

To: Toronto Board of Health and City Councillors  
cc. Mayor John Tory  
Date: July 4 2016

RE: 'Supervised injection site' at the Queen West Community Health Centre

We are a growing non-partisan group of local residents from across Toronto Wards 19 and 20 who object to the democratic deficit regarding the proposal to implement a 'supervised injection site' in our neighbourhood. We call upon our elected representatives to halt the expedited approval process until such time as open transparent and meaningful dialogue can occur that is inclusive of a broad range of stakeholders in the local community. Drawing on Daniels and Sabin's (2002<sup>1</sup> Accountability for Reasonableness framework (A4R) for due process in healthcare decision-making, our concerns are the following:

- the perfunctory and rushed local 'public consultation' process
- the dissemination of misleading, biased or inaccurate information in public presentations and meetings to manufacture consent
- the failure to present all evidence impartially (both positive and negative)
- lack of due consideration to balancing public safety and public health
- the inappropriate location close to a school
- the lack of consideration of alternative options that pose less risk of harm to individual injection drug users and to neighbourhoods
- the lack of due process according to the protocol outlined in the *Toronto Drug Strategy* (Recommendation 65 as amended and approved by City Council) as well as recommendations outlined in reports (*TOSCA* and *Toronto Residents Reference Panel*), and the Supreme Court Ruling of 2011.

Local residents and businesses have been excluded from the decision-making process until the eleventh hour. In the interests of democratic governance, we urge the Mayor and all Toronto City Councillors to slow down the expedited process initiated by SIS advocates, and to insist on local participation and genuine unbiased public consultation at the community level. We expect our elected local representatives to listen to, and represent the interests of all constituents and stakeholders, not just the particular interests of organized lobby groups that arguably stand to benefit from SISs.

Attached is a summary of our collective analysis based on public documents and a research literature review, as well as our experiences and observations of the so-called 'public consultation' process, together with endnotes of sources cited.

It has been frequently stated that the safest and most appropriate place for an SIS is in a hospital. If Toronto Public Health and SIS advocates believe so vehemently in the safety of such sites outside a hospital setting, then rather than the proposal foisted upon residential neighbourhoods by fiat, and given that drug use in Toronto is widely dispersed, it would be more prudent and appropriate to conduct a pilot

first, with a mobile SIS facility. Not only do mobile facilities offer wider outreach and greater flexibility, but also such a pilot would provide practical on-the-ground experience of city-wide drug use patterns, and an evidence base for the viability and efficacy of SISs in Toronto. Such a pilot could also contribute towards research on a hard-to-reach group with less risk of disruption and harm to local neighbourhoods. Precedents for mobile drug consumption facilities currently exist in Barcelona and Berlin.

As local residents, we urge the Mayor and Councillors to carefully consider how participatory democracy and 'evidence based policy' ought to operate in a democratic society. While other ward councillors may feel relieved that their ward escaped selection in this first round, SIS advocates are on record stating the intention to open more sites across the City of Toronto. Therefore, in voting in favour of implementing three 'supervised injection sites,' all councillors are endorsing this particularly controversial form of harm reduction in our city, and should be wary of their constituencies being impacted in future, by stealth and by increment.

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<sup>1</sup> Norman Daniels and James Sabin (2002). *Setting Limits Fairly: Can We Learn to Share Medical Resources?* Oxford, England: Oxford University Press.

See also Eastern Health (2014). *Accountability for Reasonableness (A4R): An Ethics and Values based Framework for Planning, Priority Setting, and Allocation of Resources.*

By stealth and by increment, advocates of “supervised injection sites” (SIS, also known as “drug consumption rooms”) have prepared for the implementation of three SISs in Toronto, PRIOR to and without an open or meaningful local community consultation process.

A great deal of preparatory work for the implementation of SISs has been going on behind the backs of local residents who live, work, play, and raise families in the neighbourhood of the three locations ‘chosen’ for this *most controversial of all harm reduction strategies*. SIS advocates subscribe to a narrow definition of harm reduction, monopolizing the term and polarizing the debate; according to the Canadian Centre on Substance Abuse:

Strongly-held opinions on both ends of the ‘harm reduction’ spectrum have caused a rift between people who should be working together to improve the lives of drug users and reduce societal problems. This ideological argument is unproductive and threatens the credibility of scientists and practitioners and, more importantly, hinders the implementation of well-intentioned and effective policies, supports, services, interventions, and treatments aimed at protecting all people from the adverse health and social consequences associated with drug use. (Beirness et al. 2008<sup>1</sup>, p. 3)

At one extreme end of the spectrum lie SIS advocates for drug legalization, and at the other end lie ‘tough on crime’ advocates; both adhere to strong ideological positions that rely on selective ‘scientific evidence’. Using a narrow definition of ‘harm reduction,’ SIS service providers and users present a united front, downplaying the divisions that exist among professionals working in addictions, and stacking Toronto Board of Health and ‘public consultation’ meetings with SIS lobby groups.

The writ declaring of the locations of the three sites was dropped in a media announcement on March 14 2016, with a self-imposed rushed deadline to push through local ‘public consultations’ and report back to the Toronto Board of Health for its approval on July 4 2016. A private for-profit communications company, MASS LBP, was hired to manage the message and curtail meaningful community input by preemptively framing the debate. With ready-made media packages in hand, not only did MASS LBP and its stock of ‘facilitators’ orchestrate ‘public consultations’, but it also orchestrated the Toronto Residents’ Reference Panel and the Toronto SIS survey. The fact that this company was hired and funded by SIS lobbyists raises doubts about its independence to report back impartially, without conflict of interest.

