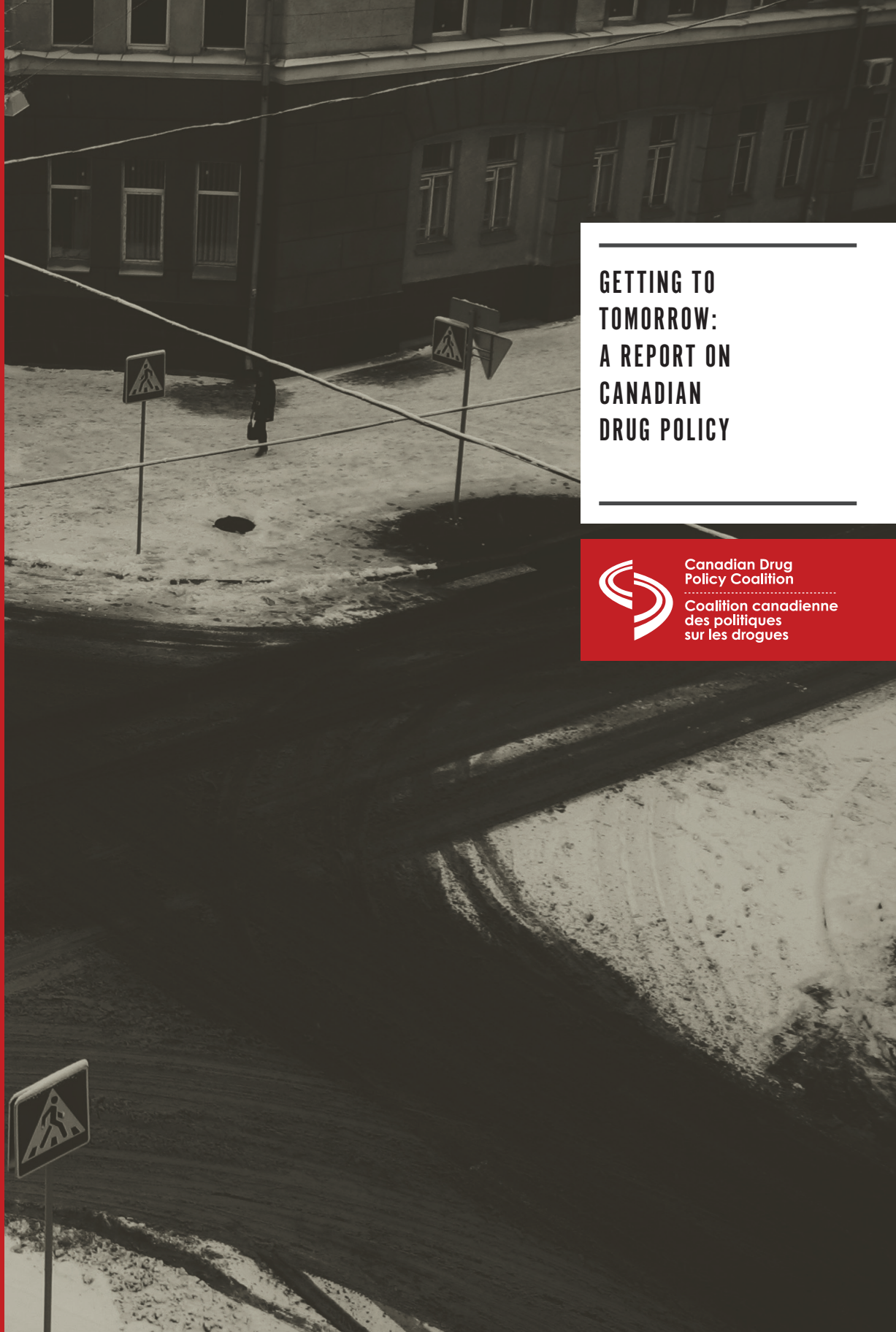
GETTING TO TOMORROW: A REPORT ON CANADIAN DRUG POLICY



Canadian Drug Policy Coalition

Coalition canadienne des politiques sur les drogues

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sur les drogues

ENGAGING THE WORLD

GETTING TO TOMORROW: A REPORT ON CANADIAN DRUG POLICY

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EXECUTIVE SUMMARY

The Canadian Drug Policy Coalition is a broad coalition of non-governmental organizations and individuals committed to working with Canadians to create an approach to drug problems that will take a radical new direction—a course that will put the protection of public health and safety, social justice and equity at the forefront of Canada's response to drugs. The primary goal of this report is to provide an overview of the state of Canadian drug policy by focusing the lens on key issues of concern to Canadians: public safety, access to services and supports for people with drug problems, national-level drug policy, and Canada's escalating role in the international war on drugs.

This report highlights the failing role that current federal drug policies play in supporting safety and health and draws attention to the acute need for an improved system of supports for people who use drugs including harm reduction. This report also highlights the patchwork of provincial policies and services that support people with drug problems. These policies, while valiant attempts to integrate and streamline services, do not always translate into meaningful changes on the front lines. This report also calls for a review of the overall use of the criminal law in responding to the use of illegal substances and drug related problems.

The findings of this report, based on interviews with change-makers and service providers, and scans of important documents and research, reveals that Canada is at a crossroads when it comes to drug laws and policies. A new direction in drug policy is required. We can continue to work within the paradigm of drug prohibition or we can begin to explore alternative approaches and chart a new course that can help save lives, respect human rights and be more cost effective.

The use of illegal substances is a complex issue and people use drugs for many reasons. Most people do not experience sig-

nificant problems because of their drug use, some do develop drug problems, and others may experience clear benefits from illegal drug use. But despite deep public purse investments in enforcement-based approaches, lifetime use of cannabis stands at 39.4% and the non-medical use of prescription opioids is the fourth most prevalent form of substance use in Canada behind only alcohol, tobacco and cannabis. Rates of HIV and HCV associated with drug use are unacceptably high particularly among some groups. In 2010, 30.4% of new infections in women versus 13.5 % of new cases in men were attributed to injection drug use. Cases of HIV attributed to injecting drug use among First Nations, Métis and Inuit persons have gone up to more than 50 per cent in the period spanning 2001 to 2008.

Deaths related to overdose of prescription opiates whether used medically or non-medically have risen sharply and are estimated to be about 50% of annual drug deaths. But like HIV and Hepatitis C infections, overdose deaths are highly preventable. This report addresses some of the urgent changes needed to support a comprehensive harm reduction and public health approach to the prevention and treatment of overdose.

Despite often heroic efforts at the provincial and local levels to improve the system of supports, many people still wait unacceptably long for services. Where sound and relatively safe treatments exist, provincial governments and health authorities drag their feet because of outmoded ideas about some drugs or shortsighted concerns about finances. The Federal government remains openly hostile to evidence-based measures like key harm reduction services and has clearly taken a punitive approach to addressing drug use problems. Failure by all levels of government to fully meet the needs of people with drug problems, means that some groups are still outright denied these lifesaving services and many community-based organizations struggle to meet the basic needs of their clients. These difficulties are particularly acute for residents in rural areas, women and First Nations, Métis and Inuit citizens.

Canada still relies on the criminal law to curb illegal drug use and stem the growth of illegal drug markets. These laws and policies disproportionally target already marginalized groups. Canada also spends enormous amounts of money annually to prevent the purchase, use and distribution of illegal drugs both inside Canada and beyond its borders. The federal government has allocated $527.8 million for the National Anti-Drug strategy for 2012-2017, much of it on enforcement related activities. This strategy only accounts for a portion of government spending on drug control. “Activities such as RCMP drug enforcement, drug interdiction, and the use of the military in international drug control efforts, drive up policing, military and border security budgets. Cannabis remains a key target of these policing activities—cannabis possession charges numbered 61,406 in 2011, a rate of 178 per 100,000 people in Canada. Police reported incidents of cannabis possession are far higher than any other illegal drug (21 for cocaine possession and a rate of 30 for all other illegal drugs combined.) And incidents of cannabis possession have increased 16% between 2001 and 2011. Cannabis remains a lucrative market—annual retail expenditures on this substance are estimated to be about $357

million per year in BC alone. Cannabis is a popular drug, and its harmful effects are certainly less than alcohol and tobacco, but the potential financial benefits of regulated and taxable product like cannabis are completely unavailable to federal and provincial treasuries.

Rather than curbing drug markets, drug enforcement has actually been shown to escalate drug trade violence. Canada's prisons are already overcrowded and the effects of recently introduced mandatory minimum sentences for some drug crimes are yet to be fully felt. And because of poor data collection we still do not have a full picture of the effects of the millions of dollars spent every year on enforcing Canada's drug laws.

One of the most urgent issues affecting Canadians is discrimination against people who use illegal drugs. This discrimination and the accompanying hostility towards people who use drugs can be felt in the derogatory statements that appear routinely in media reports of public debates about services.
The recommendations in this report address the need for urgent change in three key areas: drug law reform, discrimination, services and supports.

1. Modernize Canada's legislative, policy and regulatory frameworks that address psychoactive substances. We call for the replacement of the National Anti-Drug Strategy with one focused on health and human rights, the decriminalization of all drugs for personal use and the creation of a regulatory system for adult cannabis use.

2. Support and expand efforts to implement evidence-based approaches to eliminate stigma and discrimination, and social and health inequities that affect people who use drugs.

3. Support the scaling-up of comprehensive health and social services, including housing and treatment services that engage people with drug problems. Increase support for efforts to reduce the harms of substance use which includes robust educational programs about safer drug use, programs for distributing new supplies for injection and crack cocaine use, safer consumption services, opioid substitution therapies and heroin assisted treatment. Ensure these services are part of larger public health approach to substance use that respects the human rights of people who use drugs.

Canada has good people working at every level from front line services and organizations to provincial and federal ministries, whose efforts are severely hampered by fear, lack of leadership, and poorly informed policies based on outdated ideas and beliefs about drugs and the people who use them. At the same time, a global movement of sitting and former political leaders is emerging that acknowledges the over-reliance on the criminal law in addressing drug problems is causing more harm than good. Canada must join the chorus of voices around the globe calling for change. This report is a call for Canadians to meet these challenges head-on with creative thinking and brave policy changes.

RECOMMEN-DATIONS

It is clear that Canada needs a new approach to drug policy, nationally and internationally. Policy frameworks in place today reflect outdated understanding of the problems related to substance use. Drug policies need to be reviewed, evaluated and updated where necessary.

The CDPC is committed to working with Canadians to create an approach to drug problems that will take a radical new direction—a course that will put the protection of public health and safety, social justice and equity at the forefront of Canada's strategy.

There are four broad areas where improvements must be made if Canada is to adequately address public health and safety issues related to drug markets and substance use in communities.

1. Modernize Canada's legislative, policy and regulatory frameworks that address psychoactive substances.

▪ *Federal*: Eliminate the National Anti-Drug Strategy and replace it with a socially just, public health approach to substances that includes prevention, harm reduction, treatment, education, health promotion and enforcement. Ensure that funding to these components is equitable.

▪ *Federal:* Promote a public health and human rights approach to drug policy at international forums including within the United Nations Office on Drugs and Crime and at the UN Commission on Narcotic Drugs.

▪ *Federal:* Eliminate mandatory minimum sentences for drug crimes. They do not work, they are costly and they create unintended negative consequences.

▪ *Federal:* Remove cannabis from the *Controlled Drugs and Substances Act* and create a regulatory framework that devolves responsibility for the regulation of cannabis to provincial authorities.

▪ *Federal:* Decriminalize all drugs for personal use as the first steps towards creating a drug strategy based on a public health and human rights approach to addressing substance use.

▪ *Federal and Provincial:* Increase access to diversion programs and alternative justice strategies for people accused and convicted of drug crimes, especially for First Nations, Métis and Inuit persons.

▪ *Municipal:* Repeal bylaws that restrict the implementation of harm reduction and opioid substitution programs and work with all groups to

challenge the discrimination against people who use drugs that so often shapes public opposition to these services.

▪ *Federal/Provincial:* Develop policies to enable and guide the implementation of street drug testing programs to prevent injury and death among those who purchase drugs from unregulated dealers.

2. Support and expand efforts to create evidence-based approaches to eliminate stigma and discrimination, and social and health inequities that affect people who use drugs.

▪ *All Jurisdictions:* Develop programs that encourage, assist and support the development of local groups of people who use drugs.

▪ *All Jurisdictions:* Create and implement policy that requires agencies and authorities to seek the inclusion and participation of groups of people who use drugs as recognized stakeholders in designing, delivering and evaluating services and supports, and include people with experience as consumers in policy, planning and regulatory bodies.

▪ *Federal/Provincial:* Focus resources and program initiatives on programs that enhance the quality of life and address the social determinants of health including safe housing, employment, and education.

3. Support the scaling-up of health and social services at the provincial level that engage people with drug problems and support their efforts to change, and support work to reduce the harms of substance use:

▪ *Federal/Provincial:* Implement needle distribution programs and expand a range of drug treatment services in federal and provincial prisons. Meet the commitments set out in Section 81 and 84 of the *Corrections and Conditional Release Act* and ensure that adequate Healing Lodge capacity is provided for First Nations, Métis and Inuit persons.

▪ *Provinces:* Continue to promote system change across all sectors responsible for substance use, and recognize the principles articulated in the National Treatment Strategy.[1] Ensure that the planning and implementation of programs and services adhere to the principles and practices for cultural safety outlined by First Nations, Métis and Inuit Groups.

▪ *Provinces:* Fully integrate services for substance use into the larger health care system. The historical distance between the larger health care system and drug services must be eliminated. Ensure that the grassroots harm reduction philosophies of equality, non-judgment and access are at the forefront of drug services.

▪ *Provinces:* Promote equitable access to all aspects of an evidence-based system of supports for people who use drugs including harm reduction, treatment and other supports. Ensure that a variety of treatment modalities are available that reflect the needs and aspirations of clients. Ensure that trauma-informed approaches to care are integrated across the system of supports.

▪ *Provinces:* Scale up a comprehensive package of harm reduction services which includes robust educational programs

about safer drug use, programs for distributing new supplies for injection and crack cocaine use, safer consumption services, opioid substitution therapies and heroin assisted treatment. Ensure these services are part of larger public health approach to substance use that respects the human rights of people who use drugs.

▪ *Provinces:* Develop, promote and evaluate a comprehensive public health approach to preventing overdose that includes the following: education and training for responding to and treating overdose in a variety of settings, including community based programs, people who use drugs and a variety of first responders and others. Address the unique difficulties of expanding overdose prevention programs in rural and remote areas. Work with the provinces and territories to establish guidelines for the sale and/or distribution of naloxone that would help get this medication into the hands of those most affected by overdose including co-prescribing with opiates for persons at risk of overdose.

▪ *Federal:* Reduce the barriers to calling 911 during a drug overdose episode by implementing Good Samaritan legislation to provide protection from arrest and prosecution for drug use and possession charges if the evidence is gained as a result of the person calling 911.

▪ *All Jurisdictions:* Ensure that funding for prevention/health promotion activities is based on clearly defined principles substantiated by evidence of what works.

▪ *Provinces:* Where necessary create a central mechanism for the purchasing and distribution of harm reduction supplies. Ensure that information about the scope of supply distribution is made publicly available.

▪ *Provinces:* Implement a women/mother-centred approach to care for women with substance use problems that focuses on the mother-child as a unit before, during and after pregnancy. Challenge the stigma and discrimination against women who use drugs, and recognize that this stigma increases the risks of pregnancy and drug use.

▪ *Provinces:* Create a consistent, transparent funding and management system for all elements of opioid substitution therapy. This must include prescribing, dispensing, drug costs, travel costs, and funding for counselling as well as case management. In particular, ensure that a variety of entry points into this treatment modality are identified and coordinated across health care sites. Engage clients in the design and implementation of this system and ensure that this system cooperates fully with the larger health care system and with necessary systems of psychosocial supports.

4. Improve the collection of data on substance use and its effects across jurisdictions.

▪ *Federal and Provincial:* Work with key partners to standardize the elements of a data collection system that can measure prevalence of drug use and its harms. Ensure that data analyses are reported in a timely manner and are sufficiently robust that they can inform planning for services at the local level.

▪ *Federal:* Continue work on National Treatment Indicators and provide mechanisms for reporting publicly on the scope of services available, their costs and wait times.

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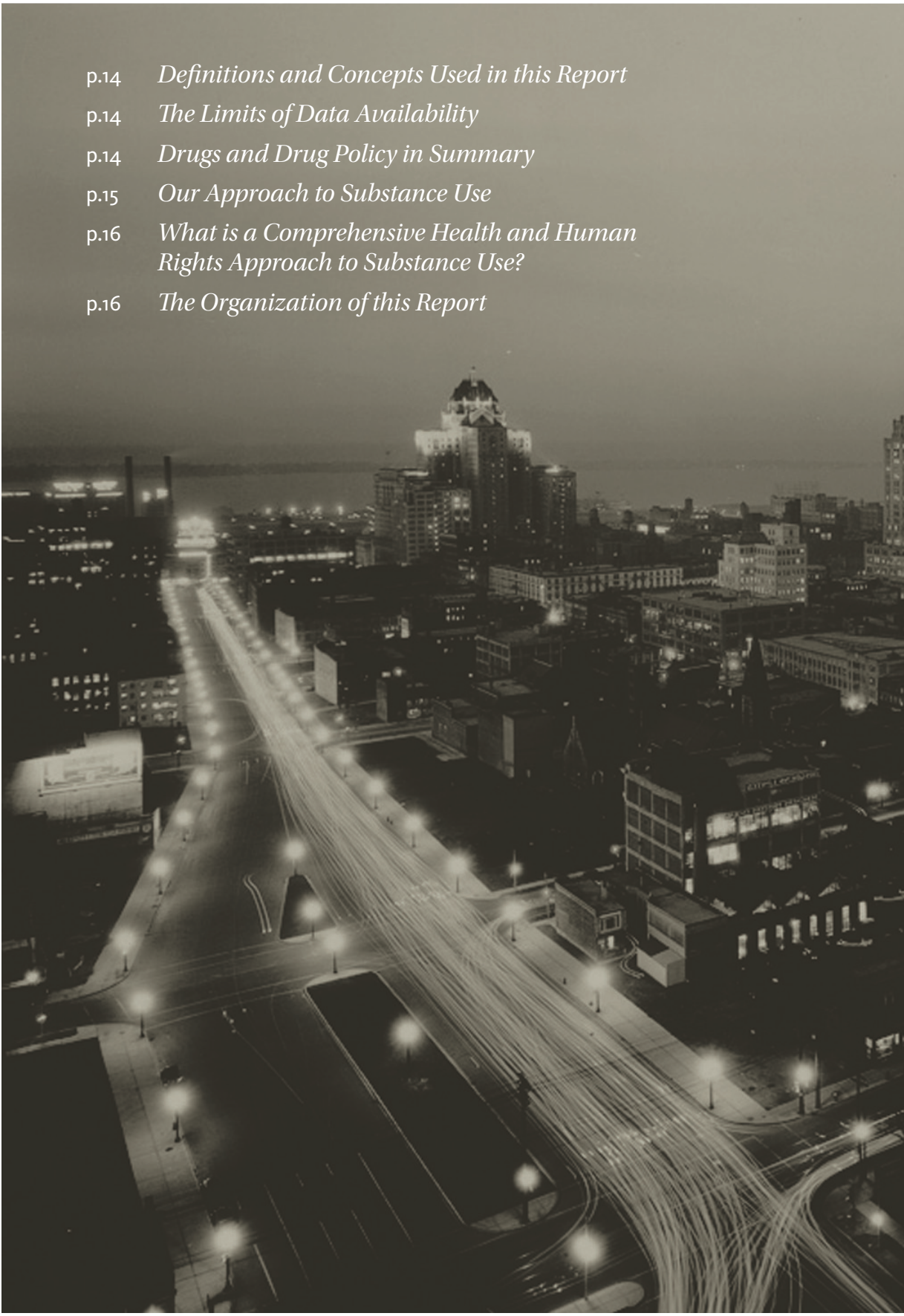

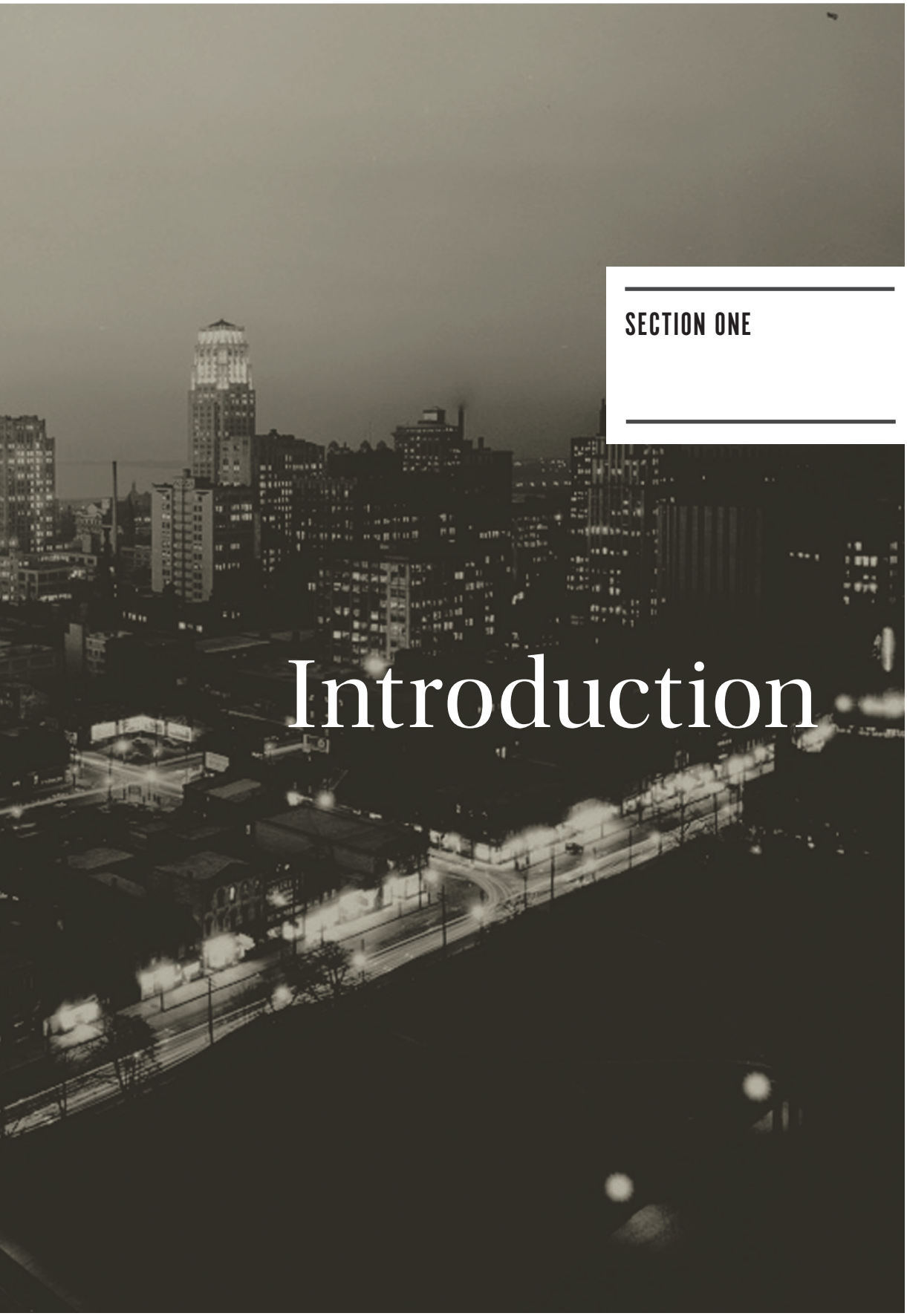

SECTION ONE

Introduction

In February 2012, the Canadian Drug Policy Coalition (CDPC) launched *Changing the Frame: A New Approach to Drug Policy in Canada.* This document opens a dialogue about the harms of our current approach and its most prominent feature—prohibition and the use of the criminal law to control the use of some substances.

