ATTACHMENT 1

Summary of Public Consultations on Drug Decriminalization

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Executive Summary

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

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

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

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

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

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

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

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

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

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

5. **A different role for police**

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

6. **Drug supply concerns**

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

7. **Determining the threshold for possession**

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

Purpose and Context

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

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

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

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

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

Key Findings

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

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

1. Centering lived experience

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

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

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

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

2. Improving access to services

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

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

Lack of infrastructure and capacity

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

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

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

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

Geographical barriers

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

Lack of affordable housing

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

Considerations

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

3. Reducing stigma

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

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

Stigma from police interventions

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

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

Social stigma

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

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

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

Stigma in healthcare

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

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

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

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

Considerations

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

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

4. Options for mandated treatment

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

Reasons for

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

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

Reasons against

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

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

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

5. A different role for police

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

Issues with police involvement

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

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

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

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

Shifts in police culture

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

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

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

6. Drug supply concerns

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

Challenges in measuring doses

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

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

Inadequacies of safe supply programs

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

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

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

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

Considerations

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

7. Determining the threshold for possession

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

Factors for determining threshold

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

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

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

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

Drawbacks of setting a threshold

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

Considerations

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

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

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

Methods

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

Key constituencies for this consultation included:

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

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

Survey questions

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

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

Organizations contacted for interviews and roundtable focus groups

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

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

Roundtables conducted: 76 participants

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

Organizations participated:

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

Key Questions:

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

Number of interview participants: 51

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

Key Questions:

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

Working Group

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

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

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

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

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

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

Membership of the Working Group included representatives from:

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

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

About MASS LBP

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

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

Appendix A: Summary of Survey Results

Appendix A: Summary of Survey Results

TORONTO PUBLIC HEALTH COMMUNITY ATTITUDES SURVEY ON DECRIMINALIZATION 2021

Original Sequences of Questions

1. Do you wish to proceed to the survey?

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

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

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

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

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

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

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

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

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

10. Do you have stable housing?

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

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

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

14. What is your age?

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

Sequence as Presented in this Report

Respondent information presented first.

10. Do you have stable housing?

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

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

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

14. What is your age?

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

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

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

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

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

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

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

Responses Representation

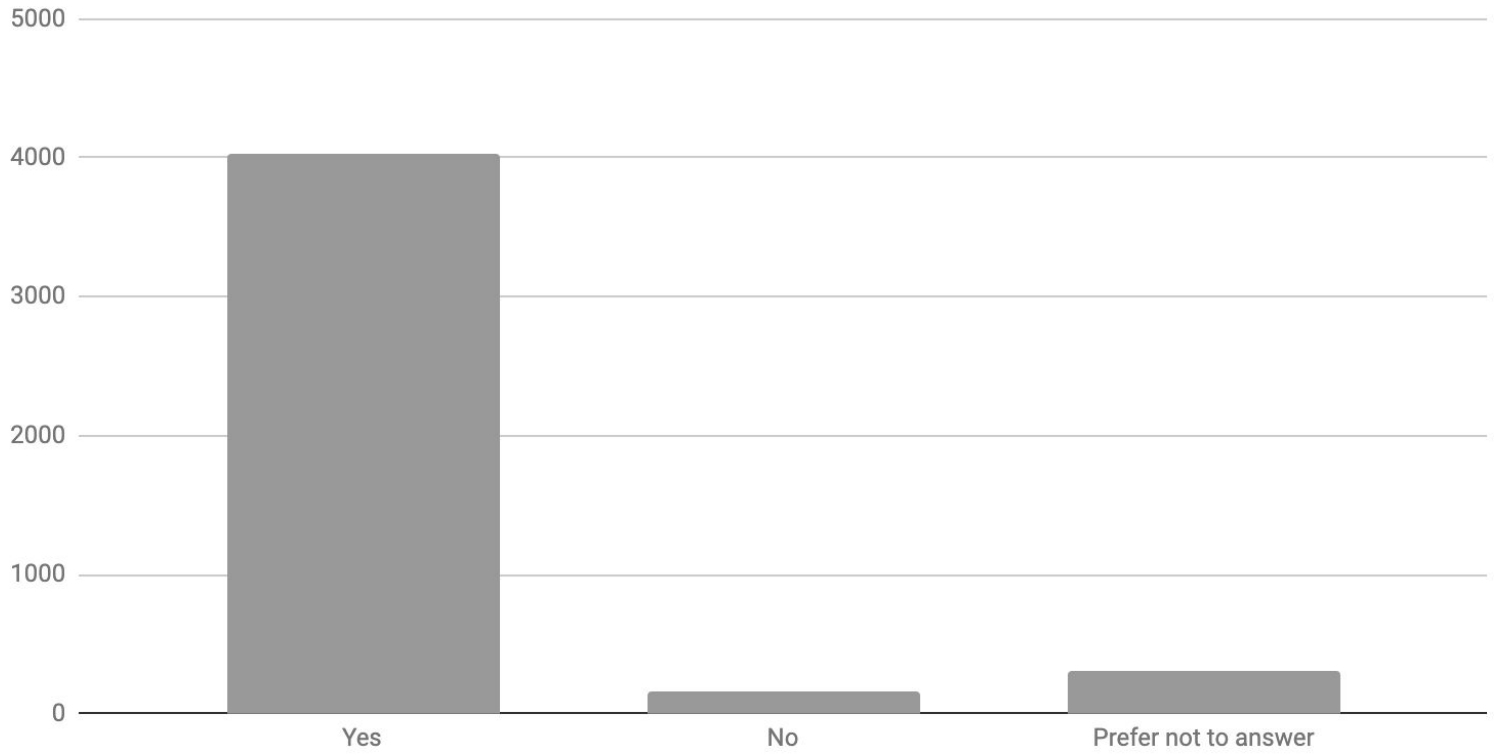
1. 6,340 Survey Records
2. 23 No (removed)
3. 6,317 Yes (kept)
4. 322 Didn't complete any Q2.X (removed)
5. **5,995 responses left to analyze**

Question 10:

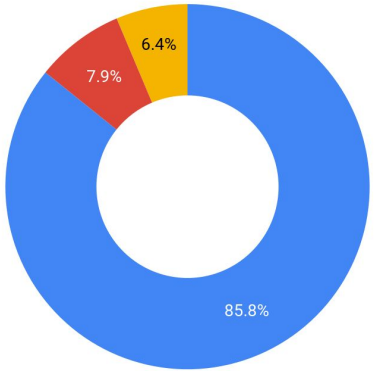
Do you have stable housing?

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

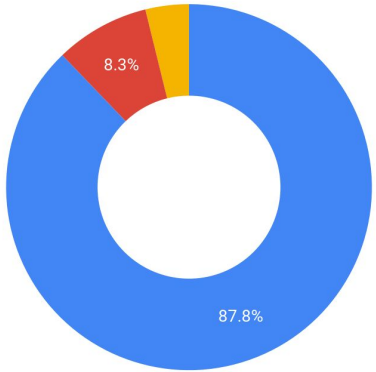
10. Do you have stable housing? *(4,481 Responses)*



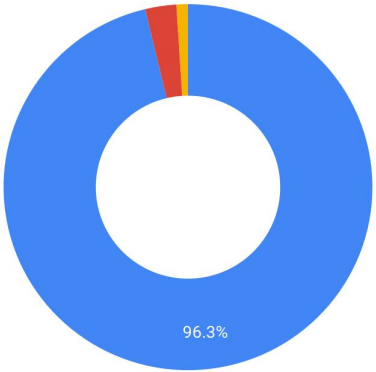
10. Do you have stable housing?



