Reframing the Four Pillar Model: Community-Led Capacity Building and Priority Setting

ONTARIO NETWORK OF PEOPLE WHO USE DRUGS
CANADIAN AIDS SOCIETY

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Canadian Research Initiative in Substance Matters
Initiative Canadienne de Recherche sur les Impacts des Substances psychoactives

CANADIAN AIDS SOCIETY
SOCIÉTÉ CANADIENNE DU SIDA

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1.0 Executive Summary

1.1 Purpose and Context

For more than two decades, the Four Pillar Model — Prevention, Treatment, Harm Reduction, and Enforcement — has guided drug policy in Canada and Ontario. While designed to balance public health and public safety, its implementation has become increasingly skewed, with enforcement dominating funding, policy influence, and public discourse. This imbalance has contributed to ongoing criminalization, stigma, and preventable harm among people who use drugs.

1.2 Leadership and Partners

This initiative was led by People With Lived and Living Experience (PWLLE), including people living with HIV who use drugs, people who use or have formerly used drugs, and others disproportionately impacted by criminalization and systemic inequities. The work was carried out in partnership with the Ontario Network of People Who Use Drugs (ONPUD), the Canadian AIDS Society (CAS), and the Canadian Research Initiative in Substance Matters (CRISM) Ontario Node, alongside community members, researchers, service providers, legal advocates, and community organizations.

1.3 Approach and Methods

The project employed a community-led, mixed-engagement approach that included one in-person priority-setting session, one virtual priority-setting session, three in-person regional priority-setting workshops, and facilitated cross-sector dialogue sessions. More than 300 participants contributed to capacity building, critical reflection, and the identification of system-level gaps grounded in lived experience and evidence.

1.4 Key Findings

Participants consistently identified enforcement as overrepresented and harmful, while harm reduction remains underfunded and politically unstable despite strong evidence of its effectiveness. Prevention and treatment services were described as fragmented, inequitable, and frequently misaligned with the realities of people who use drugs. Across all pillars, stigma and criminalization continue to undermine health equity, dignity, and access to care.

1.5 Recommendations and Strategic Shifts

The project calls for a fundamental reorientation of drug policy toward health, human rights, and community care. Key directions include:

1. **Reframe public safety** in terms of health and community care, rather than policing and punishment.

2. **Decriminalize drug use and possession** paired with investments in safe supply and wraparound services.
3. **Replace or restructure the Enforcement/Community Safety pillar,** prioritizing true justice, accountability, and equity.
4. **Invest in upstream prevention, including housing, income support, and anti-poverty measures.**
5. **Ensure system integration, legal literacy, and cross-sector collaboration and accountability measures.**
6. **Community Engagement with PWLLE should be mandatory** for all drug strategies. Legal literacy support, training, and building the capacity of PWLLE to actively participate in Drug Policy work are necessary.

1.6 Why This Matters

Transforming the Four Pillar Model in collaboration with PWLLE is essential to reducing overdose deaths, improving continuity of care, and addressing intersecting health inequities, including substance use, HIV prevention, treatment, and aging with complex needs. Engaging people with lived experience is important because their insights and perspectives can lead to more effective solutions and policies that genuinely address the needs of the community. A rights-based, community-led, and health-centered approach is both necessary and achievable with sustained political will, long-term funding, and accountability. By co-creating a new Strategy across Ontario and federally, a new path forward can be investigated where complete collaboration across sectors and with PWLLE can be central to strategy development and implementation in efforts to improve outcomes across the board when it comes to substance use.

2.0 Funding

Funding support was provided by the Canadian Institutes of Health Research through the Canadian Research Initiative in Substance Matters Ontario Node (#REN-181677).

3.0 Land Acknowledgement

We acknowledge that the conversations and collaborative work informing this paper took place on lands in what is now called Ontario, which are the traditional territories of many Indigenous Nations, including the Anishinaabe, Haudenosaunee, Huron-Wendat, and Métis Peoples. We honour the enduring relationships that First Nations, Inuit, and Métis Peoples have with these lands and waters, and recognize their longstanding stewardship, governance, and knowledge systems.

While the work described in this paper was carried out in Ontario, the organizations involved engage in work with communities across what is now known as Canada and throughout Turtle Island. We recognize that Indigenous Peoples across these lands continue to uphold diverse cultures, laws, and ways of knowing, and we acknowledge the ongoing impacts of colonial policies and structures on Indigenous communities.