Changing the Frame calls for a new approach to drug policy in Canada and a national dialogue to engage Canadians in building a more comprehensive and effective response to problems related to drugs. Canadians need to talk about how best to manage the many drugs, both legal and illegal, that are part of the Canadian landscape today and will be part of it in the future. Some progress has been made in recent years to address problematic substance use. At the same time there is a continuing and persistent resistance to innovations in the field that have been shown to save lives, prevent disease and engage those who have been marginalized by current approaches. In addition a discussion of the structural and systemic barriers to progress is urgently needed. Prohibitive drug laws have been in place for over 100 years. A global movement is beginning to emerge that acknowledges the over-reliance on the criminal law in addressing drug problems. This movement is opening a space for consideration of alternative approaches to regulating and controlling substances drawing on a public health and human rights framework. Canada needs to be a part of this discussion.

The primary goal of this document is to provide an overview of the state of Canadian drug policy drawing on the principles outlined in *Changing the Frame.* This paper focuses on key issues of concern to Canadians: public safety, access to services, national-level drug policy, and Canada's escalating role in the international war on drugs. Our report highlights the failing role that current federal drug policies play in supporting safety and health and we draw attention to the acute need for an improved system of supports for people who use drugs including harm reduction.

To compile the information for this report we used a number of approaches. We established a group of key informants from across the country who helped

identify crucial issues facing people who use drugs. Many of these informants work in harm reduction or treatment programs; some work as policy advisors and some are responsible for research programs; most importantly some are people who use drugs who have first-hand experience of the issues we discuss in the following pages. We also drew on the extensive body of research on substance use produced mainly by Canadian scholars, as well as on a review of policy documents and other jurisdictional scans. We have excluded consideration of alcohol and tobacco from this report not because they are unimportant, but because they deserve more in-depth consideration that we can provide in this first report.[2]

DEFINITIONS & CONCEPTS USED IN THIS REPORT

We use both the term "drug" and "substance" interchangeably to refer to all mind-altering or psychoactive substances. This report avoids the use of the term drug "abuse" mainly because it simply does not describe the experience of many people who use drugs. This term is often used to describe all illegal drug use regardless of its effects on the individual or their surroundings. Instead we use the term "problematic substance use" to describe harmful drug use and to separate out harmful from both non-problematic and beneficial use. We also use the phrase "people who use drugs" rather than "drug user" or "addict". Words like "addict" are stigmatizing and do not respect the dignity of people who drugs nor do they acknowledge that drug use is only one part of a person's life. It is important to recognize that that not everyone who uses illegal drugs is dependent or "addicted".

THE LIMITS OF DATA AVAILABILITY

Ideally we could frame our report on Canadian drug policy in a full understanding of how Canadians use drugs. Despite pockets of excellent research, Canada lacks comprehensive national data on the prevalence, harms and severity of substance use. The Canadian Alcohol and Substance Use Monitoring Survey (CADUMS) conducted by Health Canada on a biannual basis relies on a random survey of households in Canada using a land-line telephone; this approach excludes the homeless, institutionalized persons and individuals without home telephones.[3] CADUMS data are likely underreporting illegal drug use especially for young people between the ages of 15-34 who are less likely to have a home telephone. The response rate—i.e. the number of people who actually responded to the survey—was a low 45.5% in 2011. The broad national population data available through CADUMS are also not applicable to local contexts. The challenges with the CADUMS survey highlight the urgent need for better national data on the prevalence of substance use and its associated harms.[4] Canada also lacks comparable data on key issues including the availability of treatment services, use of prescribed opioids, and all fatal and non-fatal drug overdoses.

DRUGS & DRUG POLICY IN SUMMARY

Though humans have used substances to alter their mood for thousands of years, since the 19th century the array of drugs available has increased tremendously due to colonial expansion, global travel, emergence of synthetic drugs and the modern-day pharmaceutical industry.[5]

Attempts to prohibit many currently illegal drugs have only been implemented in the past 100 years. Drug policy is an overarching set of guidelines that shape the decisions that governments make about how to spend public monies, the types and levels of services to offer, and the laws and criminal justice activities to be undertaken by police, courts and correctional systems.

CANADA SPENDS ENORMOUS AMOUNTS OF MONEY ANNUALLY TO PREVENT THE ILLEGAL PURCHASE AND/OR DISTRIBUTION OF PROHIBITED DRUGS BOTH INSIDE CANADA AND BEYOND ITS BORDERS. SUBSTANCES CONTINUE TO BE AVAILABLE DESPITE THESE EFFORTS.

Canadian drug policy is a multijurisdictional matter. The federal government, the provinces, provincial health authorities, municipal governments, and police all play a role in deciding which issues will be a priority, how drug use issues will be understood and approached, how the illegal drug trade can be limited, and how public funds will be allocated. Drug policy decisions also cut across a number of other policy areas including policing, justice, lawmaking, the use of military force, interpretation of law and the decisions of judges. And elements of drug policy are also found in public policy areas such as health, housing, social assistance, education and immigration and citizenship.

In Canada, contemporary drug policy is expressed formally in part through federal laws namely the *Controlled Drugs and Substances Act,* which attempts to control the distribution and prevent the use of stimulant, depressant and "hallucinogenic" compounds that can be "abused." Despite such attempts at control, Canada spends enormous amounts of money annually to prevent the illegal purchase and/or distribution of prohibited drugs both inside Canada and beyond its borders. Substances continue to be available despite these efforts. Indeed, the availability and purity of many common illegal drugs is now greater than 30 years ago.[6]

OUR APPROACH TO SUBSTANCE USE

Our approach to substance use is oriented around a public health framework that explicitly acknowledges that not all drug use is problematic. People use drugs for a variety of reasons: to feel good, to feel better, to achieve more, for curiosity and social interaction, to quell emotional and physical pain and to broaden their spiritual horizons. Only a small portion of this use becomes problematic. Drug use also describes a wide range of different patterns or methods of use. Substance use occurs along a spectrum that stretches from beneficial on one end to problematic use on the other. Substance use may begin at any point on a spectrum and stay there, or move either slowly or quickly to another point. People may use one substance in a non-harmful way and another substance in a harmful way.[7] And the harms of drug use might be caused by one time heavy use resulting in injury or overdose, infection with a communicable disease, or by chronic long-term

FIGURE 1: THE SPECTRUM OF SUBSTANCE USE

BENEFICIAL	NON-PROBLEMATIC	PROBLEMATIC	CHRONIC DEPENDENCE
Use that has positive health, social or spiritual effects.	*Recreational, casual, other use that has negligible health or social effects.*	*Use that begins to have negative consequences for individuals, friends/ family or society.*	*Use that has become habitual and compulsive despite negative health and social effects.*

Adapted from: Health Officers Council of BC, 2011.

heavy use. Problematic substance use may also be episodic and then return to non-problematic use. Indeed many people use currently illegal substances on an occasional basis and suffer no harms.[8]

WHAT IS A COMPREHENSIVE HEALTH & HUMAN RIGHTS APPROACH TO SUBSTANCE USE?

According to the International Covenant on Economic, Social and Cultural Rights, a widely ratified UN treaty, all people have the right to the enjoyment of the highest attainable standard of physical and mental health. Countries must ensure that this right is exercised without discrimination of any kind.[9]

A comprehensive health and human rights approach recognizes that harmful substance use is a health not a criminal matter. This means that people who have substance use problems have the right to quality, accessible and appropriate health care. This approach explicitly acknowledges two distinct issues: 1. That the harms of drug use are borne inequitably by some groups more than others, and 2. That a broad range of social factors contribute to the context of substance use and can exacerbate harm or help to reduce or limit potential harm. These include: employment opportunities, working conditions, income, social support networks, safe housing, education, access to health services, and discrimination based on gender, race, sexual identity, or physical and mental abilities.[10] A health and human rights approach to drug use also recognizes the legitimate right of people who use drugs to participate in the planning and implementation of programs and supports.

THE ORGANIZATION OF THIS REPORT

This report is organized around key themes, each of which was identified as critical in our scan of relevant policy documents, research, and interviews with key informants from across the country. These themes reflect places where efforts are urgently needed to reorient policy approaches so that the needs of all Canadians who are affected by substance use and drug policy related harms could be effectively met. Together these themes and our recommendations comprise CDPC's first annual report on drug policy in Canada. Future iterations of this report will return to the issues identified in this document and will supplement our understanding of the state of drug policy in Canada with new quantitative and qualitative data as they emerge.

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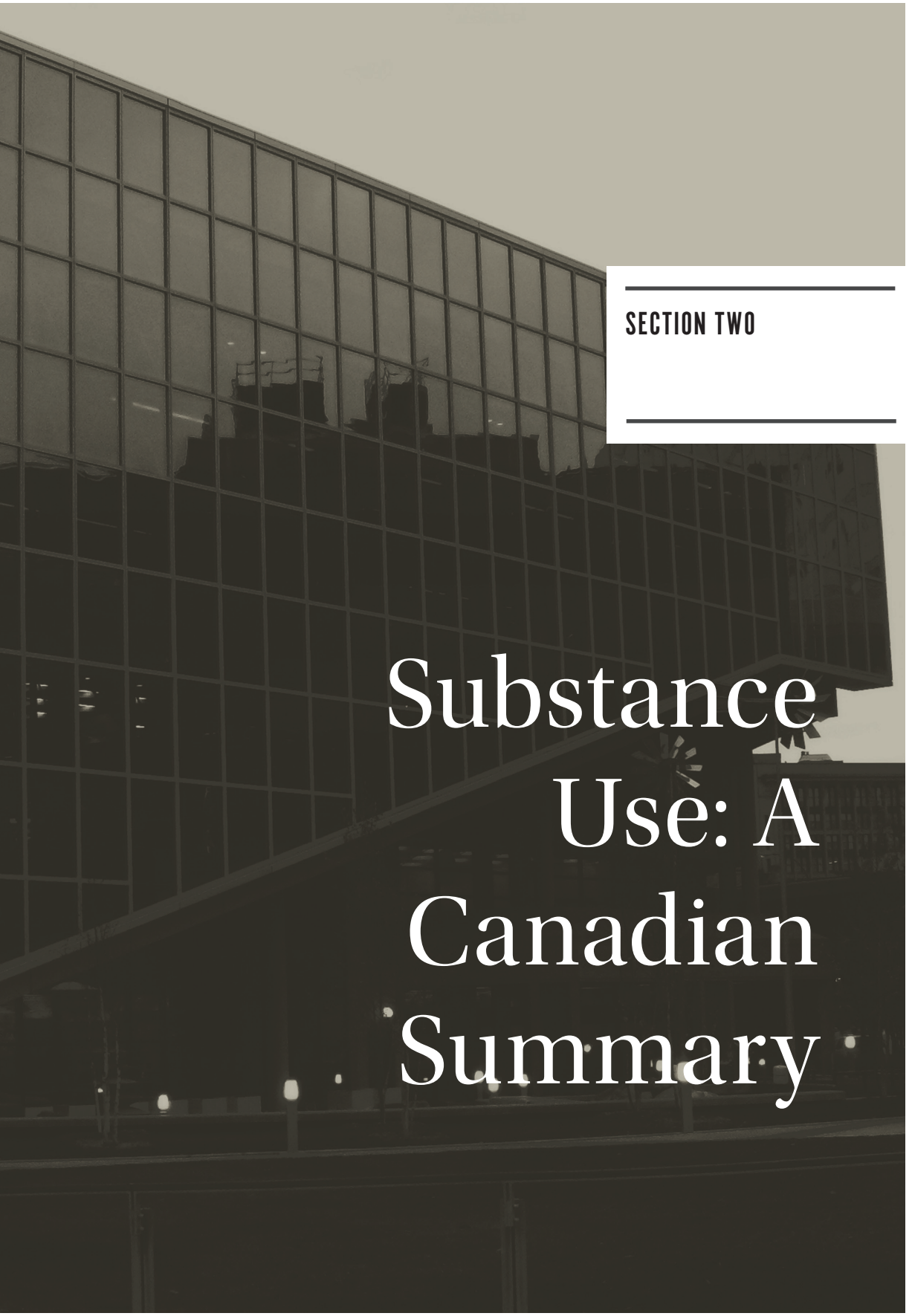


SECTION TWO

Substance Use: A Canadian Summary

The 2011 Canadian Alcohol and Drug Use Monitoring Survey (CADUMS) pegs average use of all illegal substances for individuals over 15 years of age at 40.9% for lifetime use, and 9.9% for past year use. In 2011, men were more likely to use illegal drugs than women (men—13% and women—6.9%), although women were more likely to report the use of all types of pain relievers (17.4% for women and 15.8% for men in 2011).[11]

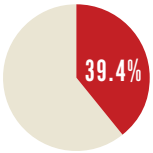
Overall, cannabis was the most widely used illegal drug with 39.4% of Canadians indicating they have used this drug in their lifetime and 9.1% in 2011. These figures vary by province with British Columbia having the highest rates of lifetime use at 44.3% and Nova Scotia having the highest rates of use for the past year at 12.4%. Overall men are somewhat more likely than women to report having either used cannabis in their lifetime or in the last year.

Data from the 2011 CADUMS on the usage of other illegal substances such as methamphetamines/crystal meth, heroin, cocaine/crack,"ecstasy," "speed," hallucinogens, are difficult to report because many of the estimates are suppressed due to high sampling variability. But data from 2008 indicate that cocaine and crack use was about 2.3% in the general population.[12]

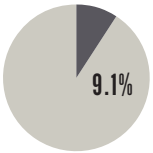
As far as we can determine with current data, the use of drugs like heroin and crack cocaine is mainly concentrated in marginalized populations. Data suggest that since the 1990s use of stimulants such as crack or methamphetamine among street-involved users has increased, primarily due to their easy availability. Among these drugs, crack is one of the most commonly used.[13] The 2006 report of the I-Track study reported that the most common injected drug, reported by an average of 77.5% study participants, was cocaine (range 58.4%- 92.5%). Just under half of study participants (45.9% on average) reported injecting non-prescribed morphine; slightly less than a third reported injecting crack and Dilaudid (31.9% and 32.9% on average, respectively). Just over one-quarter of study participants reported injecting heroin (27.6%).[14] A study of crack use in Vancouver demonstrated a large increase in crack use (at baseline, 7.4% of participants reported ever using

TABLE 1: CANNABIS USE – CANADA 2011

		Lifetime Use	Past Year Use
NEWFOUNDLAND	1,008	34.8%	10.0%
PEI	1,008	35.1%	8.9%
NOVA SCOTIA	1,008	43.7%	12.4%
NEW BRUNSWICK	1,009	37.4%	9.0%
QUEBEC	1,007	39.7%	9.0%
ONTARIO	1,009	37%	7.9%
MANITOBA	1,008	36.1%	10.4%
SASKATCHEWAN	1,007	36.5%	8.8%
ALBERTA	1,008	43.1%	8.4%
BRITISH COLUMBIA	1,009	44.3%	12.1%
CANADA	10,076		



Lifetime Use



Past Year Use

Adapted from: Health Canada, Main 2011 CADUMS Indicators - Drugs.

crack and this rate increased to 42.6% by the end of the study period) among injection drug users between 1996 and 2005.[15]

NON-MEDICAL USE OF PRESCRIPTION DRUGS

Non-medical use of prescribed opiates is now the fourth most prevalent form of substance use in Canada behind alcohol, tobacco and cannabis.[16] Between 500,000 and 1.25 million people are estimated to use prescription opioids non-medically in Canada. A study conducted in five Canadian cities indicated that the non-medical use of prescription opiates was more prevalent than the use of heroin in every setting except Vancouver and Montreal.[17] Another study observed a relative increase of 24% from 2002 to 2005 in the proportion of the street-drug using population who used non-medical prescription opioids only.[18] A more recent study found that the availability of prescribed opioids among people who use drugs in a Canadian setting increased markedly over a relatively short timeframe (2006-2010), despite persistent and high availability of heroin and cocaine.[19] Data also suggest that the harms associated with prescribed drug use, particularly opioids, are disproportionally high for some groups including some Aboriginal communities. Women are also more likely to be prescribed psychoactive drugs than men, and men are more likely to use prescribed stimulants.[20]

YOUTH

Most provinces conduct school-based surveys of youth substance use, though the frequency and the types of questions asked on these surveys can vary from province to province. Notably nine provinces conduct regular surveys including BC, Ontario, Alberta, Manitoba, Quebec, and the Student Drug Use Survey in the Atlantic Provinces (including New Brunswick, PEI, Nova Scotia and Newfoundland and Labrador). The Canadian Centre on Substance Use (CCSA) sponsored a re-analysis of data from the 2007/08 round of these surveys to create comparable measures across the country. Key findings from the 2007/08 school-based surveys include the following:

- Increase in use of alcohol and cannabis between grade 7 and grade 12. In grade 7, depending upon the province, 3% to 8% report past year cannabis use versus 30% to 53% among grade 12 students.

- Alcohol use is almost twice as prevalent as cannabis use (46%-62% of students report alcohol use and 17% to 32% report use of cannabis in the past year). Consistently more boys than girls use cannabis, though in some provinces girls report more lifetime alcohol use than boys in grades 7 through 12.
- Aside from alcohol and cannabis, ecstasy (or what is supposed to be ecstasy) is the most prevalent drug (4% to 7% lifetime use.)

- Data on use of other substances are not consistently available across the provinces due to survey design issues and low rates of response. Other than alcohol and cannabis, data are not available by gender or by age.

- 2.6% to 4.4 of students in some provinces for which data are available reported using inhalants.

- Steroids are used by 1.2% to 1.4% of students; lifetime use of heroin is only reported for four provinces and ranges from .8 to 1.3% of students. Only four provinces provide comparable measures of cocaine and crack use and three of these provinces separate out cocaine from crack. In BC 4.4% of students have used crack/cocaine. In three other provinces lifetime usage rates vary from 3.3% to 4.2% for cocaine and 1.3% to 2.1% for crack.

- Data on use of crystal methamphetamine range from .9% to 1.5%

- The CADUMS data for 2011 found that young people between the ages of 15 and 24 were the most likely age group to use illegal substances at 23.1%.[21]

- Substance use among street-involved youth is much higher than other youth. Surveillance data from seven urban centers across Canada suggests a lifetime prevalence of illicit drug use of 95.3% among street-involved youth. Additionally, 22.3% of street-involved youth had injected drugs at some time in their life.[22]

- Other data sources suggest that non-medical prescription drug use is also becoming an issue for youth. According to the 2009 Ontario Student Drug Use and Health Survey, 22% of Ottawa students said they had used a prescription drug non-medically in the past year. Of these, 70% said they got the drugs from home and a study of Toronto youth suggests that recreational use of prescribed opioids is on the increase.[23]

HARMS OF SUBSTANCE USE

Harms from substance use potentially include blood-borne viruses such as HIV or Hepatitis C (HCV), skin and respiratory problems, overdose, and disruption of personal life including troubles with family, friends co-workers and police.