RACIALIZED RESPONDENTS



RESPONDENTS WHO USE DRUGS



NON-RACIALIZED RESPONDENTS; NO REPORTED DRUG USE

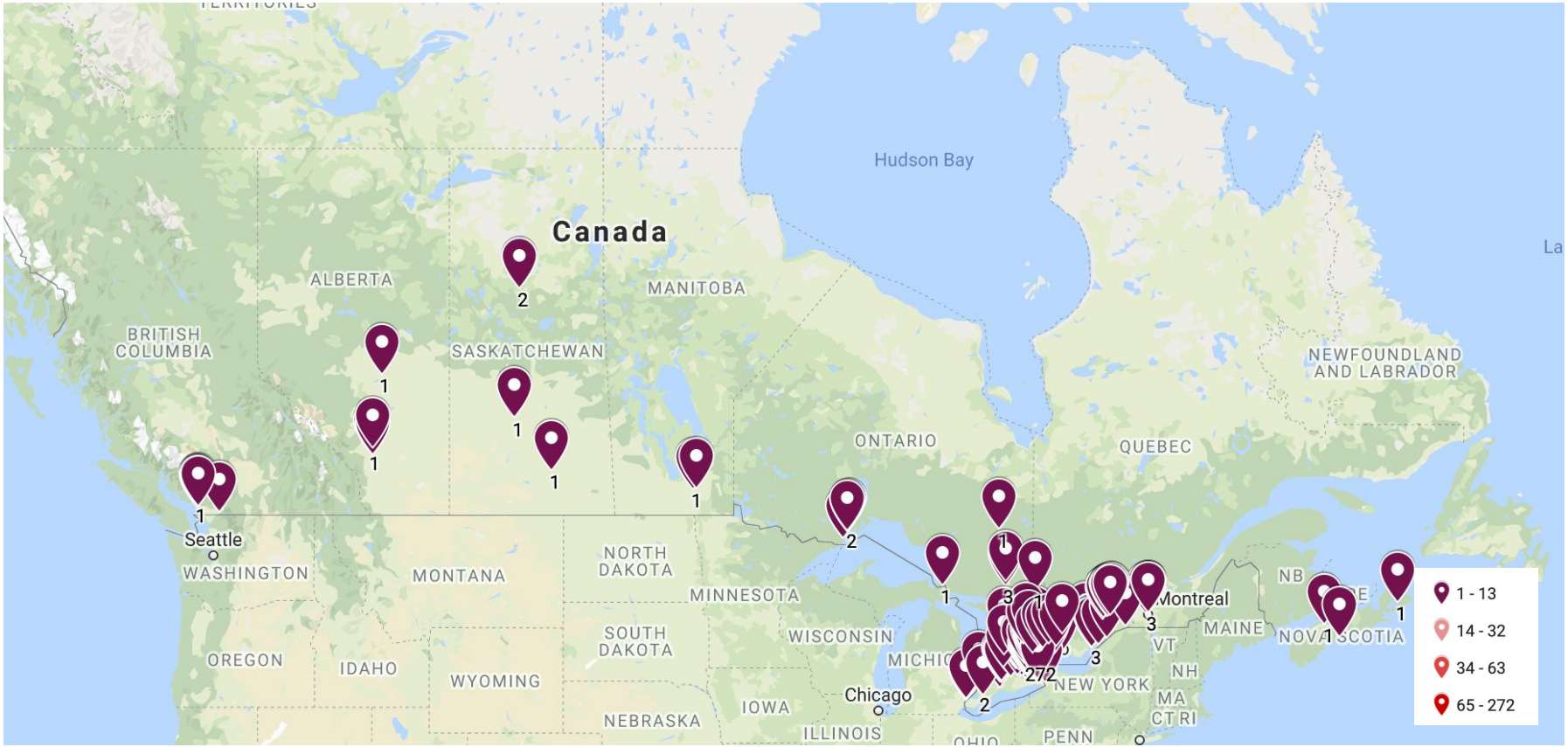
Yes No Prefer not to answer

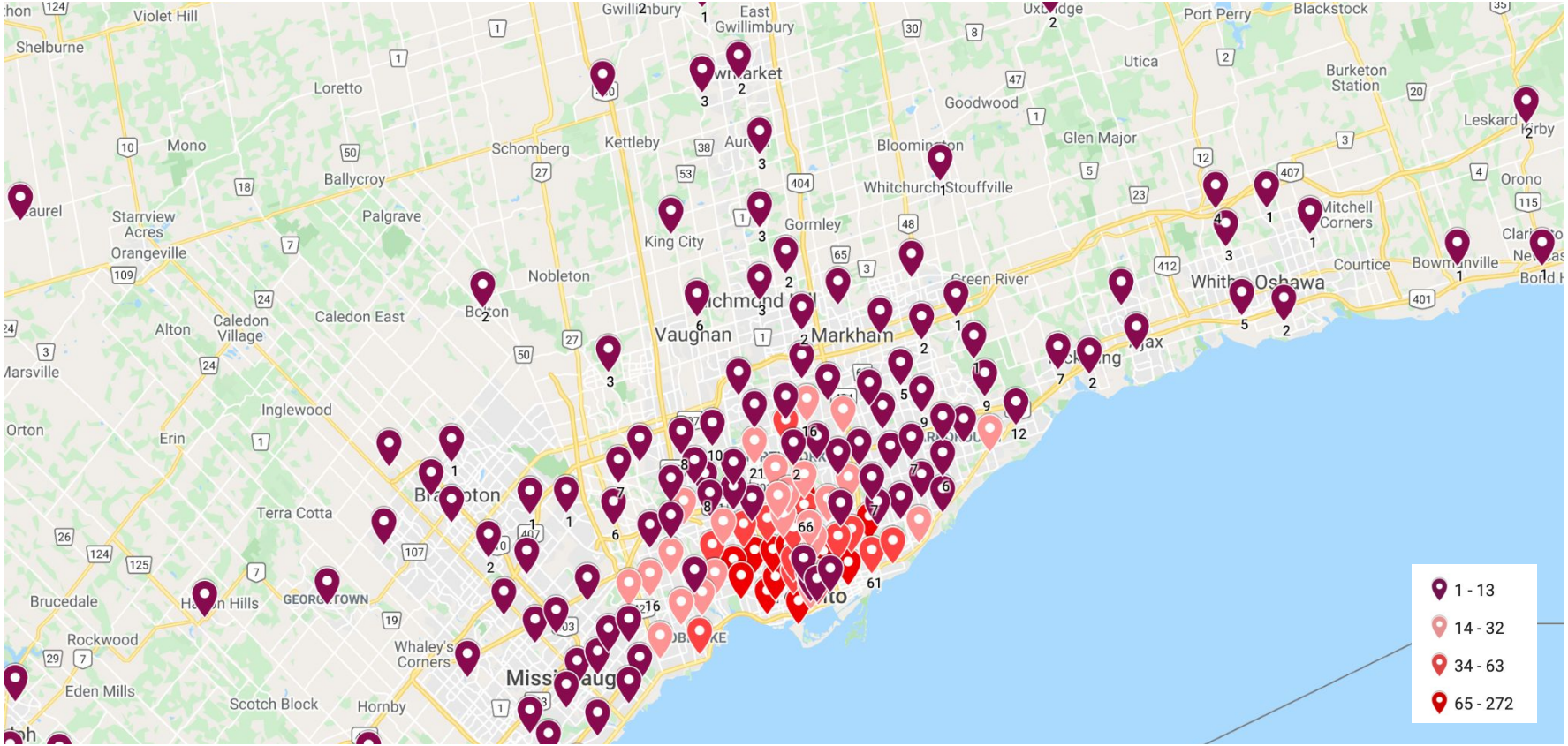
Question 11:

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

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

3,352 from Toronto (M FSAs)


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

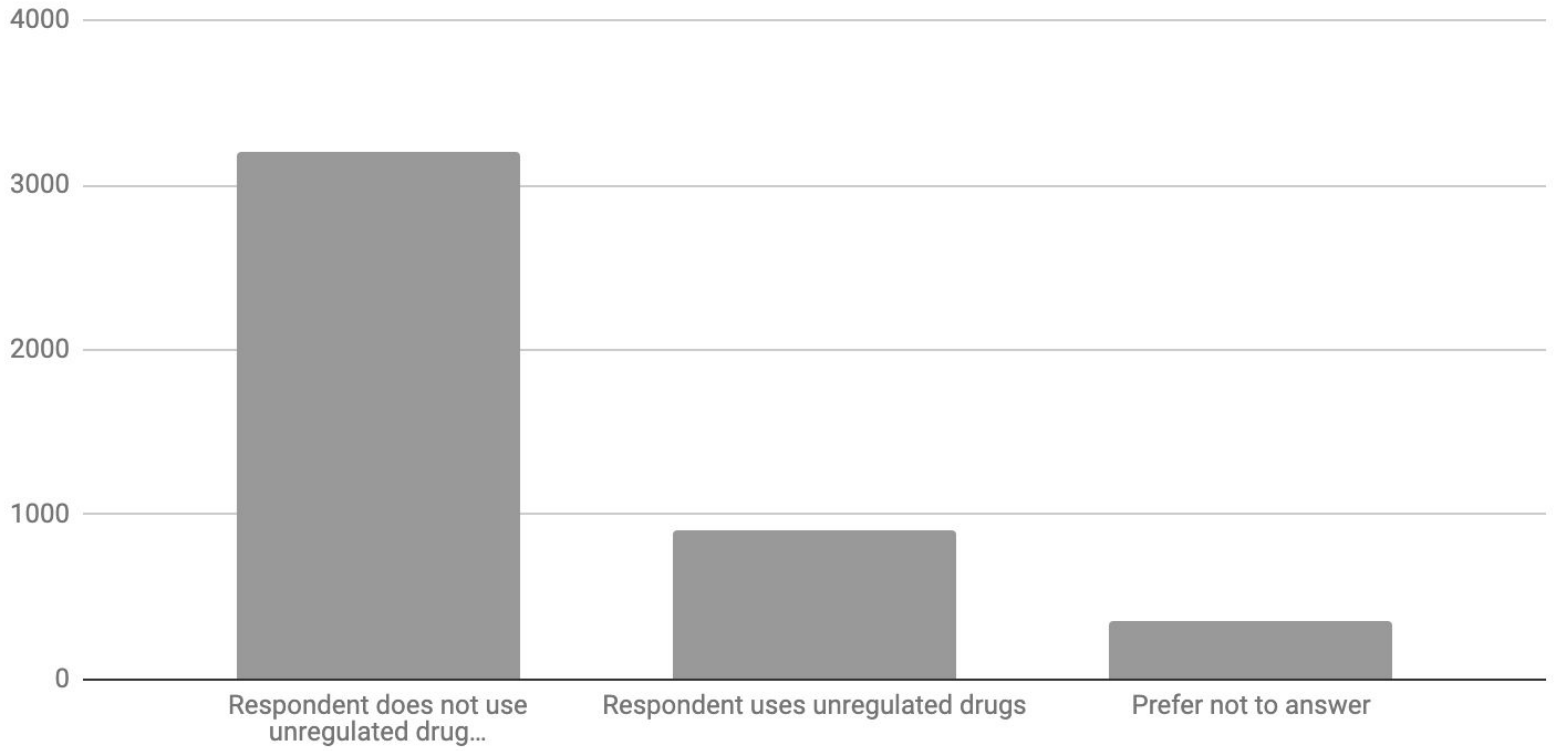

Violet Hill
Shelburne
Loretto
Mono
Ballycroy
Schomberg
Kettleby
East Gwillimbury
Newmarket
Goodwood
Uxbridge
Port Perry
Blackstock
Utica
Burketon Station
Leskard
Orono
Starrview Acres
Orangeville
Palgrave
King City
Gormley
Bloomington
Whitchurch-Stouffville
Glen Major
Mitchell Corners
Courtice
Bowmanville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

Question 12:

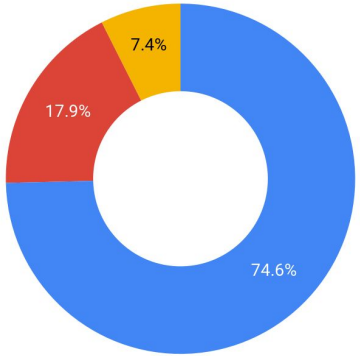
Are you someone who currently uses unregulated drugs (these are also sometimes called "drugs", "street drugs" or "illegal drugs")

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

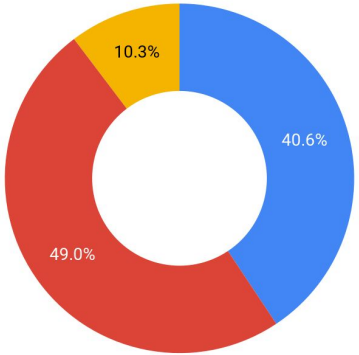
12. Are you someone who currently uses unregulated drugs (these are also sometimes called "drugs", "street drugs" or "illegal drugs") *(4,473 Responses)*



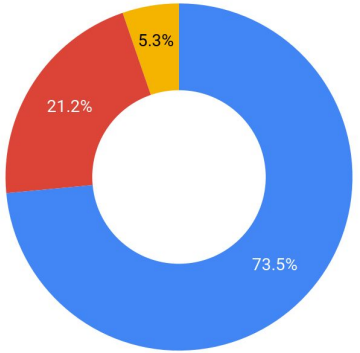
12. Are you someone who currently uses unregulated drugs (these are also sometimes called "drugs", "street drugs" or "illegal drugs")



