HIGHLANDS**	0	0	0	1	1	0

Addington Health Unit	CENTRAL FRONTENAC	0	1	0	0	0	0
	GREATER NAPANEE	3	2	1	1	1	2
	KINGSTON	19	31	39	28	46	43
	LOYALIST	0	2	0	1	1	2
	SOUTH FRONTENAC	1	0	1	3	2	1
	STONE MILLS	1	1	0	0	1	2
Lambton Public Health	BROOKE-ALVINSTON	1	1	0	0	0	0
	DAWN-EUPHEMIA	0	0	1	0	0	0
	ENNISKILLEN	1	0	3	1	0	0
	KETTLE POINT 44	0	1	2	4	1	2
	LAMBTON SHORES	0	1	0	1	1	1
	PETROLIA	0	0	0	0	0	1
	PLYMPTON-WYOMING	0	0	0	1	0	0
	POINT EDWARD	1	0	0	3	0	0
	SARNIA	8	16	33	26	30	31
	ST. CLAIR	2	2	3	2	0	0
	WARWICK	0	0	1	0	0	0
Leeds, Grenville & Lanark District Health Unit	AUGUSTA	2	0	3	0	1	0
	BROCKVILLE	1	1	3	2	4	7
	CARLETON PLACE	1	0	0	2	0	1
	DRUMMOND/NORTH ELMSLEY	1	0	0	0	0	0
	EDWARDSBURGH/CARDINAL	1	0	0	1	0	2
	ELIZABETHTOWN-KITLEY	1	1	3	1	0	0
	GANANOQUE	0	1	0	0	1	1
	LANARK HIGHLANDS	0	0	0	1	0	0
	LEEDS AND THE THOUSAND	0	0	0	1	0	0
	MISSISSIPPI MILLS	0	0	1	1	0	0
	MONTAGUE	0	1	1	0	0	0
	NORTH GRENVILLE	0	1	1	2	1	0
	PERTH	0	0	2	0	1	4
	PRESCOTT	0	0	0	0	2	2
	RIDEAU LAKES	1	0	0	0	0	0
	SMITHS FALLS	1	2	0	3	1	1
Middlesex-London Health Unit	LONDON	57	61	101	122	112	104
	LUCAN BIDDULPH	2	0	0	0	1	0
	MIDDLESEX CENTRE	1	0	1	2	4	0
	SOUTHWEST MIDDLESEX	1	0	0	0	1	1
	STRATHROY-CARADOC	0	1	3	7	3	2
	THAMES CENTRE	2	0	0	0	0	0
Niagara Region Public Health	FORT ERIE	5	8	2	10	7	9
	GRIMSBY	3	2	4	6	2	2
	LINCOLN	0	1	2	6	1	3
	NIAGARA FALLS	18	21	52	41	37	27
	NIAGARA-ON-THE-LAKE	1	2	2	2	0	3
	PELHAM	1	0	1	1	0	2
	PORT COLBORNE	4	7	6	5	4	9
	ST. CATHARINES	38	40	48	63	45	51
	THOROLD	7	3	9	5	8	6
	WAINFLEET	1	0	0	2	0	1
	WELLAND	12	11	24	24	17	20
	WEST LINCOLN	1	0	2	1	2	2
North Bay Parry Sound District Health Unit	ARMOUR	0	2	1	0	0	0
	BONFIELD	0	1	0	1	1	1
	BURK'S FALLS	0	0	0	0	0	4
	CALLANDER	0	0	0	0	1	0
	CALVIN	0	0	1	1	0	0
	EAST FERRIS	1	2	0	0	0	0
	FRENCH RIVER 13	0	0	0	0	0	1
	MAGNETAWAN	0	0	0	0	2	0
	MAGNETEWAN 1	0	0	0	1	0	0
	MATTAWA	0	0	0	1	1	2
	MCDOUGALL	1	1	0	1	0	0
	MCKELLAR	0	0	0	1	0	0
	MCMURRICH/MONTEITH	0	0	0	0	0	1
	NIPISSING	0	0	2	0	0	0
	NIPISSING 10	0	0	1	1	0	0
	NIPISSING, UNORGANIZED	0	0	1	0	0	0
	NORTH BAY	7	7	36	28	28	34
	PARRY SOUND	0	0	1	7	4	3
	PARRY SOUND, UNORGANIZED	0	1	0	2	0	0
	PERRY	0	0	1	1	0	1
	POWASSAN	0	0	0	0	0	1
	SEGUIN	0	0	1	0	0	0
	SOUTH RIVER	0	0	0	1	1	0
	SUNDRIDGE	0	0	0	0	1	1
	THE ARCHIPELAGO	0	1	0	0	0	0
	WEST NIPISSING / NIPISSING OUEST	3	6	5	3	1	1
	WHITESTONE	1	0	0	0	0	0
Northwestern Health Unit	ATIKOKAN	1	0	1	2	1	1
	CAT LAKE 63C	0	0	0	0	1	0
	CHAPPLE	0	0	2	1	0	0
	DAWSON	0	0	0	0	0	2
	DRYDEN	0	2	1	5	5	1
	EAGLE LAKE 27	0	0	0	1	0	0
	EAR FALLS	0	0	0	1	1	0
	EMO	0	0	0	1	2	0
	FORT FRANCES	1	1	5	12	8	9
	IGNACE	0	1	0	0	1	0
	KENORA	2	0	2	1	4	3
	KENORA, UNORGANIZED	1	3	1	0	0	2
	LA VALLEE	0	0	0	0	1	4
	LAC SEUL 28	0	0	1	0	2	0
	LAKE OF THE WOODS	1	0	0	0	0	0
	MUSKRAT DAM LAKE	0	0	0	1	0	0
	NORTH SPIRIT LAKE	0	0	0	0	0	1
	OSNABURGH 63B	1	0	0	0	0	0
	SAUG-A-GAW-SING 1	0	0	0	0	0	1
	SIOUX LOOKOUT	1	0	3	0	4	1
	SIOUX NARROWS-NESTOR FALLS	0	0	0	0	1	0
	WHITEFISH BAY 32A	0	2	0	0	0	0
Ottawa Public Health	OTTAWA	83	65	127	145	172	212
Peel Public Health	BRAMPTON	53	56	73	80	48	60
	CALEDON	4	1	4	5	5	5
	MISSISSAUGA	56	53	79	99	57	77
Peterborough Public Health	ASPHODEL-NORWOOD	1	0	0	0	2	1
	CAVAN MONAGHAN	0	0	0	1	1	0
	DOURO-DUMMER	0	1	1	0	0	1
	HAVELOCK-BELMONT-METHUEN	0	0	0	1	1	0
	NORTH KAWARTHA	0	1	0	0	0	0
	OTONABEE-SOUTH MONAGHAN	3	0	1	1	1	2
	PETERBOROUGH	18	27	39	34	43	46

	SELWYN	3	1	2	0	1	2
	TRENT LAKES	1	0	0	0	0	0
Porcupine Health Unit	BLACK RIVER-MATHESON	2	1	1	0	1	1
	COCHRANE	0	2	2	0	1	1
	COCHRANE, UNORGANIZED,	1	0	0	0	0	0
	CONSTANCE LAKE 92	0	0	0	0	0	1
	FACTORY ISLAND 1	0	0	0	1	1	2
	FAUQUIER-STRICKLAND	0	1	0	0	0	0
	HEARST	0	0	2	0	0	1
	IROQUOIS FALLS	0	0	2	2	2	2
	KAPUSKASING	1	0	1	3	1	5
	MOOSONEE	0	0	1	1	2	2
	SMOOTH ROCK FALLS	0	0	0	0	0	1
	TIMMINS	10	19	31	33	22	25
Region of Waterloo Public Health	CAMBRIDGE	24	15	27	31	26	22
	KITCHENER	30	38	63	61	42	43
	NORTH DUMFRIES	1	1	1	1	1	0
	WATERLOO	8	9	13	14	17	6
	WELLESLEY	0	0	0	1	2	1
	WILMOT	0	1	1	1	1	1
	WOOLWICH	1	0	2	1	1	1
Renfrew County and District Health Unit	ARNPRIOR	0	0	1	2	1	0
	BONNECHERE VALLEY	0	0	2	0	3	0
	DEEP RIVER	1	0	0	0	2	1
	GREATER MADAWASKA	0	0	1	1	0	1
	HORTON	0	0	0	0	1	0
	KILLALOE, HAGARTY AND RICHARDS	0	1	0	0	2	0
	LAURENTIAN HILLS	0	0	1	0	0	0
	LAURENTIAN VALLEY	0	0	0	2	0	2
	MADAWASKA VALLEY	0	0	0	1	0	0
	MCNAB/BRAESIDE	0	0	1	0	0	1
	PEMBROKE	4	2	4	9	2	11
	PETAWAWA	1	0	1	2	0	3
	PIKWAKANAGAN (GOLDEN LAKE 39)	0	0	0	1	0	1
	RENFREW	0	1	0	1	0	3
	WHITEWATER REGION	0	0	0	0	0	2
Simcoe Muskoka District Health Unit	ADJALA-TOSORONTIO	0	1	0	2	1	0
	BARRIE	31	27	59	75	63	53
	BRACEBRIDGE	4	4	3	7	4	2
	BRADFORD WEST GWILLIMBURY	2	2	3	4	2	8
	CHIPPEWAS OF RAMA FIRST NATION	1	0	1	0	0	0
	CLEARVIEW	1	0	3	2	0	1
	COLLINGWOOD	3	7	2	6	2	4
	ESSA	2	3	2	0	3	6
	GEORGIAN BAY	0	1	0	0	4	2
	GRAVENHURST	4	5	3	4	4	6
	HUNTSVILLE	2	8	2	7	4	4
	INNISFIL	7	3	4	3	11	2
	LAKE OF BAYS	1	1	0	0	1	0
	MIDLAND	3	3	11	6	8	6
	MUSKOKA LAKES	1	0	1	1	1	0
	NEW TECUMSETH	0	2	2	5	5	6
	ORILLIA	10	10	14	21	10	17
	ORO-MEDONTE	1	1	1	2	1	2
	PENETANGUISHENE	1	3	2	2	1	5
	RAMARA	0	0	2	4	2	4
	SEVERN	1	2	1	3	4	1
	SPRINGWATER	0	3	1	4	1	1
	TAY	0	0	1	2	1	7
	TINY	2	1	0	4	3	2
	WASAGA BEACH	1	3	14	10	5	5
Southwestern Public Health Unit	AYLMER	0	0	0	1	0	2
	BAYHAM	1	0	0	1	2	0
	BLANDFORD-BLENHEIM	0	1	0	0	0	0
	CENTRAL ELGIN	2	0	0	2	1	1
	DUTTON/DUNWICH	1	0	0	0	0	0
	EAST ZORRA-TAVISTOCK	0	0	1	0	1	0
	INGERSOLL	2	0	2	3	2	1
	MALAHIDE	0	0	1	2	0	0
	NORWICH	2	0	1	2	0	1
	SOUTH-WEST OXFORD	1	0	3	1	1	0
	SOUTHWOLD	0	0	0	0	0	1
	ST. THOMAS	8	6	7	10	11	3
	TILLSONBURG	3	2	3	3	7	3
	WEST ELGIN	1	0	0	1	1	2
	WOODSTOCK	3	8	8	17	11	9
	ZORRA	0	0	0	0	1	0
Sudbury and District Health	ASSIGINACK	0	0	0	1	0	0
	BURPEE AND MILLS	0	0	1	0	0	0
	CENTRAL MANITOULIN	0	0	0	0	1	1
	CHAPLEAU	0	0	0	2	2	1
	ESPANOLA	0	0	0	4	6	0
	FRENCH RIVER / RIVIÈRE	0	0	0	1	0	0
	GREATER SUDBURY	32	52	95	78	94	88
	M'CHIGEENG 22	0	0	0	1	0	0
	M'CHIGEENG 22 (WEST BAY 22)	0	0	3	2	0	0
	NORTHEASTERN MANITOULIN AND THE ISLANDS	1	0	1	0	1	1
	SABLES-SPANISH RIVERS	1	0	4	4	3	1
	SUDBURY	0	0	1	0	0	0
	SUDBURY, UNORGANIZED, NORTH PART	0	1	1	0	2	0
	WHITEFISH RIVER 4	0	0	0	0	1	0
	WIKWEMIKONG UNCEDED	0	2	1	5	3	4
Thunder Bay District Health Unit	FORT WILLIAM 52	1	0	1	0	0	1
	GREENSTONE	3	1	2	0	0	2
	LANSDOWNE HOUSE	0	0	0	1	0	0
	MANITOUWADGE	1	0	0	0	0	0
	MARATHON	0	1	0	0	0	1
	NEEBING	0	0	0	0	0	2
	NIPIGON	0	1	1	0	0	0
	OLIVER PAIPOONGE	2	1	0	0	2	0
	RED ROCK	0	0	1	0	0	0
	ROCKY BAY 1	0	0	0	1	0	0
	SHUNIAH	1	0	0	1	0	0
	THUNDER BAY	40	38	62	125	84	77
	THUNDER BAY, UNORGANIZED	0	1	1	0	0	1
Timiskaming Health Unit	ARMSTRONG	0	0	0	0	0	1
	COLEMAN	0	0	2	1	0	0
	ENGLEHART	0	0	0	0	1	2
	KIRKLAND LAKE	1	4	4	2	1	1
	LATCHFORD	1	0	0	0	1	0
	TEMISKAMING SHORES	1	1	1	1	4	5

	TIMISKAMING, UNORGANIZED, WEST PART	0	1	0	0	0	0
Toronto Public Health	TORONTO	312	301	552	592	510	506
Wellington-Dufferin-Guelph Public Health	AMARANTH	0	0	0	0	0	1
	CENTRE WELLINGTON	1	2	2	4	0	1
	EAST GARAFRAXA	0	1	0	0	0	0
	ERIN	1	1	0	1	0	0
	GUELPH	14	18	22	26	30	28
	GUELPH/ERAMOSA	1	1	1	1	1	0
	MELANCTHON	0	0	0	0	1	1
	MINTO	1	0	0	0	0	0
	MONO	1	2	0	0	0	1
	MULMUR	1	0	0	0	0	0
	ORANGEVILLE	3	10	1	3	2	4
	PUSLINCH	2	0	0	1	1	2
	SHELBURNE	0	0	0	2	0	0
	WELLINGTON NORTH	1	2	0	1	3	0
Windsor-Essex County Health Unit	AMHERSTBURG	3	1	2	2	1	3
	ESSEX	2	1	1	0	2	4
	KINGSVILLE	1	0	0	1	3	1
	LAKESHORE	1	3	2	2	4	4
	LASALLE	0	3	3	4	1	0
	LEAMINGTON	2	2	1	4	3	7
	TECUMSEH	2	1	3	0	2	1
	WINDSOR	45	40	58	71	94	106
York Region Public Health	AURORA	5	1	2	5	3	8
	EAST GWILLIMBURY	1	2	0	0	2	4
	GEORGINA	4	7	11	9	10	8
	KING	1	4	3	1	0	0
	MARKHAM	4	15	14	7	9	12
	NEWMARKET	8	9	9	12	14	17
	RICHMOND HILL	7	15	10	9	6	18
	VAUGHAN	6	7	12	20	12	12
	WHITCHURCH-STOUFFVILLE	2	2	3	2	3	0

*Data are preliminary and subject to change. Includes confirmed and probable cases.

**PHU and CSD are based primarily on location of incident.

Note:

- A CSD is a municipality or an area treated as an equivalent to a municipality for statistical purposes, assigned based on postal code.
- If a CSD is not listed, there were no opioid toxicity deaths recorded in that region over the years reported.
- Probable cases are pending conclusion on cause of death, but suspected to be drug-related and toxicology positive for opioids.

THE NEIGHBOURHOOD GROUP COMMUNITY SERVICES et al.	and	HIS MAJESTY THE KING IN RIGHT OF ONTARIO	Court File No. CV-24-00732861-0000
Applicants		Respondent	

ONTARIO
SUPERIOR COURT OF JUSTICE

Proceeding commenced at TORONTO

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TAB 9

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 LIN SALLAY

I, LIN SALLAY, of the City of Toronto, in the Province of Ontario, **MAKE OATH AND SAY:**

1. I am the Executive Director of Street Health Community Nursing Foundation (**"Street Health"**) a non-profit, community-based organization working to improve the health and wellbeing of the homeless and under-housed population in Toronto. As such I have knowledge of the matters contained 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.

A. Background Information about Street Health

2. Street Health is a registered charitable organization bearing registration number 119200541 RR 0001. It was established in 1988. Street Health is a community-based organization working to improve the health and wellbeing of the homeless and under-housed population in Toronto. It has a long history of providing a variety of services to marginalized people who use drugs and who are experiencing homelessness. For our 2024 fiscal year (April 1, 2023-March 31, 2024), Street Health had total revenues (from donation and government finding, as well as other sources) of $4,622,164.00. It spent approximately 84% of those funds ($3,889,002.00) on its delivery of its charitable programs. Although Street Health is a charitable organization, last year its expenditure exceeded its revenues.

3. Street Health operates out of a facility that is located at 338 Dundas Street East, Toronto, Ontario. This is near the Dundas-Sherbourne intersection in Toronto.

4. Out of this location, Street Health delivers a number of services. These services include (but are not limited to):

(a) **Nursing**: Street Health's Nursing team includes Registered Nurses and a Nurse Practitioner to provide low-barrier, non-judgmental primary healthcare. Our Nurse Practitioner possesses advanced education in providing addiction treatment. Clients are seen on a drop-in basis and do not require a health card. High demand services include: wound care, crisis and supportive counselling, help accessing shelters and dispensing over the counter medication. Nurses also assist clients with referrals, appointments and service coordination.

(b) **Mental health counseling/case management**: Mental Health Workers provide long-term, intensive case management support for people who are living with

mental health challenges and are either homeless or precariously housed. Clients are assigned a worker who provides support in accessing and maintaining basic needs, including: healthcare, income supports, shelter and legal assistance. Staff provide accessible and flexible support, often further reducing barriers by meeting with clients at a convenient community location.

(c) **Identification replacement and storage**: Getting and keeping identification is difficult for those who are on the street or in the shelter system. Theft and lacking a secure place to store ID mean clients often have no identification. The Identification Service helps people obtain an Ontario Health Card and, when necessary, apply for a birth certificate or proof of legal status. These documents then support an application for a social insurance number.

(d) **Harm reduction**: Harm Reduction means the policies, programs, and practices that reduce negative health, social, and economic consequences from the use of both legal and illegal drugs. All Street Health services are offered within a harm reduction framework, we meet people "where they are" and respect each client's right to self-determination. Harm reduction staff support marginalized populations who, due to stigma and discrimination, may avoid healthcare providers. The harm reduction staff run drop-ins at several locations in Moss Park to provide education, social recreation and hot meals to community members. Staff also help identify and provide advocacy concerning broader social determinants of health.

(e) **Supplies and referrals**: Street Health's Client Services is the first point of contact. Many clients require personal care, hygiene and harm reduction supplies, which are

provided free of charge upon request. This reliable source of basic necessities enables frontline staff to build relationships with clients to support information sharing and referrals to additional services, both at Street Health and at other local service providers.

(f) **Housing support:** Street Health also works in partnership with St. Clare's Multi-Faith Housing Society to provide high-quality case management and support services for 26 tenants who were formerly homeless. Staff assist clients in living successfully and independently in their own affordable housing unit. In doing so, we collaborate with 16 other onsite partner agencies. Street Health also provides onsite harm reduction services, including needle exchange, support groups and counselling.

5. Street Health is part of a partnership (the Harm Reduction Community Care Project) that retrieves discarded harm reduction equipment from private properties via a 1-800 number, email address and through a QR code. We also distribute naloxone kits and provide training on how to use naloxone to reverse opioid overdoses.

6. An additional service that Street Health provides to clients is its supervised consumption site (**"SCS"**) services. I will discuss Street Health's provision of these services in greater detail below.

B. Street Health's Provision of Supervised Consumption Services

7. Since 2018, Street Health has offered SCS services to its clients through the Street Health Overdose Prevention Site (**"OPS"**). Street Health decided to open its OPS in response to the

numerous overdoses and overdose deaths that were taking place in our neighbourhood, including in and around Moss Park, Allen Gardens, and Regent Park. Street Health's OPS is a safe, hygienic environment for people to inject pre-obtained drugs under the supervision of trained staff. We provide sterile injection supplies, education, overdose prevention and intervention, as well as referrals to services at Street Health and other agencies. The OPS also has available naloxone kits as well as training and sterile drug use equipment for its clients.

8. Street Health's OPS consists of a welcoming area and three booths wherein clients can go to consume substances. In total Street Health has 15 staff including 1 manager, 1 coordinator, 3 full time OPS workers and 10 relief staff. We open Monday, Wednesday, Thursday and Friday 9:30-4:30pm and Tuesday 11-4:30pm.