Sharing used syringes and other drug use equipment is the main modes of HIV and HCV transmission among people who use drugs. Of the 2,358 new infections reported in Canada in 2010, 16.8% were attributed to injection drug use. These figures differ considerably from province to province, between men and women overall, and for Aboriginal people compared to other Canadians. In 2010, 30.4% of new infections in women versus 13.5 % of new cases in men were attributed to injection drug use. Cases of HIV attributed to injecting drug use among Aboriginal persons have gone up to more than 50% in the period spanning 2001 to 2008.[24]

Rates of HIV infection related to injection drug use vary by location and population group. In Saskatchewan, for example, results from the 2009 Canadian Alcohol and Drug Use Monitoring Survey suggest that rates of drug and alcohol use in Saskatchewan were lower than the Canadian average for that year.[25] But rates of HIV in Saskatchewan have been rising, and Saskatoon has experienced some of the largest increases in the province. HIV continues to disproportionately affect marginalized populations, including young Aboriginal women and street-involved individuals. According to 2009 data, 77% of new cases of HIV diagnosed in the province were among individuals who inject drugs, and of this group, 84% were of Aboriginal ancestry.[26] In response to increasing concerns about HIV in Saskatchewan, the province released a multi-year HIV strategy, aimed at both reducing new cases of HIV and improving the lives of those already living with the disease.

The majority of HCV cases in Canada are among people who inject drugs. As of 2009, injection drug use was associated with 61% of newly acquired HCV cases with known risk factor information. In British Columbia, HCV infection related to injection drug use has decreased over the past decade due to increased harm reduction and other prevention measures. Elsewhere in Canada studies show that people who inject drugs are infected with HCV within one to two years of initiating drug injecting behaviour, leaving a short but important period of time for interventions to prevent the transmission of HCV.[27] A discussion of the harms related to drug overdose are included in chapter 5 of this report.

OTHER ISSUES OF CONCERN

Data on the nonmedical use of prescription drugs and the health, social and economic impacts among First Nations people in Canada is very limited, but concerns about use of these drugs has risen in recent years. Recent data on prescription drug use suggests that 18.4% of Inuit youth aged 12-17, 11% of Aboriginal youth, and 8.9% of Metis youth living in urban Canada, compared to 5.6% of non-Aboriginal youth, report using prescription drugs for non-medical purposes.[28] In early 2012 Cat Lake First Nation in Ontario was the latest First Nations community to declare a state of emergency to federal and provincial officials due to the widespread use of prescription drugs. The nonmedical use of prescription drugs has

MOST DRUG RESEARCH IGNORES THE REASONS PEOPLE CHOOSE TO TAKE DRUGS, AND WHY THEY VALUE THEM. SYSTEMATICALLY ASSESSING BOTH THE MEDICAL AND NON-MEDICAL BENEFITS OF SUBSTANCE USE MIGHT SHED MORE LIGHT ON WHY PEOPLE USE DRUGS AND PROVIDE INFORMATION THAT CAN HELP PREVENT THE HARMS ASSOCIATED WITH SUBSTANCE USE.

been linked with the impoverished health status of First Nations across Canada.[29]

In addition, the BC Centre of Excellence for Women's Health has cautioned that women as a group, and First Nations women in particular, are overprescribed benzodiazepines (anti-anxiety medications) and sleeping pills. Data estimate that 3 to 15% of any adult population is using and may be dependent on this class of drugs and of this group 60 to 65% are women. As researchers suggest, physicians "prescribe benzodiazepines (tranquilizers) and sleeping pills to help women cope with work or family stress, pre-menstrual syndrome, grief, and adjustment to life events such as childbirth and menopause, or for chronic illness and pain. Non-drug treatments for these circumstances and conditions are under- promoted and under-used."[30] In addition, women who inject drugs have twice the number of deaths than men.[31] These findings suggest that any strategy to address drug use must account for population differences such as gender and First Nations status and must be rooted in an examination of the social determinants of substance use.

BENEFITS OF SUBSTANCE USE

There are undoubtedly perceived and sometimes real benefits of psychoactive substance use, even if the substances used are illegal and deemed of no medical or scientific value. Of course, many psychoactive but illegal substances are also used medicinally or in therapeutic settings (i.e. LSD, MDMA, Ayahuasca) to great benefit, including opioids for pain relief, stimulants for ADD and ADHD, and cannabis for relief of many symptoms of illness. In fact, the federal government in Canada operates a medical cannabis program for patients who use this drug for therapeutic purposes. Reported anecdotal benefits from non-medical uses of different kinds of substances include pleasure and relaxation, cognitive or creative enhancement, heightened aesthetic appreciation (food, music, art, sex), mystical or spiritual experiences and pain relief. However, the politics of drug research mean that few researchers think about or inquire into benefits of substance use, and few have systematically developed an approach for measuring such benefits.

Intellectually, this means that most drug research ignores the reasons people choose to take drugs, and why they value them. Systematically assessing both the medical and non-medical benefits of substance use might shed more light on why people use drugs and provide information that can help prevent the harms associated with substance use.[32]

CONCLUSIONS

Clearly, illegal substance use is part of everyday life for many Canadians. Substance use also brings both benefits and harms. But the harms of drugs are compounded and in some cases wholly created by drug policy. The unique pharmacology of any drug is only part of the story. The user's mindset and the environment of use also shape the effects of drugs; drug policies and drug laws are key components that also shape the environment of use. Social factors like homelessness, imprisonment and law enforcement activities have been found to exacerbate the harms of drug use. Use of injection drugs in public, for example, can lead people to rush and/or disregard practices of safer use because of fear of police or public detection, leading to infections and overdose.[33] And the reasons people use drugs in public are likely related to lack of housing and/or available private spaces. What this means is that we need to be careful about conflating the harms of drugs with the harms posed by policy contexts. The challenge for drug policy is then to create a climate that maximizes safety while minimizing harm. This is not an easy challenge but one that Canadians must undertake. In the next sections of this report we review some of the key areas of concern for Canadian drug policy including services for people who use drugs, drug policy at the federal level and Canada's on-going participation in the international war on drugs.

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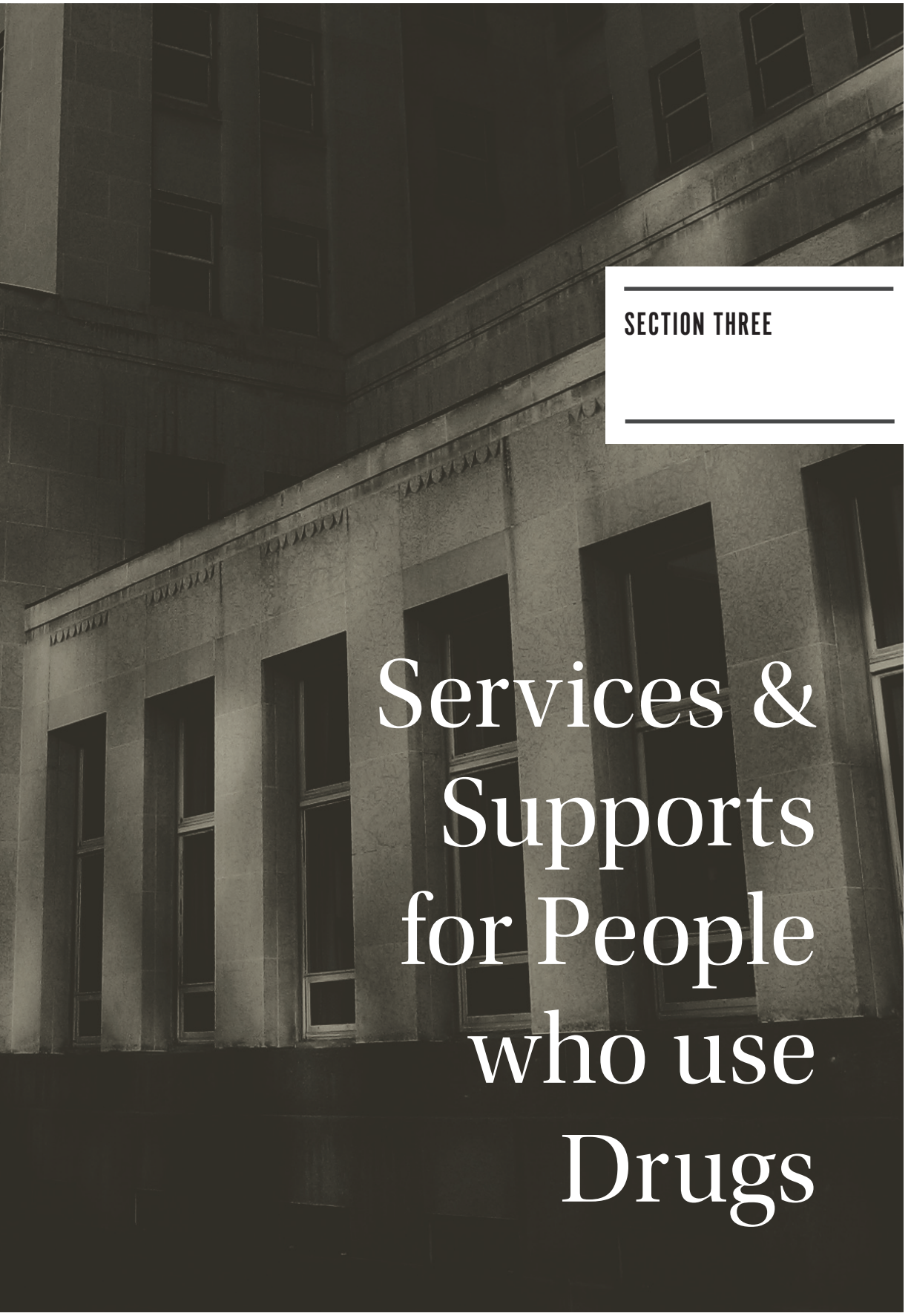


SECTION THREE

Services & Supports for People who use Drugs

The availability and scope of services is of crucial importance to Canadians seeking help with substance use problems. This chapter focuses on some of the key pressures facing Canadians seeking treatment services for substance use.

There is a large body of research on the effectiveness of various treatment modalities; there is also a great deal of research about how drug-related services should be implemented and organized. We acknowledge this important body of literature, but this chapter focuses on the issues our key informants identified in Canada's system of supports for people who use drugs. This chapter takes a different standpoint from the one that readers might find in the above noted literature. Rather than looking at the person who uses drugs from the standpoint of the system, this chapter draws on the perspective of people who are involved at the ground level including practitioners and people who use drugs. The issues we identify below are the ones that most acutely affect these people as they attempt to navigate a system of supports. This chapter focuses mainly on drug treatment systems and the next chapter includes a detailed discussion of harm reduction.

Access to treatment for drug dependence is an essential element of human rights. Governments have a responsibility to ensure that all people can access services that will help them attain the highest possible level of physical and mental health. Though drug treatment may not always lead to abstinence, research and practice demonstrates that treatment can dramatically improve the mental and physical health of people who use drugs. According to the Canadian HIV/AIDS Legal Network, treatment for drug dependence shares three of the principal conditions identified in international law as necessary for the full realization of the right to health: it is an important element of controlling epidemic illnesses because of its role in reducing the risk of HIV/AIDS and Hepatitis C; it provides a health service to those who are ill; and treatment for parents and pregnant women can contribute to improved health and the development of young children.[34]

WHAT ARE WE DOING WELL?

In preparing this report we heard about many problems with the current system of supports for people who use drugs. But we also heard numerous stories about things that are working well.

Canada possesses a wealth of expertise when it comes to putting our commitments into action. Many highly skilled, committed and passionate people work very hard to create policy, and provide care and services. These include the many peer groups, professionals in health care and justice, educators, and community-based organizations committed to helping people address problematic substance use and challenging the heavy burden of discrimination. Community-based agencies in particular often lead when it comes to putting innovative policy initiatives into action. And sometimes they provide this leadership while under intense public scrutiny and in communities resistant to change.

A bright spot is the number of provinces that have made public commitments to improve their system of supports for people who use drugs. Virtually all provinces and territories have a strategic plan to address substance use either in existence or under development. Several of these plans stress the integration of mental health and substance use services and the importance of integrating substance use services into primary care services such as family doctors and community clinics. These plans also underline the importance of accessibility, with emphasis on seamless access to services and reduced wait times for underserviced populations. Some of these plans also stress the need for more health promotion and prevention of the harms of substance use, most notably through early intervention programs, along with training for people working in these systems, provision of more services to caregivers, attention to the needs of people living in rural and remote areas, and collaboration between service providers, especially for people with complex needs.[35] These strategies almost universally emphasize the importance of evidence-based and best practice models of policy development and service delivery. British Columbia's plan is exemplary for promoting efforts to alter its system of services and supports (rather than just focusing on changing people's behaviour), and it explicitly includes harm reduction in its system of services.

Another bright spot is the existence of the recommendations of the National Treatment Strategy Working Group. Their report, *A Systems Approach to Substance Use in Canada: Recommendations for a National Treatment Strategy,* lays out a set of principles to guide the development of treatment systems, a set of strategic areas that require action including building increased capacity using a tiered model,[36] and supporting a continuum of services and supports. This report also acknowledges the importance of increased research capacity about treatment, the importance of reducing discrimination against people who use drugs and the need to measure and monitor system performance. The principles of this report lay out a model for a person-centred approach through services and supports that put consent to treatment at the heart of effective programs.[37] The report also acknowledges the important role that leadership must play in moving its recommendations forward, including the involvement of people who use drugs.

ORGANIZATION OF SERVICES IN CANADA

Health service delivery is the jurisdiction of the provinces and territories, each of which is

THE SYSTEM OF DRUG TREATMENT AND DETOXIFICATION SERVICES IS STILL A COLLECTION OF CLINICS, HOSPITALS, COMMUNITY AGENCIES AND PRIVATE SERVICE PROVIDERS DEVELOPED OVER TIME IN RESPONSE TO LOCAL PRESSURES, POLITICAL ADVOCACY, AND AVAILABILITY OF FUNDING WITHOUT A GREAT DEAL OF SYSTEMATIC ATTENTION TO THE ACTUAL NEEDS FOR SERVICES.

responsible for the enactment of laws and policies related to health and the delivery of health services. The provinces and territories receive funding for substance use services from their Ministries of Health. These services are delivered either by provincial health authorities (centralized) or by regional health authorities (regionalized). Many provinces strive to provide a range of services that run the gamut from education, harm reduction, prevention, screening, early intervention, withdrawal management (detox), to day treatment, residential treatment and supportive recovery services. Generally more intensive and specialized drug treatment services are offered in more populated, urban areas.[38]

The actual structure of substance use services across Canada varies widely, for a number of reasons: health system regionalization, geographic differences, and differing political priorities related to substance use.[39] Across the provinces and territories there are currently 87 "heath authorities" responsible for service provision in Canada. Individual health authorities and other jurisdictions have developed their own systems of services and supports, with little emphasis on consistency and co-ordination within or between jurisdictions. The result has been fragmentation and inconsistency, rather than an integrated system of services and supports.[40]

Recent policy statements from many provinces suggest planning for a more integrated system is underway.[41] Despite these positive indications, the system of drug treatment and detoxification services is still a collection of clinics, hospitals, community agencies and private service providers developed over time in response to local pressures, political advocacy, and availability of funding and without a great deal of systematic attention to the actual needs for services.[42] The development of these services has also been hindered by longstanding moralistic attitudes about substance use.

What this means is that people who seek help with their substance use often must navigate a complicated and sometimes labyrinthine system of services characterized by long wait times, lack of coordination and questionable accessibility. In the next section we review some of the key issues that face people as they try to navigate these systems of care.

KEY PRESSURE POINTS IN THE SYSTEM OF TREATMENT SERVICES[43]

Discrimination: Discrimination against people who use drugs is one of the main obstacles to reducing substance-related harm. Discriminatory attitudes and

behaviours by health care providers can be barriers to accessible, respectful and equitable care.[44] People who use drugs report unmet treatment and harm reduction service needs, and can be under-medicated or denied medication because they are labeled as "drug-seeking."[45]

Lack of consistent and meaningful participation of people who use drugs: People who use drugs have set up groups across Canada, and have received support and endorsement from a number of agencies and organizations. These groups promote both the health and human rights of people who use drugs and their social inclusion. But their involvement as recognized stakeholders in planning and implementing services and supports, and in helping services evolve to be more person-centred, is still insufficient. These organizations must be involved in helping to set the direction of Canadian drug policy.

The chronic underfunding of services: Despite several well-thought-out provincial strategic plans, many jurisdictions still lack a full continuum of services. While some services are well resourced, others still operate continuously in "survival mode" and do not have the resources to serve all those who need assistance.[46] And access to services is often still chaotic and confusing for people who use drugs and for their families.[47] Wait times for drug treatment can be long and can also vary significantly from jurisdiction to jurisdiction. Long wait times have been shown to discourage people from seeking treatment. In Canada, publicly available information on wait times is scarce.[48]

Privately run services in a publicly funded system: In most jurisdictions, treatment services are still provided by a mix of private and public providers and the cost of private treatment is a barrier to service for many individuals. In Canada, private treatment providers are not subject to mandatory accreditation requirements. Such a mix of public and private service providers would not be tolerated for any other health issue in Canada's publicly funded health care system.

Bridging between services is lacking in many jurisdictions: One of the most acute difficulties reported by key informants was the issue of bridging between services. In times of transition between services, the risks of gaps in service where people may "fall between the cracks" are significant. This can happen when youth transfer to adult services, when persons with concurrent disorders transfer between mental health and addictions services, when people transition from withdrawal management to drug treatment, and when patients are discharged from inpatient treatment programs to community-based or outpatient services and when people are released from jail or prison. This is especially challenging for people whose housing is unstable or non-existent. Without a safe place to stay, chances of relapse are higher. In addition, lack of after-care services is a challenge for many people exiting drug treatment services.[49]

Gender-based needs are not well integrated into planning and implementation: Scholars and practitioners in Canada have illuminated the role that gender relations play in shaping problematic substance use. The BC Centre for Excellence in Women's Health has helped to foreground issues like the over-prescription of benzodiazepines to women and they have

articulated a set of principles for gendering initiatives like the *National Framework for Action to Reduce the Harms Associated with Alcohol and Other Drugs and Substances in Canada.*[50] Yet gender-based needs are either completely ignored or underplayed when planning and delivering services and supports.

Services do not exist to meet the diverse needs of all Canadians: Many groups such as First Nations and Métis individuals have been under or not served by existing systems for generations. Lack of access to services can result in a higher burden of illness and greater risk for substance use problems. Young people too experience difficulties accessing appropriate drug treatment, particularly when they are homeless.[51] In addition, available services and their chosen modalities of treatment are not always appropriate. Twelve step programs, for example, though immensely valuable for some, may not be appropriate for others.

Rural and remote areas are underserved: There are significant differences in the availability of treatment services depending upon geographic location. This is most acutely the case for rural and remote areas, though there can be significant differences between the services offered in medium-sized cities as compared to large metropolitan areas even within the same jurisdiction.

Making a lasting difference depends on addressing all needs: Key informants repeatedly stressed that the system of supports lacks the tools to address key issues that increase the harms of problematic substance use including poverty, homelessness, discrimination, and lack of consistent and quality community supports like childcare.

Funding mechanisms lack transparency: In many cases, the funding mechanisms used in regionalized health care systems lack transparency. For example, it is unclear to many frontline service providers how provincial ministries of health allocate funding, and then how monies are spent at the regional level. Indeed, health care spending on substance use is insufficiently accountable to the people most affected by the issues. More than this, as our discussion of the National Anti-Drug Strategy will reveal, at least at the federal level, the lion-share of funding still goes to enforcement activities.

No challenges to Prohibition: No province explicitly challenges the reality of drug prohibition. Though the legal context for substance use is not a provincial responsibility, provinces and territories must routinely shoulder the costs of prohibition either through criminal justice costs or through health and social harms of substance use that are exacerbated by the lack of regulation of substances. The legal framework for substances in Canada constrains the ability of provinces and local jurisdictions to respond to substance use in innovative ways.

THE INTEGRATION OF MENTAL HEALTH AND SUBSTANCE USE SERVICES: SOME QUESTIONS

Most provinces have issued policy statements that support the integration of mental health and substance use services.[52] Impetus for this integration has been driven by evidence that many people who experience problematic substance use may also experience mental health challenges, and that two independent systems of services

cannot effectively or efficiently meet people's needs. Over the years, it has become apparent that people can be bounced from one system of services to another without a holistic approach to their needs. This lack of coordination is most acutely felt at the service level when mental health services do not accept clients who use drugs, including clients on methadone, while some addiction services do not accept clients on certain types of prescription medications, including antipsychotic drugs. These situations add to the already frustrating process of accessing services.

