

STOPPING THE HARM

DECRIMINALIZATION OF PEOPLE WHO USE DRUGS IN BC



Office of the
Provincial Health Officer

**PROVINCIAL HEALTH OFFICER'S
SPECIAL REPORT**

TABLE OF CONTENTS

| | |
|--|----|
| Acknowledgements | 2 |
| Executive Summary | 3 |
| The Overdose Crisis in BC..... | 3 |
| Decriminalization of People Who Use Drugs..... | 4 |
| Chapter 1: The Illegal Drug Overdose Crisis in BC | 6 |
| Illegal Drug Overdoses in BC..... | 6 |
| BC’s Illegal Street Drug Supply is Highly Toxic | 7 |
| BC’s Response to the Overdose Crisis | 8 |
| Pharmaceutical Alternatives to Street Drugs as Part of a Harm Reduction Approach | 8 |
| Key Messages..... | 9 |
| Chapter 2: History of Canada’s Drug Laws, National Strategies, and International Drug Conventions | 10 |
| Key Messages..... | 16 |
| Chapter 3: Harms Associated with Prohibition-Based Drug Laws and Policies | 18 |
| Greater Harms Are Experienced by Women | 18 |
| Health Harms..... | 19 |
| Stigma | 20 |
| A Lucrative Illegal Drug Market..... | 21 |
| Incarceration | 21 |
| Economic Costs..... | 21 |
| Drug Offences in BC | 22 |
| Key Messages..... | 22 |
| Chapter 4: Alternatives to Criminal Justice Approaches to Substance Use and Possession | 24 |
| Alternatives to Prohibition and Criminalization | 24 |
| Decriminalization of People Who Use Drugs | 26 |
| Threshold of Personal Use | 26 |
| Determining Penalties..... | 26 |
| Decision-making Authority | 27 |
| Establishing an Alternative Pathway..... | 27 |
| Growing Support for the Decriminalization of People Who Use Drugs..... | 31 |
| International Support | 31 |
| Canada..... | 32 |
| British Columbia..... | 32 |
| Response to Support for Decriminalization | 33 |
| Key Messages..... | 33 |
| Chapter 5: Discussion and Recommendation | 34 |
| Discussion..... | 34 |
| Recommendation | 36 |
| Options for Implementation in BC..... | 37 |
| Option 1: Amend Provincial Policing Policy..... | 37 |
| Option 2: Amend Provincial Policing Regulation..... | 37 |
| Conclusion | 38 |
| Appendix A: Glossary | 39 |
| References | 41 |

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EXECUTIVE SUMMARY

The Provincial Health Officer (PHO) is the senior public health official in BC, with responsibility for providing independent advice and public reporting to support and advance the health of British Columbians. The following is a PHO Special Report written under the authority of the *Public Health Act*, which provides an urgent recommendation to reduce the harms associated with the toxic street drug supply and the criminalization of people who use drugs in BC. A more comprehensive PHO Annual Report will be released in the coming months that examines overdose deaths, response efforts, and some related impacts of overdose deaths across the province, including a decrease in life expectancy at birth for all British Columbians.

In April 2016, in response to an ongoing, escalating crisis of illegal-drug-related overdose deaths, the BC PHO declared a public health emergency under the *Public Health Act*; a first in BC and Canada. Following this declaration, a multi-sector response was launched by the provincial government and its partners to keep people who use drugs safe from harm. Despite continuous efforts in BC to resolve the overdose crisis, and the declaration of a public health emergency, there has been minimal success in stopping the rising death toll since the crisis started, and additional alternative solutions are warranted immediately. This PHO Special Report examines the criminalization of people who use drugs in BC, Canada, and beyond, and based on existing evidence, offers a single recommendation: decriminalization of people who use drugs in BC.

The Overdose Crisis in BC

The response to the overdose crisis has been extensive and multi-faceted, and has brought together local, provincial, and federal partners. The response has involved engagement with people with lived experience, public education and targeted information campaigns, enhanced data collection and analyses, increased access to evidence-based treatment for opioid use disorder, rapid distribution of publicly funded naloxone to reverse overdoses, enhanced toxicological testing capability, passage of Good Samaritan legislation and other legislative changes, significant harm reduction enhancement (e.g., the establishment of overdose prevention services, expansion of supervised consumption sites and the provision of drug-checking services), and the creation of a separate ministry dedicated to mental health and addictions. Early findings of overdose response strategies have shown that many lives have been saved through these efforts. The combined impact of these interventions has been shown to have averted 60 per cent of all possible overdose deaths since the declaration of the public health emergency.

Early in the response efforts, law enforcement throughout the province adopted a policy that police officers will not attend 9-1-1 calls for overdose intervention unless they are the only available first responders or unless police presence is specifically requested. The purpose of this policy is to allay fears of arrest for drug possession and to encourage people to call for medical assistance in the event of an overdose.

Despite these life saving activities, the BC Coroners Service reports that the number of deaths has continued to rise and remains at consistently high levels throughout the province. Overrepresented sub-populations in these deaths are Indigenous peoples and males age 30 to 59. The majority of people who died were using drugs alone and inside. Overdose deaths in the province have become so pervasive that there has been a measured decrease in life expectancy at birth for all British Columbians.

One substantial factor in the ongoing overdose crisis is BC's highly toxic illegal drug supply. Toxicology reports and growing numbers of drug seizures have identified that highly toxic illegally manufactured synthetic opioid analogues (substances that are chemically similar to another substance; e.g., fentanyl and carfentanil are opioid analogues) are nearly completely displacing diverted prescription opioids (i.e., prescription medication that is sold illegally on the street) and illegal heroin in the street drug supply. Drug testing has found fentanyl in varying amounts in all illegal street drugs.

People use psychoactive drugs for a myriad of reasons, including self-medication for pain management (including physical, mental, and emotional pain, and trauma), to deal with anxiety, to experiment, out of curiosity, or to stimulate artistic endeavours. Substance use occurs on a continuum, from beneficial and/or cultural usage through to chronic dependence and substance use disorder or addiction. Not all substance use is harmful; however, in the context of a toxic, unregulated illegal drug supply, unintentional overdose and death has become an inherent, persistent risk. People living with addictions who are dependent on the toxic street supply are most at risk of death.

Decriminalization of People Who Use Drugs

There is widespread global recognition that the failed "war on drugs" and the resulting criminalization and stigmatization of people who use drugs has not reduced drug use but instead has increased health harms. The predominately criminal-justice-based approach that channels people who use drugs—some of whom live with a substance use disorder—into the criminal justice system (e.g., jail sentences for possession of a small amount of an illegal substance) does not address what is ultimately a health issue. In addition, engagement with the criminal justice system exposes non-violent, otherwise law-abiding people to a great deal of harms that they would otherwise not experience. The societal stigma associated with drug use leads many to use drugs alone and hidden, increasing their risk of dying. British Columbia cannot "treat" its way out of this overdose crisis, or "arrest" its way out either.

Many public health professionals, people with lived experience, families impacted by illegal drug harms, legal scholars, drug policy experts, and a growing number of public safety officials are critically re-evaluating the current approach of prohibition and the criminalization of people who use controlled drugs in Canada.

In BC, there has been a shift in focus for police to support a harm reduction approach when interacting with people who use drugs; pilots operating in three cities are creating alternative pathways for police to link people who use drugs to receive treatment and other supports. Simple possession of drugs for personal use is also subject to police discretion; for example, the Vancouver Police Department policy on drugs prioritizes the *context* of drug use rather than the

possession of drugs, and supports charges only if the behaviour and circumstances of the person using drugs is harmful to that person, to others, or to property.

Other jurisdictions provide an evidence base to examine alternative approaches. Notably, Portugal adopted a decriminalization approach to drug possession for personal use in 2001, and this model has potential applications for BC. Under the Portuguese model, the possession of a small amount of drugs for personal use was changed from a criminal offence (with a potential jail sentence) to an administrative one. Administrative offences entail sanctions that range from warnings, fines, bans on associating with specific people or visiting certain places, to removing the right to carry a firearm and suspending the right to practice a licensed profession that has the potential to endanger another person (e.g., a taxi driver or a physician). Criminal penalties are still applicable to illegal drug manufacturers, dealers, and traffickers. Evidence has shown that this drug policy model, along with other interventions (e.g., harm reduction, prevention, enforcement, and treatment strategies) has led to an increase in treatment uptake, a reduction in drug-related deaths, and importantly, no increase in drug use rates.

The legal framework for illegal substance use in BC falls under the federal *Controlled Drugs and Substances Act* (CDSA). While legalization and regulation of all controlled drugs is something recommended by many experts, including the Health Officer's Council of BC, the federal government has indicated that they are not planning to make any further changes in this regard after the legalization of cannabis in 2018. The Minister of Mental Health and Addictions has, however, stated that she will continue to engage in conversations with the federal government as a priority for British Columbia.

As BC's Provincial Health Officer, I have called on the federal government to move toward regulating access to currently controlled drugs, with a focus on harm reduction associated with the use of those substances, as well as the harms associated with the current prohibition-based regulatory regime and its application.

But in the context of the continuing overdose crisis that is affecting families and communities across BC, the province cannot wait for action at the federal level. **Immediate provincial action is warranted, and I recommend that the Province of BC urgently move to decriminalize people who possess controlled substances for personal use.** This is an important additional step to stem the tide of unprecedented deaths.

Decriminalization of people who use drugs can be achieved through two provincial mechanisms. The first option is to use provincial legislation (specifically, the *Police Act*) that allows the Minister of Public Safety and Solicitor General to set broad provincial priorities with respect to people who use drugs. This could include declaring a public health and harm reduction approach as a provincial priority to guide law enforcement in decriminalizing and de-stigmatizing people who use drugs. This type of approach would provide pathways for police to link people to health and social services, and would support the use of administrative penalties rather than criminal charges for simple possession. The second option is to develop a new regulation under the *Police Act* to include a provision that prevents any member of a police force in BC from expending resources on the enforcement of simple possession offences under Section 4(1) of the CDSA.

1

THE ILLEGAL DRUG OVERDOSE CRISIS IN BC

The Provincial Health Officer (PHO) is the senior public health official in BC, with responsibility to provide independent advice and public reporting to support and advance the health of British Columbians. This includes making recommendations for policies and programs that will improve health in the province. Illegal drug overdoses have been increasing in BC since 2012; this increase has accelerated exponentially since 2015. Despite sustained efforts in BC to resolve the overdose crisis, and the declaration of a public health emergency, there has been minimal success in stopping the rising death toll since the crisis started. Alternative solutions are warranted immediately.