9. Staff members are responsible for operating and supervising the SCS. Clients are greeted upon entry to the Intake Area. Depending on their needs, clients are escorted to the Nursing Clinic on site or to the Consumption Room. OPS staff are situated in the Consumption Room and clients are designated to one of three booths where they can inject, snort, or orally consume their pre-obtained drugs with experienced staff ready to respond in case of an emergency. After consuming, clients can wait in the couch area in the Consumption Room, or they can return to the Intake Area. Throughout their visit, clients are constantly supported and receive care. Staff also refer clients to other services including detoxification, crisis intervention and financial support.

10. We also provide drug checking strips as a drug checking service and we are a collection site for the Toronto Drug Checking Service (**"TDCS"**). TDCS offers people who use drugs timely and detailed information on the contents of their drugs, helping them to make more informed decisions. Clients bring samples of their drugs to collection sites like Street Health, and we send

those samples to laboratories to be tested. In addition to enabling our clients to identify the contents of their own drugs and take steps to protect their health and safety, Street Health also relies on the information coming out of TCDS to help us identify and react to emerging dangers.

11. A number of other sites near Street Health also serve as collection sites for TDCS, however, as I will explain in further detail below, Street Health's understanding is that a number of these (three) will close. This means that there will be an increased demand on Street Health for this critical drug checking service. As things currently stand, we are not certain we will have the funding that would allow us to increase our capacity to meet this demand. Street Health expects that the closure of these three other sites (and Street Health's inability to make up for the increased demand) will impact (i) clients' access to drug checking services; (ii) impact access to a continuum of care usually provided during drug checking at these sites; and (iii) impact our ability as a network of clinicians, community health workers and first responders, to monitor and share information on the composition of the unregulated drug supply in Toronto.

12. At all times during operation of the OPS, Street Health held the requisite legal exemptions that allowed it to provide these services. It currently holds a Section 56.1 Exemption for Medical Purposes under the *Controlled Drugs and Substances Act* for Activities at a Supervised Consumption Site with Health Canada. This Exemption expires on March 31, 2025. Street Health has applied to renew its Exemption until March 31, 2027. Attached as **Exhibit "A"** to this affidavit is a copy of our current exemption.

13. As I noted above, Street Health's facility is located near the Dundas-Sherbourne intersection in Toronto. This is a part of the city that was hard-hit by the overdose crisis. We (Street

Health staff) were witnessing overdoses in public spaces in this part of the city, such as in alleyways, building stairwells, public washrooms, parks and in shelters and drop-in centres.

14. Given our objective is to improve the health and wellbeing of the homeless and under-housed population in our community, we saw a demand to provide SCS services in this area. That is what led us to apply for our first exemption in 2018.

15. In 2023, Street Health's OPS served 688 unique clients for 1,721 visits. The numbers were similar in 2024, with the OPS servicing 588 unique clients for 1,288 visits (not including the months of November and December). This is in addition to the many other clients that Street Health serviced to provide hygiene supplies, clothing, shelter and housing referrals (among other services).

16. In total, since the OPS opened, Street Health has reversed 330 overdoses. Between May 2020 and March 2024, our OPS gave clients 7,303 referrals to other services. This includes referrals to other low-barrier, client-centred Street Health services, such as nursing, primary healthcare, Opioid Agonist Therapy programs,[1] mental health counselling, case management, drop-in programs, ID replacement and storage. It also includes referrals to a wide network of offsite services such as shelter, detox/residential treatment, medical specialists, and dentists.

17. In terms of information regarding the individuals who have used Street Health's OPS services, the overwhelming majority of these clients are individuals who appear to Street Health staff to suffer from a substance use disorder. Although Street Health has not obtained formal

[1] Opioid agonist therapy is an effective treatment for addiction to opioid drugs such as heroin, oxycodone, hydromorphone (Dilaudid), fentanyl and Percocet. The therapy involves taking the opioid agonists methadone (Methadose) or buprenorphine (Suboxone). These medications work to prevent withdrawal and reduce cravings for opioid drugs. People who are addicted to opioid drugs can take OAT to help stabilize their lives and to reduce the harms related to their drug use.

diagnoses for these clients, this view is informed by staff's training in addressing individuals who suffer with substance use disorder as well as its observations and experiences in dealing with these clients.

18. Street Health collects some data about its clients that use its OPS services. This data shows that:

(a) Street Health's SCS supports a high number of people who identify as female. In fact, approximately 38% of the clients who access our services identify as female. The women who access our SCS have most often experienced trauma in their lives. Our female clients report feeling 'safer' at our smaller site and supported well by the high number of Street Health SCS staff who also identify as female.

(b) Approximately 10% of our clients are over the age of 60 and most of those over 60 years of age have a physical disability. Many have mobility challenges and use walkers or wheelchairs.

19. Attached as **Exhibits "B"** and **"C"** are copies of our two most recent annual reports, which track the data of the clients we have serviced.

C. The Impact of the *Community Care and Recovery Act*

20. Street Health will not be directly impacted by the *Community Care and Recovery Act* (the **"CCRA"**) in that it will not require the immediate closure of Street Health's OPS. Street Health's OPS is not within 200 metres of a school or child care facility (or any other facility that triggers application of the Act). Nor is Street Health run by a municipality or a public health board. As such, the CCRA will not require the closure of Street Health's OPS.

21. That said, Street Health is concerned that the ramifications of the CCRA will result in Street Health's OPS becoming overwhelmed by demand caused by the closure of the other Toronto-based SCSs that are expected to close. We have begun contingency planning for how we can best deal with what we expect will be a sudden increased demand for our OPS services.

i. Street Health's Review of the Data (Informing its Understanding)

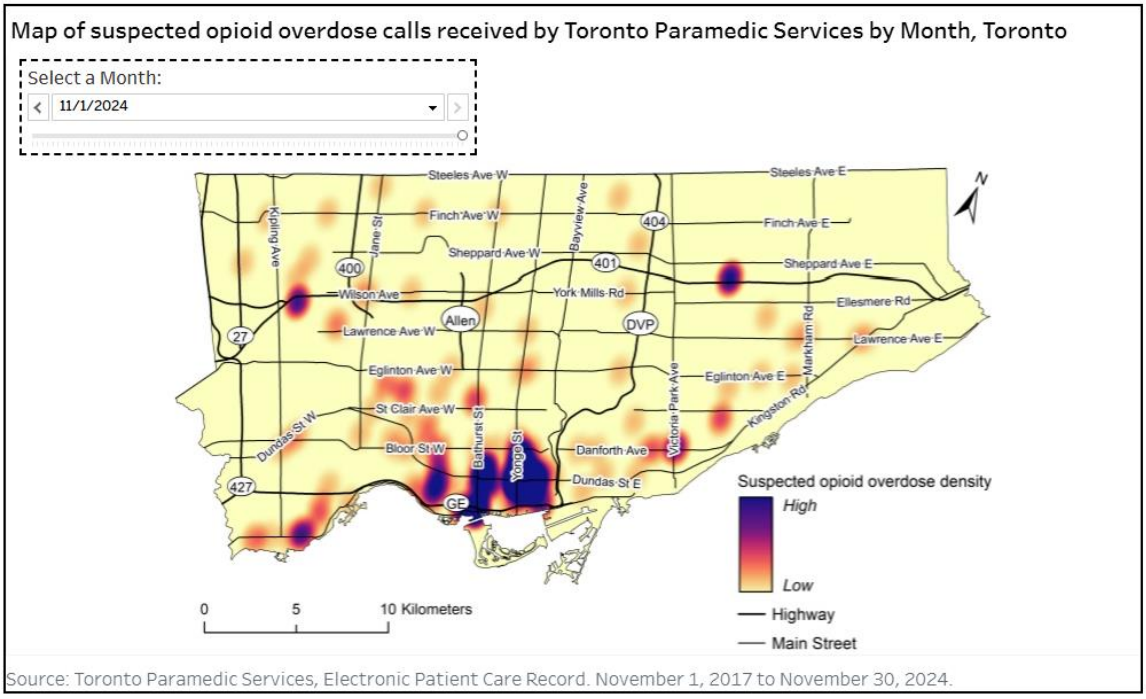
22. Our review of publicly available data suggests that the greatest demand for SCS services in Toronto, in general, is in the downtown area.

23. For example, in preparing for a post-CCRA world, we have been reviewing data from Toronto Paramedic Services that shows that the overwhelming majority of suspected overdose calls occur in the downtown area. For instance, the below is a heat map that we obtained from Toronto Paramedic Services that shows where paramedics made contact with patients for suspected opioid overdose calls in Toronto in November 2024. This map is publicly available at the following site: Toronto Overdose Information System | Tableau Public.

24. This map is part of the research we have undertaken to deal with a post-CCRA world. It shows that the majority of suspected overdose calls occurred in downtown Toronto, all near by Street Health's OPS. In fact, Street Health's OPS is almost directly in the middle of the largest heat blob on this map:

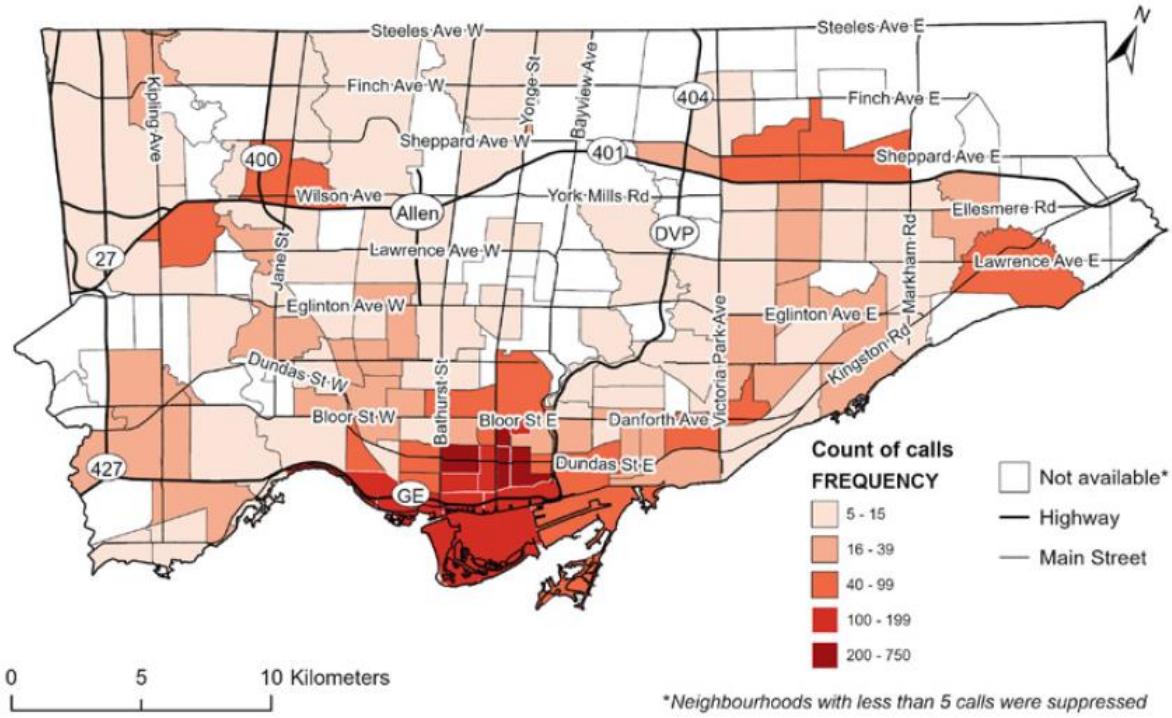
Locations

The map shows the distribution of suspected opioid overdose calls received by Toronto Paramedic Services. It includes all suspected opioid overdose calls (non-fatal and fatal). The map shows the locations where paramedics made contact with patients. Please see the Technical Notes tab for more information.



25. Data that we have reviewed from Toronto Public Health tells a similar story. This data again shows a high call volume related to overdoses in the downtown area, including the area that is nearby Street Health's facilities. Below is a map that we obtained from Toronto Public Health that shows the number of overdose calls by neighbourhood in Toronto:

Figure 1: Map of suspected opioid overdose calls by neighbourhood, Toronto, July 1, 2023 to June 30, 2024.



26. Attached as **Exhibit "D"** is a copy of the report from which we obtained this map.

27. Currently, this area is being serviced by Street Health, as well as three other SCSs that are within 3 kilometres of Street Health that Street Health anticipates will close because of the CCRA (either directly or indirectly):[2]

(a) Regent Park Community Health Centre, located at 465 Dundas Street East (which is 350 metres from Street Heath);

[2] To be clear, there two other SCSs within 3km of Street Health that are not expected to close as a result of the CCRA (Fred Victor SCS and Casey House). Casey House is primarily a hospital-based SCS that is available to outpatient and inpatient clients, rather than the general public.

(b) Toronto Public Health's The Works, located at 277 Victoria Street (which is 850m from Street Health); and

(c) South Riverdale Community Health Centre's KeepSix SCS, located at 955 Queen Street East (which is approximately 2.9km from Street Health).

28. These three SCSs will be closed as a direct result of the CCRA. I understand from Sarah Greig, Director of Substance Use and Mental Health for South Riverdale Community Health Centre, that the lease for its Moss Park CTS will be expiring soon and will be changed to month-to-month because there is a prospect that the property will be redeveloped to create condominiums. As such, there is a real risk this SCS will need to relocate in the near to medium future. In this current environment it is not clear where (or even whether) it could relocate.

29. As such, Street Health's OPS will be operating in an area that will have lost the services of three SCSs (and potentially a fourth, though that is not certain). This is all in an area that the data suggests is one of the hardest hit in Toronto by suspected opioid overdoses.

30. Even taking into account the research that suggests that people who use drugs will only travel 500m to a SCS, Street Health is preparing for the probability that some users of these other three SCSs that are about to close will come to Street Health's OPS. Below, I discuss these measures that we are taking in further detail.

ii. Street Health's Expectations of Being Overrun and its Contingency Planning

31. Street Health has limited funding and limited space. Given these restrictions, we estimate that we can only accommodate an approximate 10-20% capacity increase. We expect that the

demand that we will get for our services as a result of the three above-noted SCSs closing down will far outstrip this capacity.

32. We have begun contingency planning to assess how Street Health can respond to a post-CCRA world. Part of that planning included a review of publicly available literature regarding the number of clients serviced by Regent Park, The Works and KeepSix SCSs (*i.e.*, the SCSs in proximity to our OPS that will close down). This literature demonstrates to us that these other sites are much larger than Street Health and service a far greater number of clients than we do. For example, the Centre on Drug Policy Evaluation published a report that we reviewed which summarized this data, and which demonstrated the disparity between the capacity of Street Health and these other sites. Namely, the report contained a chart with the following data regarding the number of visits and unique clients these clinics serviced from March 2020 to May 2024:

Site	Visits	Unique Clients	Referrals	Non-fatal overdoses
Street Health	7,945	3,132	7,303	223
Regent Park	22,960	6,529	11,740	382
The Works	71,092	17,113	4,945	2,478
KeepSix	45,078	6,139	9,146	1,032

33. Attached as **Exhibit "E"** to this affidavit is a copy of this report from the Centre on Drug Policy Evaluation.

34. As the above chart demonstrates, the sites that are nearby Street Health which are closing range from being three times as big as Street Health (Regent Park) to being almost ten times as big

(The Works) (from the perspective of number of visits). In total, these three SCSs serviced 32,913 clients—more than ten times the amount that Street Health serviced during the same time period.

35. We are expecting that the clients that are closest to Street Health that formerly attended one of these other SCSs will now attempt to use the services of our OPS. However, given the deluge of clients that we are expecting, we are concerned that we will be overwhelmed. We are taking some steps to try to deal with this. For example:

(a) We foresee needing to increase our hours of operation to extend into the evening and perhaps on weekends to meet the demand.

(b) We also see the need to hire 2-3 more staff ($82,000/annually with salary and benefits) to support community members who use drugs, monitor client flow at our building, provide life-saving responses as needed and refer clients to services both on and off-site.

(c) We are also considering opening a fourth booth at our site, but this would require approval from Health Canada and would need to be supported financially for renovations and 1 additional SCS staff per day ($82,000 for salary and benefits).

(d) These steps will require access to funds that we currently do not have. As such, we will have meetings with the Ministry of Health in mid and late January 2025 to discuss the impact of closures and to seek funding in order to respond to the increased demand.

(e) We have also launched a campaign to raise increased funds, given Street Health's OPS operates solely through donations, and we are speaking at a public meeting

"Sites Save Lives" on January 13, 2025 to raise awareness, speak to the public about these challenges and seek financial support.

36. That said, we do not expect that any of these steps will ultimately suffice. There is a limit as to how much Street Health can do in the face of this massive gap in services for a marginalized group.

37. As a result, we expect to have queues of people lined up outside the doors of our OPS. Currently, we have almost never had a line-up outside of our OPS of people waiting to access those services, but with our present staffing and space limitations this is likely to occur if there is a significant increase in demand. Given what will likely be long wait lines, we also expect that some clients will use their drugs outside our building in public. We expect that all staff, including our Nurses, Nurse Practitioner, ID Workers and Front Desk/Reception staff will need to deal with an increased number of overdoses onsite and be ready to respond by providing naloxone treatment and calling Emergency Medical Services.

38. We expect an increase in the number of people in our community who will die due to the closures. This itself will take a significant toll on our staff, who ultimately make our services possible. As such, we are taking the following steps:

(a) We are working with two private grief counsellors and therapists in order to offer support and counselling to our staff.

(b) We are looking to increase our Employee Assistance Plan for staff support which, if possible, will also result in additional costs to Street Health.

(c) We are planning workshops for staff related to resiliency, given that our staff are already experiencing a high amount of compassion fatigue, burnout and stress due to drug toxicity crisis.

(d) We also plan to offer grief service and counselling to community members in our area at the 3 weekly drop-in programs we operate.

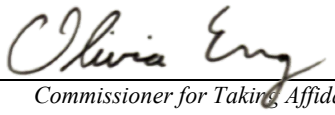
SWORN REMOTELY by Lin Sallay of the City of Toronto, in the Province of Ontario, before me at the City of Toronto, in the Province of Ontario, on January 9, 2025, in accordance with O. Reg. 431/20, Administering Oath or Declaration Remotely.

Commissioner for Taking Affidavits
(or as may be)

Olivia Eng (84895P)

LIN SALLAY

This is Exhibit “A” referred to in the Affidavit
of Lin Sallay sworn January 9, 2025.



Commissioner for Taking Affidavits

Health Canada Santé Canada

Address Locator 0300B
Ottawa ON K1A 0K9

2024-07-12

24-105206-831
HC6-53-139-57

Lin Sallay
Executive Director
Street Health
338 Dundas St E
Toronto ON M5A 2A1

Lin Sallay:

In response to your request for an exemption from the *Controlled Drugs and Substances Act* (CDSA) to operate a supervised consumption site at the Street Health, we would like to inform you that an exemption is being granted to you pursuant to section 56.1 of the CDSA. This letter authorizes the exemption for the Street Health Site, and sets out the terms and conditions that must be followed. This exemption replaces the one that was issued to Jann Houston on March 22, 2024.

The following definitions apply to this exemption:

"Alternate responsible person in charge" means any person, designated by the applicant, who is responsible, when the responsible person in charge is absent from the supervised consumption site, for ensuring that every person or class of persons who is exempted for a medical purpose under subsection 56.1(1) from the application of all or any of the provisions of the CDSA complies with the terms and conditions specified by the Minister in the exemption when they are at the Site;

"Client" means an individual who is at the Site to consume illegal substances by self-injection, oral or intranasal means, to have substances administered by a peer and/or to receive other services;

"Designated criminal offence" means

(a) an offence involving the financing of terrorism against any of sections 83.02 to 83.04 of the *Criminal Code*;
(b) an offence involving fraud against any of sections 380 to 382 of the *Criminal Code*;
(c) the offence of laundering proceeds of crime against section 462.31 of the *Criminal Code*;
(d) an offence involving a criminal organization against any of sections 467.11 to 467.13 of the *Criminal Code*; or

(e) a conspiracy or an attempt to commit, being accessory after the fact in relation to, or any counselling in relation to an offence referred to in any of paragraphs (a) to (d);

“Designated substance offence” means
(a) an offence under part I of the CDSA, except subsection 4(1), or
(b) a conspiracy or an attempt to commit, being an accessory after the fact in relation to, or any counselling in relation to, an offence referred to in paragraph (a);

“Drug checking” means a service where substances, which may be illegal substances, are tested at the Site, or offsite by a Health Canada laboratory, licensed dealer, section 56.1 exemption holder or subsection 56(1) exemption holder, to determine their purity and/or content;

“Health Canada laboratory” means any analytical laboratory operated by Health Canada;

“Illegal substance” means a controlled substance or precursor that is obtained in a manner not authorized under the CDSA or its regulations;

“Key staff member” means any person, designated by the applicant, who is responsible for the direct supervision, at the supervised consumption site, of the consumption of an illegal substance by a client;

“Licensed dealer” means the holder of a valid controlled substances dealer’s licence issued under the *Narcotic Control Regulations*, the *Benzodiazepines and Other Targeted Substances Regulations*, *Part G* of the *Food and Drug Regulations*, and/or *Part J* of the *Food and Drug Regulations*;

“Minister” means the federal Minister of Mental Health and Addictions and Associate Minister of Health;

“OCS” means the Office of Controlled Substances, Controlled Substances and Overdose Response Directorate, Health Canada;

“Peer” means an individual who is not the responsible person in charge, an alternate responsible person in charge, a key staff member or a staff member, and is identified by a client to provide said client with peer assistance at the Site;

“Peer assistance” means the activities of a peer preparing illegal substances for a client and the administration of illegal substances by a peer to a client;

"Responsible person in charge" means the person, designated by the applicant, who is responsible, when the person is at the supervised consumption site, for ensuring that every person or class of persons who is exempted for a medical purpose under subsection 56.1(1) from the application of all or any of the provisions of the CDSA complies with the terms and conditions specified by the Minister in the exemption when they are at the Site;

"Section 56.1 exemption holder" means the holder of a valid section 56.1 exemption authorizing activities, including drug checking, at a supervised consumption site;

"Site" means the premises located within the Coach House at 338 Dundas Street E, Toronto, Ontario;

"Staff member" means an individual employed by or under contract with the Street Health to work at the Site, an individual employed by or under contract with the St. Michael's Hospital for the purposes of drug checking at the Site, or a courier service and its employees under contract with the St. Michael's Hospital to transport drug checking samples to or from the Site for the purpose of drug checking; and

"Subsection 56(1) exemption holder" means the holder of a valid subsection 56(1) exemption authorizing drug checking activities involving illegal substances.