It is beyond the scope of this report to comprehensively examine the integration of mental health and addictions. There are several excellent reports and literature reviews on this issue.[53] We can however, raise some important questions about this integration from the perspective of a comprehensive and socially just approach to substance use.

It is important to think and act comprehensively when it comes to complex and intertwined issues like substance use and mental health. People should be able to easily access services that can address the full spectrum of their needs. The integration of mental health and substance use services, however, suffer from two interrelated challenges: 1. The need to continue to provide comprehensive services to individuals who do not experience mental health challenges; and 2. The need to acknowledge that substance use issues overlap and are shaped by other key issues like trauma, poverty, racism, and drug policy itself. This latter point is important because the majority of people who experience challenges with substance use do not have co-occurring disorders.[54] Approximately 20% of people who have mental health issues experience co-occurring problematic substance use. The overlap between mental health and substance use issues is higher in some sub-populations including incarcerated individuals, and young men diagnosed with personality disorders.[55]

IT IS IMPORTANT TO THINK AND ACT COMPREHENSIVELY WHEN IT COMES TO COMPLEX AND INTERTWINED ISSUES LIKE SUBSTANCE USE AND MENTAL HEALTH. PEOPLE SHOULD BE ABLE TO EASILY ACCESS SERVICES THAT CAN ADDRESS THE FULL SPECTRUM OF THEIR NEEDS. THE INTEGRATION OF MENTAL HEALTH AND SUBSTANCE USE SERVICES, HOWEVER, SUFFER FROM THE NEED TO ACKNOWLEDGE THAT SUBSTANCE ISSUES OVERLAP AND ARE SHAPED BY OTHER KEY ISSUES LIKE TRAUMA, POVERTY, RACISM, AND DRUG POLICY ITSELF.

While it is very important to have services that can address this important overlap, systems must protect already existing services that address the needs of people who experience problematic substance use and its related issues. Indeed many people accessing services for their substance

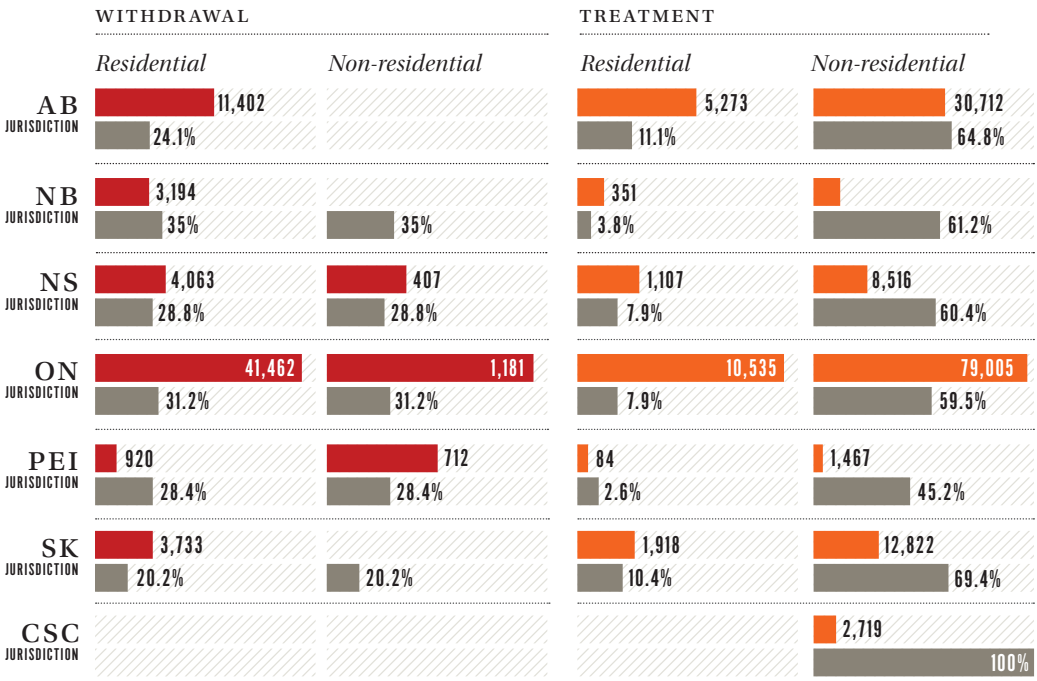
use have experienced trauma. This trauma is not a mental illness, but often the lived effects of systematic issues like colonialism and residential schools, discrimination and violence, including systemic forms of violence like violence against women in intimate relationships and violence against Indigenous women. Services need to be able to deal with the complexity of people's lives without necessarily medicalizing substance use issues. Most importantly services must be offered in a way that recognizes the need for physical and emotional safety and choice and control over how interventions will be applied. Trauma-informed approaches are similar to harm-reduction-oriented approaches in that they focus on safety and engagement.[56] (See the following chapter for more information on harm reduction.)

The harms of substance use are also related to a number of factors including acuity, chronicity, and complexity. In other words, harms from substance use can occur from one time drug use, from moderate to heavy drug use over time and may be complicated by other challenges including mental health status, poverty, and/or overall health status.[58] Mental health status may or may not play a role in shaping these issues. Personal well-being can only be enhanced if these underlying social issues, and the particular circumstances of substance use, are addressed. It is unlikely that one system or set of services can ever address all needs, thus a range of services and systems must be mobilized to address complex issue like problematic substance use. Advocates of "housing first," for example, stress its importance because safe and stable housing is often the first step to long-term healing.[59]

THE AVAILABILITY OF DATA ON DRUG TREATMENT SERVICES

Effective service planning relies on good data that can assess what services people need and how clients utilize services. Until now comparable data on Canada's system of treatment supports has been unavailable. Though the Canadian Centre on Substance Abuse has initiated the process of gathering national data on treatment programs, a report released in 2012[60] suggests that the availability of comparable data from all provinces and territories is uneven at best and work remains on developing comparable data collection systems in each of the provinces. The first CCSA report focuses on publicly funded specialized services; data is available on treatment episodes, usage of services by treatment type, gender, age, and use of public opioid substitution by age. The report does not measure community-based, non-specialized and private service providers. Nor can it assess the gap between the need for services and the existing capacity of treatment programs. And to-date comparable data is not available on service wait times. The intention of the National Treatment Indicators Working Group is to build on this first step in subsequent annual reports by continuing to improve the scope and quality of the data collected. The table to the right shows one portion of the data available in this report—in this case, individual episodes (not persons) of withdrawal management and drug treatment in jurisdictions with comparable data.

TABLE 2: WITHDRAWAL MANAGEMENT & TREATMENT, 2009/10[61]



Source: CCSA, National Treatment Indicators Working Group, 2012.

DRUG COURTS: SOME KEY QUESTIONS

Drug courts are promoted as a way to reduce drug use and prevent crime. Drug courts have been set up in Toronto, Edmonton, Vancouver, Winnipeg, Ottawa and Regina. Drug treatment courts (DTC's) are often touted as the solution to a cycle of drug addiction and crime. But are they? That's the question the Canadian HIV/AIDS Legal Network sought to answer in a 2011 publication that reviews the operations of six federally funded drug courts in Canada.

The report does not dismiss DTC's but raises some serious questions about how they operate and their effectiveness.

This report found that drug courts use quasi-coercive and punishing methods more akin to the criminal justice system. Applicants to a drug court treatment program must plead guilty to a crime and submit to a mandatory urine screening. This report also raises serious questions about the methodology of current research on drug courts. Because of the lack of follow-up research on the experiences of participants, and the low retention rates in many DTC programs, it is difficult to conclude at this stage whether or not drug courts result in decreased drug use and/or recidivism. Women are less likely to apply to DTC's and less

likely to graduate at comparable levels to men, partly due to a lack of gender-specific programming and program flexibility that accommodates parenting responsibilities. Indigenous women and men are also less likely to complete drug court programs due in part to the lack of Indigenous-specific treatment services. The report also questions how voluntary one's entry to treatment is when prison is the alternative and access to other treatment is limited. Drug courts may also violate human rights, specifically, the right to health outlined in Article 12 of the International Covenant on Civil and Political Rights because participants can be denied access to a health service if they do not follow the rules of a DTC program.[62]

FIRST NATIONS, MÉTIS AND INUIT COMMUNITIES

First Nations, Métis and Inuit communities face severe deficiencies in funding for substance use services. Funding issues combined with health issues such as higher rates of HIV infection and tuberculosis compared to other Canadians reflects the colonial history of Canadian society. Racism and other forms of legal and social discrimination are key issues that affect the health of First Nations, Métis and Inuit people. Systemic racism has resulted in policies of assimilation, residential school, lost culture and language, and over-representation in the justice system, all of which affect the health and well-being of communities and contribute to lower social and economic status, crowded living conditions and high rates of substance use.[63] Compounding this is the institutional racism enshrined in federal, provincial and municipal policies, police, RCPM, criminal justice and other professional practices such as health care and social work, and at the societal level, violence against First Nations women.[64]

Failure to keep agreements made with First Nations, Métis and Inuit groups, along with jurisdictional conflicts between the provinces and the federal government have also plagued the development of services for First Nations, Métis and Inuit persons. The history of colonialism combined with the numerous authorities involved in the provision of health care have resulted in a complex policy context and uneven service provision between geographic areas as well as conflicts between the federal and provincial governments over who should pay for services.[65] Other challenges facing First Nations, Métis and Inuit communities include differences in access to services between Status and non-Status First Nations between on-reserve and urban First Nations persons, limited access to provincial detoxification services, lack of culturally appropriate services, lack of coordination of care between services, and lack of adequate training for service providers.[66]

In 2011, a report entitled *Honouring Our Strengths: A Renewed Framework to Address Substance Use Issues Among First Nations People in Canada* was released. This framework for action was developed by a comprehensive community-based review of substance use-related issues and services driven by the Assembly of First Nations, the National Native Alcohol and Drug Abuse Program (NNADAP), and Health Canada's First Nations and Inuit Health Branch (FNIHB). This framework clearly articulates culturally based values and principles that should drive a renewal of substance use services for First Nations People on reserves. This strategy

offers a comprehensive vision for the design, delivery and evaluation of services required to meet the needs of First Nations people. This strategy shows promise, but there is no guarantee that the work put into its development will translate into concrete, lasting federal support for effective programs despite recent budget increases to the National Native Alcohol and Drug Program.

Another promising sign is a recent strategic plan to address BC First Nations and Aboriginal People's Mental Wellness and Substance Use. This plan clearly recognizes the need to acknowledge the colonial history of Canada and the impact of that history on First Nations, Métis and Inuit people especially when it comes to understanding the context of substance use. The plan also offers the following analysis of the role that cultural safety can play in fostering change:

"First Nations and Aboriginal people need a range of culturally safe services and supports that respect their customs, values, and beliefs. Cultural safety in health care is about empowering individuals, families, and communities to take charge of their own health and well-being. It is important to note that achieving cultural safety requires that health institutions and service providers respect the diversity between and amongst First Nations and Aboriginal people and their worldviews. Currently there is an abundance of evidence to show that First Nations and Aboriginal people do not receive the same quality of health services or report health outcomes on par with other Canadians."[67]

This strategic plan recognizes that healing and reconciliation between Indigenous and non-Indigenous Canadians is necessary to further the wellness of all.[68] But like the NNADAP plan noted above, the promise of these words can only be fulfilled by meaningful follow through on the part of governments.

RACISM IN HEALTH CARE: WHAT'S IT GOING TO TAKE FOR CANADA TO CHANGE?

As the discussion above indicated, legal and social policies that discriminate against First Nations, Métis and Inuit people in Canada can permeate health care settings. Racism can impact health in several ways. Racist treatment and policies are not only added stressors, but lead to mistreatment in education, employment and health care settings. Discriminatory policies, attitudes and practices result in discrimination against Aboriginal people, misinformation about Aboriginal people and about Canadian history, as well as a lack of trust between Aboriginal people and non-Aboriginal Canadians. A recent report by the Health Council of Canada on the experience of health care for urban Aboriginal Canadians, found that many Aboriginal respondents reported that they had been treated with contempt and judgment, and their health concerns were downplayed or ignored due to racist stereotypes. This was especially true when it came to stereotypes about substance use. Racist attitudes not only support practices and policies that result in discrimination against Aboriginal people, but also create a lack of trust between Aboriginal and non-Aboriginal Canadians. When accessing health care, people are often at their most vulnerable. Racist treatment can drive people away from services and thus exacerbate the harms of problematic substance use.[69]

The report makes recommendations directed at all levels of the health care system including enhancing the cultural competency of workers and organizations, and creating opportunities for partnerships and collaborations that will enhance cultural safety for First Nations, Inuit and Métis people.[70]

These attitudes and discriminatory practices have been well documented by researchers, Aboriginal organizations and others in Canada over the years.[71] What will it take for all Canadians to listen and change?

CASE STUDY

Organizing for Change: People Who Use Drugs

People who use drugs have been organizing in cities and regions in Canada for a number of years. Groups are active in Vancouver (VANDU), Victoria (SOLID), and Toronto (TODUU), Ottawa (DUAL) and in Quebec (ADDICQ). Two groups—the BC/Yukon Association of Drug War Survivors and AAWEAR in Alberta—operate at the regional level. The Canadian Association of People Who Use Drugs operates at a national level. Though most organizations of people who use drugs remain small and have minimal funding and budgets, they have had key impacts on drug policy. The Vancouver Area Network of Drug Users, for example, emerged in 1998 to play a key role in mobilizing community support for change in response to over 1,000 overdose deaths and high rates of HIV infection among people who injected drugs. People who use drugs have been employed as researchers and have also driven many innovations in harm reduction such as supervised injection facilities. The involvement of people who use drugs in planning and program implementation improves the quality and accessibility of services by ensuring these services are conceptualized, designed and delivered with attentiveness to the distinctive needs of the clients they serve. These groups also play an important role in fostering a liberation perspective by creating a cultural and social space for people who use drugs, challenging drug prohibition and the pernicious forms of discrimination against people who use drugs, advocating for improved living conditions, and by building fruitful relationships with local authorities including health, education, government, law enforcement, and media.

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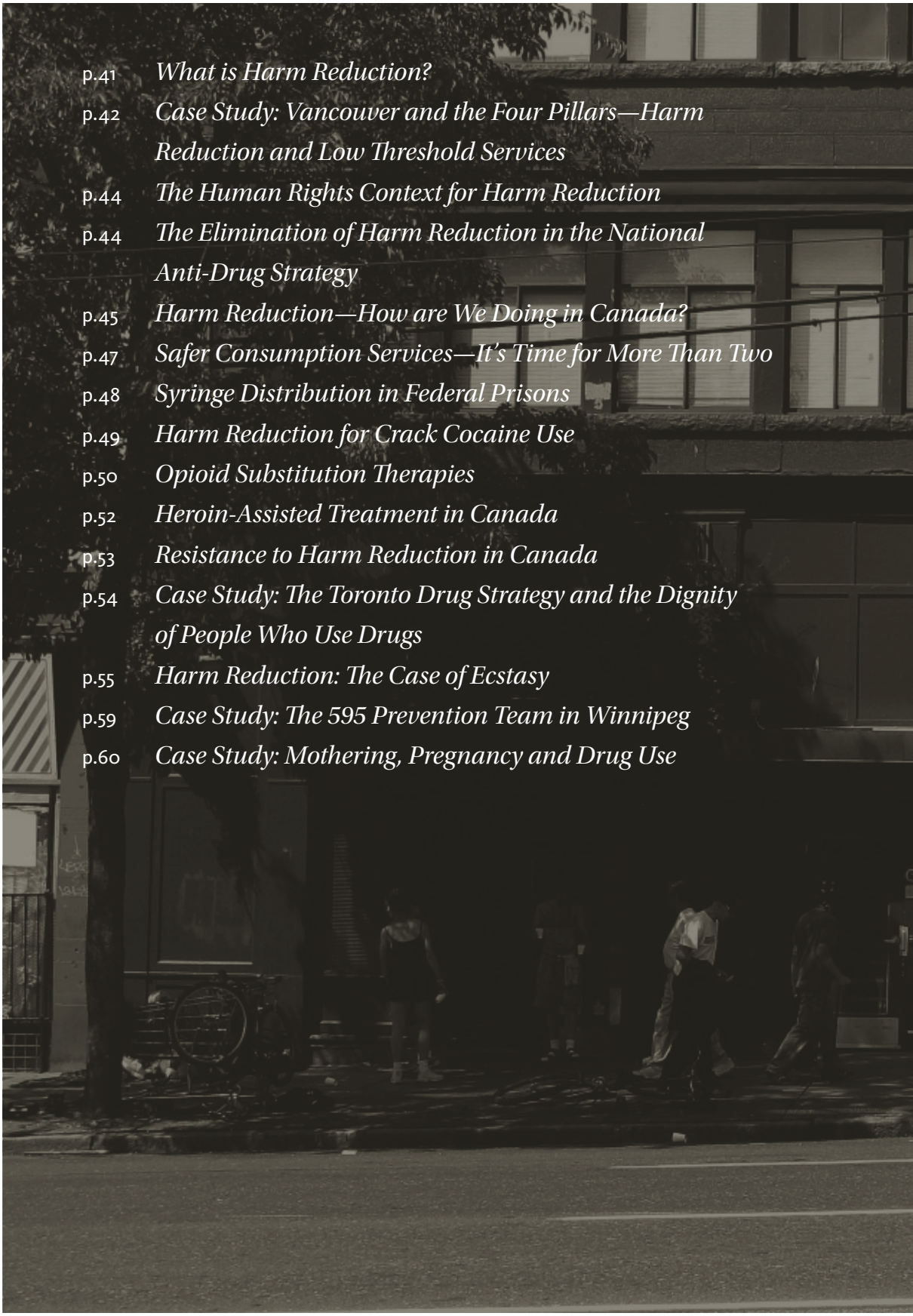
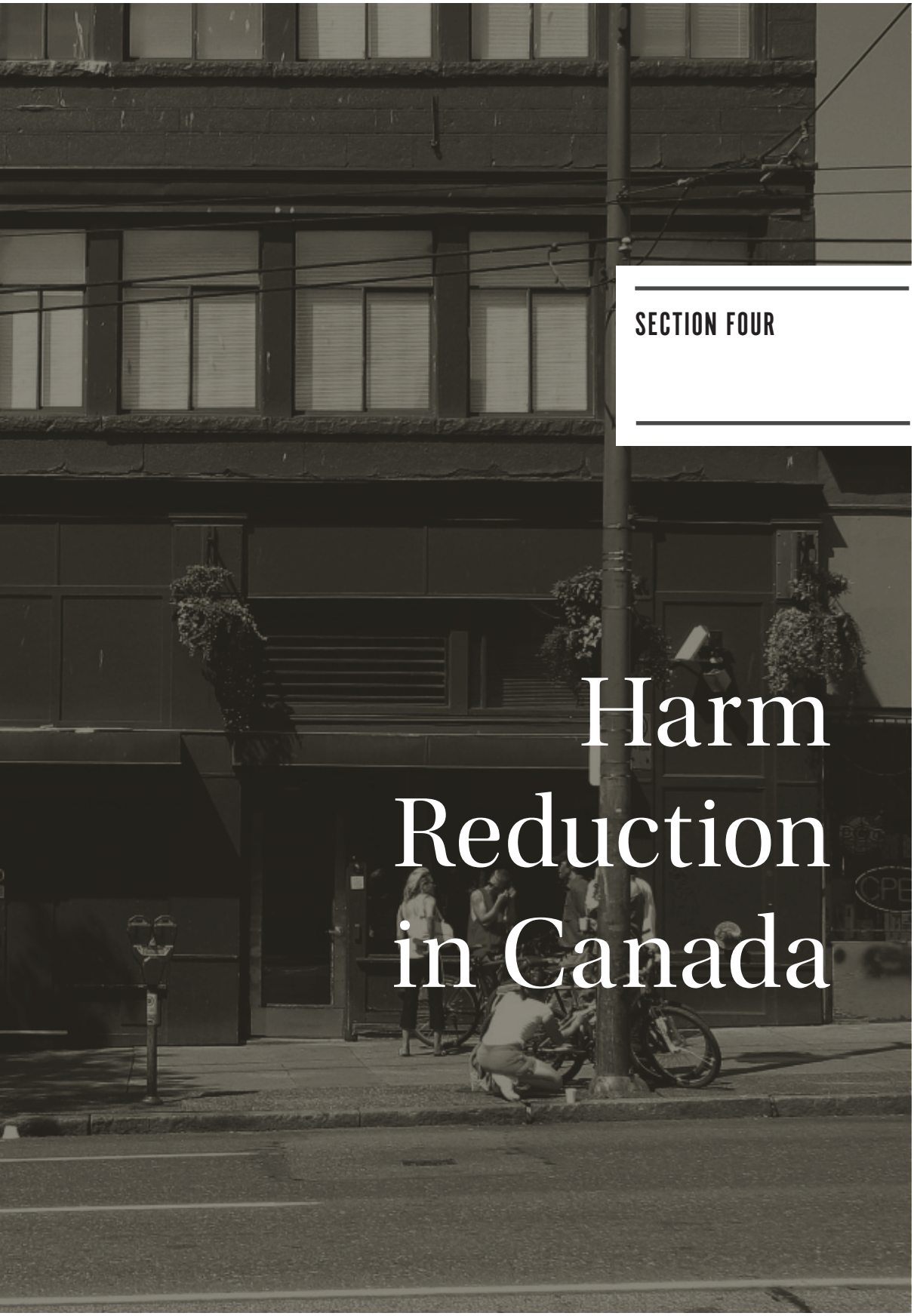




SECTION FOUR

Harm Reduction in Canada

Harm reduction is a key pillar of any strategy to address the harms of problematic substance use. The CDPC sees the reduction of harm to individuals, families and communities as the fundamental goal of drug policy and the standard against which all drug policies should be evaluated. Harm reduction is a proven approach that offers many benefits and the scale-up of harm reduction services is urgently needed in Canada. This section examines the key barriers that prevent the scale-up of harm reduction services across the country.