We offer this acknowledgment as a gesture of respect and responsibility, and as a reminder of the importance of Indigenous leadership, partnership, and self-determination in the work we undertake.

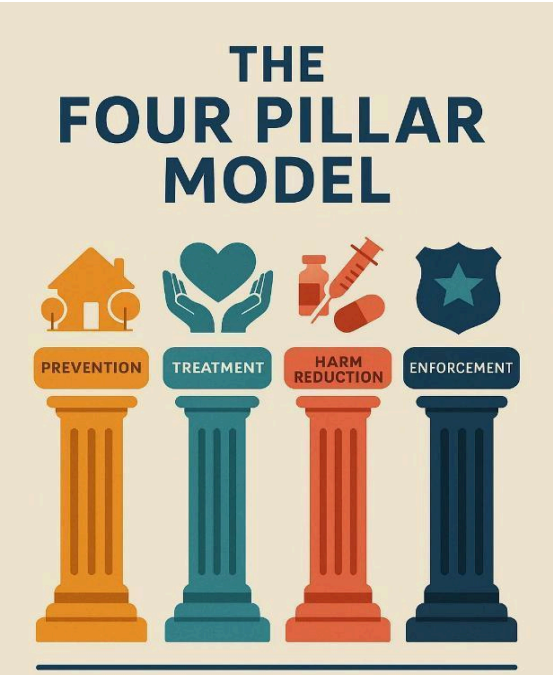
4.0 Introduction

This initiative was designed by People Who Use Drugs (PWUD) and People with Lived Experience (PWLLE), in collaboration with The Canadian AIDS Society, in order to center the leadership and expertise of PWLLE in drug policy reform and health-system transformation. Using the existing Four Pillar Model as a starting point, the project aimed to strengthen community knowledge, support collaborative priority setting, and generate practical tools to inform policy and service redesign in Ontario, in hopes of expanding this work nationally.

The work was grounded in equity-based and rights-informed principles, emphasizing meaningful participation by those most directly impacted by substance use, criminalization, and structural inequities. Project activities included four regional virtual priority setting workshops, 1 in-person provincial priority setting workshop, a report, which will help to guide us to create community resources and a webinar. Throughout the duration of the project, there were many multi-disciplinary, cross-sector dialogues facilitated by PWLLE from The Ontario Network of People Who Use Drugs (ONPUD).

Together, these activities created space for lived experience leadership, shared learning, critical reflection, and collective visioning, while challenging widespread assumptions about drug use, public safety, and effective policy responses.

5.0 Overview of the Four Pillars



5.1 Prevention

The current framework claims the **Prevention** pillar aims to reduce the initiation and escalation of substance use by addressing risk factors and strengthening protective factors, particularly among PWUD, youth, newcomers, people living with HIV, and other populations experiencing social inequities. Prevention strategies include public education, early intervention, school-based programming,community-based programming, and policy measures that promote accurate knowledge, resilience, social inclusion, and mental wellness.

The Government of Canada's national drug strategy, along with federal and provincial approaches, including Ontario's framework, emphasizes prevention as a central priority. This includes evidence-informed public awareness campaigns, integration with mental health initiatives, and cross-sector collaboration with education and social services. Similarly, Ontario's opioid strategy identifies prevention as a core area of investment, with a focus on reducing stigma surrounding addiction and increasing awareness of the risks associated with opioid use.

However, prevention programming across jurisdictions suffers from **fragmentation and inequity in access**, particularly in northern, rural, and Indigenous communities. As noted in regional frameworks like the Waterloo Region Integrated Drugs Strategy and the Thunder Bay Drug Strategy, prevention requires long-term, sustained investment — including culturally appropriate resources for Indigenous and equity-deserving populations, trauma-informed early childhood interventions, and upstream measures like income security and housing access (City of Thunder Bay, 2017; Waterloo Region Crime Prevention Council, 2011). These foundational determinants of health are insufficiently integrated into current prevention work. Networks, collaborations, and structures are fragmented and not accessible, navigation is complex, complicated and redundant, and PWLLE are often left out of very important youth prevention work and education.