The following is a PHO Special Report written under the authority of the *Public Health Act*, which provides an urgent recommendation to reduce the harms associated with the toxic street drug supply and the criminalization of people who use drugs. A more comprehensive PHO Annual Report will be released in the coming months that examines overdose deaths, response efforts, and some related impacts of overdose deaths across the province, including a decrease in life expectancy at birth for all British Columbians.

Illegal Drug Overdoses in BC

In BC, illegal drug overdose deaths (both accidental and undetermined) and **fentanyl**-detected^a illegal drug overdose deaths are regularly and publicly reported by the BC Coroners Service.¹ Illegal drug overdose deaths include the presence of controlled drugs (i.e., drugs identified by the federal government as having a high potential for **dependence**, including illegal drugs) and prescription drugs obtained from the street supply or by other, unknown means.^{2,3}

Illegal drug overdoses have been increasing in BC since 2012 from a baseline average of 250 deaths per year.³ In 2015, however, there was a significant increase both in number and in geographic spread of overdose deaths that has continued to impact every corner of the province. As the number of overdose deaths continued to increase unabated, in April 2016 BC's PHO declared a province-wide public health emergency under the *Public Health Act*.⁴ This was the first time a public health emergency had been declared at a provincial level in BC and in Canada.

Declaring a public health emergency provided more organizational power to respond to the crisis (e.g., more timely access to data) but it has not sufficiently curbed the increase

^a Bolded text throughout this report indicate glossary terms, which are defined in Appendix A.

in overdose deaths. Since the declaration of the public health emergency, more than 3,700 British Columbians have died from a preventable overdose—as many as four people a day. Overdose deaths have become the leading cause of unnatural death in BC since 2016; in 2018, there were 4.5 times more overdose deaths than deaths from motor vehicle crashes.⁵

Overdose deaths are occurring among all walks of life, across age groups, and across the socio-economic spectrum; however, there is a disproportionate impact on males age 30 to 59, and among Indigenous people in BC.^{3,6} The vast majority of people who die from an overdose are using drugs alone and indoors.³ The rate of overdose in BC overall for 2018 was 30.8 deaths per 100,000 people; however, this rate varied by regional health authority, ranging from a low of 28.0 deaths per 100,000 people in Fraser to a high of 36.8 deaths per 100,000 people in Vancouver Coastal.⁷ While the overdose death *rate* was highest in Vancouver Coastal in 2018, Fraser reported the highest *number* of overdose deaths (513) in 2018, a trend that had been identified back to 2010.³

Overdose deaths in the province have become so pervasive and severe that they have been found to contribute to a measurable decrease in life expectancy at birth for British Columbians.^b Between the years 2014 and 2016, **life expectancy** at birth declined by 0.38 years; illegal drug overdose deaths were responsible for 32 per cent of this decrease.⁸ These troubling findings show that while not everyone in BC may be directly impacted by the overdose crisis, the impacts on communities across the province affects everyone indirectly.

BC's Illegal Street Drug Supply is Highly Toxic

Illegal street drugs have always been subject to additives and contaminants due to their unregulated nature. However, fentanyl, a powerful synthetic opioid that is 50 to 100 times more potent than morphine, began to be detected in increasing amounts in BC after 2012. In 2012, fentanyl was detected in 5 per cent of illegal drug overdose deaths; by the end of 2018, fentanyl had been detected in 85 per cent of overdose deaths.⁵ The BC Coroners Service reports that fentanyl-related deaths appear to account for the increase in illegal drug overdose deaths since 2012, as the number of illegal drug overdose deaths excluding fentanyl has remained relatively stable, averaging 285 deaths per year, during this time period.⁷ Fentanyl and other opioid **analogues**, including **carfentanil** (which is 100 times more potent than fentanyl), have become a persistent threat to the health and safety of British Columbians who use drugs.⁹

Substance use occurs on a spectrum, from beneficial (e.g., social activity, cultural practices) to non-problematic (e.g., recreational or occasional use), to problematic (where negative impacts begin to occur because of use), to chronic dependence and addiction (where use is compulsive and continues to occur despite considerable negative impacts).¹⁰ However, due to the toxicity of BC's illegal drug supply, there is considerable risk of overdose and overdose death related to illegal drug use in any capacity, including use that is otherwise beneficial or non-problematic.

^b Life expectancy at birth is an estimate of how long, on average, a person can expect to live at birth, and it is one of the most common measures of population health and wellness. When life expectancy stagnates or fails to improve, it can be an early indication that there is something wrong; the health care system could be weakening or there could be socio-economic circumstances impacting the health of the population. A decline in life expectancy is cause for serious concern.

BC's Response to the Overdose Crisis

The province's response to the overdose crisis has focused on increasing **harm reduction** activities and interventions (e.g., widely distributing publicly funded **naloxone**, establishing **overdose prevention services** and new **supervised consumption services**, and offering **drug checking** for people who use drugs) and increasing access to evidence-based treatment (e.g., rapid access clinics that can initiate people onto **opioid agonist treatment**, establishing clinical guidance for providers on how to best manage **opioid use disorder**, and increasing the range of available treatment options for people living with opioid addiction).

Efforts to reduce stigma have encouraged people to view substance use as something that many people—including friends, colleagues, and family members—engage in for a number of reasons, with the message that people who use drugs are real people and are part of our families and communities.^c Law enforcement in BC have adopted a policy that police will not attend overdose calls unless they are the only available first responders or unless police presence has been requested. Police have also worked with the Canada Border Services Agency to intercept, detect, and investigate drugs illegally imported into the province. To help inform response efforts, monitoring, **surveillance**, and applied research have been enhanced to better understand the characteristics of people who are at risk of an illegal drug overdose.

Modeling and evaluation have shown that the efforts underway are successfully working to save lives. For example, providing

free naloxone has averted hundreds of deaths; for every 10 naloxone kits that are used, one death has been averted. Additional modeling is showing the same promising findings for opioid agonist treatment, overdose prevention services, and supervised consumption services. The combined impact of these interventions has been shown to have averted 60 per cent of all possible overdose deaths since the declaration of the public health emergency. This means that in the absence of these interventions the death toll could have been 2.5 times higher—as many as 4,700 people. Unfortunately, even with these successful initiatives, the number of people in BC dying from and vulnerable to overdose remains unacceptably high.¹¹

Pharmaceutical Alternatives to Street Drugs as Part of a Harm Reduction Approach

Work is being initiated in BC to establish a framework to protect the health and safety of people in BC who use illegal drugs. This includes proposed initiatives that aim to provide pharmaceutical alternatives to street drugs to people at high risk of overdose using a public health **harm reduction** and human-rights-oriented approach. These innovative and experimental programs are designed for people who use drugs who are not at this time interested in or responsive to treatment, and/or people at high risk of overdose death due to dependence on the illegal drug supply. These programs will be closely linked to oversight by health authorities, the Ministry of Health, and the Ministry of Mental Health and Addictions and will be independently and rigorously evaluated.

^cFor more information, visit www.StopOverdoseBC.ca.

Key Messages

- An average of four people a day continue to die from overdoses due to a highly toxic illegal drug supply—all of which are theoretically preventable.
- Overdose deaths are so pervasive across the province that they are having a measured, negative impact on life expectancy at birth in BC, affecting all British Columbians.
- The province's response to the overdose crisis has focused on increasing harm reduction activities and interventions and increasing access to evidence-based treatment.
- A safer supply of opioids for people who are at high risk of overdose is being explored in BC.
- Efforts underway are working to save lives; however, the number of British Columbians dying from and vulnerable to overdose remains unacceptably high.

2

HISTORY OF CANADA'S DRUG LAWS, NATIONAL STRATEGIES, AND INTERNATIONAL DRUG CONVENTIONS

Canada's drug laws demonstrate how the negative discourse around drug use, people who use controlled drugs, and the application of criminal law to address drug use has integrated into Canadian society for several generations. Early drug legislation was rooted in moral panic and racism; cruel and unusual—and later found to be unconstitutional—sanctions (including corporal punishment) were included in these Acts, even for **simple possession**.¹² This chapter provides a brief history of Canada's drug laws and identifies milestone strategies and legislation over the last 110 years.

Legend:

Federal government drug legislation

Federal government drug strategy

International drug convention

Other key developments

1908

The *Opium Act* came into force, prohibiting unauthorized importation of opium, and prohibiting the manufacture, sale, and possession of opium for purposes other than medicinal. This was the first instance of drug prohibition in Canada and was aimed mainly at dealers of opium rather than people who used it. Offences under this Act were subject to a maximum of three years in prison, and/or a fine between \$50 and \$1,000.¹²

1911

The *Opium and Narcotic Drugs Act* was passed in reaction to an increase in cocaine use and resulting moral panic, the Shanghai Commission (the world's first international conference to discuss drug issues), and the need to provide increased powers to police to enforce the *Opium Act*.^{12,13} The *Opium and Narcotic Drugs Act* added additional drugs to the Schedule, including cocaine, opium, morphine, and eucaine. The Act also provided power to the Governor General in Council to add additional substances to the Schedule as deemed necessary in the context of the public interest, to avoid having to enact new legislation.¹² This authority still exists today.