Scope

This authority is being exercised pursuant to section 56.1 of the CDSA. The following classes of persons are hereby exempted for a medical purpose as set out below to engage in certain activities in relation to an illegal substance within a supervised and controlled environment as specified below:

- The Responsible Person in Charge (RPIC), Alternate Responsible Persons in Charge (A/RPICs), key staff members and all staff members are exempted, while they are within the interior boundaries of the Site, from the application of subsection 4(1) of the CDSA with respect to any illegal substance in the possession of a client or a peer, or that is left behind by a client or a peer within the interior boundaries of the Site, if such possession is to fulfill their functions and duties in connection with the operation of the Site;

- The RPIC, A/RPICs, key staff members and all staff members are exempted, while they are within the interior boundaries of the Site, or during transport from the Site to a Health Canada laboratory, licensed dealer, section 56.1 exemption holder or subsection 56(1) exemption holder, from the following provisions of the CDSA and its regulations when possessing, producing, transferring or transporting for the purposes of drug checking or disposal, any illegal substance in the possession of a client or a peer, or that is left behind by a client or a peer within the interior boundaries of the Site:

    a. subsections 4(1), 5(1), 5(2) and 7(1) of the CDSA, and
    b. subsections 6(1) and 6(2) of the *Precursor Control Regulations* (PCR);

- Clients are exempted, while they are within the interior boundaries of the Site, from the application of subsections 4(1) and 7(1) of the CDSA with respect to an illegal substance, if possession or production of the illegal substance is for the purposes of self-injection, oral or intranasal consumption by the client;

- Clients are exempted, while they are within the interior boundaries of the Site, from the following provisions of the CDSA and its regulations when possessing, producing or transferring an illegal substance for the purposes of drug checking, disposal or peer assistance:

    a. subsections 4(1), 5(1), 5(2) and 7(1) of the CDSA, and
    b. subsections 6(1) and 6(2) of the PCR;

- Peers are exempted, while they are within the interior boundaries of the Site, from the following provisions of the CDSA and its regulations when possessing, producing, transferring or administering an illegal substance for the purposes of drug checking, disposal or peer assistance:

    a. subsections 4(1), 5(1), 5(2) and 7(1) of the CDSA, and
    b. subsections 6(1) and 6(2) of the PCR.

Suspension Without Notice

A suspension without prior notice may be ordered if the Minister or their designate under section 56.1 deems that such a suspension is necessary to protect public health, safety or security including, without limiting the generality of the foregoing, to prevent controlled substances from being trafficked or otherwise diverted within or from the Site for illegal purposes.

Revocation

This exemption may be revoked if the Street Health or any staff member of the Site has contravened any of the terms and conditions set out in this document. Please note that such a contravention may, in some cases, also constitute an offence under the CDSA.

Duration

The exemption expires on the earliest of the following dates:

- March 31, 2025; or
- the date on which the exemption is revoked.

Other Terms and Conditions

(1) The Street Health must inform and train the RPIC, A/RPICs, key staff members and all staff members on their roles and responsibilities;

(2) The RPIC, A/RPICs, key staff members and all staff members must follow the Site's policies and procedures, including those regarding peer assistance and drug checking;

(3) The RPIC, A/RPICs, key staff members and all staff members may only possess, produce, transfer or transport illegal substances for the purposes of drug checking or disposal;

(4) The RPIC, A/RPICs, key staff members and all staff members may only transfer an illegal substance for the purposes of drug checking or disposal to the RPIC, an A/RPIC, a key staff member or other staff member of the Site;

(5) The RPIC, A/RPICs, key staff members and all staff members may only transport and transfer an illegal substance from the Site to a Health Canada laboratory, licensed dealer, section 56.1 exemption holder or subsection 56(1) exemption holder, if the transport and transfer is for the purposes of drug checking;

(6) The RPIC, A/RPICs, key staff members and all staff members may only accept an illegal substance for the purposes of drug checking from a client or a peer, or that is transported from a Health Canada laboratory, a licensed dealer, a section 56.1 exemption holder or a subsection 56(1) exemption holder, for the purposes of drug checking at the Site;

(7) Only clients who are properly enrolled, or peers who have been identified as per the Site's policies and procedures with respect to peer assistance, may have access to the areas of the Site where supervised consumption services and drug checking services occur;

(8) Only clients who are properly enrolled, or peers who have been identified as per the Site's policies and procedures with respect to peer assistance, may possess, produce or transfer illegal substances for the purposes of drug checking, disposal or peer assistance;

(9) Clients or peers may only transfer an illegal substance for the purposes of drug checking or disposal to the RPIC, an A/RPIC, a key staff member or other staff member of the Site;

(10) Clients may only transfer an illegal substance to the individual identified as their peer, and the transfer may only be for the purposes of drug checking or peer assistance;

(11) Peers may only transfer an illegal substance to a client who has identified them as their peer, and the transfer may only be for the purposes of peer assistance;

(12) Only peers may administer an illegal substance for the purposes of peer assistance;

(13) Peer assistance within the Site cannot involve any exchanges for financial compensation, goods or services;

(14) The RPIC, or in their absence an A/RPIC, must be present at the Site at all times to oversee the operation of the supervised consumption site services;

(15) The RPIC must have a valid criminal record check. The criminal record check must be a document issued by a Canadian police force in relation to the RPIC, stating whether, in the 10 years before the day on which the application was made, the person was convicted as an adult in respect of a designated substance offence or a designated criminal offence. If the RPIC has ordinarily resided in a country other than Canada in the 10 years before the day on which the application was made, a document issued by a police force of that country stating whether in that period the person was convicted as an adult for an offence committed in that country that, if committed in Canada, would have constituted a designated substance offence or a designated criminal offence must be submitted to the OCS;

(16) A new RPIC may not work at the Site without the Street Health having obtained and submitted a valid criminal record check to the OCS;

(17) Where the RPIC is found guilty of a designated substance offence or a designated criminal offence, the Street Health must advise the OCS, and that person will no longer be covered by the exemption;

(18) The RPIC, or in their absence an A/RPIC, must take necessary precautions to prevent drug trafficking within the Site, including having staff members draw to the attention of clients the *Community Guidelines*, which prohibits the dealing, exchanging or passing of illegal substances, unless for the purposes of drug checking, disposal or peer assistance as authorized under this exemption, and must remove from the Site any client caught attempting to traffic or trafficking an illegal substance;

(19) The RPIC, or in their absence an A/RPIC, must be notified of an incident of any amount of 'unidentified substance' that may be an illegal substance that has been left behind by clients or peers. The substance must be placed in a bag or envelope that is sealed, dated and signed by a staff member. The staff member must then place the bag or envelope in a safe, fill out an *Unknown Substances Left Behind Form,* and log tracking information in the Site's *Unknown Substance Left Behind Log*. The RPIC, or in their absence an A/RPIC, must notify the Toronto Police Service (TPS) within 24 hours of the occurrence. When the bag or envelope containing the substance is picked up for disposal by the TPS, it must be logged out by the police officer;

(20) In the event of loss or theft of illegal substances left behind by clients or peers, the RPIC, or in their absence an A/RPIC, must notify the TPS immediately and the OCS within 24 hours of the occurrence. The RPIC, or in their absence an A/RPIC, must maintain a record of losses and thefts of illegal substances left behind by clients or peers;

(21) The return of used or contaminated syringes, needles and other consumption equipment and supplies must be supervised by the RPIC, an A/RPIC or a key staff member and managed safely as per Street Health procedures;

(22) The security system intended to provide physical security at the Site must be operational at all times, and access to the Site and to various rooms within the Site must be controlled, as submitted in your application. The RPIC, or in their absence an A/RPIC, must ensure that a record of entry and exit from the consumption room is maintained for all clients and visitors;

(23) The Street Health must notify the OCS of changes affecting the security, physical layout of the Site or resources available to support the maintenance of the Site, and provide the OCS with a copy of the revised policies and procedures no later than 10 working days following the effective date of the changes;

(24) All records or other information required to be kept under this exemption must be maintained at the Site for the duration of the exemption and made available to Health Canada upon request;

(25) The Street Health must notify the OCS within 24 hours in the event of a death related to activities involving illegal substances at the Site;

(26) The Street Health must notify the OCS within 48 hours should the Site be closed permanently, or for longer than 24 hours;

(27) The Street Health must notify the OCS within 48 hours should the Site no longer allow for peer assistance or provide drug checking services;

(28) The Street Health must continue to maintain engagement with the community and other service providers impacted by the Site. This engagement must include outreach to organizations such as school boards, childcare providers, business associations and other local community groups. Any concerns raised must be documented and where appropriate, the Street Health must implement relevant mitigation strategies in response to concerns raised;

(29) In accordance with any applicable privacy laws, the Street Health will provide the Minister, upon request, with access to any relevant data gathered or collected related to the Site, including data regarding peer assistance and drug checking; and

(30) The Street Health must provide a report every month to the OCS summarizing the activities undertaken and clients served at the Site, the impact of the services on the clients and the community, and any other information related to the services offered. The report must be submitted monthly (by the 15th of each month) to exemption@hc-sc.gc.ca and should include, but is not limited to:

- the total number of visits and total number of consumption visits;
- the number of total visits that involved peer assistance;
- the number of unique clients and number of new clients per month;
- the number of unique clients that received peer assistance per month;
- the general demographics of the clients and peers served, such as age and gender;
- the number of referrals to other health and social services within the Site, onsite and offsite;
- the number of overdoses/drug emergencies (fatal, non-fatal, and requiring naloxone administration) at the Site per month;
- the number of overdoses/drug emergencies that occurred following peer assistance;
- the number of service calls made to law enforcement and to emergency medical services;
- the percentage of the most prevalent drugs used at the Site according to the client;
- the number of drug checks performed at the Site;
- the results of drug checking performed at the Site, including whether the substances identified were as expected, or inconclusive;
- if known, whether the results of the drug checking influenced the client's decision to consume the illegal substance;
- the number of illegal substance samples sent offsite for drug checking; and

- if known, the results of drug checks conducted offsite, including whether the substances identified were as expected, or inconclusive, for any substances that resulted in a client overdose/drug emergency at the Site.

Should it be necessary to change the terms and conditions, you will be informed in writing and a reason for the change will be provided.

Please note that it is recommended that you establish a mechanism to collect information required for subsequent applications, as set out in subsection 56.1(3) of the CDSA, including any information related to the public health impacts of the activities at the Site, and as described in subsection 56.1(3).

It is your responsibility to verify that the operation of the supervised consumption services at the Site is, and continues to be, in compliance with other applicable federal, provincial and municipal legislation to maintain public health and public safety.

Finally, the OCS welcomes receiving any information you feel pertinent to your exemption throughout its validity period. We are available to answer questions on any aspect of your exemption, and look forward to working with you to assist in the continued legal operation of your endeavour.

Sincerely,

Carol Anne Chénard
A/Director General
Controlled Substances and
Overdose Response Directorate
Health Canada

Attachment

Record of approved RPIC on date of July 12, 2024
Street Health

RPIC (Responsible Person in Charge)

Kelly White

This is Exhibit “B” referred to in the Affidavit
of Lin Sallay sworn January 9, 2025.

Commissioner for Taking Affidavits

2023	Jan 2023	Feb 2023	Mar 2023	April 2023	May 2023	June 2023	July 2023	Aug 2023	Sept 2023	Oct 2023	Nov 2023	Dec 2023	Total
Total Number of Visits	110	122	144	131	138	211	248	221		143	148	105	
Visits for Consumption	148	203	187	163	196	261	294	252		173	212	131	
Unique Clients	54	57	66	57	46	84	76	47		69	76	56	
New Clients	10	6	10	3	9	9	8	8		13	12	4	
Gender Report													
Male	53	65	68	81	69	123	51	29		39	44	37	
Female	53	49	56	41	58	77	24	18		29	32	19	
Other	4	8	20	9	9	11	1	0		1	0	0	
Number of clients in each age range per visit													
Under 20	0	0	0	0	0	1	0	0		0	0	0	
20-29	21	10	21	8	18	33	9	5		7	3	1	
30-39	34	43	46	54	71	86	30	17		22	30	21	
40-49	30	40	42	36	28	36	19	13		22	26	24	
50-59	6	6	14	19	10	34	10	9		11	9	6	
60+	19	23	21	14	9	21	8	3		7	8	4	
Unknown/not specified	0	0	0	0	0	0	0	0		0	0	0	
Overdose Events													
Non-Fatal Overdoses	2	1	3	0	2	5	4	3		1	5	1	
Fatal	0	0	0	0	0	0	0	0		0	0	0	
Number of overdose events requiring naloxone	2	0	1	0	1	0	0	0		0	2	0	
EMS services called	0	0	0	0	0	0	1	0		0	2	0	
Other medical emergencies	2	0	0	0	0	0	0	0		0	0	0	
Law enforcement calls	0	0	0	0	0	0	0	0		0	0	0	
Referral Information													
Referrals to services provided within the SCS	76	80	113	99	122	124	169	149		119	100	67	
Referrals to onsite services (outside SCS – ie. Nursing, Primary Care, ID, Etc.	12	17	19	20	25	29	31	25		17	16	5	

Referrals to services provided offsite	4	1	1	0	4	1	2	1		2	1	3	
Drugs consumed by visit													
Cocaine	0	5	2	1	4	14	17	17		7	12	4	
Crack	0	3	2	8	7	13	16	2		4	2	9	
Methamphetamine	29	17	27	12	30	26	34	18		15	13	17	
Amphetamine	0	0	0	0	0	0	0	0		0	0	0	
Heroin	1	0	0	1	2	0	0	1		0	1	2	
Fentanyl	**66**	**66**	**73**	**91**	**92**	**168**	**193**	**159**		94	114	57	
Oxycontin/oxycodone	13	11	10	9	5	11	12	11		6	3	3	
Morphine	0	2	0	0	0	0	0	0		0	0	0	
Hydromorphone/Dilaudid	5	23	34	13	12	4	7	6		12	14	11	
Unspecified opioid	0	0	0	0	0	0	0	0		0	0	0	
Speedball	1	0	1	0	0	28	33	16		13	2	5	
Other substances	1	2	1	1	0	2	1	3		1	1	3	
Unknown/not specified	1	2	2	1	0	1	0	0		9	0	3	

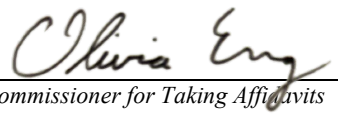
This is Exhibit “C” referred to in the Affidavit
of Lin Sallay sworn January 9, 2025.

Commissioner for Taking Affidavits

2024	Jan 2024	Feb 2024	Mar 2024	April 2024	May 2024	June 2024	July 2024	Aug 2024	Sept 2024	Oct 2024	Nov 2024	Dec 2024	Total
Total Number of Visits	134	113	100	105	108	159	149	142	116	162			
Visits for Consumption	159	113	100	105	108	159	149	139	116	161			
Unique Clients	67	55	50	49	57	49	74	63	53	60			
New Clients	14	4	8	9	7	10	5	1	2	4			
Gender Report													
Male	42	35	40	25	32	23	38	35	28	31			
Female	23	19	10	23	25	1	35	28	23	26			
Other	2	1	0	1	0	2	1	0	2	3			
Number of clients in each age range per visit													
Under 20	0	0	0	0	0	0	0	0	0	0	0	0	
20-29	6	3	4	8	3	6	5	3	2	3			
30-39	25	19	23	12	14	19	30	29	19	29			
40-49	23	19	9	15	22	16	19	20	19	17			
50-59	5	8	9	9	13	4	12	9	6	6			
60+	8	6	5	5	5	4	8	2	6	5			
Unknown/not specified	0	0	0	0	0	0	0	0	1	0	0	0	
Overdose Events													
Non-Fatal Overdoses	1	3	5	5	5	9	3	4	5	2			
Fatal	0	0	0	0	0	0	0	0	0	0	0	0	
Number of overdose events requiring naloxone	0	0	4	2	1	1	0	0	4	0			
EMS services called	0	0	0	3	0	0	0	0	1	1			
Other medical emergencies	0	0	0	0	0	0	0	0	0	0			
Law enforcement calls	0	0	0	0	0	0	0	0	0	0			
Referral Information													
Referrals to services provided within the SCS	101	88	91	87	109	139	165	108	93	161			
Referrals to onsite services (outside SCS – ie. Nursing, Primary Care, ID, Etc.	12	11	12	15	7	29	41	11	10	20			

Referrals to services provided offsite	5	6	1	4	6	6	7	7	2	6			
Drugs consumed by visit													
Cocaine	13	9	3	5	7	10	3	1	12				
Crack	2	4	2	1	0	1	9	32	0				
Methamphetamine	12	10	16	13	6	7	11	5	13				
Amphetamine	0	0	0	0	0	0	0	0	0				
Heroin	1	1	0	0	0	0	0	0	0				
Fentanyl	99	93	74	78	93	141	132	132	96				
Oxycontin/oxycodone	2	0	2	1	1	1	1	0	0				
Morphine	3	0	0	0	0	0	0	0	0				
Hydromorphone/Dilaudid	11	2	2	6	6	1	1	1	1				
Unspecified opioid	0	0	0	2	0	0	0	0	0				
Speedball	2	2	0	9	1	5	0	0	1				
Other substances	1	0	5	0	1	0	4	0	1				
Unknown/not specified	2	1	0	0	0	0	2	1	1				

This is Exhibit “D” referred to in the Affidavit
of Lin Sallay sworn January 9, 2025.



Commissioner for Taking Affidavits

Calls to Paramedic Services for Suspected Opioid Overdoses Geographic Information

July 2024

Updated: October 2024

Prepared by: Toronto Public Health

Key Messages

Data from Toronto Paramedic Services show that the highest concentration of calls for suspected opioid overdoses between **July 1, 2023 and June 30, 2024** were in the downtown area. The top five neighbourhoods and nine of the top ten main intersections with the highest number of calls were bounded roughly by Roncesvalles Avenue to the West, Bloor Street to the North, Don Valley Parkway to the East, and Lake Ontario to the south.

They also responded to a higher volume of calls in multiple neighborhoods surrounding the downtown core and parts of Scarborough. However, Figure 1 shows that Toronto Paramedic Services attended suspected opioid overdose calls across the entire city.

Please review the Data Notes section for more information on the Toronto Overdose Information System.

Important update regarding City of Toronto neighbourhoods

Effective April 12, 2022, Toronto's social planning neighbourhoods have changed from 140 neighbourhoods to 158. The subsequent map and table of suspected opioid overdose calls received by Toronto Paramedic Services by neighbourhood reflects this change.

For more information, please visit the About Toronto Neighbourhoods webpage.

Data Source

Toronto Paramedic Services. Electronic Patient Care Record. 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 provided in this document includes only instances where 911 is called and likely underestimates the true number of overdoses in the community.
- 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 information in this report 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.

- The location refers to where paramedics made contact with patients, which may or may not be the same location 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.
- Where applicable, calls have been aggregated to the nearest main intersection, as defined by the City of Toronto. Note that in areas of the City where main intersections are further apart, location of calls might be less exact compared to areas of the downtown core where main intersections are closer together.
- Information on neighbourhoods and intersections with less than five calls over the one-year period were suppressed to prevent identification of individuals.

For more information and/or clarification for any of the following maps or tables, please contact edau@toronto.ca.