5.2 Treatment

The **Treatment** pillar supports individuals in managing impactful substance use through a continuum of care that includes withdrawal management, residential and community-based programs, medication-assisted therapies (such as Methadone, buprenorphine, morphine, stimulants, and other replacement therapies, as well as mental health and withdrawal management medications), and psychosocial support (Health Canada, n.d.; Taha, 2018). The goal of the Treatment Pillar is to promote wellness, healing, and quality of life, while respecting individual autonomy and choice. It is important to note that for people living with HIV who use drugs, fragmentation and abstinence requirements can disrupt continuity of HIV care and worsen health outcomes, particularly for those aging with multiple chronic conditions.

Both Ontario and Canada's frameworks recognize the need to expand access to evidence-based treatment, particularly for opioid use disorder. The Canadian Drugs

and Substances Strategy (CDSS) emphasize low-barrier access, trauma-informed care, and increased funding for treatment services across the country. Ontario has de-vested from Harm Reduction to invest in abstinence-based treatment options, yet despite these efforts, treatment remains one of the **most ambiguous, inaccessible, and under-utilized services in the Treatment Pillar.** Long wait times, lack of access to services across regions, and abstinence-based requirements persist across Ontario.

Additionally, there is insufficient integration between treatment and other healthcare or social systems, as well as fragmented pathways post-in-patient treatment, leaving many individuals unsupported as they move through the continuum of care. There are many particularly acute barriers for people living with HIV who use drugs, for whom fragmented HIV care can disrupt substance use and HIV treatment and worsen health outcomes, particularly for those aging with multiple chronic conditions.

Abstinence-based treatment systems frequently operate in silos, disconnected from harm reduction, housing, primary care, and social supports. This fragmentation contributes to disengagement, relapse or disruptions in wellness, and avoidable harm, reinforcing the very cycles the treatment system is meant to disrupt. The lack of collaboration with Harm Reduction services or refusal to adopt harm reduction policies is concerning, given what we know about opioid toxicity deaths among people who have been released from hospital, jail or in-patient treatment.

Treatment is not just about abstinence-based programs but also encompasses the plethora of services aimed at the goal of supporting people through substance use. Examples include, but are not limited to, the following services:

- In-Patient Rehabilitation
- Withdrawal Management
- Opioid Assisted Therapies
- Medicated-Assisted Therapies
- Support Groups (Abstinence-Based and Non-abstinence-based)
- Overdose Response Services (such as Safe Consumption Sites or Consumption and Treatment Services)
- Outpatient Rehabilitation Programs
- Wholistic Substance Use Supports
- Cultural Treatment Options

5.3 Harm Reduction

The **Harm Reduction** pillar reframes substance use as a health and social issue rather than a moral failing. Grounded in lived experience, activism, compassion, and public health interventions, Harm Reduction programming is an evidence-based, person-centered approach designed to meet people where they are at, minimize the negative health, social, and legal impacts of substance use without requiring abstinence as a precondition for support (Canadian Drug Policy Coalition, n.d.; Canadian Mental Health Association Ontario, n.d.), as is the case with many abstinence-based initiatives. It follows a compassionate, non-judgmental philosophy focused on improving health, safety, and

well-being despite substance use. Harm reduction strategies are designed to **minimize the negative health, social, and legal impacts** of drug use, and have been utilized in substance use programs with great success for some time.

In Canada and Ontario, harm reduction interventions, including supervised consumption services (SCS), safer supply programs, overdose prevention sites, drug checking services, needle and syringe programs, and naloxone distribution have demonstrably reduced overdose deaths, prevented transmission of HIV and other Sexually transmitted and blood-borne infections, and improved health system navigation and engagement (Harris, 2021; Ontario HIV Treatment Network, 2024).

Despite this evidence, harm reduction remains **highly politicized and inconsistently funded or defunded**. In Ontario, the provincial government's selective support of abstinence-based services, restrictions on site location and service models, defunding of eligible consumption sites and other harm reduction cuts have curtailed the potential reach of this pillar (Centre on Drug Policy Evaluation, 2024). Ongoing criminalization, stigma within healthcare, and lack of funding and access undermine the potential impact.

5.4 Enforcement / Community Safety

Historically, **the Enforcement/Community Safety** pillar addressed the regulation of controlled substances and the policing of illicit drug production, trafficking, and distribution (Waterloo Region Crime Prevention Council, 2011), and has been a **priority pillar** within Canada's drug policy landscape, underpinned by the Controlled Drugs and Substances Act and decades of punitive approaches to drug use. The Drug Strategy Network of Ontario (DSNO) and Public Health Ontario (PHO) use Community Safety instead of Enforcement as a title, which encompasses a wider group of services that are relevant to the community, rather than criminalization.