Between 1911 and 1960, several amendments were made to the *Opium and Narcotic Drugs Act*. Over 15 substances were added to the Schedule, including derivatives or salts of controlled substances, cannabis, and many natural (e.g., cocoa leaf) and synthetic drugs. Additional offences were included, such as sale or distribution of a controlled substance to a minor, obtaining drugs through multiple providers, trafficking drugs through the mail system, and possession of drug use equipment. Sanctions ranged from prison sentences, forced labour, corporal punishment, and an increase to the minimum fines (starting at \$200) and maximum prison sentences (up to seven years).¹²

The authority of police was increased to allow searches without restrictions on time or place, and the Act authorized the use of force if needed to conduct a search—with or without a warrant.¹² Control measures were enhanced to create a system to regulate drugs for medical or scientific purposes as well. This system included issuing permits to import, export, manufacture, sell, and distribute drugs; requiring physicians to record and report information on prescribed drugs to federal authorities; and requiring pharmacists to record and report the manufacture, sale, and purchase of drugs.¹²

A Senate Special Committee was struck in 1955 to examine how the government could address the increasing spread of drug use in Canada.¹⁴ After consulting with multiple stakeholders, the Committee reported that 3,212 people in Canada were living with a substance dependence; the majority lived in BC, and others lived in Ontario and Quebec.¹⁴ The Committee separated these people into three groups: “medical addicts” (16 per cent) (i.e., individuals who developed a dependence during the course of treatment for another condition); “professional addicts” (10 per cent) (i.e., those in the medical profession); and “criminal addicts” (74 per cent) (i.e., those who fit neither of the other groups but had convictions under the *Opium and Narcotic Drugs Act* and/or other legislation).¹⁴ The Committee unanimously rejected the idea of providing criminal addicts with legal drugs, and noted that provinces have the jurisdiction to utilize legislation to encourage voluntary treatment or facilitate compulsory treatment for these individuals.¹⁴ The Committee noted that compulsory segregation and isolation of “addicts” for “long periods of time” to receive treatment and potential rehabilitation should be explored.¹⁴ Scare tactics in drug education were recommended to prevent youth from using drugs.¹⁴ The federal government took the Committee’s findings and developed a new piece of legislation in 1961.

1961

The *Narcotic Control Act* continued the focus on criminalizing drug use despite drug use emerging as a public health issue during the 1960s. The Act was separated into two sections: Offences and Enforcement (under the Minister of Health) and Preventative Detention and Detention for Treatment (under the Minister of Justice).¹² The maximum prison term for trafficking or for possession with intent to traffic was raised from 14 years to 25.¹² Under this Act, the courts had the power to order that an individual convicted of trafficking or intent to traffic—in the presence of previous related offences—could be detained in “preventative detention” for an indeterminate amount of time. The courts could also order the examination of an offender—even someone charged with simple possession—to determine if that person was a candidate for “detention for treatment” in a federal institution for a period not exceeding 10 years.¹²

Between 1969 and 1973, the Commission of Inquiry into the Non-Medical Use of Drugs (the Le Dain Commission)¹⁵ was formed under a federal directive to examine drug laws and drug policy in Canada, including the impact of these laws and policies on people who use drugs (i.e., within the concept of harms). The final report was progressive; while it recommended discouraging non-medical use of drugs overall, it also recommended an incremental shift away from criminalizing people who use drugs. Specifically, the report recommended the immediate decriminalization of cannabis possession, and that treatment services—not criminal penalties—be provided to those living with opioid dependence. The Commission highlighted that the harms caused by the application of criminal law—especially for people who use drugs—were more serious than the harms associated with substance use.¹² Additionally, the Commission found that the proportionality of the sentences were not equal to the harm associated with substance use.¹² In keeping with modern, evidence-based drug use prevention and education strategies, the report discouraged fear-based approaches to drug use prevention.¹⁵

1961

Canada signed the *Single Convention on Narcotic Drugs*, which requires controlled/scheduled drug possession to be a punishable offence.¹⁶

1971

Canada signed the *Convention on Psychotropic Substances*, which prescribes the list of substances to be controlled/scheduled by signatory countries.¹⁷

In 1974, a bill was introduced that would meet some of the recommendations of the Commission: cannabis and people who used cannabis would be added to the *Food and Drugs Act* and removed from the *Narcotic Control Act*, with fines preferred over prison time; and someone who received an absolute or conditional discharge (a type of finding in criminal court that does not result in a conviction or jail sentence) would be automatically pardoned to avoid a criminal record.¹² The bill did not pass. Minor amendments were made to the *Narcotic Control Act* and *Food and Drugs Act* in relation to the growing illegal drug enterprise in 1988, and then no further drug legislation was enacted until 1996.¹²

In 1978, BC introduced the *Heroin Treatment Act*, legislation that allowed compulsory treatment for people addicted to heroin by detaining people in the province's treatment centre located in Brannen Lake.¹⁸ The Act was repealed in 1982 when the legislation was challenged under the Canadian Charter of Rights and Freedoms.¹⁹

1987

The federal government released *Canada's Drug Strategy*, which modeled the four pillars approach; a comprehensive, evidence-based approach to drug policy that includes harm reduction, prevention, treatment, and enforcement.²⁰

1988

Canada signed the *United Nations Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances*, which provides additional legal provisions to enforce the other international conventions.

1996

The *Controlled Drugs and Substances Act* was the first major drug reform since 1961. This Act created the framework for a system that regulated the importation, production, exportation, distribution, and use of scheduled substances under previous acts. Schedules from the *Food and Drugs Act* and the *Narcotic Control Act* were merged under this new Act, and several additional substances were included—such as benzodiazepines and the chemicals used in the production of existing illegal drugs—totalling over 150 drugs, distributed across five schedules.¹² The Le Dain Commission recommendations were again largely disregarded in the development of this legislation.

Critics have noted that penalties remained disproportionate for drug offences compared to other offences that garner the same level of sentencing; for example, a person in possession of a Schedule I substance (e.g., heroin, cocaine, methamphetamine) for personal use can receive up to seven years in prison, whereas someone who commits arson can receive up to five years in prison.²¹ Someone charged with possession for the purpose of trafficking, exportation, or production of a Schedule I or II substance can receive life imprisonment without parole for up to 25 years.²¹ Other offences that garner a maximum life imprisonment sentence under the *Criminal Code* include first- and second-degree murder, aggravated sexual assault, and hijacking an aircraft.²²

Days ahead of a United Nations General Assembly Special Session (UNGASS) on Drugs in 1998, several members wrote a public statement to then United Nations Secretary General, Kofi Annan, to encourage honest and pointed discourse around the efforts to control illegal drugs and the harms caused by failed war-on-drugs policies. Over 500 representatives from 41 countries wrote together: **“We believe that the global war on drugs is now causing more harm than drug abuse itself.”**²³

At the June 1998 Special Session, UNGASS adopted international agreements that called for international cooperation to address the individual and collective harms associated with problematic substance use.²⁴ The agreements recognized that countries had a shared responsibility to work towards a solution with a balanced, human-rights-based approach, and that strategies and initiatives were to be focused on reducing illegal drug supply and demand with the goal of a “drug-free world.”²⁵ Ten years later, the United Nations Office on Drugs and Crime released a progress evaluation report on UNGASS’s 1998 agreements, and the assessment determined that global trends had not met the goals of the agreements.²⁶

“ The global war on drugs has failed, with devastating consequences for individuals and societies around the world. ”

~ Global Commission on Drug Policy, June 2011²⁹

2001

Canada became the second country to adopt a formal system to regulate the production, distribution, and use of cannabis for medical purposes through the Marihuana Medical Access Regulations.²⁷ Patients had to be authorized by Health Canada to be in possession of cannabis for medical purposes, and the products available to patients were limited to Health Canada products.

In 2003, the federal Minister of Health granted an exemption under Section 56 of the *Controlled Drugs and Substances Act* that allowed Vancouver Coastal Health, in partnership with the PHS Community Services Society, to establish North America’s first legally sanctioned supervised consumption site, Insite.

2007

Despite growing evidence of the importance of harm reduction in drug policy, the federal government released a revised drug strategy, the National Anti-Drug Strategy, that eliminated the harm reduction pillar (which in turn stalled federal exemptions to operate new supervised consumption services) and introduced mandatory minimum sentencing for even minor drug crimes.²⁸ While reporting about this strategy suggested that funding equally weighted law enforcement initiatives with drug prevention and treatment strategies, the strategy was heavily invested in law enforcement initiatives.²⁸

2013

After parts of the Marihuana Medical Access Regulations were found by federal courts to be unconstitutional, the federal government repealed the Regulations and replaced them with the Marihuana for Medical Purposes Regulations. The new Regulations removed the need for patients to be authorized for cannabis possession as long as they had the support of a health care provider to use cannabis; allowed patients to apply for licences to grow cannabis; and gave patients access to cannabis seeds or dried cannabis.³⁰

2016

A new federal government introduced the Canadian Drugs and Substances Strategy, which returned the focus to a public-health-oriented four pillars approach (harm reduction, prevention, treatment, enforcement).³¹ This strategy had a number of implications, including the following: harm reduction was restored to support the federal government to address the overdose crisis; supervised consumption service exemptions were reinstated; naloxone access was increased; and a process to facilitate streamlined approval of overdose prevention services was established.^{31,32,33,34,35} Further investments have been made by the federal government to support evidence-based approaches to preventing harms related to substance use, including expanding the range of treatment options for people living with opioid use disorder.^{31,36}

Also in 2016, the United Nations General Assembly Special Session (UNGASS) and the United Nations Office on Drugs and Crime released a joint commitment to address the world's drug problem.³⁷ While still largely focused on demand reduction (similar to the UNGASS 1998 Declaration, the commitment represents a shift to a health-oriented and human rights approach to substance use issues.³⁷ Although many member states support harm reduction initiatives, UNGASS does not consider it a broad drug policy philosophy; therefore, UNGASS has an overarching concern for the health, safety, and well-being of all individuals, but the commitment does not explicitly note harm reduction as a guiding principle.³⁷

2016

The federal government adopted new regulations for its medical cannabis program when it was found by the federal court that access to medical cannabis was too restrictive; the Access to Cannabis for Medical Purposes Regulations allowed broader access to a range of medical cannabis products and allowed for people in the program to grow a limited amount of cannabis for their own use.³⁸

2017

Recognizing the reluctance of some people to call for medical assistance when at the scene of an overdose, the federal government passed the *Good Samaritan Drug Overdose Act*.³⁹ This law protects people from being charged or convicted under the *Controlled Drugs and Substances Act* if they call for emergency assistance (including conditions related to existing drug-related charges, such as breach of parole conditions or conditional sentence).³⁹

2018

The *Cannabis Act* passed, along with related amendments to the *Criminal Code*. These changes removed cannabis from the prohibition framework of the *Controlled Drugs and Substances Act* and established a legal, regulated model for cannabis production, distribution, and sale. The federal government considers the *Cannabis Act* to be part of a comprehensive public health approach to reducing harms related to cannabis use in youth and to reducing its contribution to the illegal drug market.⁴⁰ Regulations associated with the medical cannabis program also changed, falling under the new Cannabis Regulations.⁴¹

Key Messages

- Canada has had a long history of prohibition-based drug laws and drug policies.
- The “war on drugs” has been recognized as a failure at a global level.
- In recent years, the federal government has adopted more evidence-based strategies, such as reinstating harm reduction as a pillar of the national drug strategy, and has invested in progressive legislation, such as the *Cannabis Act* and the *Good Samaritan Drug Overdose Act*.
- Criminal penalties for drug-related offences remain disproportionate compared to penalties for other, more violent crimes.