WHAT IS HARM REDUCTION?

"'Harm Reduction' refers to policies, programmes and practices that aim primarily to reduce the adverse health, social and economic consequences of the use of legal and illegal psychoactive drugs without necessarily reducing drug consumption. Harm reduction benefits people who use drugs, their families and the community."[72]

The evidence supporting harm reduction strategies is significant.[73] Harm reduction programs vary from place to place but may include some or all of the following services: education about safer drug use and safer sex, distribution of new supplies for injection and inhalation, condoms, safer consumption services and/or facilities, programs to prevent and treat overdose and methadone and other opioid substitution therapies.

Harm reduction involves a pragmatic, non-judgmental approach to the provision of health services that respects the dignity of people who use drugs and values their human rights. Harm reduction provides skills in self-care (and care for others), lowers personal risk, encourages access to treatment, supports reintegration, limits the spread

of disease, improves environments and reduces public expenses. It also saves lives. People who use drugs were responsible for initiating some of the first harm reduction programs in the 1970s. These were guerilla groups organized to address the transmission of Hepatitis C. With the arrival of HIV/AIDS, harm reduction programs began to appear in front-line services. These programs were underscored by a strong philosophical belief that people who use drugs are key participants and allies in their own individual and collective health. As a result, harm reduction programs are often very committed to including people who use drugs in the planning and implementation of services.[74]

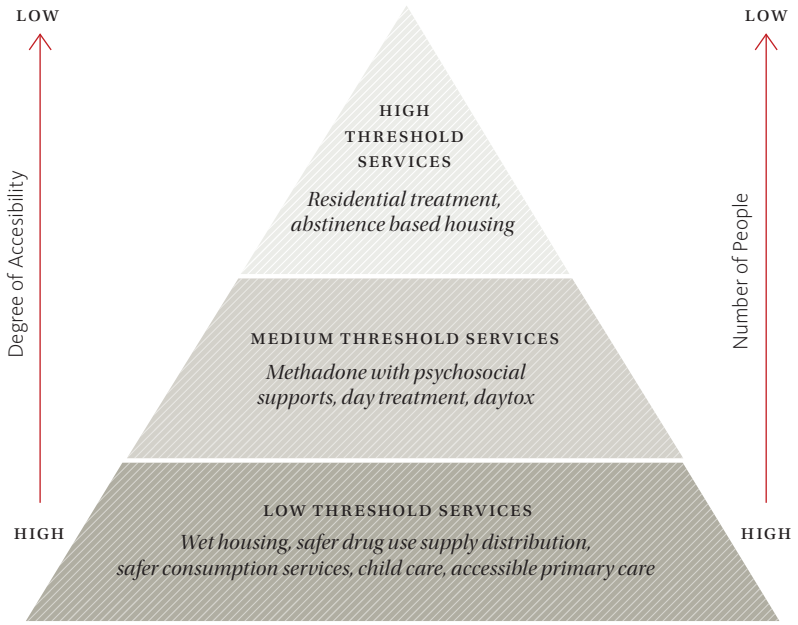
Harm reduction is both an approach to service delivery and a philosophy of care. Both abstinence-based and harm reduction approaches are part of an integrated continuum of care. But where abstinence-based approaches generally require people to completely stop using all non-prescribed drugs and methadone to access drug treatment and to be in a "state of readiness", harm reduction services do not require people to stop using drugs, but meet people "where they are" in terms of their drug use. Exemplary harm reduction services have minimal requirements for involvement and are points of entry to other health and social services. Ideally harm reduction services are culturally appropriate and implemented in a variety of contexts that maximizes people's positive contact with these services.[75] Harm reduction is not the only approach to substance use, but it is a major means of preventing the transmission of disease and overdose, connecting people to services, opening a pathway to change and preserving the dignity of all Canadians. Harm reduction services have key secondary benefits such as increased access to health services, housing referrals, drug treatment, counselling, education, and testing for HIV and HCV.[76]

CASE STUDY

Vancouver and the Four Pillars: Harm Reduction and Low Threshold Services

In the 1990's the availability of high-grade heroin and cheap cocaine combined with poverty and marginalization in Vancouver's Downtown Eastside precipitated a public health disaster marked by escalating rates of HIV infection and overdose deaths. A report by Coroner Vince Cain in 1994 responded to this emergency by calling for an overhaul of drug treatment and a reorientation that would see drug use as a health not a criminal matter. Though Cain's report did not immediately galvanize leaders it signalled the beginning of a growing movement of people who wanted to change the way things were done in Vancouver. These changes were driven by a combination of efforts: a grassroots social movement comprised of people who use drugs, the initiation of a formal declaration of a public health emergency by the local health authority and the growing awareness that change was needed by leaders including then-Mayor Philip Owen.[77] In 2000 to complement the efforts of other partners, the City of Vancouver released a drug strategy: "A Framework for Action: A Four Pillar Approach to Drug Problems in Vancouver." The strategy called for a comprehensive

FIGURE 2: TRIANGLE OF SERVICES & SUPPORTS



approach to address the dire circumstances in Vancouver and challenged the status quo by calling for new and innovative interventions such as supervised injection sites and heroin-assisted treatment programs. The strategy included health and enforcement and had as its two main goals, public health and public order.[78]

The Four Pillars approach drew on a model developed by the Swiss in the 1980's to address the problems Swiss communities were experiencing with open drug scenes, homelessness, high rates of drug overdose deaths and HIV infection among drug users. Up until that time, services for street-involved people, many of whom were homeless, relied primarily on a system of high threshold treatment services. These high threshold services often required individuals to stop using substances before entry into treatment services, or created administrative barriers for people seeking substitution treatment such as methadone and other health or medical services. Consequently few people at the street level were able to access these services. The results of the traditional approach left thousands of individuals out in the cold, effectively without services of any kind, as few were able to navigate the "system of care." The problems the Swiss were having in the 1980s mirrored the experience of Vancouver in the 1990s and beyond.

One of the key innovations borrowed from the Swiss experience and only partially implemented through the Four Pillars Approach was to put a

strong emphasis on outreach and harm reduction initiatives to engage people using drugs and bring them into low threshold services—services that were specially created and immediately accessible to people. These services provided an exit from the street and an entry into health, social services, supportive housing and employment services. These innovations were complemented by innovations in substitution treatment and the hoped for introduction of heroin-assisted treatment (HAT) for long-term heroin users, through a clinical trial. These services were meant to operate as entry points into a larger system of care and provide people with options beyond what existed at the time. Figure 2 shows how low threshold services can help people access other services in the system.

A combination of efforts by the people who use drugs, the health authority, the city and the Vancouver Police Department put in place an expanded treatment system, more harm reduction services including needle exchange/distribution program, and a supervised injection site.

THE HUMAN RIGHTS CONTEXT FOR HARM REDUCTION

Harm reduction services are supported by international human rights conventions. According to these conventions, all people have the right to life-saving health services. The right to health and health services is protected in numerous international human rights documents. The International Covenant on Economic, Social and Cultural Rights (ICESCR), which binds Canada, recognizes in Article 12, that states must take all necessary steps for "the prevention, treatment, and control of epidemic… diseases." The right to health "requires the establishment of prevention and education programs for behaviour-related health concerns such as sexually transmitted diseases, including HIV/AIDS. These provisions of the ICESCR support harm reduction as a legitimate and necessary health service.[79]

THE ELIMINATION OF HARM REDUCTION IN THE NATIONAL ANTI-DRUG STRATEGY

Despite the positive effects of these programs, in 2007, the federal government eliminated harm reduction from the National Anti-Drug Strategy, and since that time, it has been either indifferent or hostile to harm reduction services. Many Canadians are concerned about this hostility to a well-established health practice supported by global organizations such as the United Nations Office on Drugs and Crime, UNAIDS, and the World Health Organization.[80] The lack of federal government support for harm reduction has undermined efforts to establish new harm reduction services and to more fully integrate and expand currently existing programs into the health care system. In fact, the CCSA recently released a strategy to address "prescription drug misuse" in Canada. This document avoids the use of the term "harm reduction" altogether though it nods in several places to the need to address the harms of prescribed drug use by drawing on an evidence-based public health approach. The strategy recommends, for example, that Health Canada and the Public Health Agency of Canada "develop and promote risk reduction programs for individuals who use prescription drugs,"[81] though no specifics about the nature of these "risk re-

duction" programs are provided. Unfortunately the open hostility of the federal government to harm reduction has made it increasingly difficult for both federal agencies and groups funded by the federal government to openly discuss the merits of this important health care service.[82]

HARM REDUCTION: HOW ARE WE DOING IN CANADA?

In Canada, the provinces are responsible for the provision of health care services. But provincial commitments to harm reduction are mixed and in some cases absent. Some provinces include harm reduction in their overall mental health and substance use strategies and some do not. Some provinces include harm reduction only in HIV strategies such as Saskatchewan and Manitoba.[83] British Columbia and Quebec include strong commitments to harm reduction in their strategic documents. On the other hand, Ontario and Nova Scotia's recently released strategies on mental health and substance use do not mention harm reduction, though it is part of Ontario's public health standards and receives a brief mention in Nova Scotia public health standards. Harm reduction is also a key component of the 2012 Ontario document entitled *The Way Forward: Stewardship for Prescription Narcotics in Ontario,* prepared as an advisory report for the Minister of Health. Alberta's recent strategy on mental health and addictions notes that harm reduction will be offered to people with "complex needs."[84]

Though most provinces and territories provide some form of support for harm reduction, the range of harm reduction services varies considerably across the country. Harm reduction services are also plagued by a number of issues:

▪ *Services are Siloed:* In 2013, the "siloing" of harm reduction in HIV policy and program areas continues. Provincial and health authority funding arrangements for harm reduction services usually flow from programs to prevent the transmission of blood-borne pathogens such as HIV and HCV and are not integrated with other substance-related program areas (i.e. drug treatment). These funding arrangements partly originate in the historical development of harm reduction services in Canada. Due to the slowness of government response to the HIV epidemic in the 1980s, peer-based and other community groups created harm reduction services to respond to this crisis. But due to a lack of leadership on the part of governments, services for the prevention of blood-borne pathogens remained isolated from other drug-related services. This separation occurs at multiple levels and sites including in policy, funding, information flow, approaches to admission to services, and varying philosophical approaches to treatment and recovery. These programmatic arrangements have been partly responsible for a failure to fully integrate harm reduction services into the overall system of health care. They also perpetuate the notion that harm reduction is somehow the opposite of abstinence-based services rather than both being seen as part of a continuum of care.

The result is that many jurisdictions still treat harm reduction as simply "supply distribution" for the prevention of HIV and other blood-borne pathogens. As the numerous harm reduction services across the country have demonstrated, it is much more than this; because of its philo-

sophical underpinnings in non-judgmental client-centred care, it is also an exemplary practice of health engagement that could potentially be a model for other health issues.

▪ *Meeting a Wide Range of Important Needs:* Because harm reduction services draw on non-judgmental and accessible approaches to care, clients routinely request assistance with other issues like housing and income support. But because harm reduction is still seen as "supply distribution" many harm reduction services remain grossly underfunded to meet the full range of client needs, such as stable housing, employment, access to income support programs, prenatal and antenatal care, and childcare. Provincial and/or health authority funding mechanisms for harm reduction services do not always recognize the broader services provided by harm reduction; nor do provincial policy and funding mechanisms recognize the broader needs of clients. In fact social assistance rates are not adequate for people to find and keep stable housing and meet basic needs such as nutritious foods. The lack of adequate social supports undermines the ability of some Canadian's to live healthy and safe lives.[85]

▪ *Good Relationships Can Change:* Successful and effective harm reduction service providers are often dependent upon good relationships with provincial government and/or health authority counterparts for the continued funding of their services. This is a concern because relationships can change as people change employment, or as political and policy priorities change.

▪ *More Rural and Remote Services are needed:* In many places in Canada there is no comprehensive plan to recognize the harm reduction needs of people living in rural areas. In many rural contexts, harm reduction supplies are either not available or are available only through secondary or "natural helper" distribution.[86] These forms of distribution are often reliant on unpaid helpers and are vulnerable because of a lack of formal mechanisms to provide these services. The scale up of services in rural and remote areas is also hindered by discrimination against people who use drugs.

▪ *Policy Does Not Guarantee Implementation:* Even when provinces have clearly articulated provincial level policy frameworks that support harm reduction, this does not guarantee that all municipalities or health authorities will support harm reduction services appropriate to their needs. The city of Abbotsford, BC, is one such example; in 2005 this municipality used its municipal bylaws to "zone-out" harm reduction. Another case in point is the City of Victoria, BC, which has had no stand-alone fixed needle distribution site since 2008 when public controversy forced its closure despite the inclusion of both fixed and mobile services in BC's best practices document on harm reduction.[87]

▪ *Centralized Supply Purchasing Creates Efficiencies:* Only three provinces have centralized the purchasing and distribution of harm reduction supplies including BC, Ontario and most recently Alberta. Centralized mechanisms for supply distribution (such as syringes and alcohol swabs) are cost-effective ways of purchasing and distributing supplies. Centralized services can collect data on the amount and type of supplies distributed and can assess shifts in supply requirements that

may signal emerging drug use issues. In the absence of these centralized mechanisms, harm reduction providers must make arrangements with local health authorities or others to access cost-effective supplies and staff time must be allocated to purchasing supplies.[88]

- *Women, Pregnancy, and Harm Reduction:* Despite improvements, Canada lacks a comprehensive system of harm reduction supports for pregnant women who use drugs. A harm reduction approach to pregnancy and drug use focuses on providing basic needs such as prenatal and antenatal care, housing and nutrition and takes a pragmatic approach to drug use. This approach recognizes that discrimination against pregnant and mothering women who use drugs drives them away from prenatal and antenatal care. Most harm reduction programs are not funded to provide these services and in some jurisdictions, services simply do not exist for pregnant and mothering women who use drugs. (See case study below for examples of existing programs.)

- *Harm Reduction is Still Profoundly Misunderstood by Some:* Media reports and some key politicians still claim that harm reduction services operate in opposition to abstinence-based and other drug treatment programs. In fact media reports are not sufficiently critical of the suggestion that funding for harm reduction services detracts from drug treatment programs.[89] These claims pit harm reduction programs against the rest of the system of supports for drug use. It cannot be emphasized enough that harm reduction services are part of a larger continuum of care that includes other low threshold services and treatment and aftercare.

SAFER CONSUMPTION SERVICES: IT'S TIME FOR MORE THAN TWO

Since 2003, the city of Vancouver has been the location of a rigorously evaluated and highly successful stand-alone supervised injection site (SIS). The vast amount of evidence from the reviews conducted of Vancouver's supervised injection site—Insite—suggest that this unique service has several beneficial outcomes: it is used by the people it was intended to serve, which includes over 10,000 clients. And it's being used by people who might ordinary inject drugs in public. This service has also reduced risk behaviours by reducing the sharing of needles and providing education on safer injecting practices. Insite has promoted entry into treatment for drug dependency and has improved public order. It has also been found to reduce overdose deaths, provide safety for women who inject drugs, and does not lead to increased drug use or increased crime. [90]

Vancouver is also the site of the Dr. Peter Centre, a combined day and residential program for people living with HIV/AIDS. The Dr. Peter Centre is a multiservice site offering low-threshold access to care, including counseling, illness prevention, advocacy and referral services. Recognizing the needs of its many clients who use drugs, the Centre added to its harm reduction programs by integrating supervised injection services into its health services beginning in 2001. The Centre has been instrumental in establishing supervised injection as a legitimate aspect of nursing practice because of its intent to provide care, prevent the transmission of illness and prevent death and injury from overdose.[91]

Given the relationship in Canada between injection drug use and HIV and HCV infections, scale-up of these services is urgently needed. But opposition from the federal government has stalled the implementation of these beneficial services. In 2007, the federal government refused to grant a continuation of the legal exemption to Insite (Section 56 of the *Controlled Drugs and Substances Act*). Proponents of the site including the PHS Community Services Society, VANDU, and Vancouver Coastal Health challenged this refusal all the way to Canada's Supreme Court. In 2011, that Court ruled in favour of the exemption and ordered the federal Minister of Health to grant a continuation of the exemption.

In the light of this court decision, other Canadian cities are considering the establishment of similar services. To shield clients and staff from criminal prosecution, each new site will be required to submit an application for an exemption to the *Controlled Drugs and Substances Act* to the Federal Minister of Health. These applications are time-consuming to prepare and there is no guarantee that the federal government will look favourably on these applications. To-date Health Canada has not issued clear criteria for how it will assess these applications. Provincial governments have also been tight-lipped about whether or not they support establishing these important health services in their jurisdictions.

Notable exceptions are the BC Ministry of Health and the Quebec Ministry of Health. The BC Ministry has signalled its support of these services by revising and reissuing its "Guidance Document for Supervised Injection Services" while the Quebec Ministry of Health has recently drafted a similar document. Written for health care professionals, these documents provide advice to health authorities and other organizations that plan to submit an application for supervised injection services in their local areas.[92]

SYRINGE DISTRIBUTION IN FEDERAL PRISONS

People do not surrender their human rights when they enter prison. Instead, they are dependent on the criminal justice system to uphold their human rights—including their right to health. Prison health is public health.

These statements may seem self-evident to some, but the right to adequate health care services is the basis of a legal case brought against the Canadian federal government. Prison syringe exchange programs are a crucial component of a comprehensive strategy to prevent the spread of infectious diseases but the federal correctional service does not permit this life-saving health service in Canada's federal prisons. To challenge this policy, the Canadian HIV/AIDS Legal Network, Prisoners with HIV/AIDS Support Action Network (PASAN), CATIE, the Canadian Aboriginal AIDS Network (CAAN) and Steven Simons, a former federal prisoner, launched a lawsuit in September 2012, against the Government of Canada over its failure to protect the health of people in prison through its ongoing refusal to implement new clean needle and syringe programs. In fact, this case challenges Canada's federal correctional system to ensure that incarcerated persons are provided with equivalent access to health care as other Canadians.[93]

Drug use in prisons is a reality. A 2007 survey by the Correctional Service of Canada (CSC) revealed that 16% of men and 14% of women had injected drugs while in prison.[94] Some prisoners are not ready to partake in treatment, treatment may be unavailable or treatment may not be appropriate. Despite the fact that drug use and possession is illegal in prison and despite efforts to prevent drugs from entering the prisons, drugs remain widely available. In fact, no prison system in the world has been able to keep drugs completely out. Sharing syringes is an efficient way of sharing blood-born illnesses. In a 2007 nationwide survey by the Correctional Service of Canada, the rates of HIV and HCV among federally imprisoned women were 5.5 and 30.3 percent, compared to 4.5 and 30.8 percent among federally incarcerated men. Aboriginal women reported the highest rates of HIV and HCV, at 11.7 and 49.1 percent, respectively.[95] This means that people in prison have rates of HIV and Hepatitis C (HCV) that are at least 10 and 30 times higher than the population as a whole, and much of this infection is occurring because prisoners do not have access to sterile injection equipment.[96]

This legal case challenges the belief that people revoke their rights when they enter a prison and are thus not entitled to equitable access to health care. In fact, prisoners retain all the human rights that people in the community have, except those that are necessarily restricted by incarceration. This includes the right to the highest attainable standard of health, a right enshrined in several UN Treaties and Conventions. This right encompasses measures such as syringe exchange that have been shown repeatedly to prevent the transmission of diseases.[97] These services are available in many parts of the world and evaluations have found that they reduce needle sharing, do not lead to increased drug use or injecting, help reduce drug overdoses, facilitate referrals of users to drug treatment programmes, and have not resulted in needles or syringes being used as weapons against staff. When these services were introduced in Swiss prisons, staff were initially relunctant, but because syringe exchange reduced the likelihood of a needle stick they realized that distribution of sterile injection equipment was in their own interest, and felt safer than before the distribution started.[98]

The vast majority of prisoners eventually return to the community, so illnesses that are acquired in prison do not necessarily stay in prison. This means that when we protect the health of prisoners we protect the health of everyone in our communities.