### ***Toronto Residents’ Reference Panel (2014<sup>2</sup>)***

The Toronto Residents’ Reference Panel was comprised of 36 residents (of whom two dropped out) from the catchment area of the Toronto Central Local Health Integration Network (LHIN). The panel met over four Saturdays and was oriented to the task by ‘expert’ presentations and weekly readings. Out of 16 presentations, 14

were SIS proponents, with only two SIS skeptics. Such an imbalance in the orientation process suggests biased priming to deflect attention away from the highly contentious nature of the issue. Given a limited mandate, the panel's task was explicitly not to decide whether a SIS is appropriate in Toronto, nor to determine locations, but to design a community consultation framework to "tackle a difficult, highly charged issue" (p. 7). The underlying premise assumes SIS implementation as a *fait accompli*; the panel's task was merely to preemptively satisfy the legislative requirement of community consultations, and find ways to conduct them to allay public concerns or overcome opposition to these facilities. As stated in the Toronto Residents' Reference panel report:

He [Peter McLeod, panel chair and co-founder of MASS LPB] explained that if a federal Health Minister were to reject an application to open such a facility on the grounds of inadequate evidence of public consultation, the Supreme Court could turn to their report as a guiding document on reasonable community consultation. He also explained that the provincial government, if asked to fund a SIS in Toronto, would likely take into account the guidance described in the panel's report. (p. 49)

From this statement, it seems that the Reference panel was set up as a preemptive strike to gather evidence for Supreme Court litigation, as well as to suppress local opposition. The Reference Panel itself does not constitute local community consultation as participants were selected from a broader catchment area than the three sites. The selected panelists were called upon to anticipate likely concerns, and to make recommendations for counteracting them. In coming up with their recommendations, the panelists were outnumbered by 65 'invited' guests (p. 52) and overseen by "senior staff from St. Christopher House and the Toronto Central LHIN" (p. 53). The final report was edited by MASS LBP's "facilitation team" (p. 54). As such the residents' reference panel can more accurately be described as a workshop exercise on how to manufacture consent for SISs.

An issue identified by the panel (across all subgroups) was that consideration be given to locating any SIS away from proximity to facilities for vulnerable children and youth:

"We feel that children are one of these important stakeholder groups, especially when determining whether a location is appropriate for a SIS, since children may be particularly vulnerable to inadvertent contact with drug paraphernalia." (p. 32); such facilities should be "a reasonable distance from schools and other child-friendly settings" (p. 33); "the needs of vulnerable children and youth in the neighbourhood where a SIS could be located should be paramount." (p. 35), and "the protection of vulnerable children and youth should come first." (p. 36)

In this hypothetical context, a community-conscious panel member stressed the importance of taking local neighbourhood input seriously:

However, if local residents and businesses express strong opposition to a proposed SIS being located in their neighbourhood, governments should

require the operator of the proposed SIS to find another location. ... The concerns of ordinary people who live, work, play, go to school, earn their livelihood or raise their children in a neighbourhood, should be paramount. (p. 60)

### **Town Hall Meeting: Scadding Court (April 14 2016)**

The evidence presented at our 'public consultation' meeting on April 14 2016 at Scadding Court Community Centre was one-sided and highly selective, thereby giving a positive spin to SISs, deliberately ignoring any countervailing evidence, or alternative harm reduction strategies. Modelled on Vancouver's Insite supervised injection site, it would appear that the SIS proposal for Toronto was a "done deal" before local residents were notified or consulted. Despite vast differences between Vancouver and Toronto in drug use and concentration patterns, and HIV and Hepatitis C infection rates, the Insite model is to be copied in Toronto, albeit in three locations within a few kilometers of one another. In his PowerPoint presentation, the Medical Officer of Health showed a pretty photograph, not of Insite, but of the Dr. Peter Centre in Vancouver; this is misleading as this Centre began primarily as a small residential facility for HIV/AIDS patients and is therefore not comparable to a drop-in supervised injection site.<sup>3</sup>

In his presentation, the Medical Officer of Health emphasized the spike in overdose deaths in all of Toronto in 2014. While serving a highly emotive purpose and framed as a 'crisis,' the Medical Officer failed to acknowledge that determining a cause of overdose death, with certainty, can be difficult. However, a communiqué with the Coroner's Office shows that overdose death statistics are only aggregate level data that are not broken down by ward or local district, and do not distinguish by method of consumption (injecting, inhaling or swallowing), or whether death was accidental or by suicide. As such, Coroner's statistics are inadequate to establish evidence of local need for an SIS in any particular location. What was not mentioned is that SISs can only intervene to prevent overdose deaths within the SIS facility itself (where the average length of stay is 20-30 minutes), or that only 5% of illegal drug injections in the DTES of Vancouver take place at Insite.<sup>4</sup>

The Executive Director of Queen West Central Toronto Community Health Centre (Angela Robertson) showed architectural plans of the injection facility (apparently well under way) and some ambiguous statistics: numbers of needles distributed; numbers of client visits; estimates of numbers of clients who inject drugs (anywhere from 368 to 774). While undoubtedly well-intentioned, presenting numbers in this way reads like fee-for-service data, without clarifying the nature or extent of local need in the immediate neighbourhood in terms of reliable data on problem injection use. While Queen West Community Health Centre apparently draws from a wide catchment area (spanning from the lake to College St, and from Yonge St. to Dovercourt Rd.), 51% of clients at the Centre are without stable housing or homeless.

There were no police officers present, nor anyone else to address related public safety issues. The purpose of the meeting was not about community input on the needs of our local community and how best to address them, but to assuage or placate public concerns about a SIS in our neighbourhood; that is, channeling complaints to silence opposition.

Peter McLeod of MASS LBP acted as master of ceremonies and permitted only a handful of questions following PowerPoint presentations by the 'experts': Toronto Medical Officer of Health (David McKeown) and the Executive Director of Queen West Community Health Centre (Angela Robertson). Most questions were not aired as the facilitator in control of the microphone had apparently determined in advance the maximum number of questions to be allowed, despite objections from residents. Some of the comments expressed publicly were: the partiality or lack of objectivity of the data presented; the location of the facility close to an elementary school (St. Mary Catholic School), and security concerns of local businesses.