3

HARMS ASSOCIATED WITH PROHIBITION-BASED DRUG LAWS AND POLICIES

The predominately criminal-justice-based approach to psychoactive substance use has given the overwhelming balance of power to law enforcement as a policy tool in the context of attempting to prevent harms from substances. If the intention of a prohibition-based system was to protect individuals from harms inherent to substance use, then this policy approach has significantly failed to achieve this goal at an individual or population level.⁴² Evidence shows that this approach has had the opposite effect and has substantially increased harms.⁴³ Law enforcement and health officials recognize that BC cannot arrest its way out of the overdose crisis.^{44,45} This chapter explores some of the impacts of criminalization on people who use drugs, society, and on the economy in BC and Canada.

Greater Harms Are Experienced by Women

Incarcerating women with addictions or who sell drugs to survive negatively impacts their families and children in a much greater way than incarcerating men. Women who rely on sex work or low-level drug dealing to survive are often subject to criminal sanctions that are just as harsh as those who engage in these activities who do not need to do so to survive. Because the criminal justice system

is largely set up to serve males, it often does not consider the specific health and safety needs of women.

Women who are incarcerated in BC tend to be younger than the general prison population and are often undereducated. Hepatitis C and HIV infections are more prevalent among incarcerated women than men, and women commonly have a diagnosed mental disorder and a history of victimization.⁴⁶ Many are also mothers. Separating women from their children is immediately destabilizing, often resulting in foster care placement; in the long term, evidence has shown that children with parents in prison are more likely to drop out of school and to become involved with the criminal justice system themselves.⁴⁷

Women who are pregnant and dependent on opioids face particular difficulties if they are incarcerated or held in custody even for a short time; if opioid withdrawal symptoms occur they can cause miscarriage and maternal death.⁴⁷ When released from custody, women are faced with conditions that restrict where they can go and what they can do. For example, prohibiting women to be in areas they are familiar with as part of release or parole conditions because of the types of activities that occur there (such as open drug use or sex work) isolates

women from social safety networks.⁴⁸ This is particularly troubling for women who are street involved because it increases their risk of assault, robbery, and even murder.⁴⁸ In instances where release conditions prohibit the possession of harm reduction supplies (because they are considered drug paraphernalia), women—particularly Indigenous women—are more likely to share needles, resulting in an increased risk of acquiring HIV and hepatitis C.⁴⁸

Health Harms

Prohibition-based drug policies have not only failed to reduce supply or demand for illegal drugs, they have impeded public health initiatives to reduce harms related to substance use (e.g., provision of sterile needles to prevent the transmission of blood-borne communicable diseases such as HIV and hepatitis C). Some people in possession of illegal drugs will not seek out supervised consumption, overdose prevention, or treatment services for fear of being arrested; instead, they will use drugs alone, increasing their risk of dying from a potential overdose. In the context of the toxic street drug supply in BC, this is being witnessed with alarming frequency. People who are released from custody with conditions that do not allow them to have drug paraphernalia (e.g., sterile needles) are either forced to hide their use, use unsafely, or face re-arrest for possessing harm reduction supplies.⁴⁸ (See textbox: *Increased Enforcement Leads to Increased Harms: A Case Study*).

In situations where people living with opioid use disorder are exposed to situations where they cannot avoid withdrawal symptoms (e.g., in police holding cells, or court cells), or where they are unable to access their life-saving medication, tolerance is lost, leading to an increased

risk of overdose and death when they seek out and use opioids at the same dose they would have typically taken.

Increased Enforcement Leads to Increased Harms: A Case Study

Ethnographic research was conducted in 2003 in Vancouver's Downtown Eastside to examine a police initiative that focused on increased enforcement. This research found that an intensified police presence compromised safer injection practices, including people who inject drugs being more reluctant to carry sterile syringes due to police confiscating syringes; rushing to inject drugs (a behaviour that can increase the risk for overdose); using drugs in riskier situations and places; and discarding used syringes.⁴⁹ The study found that while the intensified police presence led to less drug-related activity in the Downtown Eastside, drug use overall did not diminish but rather was displaced to other locations.⁴⁹

Law enforcement routinely encounter people living with substance use disorders who need treatment services; however, there is a marked lack of immediately available treatment services or avenues for police to take people with a substance use disorder throughout the province, which leads to the continued cycle of crime, criminal justice system involvement, and perpetuation of addiction.⁴⁴ In 2017, the Vancouver Police Department released a report identifying the need for immediate access to evidence-based treatment services and intake services where first responders could transport those seeking treatment.⁴⁴

Stigma

Stigma is a set of negative attitudes and/or opinions, such as discrimination or prejudice, about a person or group of people due to a certain behaviour (e.g., substance use) and/or life circumstance (e.g., homelessness).⁵⁰ It can be generated in a multitude of ways, both from internal (self) and external (interpersonal) sources, and from micro scales (such as the way someone is treated, the language used to speak to someone, or the manner in which they are spoken to) and macro scales (socio-structural elements such as organization of health services). Substance use—including legal and illegal, and problematic, recreational, or experimental use—is subject to three types of stigma:

1. Social stigma, which includes isolating people who use substances, using disrespectful language when talking to or about people who use substances.
2. Structural stigma, which is stigma at a system level that is perpetuated by service providers, and programs that are intentionally or inadvertently designed to inhibit access for people who use substances.
3. Self-stigma, which includes an individual adopting or taking on stigma and internalizing it.⁵⁰

People who attempt to access help for substance use and experience external stigma are less likely to seek help in the future.⁵⁰ Stigma and stigmatizing language affect people who use substances, people who are receiving treatment for a substance use disorder, and the families and friends of these people. The resulting feelings of shame and isolation cause people to hide

their substance use, to use alone, and to be less likely to seek out help or treatment, to start a conversation about substance use, and/or to attend harm reduction services such as overdose prevention or supervised consumption services.⁵¹

In November 2018, Statistics Canada released results of a survey conducted on opioid awareness, including questions on stigma; findings showed that 36 per cent of respondents would not want their families or friends to know if they were using opioids without a prescription, and 14 per cent would not want their families or friends to know if they were using opioids even *with* a prescription.⁵²

Stigma matters because it undermines the response to the overdose crisis in BC at every turn. It negatively impacts the lives of people and the ability of some individuals to receive or access basic health (e.g., harm reduction, treatment) and social needs (e.g., housing, employment). Stigma influences public support for evidence-based strategies that save lives and link people to treatment, such as supervised consumption services.⁵³ Additionally, system-level stigma compromises the quality of care received by an individual if they do access treatment.

While a component of the overdose response in BC has been a public awareness campaign to reduce stigma (see www.StopOverdoseBC.ca), it is difficult to stop stigma, and so it is still occurring. This is particularly problematic in a context where effective treatment options are underutilized, ineffective interventions are still prevalent, and coherent, accessible systems for managing either chronic pain or substance use disorder are simply not available.⁵⁴

A Lucrative Illegal Drug Market

Just as prohibition created an unregulated alcohol supply in the early 1900s, the current regulatory structure for drugs has created a multi-billion-dollar illegal global drug market with escalating drug trade violence.²⁹ Illegal drugs have grown to be the largest illegal commodity in the world.⁵⁵ Street-level crime, such as robbery and violence, have been linked to the illegal drug trade. Higher-level drug traffickers often use violence to enforce, protect, and expand their enterprises.⁵⁵ Prohibition drives manufacturers of illegal drugs to synthesize more potent drugs to be able to export these substances in smaller quantities to avoid detection.⁵⁶ When divided inconsistently into street drugs for individual doses, these substances pose a significant health risk to anyone who uses them. The advent of the world wide web and global e-commerce networks has rendered interdiction of illegal drugs even more challenging than it originally was.

Incarceration

Many people apprehended for simple possession of drugs are non-violent, low-level offenders; however, penalties and sentencing for simple possession offences (without intent to traffic) are disproportionately severe. Depending on the substance and presence of aggravating circumstances, penalties are typically a fine of between \$250 and \$2,000, and between a minimum of six months and up to seven years in prison.^{d,57,58} Many people who use substances, including infrequent or recreational use, are otherwise law-abiding citizens of BC. The current regime has resulted in the criminalization of hundreds of thousands of British Columbians whose only “crimes” were the desire or need to use illegal substances.^{3,59}

There are considerable harms associated with engagement with the criminal justice system, including trauma, stigma (structural and societal), human rights violations, violence, inadequate medical care, increased rates of HIV and hepatitis C, exposure to criminal subculture, exposure to illegal drugs (including sometimes initial use of opioids), and compromised housing, employment, and treatment services in the community post-release.^{15,60,61,62} In the cases of absolute and criminal discharges (i.e., cases that do not result in a conviction, but result in a finding of guilt), this leads to a criminal record, even if that record only shows the discharge; the criminal record lasts for one year before the discharge can be removed.²² This impacts activities that require a criminal background check, such as applying for employment, a mortgage or loan, or entry into another country.¹⁵

Economic Costs

In June 2018, the Canadian Centre on Substance Use and Addiction (CCSUA) released the report *Canadian Substance Use Costs and Harms (2007–2014)*; this was the first update since the milestone study on substance use costs was released in 2006, but does not capture the significant increase in overdose deaths or shifts in policies as a result of the crisis that began in 2015.⁶³ The updated report measured costs associated with substances including alcohol, tobacco, cannabis, opioids, cocaine, stimulants such as methamphetamine and ecstasy, depressants such as benzodiazepines, and other substances such as inhalants and hallucinogens.

^d In the Crime Severity Index, the method by which police-reported crime in Canada is measured, drug-related offences are considered non-violent.

The cost impacts of these substances were divided among four categories:

1. Lost productivity: including work absenteeism, impaired job performance, long-term disability, and premature mortality.
2. Health care: including inpatient hospitalizations, presentations to the emergency department, prescription drug costs, physician time, and treatment for substance use disorders.
3. Criminal justice: including police work, corrections, and courts, expenditures directly related to offences under the *Controlled Drugs and Substances Act*, and expenditures for offences related to substance use (such as homicide or theft) that would not have occurred in the absence of a substance or the act of seeking a substance.
4. Other direct costs: including research and prevention, and workplace costs such as employee assistance programs.