RACIALIZED RESPONDENTS



UNDERHOUSED RESPONDENTS



NON-RACIALIZED RESPONDENTS; HOUSED

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

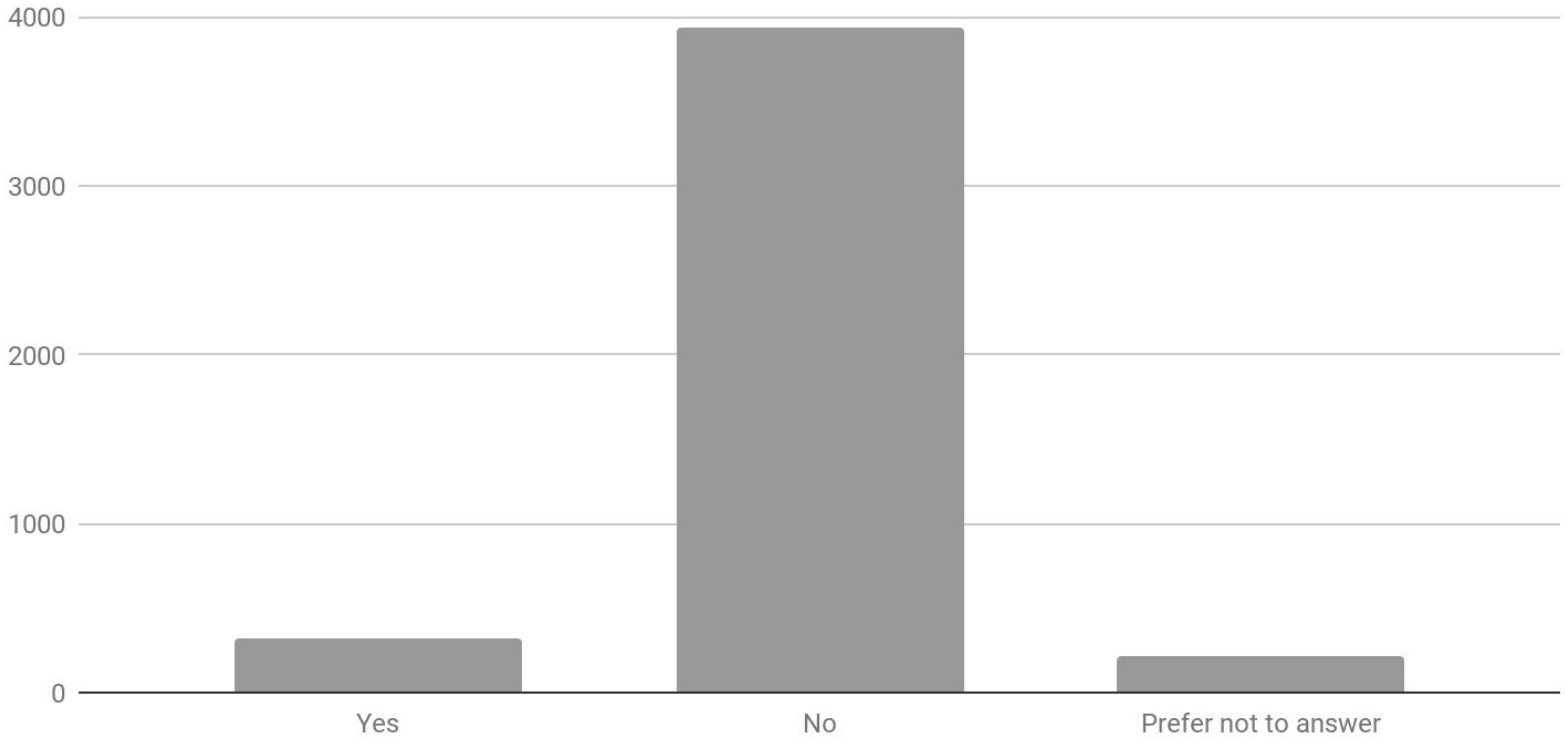
Question 13:

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

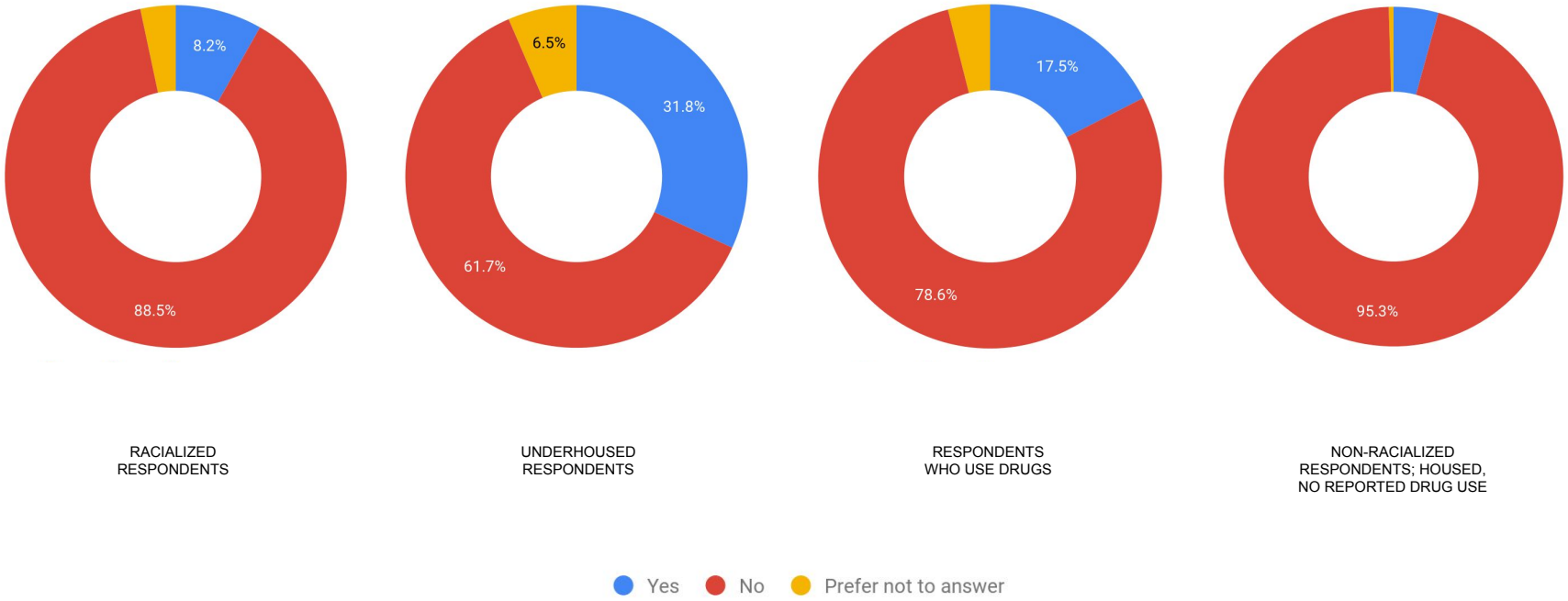
Single choice
4,467 Responses, 1,528 No response

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

(4,467 Responses)



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



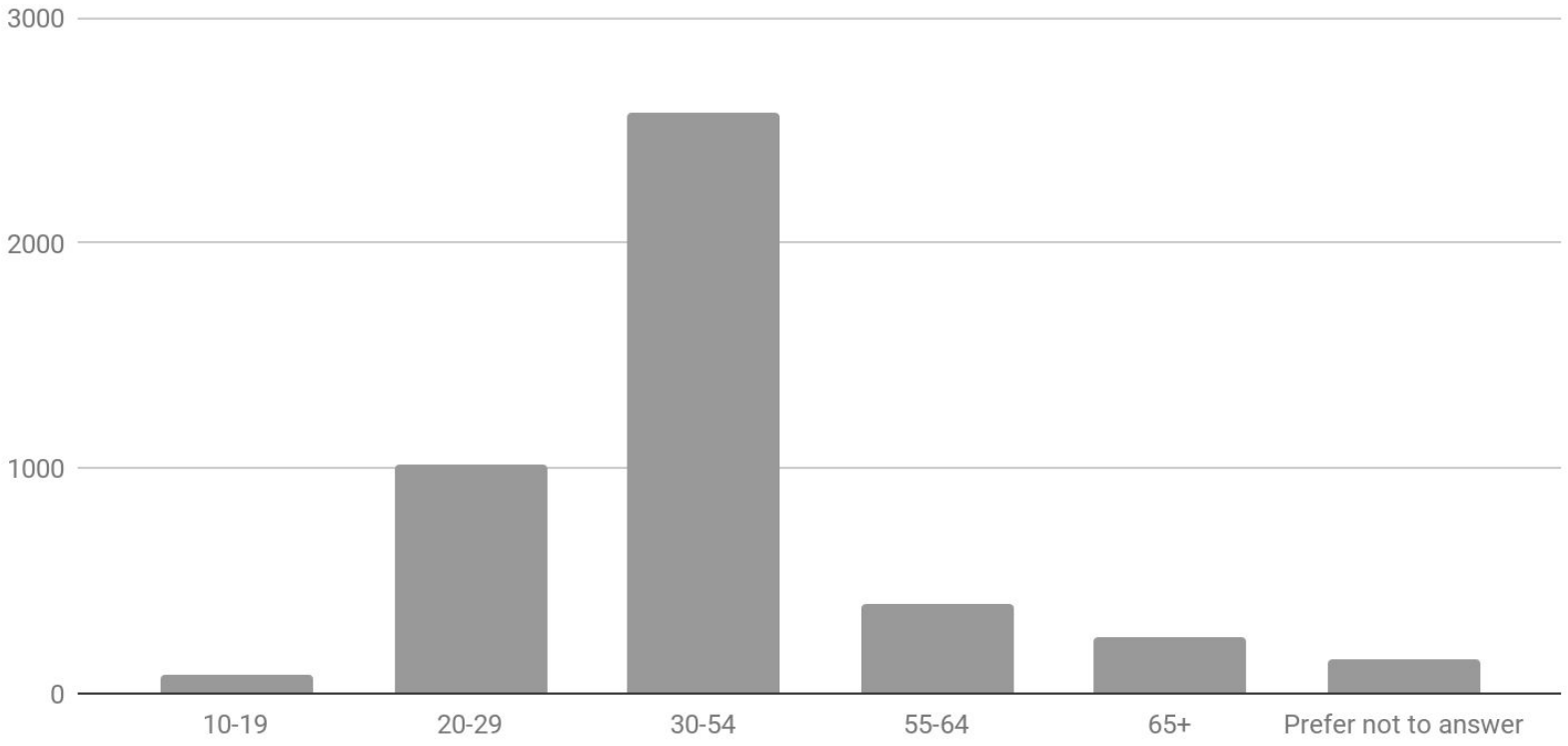
Question 14:

What is your age?

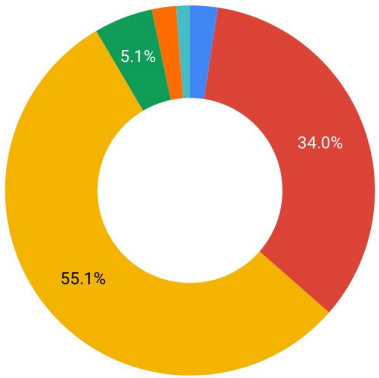
Single choice
2,184 Responses, 3 No response

14. What is your age?

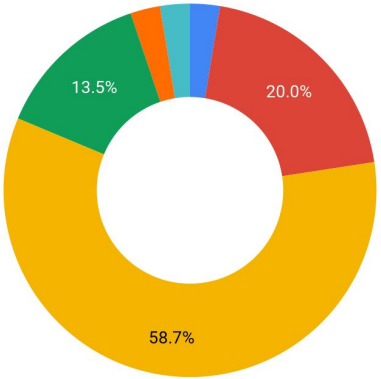
(2,187 Responses)



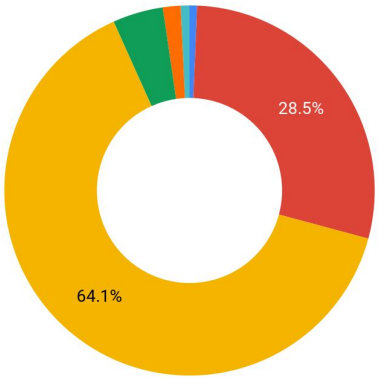
14. What is your age?