Calls to Paramedic Services for Suspected Opioid Overdoses - Geographic Information
Toronto Public Health
July 2024

Figure 1: Map of suspected opioid overdose calls by neighbourhood, Toronto, July 1, 2023 to June 30, 2024

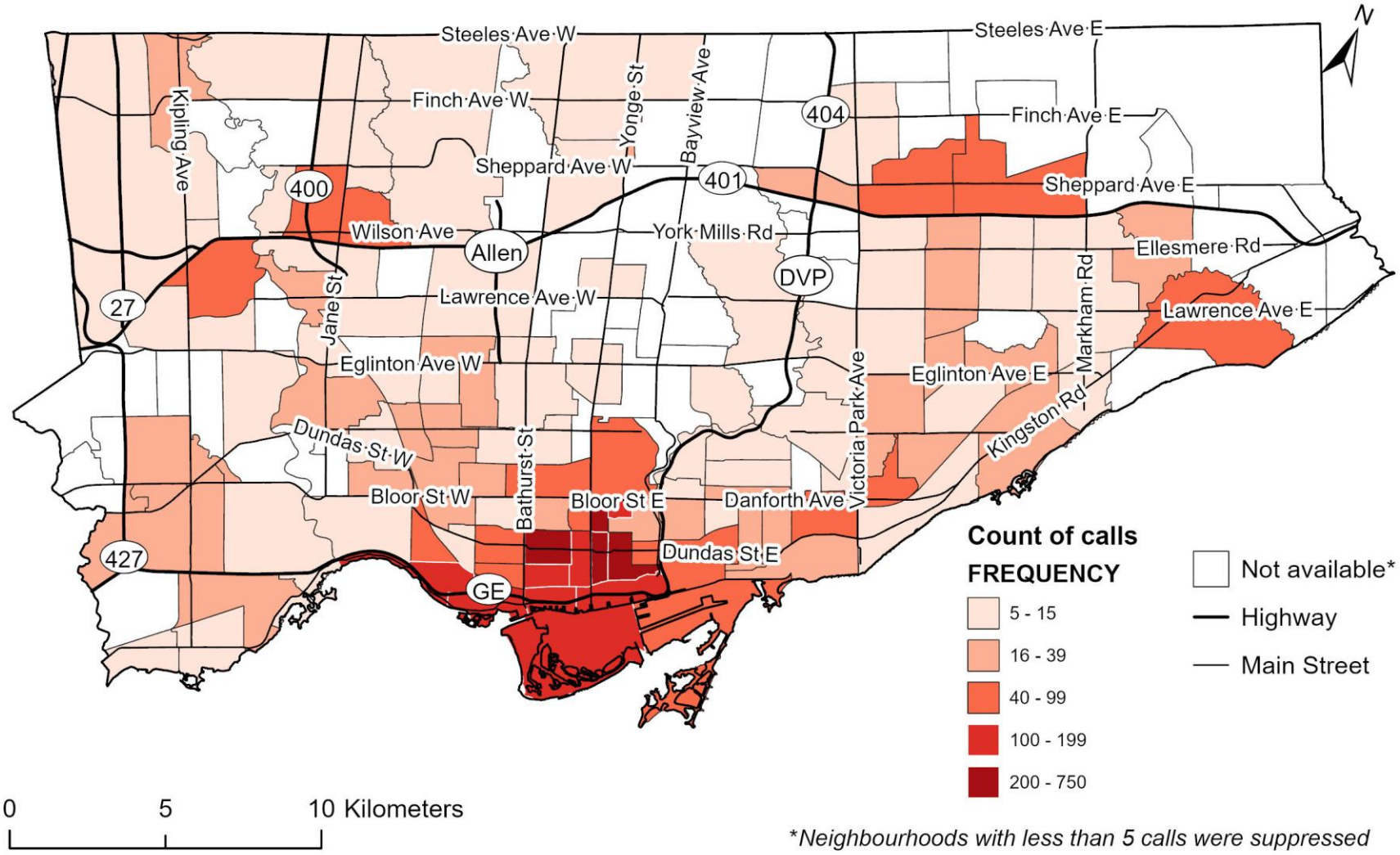


Table of suspected opioid overdose calls by neighbourhood*, Toronto, July 1, 2023 to June 30, 2024

Neighbourhood Number	Neighbourhood Name	Number of calls	Neighbourhood Number	Neighbourhood Name	Number of calls
168	Downtown Yonge East	743	84	Little Portugal	15
73	Moss Park	648	67	Playter Estates-Danforth	15
167	Church-Wellesley	220	174	South Eglinton-Davisville	15
78	Kensington-Chinatown	220	119	Wexford/Maryvale	15
170	Yonge-Bay Corridor	181	31	Yorkdale-Glen Park	15
85	South Parkdale	157	122	Birchcliffe-Cliffside	14
165	Harbourfront-CityPlace	124	69	Blake-Jones	14
163	Fort York-Liberty Village	115	18	New Toronto	14
164	Wellington Place	108	36	Newtonbrook West	14
166	St Lawrence-East Bayfront-The Islands	107	139	Scarborough Village	14
74	North St.James Town	100	155	Downsview	13
95	Annex	85	25	Glenfield-Jane Heights	13
154	Oakdale-Beverley Heights	79	80	Palmerston-Little Italy	13
128	Agincourt South-Malvern West	75	1	West Humber-Clairville	13
70	South Riverdale	63	90	Junction Area	12
6	Kingsview Village-The Westway	61	173	North Toronto	12
162	West Queen West	60	100	Yonge-Eglinton	12
121	Oakridge	57	23	Pelmo Park-Humberlea	11
98	Rosedale-Moore Park	57	94	Wychwood	11
81	Trinity-Bellwoods	52	42	Banbury-Don Mills	10
72	Regent Park	48	24	Black Creek	10
136	West Hill	46	106	Humewood-Cedarvale	10
118	Tam O'Shanter-Sullivan	44	61	Taylor-Massey	10
62	East End-Danforth	43	43	Victoria Village	10
86	Roncesvalles	42	161	Humber Bay Shores	9
169	Bay-Cloverhill	41	142	Woburn North	9
71	Cabbagetown-South St.James Town	39	96	Casa Loma	8
79	University	36	32	Englemount-Lawrence	8
171	Junction-Wallace Emerson	33	141	Golfdale-Cedarbrae-Woburn	8

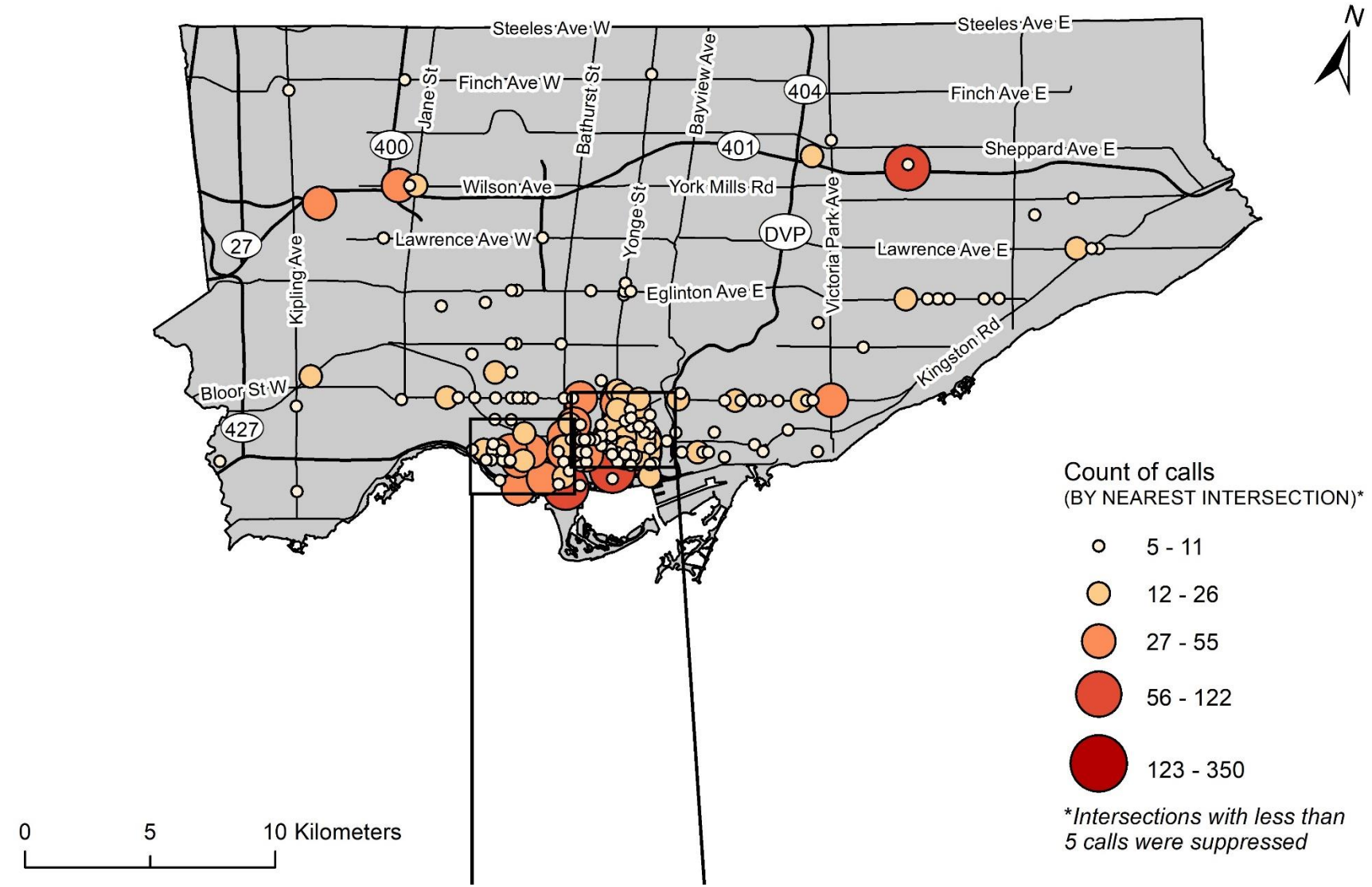
Calls to Paramedic Services for Suspected Opioid Overdoses - Geographic Information
Toronto Public Health
July 2024

Neighbourhood Number	Neighbourhood Name	Number of calls	Neighbourhood Number	Neighbourhood Name	Number of calls
172	Dovercourt Village	31	115	Mount Dennis	8
66	Danforth	29	50	Newtonbrook East	8
88	High Park North	28	37	Willowdale West	8
160	Mimico-Queensway	26	27	York University Heights	8
107	Oakwood Village	26	30	Brookhaven-Amesbury	7
138	Eglinton East	25	109	Caledonia-Fairbank	7
113	Weston	25	102	Forest Hill North	7
83	Dufferin Grove	24	147	L'Amoreaux West	7
159	Etobicoke City Centre	23	28	Rustic	7
53	Henry Farm	23	16	Stonegate-Queensway	7
64	Woodbine Corridor	23	156	Bendale-Glen Andrew	6
65	Greenwood-Coxwell	22	57	Broadview North	6
111	Rockcliffe-Smythe	21	101	Forest Hill South	6
120	Clairlea-Birchmount	19	110	Keelesdale-Eglinton West	6
158	Islington	19	38	Lansing-Westgate	6
135	Morningside	19	54	O'Connor-Parkview	6
68	North Riverdale	19	46	Pleasant View	6
123	Cliffcrest	18	59	Danforth East York	5
92	Corso Italia-Davenport	18	9	Edenbridge-Humber Valley	5
2	Mount Olive-Silverstone-Jamestown	18	21	Humber Summit	5
63	The Beaches	18	105	Lawrence Park North	5
108	Briar Hill-Belgravia	16	19	Long Branch	5
126	Dorset Park	16	58	Old East York	5
125	Ionview	16	4	Rexdale-Kipling	5
91	Weston-Pelham Park	16	55	Thorncliffe Park	5
151	Yonge-Doris	16	35	Westminster-Branson	5
87	High Park-Swansea	15	7	Willowridge-Martingrove-Richview	5
124	Kennedy Park	15			

*Neighbourhoods with less than 5 calls are suppressed to prevent identification of individuals.

Calls to Paramedic Services for Suspected Opioid Overdoses - Geographic Information
Toronto Public Health
July 2024

Map of suspected opioid overdose calls by nearest main intersection*, July 1, 2023 to June 30, 2024.



Calls to Paramedic Services for Suspected Opioid Overdoses - Geographic Information
Toronto Public Health
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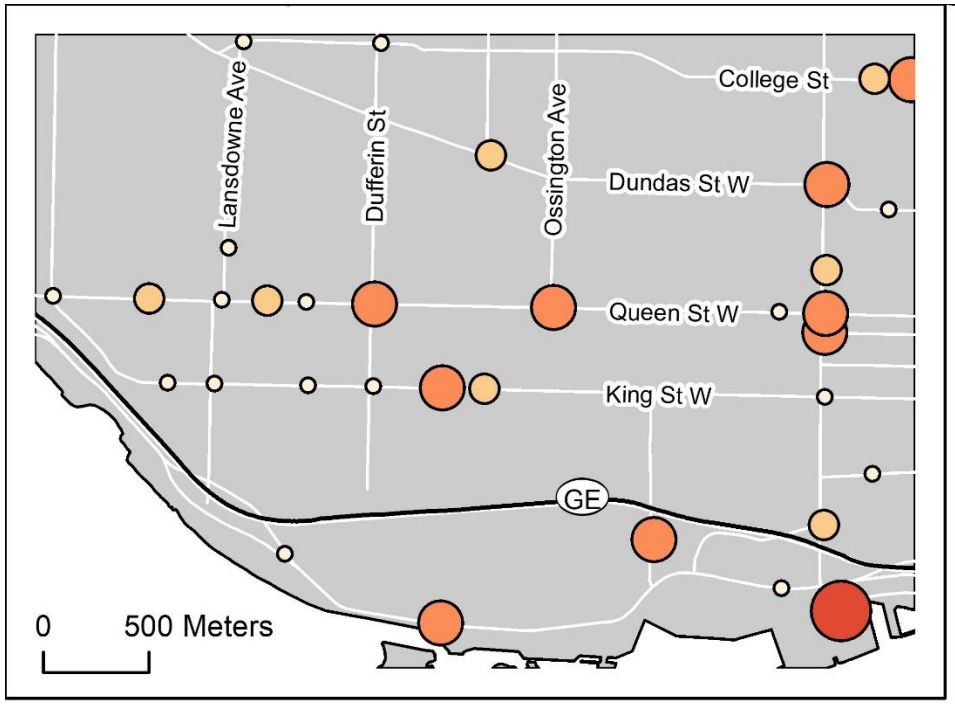

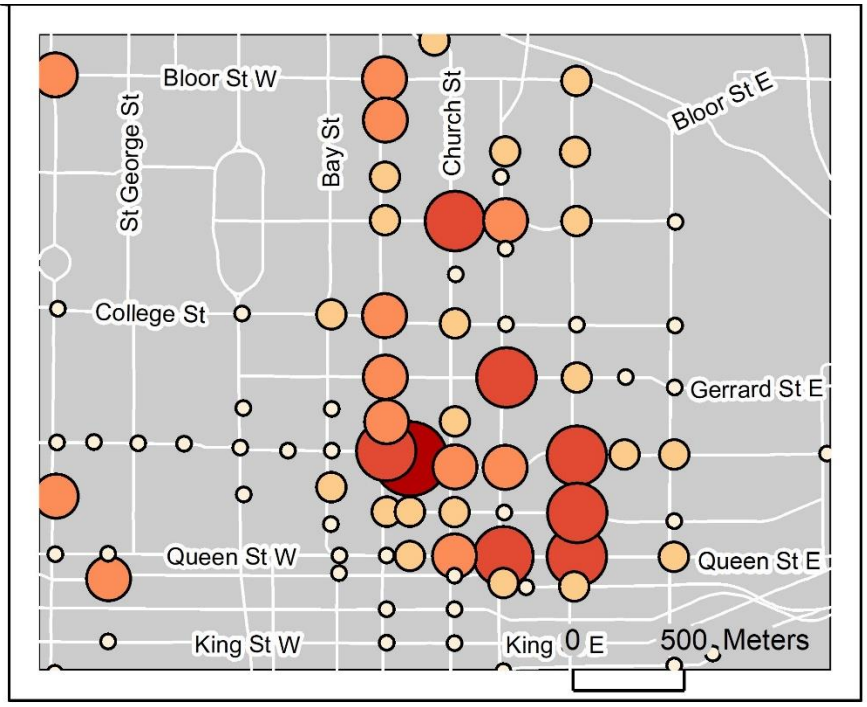

Calls to Paramedic Services for Suspected Opioid Overdoses - Geographic Information
Toronto Public Health
July 2024

Table of suspected opioid overdose by nearest main intersection*, Toronto, July 1, 2023 to June 30, 2024

Nearest Main Intersection	Number of calls	Nearest Main Intersection	Number of calls
Dundas St E / Victoria St	337	Yonge St / Eglinton Ave W	9
Jarvis St / Gerrard St E	122	Danforth Ave / Coxwell Ave	8
Kennedy Rd / 401 C W Kennedy Rd Ramp	102	Danforth Ave / Donlands Ave	8
Dundas St E / Sherbourne St	99	Danforth Ave / Main St	8
Queen St E / Sherbourne St	99	Dufferin St / Bloor St W	8
Jarvis St / Queen St E	93	Eastern Ave / Leslie St	8
Yonge St / Dundas St	92	Eglinton Ave E / Falmouth Ave	8
Sherbourne St / Shuter St	84	Gerrard St E / Ontario St	8
Queens Quay W / Bathurst St	81	Jarvis St / Carlton St	8
Church St / Wellesley St E	74	Kingston Rd / Lawrence Ave E	8
Bay St / Front St W	72	Parliament St / Shuter St	8
Islington Ave / Monogram Pl	55	Richmond St E / George St	8
Yonge St / Carlton St	55	Spadina Ave / Dundas St W	8
Lake Shore Blvd W / Ontario Dr	50	Spadina Ave / Queen St W	8
Wilson Ave / Beverly Hills Dr	50	St Clair Ave W / Northcliffe Blvd	8
Bathurst St / Richmond St W	49	Weston Rd / Lawrence Ave W	8
Spadina Ave / Sullivan St	49	Yonge St / Bishop Ave	8
Danforth Ave / Victoria Park Ave	47	Bay St / Elm St	7
King St W / Joe Shuster Way	43	Bloor St W / Dovercourt Rd	7
Bloor St / Yonge St	39	Bloor St W / Havelock St	7
Yonge St / Gerrard St	38	Church St / Adelaide St E	7
Strachan Ave / Fleet St	37	Danforth Ave / Woodbine Ave	7
Bloor St W / Spadina Ave	36	Eglinton Ave E / Midland Ave	7
Jarvis St / Dundas St E	35	Eglinton Ave W / Northcliffe Blvd	7
Jarvis St / Wellesley St E	35	Finch Ave W / 400 N Finch E Ramp	7
Queen St E / Church St	34	Jarvis St / Gloucester St	7
College St / Augusta Ave	33	King St E / Church St	7
Dundas St E / Church St	33	King St W / Dowling Ave	7
Queen St W / Ossington Ave	33	King St W / Jameson Ave	7

Calls to Paramedic Services for Suspected Opioid Overdoses - Geographic Information
Toronto Public Health
July 2024

Nearest Main Intersection	Number of calls	Nearest Main Intersection	Number of calls
Dundas St W / Bathurst St	32	Kingston Rd / Waverley Rd	7
Queen St W / Dufferin St	32	O Connor Dr / Wakunda Pl	7
Yonge St / Charles St E	31	Parliament St / Wellesley St E	7
Bathurst St / Queen St W	30	Queen St W / Brock Ave	7
Richmond St W / Peter St	29	Queen St W / King St W	7
Yonge St / Gould St	28	Queens Quay W / Lower Spadina Ave	7
Lake Shore Blvd E / Parliament St	26	University Ave / Armoury St	7
Sherbourne St / Gerrard St E	22	Victoria Park Ave / Patrick Blvd	7
Yonge St / Shuter St	22	Warden Ave / St Clair Ave E	7
Jarvis St / Isabella St	21	Bloor St W / Bathurst St	6
King St W / Atlantic Ave	21	Bloor St W / Brunswick Ave	6
Sherbourne St / Wellesley St E	21	Bloor St W / Lansdowne Ave	6
Bay St / Hagerman St	20	Bloor St W / Ossington Ave	6
Queen St E / Parliament St	20	Broadview Ave / Pretoria Ave	6
Consumers Rd / Yorkland Blvd	19	Danforth Ave / Linnsmore Cres	6
Sherbourne St / Richmond St E	19	Dufferin St / Dupont St	6
Dundas St E / Parliament St	18	Dufferin St / Eglinton Ave W	6
Dundas St W / Dovercourt Rd	18	Dufferin St / St Clair Ave W	6
Jarvis St / Richmond St E	18	Dundas St E / Coxwell Ave	6
Queen St E / Victoria St	18	Dundas St W / Mc Caul St	6
Sherbourne St / Isabella St	18	Eastern Ave / Trinity St	6
Bathurst St / Robinson St	17	Jarvis St / Front St E	6
Church St / Carlton St	17	Kennedy Rd / Sufferance Rd	6
Dundas St E / Ontario St	17	King St W / Blue Jays Way	6
Yonge St / Wellesley St	17	King St W / Dufferin St	6
Queen St W / Sorauren Ave	16	Lansdowne Ave / Seaforth Ave	6
Wilson Ave / Jane St	16	Queen St E / Beech Ave	6
Lansdowne Ave / Dupont St	15	Queen St E / Pape Ave	6
Queen St W / Dunn Ave	15	Sherbourne St / Carlton St	6
Yonge St / Church St	15	St Clair Ave W / Vaughan Rd	6
Bathurst St / Fort York Blvd	14	University Ave / Elm St	6