While originally intended to complement health-based approaches, enforcement agency efforts have frequently undermined prevention, treatment, and harm reduction work by operating in a siloed nature and often in direct conflict, yet Enforcement/Community Safety Initiatives receive more funding than many other initiatives (Canadian Drug Policy Coalition, 2015). People who use drugs, especially those experiencing homelessness, poverty, and/or racism, are disproportionately targeted by policing and incarceration, deterring access to services, increasing overdose risk, and reinforcing structural and historical harms and stigma (Godkhindi et al., 2022).

Practices such as encampment evictions, raids, street-level surveillance, and the criminalization of PWUD and public drug use persist, despite evidence that such practices are ineffective, can be harmful and have life-threatening consequences (Canadian Public Health Association, 2025; Godkhindi et al., 2022).

For regions with a Community Safety rather than an Enforcement pillar, the services usually encompass a wide range of community safety initiatives such as (but not limited to):

- Non-Policing alternatives
- Police
- Fire & Rescue
- Security Services
- Liaisons or Mental Health Workers who accompany police on calls
- Paramedics

6.0 Where the Four Pillar Model Falls Short

Although the Four Pillar Model was intended to promote a balanced and coordinated response to substance use, its implementation across Canada and Ontario, more specifically, has revealed substantial flaws. These issues are structural, colonial, and deeply embedded in systems of policy, funding, and ideology. With the status quo of the 4 Pillar Model, there is persistent misalignment between what evidence and lived experience call for, and what governments have been willing or able to implement.

There is a refusal to:

- Accept the crisis and what is driving it
- Fund the necessary life-saving interventions at the level needed to make a real impact in every community
- Acknowledge the colonial structure of frameworks and adjust to decolonize
- See the issues that come with substance use in a holistic way
- Offer cultural or individualized pathways for treatment and care

Reimagining the framework for drug strategy in Ontario and nationally is essential for fostering a more inclusive and effective approach. The prevailing four-pillar model, while established, appears increasingly outdated and disconnected from the realities faced by people who use drugs (PWUD) and those with lived experience (PWLLE). This colonial and siloed structure not only stifles collaboration but also undermines the holistic understanding of wellness and recovery that individuals seeking support truly require.

A contemporary framework should prioritize a collaborative partnership with PWUD and PWLLE. By meaningfully engaging these communities, we can create a drug strategy that genuinely reflects their experiences, needs, and aspirations. This co-creation process is vital; it brings forth a diverse spectrum of voices and insights that can enrich the development of more effective programs and services.

Furthermore, embracing innovative methods and strategies is crucial for enhancing substance use programs. These could include peer-led initiatives, harm reduction strategies, and integrated health services that acknowledge the interplay of social, economic, and health factors influencing substance use. A reimagined framework would not only address the immediate needs of individuals but also promote community resilience and support recovery pathways that are personalized and culturally relevant.

Ultimately, revitalizing our approach to substance use strategies can rekindle enthusiasm and support for these essential services. It is an opportunity to create a future where PWUD and PWLLE are seen as partners in their recovery journey, fostering an environment where their voices are central and their experiences are valued. By taking these steps, we can work towards a more compassionate and effective drug strategy that aligns with modern understandings of health and wellness.

This section highlights the five major issues that emerged through our community engagement work and cross-sector regional and provincial discussions in Ontario. This process should be completed in each Province and Nationally to address issues and meet the needs of the community.

6.1 Enforcement Remains Overrepresented and Overfunded

Despite rhetorical commitments to balance all pillars equally, the Enforcement pillar continues to dominate the operational reality of drug policy in Ontario and Canada (Canadian Drug Policy Coalition, 2015). Policing, surveillance, and criminal prosecution are routinely prioritized over health-based interventions, both in terms of budget allocation and political attention (Canadian Drug Policy Coalition, 2015; Fischer, 2023). According to community feedback, this manifests in the aggressive policing of public drug use, encampment evictions, and increased criminalization of marginalized communities — all of which increase risk and harm rather than safety.