When no more questions were allowed and attendees were ordered to break out into small groups, a local resident objected: "We have listened to you, now you listen to us!" Nevertheless, community input was reduced to passively registering individual concerns with an MASS LBP 'facilitator,' to be compiled and edited into a report for the next phase of implementation.

As one business operator present at the 'public consultation' meeting remarked later: "I did join that community information held in April. Like 99% of the people that showed up I did not get a chance to ask my questions as they specifically stated that only 4 questions would be allowed in. Essentially I also feel they are rushing this process and the meeting felt like they just wanted us to 'drink the Koolaid.'" (email communiqué, May 12, 2016)

### **Town Hall Meeting: Trinity Community Recreation Centre (June 20 2016).**

A group of residents, who were either not informed about the April 14 meeting or objected to how it was conducted, requested Councillor Mike Layton hold a second meeting specifically to address *public safety* concerns. While the firm MASS LBP was not visible at this meeting, the panel was again comprised exclusively of public health proponents (Dr. McKeown, Angela Robertson, Carol Strike etc.). This meeting can more accurately be described as an SIS rally, and not a local public consultation. Again the spike in overdose deaths was raised as the main rationale for SISs.

No police spokesperson or anyone else was on the panel to address potential impacts of drug-related crime or harm to the neighbourhood. 'Public safety' was reduced to 'public nuisance,' with claims that SISs reduce public injection and discarded needles. Loud clapping and cheering from SIS advocates – many of whom do not live in the neighbourhood – intimidated local residents and inhibited them from raising questions. An avid supporter declared how "excited" she was about the SIS. A woman from Riverdale spoke of her brother's 15-year addiction that ended in death by overdose outside the Works site which he

frequented, vowing he'd still be alive had there been an SIS. Another SIS advocate went so far as to proclaim in no uncertain terms that she wanted no police in the neighbourhood, harassing people hanging out around the Queen West Health Centre. At that point, the Medical Officer of Health did intervene to say that SISs work best with police support. Amidst such emotional intensity and ideological fervor, there was no space for reasonable, open and transparent debate. While the intention may have been to demonstrate overwhelming support by bringing out staunch advocacy lobby groups, for many local residents it raised concerns about the democratic deficit in 'public consultation.'

CTV Toronto News aired a clip on the meeting, titled: *A Community Divided*.<sup>5</sup>

### **Supreme Court Ruling (2011<sup>6</sup>)**

The Supreme Court ruling on Insite (2011) stressed the dual importance of public health and *public safety*, and of striking a balance between them. This ruling pertains to the specific case of the renewal of an exemption for the pre-existing site of Insite, under section 56 of the *Controlled Drugs and Substances Act*. The ruling rejected the cross-claim of VANDU (Vancouver Area of Network Drug Users) and states explicitly that the ruling is "...not a licence for injection drug users to possess drugs wherever and whenever they wish. Nor is it an invitation for anyone who so chooses to open a facility for drug use under the banner of a 'safe injection facility.'" (paragraph 140)

Based on the evidence and arguments before them, the ruling explicitly states at paragraph 151 that it is not intended to fetter the Minister's discretion with respect to future applications for exemptions for other premises (nor for Insite in future). In fact, the ruling itemized five factors that the Minister "must" consider in deciding on future injection sites, among which are "expressions of community support or opposition." At paragraph 153, the Supreme Court ruling states in full:

[153] The *CDSA* grants the Minister discretion in determining whether to grant exemptions. That discretion must be exercised in accordance with the *Charter*. This requires the Minister to consider whether denying an exemption would cause deprivations of life and security of the person that are not in accordance with the principles of fundamental justice. The factors considered in making the decision on an exemption must include evidence, if any, on the impact of such a facility on **crime** rates, the local conditions indicating a **need** for such a supervised injection site, the **regulatory structure** in place to support the facility, the **resources** available to support its maintenance, and **expressions of community support or opposition**. (bold added)<sup>7</sup>

### ***Toronto and Ottawa Supervised Consumption Assessment (TOSCA 2012<sup>8</sup>)***

The TOSCA feasibility study (principal co-investigators Bayoumi and Strike) identifies 'NIMBYism' as the greatest challenge to implementation. In using this pejorative term, the authors assume self-interest of local stakeholders as the motivation for resistance, rather than valuing the first-hand knowledge that residents and business owners have of their local communities, thereby dismissing

any genuine legitimate concerns about impacts on the quality of life in the local neighbourhood. For these reasons, the NIMBY concept is severely limited in understanding public engagement in controversial siting disputes (Burningham, Barnett & Thrush 2006<sup>9</sup>), such as the location of an SIS.

The TOSCA study reiterates on several pages that:

“Even residents and business owners who were supportive of supervised consumption facility implementation did not necessarily want to see a facility in their own residential neighbourhoods or near their businesses.” (p. 10, 182-3, 211)

“Acceptance of a supervised consumption facility often hinged on the condition that a supervised consumption facility would not be located near their own homes, even among stakeholders who supported supervised consumption facilities.” (p. 100)

To combat ‘NIMBYism,’ locations are identified where opposition would impede implementation: not in affluent neighbourhoods, not in the suburbs, and not in neighbourhoods overburdened with drug-related facilities:

“Various stakeholders perceived that affluent neighbourhoods will not be chosen as potential supervised consumption facility locations because such neighbourhoods would be better equipped politically to resist implementation.” (p. 213)

“Some stakeholders believed that certain communities (for example, affluent communities) are more likely than others to be consulted and to be heard when they raise concerns.” (p. 215)

“Some stakeholders worried that supervised consumption facilities would ‘overburden’ neighbourhoods where drug-related and other social services are already located.” (p. 213)

In the suburbs, SISs “wouldn’t be tolerated.” (Ottawa EMS participant, p. 212)

The police in the TOSCA study were unequivocally opposed to SIS:

“Police often stated that there would be **no appropriate location** for a supervised injection site” (p. 213, bold added).