Calls to Paramedic Services for Suspected Opioid Overdoses - Geographic Information
Toronto Public Health
July 2024

Nearest Main Intersection	Number of calls	Nearest Main Intersection	Number of calls
Bay St / College St	14	Weston Rd / Black Creek Dr	6
Danforth Ave / Broadview Ave	14	Wilson Ave / Dallner Rd	6
Main St / Danforth Ave	14	Yonge St / Adelaide St	6
Church St / Gould St	13	Yonge St / Eglinton Ave	6
Church St / Park Rd	13	Albion Rd / Kipling Ave	5
College St / Borden St	13	Avenue Rd / Davenport Rd	5
Queen St E / Logan Ave	13	Bay St / Richmond St W	5
Shuter St / Victoria St	13	Bloor St W / Keele St	5
Yonge St / Gloucester St	13	Bloor St W / South Kingsway	5
Bloor St E / Sherbourne St	12	Caledonia Rd / Kitchener Ave	5
Bloor St W / High Park Ave	12	Church St / Alexander St	5
Church St / Shuter St	12	Church St / Richmond St E	5
Danforth Ave / Greenwood Ave	12	College St / Dufferin St	5
Dundas St W / Mabelle Ave	12	College St / Lansdowne Ave	5
Eglinton Ave E / Kennedy Rd	12	Danforth Ave / Dawes Rd	5
Lawrence Ave E / Galloway Rd	12	Dundas St W / Beverley St	5
Bay St / Queen St W	11	Dundas St W / Huron St	5
Eglinton Ave E / Mason Rd	11	Eglinton Ave E / Bellamy Rd N	5
King St W / Spencer Ave	11	Eglinton Ave E / Brimley Rd	5
Queen St E / Carlaw Ave	11	Eglinton Ave E / Dunfield Ave	5
Scarborough Golf Club Rd / Bankwell Ave	11	Eglinton Ave W / Heddington Ave	5
Spadina Ave / Wellington St W	11	Ellesmere Rd / Neilson Rd	5
Yonge St / Queen St	11	Front St W / Portland St	5
Dundas St E / River St	10	Gerrard St E / St Matthews Rd	5
Dundas St W / Bay St	10	Jarvis St / Maitland Pl	5
Dundas St W / Chestnut St	10	King St W / Bathurst St	5
Kipling Ave / Horner Ave	10	Kipling Ave / Olivewood Rd	5
Morningside Ave / Lawrence Ave E	10	Lake Shore Blvd W / British Columbia Rd	5
Bay St / Albert St	9	Lake Shore Blvd W / Stadium Rd	5
Danforth Ave / Woodington Ave	9	Lawrence Ave W / Allen X N Lawrence Ramp	5

Calls to Paramedic Services for Suspected Opioid Overdoses - Geographic Information
Toronto Public Health
July 2024

Nearest Main Intersection	Number of calls	Nearest Main Intersection	Number of calls
Davenport Rd / Osler St	9	Parliament St / Front St E	5
Dundas St W / Bloor St W	9	Queen St E / Kingston Rd	5
Dundas St W / Denison Ave	9	Queen St W / Palmerston Ave	5
Gerrard St E / Marjory Ave	9	Queen St W / Peter St	5
Jarvis St / Shuter St	9	Spadina Ave / College St	5
Lake Shore Blvd W / Bay St	9	The West Mall / Sherway Dr	5
Parliament St / Carlton St	9	University Ave / College St	5
Parliament St / Gerrard St E	9	Yonge St / Broadway Ave	5
Queen St E / Broadview Ave	9	Yonge St / King St	5
Queen St W / Lansdowne Ave	9		
University Ave / Dundas St W	9		

*Calls have been aggregated to the nearest main intersection, as defined by the City of Toronto. Intersections with less than 5 calls have been suppressed to prevent identification of individuals.

This is Exhibit “E” referred to in the Affidavit
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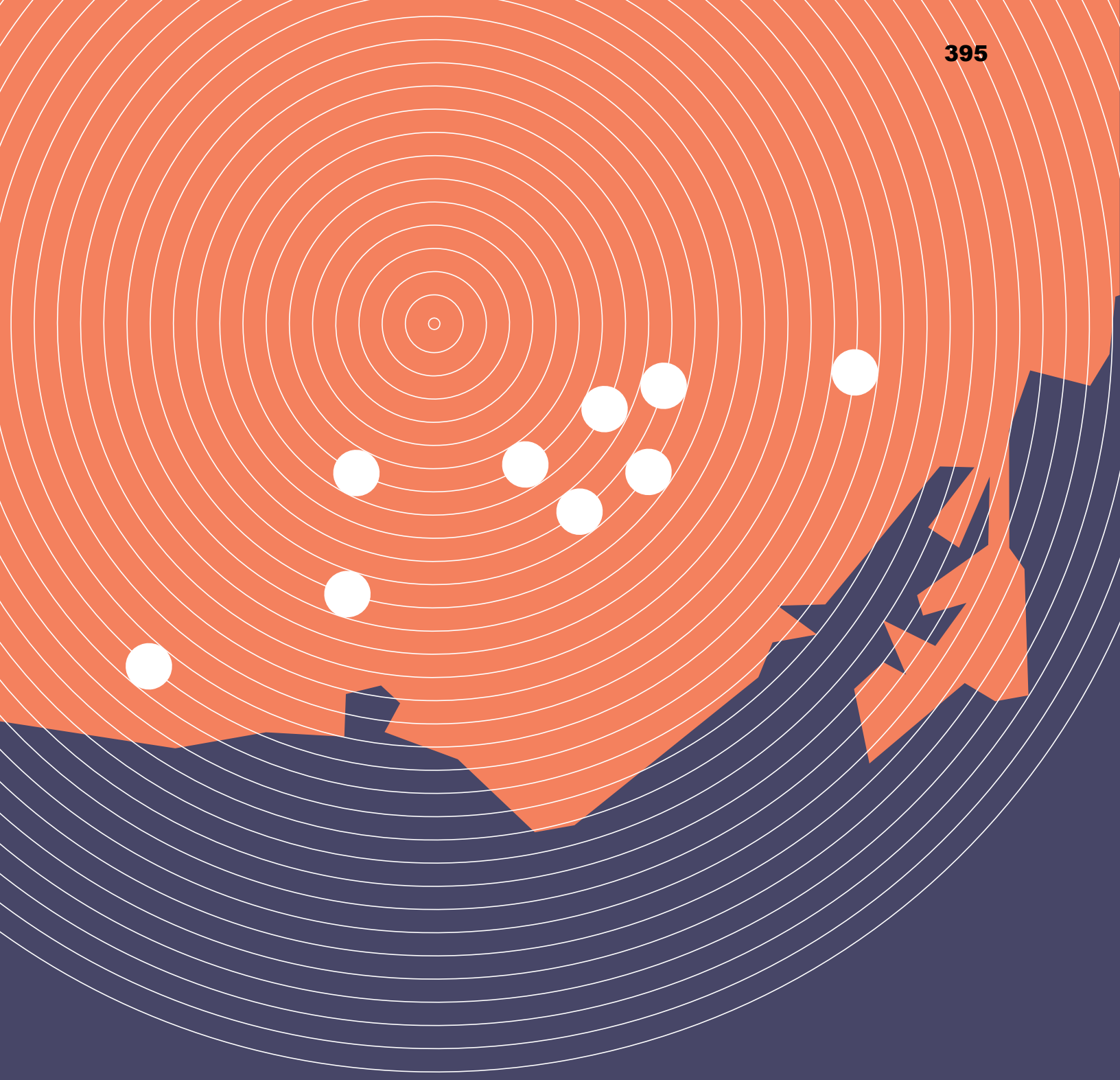
Commissioner for Taking Affidavits



Supervised Consumption Services in Ontario:

Evidence and Recommendations

CENTRE ON DRUG POLICY EVALUATION

NOVEMBER 2024

The Centre on Drug Policy Evaluation is dedicated to supporting people who use drugs and their communities to be healthier and safer. We do this by generating scientific evidence and sharing knowledge on the most effective policies, programs and practices to minimize the risks of drugs and maximize their benefits. We work closely with community members including people who use drugs, civil society, researchers, frontline service organizations, and governments at local, provincial, national and international levels. Our focus is on innovative research and actions that have a measurable positive impact on people's lives. Our immediate goal is to end Canada's overdose epidemic by developing an innovative, effective, equitable, and evidence-based national public health strategy that responds to the epidemic's root causes: government neglect, the unregulated drug supply, the ongoing impact of colonization and systemic racism, and the housing crisis.

Suggested citation: Centre on Drug Policy Evaluation. Supervised Consumption Services in Toronto: Evidence and Recommendations (Toronto, November 2024).

Disclaimer: The content of this publication does not necessarily reflect the views or policies of Unity Health Toronto or St. Michael's Hospital.

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Executive Summary

On August 20th, 2024, the Ontario provincial government announced new legislation that would force the closure of most of Ontario's 17 supervised consumption services. The government's rationale for this ban centered on alleged public safety impacts of supervised consumption services on surrounding areas, with government representatives citing increased violent crime in neighbourhoods that implemented the facilities. The proposed legislation would mandate distance requirements of greater than 200 meters from schools or childcare facilities, which would result in 10 supervised consumption services to close across the province. The announcement also stated that no new sites would be opened to replace those forced to close.

This legislative proposal comes amid an ongoing overdose crisis that has claimed the lives of over 26,000 Ontarians since 2016—surpassing the province's COVID-19 mortality rate and representing an unprecedented public health emergency. The government announced this ban without presenting any supporting scientific, clinical, or public health evidence. This report, prepared by the Centre on Drug Policy Evaluation, is intended to fill this gap. Herein, we present data from multiple data sources, including: 1) evidence compiled by the provincial government itself; 2) international scientific evidence; as well as evidence from an ongoing Toronto-based scientific evaluation of supervised consumption services in Ontario on 3) public health impacts of supervised consumption services; and 4) the association between supervised consumption services and major crimes in Toronto.

Both internal ministry reports and taxpayer-funded external expert analyses consistently demonstrate a range of public health and public safety benefits of supervised consumption services. International evidence supports these findings, with multiple systematic reviews documenting positive impacts of supervised consumption services on preventing fatal overdose, improving uptake and retention in substance use treatment, reducing drug-related litter (e.g., discarded needles), and reducing infectious disease transmission risk.

Since March 2020, Ontario's supervised consumption services have recorded 1.12 million visits from 178,000 unique clients. These facilities have facilitated more than 530,000 service referrals—including housing, case management, and substance use treatment—and successfully reversed 22,000 overdoses. Additionally, data from Toronto demonstrate that neighbourhoods with supervised consumption services subsequently experienced 67% reductions in overdose mortality, while other neighbourhoods showed no significant decreases.

Analysis of crime data reveals two key findings. First, using 13 years of homicide data in Toronto from the Office of the Chief Coroner of Ontario, we found that after the opening of supervised consumption services, areas within 500 meters experienced a minimal but significant decrease in the homicide rate, while areas

further than 3 kilometers away from sites experienced a minimal but significant increase. Second, analysis of nine years of Toronto Police Services data showed that neighbourhoods with supervised consumption services experienced significant decreases in assault and robbery rates after their implementation, while other downtown neighbourhoods showed no such decline. While there were no significant changes in thefts over $5000 after the opening of sites, both neighbourhoods with and without supervised consumption services experienced initial increases in the break and enter rates, followed by significant downward trends. These findings directly contradict the Ontario provincial government's claims that crime increased in neighbourhoods with supervised consumption services relative to other neighbourhoods.

Based on this comprehensive evidence review, we recommend the following steps:

1. Reverse the decision to close supervised consumption services in Ontario.
2. Make public all scientific evidence related to the provincial government's decision to ban supervised consumption services.
3. In line with taxpayer-funded expert reports, provide supervised consumption services with increased funding to expand their services and mitigate any potential public safety issues that may arise.
4. Meaningfully expand Ontario's addiction treatment system.
5. Properly fund a comprehensive system of care for substance use in Ontario that integrates supervised consumption services, other frontline service providers, a responsive treatment system, and supportive housing.

Background

On August 20th, 2024, Ontario's provincial government announced impending legislation that would close over half of the province's supervised consumption services and prohibit municipalities from opening additional ones. According to Ontario's provincial government, the rationale for this policy decision is 'protecting the safety of children and communities'[1] This announcement is the culmination of a provincial audit of supervised consumption services in Ontario, which was undertaken after the accidental homicide of a community member within 100 meters of a supervised consumption service operating in the South Riverdale neighbourhood in Toronto. The government announcement specifically noted that, "[c]rime in the vicinity of these sites is significantly higher compared to surrounding neighbourhoods. In Toronto, reports of assault in 2023 are 113% higher and robbery is 97% higher in neighbourhoods near these sites compared to the rest of the city."

This legislative decision is being made in the context of an escalating overdose epidemic. Since the saturation of fentanyl in Ontario's drug supply beginning in 2016, more Ontarians have died of an overdose than of COVID-19. Additionally, between 2016 and 2023, the annual rate of opioid overdose mortality increased by 200%, from 867 (2016) to 2,647 (2023). During that time, 26,673 Ontarians have died of an opioid or stimulant overdose.[2] The overdose epidemic is therefore deadlier in Ontario than COVID-19, which has to date resulted in 18,873 deaths.

The Centre on Drug Policy Evaluation is conducting an ongoing investigation of overdose mortality, service access, health outcomes, and crime in Toronto via grant funding from the Canadian Institutes of Health Research (PJT-153153; PCS-190985) and the New Frontiers in Research Fund (NFRFR-2022-00077). In an effort to inform the best possible policy responses to Ontario's overdose epidemic, we sought to summarize existing and emerging evidence on supervised consumption services in Toronto, including their impact on referrals, client health, and community health and safety. Additionally, we summarize the recommendations on supervised consumption services in expert reports funded by provincial taxpayers. Finally, we propose actionable steps to optimize Ontario's response to the overdose epidemic.

[1] Ontario Protecting Communities and Supporting Addiction Recovery with New Treatment Hubs. (August 20, 2024). Toronto, Government of Ontario. Available at: https://news.ontario.ca/en/release/1004955/ontario-protecting-communities-and-supporting-addiction-recovery-with-new-treatment-hubs.

[2] Government of Canada. (2024). "Opioid- and Stimulant-related Harms in Canada." Available at: https://health-infobase.canada.ca/substance-related-harms/opioids-stimulants/.

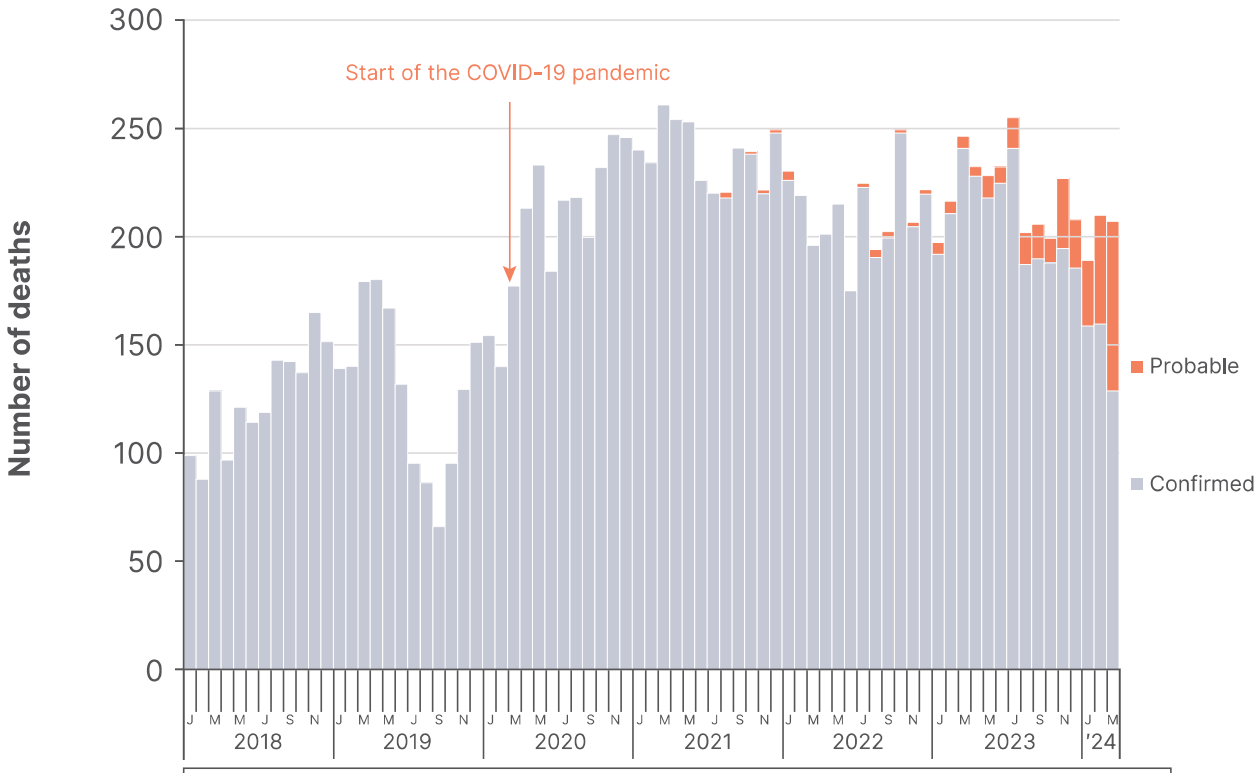
Contents

1. How we got here: The drug toxicity crisis in Ontario

> In 2017, the year prior to the opening of supervised consumption services in Ontario, the opioid overdose mortality rate had increased by roughly 50%, from 867 deaths in 2016 to 1,294.

Figure 1. Quarterly Update from the Office of the Chief Coroner[3]

Opioid toxicity deaths in Ontario by month, January 2018–March 2024

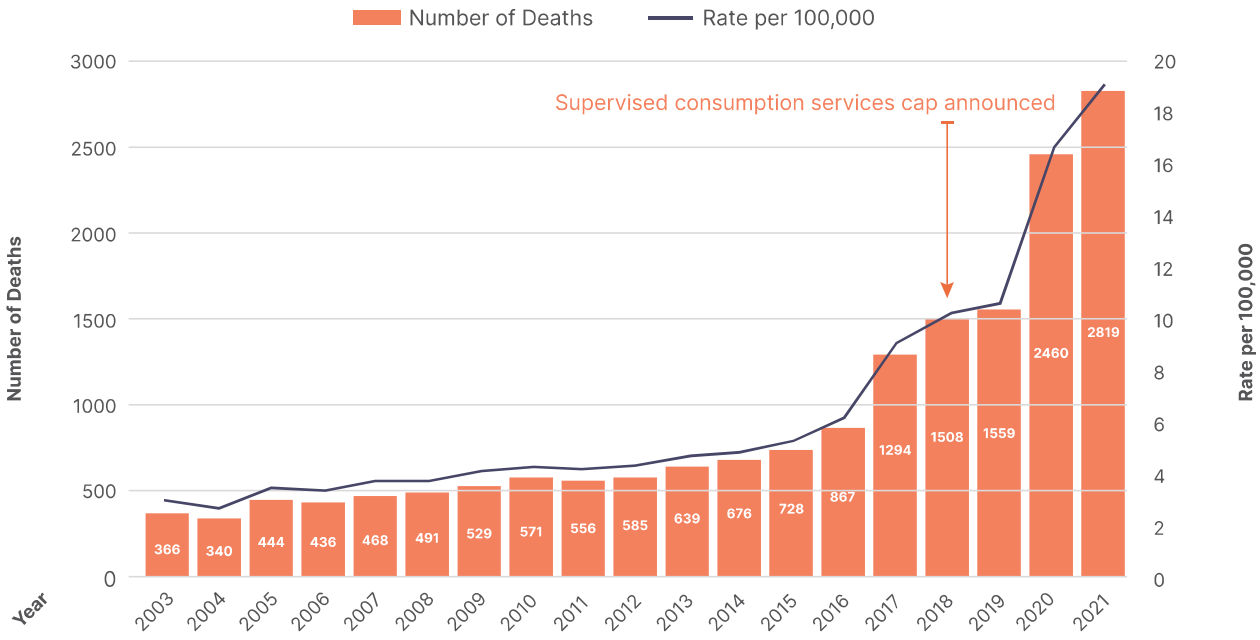


	2018	2019	2020	2021	2022	2023	'24
Average deaths per month*	126	130	205	238	211	221	202
Average deaths per day	4	4	7	8	7	7	7

Source: Office of Chief Coroner (OCC) - Data effective July 29, 2024.
Includes confirmed and probable opioid toxicity deaths and ongoing investigations where information may be pending. Data are preliminary and subject to change.

[3] Ontario Drug Policy Research Network. Suspect Drug-Related and Drug Toxicity Deaths in Ontario. 2024. Available at: https://odprn.ca/occ-opioid-and-suspect-drug-related-death-data/2024.