HARM REDUCTION FOR CRACK COCAINE USE

Crack cocaine use remains prevalent in Canada. The BC Centre for Disease Control, for example, reports that the prevalence of local crack cocaine smoking has been rising amongst injection drug users. Crack smoking is independently associated with HIV and HCV status and linked to outbreaks of tuberculosis and streptococcus pneumonia. Harm reduction for crack use remains a neglected issue even in comparison to other underfunded harm reduction services.[99]

Given the prevalence of harms associated with crack cocaine use and the lack of a widely deliverable treatment option, there is an urgent need for health-oriented interventions such as harm reduction programs that deliver safer smoking sup-

GIVEN THE PREVALENCE OF HARMS ASSOCIATED WITH CRACK COCAINE USE AND THE LACK OF A WIDELY DELIVERABLE TREATMENT OPTION, THERE IS AN URGENT NEED FOR HEALTH-ORIENTED INTERVENTIONS SUCH AS HARM REDUCTION PROGRAMS THAT DELIVER SAFER CRACK USE PROGRAMS THAT INCLUDE SAFER SMOKING SUPPLIES.

plies. A recent study on the distribution of safer crack use kits in Winnipeg shows that this harm reduction service is cost effective over both the short and long run. Average costs of kits were 59 cents while the costs of treating one patient with HCV over one year were $10,000 ($100,000 over a lifetime). As this report notes, preventing "only one case of HCV or HIV infection annually with the use of safer crack use kits can translate into a very cost effective harm reduction program."[100] Safer crack use supplies have also been found to help reduce unsafe smoking practices that can lead to HIV/HCV infection including pipe sharing and use of broken supplies, and to engage marginalized individuals in health care services.[101]

More importantly, people who use crack are on the blunt end of discriminatory practices and are often extremely marginalized. The distribution of safer crack use kits offer an important means of engaging a marginalized population to provide education and refer people to health, treatment and other services.[102] A recent review of the safer crack use kit distribution in Winnipeg found that relationships of trust were developed between people who smoke crack and service providers through outreach and supply distribution.[103]

The availability of safer crack use supplies varies greatly across the country. A recent study suggests that a substantial proportion of people who smoke crack have difficulty accessing crack pipes in a setting where pipes are available at no cost, but are limited in quantity.[104] Some programs in Newfoundland, New Brunswick, Ontario, Quebec, Manitoba, Alberta, and British Columbia provide safer crack supplies on a routine basis. BC's Harm Reduction Supply Program makes three sizes of mouthpieces and push sticks available but pipes are not available. Vancouver Coastal Health has recently begun a pilot project to distribute safer crack use kits including glass pipes in Vancouver.[105] Other programs throughout the country offer safer crack supplies as their budgets permit, though often the distribution of these supplies is done quietly because of public opposition. In fact, opposition to the distribution of safer crack supplies has resulted in the closure of programs in Ottawa and Calgary, and Nanaimo though the project in Ottawa was reinstated.[106]

OPIOID SUBSTITUTION THERAPIES

Pharmacotherapy for opioid dependence includes substitution medications like methadone and buprenorphine. In Canada, most provinces support opioid substitution therapy including methadone maintenance

therapy (MMT) programs. Best practices for these programs typically suggest that a multidisciplinary approach is needed that includes physician prescribing, pharmacy dispensing, and provision of psychosocial supports (e.g. counselling, housing, etc.), though the psychosocial support services are often in short supply. MMT requires pharmacist observed daily dosing until a patient is stabilized, after which time, take home doses may be granted. In Canada, the organization and implementation of opioid substitution therapies is plagued by several key problems.[107]

Services can vary considerably from province to province; some offer more comprehensive services including low threshold, intensive and primary care services and some do not. Low threshold services remove barriers that can limit or delay access to MMT and usually have an open referral processes meaning people can be referred from many places in the system. Conversely, high threshold services, offer psychosocial supports and can be thus be more limited by the availability of resources.[108] As of 2012 there were approximately 65,000 people on opioid substitution therapy in Canada.[109]

Some family physicians offer MMT, and it is also available through private clinics, and in prisons. Even within the same jurisdiction, services can vary considerably between urban and rural areas. In rural areas, lack of transportation to services, few pharmacies that dispense methadone, and shorter pharmacy hours may affect the success of MMT treatment. Unlike most other health care services, in most jurisdictions, MMT is offered through a mix of public and private settings, meaning that some people must pay for this essential health service. In many cases, private providers are not integrated with other important services and supports in the health care system and beyond. But in some areas, private providers are the only source of services.

Methadone can only be made available by a prescriber who has an exemption to the *Controlled Drug and Substance Act*. To receive this exemption prescribers must obtain specialized physician training usually offered by provincial Colleges of Physicians and Surgeons or in Ontario by the Centre for Addiction and Mental Health. Not all provinces and territories provide this training thus decreasing the number of available prescribers. This exacerbates the problem of already long wait lists for services in some regions. At the same time, opportunities to access opioid substitution therapy in settings like emergency rooms and primary care can be limited by a lack of accredited prescribers.

MMT programs are plagued by a lack of public accountability for the implementation of psychosocial supports, the role of physicians and pharmacists in the system, and oversight of physician services and billing and pharmacy dispensing fees.

Retention rates in treatment can vary considerably both within and between jurisdictions. Retention rates are affected by how services are organized and by issues like discrimination. Clients report that the attitudes of some health professionals can be shaming, and that practices like mandatory and observed urine screening effectively treat individuals as criminals rather than people in need of health care.[110] Likewise, in some cities

and towns, proposals for methadone services have been met with community hostility due to discrimination against people who use drugs. This can even take the form of discrimination against prescribers of methadone.

Most jurisdictions do not cover the costs of buprenorphine except for patients who cannot tolerate methadone. Buprenorphine may be an appropriate approach for some people because the risk of overdose is less than methadone and it does not always require daily dosing. But recent reanalysis of research comparing these medications indicates further research is needed to determine the comparable safety risks between methadone and buprenorphine.[111]

Clearly there is an urgent need to streamline the opioid substitution system and address the concerns expressed by patients and service providers.

HEROIN-ASSISTED TREATMENT IN CANADA

Heroin-assisted therapy as a treatment modality for drug dependence can be very challenging for some people who advocate only for abstinence-based services. But several research trials, along with the continued existence of programs that provide pharmaceutical-grade heroin, have demonstrated clear benefits.

Recognizing that methadone maintenance therapies (MMT) and abstinence–based treatments programs do not work for some people, Switzerland implemented heroin-assisted therapy (HAT) in several cities in the 1990s. The UK has long had heroin prescription as part of their treatment services, and the success of the Swiss program led other countries to adopt similar models, including Germany, the Netherlands, Spain, Belgium, and Denmark. There is now a large evidence base on the safety and effectiveness of HAT.[112] In 1998, the first North American Opiate Medication Initiative (NAOMI) Working Group was formed to conduct a HAT trial in the US and Canada. NAOMI eventually opened its doors in the Downtown Eastside Vancouver, BC and Montreal, Quebec.

The target population for NAOMI included individuals over the age of 25 who were "chronic, opioid dependent, daily IDUs" and who had previously been unsuccessful with methadone maintenance and other treatment modalities. Researchers randomized participants in the NAOMI study to one of two groups: one received injections of diacetylmorphine (heroin) or hydromorphone (Dilaudid a licensed medication), and the other received oral methadone. The NAOMI study provided heroin/hydromorphone for 12 months, followed by a 3-month transition period.

People in the heroin arm of the NAOMI study experienced marked health and other improvements, including decreased use of illicit "street" heroin, decreased criminal activity, decreased money spent on drugs, and improved physical and psychological health.[113] Yet, NAOMI patients were not kept on HAT following the study's termination. Canada is the only country that did not continue to provide HAT to its patients following its clinical trial, rather, they were returned to methadone or other conventional treatments—treatments that had not worked for them in the past.

In December 2011, another

clinical trial, the SALOME study (Study to Assess Longer-term Opioid Medication Effectiveness) opened its doors in the downtown Eastside of Vancouver, BC. The study compares the effectiveness of six months of injectable diacetylmorphine (heroin) with six months of injectable hydromorphone (Dilaudid) and the effects of switching from injectable to oral heroin or Dilaudid. Participants will be in the study for one year, followed by a 1-month transition period where they will be encouraged to, once again, take part in conventional treatments such as methadone maintenance, drug-free treatments, and detox programs (treatments that have proven to be ineffective for these participants). Like the NAOMI study, the repeated failure of other treatment efforts for participants is in fact, part of the criteria for selection of participants in SALOME.

In response to Vancouver HAT clinical trials failing to incorporate plans for permanent programs, in January 2011, Dave Murray, a participant in the NAOMI trial organized a group of participants from the heroin stream of the NAOMI clinical trial. The independent group, NAOMI Patients Association (NPA), currently holds its meetings every Saturday at offices of the Vancouver Area Network of Drug Users (VANDU). In 2012, many SALOME participants joined the NPA. The NPA has been at the forefront of advocating for permanent HAT programs to be set up in Canada.[114] From the perspective of people who had been enrolled in the NAOMI research trial, ending the trial without the implementation of a permanent program was responsible for significant declines in health and social status of some participants. NPA recognized that were this any other health issue, people would not be denied access to an effective treatment and that by not putting in place an adequate exit strategy, the study is putting marginalized and vulnerable people at further risk. The NPA continues to raise these concerns with the authorities responsible for this research.

The evidence base for HAT is well established and it is time for research trials to stop and for permanent HAT programs to be set up in Canada.

RESISTANCE TO HARM REDUCTION PROGRAMS IN CANADA

Harm reduction programs in Canada are sometimes on the receiving end of public backlash. Resistance by community groups, municipalities and even Medical Health Officers can lead to delays or denial of harm reduction services. Municipalities have become another site for public conflicts over the provision of harm reduction and methadone services. Since 2005, some municipalities in British Columbia have become involved in regulating illegal substances through the use of bylaws and residential inspection programs. These activities have focused mainly on using municipal bylaws to control the cultivation of cannabis and the production of methamphetamines. But bylaws and zoning provisions have also been used to restrict the availability of harm reduction services. In 2012, Mission, BC, passed a bylaw that prevents the establishment of pharmacies in its downtown area effectively preventing methadone dispensing in their Core Commercial Downtown Zones.[115] In 2005, Abbotsford, BC passed an amendment to its zoning bylaws that restrict harm reduction services (needle exchanges, mobile dispensing vans, supervised injection sites) in its municipality.

In Coquitlam, BC a 1996 bylaw restricts the location of methadone clinics and another Bylaw designates methadone clinics as "undesirable businesses." [116]

In Ontario, resistance to harm reduction services and opioid maintenance programs has occurred in several communities in recent years, sometimes spearheaded by local politicians. Several municipalities, for example, including Windsor, Pembroke, London and Oshawa, have also passed bylaws or land-use requirements that restrict methadone clinics. [117]

In a 2012 review of the safer inhalation program in Ottawa, the author, Dr. Lynne Leonard, noted what she called the "demonstrated capacity of individual Medical Officers of Health to prevent the full implementation of the program in their region". Reportedly one third of public health units in Ontario do not distribute harm reduction supplies despite the inclusion of this requirement in the province's Public Health Standards. As this author notes, this non-distribution of harm reduction supplies has significant impacts on the sharing of drug use equipment.[118]

This resistance is fed by lack of understanding—or the resistance to understanding—the effectiveness of these services and by discriminatory attitudes and behaviours against people who use drugs. Media coverage

CASE STUDY

The Toronto Drug Strategy and the Dignity of People who Use Drugs

In 2005, the City of Toronto developed a drug strategy encompassing prevention, harm reduction, treatment and enforcement. The Toronto Drug Strategy (TDS) is a multifaceted effort to address the harms of substance use drawing on health and other policy approaches. Like other municipal drug strategies in Vancouver, Thunder Bay and the Waterloo Region, the TDS does not shy away from the importance of harm reduction services as part of a full continuum of care for people who use drugs. The TDS also centres the rights and dignity of people who use drugs in its vision statement and principles and draws attention to the role that discrimination plays in undermining health.

In 2010, the TDS conducted focus groups to hear directly from people who use alcohol/other drugs about their experiences of stigma and discrimination. The purpose of the research was to identify types and sources of stigma and discrimination experienced by people who use alcohol/other drugs, document the impact of these experiences, and identify strategies to help reduce their negative impacts. Six focus groups were held at a range of community-based agencies across Toronto, with a total of 60 participants. People who are homeless and/or otherwise living in poverty were the main focus of this study as they represent the most marginalized group of people who use drugs in our society. Key findings of this study included the following:

› Families are the most significant source of discrimination, with the most negative impacts.
› People are facing multiple forms of discrimination at the same time (e.g., related to their substance

use, poverty, race, gender and age), and the compounded effect intensifies the severity of the stigma and discrimination.
› Discrimination creates barriers to accessing services people need to stabilize their lives, and discrimination stops people from seeking help due to fear of how they will be treated.
› Peer support is an important coping strategy for people affected by stigma and discrimination, and people need to be better informed of their rights to access services, and language about substance use needs to be more neutral and less judgmental.

Recommendations for action in this report to help reduce stigma and discrimination include the following: training and education for health and social service workers; storytelling and peer initiatives; support and education for family members; and, promoting expanded delivery of health services in community-based settings.[119]

of backlash against these services can exacerbate tensions between people who use drugs and other community members. This backlash and subsequent media reporting can reinforce common myths and stereotypes that contribute to exclusionary public policies.

HARM REDUCTION: THE CASE OF ECSTASY

On any given night in Canada thousands of young people are attending dance events or parties held in clubs or private homes. A significant number of these party goers will choose to use substances to enhance their experience including alcohol, cannabis, ecstasy and other mood-altering substances, some illegal and some legal. One of the more popular substances used at these parties is ecstasy. Ecstasy is also a street name for MDMA (methylenedioxymethamphetamine). Since illegal psychoactive substances used for non-medical purposes are not subject to government regulations for safe manufacture and distribution, ecstasy created in clandestine laboratories is often tainted with potentially damaging chemicals. In 2011 and 2012, 5 people in BC died as a result of ingesting ecstasy, causing uproar in the health and enforcement community about how to best respond to this situation. Toxicology results showed that the MDMA purchased by these people was tainted with PMMA (paramethoxy-metamphetamine).[120] These deaths created a new, and a familiar dilemma: we know that despite drug prohibition, people will use ecstasy on a regular basis and we know that this drug will be purchased from an unregulated market. Given these realities, how do we best respond to minimize or significantly reduce the risks associated with the act of ingesting ecstasy of unknown potency, composition, and quality that has been purchased from an unregulated source within an illegal unregulated market?

Traditional approaches try to ensure that drugs are not available to young people. Typically one approach is to use security and policing efforts to make events drug and dealer free. Despite these efforts, drugs like ecstasy are often available at dance events, clubs and private parties. Or they may be purchased in advance of the event. Some efforts have been made by non-profit volunteer organizations to either test pills using rudimentary tests that determine if MDMA or other drugs are present in substances that

are supposed to be ecstasy.[121] Testing programs recognize the reality of drug use but prioritize health effects and outcomes.

It may be time to acknowledge that young people in our society will continue to experiment with ecstasy, and that to better protect these people pill testing services should be a part of our monitoring and early warning system. The Dutch have had a system of pill testing available to people who use drugs for many years and attribute their extremely low rate of injury and death from "bad" drugs at dance parties to the increased knowledge that young people have of the risks of ecstasy and their desire to test what they buy on the street before they use it. They also maintain that testing these pill products helps to "clean up" the illegal market in that dealers who sell toxic, dangerous or poor products are quickly exposed which rewards those in the business who sell safer drugs.[122]

A comprehensive street drug testing service is an important part of a continuum of harm reduction responses to illegal drug use. Drug testing that provides feedback to clients and allows them to make better-informed decisions, which contributes to improved self-determination and safety. Drug testing also gives health and other service providers a means to collect and assess information about illegal drug markets, the monitoring and surveillance of which are otherwise notoriously difficult. A street drug testing service that provides quick feedback to clients creates a level of accountability between the consumers of street drugs and those who supply them. When consumers of street drugs are able to have their drugs tested for purity and quality, or to test them themselves, they are empowered to boycott those dealers who sell poor-quality or heavily adulterated products.

A STREET DRUG TESTING SERVICE THAT PROVIDES QUICK FEEDBACK TO CLIENTS CREATES A LEVEL OF ACCOUNTABILITY BETWEEN THE CONSUMERS OF STREET DRUGS AND THOSE WHO SUPPLY THEM. WHEN CONSUMERS OF STREET DRUGS ARE ABLE TO HAVE THEIR DRUGS TESTED FOR PURITY AND QUALITY, OR TO TEST THEM THEMSELVES, THEY ARE EMPOWERED TO BOYCOTT THOSE DEALERS WHO SELL POOR-QUALITY OR HEAVILY ADULTERATED PRODUCTS.

In a comprehensive review of street drug testing, the European Monitoring Centre on Drugs and Drug Addiction concluded that it is an important measure to contact hard to reach populations and raise their interest in preventive and harm reduction messages. The review found that street drug testing is an important source of information on new substances and consumption trends. It stressed that testing should be closely linked to the provision of safer use messages through a wide range of information supports.[123]

The tragic outcome of our current drug policies which perpetuate a strict prohibition on assisting young people to determine the safety of their drugs, is that some will needlessly be injured or

die as a result of tainted unregulated and untested products. Current prohibitionist policies rely on the sacrifice of some young people in an attempt to keep drugs out of their hands, and to create the perception that taking illegal drugs is always a high-risk activity.

It appears that we have a choice to make as a society: since we know that drug taking by young people will continue to occur, will we continue to rely on enforcement and scare tactics to discourage this activity from taking place or is it time to implement a system that will help young people gain knowledge of what they are buying, the associated risks of drug use and safer practices in taking these drugs and at the same time, put dealers and producers on notice that they will be exposed if their products are tainted.

CASE STUDY

The 595 Prevention Team in Winnipeg

The 595 Prevention Team is a network of over 100 member organizations interested in addressing the determinants of health and preventing the transmission of sexually transmitted infections and blood borne infections (STBBIs), primarily HIV and HCV, in Manitoba. The mandate of The 595 is to work with peers, network members, policy makers, and community leaders to make recommendations regarding the development, implementation and evaluation of STBBI prevention initiatives based on evidence and best practice with priority populations. Core values of the 595 include client centred and non-judgmental care, relationship building and creating supportive environments for people who use drugs. The 595 believes in best practice, especially when working with underserved populations. They offer a selection of workshops in conjunction with a consultation process that includes communities, participants, and service providers. All workshops have a foundation of consistent core information, and are tailored to ensure that specific community needs are addressed. Workshops have been delivered throughout Manitoba as far north as Thompson and are thoroughly evaluated. Since 2008 they have trained over 1200 service providers. http://www.the595.ca/

CASE STUDY

Mothering, Pregnancy, and Drug Use

In Canada, there are excellent examples of harm reduction oriented and pragmatic care for pregnant and mothering women. *Sheway* is a Pregnancy Outreach Program (P.O.P.) located in the Downtown Eastside of Vancouver. The program provides health and social service supports to pregnant women and women with infants under eighteen months who are dealing with drug and alcohol issues. The focus of the program is to help women have healthy pregnancies and positive early parenting experiences. *Fir Square,* a maternity unit at BC Women's Hospital, offers a harm reduction approach for women unable to practice abstinence during pregnancy. Fir Square has 11 beds mixed between antepartum and postpartum care for women who want to stabilize or withdraw from drug use during pregnancy. The *Jean Tweed Centre* in Toronto provides counselors at multi-sites to offer support services to women and children and connect mothers with local resources. The *Healthy Empowered, Resilient Pregnancy Program* (H.E.R.) program operations in conjunction with Streetworks in Edmonton. Other programs are in the process of opening including *Herway Home* in Victoria and the *Mothering Project* in Winnipeg.