The 2019 Strike et al. article underscores that enforcement-oriented approaches often work at cross-purposes with harm reduction, prevention, and treatment (Strike & Watson, 2019). For example, the presence of police near supervised consumption services has been shown to deter use of these facilities, contributing to higher overdose rates and less engagement with healthcare services. Community feedback consistently identified fear of arrest, stigma from law enforcement, and past criminalization as major barriers to accessing care.

6.2 Harm Reduction is Politicized and Unevenly Supported

Harm reduction is perhaps the most evidence-supported pillar, yet it remains the most politically vulnerable. Ontario's provincial government has placed restrictions on the number, location, and operating criteria of supervised consumption services — despite overwhelming evidence of their effectiveness in saving lives (Kolla & Gomes, 2026). This has created a patchwork of access, where some regions benefit from robust harm reduction infrastructure, while others have less access.

Canada's national drugs strategy formally includes harm reduction as a core pillar; however, harm reduction implementation continues to operate within a broader legal and policy environment where substance use remains criminalized. This creates ongoing practical and operational constraints that can limit service reach, integration, and sustainability (Hyshka et al., 2017). Many frontline organizations operate under threat of defunding, or hostile public opposition. This political instability can hinder long-term

planning, workforce retention, and coordinated service delivery, especially in rural, remote, and Indigenous communities where health and social systems are already under strain.

6.3 Prevention Lacks Upstream Investment and Equity Focus

The Prevention pillar is often underdeveloped and misaligned with the structural determinants of health. While public education campaigns and school-based programs can increase awareness of substance use and related risks, they have limited impact when implemented in isolation. Such approaches typically do not address the root causes of problematic substance use, including poverty, trauma, systemic racism, housing insecurity, and lack of community support (Crowley et al., 2024). These upstream conditions also shape broader health vulnerabilities and access to care. For example, they influence exposure risk and service access related to HIV and other sexually transmitted and blood-borne infections, particularly among people who use drugs.

Consultation participants and regional strategy documents consistently emphasized that effective prevention requires sustained upstream investments, including universal housing access, food security, income supports, culturally safe spaces, and early childhood development programs. However, these approaches are often treated as outside the scope of “drug strategy” and therefore remain underprioritized in policy and funding frameworks. This common misunderstanding of prevention limits overall impact and fails to address the social determinants of health in which substance-related harms emerge and persist.

6.4 Treatment Access in Inconsistent and Often Exclusionary

While treatment services are a core pillar, access remains deeply inconsistent, exclusionary, and poorly coordinated. Across Ontario, participant consultants in this initiative reported long waitlists, abstinence-only programs, lack of culturally appropriate care, and treatment models that are disconnected from harm reduction. These barriers disproportionately affect people in rural and remote regions, Indigenous communities, and those who use drugs.

In many parts of Canada, the treatment system is still driven by abstinence-based philosophies and lacks integration with primary care, mental health, and social support in a combined circle of care. This siloed effect contributes to relapse, treatment dropout, and re-incarceration — reinforcing cycles of harm rather than breaking them (Brooks et al., 2023; Taha, 2018).

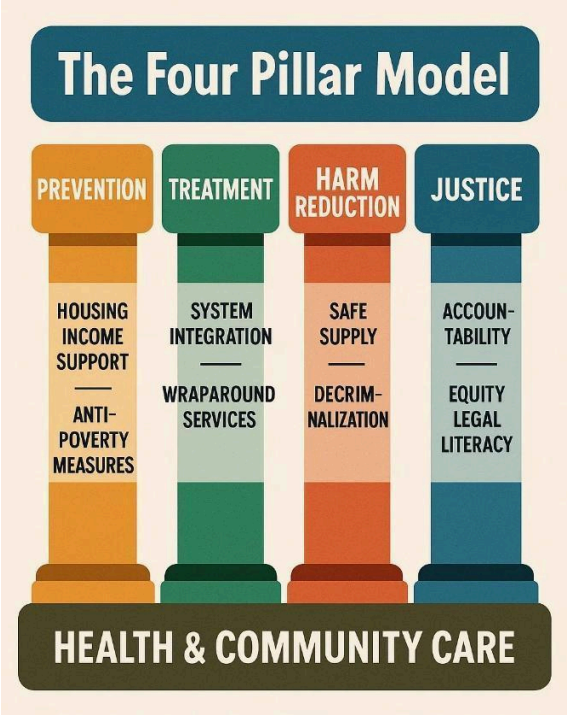
Ontario’s opioid strategy recognizes the importance of low-barrier and trauma-informed treatment, but implementation lags policy (Government of Ontario, 2020; Kolla & Gomes, 2026). Canada’s CDSS calls for person-centered and integrated care, yet frontline organizations continue to operate in fragmented and underfunded silos. Without serious investment in peer-led navigation support, culturally grounded healing services, and trauma-informed approaches, treatment will remain out of reach for many.