TOSCA was not called upon to select a specific *location* – the most contentious aspect of implementation. The report recommended that there be three sites in Toronto (and two in Ottawa) to avoid a single facility becoming a focus of opposition, and “to minimize possible impacts on local neighbourhoods.” (p. 14)

It should be noted that in conducting their feasibility study, residents and business owners constituted only a minor contingent of key informants: for Toronto the TOSCA team interviewed only two residents and held two focus groups of residents with a total of 11 participants. It conducted no interviews with business owners, and held one focus group of business owners with a total of six participants (Table 1, p.

295). How participants were selected is unknown. No interviews and no focus groups were conducted with community safety groups; that is, it would appear that residents and business owners were a negligible afterthought, dismissively labelled as 'NIMBY' impediments to implementation of TOSCA's recommendation to open three supervised consumption facilities in Toronto.

### **What is evidence-based research?**

Insite's embedded team of researchers (Evan Wood, Thomas Kerr, Julio Montaner from the B.C. Centre for Excellence in HIV/AIDS) have produced the vast majority of research and branded themselves as *the* 'expert' authority for 'evidence-based' policy on SISs in Canada and elsewhere.

Critiques of the B.C. team's research reveal methodological flaws, and expose the findings as overstating positive outcomes and understating negative outcomes, suggesting the problem of researcher bias. The exclusion of countervailing evidence or alternative propositions from the public debate is irresponsible and anti-democratic; it is also contrary to the spirit of scientific inquiry. In fact, the lead investigators of the B.C. team engaged in lobbying efforts with Insite's operators and clients from the outset, years before Insite opened in 2003. Such activist research blurs the line between science and advocacy. When conflicts of interest are not declared, ideological bias is hidden behind a neutral banner of scientific 'objectivity.' It is important to recognize the controversies and debates in academic, professional and political circles about SISs. 'Evidence-based' decision making should take into account *all* available research; that is, not just the current dominant view of SIS advocates that crowds out the research literature, with a propensity for relatively simple studies that take few factors into account. Such research is readily amenable to media packaging by politically savvy communications strategists, repeating catchy slogans ad nauseum: 'Insite saves lives,' or 'the war on drugs hasn't worked;' such simplistic slogans belie the complexities of the issues involved.

It is especially crucial to view 'evidence-based' research with a critical eye when there are policy implications that could have significant impacts on people's lives. It is noteworthy that 'facts' picked as evidence for SISs for public dissemination have been lifted from the contexts in which they were published, where responses, commentaries and critiques show the wider scientific debate in medical journals (see for example, controversies in the *Canadian Medical Association Journal*<sup>10</sup> and the *Lancet*<sup>11</sup>).

It is irresponsible for the 'experts' to selectively pick the 'facts' in order to make their case with categorical statements that are false: no increase in drug dealing, no increase in crime, and no overdose deaths within an SIS. However, a survey of European sites shows 40% of sites reported an increase in drug dealing, and 20% of sites reported negative impacts on the community including increases in aggressive incidents and petty crime in the vicinity (Kimber et al. 2005<sup>12</sup>). There has been at least one report of an overdose death within a facility (Gerlach and Schneider 2002<sup>13</sup>).

Whereas the notion of “drug consumption rooms” originated in Europe over three decades ago in response to the HIV/AIDs crisis of the time, Insite in Vancouver and the Medically Supervised Injection Centre (MSIC) in Sydney, Australia have popularized the notion as the latest hot idea, as if ‘there is no alternative.’

A recent meta-study of the research literature on supervised injection services found that while the majority of SISs are in Europe, 85% of journal articles emanate from Vancouver (68%) and Sydney Australia (17%), thus drawing attention to the dominance of well-funded research conducted by researchers at these two sites:

...the majority of the systematically identified publications were related to the Canadian or Australian SISs, which have received significant means to evaluate their structures. ... This lack of inclusion [of European studies] in databases results in a lack of visibility of European data on SISs, although SISs are most numerous in Europe. Consequently, there is a noticeable geographic imbalance between the actual representation of the active SISs in the world and the places where the majority of data were collected (Potier et al. 2014,<sup>14</sup> p. 65).

While the majority of drug consumption rooms are located in northern Europe, only a handful of countries have opted for them, including Switzerland, the Netherlands, Germany, and Spain. Some sites in these countries have closed due to a reduction in injecting heroin use and a decline in need, cost considerations, or the emergence of alternative programs, such as in the Netherlands (EMCDDA 2011, 2015<sup>15</sup>). However, the majority of European countries have not opted for drug consumption rooms. Sweden and Portugal constitute two examples of alternative harm reduction approaches.<sup>16</sup>

SISs may in fact be passé due to a shift in drug use patterns and profiles of people who use drugs, from injection to smoking, and an increasing number of users of cocaine, alcohol, and prescription drugs. The shift from a singular public health perspective towards more progressive multidisciplinary approaches takes into account broader social, economic and legal supports (Schat and Nougier 2012<sup>17</sup>). As a result in Europe where the vast majority of sites are located, “in recent years, political support for harm reduction has faded in many countries” (Sara Woods 2014<sup>18</sup>).

Local resistance is common in every location where SISs have been proposed. A German study identifies parents of children as a group most likely to oppose drug consumption rooms (Schu et al. 2005<sup>19</sup>) due to the impact on the quality of the environment in which to raise children. Other research has indicated that homeless and street-involved youth who are vulnerable and gravitate to such facilities may be twice as likely to start injecting hard drugs. This raises serious concerns about the impact of such facilities on children and youth.