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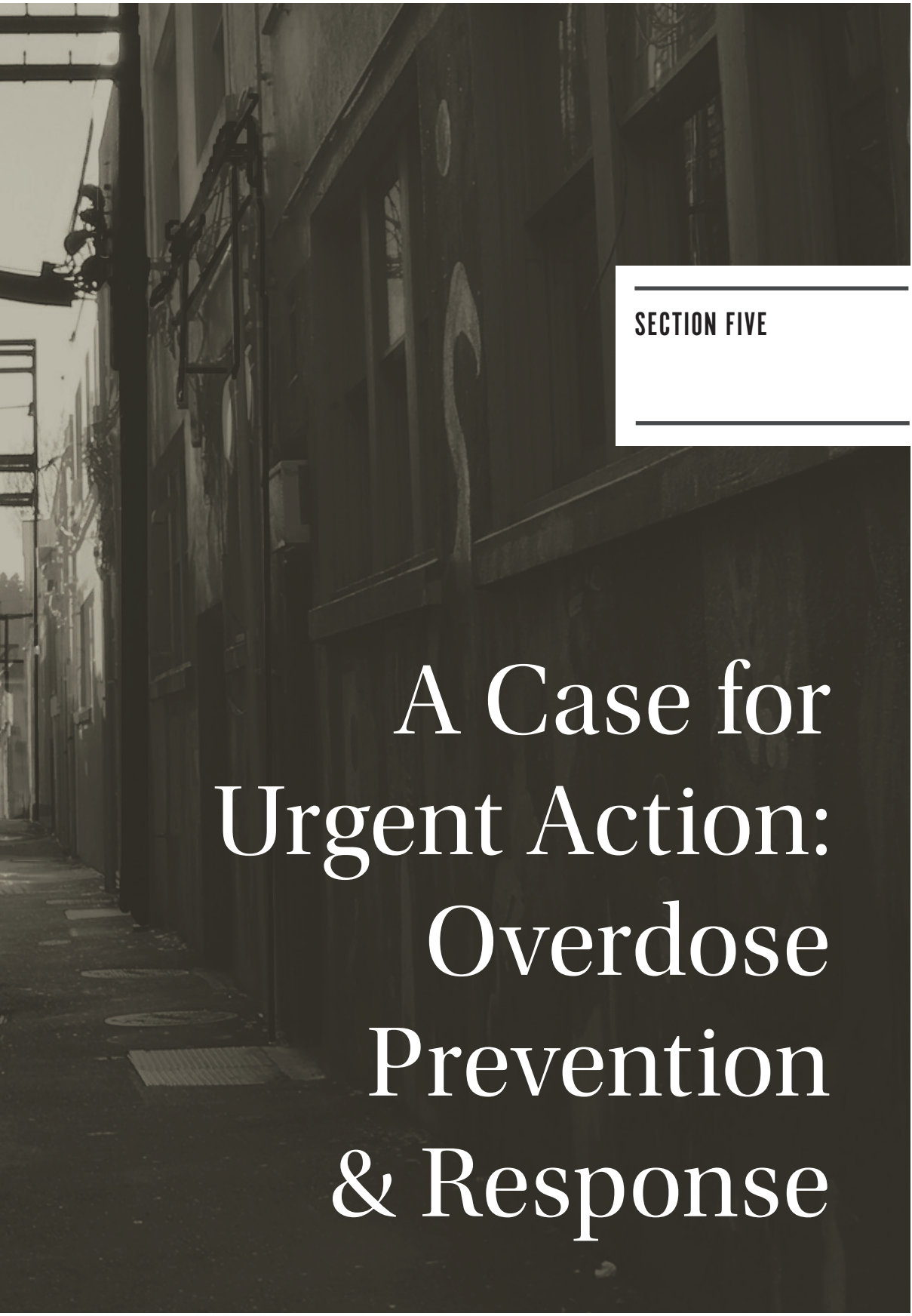
p.63 *Overdose Deaths are Preventable*
p.63 *We Can Reduce the Barriers to Calling 911*
p.64 *Case Study: Toronto Public Health—Education and Training to Prevent Overdose*



SECTION FIVE

A Case for Urgent Action: Overdose Prevention & Response

Across Canada, far too many people are dying from drug overdoses. Unintentional overdose among people who use opioids (both licitly and illicitly) contributes significantly to the illness and death of Canadians. The tragedy is that many of these deaths could have been prevented. Clearly policy changes and interventions aimed at improving these disturbing statistics are urgently needed.

Recent data suggest that rates of overdose are unacceptably high in Canada, especially since overdose can be prevented. Overdose can occur during the use of illegal drugs, non-medical use of prescription opioids and even when opioids are used as prescribed.

Though no comprehensive national data exists on overdose, pockets of research have illustrated a growing problem in Canada. For people who inject illegal opioids, the annual rate of fatal overdoses is estimated to be between 1% and 3% per year.[124] Between 2002 and 2010 there were 1654 fatal overdoses attributed to illegal drugs in BC and between 2002 and 2009 there were 2,325 illegal drug-related overdose hospitalizations.[125]

PRESCRIPTION DRUGS ARE PART OF THE PROBLEM

Deaths related to overdose of prescription opiates whether used medically or non-medically have risen sharply and are estimated to be about 50% of annual drug deaths.[126] Increases in the use of prescribed medications like Oxycodone have also precipitated increases in overdose. In October 2012, the BC-based Interior Health Authority released a warning that overdoses in southeastern BC were about twice the rate in the rest of the province. Most of these overdoses were accidental and were associated with the legal use of prescribed medications.[127] The rate of prescription overdose deaths in one health region (2.7 per 100,000 persons) in BC is similar to that of the number of residents killed in any given year in motor vehicle accidents involving alcohol in the province.[128] In Ontario, prescriptions of Oxycodone increased by 850% between 1991

and 2007, and each year between 300 and 400 people die from overdose involving prescription opioids—most commonly Oxycodone.[129]

Research found that in Ontario the addition of long-acting oxycodone to the drug formulary was associated with a 5-fold increase in Oxycodone-related mortality and a 41% increase in overall opioid-related mortality.[130] This same study showed that in 56.1% of overdose deaths between 1991 and 2004, patients had been prescribed an opioid within four weeks before death. A study of patients admitted to the Centre for Mental Health and Addiction in Toronto for opioid dependence found that 37% received opioids by prescription, 26% from both a prescription and from the street and 21% exclusively from street sources.[131] A recently released strategy on the misuse of prescription drugs reports that opioid-related deaths in Ontario nearly tripled over an eight-year period, from 168 in 2002 to 494 in 2010. Of the total 3,222 opioid-related deaths reported during this period, deaths related to oxycodone (n=970) were found to be the most prevalent, followed by morphine (n=722) and methadone (n=595).[132]

The challenges presented by prescription opiates constitute a potentially tragic 'natural' experiment in drug policy options. In response to high rates of prescription of the opiate drug OxyContin—more than 30% of all strong prescribed opioid prescriptions in 2012 (about 2.2 million) were for OxyContin products—two major events occurred. In February 2012, the drug's manufacturer, Purdue Pharma, announced that OxyContin would be replaced by a new and supposedly tamper-proof formulation, OxyNeo. In response, seven provinces announced that both OxyNeo and OxyContin would be removed from provincial drug formularies. Health Canada also implemented the same for its federal drug plan. The rationale behind these provincial and federal changes was the suppression of the widespread use of these drugs and the prevention of their diversion to an illegal market. But, early anecdotal reports from across the country suggest some of the estimated 1–2 million individuals using non-medical prescription opioids turned to other drugs such as morphine, heroin, fentanyl, and codeine. Many of these drugs carry the same or higher risks of overdose. These shifts in drug use could potentially trigger shifts to higher-risk activities such as increased needle sharing and overdose. Indeed, anecdotal reports suggest that the delisting of Oxy products appears to have increased the street prices for this drug, and increased drug market volatility and related crime.[133]

The CCSA in conjunction with the National Advisory Council on Prescription Drug Misuse recently released a strategy that calls for action to address the increasing harms associated with prescription medication use.[134] The strategy focuses on opioids, sedative-hypnotics (i.e. diazepam) and stimulants and makes a series of recommendations to government to ameliorate the harms of these substances. The strategy also attempts to address the harms of prescription drug use while acknowledging their beneficial medical purposes especially for the relief of pain. The strategy includes 58 recommendations focused on prevention, treatment, education, monitoring and surveillance (data collection). While the strategy makes excellent recommendations about the need to collect better data, and address prescribing

practices, educate prescribers, patients and family on the appropriate use of medications, it does not give significant attention to two key activities that can help prevent overdose. Though mention is made of the need to review the evidence for community-based take-home naloxone programs,[135] the strategy does not recommend a comprehensive health and human rights approach to overdose prevention and treatment; nor does it call for improved access to naloxone or the need for federal 911 Good Samaritan legislation. Below we discuss the importance of each of these measures.

OVERDOSE DEATHS ARE PREVENTABLE

Community based programs that provide training on how to recognize the signs of overdose and treat overdose have been shown to be highly successful at preventing death and injury.
The U.S. has over 180 Take Home Naloxone programs to train friends and family to resuscitate overdose victims and administer naloxone. Scientific studies of these programs have demonstrated that they are effective at reducing overdose deaths.[136] Several U.S. jurisdictions also have best practice policies for physicians to support co-prescribing naloxone with any opioid for people at-risk of an overdose.[137]

Take home programs were pioneered in Canada by Streetworks in Edmonton in 2005. The Works (a harm reduction program at Toronto Public Health) began a peer-based program in 2011. This program dispensed 610 kits since its inception and peers have reported 65 administrations of naloxone.[138] In 2012 Ontario launched a provincial program to provide naloxone education and kits through harm reduction services. BC's program, which began in 2012, is modeled on these pre-existing initiatives and combines education on prevention, identification and response to overdose, with take-away naloxone kits for people who are using opioids. These training programs combined with the availability of naloxone help people to be prepared in the event of an opioid overdose.[139]

Naloxone, a safe and simple medication that reverses opioid overdoses, has been used in emergency settings for over 40 years in Canada and is on the WHO List of Essential Medicines. The BC ambulance service administered naloxone 2,367 times in 2011.[140] Unfortunately, efforts to increase the reach of this drug are hindered by legal and jurisdictional issues. Naloxone is not covered by provincial drug plans; nor is this drug as widely available due to its cost even though its patent has expired. And naloxone is a regulated substance available only by prescription in most provinces.

WE CAN REDUCE THE BARRIERS TO CALLING 911

Most overdoses occur in the presence of other people. The chance of surviving an overdose, like that of surviving a heart attack, is almost entirely dependent on how fast one receives emergency medical services (EMS). Though witnesses to heart attacks rarely hesitate to call 911, witnesses to an overdose too often waver on whether to call for help, or in many cases simply don't make the call. Many overdose deaths occur because those who witness overdoses are fearful of arrest and will avoid calling even in urgent cases where EMS are needed for a friend or family member who is over-

dosing. Anecdotal reports from across the country have also found that victims of overdose will often ask friends not to call 911 because they fear police interaction, and/or because they are on parole or do not want to go to jail. In addition, recent amendments to Canada's *Controlled Drugs and Substances Act* stipulate mandatory minimum prison sentences for some drug-related offences. These provisions will unquestionably intensify fear of prosecution for witnesses of drug overdose and increase rates of preventable overdose deaths. The more practical solution to encourage overdose witnesses to seek medical help is to provide exemption from criminal prosecution, an approach commonly referred to as "911 Good Samaritan Immunity" legislation. In general, this law could provide protection from arrest and prosecution for drug use and possession charges if the evidence is gained as a result of the person calling 911.

911 Good Samaritan legislation is a step toward saving lives and urgent action is needed to enact this legislation in Canada.[141] States south of the border—including California, New Mexico, Colorado, Washington, Illinois, New York, Rhode Island, Connecticut, Massachusetts and Florida—have all passed Good Samaritan legislation in the last four years. In states like New York and Florida, support for these laws was bipartisan and these bills passed nearly unanimously. These laws send the message that accidental drug overdose is a health issue, and that fear of criminal justice involvement should not be a barrier to calling 911 in the event of an overdose.

CASE STUDY

Toronto Public Health: Education and Training to Prevent Overdose

In spring 2012, Toronto Public Health (The Works) created educational webinars on peer-based naloxone training, prescription and distribution to supplement its already existing peer-based training program on overdose prevention and treatment. Staff at community health centres, hospitals, prisons, First Nations communities and methadone programs viewed these webinars across Ontario. Training and consultation were also provided for agency administrators. This action came in response to concerns about the potential impact of OxyContin™'s removal from the market in Ontario, and the increased risk of overdose as people transition to other, potentially more harmful opiates such as fentanyl. In addition, The Works and the Toronto Harm Reduction Task Force (THRTF) also partnered to produce a short film, entitled The First 7 Minutes, which promotes developing and implementing overdose protocols at agencies that serve marginalized populations. The video can be used in combination with a broader peer-based overdose prevention curriculum in trainings with peer workers, people who use drugs, and frontline workers. Eight training sessions have been conducted since spring 2010 with a total of 223 participants.[142]

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p.68 *What Does Canada Spend on the National Anti-Drug Strategy?*
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p.71 *Promising Practices in Prevention/Health Promotion*
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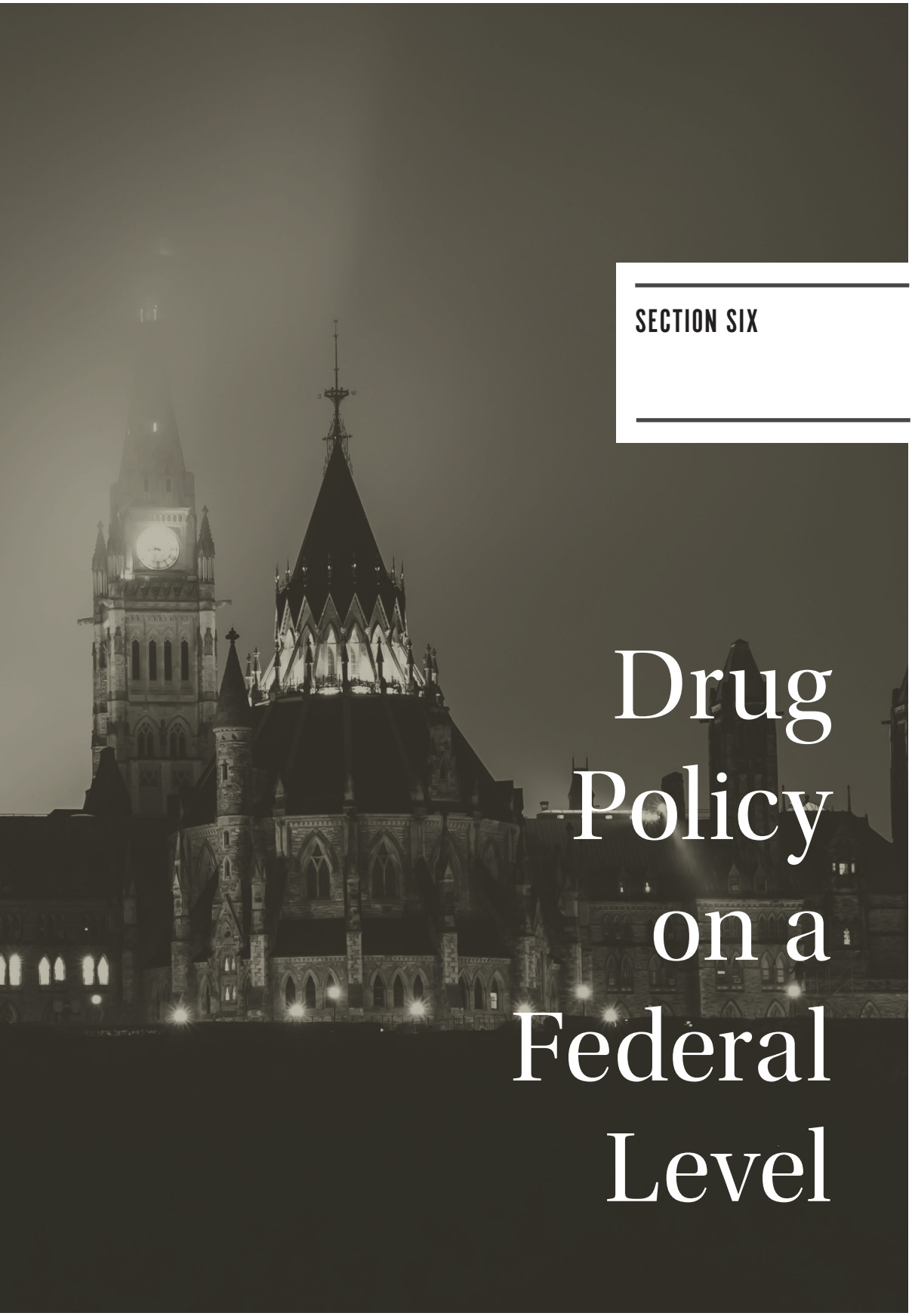

SECTION SIX

Drug Policy on a Federal Level

Beginning in 1987, a series of drug strategies outlined the principles of federal policy. By 2003, the Liberal federal government announced an investment of $245 million over the subsequent five years to renew its drug strategy by focusing on four broad areas including enforcement, prevention, treatment, and harm reduction. These strategies reflect a long debate about how to address drugs—as a health issue or as a criminal matter.

As recently as 2005, this debate culminated in a number of policy decisions that emphasized the health aspects of drug use including a renewed framework for action on substance use that included expanded harm reduction, treatment and other supports.[143]

However, beginning in 2007, the federal Conservative government initiated the National Anti-Drug Strategy (NADS), a $527.8 million effort to address illegal drug use. This strategy was accompanied by other "tough-on-crime" efforts that expand a punitive approach while doing little to address the root causes of crime. Further amplifying this shift, in 2008 the leadership for the new National Anti-Drug Strategy was removed from Health Canada and relocated within the Justice Department. NADS also downplays the importance of robust health promotion programs and does not address the harms associated with legal drugs like alcohol.

THE NATIONAL ANTI-DRUG STRATEGY

The National Anti-Drug Strategy is a "horizontal initiative" comprised of 12 federal departments and agencies, led by the Department of Justice Canada. The initiation of this strategy was informed by antagonism against previous attempts by the Liberal government to decriminalize possession of small amounts of cannabis. When the new strategy was announced, Tony Clement, Minister of Health in 2007, reportedly stated, "In the next few days, we're going to be back in the business of an anti-drug strategy," Clement told The Canadian Press. "In that sense, the party's over."[144] Clement's comments echoed the get-tough stance of the new Conservative govern-

ment. The stated priority areas of the strategy include prevention, treatment and enforcement. As we noted previously, NADS excludes federal support for evidence-based harm reduction programs recommended by the World Health Organization and actively opposed the existence of Vancouver's supervised injection site.[145]

This strategy is not national, in that it was not developed in collaboration with, or endorsed by, provinces and territories. More accurately, it is a federal government strategy. And many groups in Canada have expressed concerns about key features of the NADS including the Canadian Nurses Association and the Centre for Addiction and Mental Health in Ontario among others.[146]

WHAT DOES CANADA SPEND ON THE NATIONAL ANTI-DRUG STRATEGY?

In 2007, the NADS was rolled out with a five-year plan for funding that totalled of $578.6 million dollars. It was renewed in 2012 with another five-year commitment of $527.8 million.[147] Even before the initiation of the NADS, Canada's federal drug strategy favoured the use of enforcement and other criminal justice approaches to address illegal substance use despite mounting international, peer-reviewed evidence of the ineffectiveness of this approach.[148] Under NADS, law enforcement initiatives continue to receive the overwhelming majority of drug strategy funding (70%) while prevention (4%), treatment (17%) and harm reduction (2%) combined continue to receive less than a quarter of the overall funding.[149] In 2012, the Department of Justice released the budget for the next five years of the National Anti-Drug Strategy (2012/13 to 2016/17). Compared to the first five years (2008/2009 to 2011/12), the overall budget has decreased almost 12%.[150] These figures do not account for the myriad of other enforcement activities that go on at the municipal, provincial and federal levels.

Despite decreases in overall spending, the proposed budget for 2012 - 2017 signals significant changes in the priorities of the NADS. Funding for the Drug Treatment Funding Program (DTFP) and the Drug Strategies Community Initiatives Fund (DSCIF) has been decreased and funding for Crime Prevention Programs has also been eliminated.[151] Despite concerns about the overall direction of the NADS, other jurisdictional scans suggest that the DTFP funding has been an important driver of innovation. An example is the "Needs-Based Planning Model" research undertaken at Centre for Addiction and Mental Health in Toronto. This project is developing methods for estimating the actual population-based need for substance use services and supports in Canada.[152] Despite promising efforts, funding for the DTFP has decreased from $124.7 in 2007/12 to $80.4 million in 2012/2017. The one bright spot is a funding increase to National Native Alcohol and Drug Abuse Program from $36 to $45 million though it is certainly too early to tell if this funding will be used to create diverse services and whether it will address the scope of issues identified by Aboriginal people in Canada.

At the same time, components of NADS related to the criminal justice system received increased funding including the RCMP, Correctional Service of Canada, Parole Board of Canada, and the Canada Border Security Agency. Overall the

RCMP will receive an additional $16 million (for a total of $112.5 million) between 2012 and 2017 for enforcement against cannabis growing operations and clandestine drug labs.

This strategy only accounts for a portion of federal government spending on drug control. Common drug enforcement activities such as drug interdiction, border services, use of military personnel in international drug control efforts and costs of prison expansion are not fully included in the NADS. Interdiction, for example, includes efforts to seize drugs, couriers or vessels, between source countries and Canada, including as they enter the country. Accounting for expenditures on interdiction is complicated, since many interdiction efforts serve multiple functions, not just drug control. Nor can policing and corrections costs related to drugs be easily determined. Like drug interdiction, policing and corrections costs are not easily broken down in terms of amount of resources spent on drug enforcement and incarceration due to drug crime. Clearly Canadians need more transparency when it comes to the costs and effectiveness of current policies.

POLICING AND COURTS AND THE NATIONAL ANTI-DRUG STRATEGY

Since 2007, the Conservative government has ensured that law enforcement and criminal justice strategies are the main means of addressing drugs and crime. This government has increased the range of mandatory minimum sentences for drug and gun crimes; parole review criteria have been abolished or tightened; and reduced credit for time served in pre-trial custody and restricted use of conditional sentences has been eliminated.[153] A wide variety of evidence suggests these approaches have limited effects in deterring drug demand and supply or increasing overall public safety.[154] And overall tough sentences do not deter people from committing crimes.[155]

The federal government's current approach to drug policy does not address the broad social determinants of problematic substance use. The government has abandoned the highly valuable crime prevention through social development approach of previous governments. There is little if any coordinated effort to address issues like poverty, homelessness, cultural dislocation, and lack of economic opportunity that tend to affect rates of problematic substance use. For example, the harms of drug use are often exacerbated by homelessness with increased harms associated with the twin problems of substance use and lack of housing.[156] Until these issues are meaningfully incorporated into a broader strategy to prevent problematic substance use the strategy will remain narrowly focused and have limited results.