6.5 The Model Reinforces Stigma and Fails to Center Human Rights

The most fundamental critique of the Four Pillar Model is that it does not sufficiently center the rights, dignity, and leadership of people who use drugs. As currently implemented, the model allows enforcement to continue to shape the public narrative around drug use, reinforcing stigmatization, criminalization, and moral judgment.

Participants in this initiative repeatedly highlighted how institutional and prosecutorial bias impacts everything from police interactions, child welfare involvement and court decisions. The lack of legal literacy among healthcare and social service providers exacerbates these harms. While municipal drug strategies across Ontario, including Toronto, Ottawa, Peel, Niagara, Waterloo, and Hamilton, consistently emphasize anti-stigma initiatives and peer inclusion, these are often tokenized or under-resourced (Piscitelli, 2017).

7.0 Changes and Strategies for a Better Future for People Who Use Drugs



The need for change is clear. As described in the previous sections, the current application of the Four Pillar Model in Ontario and across Canada fails to meet the urgent needs of people who use drugs, particularly those who are Indigenous, racialized, unhoused, or marginalized.

Although the model was built on a vision of balance and integration, it has in practice become skewed, showcasing a reliance on punitive enforcement, fragmented service delivery and limitations in their structural reach.

A better future for people who use drugs requires **not just improved implementation**, but a **fundamental reimagining** of how we define safety, health, and community care. The following section outlines a series of concrete changes and long-term strategies for transforming drug policy in Canada and Ontario, as outlined via our engagement and consultations.

7.1 Reframe Public Safety Through Health, not Enforcement

The most urgent and consistent call from PWLLE and community advocates is the need to **de-prioritize enforcement as a central pillar of drug policy**. While public safety remains important, it must no longer be narrowly defined as policing and

incarceration (Canadian Drug Policy Coalition, 2026). Public safety should be redefined to mean **access to stable housing, health care, harm reduction services, income support, and freedom from criminalization. This** means shifting investments away from reactive, carceral responses and toward proactive, community-based support. Crisis responses should be led by peer teams, nurses, and social workers — not police. Municipalities and provinces should adopt **non-police models of emergency response**, such as CAHOOTS in Oregon or Toronto's Community Crisis Support Service pilot, to ensure they are rooted in community knowledge and trauma-informed care (Canadian Mental Health Association Toronto, n.d.; White Bird Clinic, 2020).

A key structural change would involve replacing the **"Enforcement" pillar** with a new pillar, such as **"Community Safety and Accountability"** or **"Justice and Equity"** — one that focuses on restorative approaches, police accountability, and the legal rights of PWUD rather than their punishment.

7.2 Decriminalize Drug Use and Possession at All Levels

There is now a strong consensus among health experts, researchers, and PWUD that **decriminalization** is a necessary and evidence-based step toward reducing drug-related harm. Decriminalization does not mean legalization or unregulated use; rather, it shifts the approach from one of criminal punishment to one of health intervention.

The Government of Canada's Canadian Drugs and Substances Strategy (CDSS) recognizes the harms of criminalization and emphasizes stigma reduction and public health alignment. However, it stops short of calling for full decriminalization — a gap that must be addressed if Canada is to follow the lead of countries like Portugal, Norway, and others that have successfully reduced overdose deaths and improved health outcomes.

Decriminalization must be accompanied by **investments in safe supply**, low-barrier housing, wraparound health services, and robust peer support. Legal reforms should also include the **expungement of criminal records** for past drug offences and protections against discrimination in housing, employment, and child welfare systems.

7.3 Scale and Fund Peer-Led and Culturally Grounded Interventions

Across all pillars, peer-led programs are among the most effective and trusted by people who use drugs. From treatment navigation and outreach to overdose prevention and legal education, programs delivered by PWLLE provide **relatable, accessible, and empowering support** that bridges gaps in formal systems.