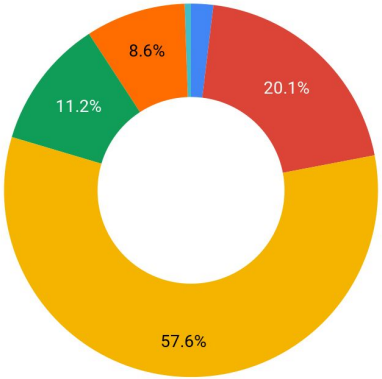
RACIALIZED RESPONDENTS



UNDERHOUSED RESPONDENTS



RESPONDENTS WHO USE DRUGS



NON-RACIALIZED RESPONDENTS; HOUSED, NO REPORTED DRUG USE

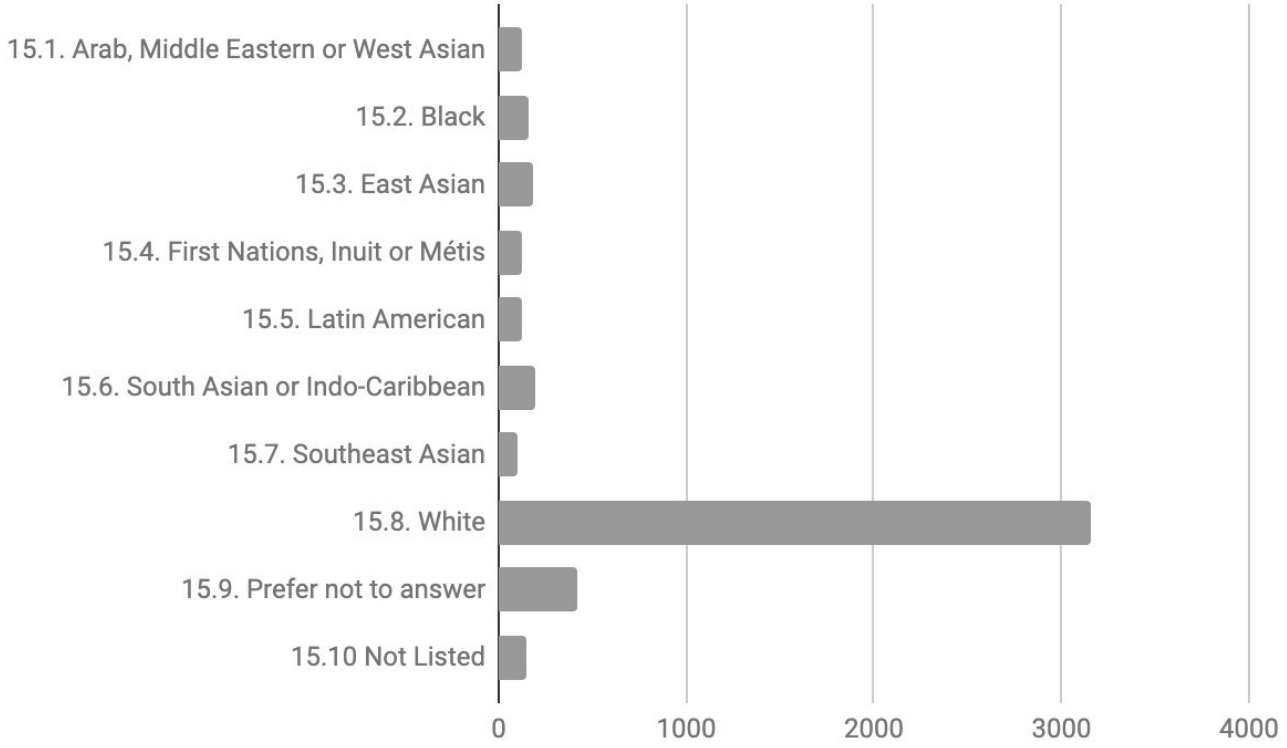
10-19 20-29 30-54 55-64 65+ Prefer not to answer

Question 15:

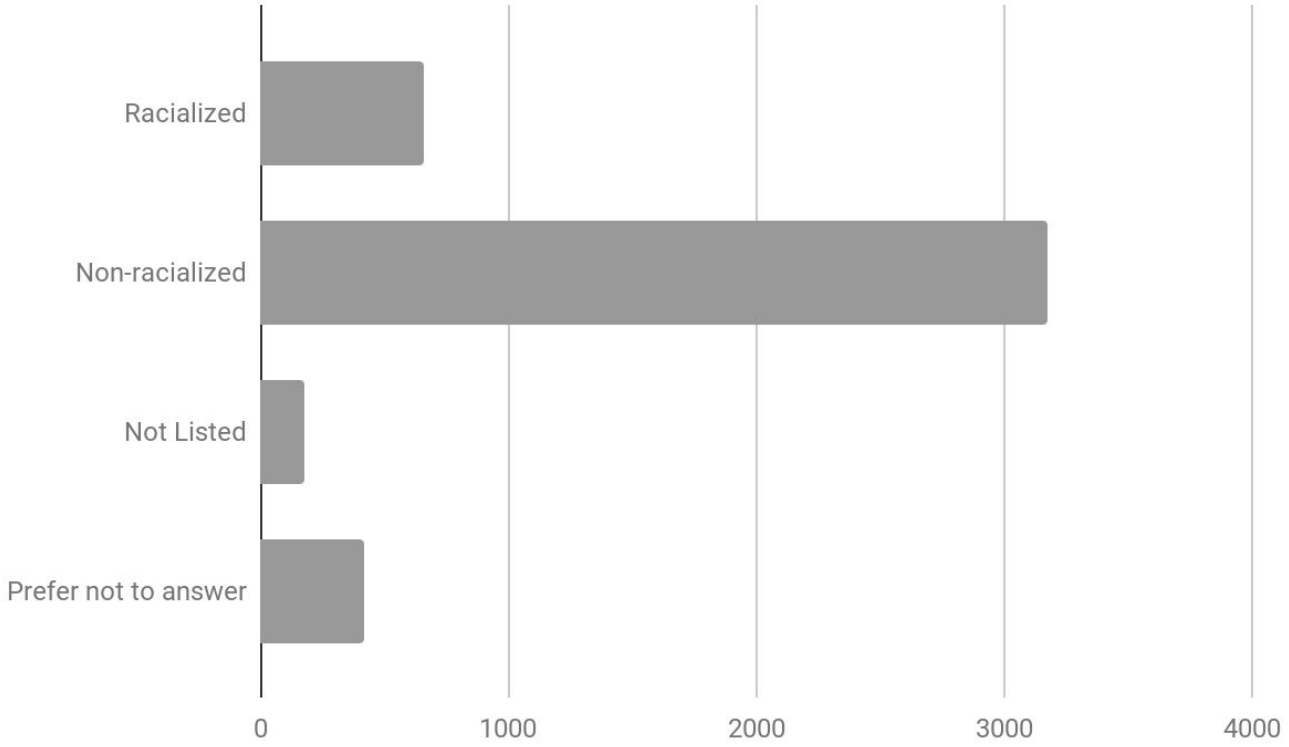
People often describe themselves by their race or racial background. For example, some people consider themselves "Black", "White" or "East Asian".

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

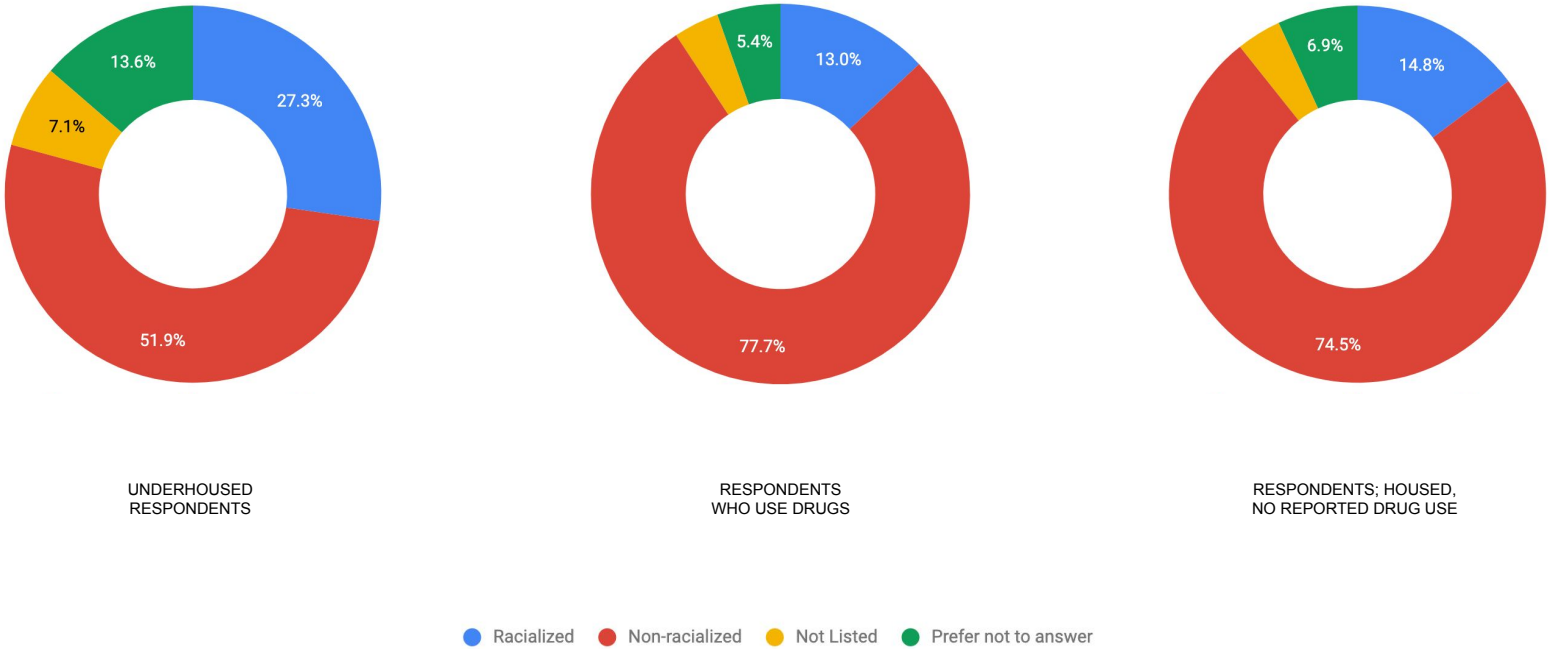
15. People often describe themselves by their race or racial background. For example, some people consider themselves "Black", "White" or "East Asian". *(2,187 Responses)*