## Human Rights & Democracy

In keeping with the *Ontario Human Rights Code*, protection of vulnerable groups must be taken into account in selecting the location of sites. This includes protection from the discriminatory effects not only on those with the disability of substance dependence, but also children and youth. While there is limited specific mention of children in the *Charter*, Canada is a signatory to the *UN Convention of the Rights of the Child*<sup>20</sup> which recognizes children under the age of 18 years of age as a vulnerable group that is entitled to special rights and protections by legislative, administrative, social and educational bodies. However, children have no voice of their own in this matter except through their parents/guardians.

Liability may ensue from locating sites in proximity to places frequented by children and youth: schools, parks, playgrounds, daycares and community centres. Due to the risk of harm from inadvertent contact with discarded needles and drug-related activity, it is preferable to locate SISs away from residential neighbourhoods where children and youth live, play and attend school.

Liability may also ensue from street-purchased contaminated drugs over which there is no quality control. The emergence of more toxic drugs poses increased risks of harm to users, such as fentanyl, and more recently, W-18 for which there is currently no overdose antidote. Changes in the lethal toxicity of street drugs increase the risk of patients/clients dying on the premises, or suffering the long-term neurological consequences of hypoxia (oxygen deprivation). Furthermore, liability may ensue from releasing intoxicated people from the site who could, for example, be hit by a street car at this busy intersection. Liability under workplace safety legislation may ensue if harm comes to an SIS front-line worker in the line of duty.

Opposition to SISs is not about stigmatizing or stereotyping people addicted to opioids or preventing access to health services for this particular disadvantaged group (the relatively small target group of injection drug users), but about considering the *kind of service/s* offered under the banner of 'harm reduction,' and the *location* of any such facility so as to minimize the risk of harm to users *and* others.

Few would deny that drug dependency invariably wreaks havoc and despair in the lives of individual users and their families. Few would want children or teenagers to start using addictive or abusable substances. Few would deny that drug dependency is associated with drawing vulnerable girls and young women into the sex trade for exploitative purposes. Few can deny that the longer a person remains on harmful addictive drugs, the greater the risk of physical, mental and social harms to him/herself. Few can deny that addiction to street drugs is associated with risky, compulsive, and sometimes uncontrollable, drug-seeking behavior, or that illicit drugs are associated with a range of anti-social or criminal activities: from shoplifting, break and entry into homes or cars, to robbery, assault and violent crime. While not everyone suffering from drug addiction engages in such activity,

and drug users themselves can be victims of crime, the Toronto Police indicate that 90% of crime is either alcohol or drug-related.<sup>21</sup>

Because injection drug users bring their own pre-obtained street-purchased drugs to the site, SISs pose a public safety risk to the community as they do not deter, and may in fact attract, drug dealers to the vicinity to prey on vulnerable user/clients. If addiction is an illness, then the remedy entails treatment; alternatively, if addiction is a disability, then it entails special accommodations by institutions to facilitate participation in society. To hold low expectations of the prospect for recovery of marginalized injection drug users is discriminatory: those with family or community support and financial means can access rehabilitation programs.

What is missing is an open and transparent debate of the pros and cons, the merits and limitations of SISs, and the imagination to come up with a unique strategy that suits the particular geographic and cultural context of Toronto neighbourhoods in 2016. To deny that the evidence is mixed and that experts are divided on the issue of SISs is blatantly disingenuous. There is no magic bullet, but there are alternatives to the cheap 'quick fix' of SISs that entail risks of harm to the social fabric of neighbourhoods. While Insite claims to have achieved its objectives in the downtown eastside of Vancouver, there is no evidentiary basis to assume that SISs are by extension, the right solution for Toronto. In fact, Toronto may not have the drug problem that Vancouver has due to Jane Jacobs influence on city planning to create mixed neighbourhoods rather than ghettoizing the downtown core.

The DTES of Vancouver is the poorest postal code in Canada, with extremely high HIV infection rates, a heavy concentration of long-term drug users within a small area engaged in an open drug scene of public drug consumption. In an area with a long history of disadvantage and impoverishment, Insite may well serve its localized purpose, if one accepts at face value the findings of Insite's researchers (Thomas Kerr, Evan Wood, Julio Montaner et al.).

However, the recent declaration of a public health emergency in B.C by the provincial health officer (on April 14 2016) in response to a dramatic surge in drug-related overdose deaths, might give pause to re-consider the efficacy of B.C.'s version of harm reduction which entails extreme permissiveness in its laissez-faire approach towards street drugs and addiction; in the larger picture, lives are being lost. BC policies may have missed the boat in not recognizing the shift away from heroin injection to prescription opioids, and the risks associated with the ever-increasing toxicity of addictive substances, a trend also reported in Europe. In view of recent trends, SISs may in fact be passé.

In any event, Insite's findings cannot be generalized to different geographic and cultural settings. In Toronto, drug use is dispersed throughout the city and HIV infection rates are relatively low (*Toronto Drug Strategy* 2005<sup>22</sup>; TOSCA 2012). Toronto is not a port city where drugs enter the country. Queen and Bathurst is not Hastings and Main: rather than a preponderance of single-room occupancy hotels

for extremely marginalized people, our neighbourhood has a rich and diverse mix of subsidized housing, condos, and million dollar homes; a vital business strip that attracts tourists to its shops, restaurants, cafes and bars; parks and playgrounds where children play, and an elementary school in close proximity to the proposed site. All of this is at stake in the proposed SIS social experiment, the impact of which is unknown and cannot be predicted with certainty.