Compared to the rest of Canada, BC reported slightly less than the national average per person cost attributable to substance use overall—\$1,050 cost per person in BC compared to \$1,081 cost per person for Canada overall.⁶⁴ In 2014, substance use cost British Columbia \$4.9 billion.⁶⁴

It has long been recognized that alcohol and tobacco—two regulated and legalized substances—are the greatest drivers of costs to the province. The June 2018 report by CCSUA reflected this understanding, showing that alcohol and tobacco were the two highest percentages of associated costs (40 per cent for alcohol and 26 per cent for tobacco, respectively).⁶⁴ The third highest cost was attributed to opioids, followed by cannabis, cocaine, central nervous system stimulants and depressants, and other substances.⁶⁴

Drug Offences in BC

Between 2008 and 2017, there were 244,715 offences under the *Controlled Drugs and Substances Act* (i.e., possession, trafficking, importation/exportation, and production) in BC. As is the case in other jurisdictions across the world, the majority (81 per cent) were non-violent offences for simple possession.^{59,65} Seventy-six percent of these possession offences in BC were cleared (i.e., a charge was laid), resulting in a total of 49,891 people charged across this time frame.⁵⁹

Key Messages

- Criminalizing non-violent individuals for possessing a substance for personal use has considerable negative harms both to the individual and society.
- Prohibition and punitive-based drug policy magnify harms associated with substance possession, such as communicable disease transmission, increase stigmatization of people who use drugs, and increase drug-related mortality, while having little to no impact on reducing drug use rates.
- There are potentially long-lasting harms associated with incarceration, including a criminal record for otherwise law-abiding British Columbians who in turn may experience barriers to employment, travel, and other situations that require a criminal background check.
- Law enforcement and health officials recognize that BC cannot arrest its way out of the overdose crisis.

4

ALTERNATIVES TO CRIMINAL JUSTICE APPROACHES TO SUBSTANCE USE AND POSSESSION

The previous chapter demonstrated that the current regulatory regime of prohibition-based drug policy and criminalization does little to address the harms related to substance use, but rather supports an increase in social and health harms, an increase in the potency of illegal drugs, as well as an increase in unsafe drug use, stigma, shame, and discrimination. In the interest of protecting the health and safety of British Columbians, a more compassionate approach is needed, based on public health and human rights. This chapter outlines the components of decriminalization and provides examples of successful initiatives in BC and internationally that incorporate public-health- and human-rights-based approaches.

Alternatives to Prohibition and Criminalization

The growing discourse and evidence regarding harms associated with a criminal justice approach to substance use is leading jurisdictions around the world to shift to a public health approach to drug policy.⁶⁵ A number of countries—at least 30, including Portugal, Australia, Spain, Uruguay, Norway, Chile, and some US jurisdictions—are exploring or have in place an alternative policy option: decriminalization of people for simple possession and use of controlled substances.^{65,66}

Decriminalization is a policy approach that occurs on the continuum between criminalization to full **legalization**; within this range are multiple options that can be designed based on needs in a given jurisdiction (see Figure 4.1). There is an increasing body of evidence that suggests that while this approach to drug policy cannot independently resolve all associated harms, it can mitigate the harms linked to substance use (e.g., overdose) and the legacy and ongoing impact of failed historical strategies and policies associated with substance use.⁶⁷

It is not always clear what the difference is between decriminalization and legalization in the context of drug policy, but the two approaches are very different:

- *Decriminalization* involves removing an action or behaviour from the scope of the criminal justice system. In the context of controlled substances, it is typically focused on possession and consumption of drugs for personal use and does not set out a system or structure for production, distribution, or sale of controlled substances.⁶⁸ Decriminalization does not exclude the application of fines or administrative penalties. For example, if possession of drugs for personal use was decriminalized (as is the case in

Portugal), the drug itself is still illegal, but possessing it does not lead to criminal sanctions (unless the possession is at a trafficking level).⁶⁸

- *Legalization* involves removing criminal prohibitions associated with an action or behaviour, while also developing a regulated system for the production, sale, use, and distribution of a substance.⁶⁸

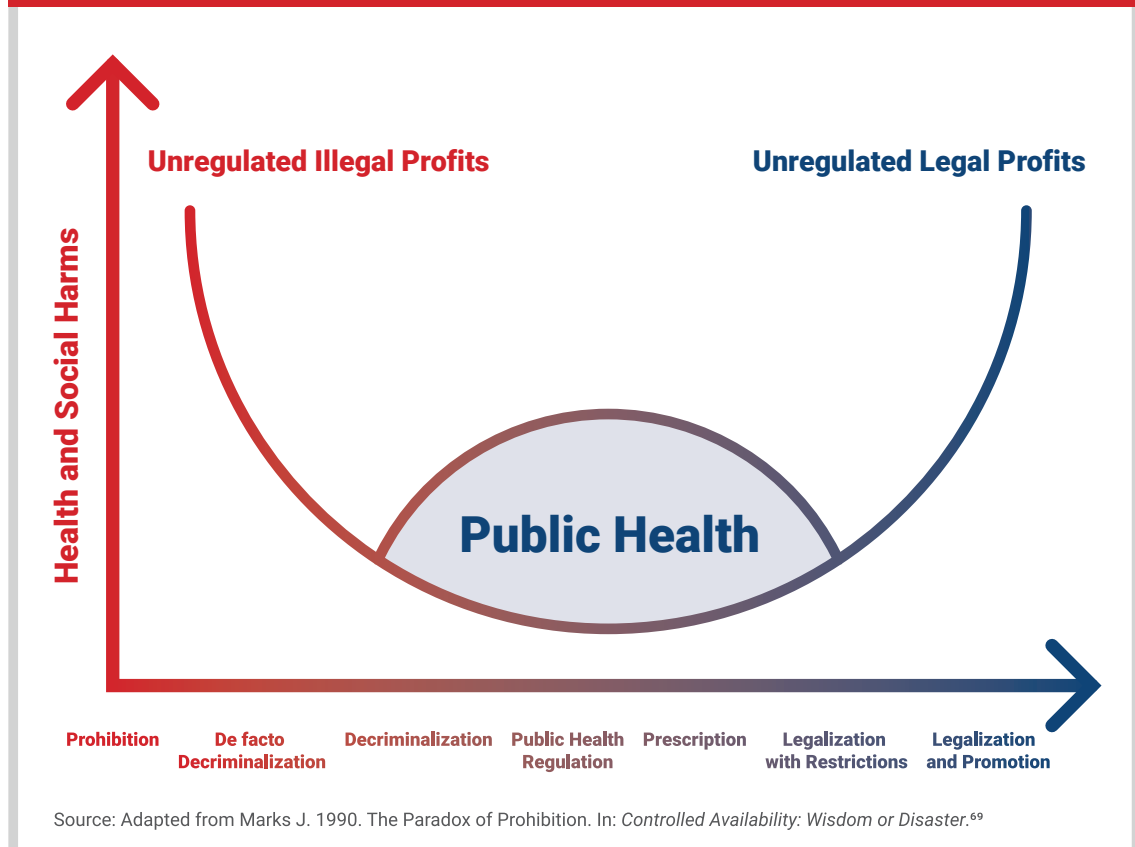
Decriminalization and legalization can be implemented using two different regulatory approaches—*de facto* and *de jure*:⁶⁷

De facto – Approaches implemented according to non-legislative/informal guidelines.

De jure – Approaches implemented under formal policy and/or legislation.

As shown in Figure 4.1, health and social harms are highest at the two ends of the spectrum (prohibition and legalization with promotion). Theoretically, harms could be mitigated or minimized if the approach to drug policy moves away from these two extremes. In the bottom of the U-shaped curve lies public health regulation, which can sometimes be viewed as at odds with proponents of a primarily commercial approach, or proponents of a primarily enforcement approach. For example, stakeholders involved in the alcohol or tobacco industries may oppose restriction (such as pricing controls) on otherwise legal goods, while law enforcement may oppose harm reduction activities (such as needle distribution or supervised consumption) that appear to increase access to illegal drugs.

Figure 4.1 - Continuum of Drug Policy Approaches



In October 2018, subject to further restrictions by provinces and territories, Canada implemented de jure (formal) legalization of cannabis possessed in small quantities for those age 18 and up.⁷⁰ Other controlled substances (e.g., heroin, cocaine) in Canada remain subject to de jure criminalization, although there are some exceptions to this approach in BC. This includes discretion exercised by law enforcement, which allow police officers, prosecutors, and regulators to choose whether or how to punish a person who has broken the law.⁷¹ Another example is the *Good Samaritan Drug Overdose Act*, which provides protection of people from arrest for possession and/or breach of conditions regarding simple possession.⁷² Further, federal legislative exemptions that allow people to possess controlled substances in approved locations to use drug checking, overdose prevention, and supervised consumption services.⁷³

Decriminalization of People Who Use Drugs

Decriminalization of people who use controlled drugs is an effective public health approach to drug policy in other jurisdictions and is the most appropriate option for BC at this time. While law enforcement in BC exercise their discretion when considering possession charges, such as the presence of harmful behaviour or identified need for treatment services, the application of the law is inconsistent across communities. As such, there is a need for a provincial-level commitment to support an official policy to decriminalize people who use drugs.

Other jurisdictions that have experienced success with this approach have also ensured robust complementary supportive measures, such as harm reduction, treatment, prevention, social supports, and enforcement.⁶⁷ There are three main considerations when looking to implement

an effective decriminalization approach to possession of controlled substances: threshold of personal use, penalties, and decision-making authority.⁶⁵

Threshold of Personal Use

The purpose of this component of decriminalization is to ensure that there are no criminal sanctions levied against an individual who is in possession of a controlled substance for their personal use.⁶⁵ In this context, threshold is concerned with the amount of controlled substance that is considered to be for personal use.⁶⁵ For example, in Canada, the federal government has imposed a threshold of 30 grams of cannabis for possession in public.⁷⁴ In some jurisdictions, such as Poland, more ambiguous terms, such as “small amount” or “small quantity” are used, leading to inconsistent applications of the law due to differences in interpretation.⁶⁵

There is no ideal threshold for a given substance—what is a typical quantity for personal use varies by the substance and the person—but thresholds that are too low have not been found to be impactful.^{65,67} Experience in Mexico, for example, where threshold amounts were set very low, resulted in increased numbers of people being charged for trafficking rather than simple possession.⁷⁵ Experience from Portugal has shown that a set objective amount for each substance should be determined to remove the subjectivity associated with interpretation of more ambiguous terms.