15. Categorized Responses



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

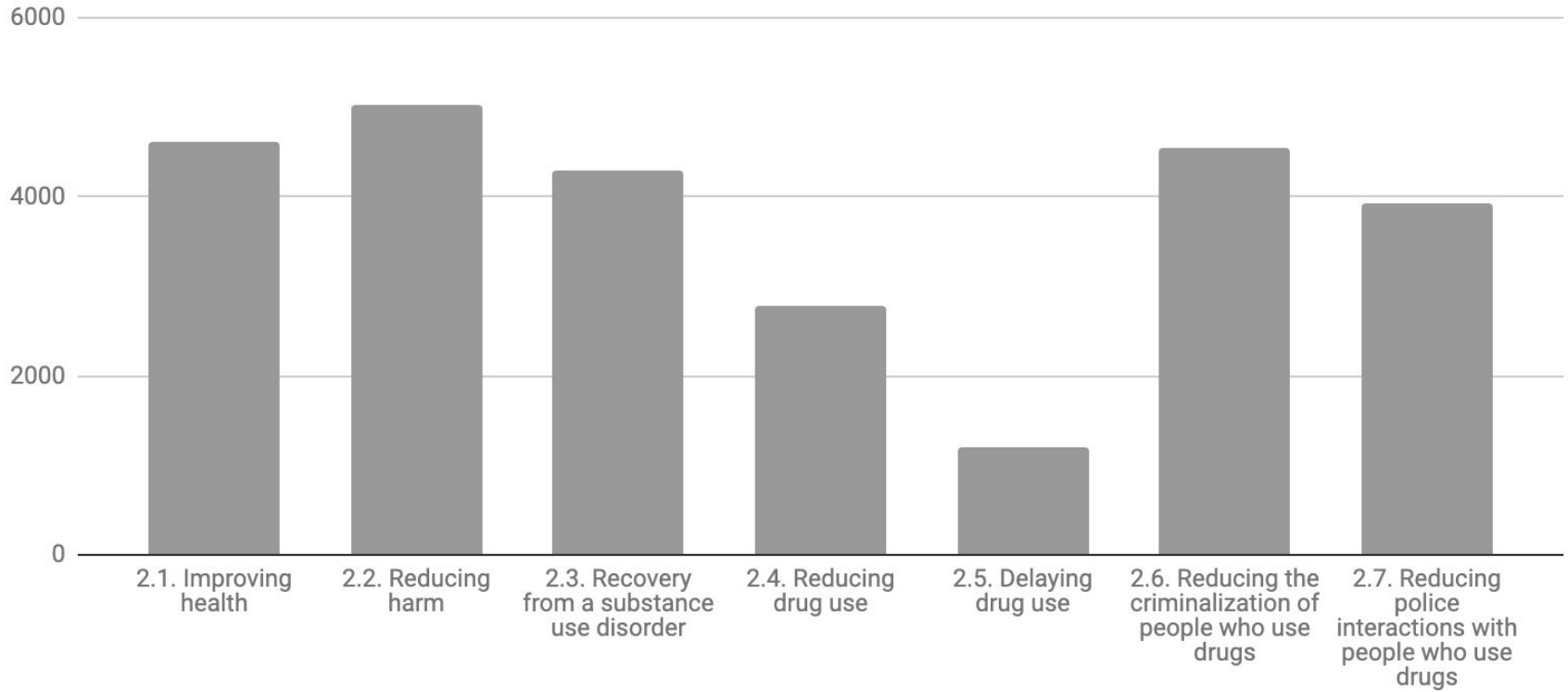


Question 2:

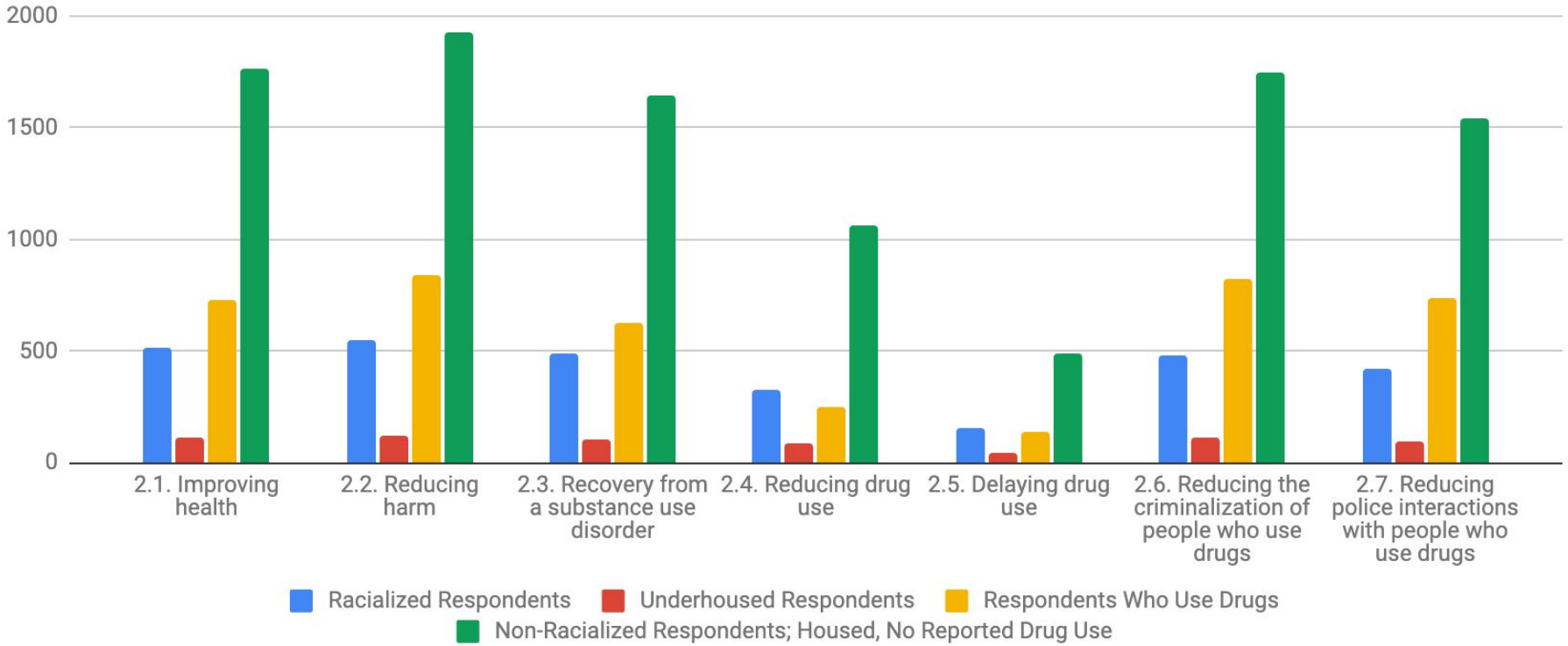
What should be the objectives of drug policy in Toronto?

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

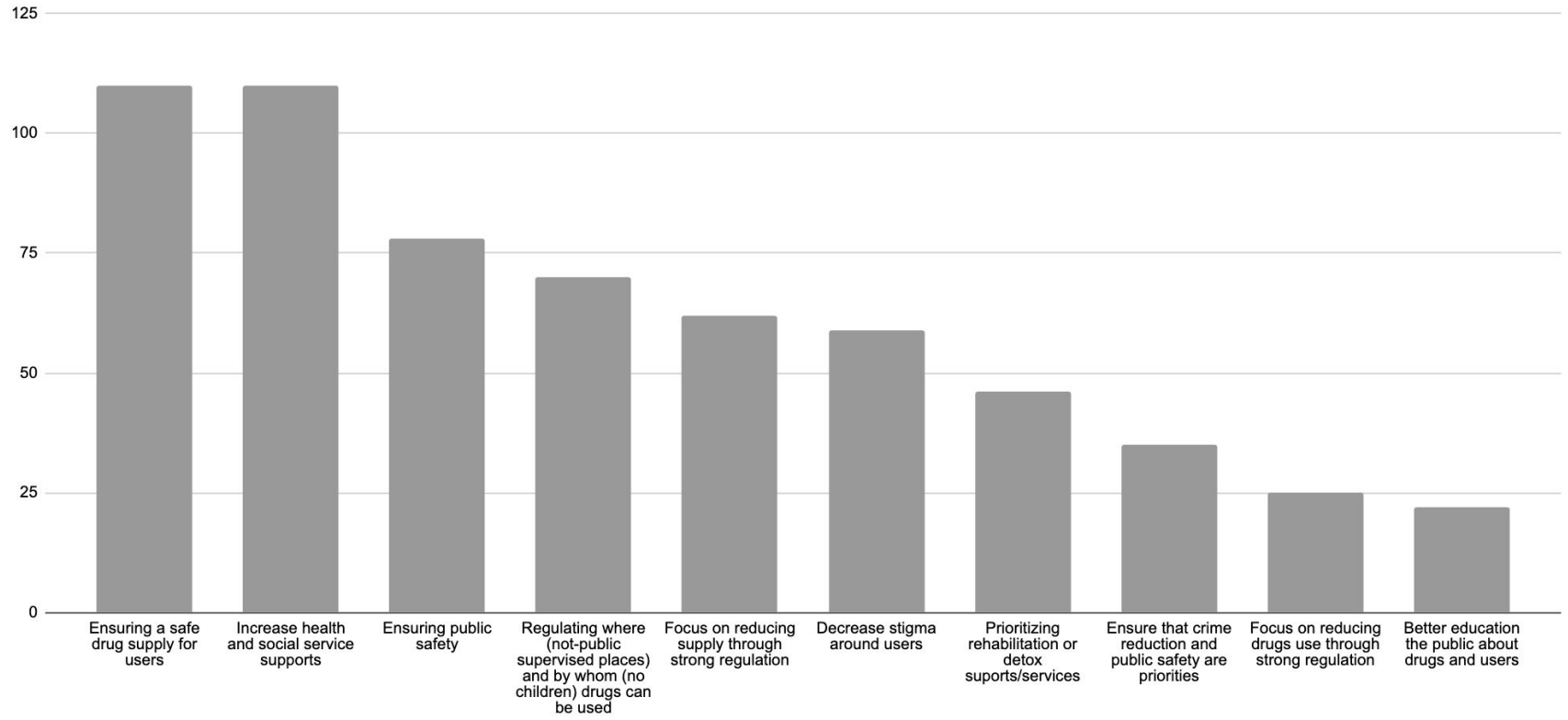
2. What should be the objectives of drug policy in Toronto? *(5,995 Responses)*



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



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



Question 3:

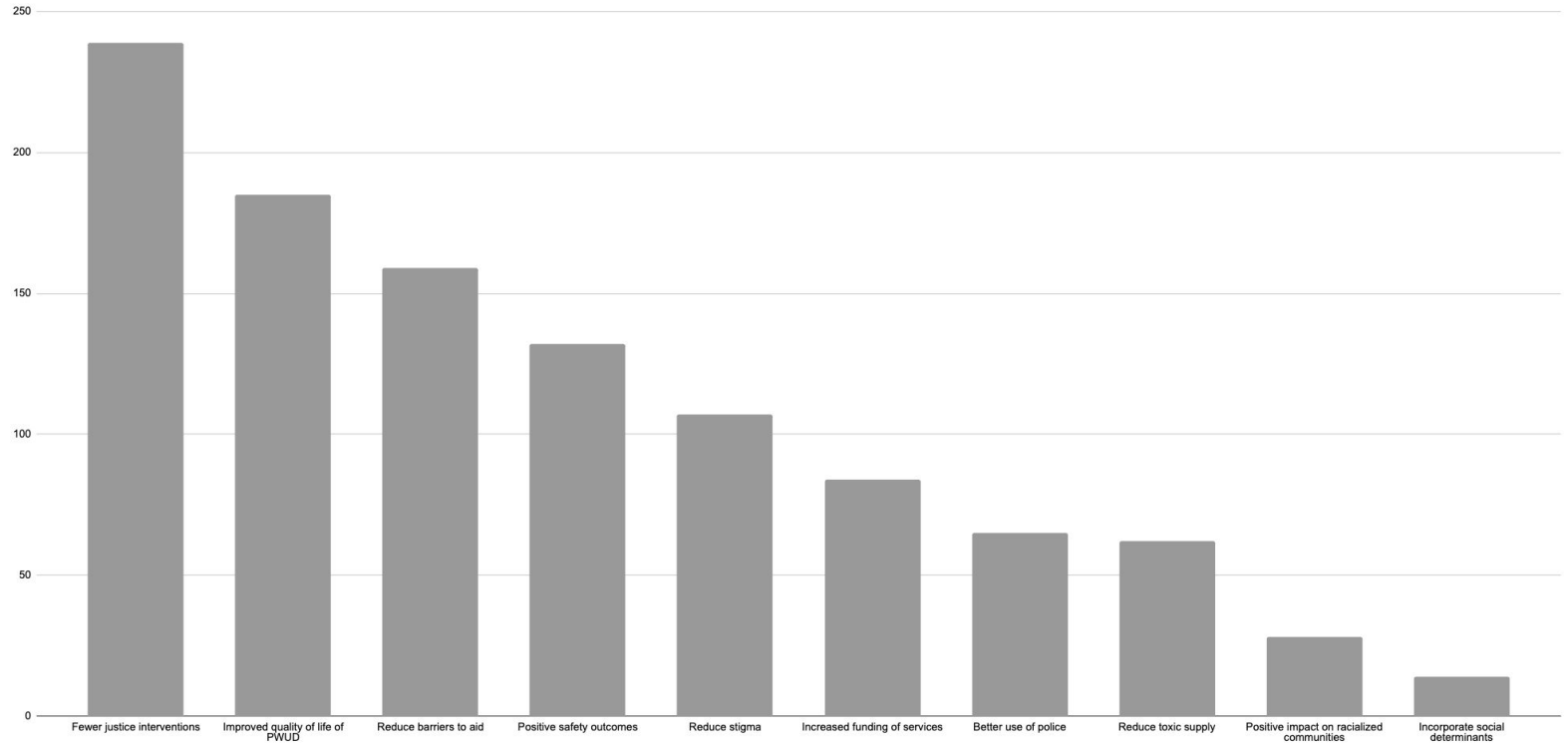
What benefits or challenges do you expect if personal possession of controlled drugs is decriminalized?

Open Text
4,308 Responses 1,687 No response

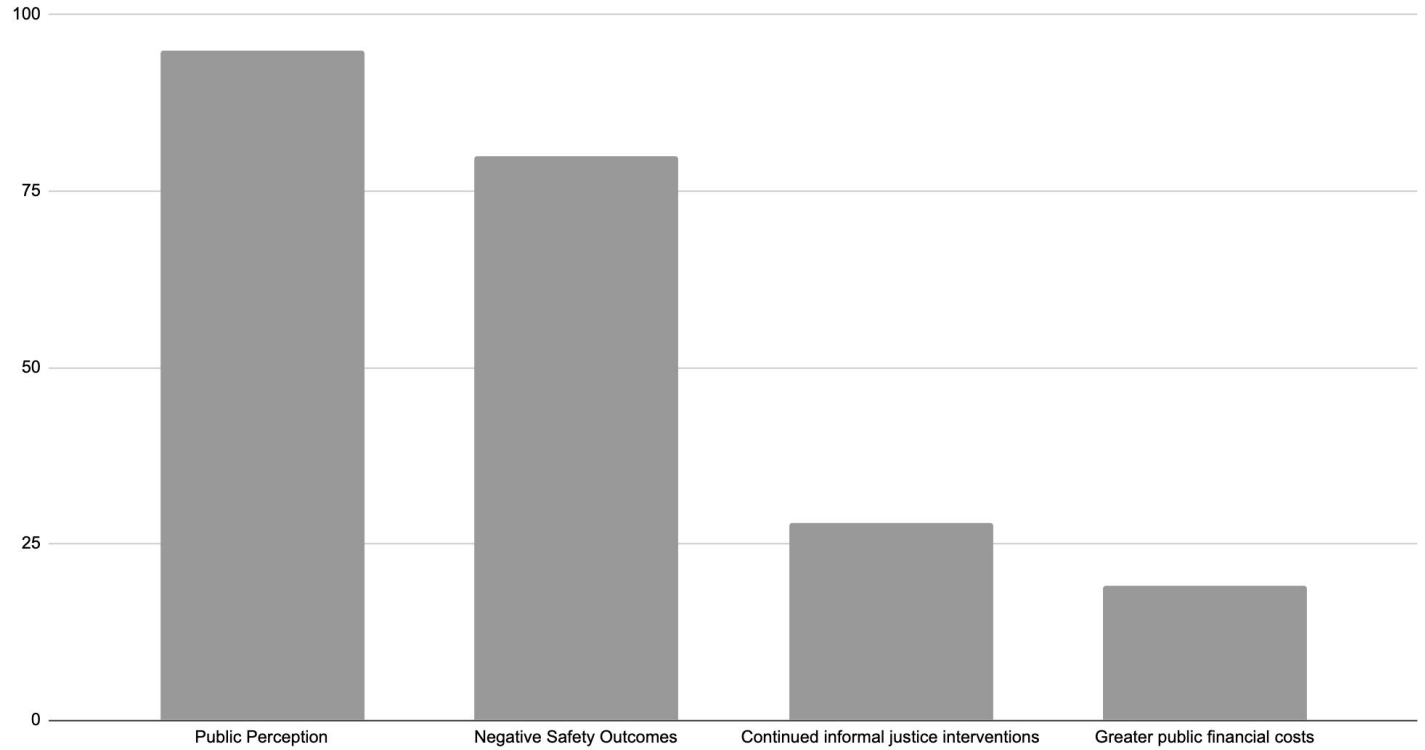
375 were randomly sampled and collated into benefits and challenges and then manually catagorized

1,092 benefits and 257 challenges were identified

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



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



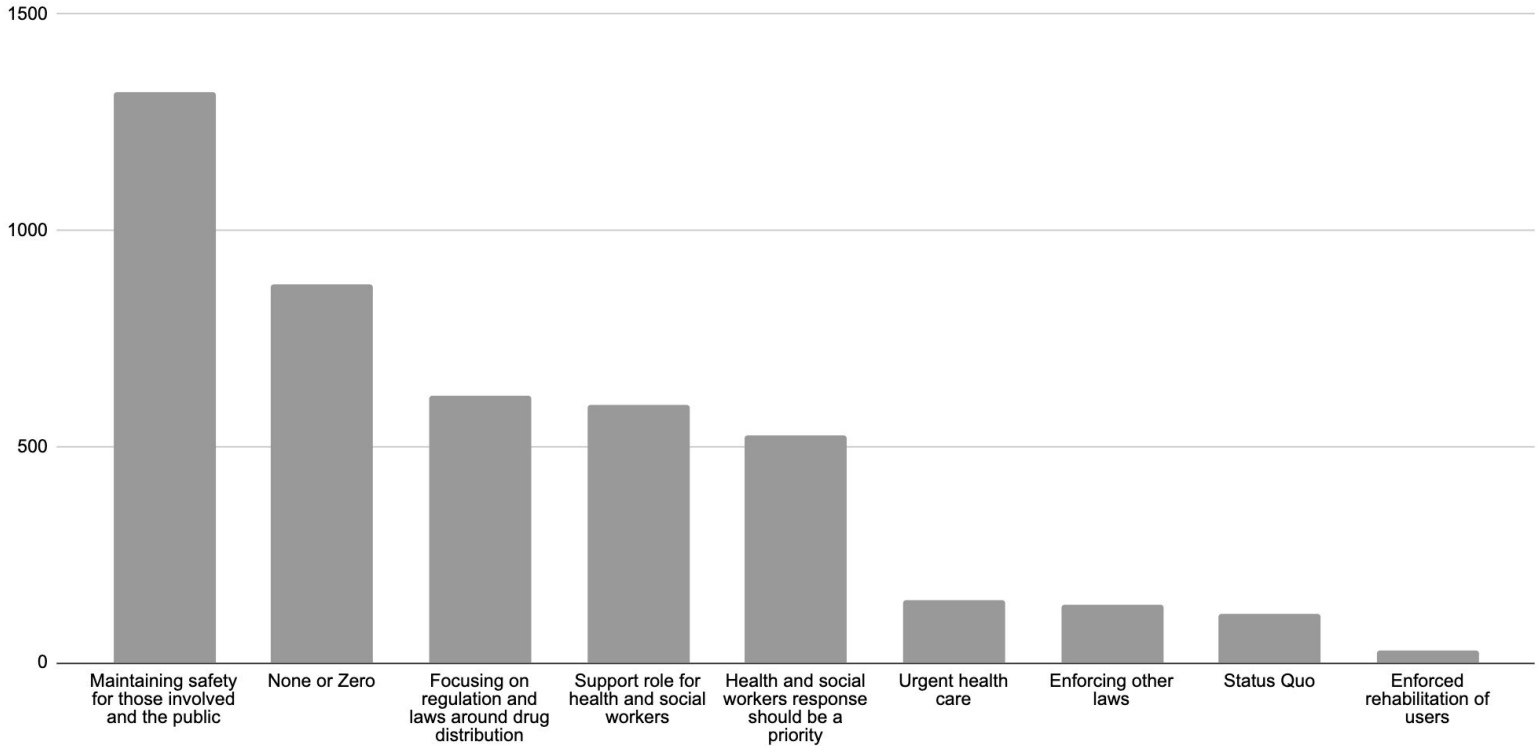
Question 4:

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

Open Text
4,451 Responses 1,544 No response

3,591 Classified using mult-tag category AI analysis

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

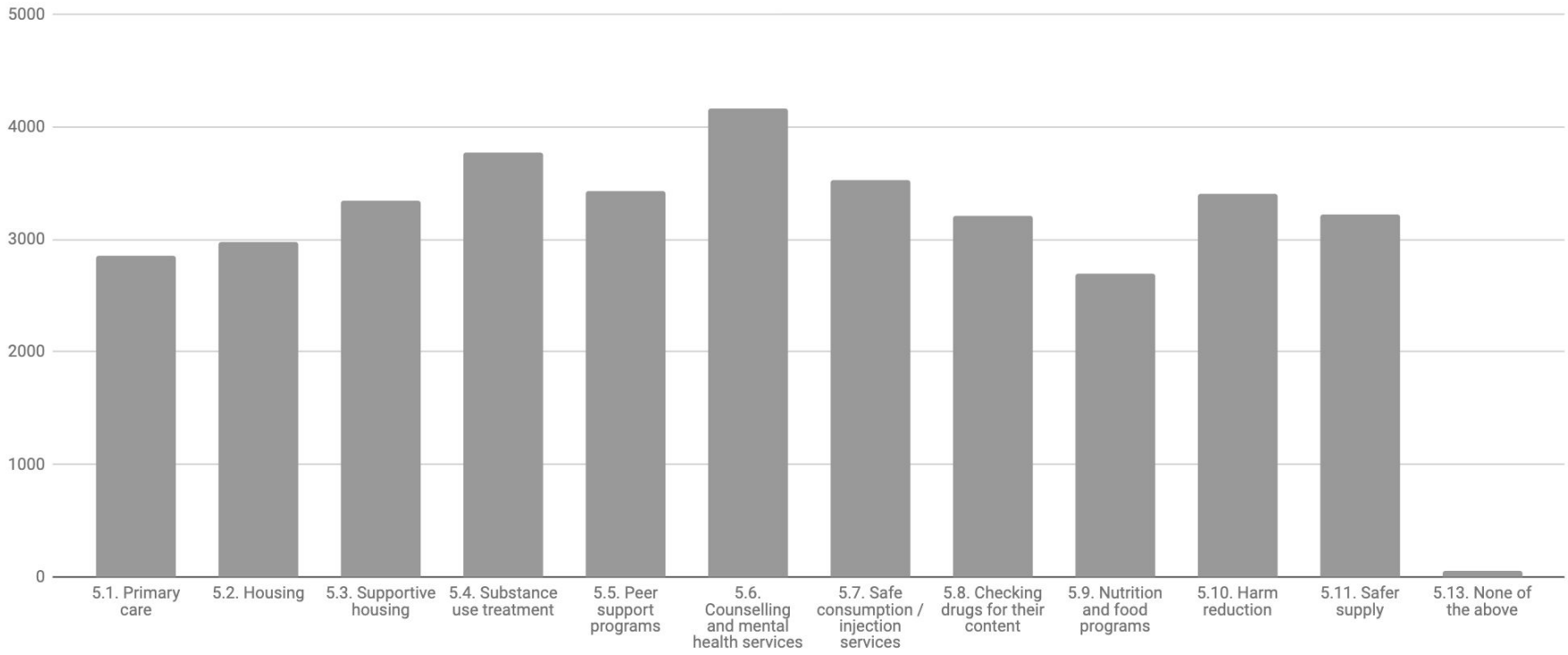


Question 5:

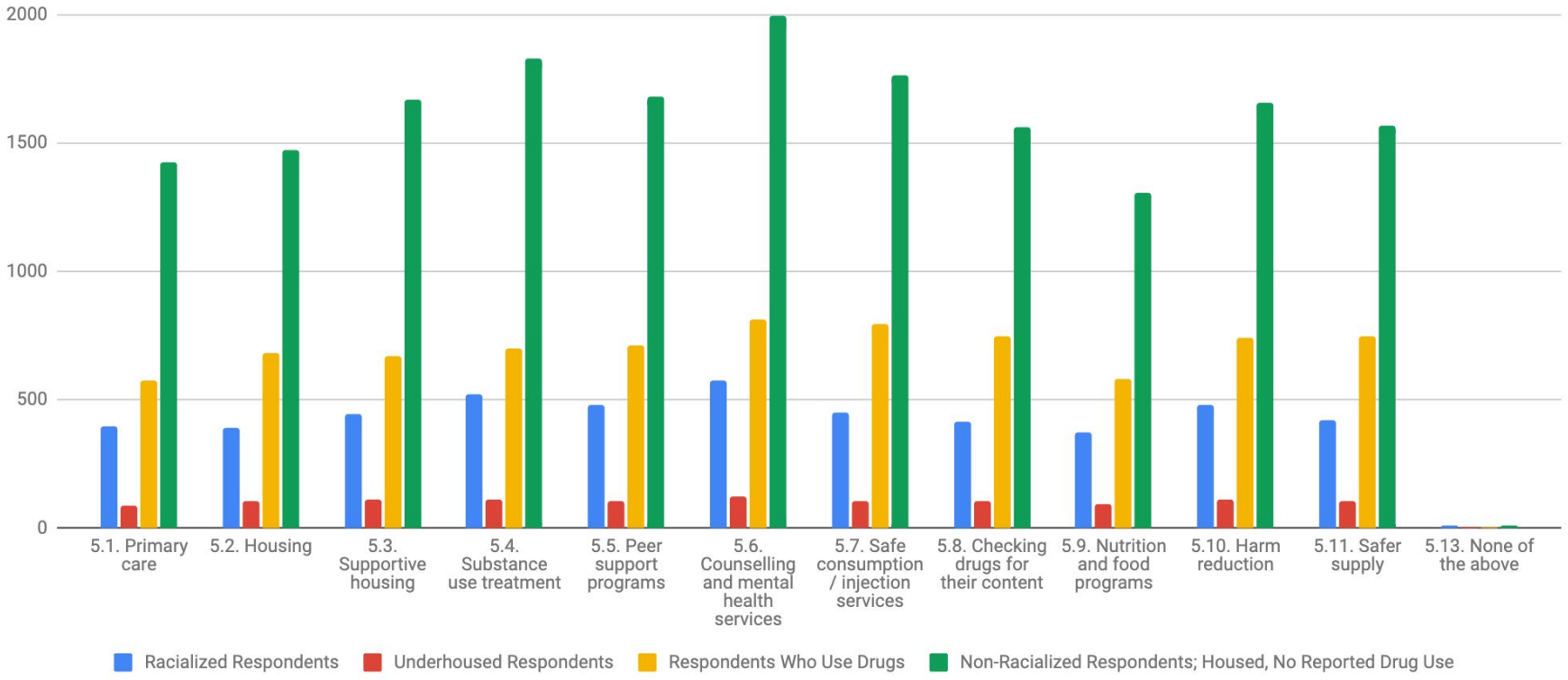
What services would help people who use drugs reduce the possibility of harm for their substance use or seek support for their substance use?

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

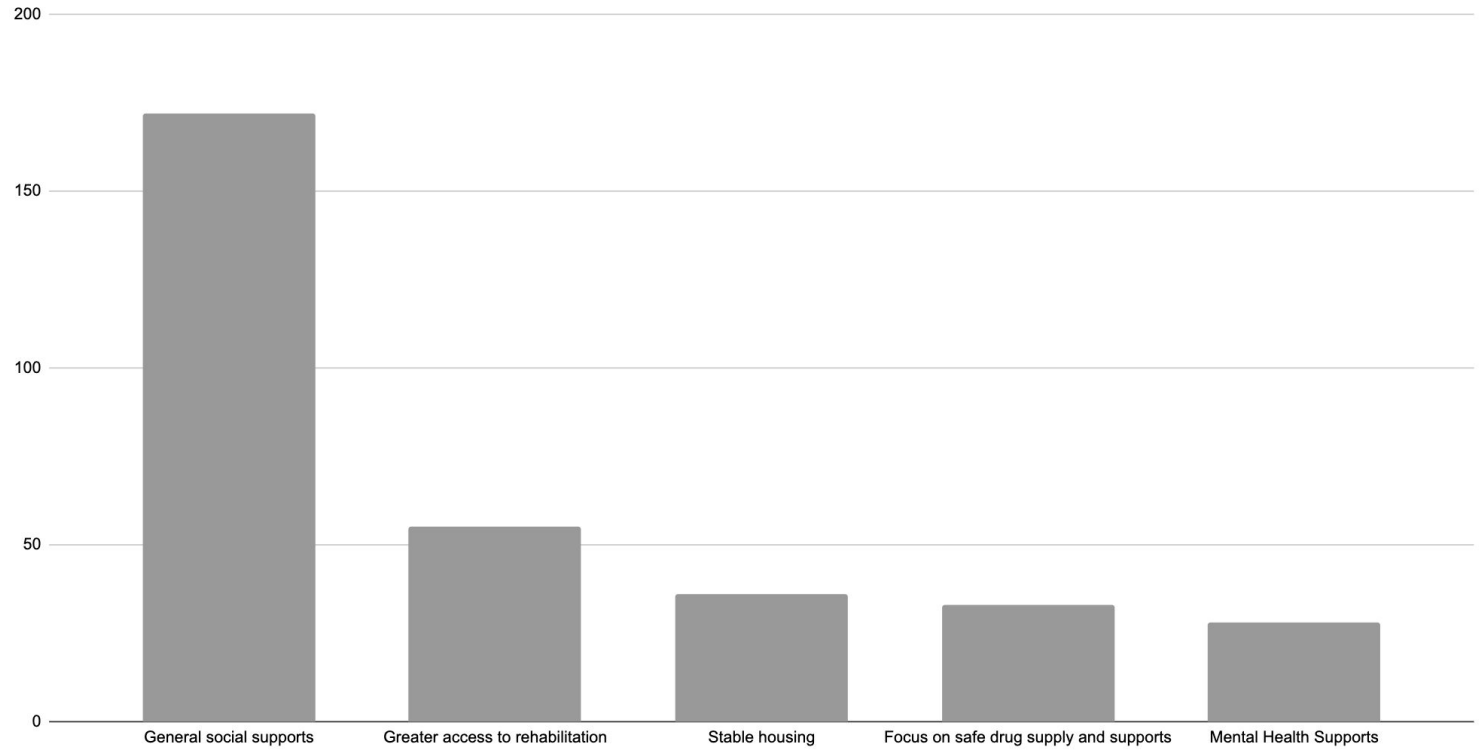
5. What services would help people who use drugs reduce the possibility of harm for their substance use or seek support for their substance use? *(4,615 Responses)*