Two of the proposed Toronto facilities are located in close proximity to Catholic schools. The Toronto District Catholic School Board should know that prior to the opening of the Medically Supervised Injection Centre in Sydney Australia, the Vatican in Rome intervened by way of a letter tabled to the New South Wales Parliament: the head of the Vatican's Congregation for the Doctrine of Faith (at the time, Cardinal Ratzinger who became Pope Benedict XVI) is quoted as stating "...these facilities encourage the abuse of and illegal trafficking in drugs, undermine respect for law, degrade social mores, and oftentimes represent the first step towards decriminalization of drugs" (in Gunaratnam 2005, p. 19<sup>23</sup>).

Aside from the objections of religious organizations, ethics and values are at the heart of debates on controversial issues. What kind of society do we want to create? How should scarce health resources be distributed? SISs remain highly controversial because of the tension between *public health* and *public safety*. Social justice entails a greater commitment to addressing the social determinants of health and redressing the impacts of years of cutbacks to affordable housing, social and medical services. In an era of scarce health dollars, the question is whether SISs are a 'solution,' or whether expanding access to primary care and a wider range of treatment options with shorter wait times is a preferable alternative for drug users and their families, local communities, and society at large. Social justice entails providing opportunities for people to make their lives better. This begs the question: Why should the wealthy get treatment and the poor get "supervised injection sites"?

Moreover, injection drug users are not a monolithic group in terms of their drug use, histories, or aspirations. Some may support SISs while others do not. Women in particular are less inclined to use SISs for various reasons, and less in favour of such sites. A young woman in recovery from heroine addiction says:

I don't think safe injection sites are really harm reduction. They are saying, 'okay, come here, you can inject, here's a safe place and there will be no consequences. ... Having somewhere to go, where everybody is shooting up it's almost like a dream come true.

(<http://www.cbc.ca/news/canada/toronto/mother-opposes-safe-injection-sites-1.3496502><sup>24</sup>).

What was presented to our local community as 'public consultation' meetings was an unequivocal singular focus on the benefits of SISs, without weighing the downside evidence, and without acknowledging the highly contentious nature of SISs, both within professional circles and local communities. To exclude

'inconvenient' evidence from the discussion leaves the feeling of being subjected to a sales pitch, designed to overcome objections and seal the deal.

The TOSCA report and the Toronto Residents' Reference Panel report indicate extensive back-room organizing work to prime the public in advance of announcing the specific locations, and prior to holding so-called 'public consultation' sessions. Moreover, Toronto's *Supervised Injection Services Toolkit*<sup>25</sup> reveals the strategy for implementing SISs (drawing heavily on Vancouver's equivalent document). The reports and timing of news releases shows a deliberate intentional well-orchestrated public relations campaign and media strategy, to sway public opinion and to formulate anticipatory responses to opposition. To circumvent public opposition to this highly controversial proposal, David McKeown was quoted in the media saying, "Public consent is not a feature of federal approval, public consultation is." In this context, **what does 'public consultation' mean?** While public health departments and officials may be accustomed to autocratic decision-making, we expect our city councillors to be inclusive towards all stakeholders in the affected ward/s and to be democratically accountable.<sup>26</sup>

'Public consultation' meetings experienced thus far have been a monologue rather than a transparent and open dialogue. 'Consultation' resembles top-down decision-making, with a manipulative strategy designed to persuade local residents and business owners to go along with a pre-determined decision, but without any real power to affect the decision; it is analogous to manufacturing consent.

Omitting any countervailing evidence, and relying on mathematical modeling techniques conveys a sense of certainty where none exists. It is widely acknowledged that mathematical modeling techniques are hypothetical and speculative, and it is a well-documented sociological finding that measurable demographic and socio-cultural characteristics at the population level cannot predict individual behavior or outcomes. Not only is there scanty evidence demonstrating local need (as stipulated in the Supreme Court ruling), but solid baseline data is also necessary to measure and compare the benefits and pitfalls of interventions in particular locations over time. Only time would tell what the overall impact would be on our particular local communities.

### ***Toronto Drug Strategy (2005)***

It is incumbent on City Council to follow the spirit of its own protocol set out in the *Toronto Drug Strategy* (2005) under Recommendation 65 and Amendment (p. 59-60), as approved by Council:

Further, that City Council reaffirm that no consumption sites will be established unless the protocol is followed, which requires that **federal, provincial, municipal and police approval** be given prior to the establishment of such a facility, and during the feasibility study, the issue of **neighbourhood impacts** be **specifically addressed**, the ward Councillors be surveyed for residential groups that would be interested, and **staff seek the**

**input of those residential groups on this matter prior to the completion of the feasibility study.** (p. 60, bold added)

Neither Councillor Cressy (Ward 20) nor Councillor Layton (Ward 19) made any mention whatsoever of bringing a “supervised injection site” to the neighbourhood in their campaign platforms or materials; thus the citizens of the affected wards have not voted on this crucial issue for their communities. The exclusion of Police from the process and from town hall meetings leaves concerns about public safety and neighbourhood impacts unaddressed. Through a spokesperson, Toronto Police Chief Mark Saunders is on record as stating that such sites “cause enormous damage to neighbourhoods.” (<http://www.theglobeandmail.com/news/toronto/torontos-top-public-health-official-urges-supervised-drug-injection-sites/article29196176/>). At the Division 14 Community Police Liaison Committee meeting on May 17 2016, it was confirmed that the Police have not endorsed the supervised injection site.

Both TOSCA and the *Toronto Residents’ Reference Panel* stressed the critical importance of the community consultation process with local residents and businesses; that it should be “meaningful,” integral to decision-making, well in advance, inclusive of diverse perspectives (that is, not just SIS advocates), and not with important milestones in midsummer (July).

It would appear that these recommendations have not been heeded.

Such disregard for due process is not only anti-democratic but also indicative of contempt for local residents as legitimate stakeholders in the decision-making process. For these reasons, implementation of an SIS should be halted until such time as transparent and open dialogue can take place.