Determining Penalties

There are several options that jurisdictions can adopt as alternatives to criminal justice responses to controlled drug possession for personal use. These options can occur on a continuum depending on the situation. Some countries do not use any penalties at all (e.g., in the Netherlands, to save costs).

Others levy administrative penalties, such as fines or community service.⁶⁵

Another way to address people living with substance use disorder is to establish pathways for law enforcement to work with the health and social systems to rapidly link people to a range of evidence-based treatment and other social services (such as housing and employment) as needed.⁶⁵ This is a practice in the city of Seattle (Law Enforcement Assisted Diversion, or L.E.A.D.), and is reflected in Portugal's drug policy as a means to avoid formal engagement with the criminal justice system.^{65,76} These alternative pathways are being explored through the Pacific Coast Collaborative (a forum with membership from BC and the states of Washington, Oregon, and California) as part of a shared statement signed by members to help address and respond to the overdose crisis.¹¹⁹ In addition, in BC, three pilot projects supporting law enforcement to link people to care are operating in Vancouver, Vernon, and Abbotsford. An evaluation for these pilot projects is being planned by the Overdose Emergency Response Centre in the Ministry of Mental Health and Addictions.

Decision-making Authority

Determining who is responsible for ascertaining whether a person is in possession of drugs for personal use depends on several factors, such as the person's or agency's level of vulnerability or strength against corruption or abuse of power, and the existence or absence of an overseeing regulatory authority.⁶⁵

Police officers who are present at the scene might be best positioned to make the decision; however, lessons learned from South Australia found that more people received fines once this approach was implemented than under the previous criminal-justice-based system, resulting in a counter-productive

trend with increased non-payment of fines and resulting incarceration.⁶⁵ Police at the scene can also make a determination whether an individual is in possession of an amount of controlled drugs for personal use or trafficking. In this case, to protect those arrested, the burden must be placed on the state to determine the intent to sell versus personal use. A rapid review process for arrests made by police with prosecutors or judges authorized to not lay charges can mitigate the potential for overreaching. In any case, circumstances such as dependence on the drug or low-level dealing for economic survival should be considered in the decision to arrest or charge a person.

The Netherlands and the Czech Republic use guidance provided by prosecutors when determining whether a detained person is carrying drugs for personal use; little is known about the impact of this approach—positive or negative—but so long as the individual in question is not being held for the duration of the determination, it may not be intrinsically problematic.⁶⁵

Judicial determination—using a judge to determine whether a person was in possession of drugs for personal use or not—has been shown to be problematic for those few Latin American jurisdictions that have used this approach, due to the resulting lengthy pre-trial detention periods (months to years in some cases) and engagement with the criminal justice system.⁶⁵

Establishing an Alternative Pathway

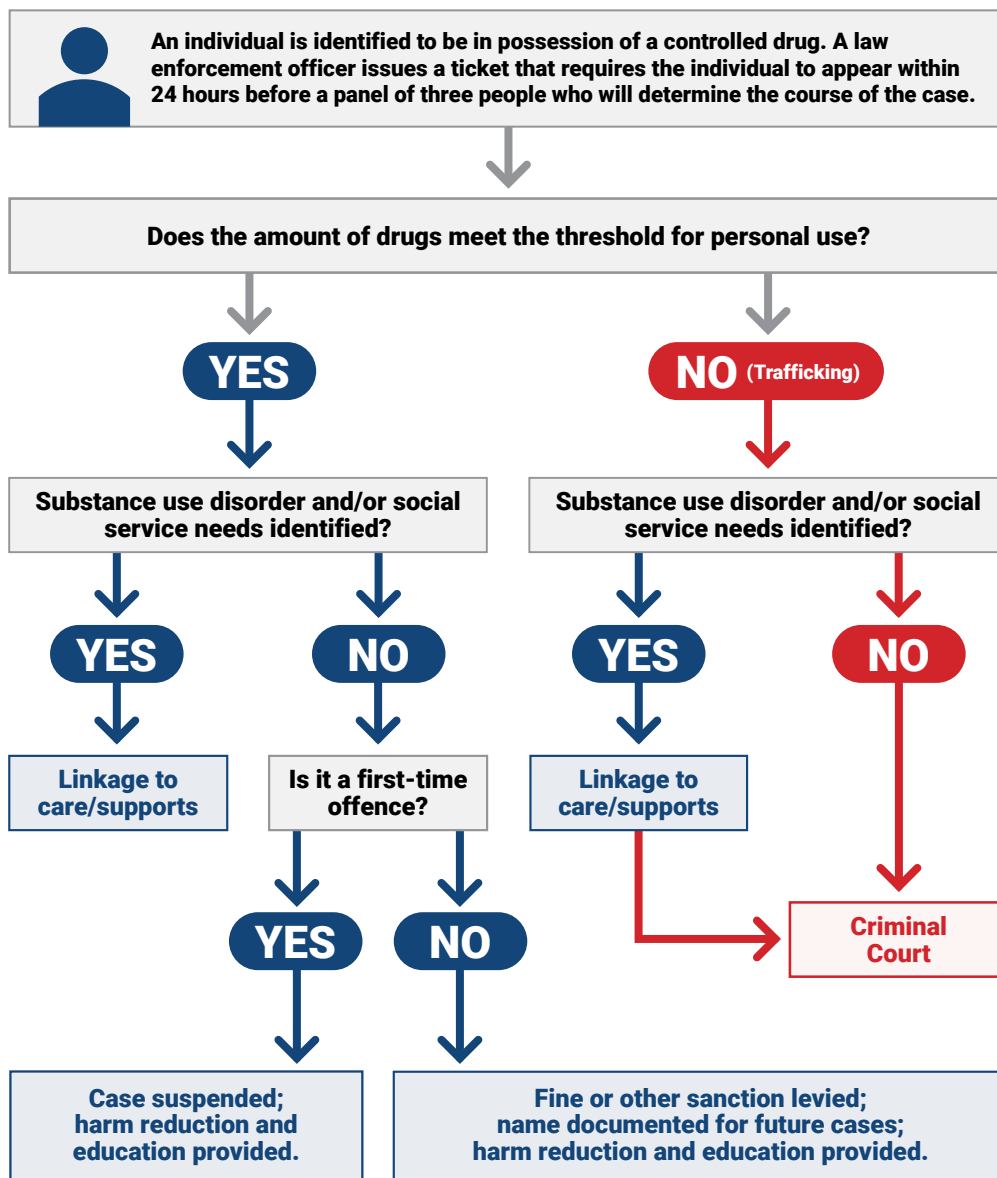
When the three components (threshold, penalties, and decision-making authority) are combined, there are still options for how to integrate them in the health and justice systems. The figure below provides an example of how a case might play out in an instance where a person is identified as being in possession of a controlled

substance in a jurisdiction that does not criminalize possession for personal use (see Figure 4.2). This pathway model shows how consideration of a substance

use disorder or other social needs can be incorporated. For a real-world example of this type of model, see textbox: *The Portuguese Model*.

Figure 4.2 - Example of an Alternative Process for Possession of a Controlled Drug

Legend: **Blue** indicates health and social system response. **Red** indicates criminal justice system response.



The Portuguese Model

Of all the contemporary alternative drug policy regimes available for review, the longest-running and best evaluated is in Portugal. In 2001, in response to an unprecedented growth in heroin addiction, overdose, and HIV, Portugal passed Law 30/2000, which made the possession of up to a 10-day supply of any illegal drug, where there is no suspicion of drug trafficking involvement, an administrative offence rather than a criminal one.⁷⁷ This comprehensive approach included significant investment and capacity building in prevention, harm reduction, outreach, treatment, and services for social reintegration, such as housing and job training.⁷⁷

The Portuguese model has the following parameters:

Threshold: 10 days worth of substance for personal use.

Penalties: Administrative (fine) for those not involved in drug trafficking; referral to criminal court for those involved in drug trafficking and those identified with drugs in a situation with one or more aggravating factors.

Decision-maker: Police (at scene); Commission for the Dissuasion of Drug Addiction (for penalties).

Discussion

Drug possession in Portugal is still illegal, but possession for personal use is not subject to criminal sanctions. An individual apprehended under Law 30/2000 receives a citation requiring an appearance before one of the regional bodies called a Commission for the Dissuasion of Drug Addiction (CDT).⁷⁷

A CDT is composed of three representatives from the legal, health, and social service sectors, who are supported by multi-disciplinary teams responsible for reviewing cases and determining the appropriate response.⁷⁷ Responses include dismissal with a warning, referral to health and/or social services, referral to treatment services, fines, restrictions (e.g., not permitted to carry a firearm), or community service.⁷⁷ The main purpose of a CDT is to explore whether or not treatment is needed and to promote healthy behaviours.⁷⁷ For first-time offenders without a substance use disorder, the CDT almost always suspends proceedings.⁶⁵ Between 2001 and 2014, the CDTs resolved 85 to 90 per cent of cases with provisional suspensions.⁷⁸

Drug-trafficking offences involve possession exceeding a 10-day supply and are referred to a criminal court.⁶⁵ Penalties can range from a custodial sentence of 1–5 years to a sentence of 4–12 years, depending on the substance and other criteria such as aggravating factors (e.g., selling to a minor). People who sell drugs to fund their own dependence receive a more lenient penalty.⁷⁷

Drug Use Trends

Although some increase in cannabis use has been identified, evidence shows that removing criminal sanctions for personal drug possession has not increased levels of other drug use (cocaine, amphetamine, MDMA, and heroin), and that punitive drug laws and rates of drug use are not correlated.^{65,77,79,80}

Drug Mortality

Since 2011, drug-induced mortality in Portugal has been below the rate recorded in 2008 to 2010; in 2016, the country recorded 0.39 deaths per 100,000 people, considerably lower than the 2016 European average of 2.1 deaths per 100,000, and the second lowest in the European Union.⁷⁷ Compare this to BC's rates in 2016 of 20.9 deaths per 100,000, and 2018 rates of 31.3 deaths per 100,000.⁸¹

Prevention

Portugal uses a national-level drug strategy framework—focused on drug demand reduction—that is implemented at the local level in response to the needs of the region.⁷⁹ Prevention interventions and strategies under this framework are used to reach the entire population and target underserved, at-risk individuals and groups.⁷⁷