Moving forward, peer-led organizations must not only be funded as service providers — they must also be treated as policy and governance partners. This includes resourcing peer advisory councils, compensating lived experience expertise equitably, and embedding peer leadership in decision-making structures across the health and justice systems.

At the same time, **culturally grounded and Indigenous-led models** of care must be

prioritized — especially in the context of northern, remote, and First Nations communities. The Four Pillar Model must be flexible enough to incorporate land-based healing, traditional medicines, and community-defined pathways of wellness, without imposing rigid, Western-centric models of abstinence or treatment.

7.4 Invest in Structural Prevention, Not Just Public Education

Current prevention strategies often focus on individual behavior change — e.g., youth education, awareness campaigns — but often **fail to address the systemic and structural drivers** of substance use. Effective prevention must be upstream, universal, and rooted in equity.

This means substantial investment in affordable housing, food security, employment opportunities, and early childhood support. It also means transforming schools, shelters, and correctional institutions into sites of prevention through trauma-informed practice and harm reduction education.

Ontario's Opioid Strategy and the federal CDSS both acknowledge the importance of prevention but rarely frame it as a structural issue. The reimagined model must expand the definition of prevention to include **policies that reduce inequities, strengthen social cohesion, and promote justice.**

7.5 Ensure Integration and Accountability Across Systems

One of the most persistent failures of the current model is the **lack of coordination and integration** across the pillars and across levels of government. People who use drugs must often navigate disconnected systems, hospitals, shelters, legal services, addiction management facilities, and income support, without help, while frequently facing discrimination and trauma.

The future must include **seamless, wraparound service delivery**, supported by shared data systems, cross-sector case management, and community hubs that offer a combined circle of care under one roof. Governments must implement **accountability mechanisms** to ensure that public funds are not reinforcing harm, particularly within policing, child welfare, and institutional care.

This includes embedding equity-based outcome measurement, funding peer-led evaluations, and ensuring the rights of PWUD in law and policy frameworks.

7.6 Sustain Cross-Sectoral Dialogue and Knowledge Exchange

The Four Pillar initiative demonstrated the power of **bringing together PWLLE, researchers, legal advocates, and service providers** so that they may learn from each other and co-create priorities. This model of cross-sectoral engagement must be sustained and expanded through communities of practice, regional knowledge exchanges, and collaborative advocacy platforms. Knowledge generated through lived experience, community organizing, and peer programming must be valued equally within academic and clinical research. Governments, funders, and institutions must

commit to **long-term, resourced knowledge exchange infrastructures** that support collective action and adaptability.

8.0 From Reform to Transformation

The Four Pillar Model has long provided a foundational framework for organizing drug policy across Canada and Ontario. Yet in practice, its application reveals deep imbalances — particularly the disproportionate power and funding allocated to enforcement, often at the expense of health, equity, and care. What was intended as a model of integration has too often reinforced systemic inequities, fragmented service delivery, and punitive approaches that harm the very people it seeks to support.

The consequences of the current model are not theoretical. They are visible every day — in preventable overdose deaths, in the criminalization of poverty and substance use, and in the continued exclusion of people who use drugs from systems of care, safety, and justice. Unless these dynamics are addressed, the Four Pillar Model will remain more symbolic than substantive.

To fulfill its original promise, the model must undergo a **fundamental transformation** — not just a rebalancing of resources, but a restructuring of its very foundation. This includes bold, sustained investment in harm reduction, prevention, and treatment; the lack of **prioritization of enforcement as a primary solution**; and a pivot toward **rights-based, community-led, and culturally grounded approaches**.

There is growing consensus among researchers, frontline providers, and community advocates — especially People with Lived and Living Experience — that enforcement, as a pillar, must be **critically re-examined** and reimagined. Public safety should no longer be equated with punishment or policing, but with access to housing, healthcare, autonomy, and dignity.

Moving forward, drug policy must be **built not just for communities, but by them** — with leadership from those most impacted by criminalization and systemic harm. Decriminalization, peer-led systems change, and Indigenous governance are not optional; they are essential to any credible path forward.

The Four Pillar initiative has laid the groundwork for this transformation. What is needed now is **political will, funding, and accountability** to move from rhetoric to action — to create a system where health, justice, and human rights are not in tension, but deeply aligned.

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