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<sup>1</sup> Douglas Beirness, Rebecca Jesseman, Rita Notarandrea and Michel Perron (2008). *Harm reduction: What’s in a name?* Ottawa, ON: Canadian Centre on Substance Abuse. <http://www.ccsa.ca/Resource%20Library/ccsa0115302008e.pdf>

<sup>2</sup> St. Christopher House (2014). *Toronto Residents’ Reference Panel on Supervised Injection Services: Final Report*. Toronto: St. Christopher House. <http://www.westnh.org/wp-content/uploads/2014/12/FinalReportResidentsPanelSISJuly2014.pdf>. Edited by MASS LBP.

<sup>3</sup> An HIV survivor, former volunteer and participant at the Dr. Peter Centre remarks on the cultural divide: “...this organization is one of the prime examples of how AIDS service organizations that were primarily but nonexclusively set up by the gay community were overtaken by homophobic drug users and men out of prisons.” (<https://plus.google.com/105844788556428716044/about>)

<sup>4</sup> Health Canada. (2008). Vancouver’s InSite service and other Supervised injection sites: What has been learned from research? Final report to the Expert Advisory Committee on Supervised Injection Site Research. Wood, E. (2005). Do supervised injecting facilities attract higher-risk injection drug users? *American Journal of Preventive Medicine*, 2005; 29(2): 126-130

<sup>5</sup> CTV News at 11:30 Toronto for Monday, June 20, 2016. <http://toronto.ctvnews.ca/video?clipId=890870&playlistId=1.2954542&binId=1.1476827&playlistPageNum=1&binPageNum=1>

<sup>6</sup> Canada (Attorney General) v. PHS Community Services Society, 2011 SCC 44, [2011] 3 S.C.R. 134. <http://scc-csc.lexum.com/scc-csc/scc-csc/en/item/7960/index.do>

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<sup>7</sup> In citing the *Charter*, it is noteworthy that 'liberty' is explicitly excluded in the ruling, although s. 7 of the *Charter* pertains to the "right to life, liberty and security of the person." If intentional, this is presumably to avoid conflict with the *Criminal Code of Canada* where conviction may entail imprisonment or loss of liberty.

<sup>8</sup> Bayoumi, Ahmed and Carol Strike (2012). *Report of the Toronto and Ottawa Supervised Consumption Assessment Study*. Toronto: St. Michael's Hospital and Dalla Lana School of Public Health.  
<http://www.catie.ca/sites/default/files/TOSCA%20report%202012.pdf>

<sup>9</sup> Kate Burningham, Julie Barnett & Diana Thrush (2006) *The limitations of the NIMBY concept for understanding public engagement with renewable energy technologies: a literature review*  
[http://geography.exeter.ac.uk/beyond\\_nimbyism/deliverables/bn\\_wp1\\_3.pdf](http://geography.exeter.ac.uk/beyond_nimbyism/deliverables/bn_wp1_3.pdf)

<sup>10</sup> See for example, controversies over Insite research in the *Canadian Medical Association Journal* and *The Lancet*. In the *CMAJ*, in response to the findings of Insite's researchers (Wood, Tyndall, Montaner, and Kerr 2006), Selby, Kahan, and Srivastava (2007) urge caution and equipoise as the claims made could indicate "increased harm to illicit drug users." Peter Selby, Meldon Kahan, Anita Srivastava, (2007). Safe Injecting Sites (SIS): need for equipoise and evidence of net benefit to illicit drug users. *CMAJ* Letter to Editor (Jan 5 2007).

[http://www.cmaj.ca/content/175/11/1399.abstract/reply#cmaj\\_el\\_6693](http://www.cmaj.ca/content/175/11/1399.abstract/reply#cmaj_el_6693)

Letter in response to Wood, Evan, Mark W. Tyndall, Julio S. Montaner, and Thomas Kerr (2006).

Summary of findings from the evaluation of a pilot medically supervised safer injecting facility.

*CMAJ* 175: 1399-1404 (November 21, 2006); doi:10.1503/cmaj.060863

<sup>11</sup> In the *Lancet* controversy, the international research group of Christian, Pike, Santamaria, Reece, DuPont, and Mangham (2012) contested Insite researchers' claims of a reduction in overdose deaths by 35% (Marshall, Milloy, Wood, Montaner, Kerr 2011). Christian, Gary, Greg Pike, Joe Santamaria, Stuart Reece, Robert DuPont, Colin Mangham (2012). Overdose deaths and Vancouver's supervised injection facility. *The Lancet* 379 (9811) (January 14, 2012), p. 117.

[http://www.thelancet.com/pdfs/journals/lancet/PIIS0140-6736\(12\)60054-3.pdf](http://www.thelancet.com/pdfs/journals/lancet/PIIS0140-6736(12)60054-3.pdf)

Correspondence in response to Marshall Brandon, M-J Milloy, Evan Wood, Julio Montaner, Thomas Kerr (2011). Reduction in overdose mortality after the opening of North America's first medically supervised safer injecting facility: A retrospective population-based study. *The Lancet* 377 (9775), pp. 1429- 1437). Published online April 18, 2011. <http://www.communityinsite.ca/inifacility.pdf>

See also: Pike, Greg, Joe Santamaria, Stuart Reece, Robert DuPont, Colin Mangham, and Gary Christian (2011). Analysis of the 2010 Lancet study on deaths from overdose in the vicinity of Vancouver's Insite Supervised Injection Facility. *Journal of Global Drug Policy and Practice* 5(3).

<http://www.globaldrugpolicy.org/Issues/Vol%205%20Issue%203/Analysis%20of%20the%202011%20Lancet%20Study.pdf>

A complaint was also registered with the University of British Columbia, which the university defended. However, Insite's researchers admitted that other factors may have contributed to the observed decline in overdose deaths, and that Insite may have had a localized yet significant effect on overdose deaths within a small area of 500 metres around the site. These controversies raise the question of data interpretation and research integrity, and draw attention to the fact that professionals in the field of drug addiction are deeply divided on the benefits of SISs.