Figure 2. 2018: The provincial government arbitrarily caps the number of supervised consumption services in Ontario



In 2018, after the number of overdose fatalities in Ontario had roughly doubled over two years (see Figure 2), the provincial government announced a provincial cap of 21 supervised consumption services, as well as a rebranding of these services as 'Consumption and Treatment Services'.[4, 5] Christine Elliott, Deputy Premier and Minister of Health and Long-Term Care, further stated that this move reflected the Ontario government's commitment to "a new, enhanced approach to treatment services," and noted that "our new delivery model would provide a pragmatic approach to overdose prevention, rooted in a relentless focus on getting people the help that they need by connecting them to treatment."

In defending his government's decision, "Premier Doug Ford stated that it was motivated by a 'great conversation with the Cabbagetown [business improvement] association,' the members of which communicated that 'It's okay, help them, but not in my backyard; that's the reality of things.'"[6] Premier Ford also noted that he was "passionate" about ensuring that treatment was available for those who need it.

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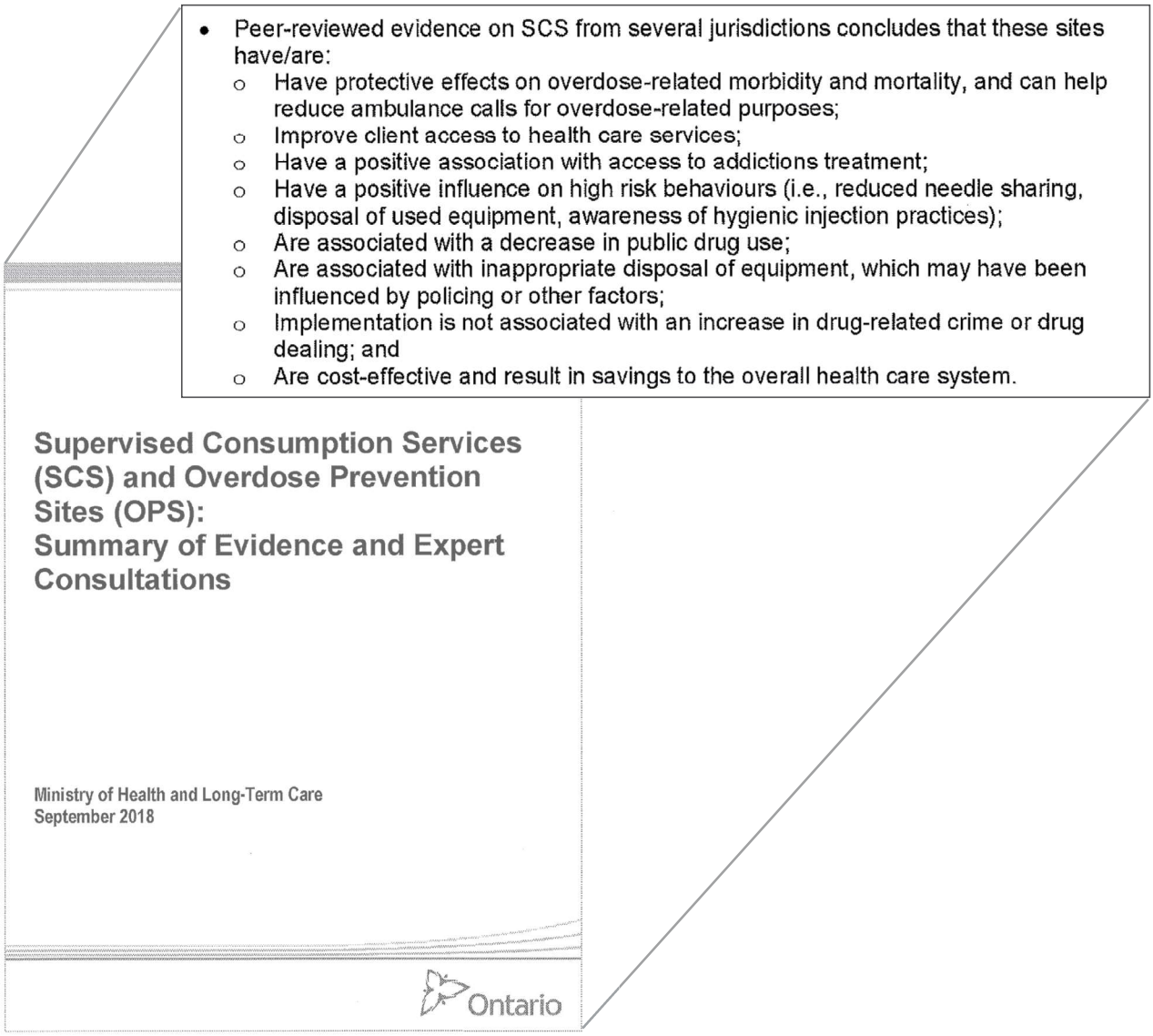
[4] Ontario Ministry of H, Long Term Care. Ontario Government Connecting People with Addictions to Treatment and Rehabilitation. Toronto: Government of Ontario; 2018. Available at: https://news.ontario.ca/en/release/50237/ontario-government-connecting-people-with-addictions-to-treatment-and-rehabilitation.

[5] This report will refer throughout to sites as supervised consumption services.

[6] CBC News. Province cut some injection sites because area residents 'upset,' Ford says. April 1, 2019. Toronto: CBC News. Available at: https://www.cbc.ca/news/canada/toronto/province-cut-some-injection-sites-because-area-residents-upset-ford-says-1.5079616.

2. Government evidence on the impact of supervised consumption services

The recommendation to cap the number of supervised consumption services was made after an extensive evidence-gathering process. **Documents obtained via a freedom of information request reveal that the final decision to restrict access and funding to supervised consumption services was inconsistent with the government's own scientific evidence and conclusions.** As can be seen below, an internal government report concluded that supervised consumption services were effective against overdose mortality, improved addiction treatment uptake, reduced public drug use, and were cost-effective, among other benefits.



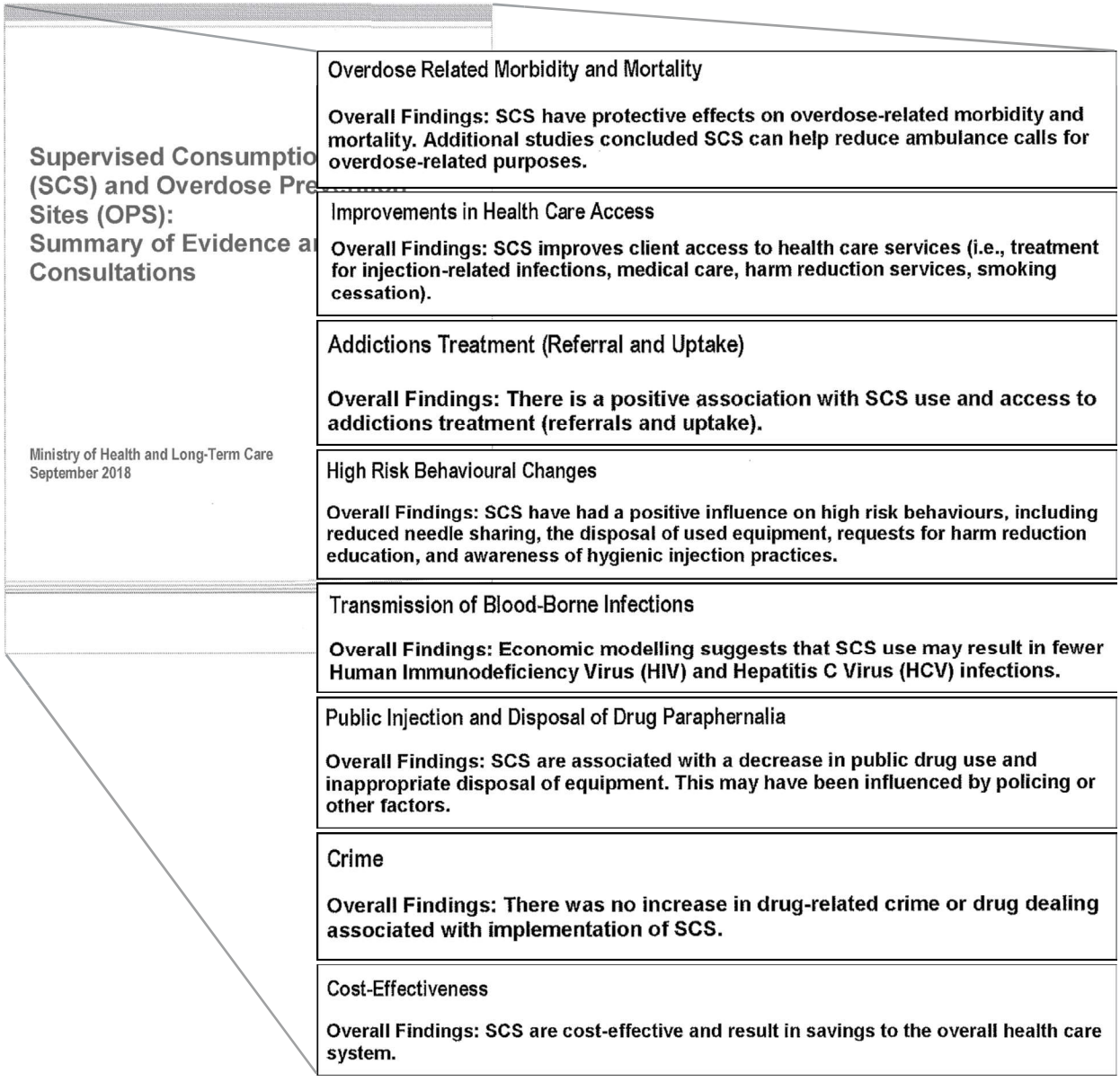
- Peer-reviewed evidence on SCS from several jurisdictions concludes that these sites have/are:
  - Have protective effects on overdose-related morbidity and mortality, and can help reduce ambulance calls for overdose-related purposes;
  - Improve client access to health care services;
  - Have a positive association with access to addictions treatment;
  - Have a positive influence on high risk behaviours (i.e., reduced needle sharing, disposal of used equipment, awareness of hygienic injection practices);
  - Are associated with a decrease in public drug use;
  - Are associated with inappropriate disposal of equipment, which may have been influenced by policing or other factors;
  - Implementation is not associated with an increase in drug-related crime or drug dealing; and
  - Are cost-effective and result in savings to the overall health care system.

Supervised Consumption Services (SCS) and Overdose Prevention Sites (OPS): Summary of Evidence and Expert Consultations

Ministry of Health and Long-Term Care
September 2018

Ontario

Summary of overall findings from Ontario provincial government report on supervised consumption services, September 2018



Additionally, the freedom of information request reveals that the membership of the Opioid Emergency Task Force—a group of scientific and clinical experts handpicked by the provincial government—unanimously supported supervised consumption services in Ontario, with "increased access to addictions treatment and other services." Only three of the 30 experts consulted indicated they did not support these sites as "an acceptable model overall."

3. Government funding for mental health and addictions after the 2018 cap

In capping supervised consumption services, government leaders stated a commitment to expanding access to treatment and enhancing the capacity of supervised consumption services to engage in treatment referrals. Following this announcement, annual provincial spending on mental health and addictions was lower than the levels announced by the preceding government in subsequent years (see Table 1). It also remained static over the following three years.

Table 1. Annual provincial budget for mental health and addictions

Budget year	Announced spending on mental health and addictions
Provincial Budget 2018-2019	$200 million*
Provincial Budget 2019-2020	$174 million
Provincial Budget 2020-2021	$176 million
Provincial Budget 2021-2022	$175 million
Provincial Budget 2022-2023	$204 million
Provincial Budget 2023-2024	$142 million**

Note: Supervised consumption service cap was announced in 2018

**Previous government annual budget allocation*

***Median annual budget allocation ($425 million over three years)*

Source: Ontario Budget[7]

[7] Government of Ontario. (2024). "Ontario Budget: past editions." Available at: https://www.ontario.ca/page/ontario-budget-past-editions.

4. Scientific evidence on supervised consumption services

Supervised consumption sites are health services that offer a safe and hygienic environment for people to use previously obtained unregulated substances under the supervision of medical professionals and trained staff.[8] In the event of an overdose, trained personnel are able to intervene immediately. The services also provide access to sterile injection equipment, connect people to basic medical care, and provide referrals to other health and social services, including substance use treatment.[9] These sites are typically situated in areas of concentrated drug use activity and are part of a continuum of services that address drug-related harms, such as needle/syringe distribution programs, safer opioid supply programs, opioid agonist treatment, and recovery focused programs.

Supervised consumption sites have been implemented in many settings, with over 100 sites in more than 60 cities across 11 countries globally.[10] A large body of rigorous 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. Supervised consumption services have been shown to:[11, 12, 13]

- Reduce overdose morbidity and mortality
- Reduce unsafe injecting behaviours (i.e., needle sharing, disposal of injecting equipment, and awareness of hygienic practices)
- Reduce the risk of transmission of injection-related infections, such as HIV, hepatitis C, and bacterial infections
- Reduce public injection and discarded injection-related litter in public places
- Promote access through referrals to health and social services, including substance use treatment
- Be cost-effective and reduce the overall burden emergency services and the health care system

Furthermore, there is no evidence to suggest that these services cause people with histories of substance use to relapse, or that they cause people who do not use to start. Given what is known about supervised consumption sites, these services are an ideal entry-point for people with complex needs to enter the system of treatment and care.

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[8] Kerr, Thomas, et al. "Supervised injection facilities in Canada: past, present, and future." Harm reduction journal 14 (2017): 1-9.

[9] Kennedy, M. C., M. Karamouzian and T. Kerr. (2017). "Public health and public order outcomes associated with supervised drug consumption facilities: A systematic review." Current HIV/AIDS Reports 14(5): 161-183.

[10] Roque Camacho ME. Drug consumption rooms: an overview of provision and evidence. Medicina y ética 2022; 33(4): 1167-78.

[11] 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." Americal Journal of Preventive Medicine 61(5): 738-749.

[12] 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.

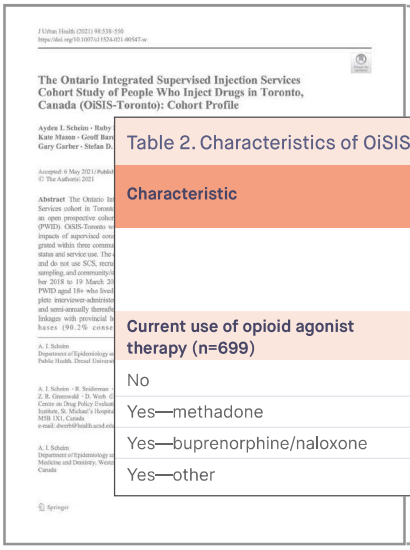
[13] Potier, C., V. Laprévote, F. Dubois-Arber, O. Cottencin and B. Rolland. (2014). "Supervised injection services: what has been demonstrated? A systematic literature review." Drug and Alcohol Dependence 145: 48-68.

5. Recent evidence on supervised consumption services in Toronto and Ontario

Access and referral patterns from supervised consumption services in Ontario

Between March 2020 and March 2024, supervised consumption services across Ontario served 178,253 unique clients who collectively made 1,120,144 visits. A total of 21,979 non-fatal overdoses were reversed onsite of which 36% occurred in supervised consumption services anticipated to close under the new provincial ban.[14] **Additionally, 533,624 service and substance use treatment referrals** were made by staff at sites.

The Ontario Integrated Supervised Injection Services study (OiSIS-Toronto study) is an open prospective cohort of people who inject drugs in Toronto,[15] funded by the Canadian Institutes of Health Research. The study was initially established to evaluate the impact of supervised consumption services within three community health agencies, including two multiservice community health centres and one harm reduction program, which opened between August 2017 and March 2018. The cohort includes participants who do and do not use supervised consumption services, who are recruited via outreach, self-referral, and other community-based methods.


J Urban Health (2021) 98:538–550
https://doi.org/10.1007/s11524-021-00547-w

The Ontario Integrated Supervised Injection Services Cohort Study of People Who Inject Drugs in Toronto, Canada (OiSIS-Toronto): Cohort Profile

Table 2. Characteristics of OiSIS-Toronto participants by recent frequency of supervised consumption services use

Characteristic	Total	Recent frequency of supervised consumption services use (proportion of all injections at supervised consumption services)*				*p*-value
	n=701 *n* (%)	All or most (≥75%) *n* = 182 *n* (%)	Some (26-74%) *n* = 215 *n* (%)	Few (≤25%) *n* = 204 *n* (%)	None *n* = 94 *n* (%)	
Current use of opioid agonist therapy (n=699)						0.01
No	472 (67.5)	107 (58.8)	142 (66.4)	142 (72.1)	72 (77.4)	
Yes—methadone	188 (26.9)	67 (36.8)	59 (27.6)	43 (21.1)	18 (19.4)	
Yes—buprenorphine/naloxone	34 (4.9)	6 (3.3)	13 (6.1)	11 (5.4)	3 (3.2)	
Yes—other	5 (0.7)	2 (0.1)	0 (0.0)	3 (1.5)	0 (0.0)	

[14] Public Health Agency of Canada. Supervised consumption sites: Dashboard. Ottawa: Health Canada. 2024. Available at https://health-infobase.canada.ca/supervised-consumption-sites/.

[15] 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.

An initial profile study using cross-sectional baseline data of 701 people who inject drugs surveyed between November 2018 and March 2020 indicated that **86% of participants had used a supervised consumption service in the past six months.**[16] Approximately a quarter of participants used a site for more than 75% of their injections. 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.** This demonstrates that clients of these sites in Toronto are among those that face the greatest difficulties in accessing substance use treatment.[16] Nevertheless, **a significantly higher proportion of participants who accessed supervised consumption services for all or most of their injections also reported currently being enrolled in addiction treatment** compared to those that did not access supervised consumption services (37% vs. 19%)[16] (see Table 2).

—

[16] Ibid

5.1 Who accesses supervised consumption services in Toronto?

Table 3 (below) presents data on the number of visits, unique clients, service and treatment referrals, and responses to non-fatal overdoses at supervised consumption services in Ontario. The table is stratified between sites that are and are not set to be closed as a result of the the provincial government's announced ban.

Table 3. Summary of supervised consumption service visits, unique clients, referrals, and non-fatal overdose response among sites operating in Ontario (March 2020 to May 2024), stratified by their anticipated closure status under the provincial ban.