Harm Reduction

Harm reduction was integrated into the health and social structures through legislation in 2001 to support the mitigation of drug-related risks; services offered include street outreach teams, supervised consumption, low-barrier access to opioid agonist treatment (OAT), and legal protection for people to carry sterile injecting equipment.⁷⁷

Treatment

Portugal's treatment system recognizes the importance of meeting the biopsychosocial needs of individuals living with a substance use disorder; publicly funded services for individuals are available at a range of levels, including therapeutic communities, and outpatient and inpatient services.⁷⁷ OAT is available at all treatment centres.⁷⁷ People living with opioid use disorder who have engagement with the criminal justice system are closely monitored to ensure treatment is continued upon admission to and after discharge from prison. OAT can also be initiated in prison.⁷⁷

Enforcement

One impact of the changes made by Portugal was a decrease in demand on criminal justice resources and the ability for law enforcement in Portugal to focus on supporting the European Union in its actions against international drug smuggling.⁷⁸

Growing Support for the Decriminalization of People Who Use Drugs

International Support

At least 30 jurisdictions around the world have adopted or are beginning to adopt a shift in drug policy that moves away from criminalizing people who use drugs to one of decriminalization, within the context of supporting human rights.⁶⁵

The Global Commission on Drug Policy released a report in 2018 that recommends progressive policy reform regarding controlled substances.⁶⁶ While recognizing the context and constraints of a given jurisdiction, the report recommends the following:

- Drugs that are currently prohibited should be regulated, with appropriate caution, using an incremental and evidence-based approach that includes robust monitoring.
- Policymakers should seek evidence on legal regulation of drugs using open and transparent methods to collect national and local level feedback on how this should be undertaken.
- Countries should consider incremental regulation of lower-potency drugs.
- Policymakers must mitigate and mend the negative health and social impacts of punitive drug policies, particularly for those most impacted by these policies.
- Countries should harness the opportunities offered by regulation of drug markets, including planning for and allocating resources to address possible displacement of organized crime to other markets.

- Members of the United Nations should “urgently consider” the modernization of international drug control policy, led by the United Nations Secretary-General.⁶⁶

As a member of the United Nations, Canada is a signatory to three international treaties associated with drug control:

- The *Single Convention on Narcotic Drugs* (1961; amended in 1972), which requires controlled/scheduled drug possession to be a punishable offence; this Convention is interpreted by the International Narcotics Control Board (the agency responsible for monitoring the implementation of international United Nations drug conventions) to require that simple possession be considered a criminal offence.^{16,67}
- The *Convention on Psychotropic Substances* (1971), which provides the list of substances to be controlled/scheduled by signatory countries.¹⁷
- The *United Nations Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances* (1988), which provides additional legal provisions to enforce the above-mentioned treaties.⁸²

The *Single Convention on Narcotic Drugs*, which is the foundational United Nations drug control convention, allows alternatives to conviction or punishment (e.g., treatment services, education) for individuals in possession of a controlled substance who are living with a substance use disorder.^{16,83} At the United Nations General Assembly Special Session on the world drug problem in 2016, the President of the International Narcotics Control Board, which monitors implementation of the United Nations

international drug control conventions, stated that the

*Portuguese approach is a model of best practices: fully committed to the principles of the drug control conventions, putting health and welfare in the centre, applying a balanced, comprehensive, and integrated approach based on the principle of proportionality and the respect for human rights.*⁸⁴

In January 2019, the United Nations Chief Executive Board, which represents 31 United Nations agencies, announced the adoption of a common position on drug policy that endorses decriminalization of possession and use of drugs.⁸⁵ This includes support to “promote alternatives to conviction and punishment in appropriate cases, including the decriminalization of drug possession for personal use, and to promote the principle of proportionality, to address prison overcrowding and overincarceration by people accused of drug crimes.”⁸⁵ This further solidifies the positioning of drug policy within the scope of public health and human rights.

Canada

A growing number of national agencies and organizations in Canada have supported a move to decriminalize possession of drugs for personal use, including the following:

- the Canadian Association of People Who Use Drugs;
- the Canadian HIV/AIDS Legal Network;
- the Canadian Public Health Association;
- the Canadian Drug Policy Coalition;
- the Canadian Mental Health Association; and
- the Canadian Centre on Substance Use and Addiction, among others.^{86, 87, 88, 89, 90}

Several grassroots organizations, such as Moms Stop the Harm (a network of individuals and families from across Canada who have lost loved ones to substance use harms) have also expressed support for decriminalizing possession for personal use.⁹¹ Three cities in Canada have been particularly vocal in the call for decriminalization: Vancouver, Toronto, and Montreal. In June 2018, Toronto’s Medical Officer of Health submitted a recommendation to the city’s Board of Health to decriminalize possession of all drugs for personal use at the federal government level in the context of scaled up harm reduction, treatment, and prevention services.⁹² In July 2018, the Board voted to support this recommendation.⁹³ Following Toronto’s call for decriminalization of drugs for personal use, Montreal’s public health department publicly supported the pragmatic, evidence-based policy to reduce the harms related to substance use.⁹⁴

British Columbia

There is increasing support from many sectors for alternatives to criminal charges or incarceration for drug possession for personal use in BC. Calls to action have been made by Vancouver’s former mayor, current and former provincial ministers, legislative members, grassroots organizations, people with lived and living experience, frontline responders, non-government organizations, addictions experts, health officials, lawyers, police services, and others.^{54, 91, 95, 96, 97, 98, 99}

Response to Support for Decriminalization

The Prime Minister, federal health minister, and the Chief Public Health Officer of Canada have consistently reported that the federal government is committed to evidence-based national drug policies.^{100,101,102} In a report on problematic substance use in youth released in December 2018, Canada's Chief Public Health Officer noted that decriminalization policies represent a public health approach to substance use and related harms when combined with prevention, treatment, social services, and harm reduction initiatives. This is a reflection of the call to action from the City of Toronto.^{93,103} The report suggests that decriminalization involves a "societal shift", and a focus on reducing stigma related to substance use is imperative for public engagement.¹⁰³

In the report on problematic substance use in youth, the Chief Public Health Officer of Canada underscores the need to address and reduce stigma and issues a call to focus on the harms related to tobacco, alcohol, and cannabis use. A spokesperson for the federal health minister responded that a Canada-based study is needed to determine if decriminalization would be effective in Canada (rather than using lessons learned from other jurisdictions, such as Portugal).⁹³ However, Canada's Department of Justice has noted that it is becoming more difficult to justify criminalizing people who use drugs, and the federal government has tabled Bill C-93, which allows for no-cost, expedited pardons for those with historical charges of possession of cannabis for personal use.¹⁰⁴

Key Messages

- Decriminalization is a drug policy approach that exists on a continuum between criminalization and full legalization.
- Decriminalization of people who use drugs is an evidence-based approach of reducing and mitigating drug-related harms, including death. It requires establishment of appropriate thresholds, penalties, and decision-making authority.
- Decriminalization of people who use drugs allows for alternative pathways for law enforcement to work with the health and social systems to rapidly link people to a range of evidence-based treatment and other social services.
- De facto decriminalization is already occurring in many areas in BC through the discretion of law enforcement when they interact with people who use drugs.
- There are examples in other jurisdictions (e.g., Portugal) where decriminalization of people who use drugs has had documented successes in reducing health and societal harms in cases of simple possession.
- The support for decriminalization of people who use drugs is growing in BC, Canada, and internationally, across health, social, and justice sectors.

5

DISCUSSION AND RECOMMENDATION

Discussion

Since 2012, there has been a steady increase of preventable, unintentional illegal drug overdose deaths in BC. In 2015, a significant spike in overdoses began. Despite the declaration of a public health emergency in April of 2016 and many related actions and initiatives to implement a substantial provincial response since that time, that spike has continued. This continued increase has resulted in illegal overdose deaths becoming the leading cause of unnatural death in the province, accounting for more deaths than suicide, motor vehicle crashes, homicide, and prescription drug overdoses combined.³

Unlike other jurisdictions where drug overdoses may occur in a restricted geographic region or among a specific sub-population, overdose deaths in BC are widespread throughout the province. They are affecting people whose history of drug use is long-term and chronically dependent, as well as people who are using illegal drugs for the first time, and people who use drugs only occasionally. Overdoses are occurring across the socio-economic spectrum and across age groups, but occur mainly among men aged 30 to 59, among Indigenous males and females, and among those who are most socio-economically disadvantaged.^{3,6}

An individual is more likely to survive an overdose if a paramedic is called to provide emergency medical assistance; however, the majority of overdose deaths occur indoors, among those who are using drugs alone, or in the presence of those who are unwilling or unable to call for medical intervention.

A complex problem requires a comprehensive and multi-faceted approach. The response to the overdose crisis has been commendable, particularly because BC is one of the first jurisdictions (globally) to encounter such an unpredictable and rapidly escalating situation. The province has worked with partners at the local, provincial, and federal levels to remove legislative barriers to life-saving medications, establish emergency overdose prevention and supervised consumption services, widely distribute publicly funded naloxone, offer drug-checking services, educate and inform the public to raise awareness and reduce stigma, facilitate rapid access to a broader range of treatment services, and generate data and intelligence to inform the response.

To encourage people to call for help in the event of an overdose, police in BC have adopted a policy that they will not attend overdose calls unless requested to do so, or if they are the only available first responders. Police have also shifted focus to a more

harm reduction-based approach to people who use drugs, recognizing that there is a cycle of crime and drug use that often impacts the most vulnerable people in our communities.

Response efforts are unwavering, despite the persistently high need. These efforts are widespread and rooted in evidence. Evidence shows that these interventions are saving lives; however, **as many as four British Columbians per day continue to die from a preventable overdose.**

Given the lack of evidence that punitive drug laws reduce rates of drug use—conversely, the global determination is that the “war on drugs” has done more harm than good—decriminalization of people who use drugs is a next step in responding to the overdose crisis. The overdose crisis in BC is complex and neither medicalizing nor criminalizing drug use will be enough to resolve the present crisis, though appropriate enforcement and evidence-based treatment services are necessary components of the solution. This is truly the crux of the problem in BC and points to one of the few options missing from the response efforts.