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



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



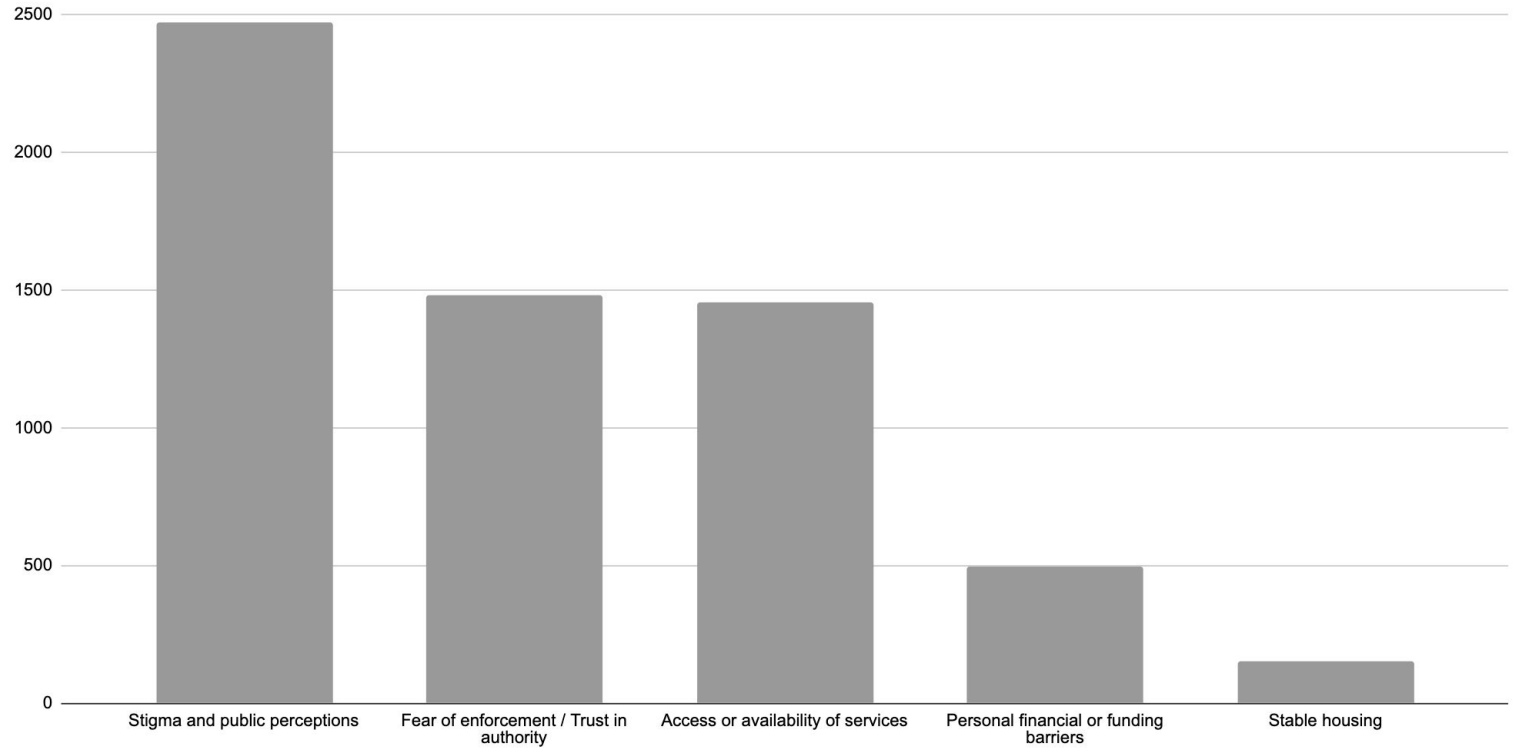
Question 6:

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

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

2,434 Classified using mult-tag category AI analysis

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



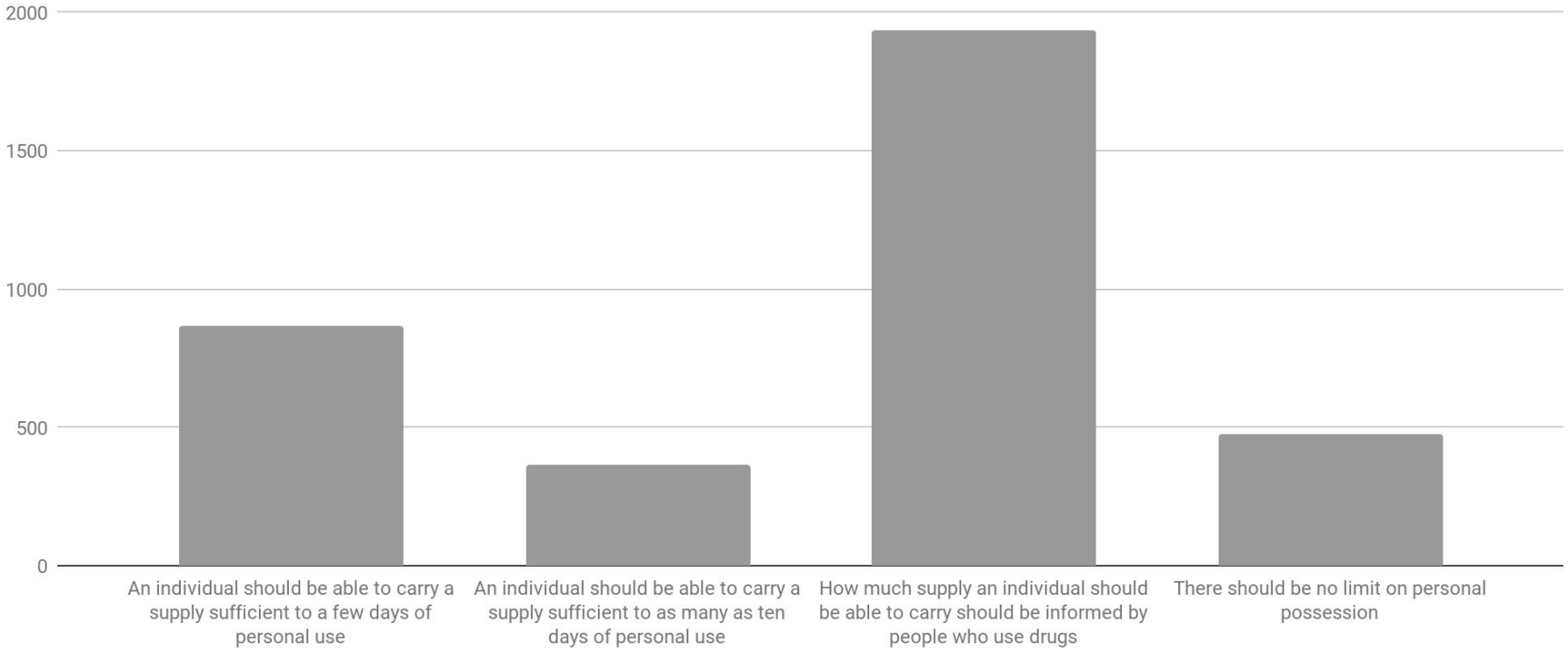
Question 7:

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

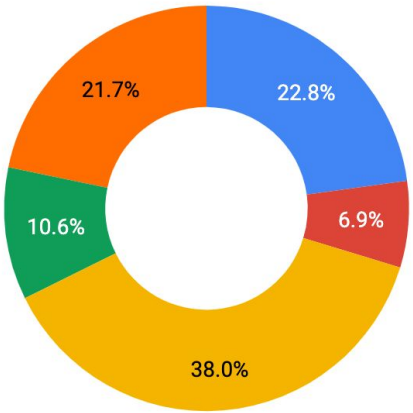
Single choice
4,599 Responses, 1,396 No response

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

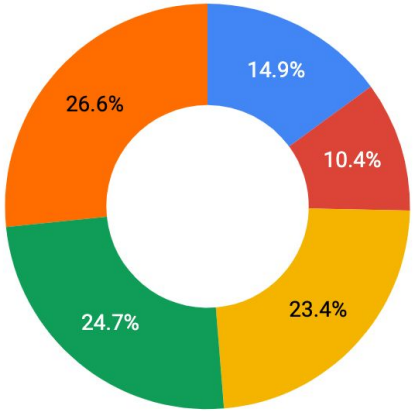
(4,599 Responses)



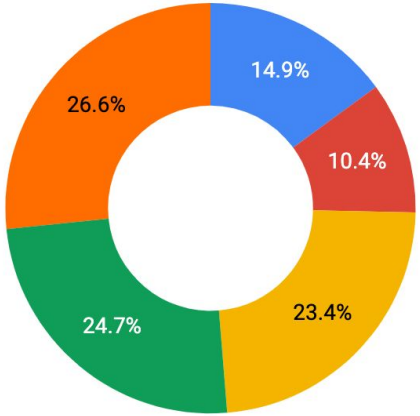
7. What should be considered when determining the quantity of drugs an individual can have for personal possession?



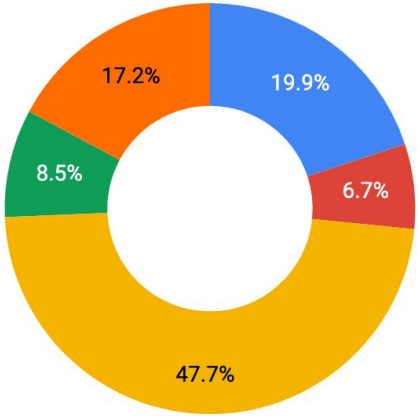
RACIALIZED RESPONDENTS



UNDERHOUSED RESPONDENTS



RESPONDENTS WHO USE DRUGS



NON-RACIALIZED RESPONDENTS; HOUSED, NO REPORTED DRUG USE

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

Question 8:

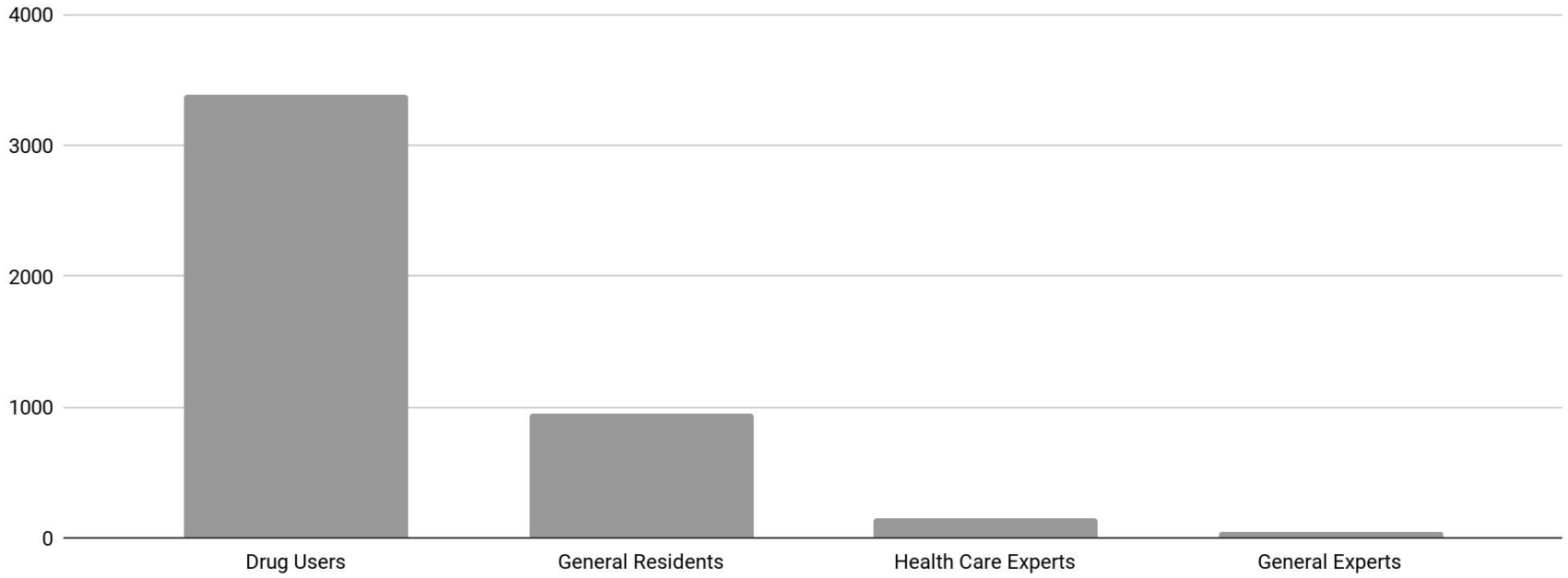
What role should community members, including people who use drugs, have in developing and evaluating this new policy?

Open Text
3,925 Responses 2,071 No response

3,636 Classified using mult-tag category AI analysis

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

(3,636 Responses)



Question 9:

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

Open Text
3,443 Responses 2,552 No response

2,434 Classified using mult-tag category AI analysis

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