City name: Supervised consumption service site	Visits	Unique clients	Referrals	Non-fatal overdoses
Closure anticipated	**382776**	**74786**	**202849**	**8471**
Guelph: Guelph CHC	28099	5464	4238	198
Hamilton: Hamilton Urban Core CHC	61667	6122	16633	400
Kitchener: Supervised Consumption Site - Kitchener/Waterloo	44731	9540	23218	935
Ottawa: Somerset West Community Centre	43800	6329	99184	1728
Thunder Bay: PATH525 (NorWest CHC)	31541	8466	14045	372
Toronto: Kensington Market Overdose Prevention Service (St. Stephen's)	14145	3705	8795	205
Toronto: Parkdale Queen West CHC (Queen West Site)	19663	5379	10905	741
Toronto: Regent Park CHC Consumption And Treatment Service	22960	6529	11740	382
Toronto: South Riverdale CHC	45078	6139	9146	1032
Toronto: The Works	71092	17113	4945	2478
No closure anticipated	**737368**	**103467**	**330775**	**13508**
Kingston: Integrated Care Hub	35159	3791	46467	574
Kingston: Street Health - Kingston	1276	194	606	0
London: Carepoint	68053	11725	86277	731
Ottawa: Healthy Sexuality And Risk Reduction Unit (Ottawa Public Health)	8666	2446	9298	139
Ottawa: Sandy Hill CHC	66817	14169	37876	2339
Ottawa: The Trailer 2.0	257628	19180	54769	2410
Peterborough: Four Cast	18039	2301	996	124
St. Catherines: Streetworks Supervised Consumption Site (Positive Living Niagara)	61109	7248	14293	1038
Sudbury: Reseau Access Network - Energy Court	2573	891	1137	32
Toronto: Casey House CHC	901	309	1214	37
Toronto: Casey House Inpatient	476	57	997	40
Toronto: Fred Victor Centre	133963	18404	20543	2503
Toronto: Moss Park Consumption & Treatment Service	60354	15511	37326	2499
Toronto: Parkdale Queen West CHC (Parkdale Site)	14409	4109	11673	819
Toronto: Street Health - Toronto	7945	3132	7303	223
Total	**1120144**	**178253**	**533624**	**21979**

Legend: CHC = community health centre. Data source; Health Canada Health InfoBase, Supervised Consumption Service Dashboard[17] and stratifications based on the Government of Ontario announcement of site closures.[18]

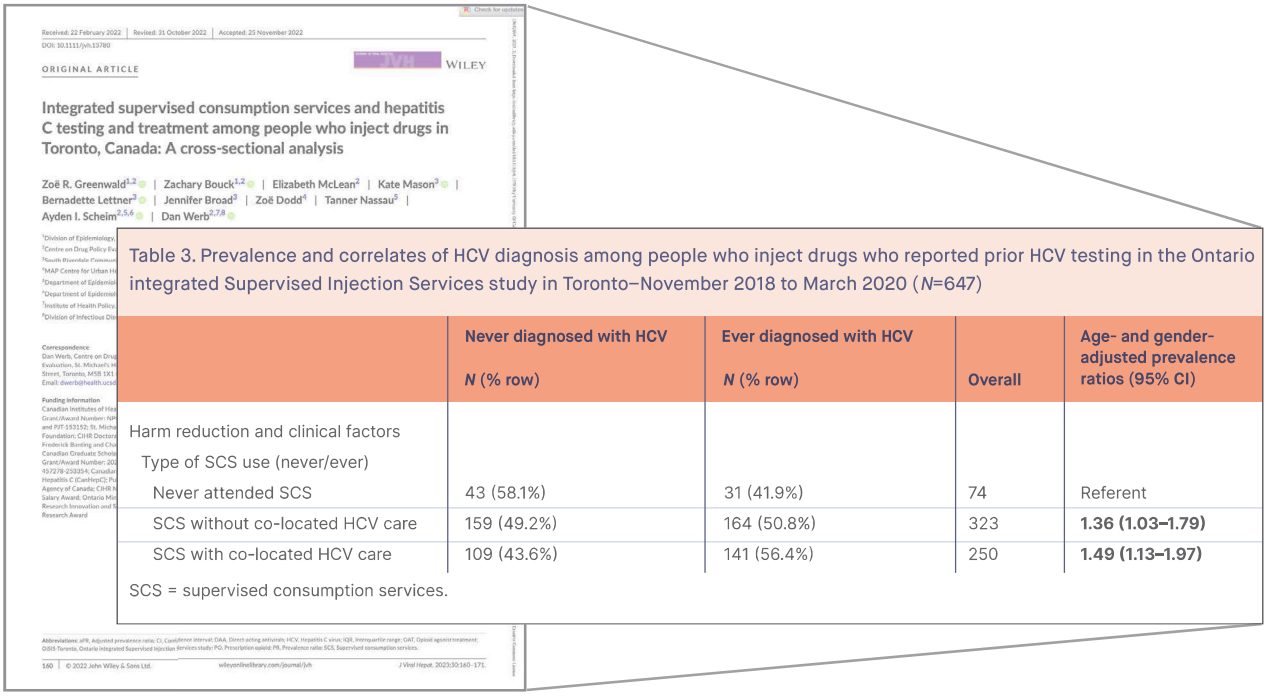
[17] Government of Canada, Health InfoBase (2024, Aug 22). Supervised consumption sites: Dashboard. Health InfoBase. Retrieved 2024-09-10 from https://health-infobase.canada.ca/supervised-consumption-sites/.

[18] Ontario Protecting Communities and Supporting Addiction Recovery with New Treatment Hubs. (August 20, 2024). Toronto, Government of Ontario. Available at: https://news.ontario.ca/en/release/1004955/ontario-protecting-communities-and-supporting-addiction-recovery-with-new-treatment-hubs.

5.2 Public health impacts of supervised consumption services in Toronto

Infectious disease treatment and prevention

Supervised consumption services in Toronto have demonstrated a range of benefits for clients and the community at large, including the integration of healthcare services within a harm reduction framework.[19] There is a high burden of Hepatitis C virus (HCV) among people who inject drugs, who historically have had difficulty accessing HCV care. In a study published in the Journal of Viral Hepatitis, among a sample of people who inject drugs in Toronto, 52% reported a prior HCV diagnosis – and notably, **those who had recently injected at a site co-located with HCV care were 12% more likely to have ever received HCV testing and 67% more likely to have been treated for HCV, compared to those who had not accessed supervised consumption services.**[20] This highlights the key role of supervised consumption services in treating and preventing the spread infectious disease and addressing Ontario's HCV epidemic among those at highest risk.



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ORIGINAL ARTICLE

WILEY

Integrated supervised consumption services and hepatitis C testing and treatment among people who inject drugs in Toronto, Canada: A cross-sectional analysis

Zoë R. Greenwald[1,2] | Zachary Bouck[1,2] | Elizabeth McLean[2] | Kate Mason[3] | Bernadette Lettner[3] | Jennifer Broad[3] | Zoë Dodd[4] | Tanner Nassau[5] | Ayden I. Scheim[2,5,6] | Dan Werb[2,7,8]

Table 3. Prevalence and correlates of HCV diagnosis among people who inject drugs who reported prior HCV testing in the Ontario integrated Supervised Injection Services study in Toronto–November 2018 to March 2020 (*N*=647)

	Never diagnosed with HCV *N* (% row)	Ever diagnosed with HCV *N* (% row)	Overall	Age- and gender-adjusted prevalence ratios (95% CI)
Harm reduction and clinical factors				
Type of SCS use (never/ever)				
Never attended SCS	43 (58.1%)	31 (41.9%)	74	Referent
SCS without co-located HCV care	159 (49.2%)	164 (50.8%)	323	**1.36 (1.03–1.79)**
SCS with co-located HCV care	109 (43.6%)	141 (56.4%)	250	**1.49 (1.13–1.97)**

SCS = supervised consumption services.

Abbreviations: aPR, Adjusted prevalence ratio; CI, Confidence interval; DAA, Direct-acting antivirals; HCV, Hepatitis C virus; IQR, Interquartile range; OAT, Opioid agonist treatment; OSIS Toronto, Ontario Integrated Supervised Injection Services study; PO, Prescription opioid; PR, Prevalence ratio; SCS, Supervised consumption services.

160 | © 2022 John Wiley & Sons Ltd. wileyonlinelibrary.com/journal/jvh J Viral Hepat. 2023;30:160–171.

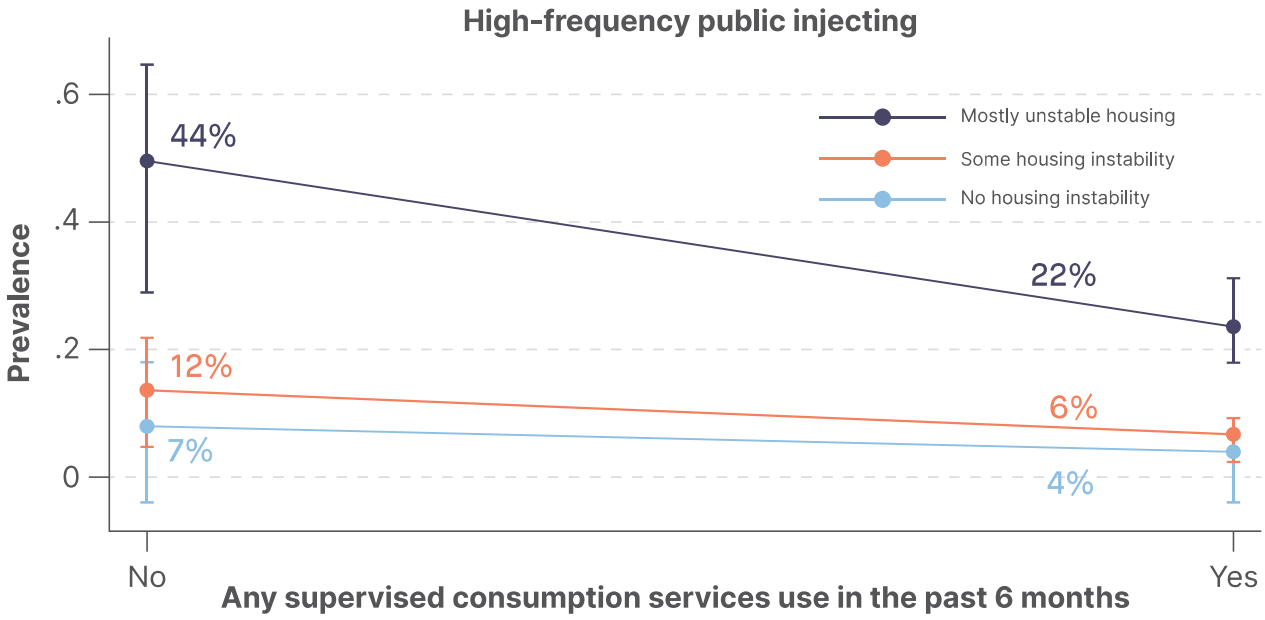
[19] Scheim A, Werb D. "Integrating supervised consumption into a continuum of care for people who use drugs." CMAJ 2018; 190(31): E921.

[20] Greenwald, Z. R., Z. Bouck, E. McLean, K. Mason, B. Lettner, J. Broad, Z. Dodd, T. Nassau, A. I. Scheim and D. Werb (2023). "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 30(2): 160-171.

5.3 Public injecting

Recent research demonstrates that supervised consumption services in Toronto play a key role in reducing public injecting. First, as shown in Figure 3, data demonstrate that **people who inject in public are more likely to be homeless and/or experience housing instability.** Furthermore, **among those who are homeless and/or unstably housed, recent supervised consumption services use was associated with a 50% reduction in the prevalence of high-frequency public injecting (44% to 22%).**[21] This strongly suggests that ensuring supervised consumption service access among the people most likely to inject in public (i.e., those without a stable housing situation) leads to reduced public injecting.[21]

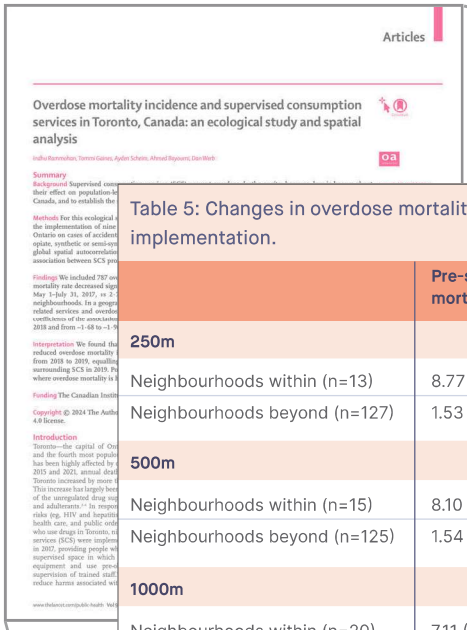
Figure 3. Impact of supervised consumption services access on high-frequency public injecting by housing status



[21] 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.

5.4 Neighbourhood overdose mortality rates

A recent spatial analysis of overdose mortality data demonstrates that **Toronto neighbourhoods that implemented supervised consumption services subsequently experienced a statistically significant 67% reduction in the overdose mortality rate.** This study, which used data from the Office of the Chief Coroner of Ontario, also found that no significant reductions were experienced in neighbourhoods that did not implement supervised consumption services.[22] Additionally, the magnitude of the protective spatial effect between supervised consumption services and overdose mortality more than doubled between 2018 and 2019, suggesting that **the community level-overdose prevention benefits of the sites increased over time.**[22]


Articles

Overdose mortality incidence and supervised consumption services in Toronto, Canada: an ecological study and spatial analysis

Table 5: Changes in overdose mortality rates in different buffer zones surrounding SCS in Toronto, before and after SCS implementation.

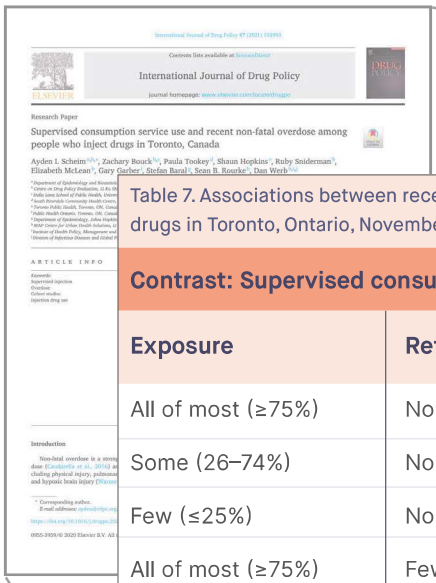
	Pre-site overdose mortality rate* (N)	Post-site overdose mortality rate* (N)	Rate reduction (95% CI)	Equivalent percentage reduction	*p*-value
250m					
Neighbourhoods within (n=13)	8.77 (27)	2.92 (9)	5.85 (1.52 to 15.86)	67%	0.037
Neighbourhoods beyond (n=127)	1.53 (37)	1.16 (28)	0.37 (-1.88 to 4.13)	24%	0.38
500m					
Neighbourhoods within (n=15)	8.10 (27)	2.70 (9)	5.40 (1.52 to 15.86)	67%	0.037
Neighbourhoods beyond (n=125)	1.54 (37)	1.17 (28)	0.37 (-1.88 to 4.13)	24%	0.38
1000m					
Neighbourhoods within (n=20)	7.11 (29)	2.21 (9)	4.91 (3.44 to 13.15)	69%	0.018
Neighbourhoods beyond (n=120)	1.64 (38)	1.20 (28)	0.43 (-2.51 to 3.88)	26%	0.53
2500m					
Neighbourhoods within (n=35)	5.25 (35)	2.10 (14)	3.15 (3.06 to 11.32)	60%	0.0077
Neighbourhoods beyond (n=105)	1.40 (29)	1.11 (23)	0.29 (-2.90 to 3.86)	21%	0.71
5000m					
Neighbourhoods within (n=54)	4.35 (44)	1.78 (18)	2.57 (1.81 to 10.12)	59%	0.0064
Neighbourhoods beyond (n=86)	1.16 (20)	1.10 (19)	0.06 (-3.68 to 3.22)	5%	0.80

*Crude rate per 100,000 people; number of mortality events is given in brackets. CIs and p-values were generated using the Wilcoxon signed-rank test on pre-SCS and post-SCS overdoes mortality rates among neighbourhoods both within and beyond the stated buffer sizes.

[22] 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.

5.5 'Risk compensation' among clients of supervised consumption services

Concerns have been expressed regarding 'risk compensation' among supervised consumption service clients. This refers to the idea that providing overdose prevention services will cause people who inject drugs to take greater risks with their substance use. However, in a Toronto-based study published in the International Journal of Drug Policy, **there was no statistically significant difference in the frequency of non-fatal overdose among people who did and did not access supervised consumption services** (see Table 7).[23]


International Journal of Drug Policy

Research Paper

Supervised consumption service use and recent non-fatal overdose among people who inject drugs in Toronto, Canada

Table 7. Associations between recent frequency of SCS use and recent non-fatal overdose among 701 persons who inject drugs in Toronto, Ontario, November 2018 to March 2020.

Contrast: Supervised consumption service		Unadjusted		Adjusted	
Exposure	**Reference**	**PR***	**95% CI**	**PR***	**95% CI**
All of most (≥75%)	None (0%)	1.90	1.25 to 2.86	1.43	0.93 to 2.21
Some (26–74%)	None (0%)	2.14	1.43 to 3.19	1.52	1.00 to 2.33
Few (≤25%)	None (0%)	1.53	0.99 to 2.31	1.25	0.81 to 1.91
All of most (≥75%)	Few (≤25%)	1.24	0.96 to 1.61	1.15	0.89 to 1.48
Some (26–74%)	Few (≤25%)	1.40	1.11 to 1.79	1.22	0.96 to 1.56
All or most (≥75%)	Some (26–74%)	0.89	0.71 to 1.10	0.94	0.75 to 1.17

PR = Prevalence Ratio

Supervised consumption service use was measured as the proportion of injecting taking place within a site in the past 6 months. All combinations of levels of SCS use were contrasted and the results show that recent non-fatal overdose likelihood was similar (no statistically significant differences) across groups. **This suggests that supervised consumption services do not inadvertently increase risk-taking among their clients.**[23]

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[23] 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.

5.6 Crime and supervised consumption services in Toronto

Supervised consumption services and spatial patterns of homicide

Investigating the Spatial Association between Supervised Consumption Services and Homicide Rates in Toronto, Canada, 2010-2023
17 Pages • Posted: 30 Sep 2024

An analysis of 13 years (2010-2023) of homicide data in Toronto sheds light on the association between the location of supervised consumption services and patterns of homicide.[24] Using data from the Office of the Chief Coroner in Ontario, our team tested whether there were changes in the monthly homicide rate in three areas: within 500 meters of supervised consumption services, between 500 meters and 3 kilometers of supervised consumption services, and areas greater than 3 kilometers away from supervised consumption services. The study period included 5 years of homicide data prior to and 5 years of data after the implementation of supervised consumption services.

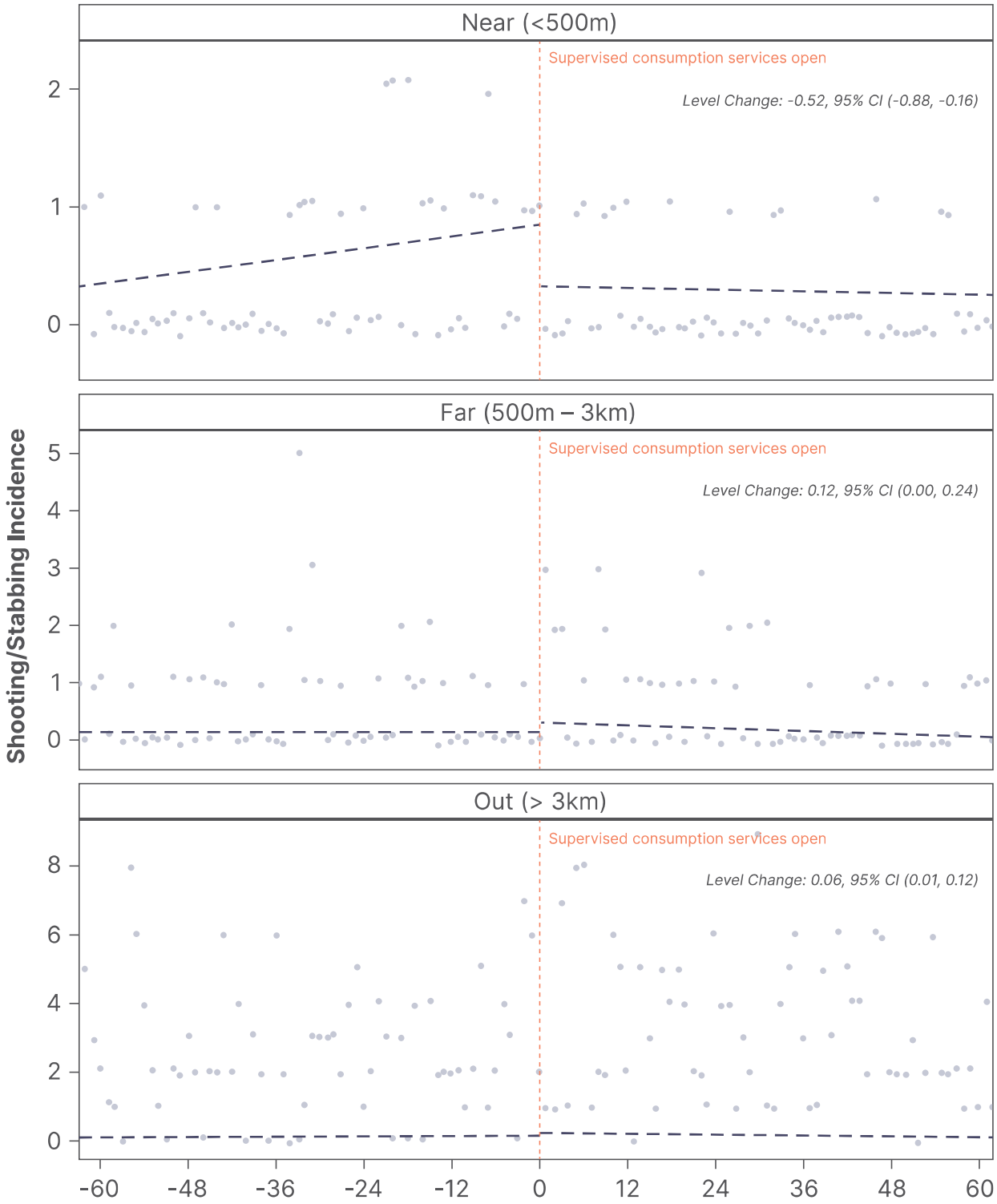
The study found no evidence that the monthly incidence of homicides increased in areas near supervised consumption services (<500 m). Instead, **there was a minimal but statistically significant decrease in the monthly incidence of homicides near supervised consumption services (<500 m; p<0.01)**, no 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).**[24] 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 the implementation of supervised consumption services.[24]

Table 8: Interrupted time series analysis of the effect of supervised consumption service implementation on shooting/stabbing rates by distance in Toronto, Canada, 2010–2023.

Distance	Parameter	Estimate	Standard Error	*p*-value
Near (< 500m)	Intercept	0.8436	0.1154	<.0001
	Overall trend across study period	0.008332	0.001997	<.0001
	Level Change Post supervised consumption site	**-0.5227**	0.1832	**0.0049**
Far (500m–3km)	Intercept	0.1391	0.0305	<.0001
	Overall trend across study period	0.000340	0.000529	0.5221
	Level Change Post supervised consumption site	0.0958	0.0490	0.0521
Out (>3km)	Intercept	0.1267	0.0184	<.0001
	Overall trend across study period	0.000420	0.000317	0.1870
	Level Change Post supervised consumption site	**0.0618**	0.0286	**0.0321**

[24] Werb, D., H. S. Sung, Y. Na, I. Rammohan, J. Eeuwes, A. Owusu-Bempah, A. Smoke, T. Kerr and M. Karamouzian (2024). "Investigating the Spatial Association between Supervised Consumption Services and Homicide Rates in Toronto, Canada, 2010-2023." Available at SSRN: https://ssrn.com/abstract=4969290 or http://dx.doi.org/10.2139/ssrn.4969290.