The current prohibitionist approach to drug policy has failed to achieve its stated ends: to prevent the growth of illegal drug markets, to curtail use of illegal substances, and to prevent harms associated with the use of these substances. Instead, harms have been magnified through the creation, in reaction to interdiction, of a highly toxic illegal drug supply, and the criminalization, stigmatization, and marginalization of individuals—many of whom have opioid use disorder, a known chronic, relapsing health condition. In addition, massive profits have been generated for violent criminal enterprises involved in the illegal drug market.

At least 30 jurisdictions around the world have adopted or are beginning to adopt a shift in drug policy that moves away from criminalizing people who use drugs to one of decriminalization within a context of supporting human rights. A range of evidence examined in this report shows that this policy shift does not increase drug use or support growth of the illegal drug market, but rather links people to treatment who need it, and otherwise ensures that people who are using drugs are doing so in as safe a way as possible.

With international differences in regional contexts and constraints, an “optimal” drug policy decriminalization model (e.g., de facto, de jure) has not yet been identified. However, countries that have implemented models of decriminalization have done so with consideration for threshold, penalties, and decision-making capacity, and have provided an evidence base for consideration in BC.

There is already de jure decriminalization of people who use drugs in supervised consumption service locations in BC; Health Canada has granted exemptions under Section 56 of the *Controlled Drugs and Substances Act* (albeit temporary, requiring regular re-application for exemption) for people who use drugs to be in possession of drugs for their personal use at these locations without the fear of being arrested.⁷³ In addition, overdose prevention sites have been designated as medically necessary health services by Ministerial Order under the declared emergency in BC; therefore, they are also sites where de jure decriminalization is in place. However, these options are temporary and dependent upon continuation of the public health emergency. In addition, while simple possession remains a criminal offence, there is currently no legal means by which a person can transport illegal drugs to these sites.

De facto decriminalization is also occurring in many areas in BC using police discretion when interacting with people who use drugs. For example, the Vancouver Police Department (VPD) drug policy prioritizes a person's behaviour or context of substance use when considering possession charges or public consumption of alcohol; as a result, VPD policy only supports enforcement of laws regarding possession or public consumption if people are engaged in behaviours that could result in harm (to the person using drugs, to the public, or to property).

As has been pointed out on numerous occasions, if an infectious or communicable disease were causing this burden of death and disease, it would be considered catastrophic. Nowhere in Canada is the need for discussion and reform of drug policy more evident than in the context of the overdose emergency in BC. As overdoses become more pervasive both domestically and worldwide, jurisdictions are looking to BC for leadership and guidance.^{105,106} The stage is set for the province to meet this call.

Recommendation

As the Provincial Health Officer of BC, I recommend that the Province of BC urgently move to decriminalize people who possess controlled substances for personal use. This is a fundamental underpinning and necessary next step for the continued provincial response to the overdose crisis in BC.

Decriminalization is an evidence-based approach to drug policy that is effective in reducing harms related to substance use when reinforced with complementary measures of harm reduction, prevention,

enforcement, social support, and treatment. Redirecting police time and resources away from the enforcement of simple possession offences reduces barriers, including fear and stigma, and facilitates a linkage to treatment and harm reduction services.

There is precedent for this in other jurisdictions (e.g., Portugal), with evidence of success that can be applied and leveraged in BC. Specifically, criteria can be determined for (a) the threshold amount of substance that can be possessed for personal use; (b) assessment of appropriate penalties; (c) how to offer and connect people to treatment; and (d) when the case should be referred to criminal court. In BC, local assessment committees could be established in each health service delivery area, with an option for those living in rural and remote areas to access the committee via teleconference or video conference.

I advise the Minister of Health and the Minister of Mental Health and Addictions to engage with the Attorney General and the Minister of Public Safety and Solicitor General to determine how BC can move to decriminalize people in possession of illegal drugs for personal use, using the discretionary powers vested in public safety officials and the policy role of the Director of Police Services.

Options for Implementation in BC

Ideally, decriminalization would involve changes to the federal *Controlled Drugs and Substances Act* (the Act). In the absence of legislative changes to the Act, BC can still take steps to achieve protection of the health of British Columbians by limiting the criminal enforcement of simple possession (possession for personal use) offences under Section 4(1) of the Act.

There are two approaches that could be effective in achieving decriminalization of possession for personal use in BC:

Option 1: Amend Provincial Policing Policy

Use the powers under the provincial *Police Act* that allow the Minister to set broad provincial priorities with respect to people who use drugs. The provincial priority could be explicitly focused on a harm reduction approach, including alternatives to criminal charges and incarceration and de-stigmatization of people who use drugs (including support for linkages to health and social services and administrative penalties rather than criminal charges for possession of defined amounts of controlled substances). The Minister of Public Safety and Solicitor General could then require that policing resources be aligned to this priority and that police services report to the Minister on how they are implementing this policy.

Option 2: Amend Provincial Policing Regulation

Enact regulation under the provincial *Police Act* to include a provision that prevents any member of a police force in BC from expending resources on the enforcement of simple possession offences under Section 4(1) of the *CDSA*. This would essentially prevent members from using police resources, including member time, on

investigations, searches, seizures, citations, arrests, and/or detentions that relate solely to actual or alleged violations of simple possession.

These actions are permitted under Section 92(14) of the *Constitution Act*, whereby provincial legislatures have exclusive authority to make laws in relation to the administration of justice, including responsibility over law enforcement (such as enforcement of federal criminal law) in the province. Changes to policy or regulation under the *Police Act* would fall within the constitutional enacting powers of the Province, specifically the powers to create, implement, and amend legislation regarding the administration of justice and the health of people in BC.

With respect to the administration of justice, such changes would aim to maintain an adequate and effective level of policing and law enforcement throughout BC, particularly in the context of a public health emergency. The result would be a redirection of police resources away from the low-level, typically victimless offence of simple possession, and instead, prioritizing higher-level criminal offences, including the production and trafficking of illegal drugs.

With respect to health, such changes would aim to improve access to harm reduction and health services by limiting the fear and stigma that people who use drugs face in seeking out drug-related supports. By reducing barriers to accessing support, the approach would also support efforts to scale up evidence-based resources for people who use drugs, including medical-assisted therapy, overdose prevention sites, and other programming.

Conclusion

A primary responsibility of a government is the duty to protect and preserve life. Due to the toxicity of the illegal drug market in BC and the unprecedented risk of overdose, use of a controlled substance—whether use is habitual, a result of a substance use disorder, or a one-time occurrence—is a public health concern. There are also significant health and social harms associated with engaging non-violent, otherwise law-abiding British Columbians with the criminal justice system due to simple possession of a small amount of controlled drugs for personal use.

Given that the current regulatory regime is ineffective, harmful, and stigmatizing, and in the absence of federal interest in moving away from criminalizing simple possession of controlled drugs, and as the overdose crisis continues, it is incumbent on the province of BC to act.

The province must continue to scale up evidence-based supports (including opioid-assisted therapy, overdose prevention sites, supervised consumption services, distribution of naloxone, treatment, provision of pharmaceutical alternative to street drugs, and other health services) to improve the health and safety of people who use controlled drugs. However, the many measures taken to date have not stemmed the tide of the overdose crisis in BC. The next step in BC's response to the public health emergency must be decriminalization of people who use controlled drugs.

Given the success of the Portugal model, and faced with the restrictions and partial successes of BC's response to the overdose crisis, the Provincial Health Officer of BC recommends that urgent additional steps

are needed to address the unrelenting toll of mortality experienced by individuals who are using illegal drugs. Specifically, that the Province of BC urgently move to decriminalize people who possess controlled substances for personal use, as a necessary next step in responding to the overdose crisis in BC.

APPENDIX A: GLOSSARY

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| Analogue | a chemical that is similar in structure to another chemical and shares similar pharmacological effects on the body as the original chemical. ¹⁰⁷ |
| Criminalization | the act of making an action criminal in nature by making it illegal; also refers to treating a person or people as criminals if they are associated or found to be engaging in an illegal activity. ⁶⁷ |
| Decriminalization | the removal of an action or behaviour from the scope of the criminal justice system. In drug policy, decriminalization refers to a spectrum of approaches that remove criminal sanctions associated with drug possession. ⁶⁷ |
| Dependence | a clinical condition, which spans across a person's body, behaviour, and thoughts, that results in prioritizing substance use over other behaviours that were once priorities for that person. Accompanied with a strong, often overwhelming compulsion to use a substance. ¹⁰⁸ |
| Drug checking | a harm reduction service that offers a range of technologies that allow a sample of an unknown or suspected substance to be checked for the presence of one or more substances. ¹⁰⁹ |
| Fentanyl | an opioid medication that is manufactured legally for pain management (available in several formulations), ¹¹⁰ and a substance that is manufactured illegally to sell for profit in the street drug supply. ¹¹¹ |
| Harm reduction | an approach that uses strategies and interventions to reduce individual and community-level harm from substance use. ¹¹² |
| Legalization | the act of making something (such as a behaviour, action, or item) that was once illegal permissible by law. ⁶⁷ |
| Life expectancy | the estimated average years of life someone is expected to live at a given age. In BC, life expectancy is measured at birth and at age 65. ¹¹³ |
| Naloxone | an opioid antagonist that blocks opioid receptors in the brain. Naloxone reverses the effects of opioids, including opioid overdose. ¹¹⁴ |
| Opioid agonist treatment | evidence-based treatment for opioid use disorder, which includes the administration of opioid agonists to alleviate withdrawal symptoms. Also referred to as opioid substitution treatment. Part of a comprehensive treatment plan for opioid use disorder, which includes psychological and social supports. ¹¹⁵ |

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| Opioid use disorder | a clinical, chronic relapsing condition characterized by at least two symptoms listed in the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) criteria for opioid use disorder, including taking opioids in amounts larger or longer than intended, craving or strong desire for opioids, and persistent desire or unsuccessful efforts to cut down or control opioid use. ¹¹⁶ |
| Simple possession | a criminal charge for possession of a controlled substance for personal use with no intent to traffic. ¹¹⁷ |
| Supervised consumption services | federally approved sites that offer safe, clean, and evidence-based services for people who use drugs to reduce harms related to that use (e.g., overdose). These services are staffed by medical professionals who provide basic health services, testing for communicable diseases, and education on safer drug use, among other services. Referrals to health and social services (e.g., counselling, treatment services, social welfare programs) are also provided. ⁷³ |
| Surveillance | in public health, the continuous, systematic collection, interpretation, and analysis of health-related data that informs the planning, implementation, and evaluation of public health practices, programs, and policies. ¹¹⁸ |

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