<sup>12</sup> Jo Kimber, Kate Dolan, and Alex Wodak (2005). Survey of drug consumption rooms: service delivery and perceived public health and amenity impact. *Drug and Alcohol Review* 24(1), 21-24. doi:10.1080/09595230500125047. "Six [of 15, i.e. 40%] DCRs reported an increase in drug dealing in the vicinity of their DCR. Three of these DCRs [i.e. 20%] also reported an additional negative impact : aggressive incidents among clients outside the premises, increases in petty crime in the area, and the resentment of local residents respectively." (p. 22-23).

<sup>13</sup> R. Gerlach and W. Schneider (2002). Consumption and Injecting Room (CIR) at INDRO, Münster, Germany: Annual Report 2002. Münster: INDRO e. V., 2003.

<sup>14</sup> Potier, Chloe, Vincent Laprevote, Francoise Dubois-Arber, Oliver Cottencin, Benjamin Rolland (2014). Supervised injection services: What has been demonstrated? A systematic literature review. *Drug and Alcohol Dependence* 145, pp. 48-68.

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<sup>15</sup> See video clip: Director, Wolfgang Götz, on the occasion of the launch of the 2011 annual report on the state of the drugs problem in Europe, press conference highlights

<https://www.youtube.com/watch?v=rCdFlgadpYQ>

European Monitoring Centre for Drugs and Drug Addiction (2015). Drug consumption rooms: An overview of provision and evidence. *Perspectives on Drugs (PODs) series*

<http://www.emcdda.europa.eu/topics/pods/drug-consumption-rooms>.

<sup>16</sup> Sweden opted to invest in expanding access to treatment and social security supports. As a result, Sweden's drug problem is well below the EU average. A country with a substantial drug problem, Portugal opted in 2001 for decriminalization (not to be confused with legalization), 'dissuasion' of illicit drug use, and social supports including a guaranteed basic income. Possession of small amounts of illegal drugs was changed from a criminal to an administrative offence. Persons in possession of drugs are referred to the Commission for the Dissuasion of Drug Addiction: these are three-person multi-disciplinary teams usually comprised of a doctor, social worker and lawyer. Evidence suggests that as a result, there has been a national decrease in drug-related overdoses, disease, and usage.

<sup>17</sup> Schat, Eberhard & Marie Nougier (2012). Drug consumption rooms: Evidence and practice IDPC Briefing Paper. International Drug Policy Consortium.

[http://www.drugsandalcohol.ie/17898/1/IDPC-Briefing-Paper\\_Drug-consumption-rooms.pdf](http://www.drugsandalcohol.ie/17898/1/IDPC-Briefing-Paper_Drug-consumption-rooms.pdf)

<sup>18</sup> Woods, Sara (2014), Organisational overview of drug consumption rooms in Europe. European Harm Reduction Network – Regenboog Groep, Amsterdam ([www.eurohrn.eu/index.php/drug-consumption-rooms](http://www.eurohrn.eu/index.php/drug-consumption-rooms)).

<sup>19</sup> Martina Schu, Peter Tossman, Kristian Coll, and Andrea Shuster (2005). Evaluation der drogenkonsumräume in Berlin: Abschlussbericht. Berlin: Köln.

<sup>20</sup> UN Convention on the Rights of the Child of 1989. See in particular Articles 24(3), 31, 33 and 36.

<http://www.ohchr.org/en/professionalinterest/pages/crc.aspx>

<sup>21</sup> Michael McCormack (President, Toronto Police Association) testifying before the Standing Committee on Public Safety and National Security session on supervised injection sites (October 29, 2014).

(<http://www.parl.gc.ca/HousePublications/Publication.aspx?Language=e&Mode=1&Parl=41&Ses=2&DocId=6747909>)

<sup>22</sup> City of Toronto (2005). *Toronto Drug Strategy: A Comprehensive Approach to Alcohol and Other Drugs*. Toronto: Author

[http://www1.toronto.ca/city\\_of\\_toronto/toronto\\_public\\_health/healthy\\_communities/files/pdf/tds\\_report.pdf](http://www1.toronto.ca/city_of_toronto/toronto_public_health/healthy_communities/files/pdf/tds_report.pdf)

<sup>23</sup> Gunaratnam, Praveena (2005). *Drug policy in Australia: The supervised injecting facilities debate*.

The Australian National University Discussion Papers. Asia Pacific School of Economics and Government. <http://unpan1.un.org/intradoc/groups/public/documents/apcity/unpan031828.pdf>

<sup>24</sup> CBC News (2016). Supervised injection sites will only enable drug use, Toronto mother says: Mother says drugs have consequences and taking consequences away will not convince addicts to quit (Posted: Mar 17, 2016 ).

<http://www.cbc.ca/news/canada/toronto/mother-opposes-safe-injection-sites-1.3496502>

<sup>25</sup> City of Toronto (2013). *Supervised Injection Services Toolkit*. Toronto: Toronto Public Health.

<http://www.toronto.ca/legdocs/mmis/2013/hl/bgrd/backgroundfile-59914.pdf>

<sup>26</sup> According to the flyer distributed to some households in the local area <http://mikelayton.to/wp-content/uploads/2016/03/PublicHealthFlyerOnlineForm.pdf>:

"Will there be an opportunity for community input?

Safe injection services are being recommended by the Toronto Medical Officer of Health as a way to prevent deaths in our city. Each local agency has a right to apply to the Federal Government for an exemption to offer these services at their existing health centres. ... provide you with as much information as possible and an opportunity to raise any issues or concerns." This implies community input is construed as one-way information sessions by the Toronto Medical Officer and SIS service providers.