Figure 5. Interrupted Time Series of Fatal Shootings and Stabbings by Distance from Supervised Consumption Services in Toronto, Canada, January 2010–September 2023



5.7 Supervised consumption services and neighbourhood crime trends

Our team conducted interrupted time series analyses of data from the Toronto Police Services Open Data Portal.[25] This involved accessing nine years of crime data—from 2014 and 2023—and comparing changes in crime rates in downtown neighbourhoods that did and did not implement supervised consumption services in the periods prior to and after these sites were implemented. Crimes included: assaults, robberies, break & enters, auto thefts, 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 supervised consumption sites.**

We also analyzed each crime type separately to determine whether there were any significant changes before and after the implementation of supervised consumption services

Assaults

Neighbourhoods that implemented supervised consumption services did not experience a significant increase in the assault rate. Instead, **neighbourhoods with supervised consumption services experienced a statistically significant downward shift in the assault rate after the sites were implemented** ($p < 0.03$). No statistically significant downwards trend was observed in downtown neighbourhoods that did not implement supervised consumption services.

Figure 6. Supervised consumption site opening effect on assault rate

[25] All data used in these analyses are public and can be found here: https://data.torontopolice.on.ca/pages/open-data

Robbery

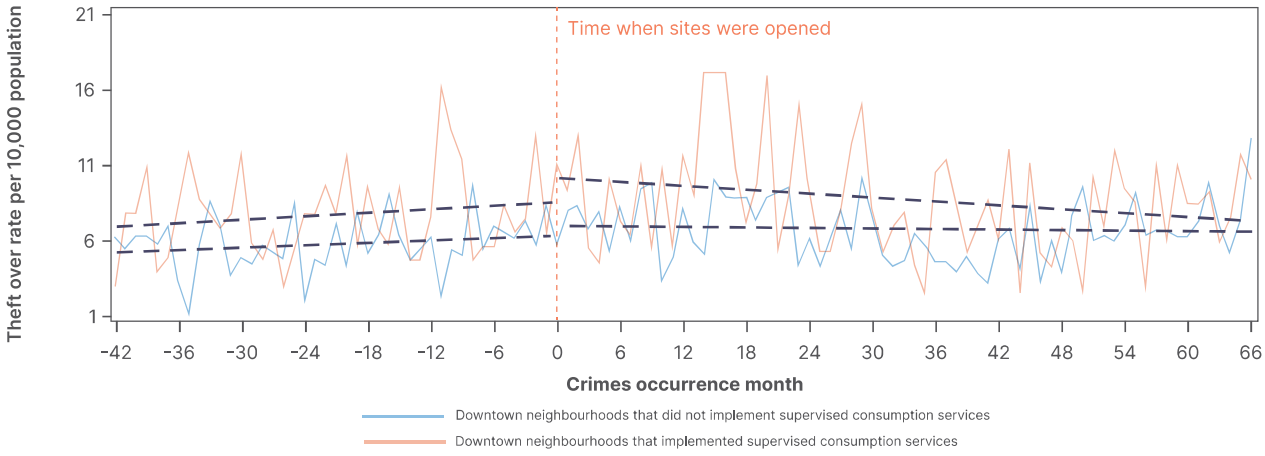
Neighbourhoods with supervised consumption services experienced a statistically significant downward shift in the robbery rate after the sites were implemented ($p < 0.01$). However, no statistically significant change in the robbery rate was observed in neighbourhoods that did not implement supervised consumption services ($p > 0.05$).

Figure 7. Supervised consumption site opening effect on robbery rate

Theft over $5000

There were no statistically significant changes in the rate of thefts over $5000 in either neighbourhoods that did and did not implement supervised consumption services.

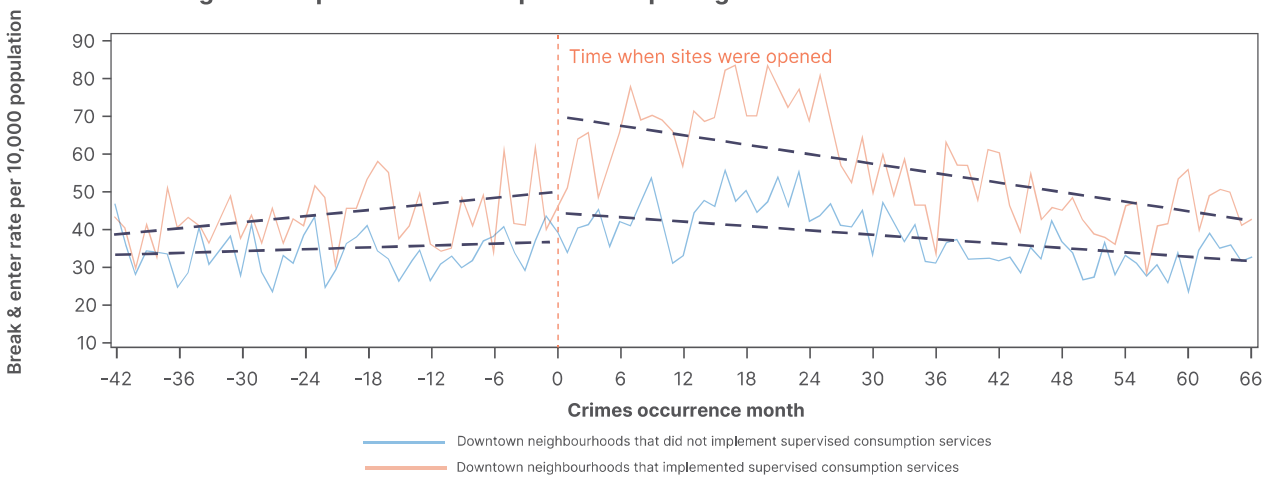
Figure 8. Supervised consumption site opening effect on theft over rate



Break & enter

Downtown neighbourhoods that did and did not implement supervised consumption services both experienced statistically significant increases in the break & enter rate after the period when supervised consumption services were implemented. **Both sets of neighbourhoods also subsequently experienced statistically significant downward shifts in the trend of break & enters** after the implementation of supervised consumption services ($p < 0.05$).

Figure 9. Supervised consumption site opening effect on break & enter rate



Crime data suggest that, contrary to claims made by the provincial government, downtown neighbourhoods that implemented supervised consumption services did not experience increases in crime. In some cases, Toronto Police Services data demonstrate that in the period after the implementation of these sites, neighbourhoods with sites experienced statistically significant decreases in major crimes.

6. Expert evidence on supervised consumption services from the Ontario provincial government: 2024

Consumption and Treatment Service Review Reports

In late 2023, the Ministry of Health appointed Jill Campbell as a supervisor of the South Riverdale Consumption and Treatment Service and asked Unity Health Toronto to conduct an external review.

- Consumption and Treatment Service Review — Prepared by Unity Health Toronto (PDF)
- Community Engagement Report — Prepared by Unity Health Toronto (PDF)
- South Riverdale Community Health Centre: Consumption and Treatment Services — Supervisor's Report (PDF)

The announcement of a provincial ban on supervised consumption services in August 2024 was accompanied by the release of two taxpayer-funded expert reports commissioned by the provincial government. One report was undertaken by staff from the office of the provincial Medical Officer of Health,[26] and another report was undertaken by staff at Unity Health Toronto. No staff involved in the report commissioned by the provincial government were involved in the production of this brief.[27] A third report, also prepared by Unity Health Toronto staff under contract to the provincial government, covered recommendations related to community engagement. We present recommendations from these reports made to government with respect to the impact and operation of supervised consumption services in Ontario.

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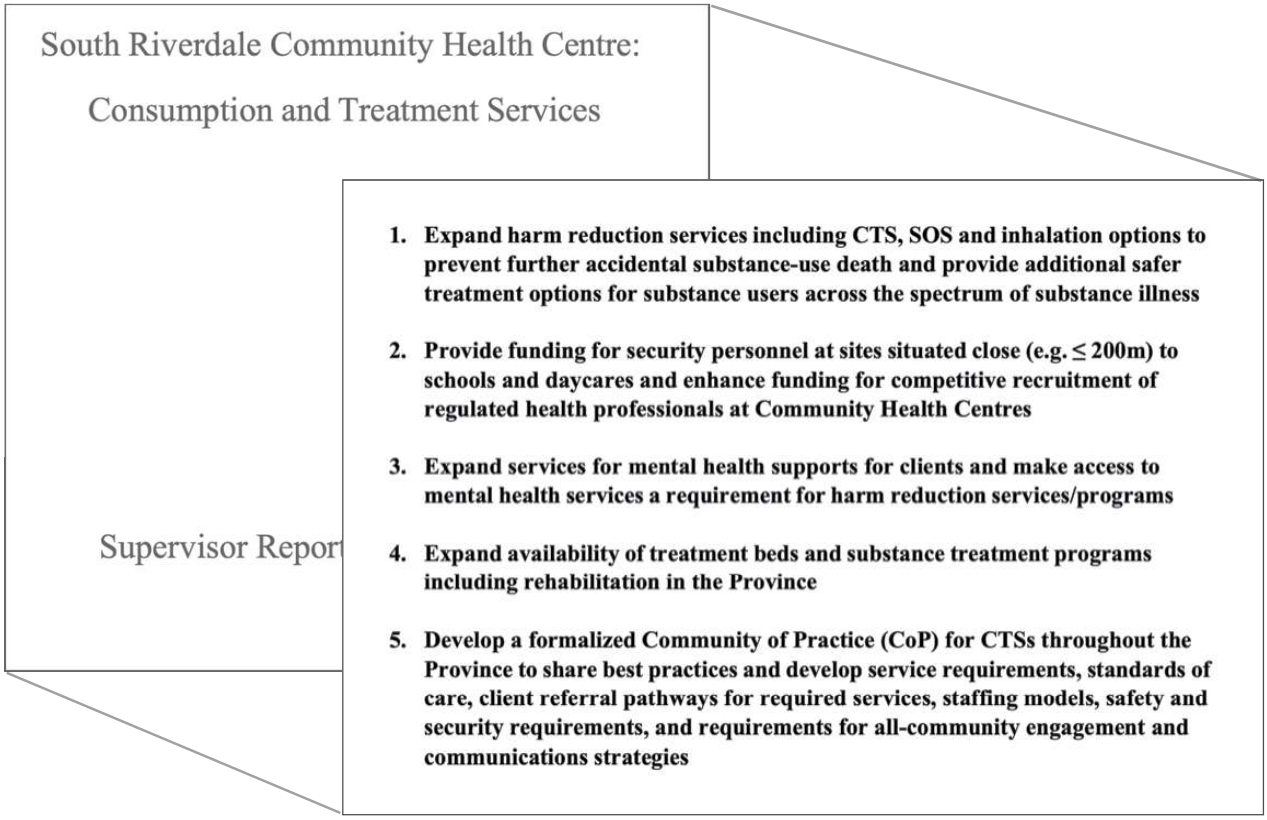
[26] This report available at: https://www.ontario.ca/files/2024-08/moh-south-riverdale-community-health-centre-cts-supervisor-report-en-2024-08-19.pdf.

[27] This report available at: https://www.ontario.ca/files/2024-08/moh-consumption-treatment-service-review-unity-health-en-2024-08-19.pdf.

6.1 The Supervisor's report


South Riverdale Community Health Centre:

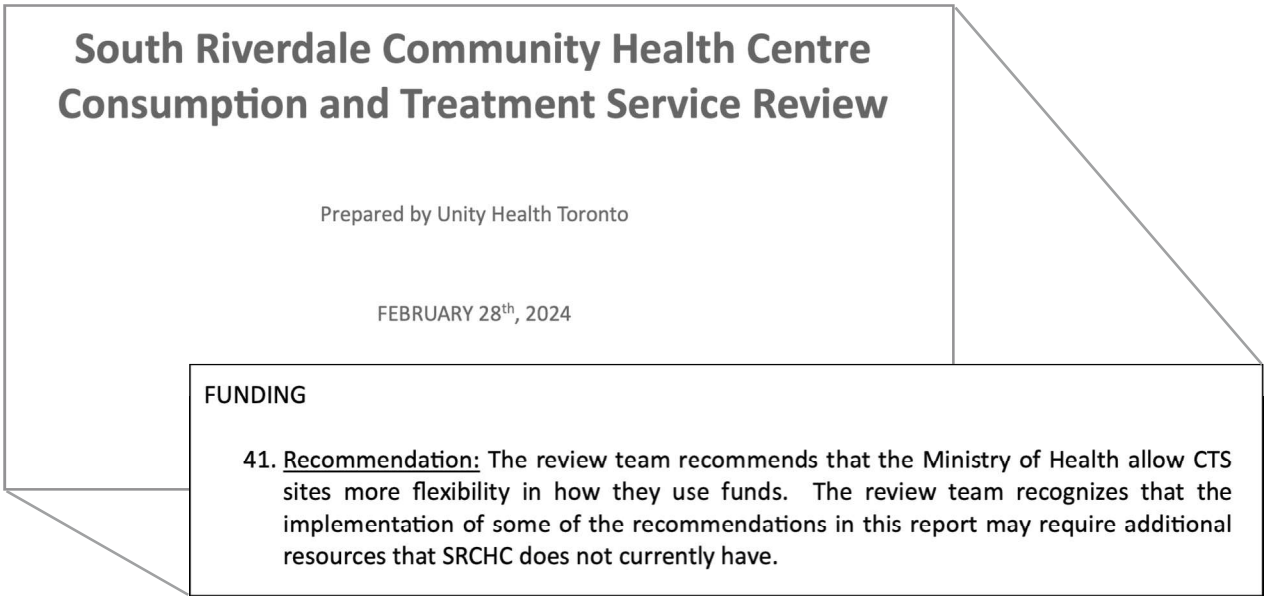
Consumption and Treatment Services

Supervisor Report

1. **Expand harm reduction services including CTS, SOS and inhalation options to prevent further accidental substance-use death and provide additional safer treatment options for substance users across the spectrum of substance illness**
2. **Provide funding for security personnel at sites situated close (e.g. ≤ 200m) to schools and daycares and enhance funding for competitive recruitment of regulated health professionals at Community Health Centres**
3. **Expand services for mental health supports for clients and make access to mental health services a requirement for harm reduction services/programs**
4. **Expand availability of treatment beds and substance treatment programs including rehabilitation in the Province**
5. **Develop a formalized Community of Practice (CoP) for CTSs throughout the Province to share best practices and develop service requirements, standards of care, client referral pathways for required services, staffing models, safety and security requirements, and requirements for all-community engagement and communications strategies**

The supervisor's report, which focused on the services offered at South Riverdale Community Health Centre, recommended **expanding** the availability of supervised consumption services at South Riverdale Community Health Centre, as well as providing additional funding to support the service. **No recommendations were made to close supervised consumption services.**

6.2 Consumption and treatment service review – Unity Health Report



> The Unity Health Toronto report also focused on services offered at South Riverdale Community Health Centre. It included 40 recommendations to improve the provision of consumption and treatment services and reduce potential issues with public safety in the surrounding area.

The report also included one recommendation (Recommendation 41) to **increase funding** to provide South Riverdale Community Health Centre the resources it requires to address potential public safety issues stemming from the provision of supervised consumption services. **No recommendations were made to close supervised consumption services.**

Both taxpayer-funded expert reports recommended expanding funding and resources to support supervised consumption services. Neither suggested closing supervised consumption services. Additionally, both reports were limited in scope to the supervised consumption services at South Riverdale Community Health Centre. No scientific evidence was provided by the government related to any other supervised consumption services operating in Ontario.

7. Summary

Scientific evidence generated over decades from a variety of jurisdictions suggests that supervised consumption services are among the most effective approaches to preventing overdose. Additionally, recent findings from Ontario demonstrate that these sites are effective at improving public health outcomes while not contributing to major crimes.

Specifically, scientific evidence demonstrates that:

- Supervised consumption services in Toronto are overwhelmingly accessed by people who are homeless or unstably housed.
- People who access these sites are also more likely to access addiction treatment.
- Accessing supervised consumption services in Toronto is not associated with increased drug-related risk-taking.
- Supervised consumption services in Ontario are key sites of referral, including to testing and treatment of referral into testing and treatment of infectious diseases such as hepatitis C.
- Accessing supervised consumption services in Toronto was associated with a subsequent 50% reduction in high-frequency public injecting among clients who were homeless or unstably housed.
- Supervised consumption services in Ontario have, over the past four years, provided services to approximately 178,000 unique clients, who have collectively made over 1.1 million visits.
- During this time, these sites have also successfully reversed 22,000 non-fatal overdoses.
- These sites have also provided over 500,000 service and treatment referrals to clients.
- Neighbourhoods in Toronto that implemented supervised consumption services subsequently experienced a two-thirds reduction in overdose mortality.
- Areas close to these sites in Toronto experienced significant reductions in the homicide rate, while areas further away experienced increases.
- The rate of major crimes in neighbourhoods with supervised consumption services generally declined after their implementation. Crime rate increases observed in neighborhoods with supervised consumption services were comparable to those seen in neighborhoods without these facilities.
- Taxpayer-funded expert reports commissioned by the provincial government unanimously recommended maintaining supervised consumption services and expanding their funding, both in 2018 and in 2024.

8. Recommendations

This report summarizes evidence generated by the Ontario provincial government, by international scientific experts, and by a team studying supervised consumption services in Ontario supported by the Canadian Institutes of Health Research.

It is imperative that public health and community safety are both prioritized in the response to overdose and other drug market-related harms. The scientific evidence collected to date strongly suggests that supervised consumption services are critical in meeting the needs of people at risk of overdose, of connecting them with services including addiction treatment, and do not appear to contribute to major crimes including homicide.

Based on this scientific evidence, we recommend the following steps:

1. Reverse the decision to close supervised consumption services in Ontario.
2. Make public all scientific evidence related to the provincial government's decision to ban supervised consumption services.
3. In line with taxpayer-funded expert reports, provide supervised consumption services with increased funding to expand their services and mitigate any potential public safety issues that may arise.
4. Meaningfully expand Ontario's addiction treatment system.
5. Properly fund a comprehensive system of care for substance use in Ontario that integrates supervised consumption services, other frontline service providers, a responsive treatment system, and supportive housing.

9. References

CBC News. Province cut some injection sites because area residents 'upset,' Ford says. April 1, 2019. Toronto: CBC News. https://www.cbc.ca/news/canada/toronto/province-cut-some-injection-sites-because-area-residents-upset-ford-says-1.5079616.

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/.

Government of Canada. (2024). "Opioid- and Stimulant-related Harms in Canada." Available at: https://health-infobase.canada.ca/substance-related-harms/opioids-stimulants/.

Government of Ontario. (2024). "Ontario Budget: past editions." Available at: https://www.ontario.ca/page/ontario-budget-past-editions.

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.

Greenwald, Z. R., Z. Bouck, E. McLean, K. Mason, B. Lettner, J. Broad, Z. Dodd, T. Nassau, A. I. Scheim and D. Werb (2023). "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 30(2): 160-171.

Kennedy, M. C., M. Karamouzian and T. Kerr. (2017). "Public health and public order outcomes associated with supervised drug consumption facilities: A systematic review." Current HIV/AIDS Reports 14(5): 161-183.

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." Americal Journal of Preventive Medicine 61(5): 738-749.

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.

Ontario Drug Policy Research Network. Suspect Drug-Related and Drug Toxicity Deaths in Ontario. 2024. https://odprn.ca/occ-opioid-and-suspect-drug-related-death-data/2024.

Ontario Ministry of Health and Long Term Care. Ontario Government Connecting People with Addictions to Treatment and Rehabilitation. Toronto: Government of Ontario; 2018. https://news.ontario.ca/en/release/50237/ontario-government-connecting-people-with-addictions-to-treatment-and-rehabilitation.

Ontario Protecting Communities and Supporting Addiction Recovery with New Treatment Hubs. (August 20, 2024). Toronto, Government of Ontario. Available at: https://news.ontario.ca/en/release/1004955/ontario-protecting-communities-and-supporting-addiction-recovery-with-new-treatment-hubs.

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.

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.

Scheim A, Werb D. "Integrating supervised consumption into a continuum of care for people who use drugs." CMAJ 2018; 190(31): E921.

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.

Werb, D., H. S. Sung, Y. Na, I. Rammohan, J. Eeuwes, A. Owusu-Bempah, A. Smoke, T. Kerr and M. Karamouzian (2024). "Investigating the Spatial Association between Supervised Consumption Services and Homicide Rates in Toronto, Canada, 2010-2023." Available at SSRN: https://ssrn.com/abstract=4969290 or http://dx.doi.org/10.2139/ssrn.4969290.

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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