The government's own in-house reviews of the NADS suggest other problems. An evaluation of the implementation of the strategy conducted in 2008, found that there were significant differences between the approach taken by the provinces and the one espoused by the federal government. As the evaluators noted, the provinces "focus on substance abuse in general rather than abuse of illegal drugs, support harm reduction, and take a more holistic approach to substance use issues (for example, many provinces have integrated or are integrating mental health and addictions)."[157] Evaluators also noted other points of discord:

Canada's current approach does not accord with international developments including recent calls by some Latin American countries to rethink prohibition as the main means of preventing drug use.[158]

DRUG PREVENTION PROGRAMS AT THE FEDERAL LEVEL

The National Anti-Drug Strategy has touted the importance of prevention over harm reduction assuming that these two approaches to drug use are mutually exclusive. Overall, drug prevention programs are plagued by a lack of success at curbing drug use. Evaluations of the programs like the RCMP's Drug Abuse Resistance Programs (DARE) indicate that there is a lack of evidence demonstrating that these programs have long-term positive effects on levels of drug use.[159] Adding to this is the fact that few prevention programs have passed the scrutiny of rigorous evaluation.[160] Prevention activities have also been criticized for being piecemeal, lacking comprehensiveness, oversight, monitoring and accountability. In Canada it is also difficult to track the effects of these programs on drug use especially given that there are no overall strategies which identify goals against which effects could be measured; and there is no way to know if the programs currently in use are weak or poorly implemented or both.[161]

As part of its Prevention Action Plan, the federal National Anti-Drug Strategy provided increased funding to the RCMP's Drugs and Organized Crime Awareness Service (DOCAS). Programs developed under DOCAS include the Aboriginal Shield Program, Drug Abuse Resistance Program (DARE), Drug Endangered Children (DEC), Deal.org, Drugs and Sport: The Score, E-aware, Organized Crime Awareness, Drug Awareness Officers Training (DAOT), the Community Education Prevention Continuum (CEPC), Racing Against Drugs (RAD) Program. Other programs receiving funding included the Prevent Alcohol and Risk-related Trauma Youth Program (PARTY), Keep Straight, and Building Capacity for Positive Youth Development.[162] Monies were also allocated to prevention projects funded under the Drug Strategies Community Initiatives Fund, though a complete list of these projects and their outcomes was unavailable.[163]

To-date, no long-term assessment of these programs has been conducted. There is also no comprehensive accounting for the content of these programs; nor has the federal government or the RCMP publicly released any information on their effectiveness. The mass media campaign, comprised of TV, radio, web and print materials, which received $13,889,000 between 2007 and 2010, was not renewed in the second funding period (2012-2017).[164] This anti-drug mass media campaign was implemented without evidence to support its efficacy and despite evidence that this kind of campaign may even be harmful. Though participants in these programs initially report increased knowledge about drugs, controlled trials of similar antidrug media messages have suggested that they may result in harmful assumptions among youth about drug use and that they lack demonstrated effectiveness over the long-term.[165]

Additionally, as part of NADS the CCSA has prepared a document entitled "A Drug Prevention Strategy for Canada's Youth." This strategy was one of the recommendations for action in 2005 the *National Framework for Action to Reduce the*

Harms Associated with Alcohol and Other Drugs and Substances in Canada. The goals of this strategy includes reducing drug use by youth, delaying onset of use, and reducing frequency of use, and identifies three activities it will use to reach these goals including: development of a Media/Youth Consortium to help carry forward the anti-drug messages in the NADS; the development of national standards for prevention; and creation of "sustainable partnerships" including a number of working groups to provide advice on the development of national standards and media-youth connections. This strategy promises an impact evaluation of these efforts that will draw on existing data on youth drug use. To date, this evaluation has not been released by the CCSA.[166]

The methods used for this evaluation and its results will be keenly important to assessing the effectiveness of the National Anti-Drug Strategy. Additionally the need for national standards for prevention programs is particularly acute given the number of community-based and other organizations that offer drug prevention programs to young people. It is, however, beyond the scope of this review to evaluate either the content or the effectiveness of the CCSA standards. There are, however, excellent resources that point to the best practices in prevention as described below.

PROMISING PRACTICES IN PREVENTION/HEALTH PROMOTION

A substantial research base points toward more effective models that have been proven to reduce health-related and community concerns attributable to drug use, and reduce the unintended negative effects of drug policies.[167] Problematic substance use does not simply arise from lack of knowledge about the dangers of drugs; thus it is important to avoid programs that simply use scare tactics or simplistic messages about the hazards of drug use. But there is no magic bullet or one program that can eradicate the harms of substance use. Programs that mobilize community wide efforts,[168] and programs that are part of larger health promotion activities show promise particularly when these programs support the development of young people's social and emotional learning skills.[169] These programs do not necessarily focus directly on substance use; rather, reduced substance use is one of the benefits of improved decision-making skills.[170]

Successful programs also draw on well-established principles of health promotion (health promotion is the process of enabling people to increase control over, and to improve their health).[171] Health promotion recognizes that good health and healthy decision-making results from healthy environments. It focuses on both universal and tailored strategies. Universal strategies address large-scale inequities in supports for health like adequate income and housing, access to information, and supportive environments. Tailored strategies help to prevent injuries and other harm. In the light of these evidence-based findings, the approach to prevention supported by the NADS is potentially quite limited. Though the CCSA has established standards that could positively reorient prevention approaches, overall efforts are hampered by the vision of the NADS that still conceptualizes prevention as a matter simply of reduced drug use. The NADS does not look beyond to the social determinants that shape substance use; nor does the

strategy measure effectiveness of its programming in terms of overall attitudes and behaviours toward all substances including alcohol.

CASE STUDY
Thunder Bay Drug Strategy

By 2009, the community of Thunder Bay was experiencing increased harms from drug use including alcohol, concerns about community safety and lack of services. Changes in the industry base and the economy had led to poor job options for many people previously well-employed in sectors such as the pulp and paper industry. And poverty was clearly linked with substance use-related problems. These concerns drew community leaders and local politicians to convene a Steering Committee to examine the need for a local drug strategy. The Steering Committee held 26 focus groups and three strategy sessions to gather information about substance use in their city. Out of this process came the Thunder Bay Drug Strategy, a five-pillar approach encompassing prevention, treatment, harm reduction, enforcement and housing. Drawing on the international body of research, groups representing each of the pillars, created actions to improve the health and well-being of Thunder Bay residents. The goals of the strategy reflect a realistic approach to substance use and acknowledge the interrelated and complex nature of this phenomenon. The Strategy leverages a wide range of policy options to meet its goals including: increasing the representation of Aboriginal people in local agencies, increasing the availability of housing comprised of transitional, and supportive housing units, with a special focus on women and youth; a commitment to supporting an evidence-based approach and urging the federal government to re-examine its National Anti-Drug Strategy (see chapter 6). The Thunder Bay Drug Strategy also acknowledges the importance of bolstering programs that support families and children in schools and in communities, supporting a scale up of harm reduction services including overdose prevention, improving methadone programs and increasing access to and quality of treatment programs.[172]

p.75 *Does the 'War on Drugs' Work?*
p.76 *Overall Crime Rates Fall While Adult Drug Crime Increases*
p.77 *Safe Streets and Communities Act—Are we any safer?*
p.80 *Prison Overcrowding is Already a Reality*
p.81 *Prison Sentences Are Inequitable*
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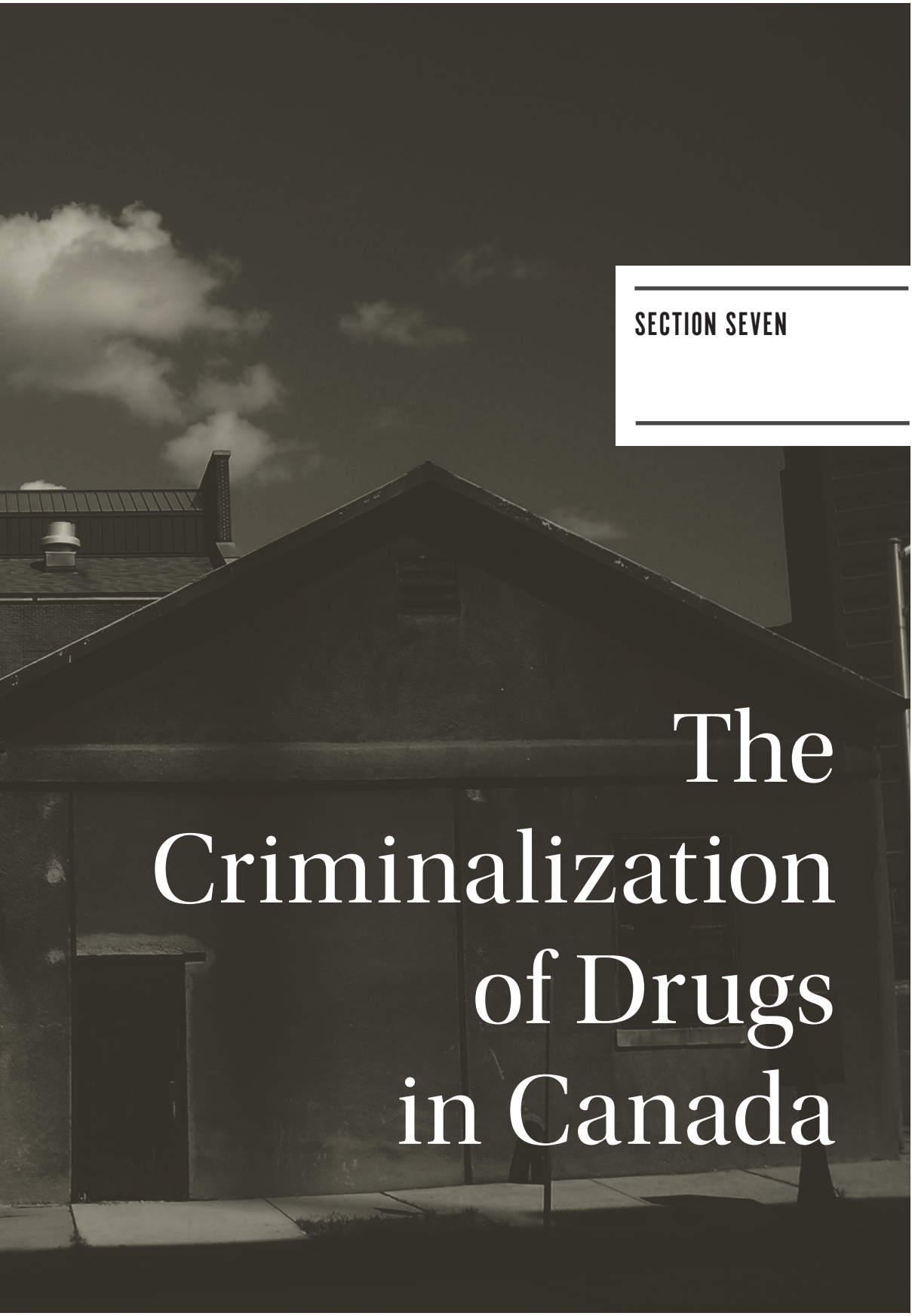
p.89 *Case Study: Waterloo Crime Prevention Council*



SECTION SEVEN

The Criminalization of Drugs in Canada

In Canada, drug crimes fall under the authority of the federal *Controlled Drugs and Substances Act* (CDSA) and include possession, trafficking, importing and exporting and production-related offences. The seriousness of penalties included in the CDSA is related to the perceived levels of harm caused by each drug. The CDSA does not recognize that drugs such as alcohol and tobacco are at least as harmful as some illegal drugs.

In general, drug law and policy in Canada has not been a benign phenomenon linked to health concerns, but a tool of social control directed unevenly at some groups of people. Historically concerns about public safety have been linked to illegal drug use or drug dealing. In Canada the response to these concerns has been to increase the scope of laws, the severity of punishments and the scale of policing. Drugs were first prohibited in Canada in 1908 with the passing of the *Opium Act*. The prohibition of opium had more to do with anti-Asian sentiments than with concerns about the health effects of this substance. Prohibition of cannabis in 1923 was likely related to a racist scare about the drug promoted by one of Canada's social reformers of the time, Emily Murphy.[174] Over time, Canadian lawmakers added more substances and harsher penalties for their use to drug laws. Alongside laws that prevented the use, production and selling of some drugs, Canada developed a legal and lucrative system for the regulation of prescribed medications, and alcohol and tobacco.

DOES THE 'WAR ON DRUGS' WORK?

Perhaps the most stunning display of unimaginative thinking when it comes to solving current drug problems is the refusal by governments to consider the failure of the overarching policy framework that not only creates much of the drug crime in Canada but also constrains our ability to address many drug-related health harms. Far from eliminating drug use and the illicit trade, prohibition (making some drugs illegal) has inadvertently fuelled the development of the world's largest illegal commodities market, estimated by the UN in 2005 at approximately $350 billion a

TABLE 3: DRUG OFFENSES IN CANADA, 2010/11[233]

POLICE-REPORTED DRUG OFFENSES, CANADA 2010/2011					CHANGE IN RATE	
	2010		2011			
POSSESSION	*Number*	*Rate*	*Number*	*Rate*	*2010/2011*	*2001/2011*
Cannabis	56,853	167	61,406	178	7%	16%
Cocaine	7,325	21	7,392	21	—	23%
Other Drugs	9,671	29	10,352	30	5%	97%
TRAFFICKING, PRODUCTION OR DISTRIBUTION	2010		2011			
	Number	*Rate*	*Number*	*Rate*	*2010/2011*	*2001/2011*
Cannabis	18,363	54	16,548	48	-11%	-26%
Cocaine	9,873	29	10,251	30	3%	37%
Other Drugs	7,047	21	7,215	21	1%	41%
TOTAL	109,222	320	113,164	328	3	14

year. Just as with alcohol prohibition in the early 20th century, the profits flow untaxed into the hands of unregulated, often violent, criminal profiteers.[175] Banning drugs and relying on enforcement-based supply-side approaches to discourage their use has not stemmed the increase in drug use or the increase in drug supply. Despite Canada's significant investment in drug control efforts, drugs are cheaper and more available than ever.[176] There is a growing consensus among international experts that drug prohibition has failed to deliver its intended outcomes, and has been counter-productive.[177]

OVERALL CRIME RATES FALL WHILE ADULT DRUG CRIME INCREASES

Compared to the U.S. where drug crime is a main driver of incarceration, Canada can seem like a more compassionate place when it comes to drugs. But Canada has a record of increasing numbers of drug crimes and high levels of incarceration due to drug convictions.

In 2011, police reported more than 113,100 drug crimes, of which more than half (54%) were for the possession of cannabis. Between 2010 and 2011, the rate of drug crime increased slightly following an increase of 10% between 2009 and 2010. These increases continue a general trend that began in the early 1990s. The increase in drug crime in 2011 was driven by a 7% rise in the rate of police reported cannabis possession offences. However, the rate of police reported incidents of trafficking, production and distribution of cannabis declined 11%. Similar to previous years, British Columbia reported the highest rate of drug offences among the provinces. While British Columbia was highest

for cannabis offences, Saskatchewan reported the highest rate of cocaine offences, with a 73% increase in 2011.[178]

The rising trend in the rate of drug crime coincides with a decreasing trend in the overall crime rate. In 2011, there were declines in most police reported offenses with the exception of homicide, sexual offenses against children, child pornography, criminal harassment, impaired driving and some drug offences. The overall police reported crime rate has decreased 21.8% since 1998, from 8,915 per 100,000 to 5,756 in 2011, while police reported incidents of drug crime increased by 14% between 2001 and 2011.[179]

Increases in police reported drug crime do not necessarily represent real increases in these crimes. Policing priorities can influence crime rates especially when time, resources and priorities permit police to focus their efforts on other crimes.[180] It is alarming that drug crime continues to rise while other crime declines in Canada.

Youth crime also fell in 2011 continuing a downward trend that has been apparent for a number of years.[181] These declines are explained by the enactment of the *Youth Criminal Justice Act* in 2003 which provided clear guidelines for the use of extrajudicial measures (i.e. informal sanctions.)[182] Regardless, there were still 172.9 (per 100,000 youth) police reported incidents of cannabis possession in 2011 among youth 12 to 17 years old, equalling a total of 4,208 young people.[183]

SAFE STREETS AND COMMUNITIES ACT: ARE WE ANY SAFER?

With the introduction of the National Anti-Drug Strategy in 2007, the Conservative government signalled its intention to "get tough" on drugs. This approach means more public spending on law enforcement and more severe penalties—approaches that have been shown to be ineffective at reducing drug use and promoting pubic safety in other places around the world. In fact, drug prohibition and increasingly punitive policies have been demonstrated to create harms that undermine public safety and human rights.[184]

In 2012, Canada's federal government passed and enacted the *Safe Streets and Communities Act* (SSCA). The SSCA introduces a wide variety of changes including mandatory minimum sentences for some drug crimes including production, trafficking, importing and exporting. These changes apply to drugs listed in both Schedule I (i.e. heroin, cocaine, methamphetamine) and Schedule II (cannabis) of the *Controlled Drugs and Substances Act*. These changes also increase the maximum penalty for the production of cannabis from 7 to 14 years, and add more drugs to Schedule I including amphetamine type substances, which will result in higher maximum penalties for activities involving these drugs. Courts can delay imposing a sentence while an offender undergoes a drug treatment program approved by the province under the supervision of the court.[185] These changes were passed despite extensive opposition. In particular, criticism of this legislation focused on the approach to crime highlighted by these changes—a reactive approach that focuses on punishment after the fact, instead of a proactive approach that focuses on key issues like early learning and development, overall health promotion,

FIGURE 3: MANDATORY MINIMUM SENTENCES FOR SOME DRUG CRIMES

In 2012, the Conservative federal government passed and enacted the Safe Streets and Communities Act. This act amends the *Controlled Drugs and Substances Act (CDSA)* to apply mandatory minimum penalties for some drug offenses including production, trafficking, possession for the purpose of trafficking, importing and exporting; and possession for the purpose of exporting. The mandatory minimum penalty applies where there is an "aggravating factor". According to information provided by Canada's Department of Justice, aggravating factors are broken down into three categories:

1. AGGRAVATING FACTORS LIST A
- for the benefit of organized crime;
- involving use or threat of violence;
- involved use or threat of use of weapons;
- by someone who was previously convicted of a designated drug offence or had served a term of imprisonment for a designated substance offence in the previous 10 years; and,
- through the abuse of authority or position or by abusing access to restricted area to commit the offence of importation/exportation and possession to export.

2. AGGRAVATING FACTORS LIST B
- in a prison;
- in or near a school, in or near an area normally frequented by youth or in the presence of youth;
- in concert with a youth
- in relation to a youth (e.g. selling to a youth)

3. HEALTH AND SAFETY FACTORS
- the accused used real property that belongs to a third party to commit the offence;
- the production constituted a potential security, health or safety hazard to children who were in the location where the offence was committed or in the immediate area;
- the production constituted a potential public safety hazard in a residential area;
- the accused placed or set a trap

For example, mandatory minimum sentences for cannabis would include:

TRAFFICKING/POSSESSION FOR THE PURPOSE OF TRAFFICKING—MORE THAN 3 KG
- 1 year, with Aggravating Factors List A
- 2 years, with Aggravating Factors List B

IMPORTING/EXPORTING/ POSSESSION FOR THE PURPOSE OF EXPORTING —1 YEAR

Production
- 6–200 plants: 6 to 9 months; maximum increased to 14 years
- 201–500 plants: 12 to 18 months; maximum 14 years
- More than 500 plants: 2 to 3 years; maximum 14 years
- Oil or resin: 12 to 18 months

Adapted from: Canada. Department of Justice. 2011. Backgrounder: Safe Streets and Communities Act; Increased Penalties for Serious Drug Crimes. Available at: http://www.justice.gc.ca/eng/news-nouv/nr-cp/2011/doc_32636.html

INCARCERATION IS COSTLY AND THE INTRODUCTION OF MANDATORY MINIMUM SENTENCES ONLY SERVES TO INCREASE THESE COSTS. EVEN VERY CAUTIOUS ESTIMATES SUGGEST THAT CHANGES ASSOCIATED WITH THE *SAFE STREETS AND COMMUNITIES ACT*, INCLUDING THE IMPOSITION OF MANDATORY MINIMUM SENTENCES, WILL COST THE CANADIAN FEDERAL GOVERNMENT ABOUT $8 MILLION AND THE PROVINCES ANOTHER $137 MILLION.

and community and economic development as a means to lower crime.[186]

Mandatory minimum sentences reduce the discretion used by justice officials through the application of predefined minimum sentences. The imposition of mandatory minimum sentences flies in the face of evidence of their ineffectiveness. Convicting people of drug-related offences does not reduce the problems associated with drug use nor do these sentences deter crime.[187] The effects of mandatory minimum sentences include increases in the prison population in already overcrowded prisons, increases in the costs to the criminal justice system; the removal of judicial discretion; failure to deter drug crimes; and a number of well-documented consequences on already marginalized populations.[188] As the Canadian Bar Association notes, mandatory minimum sentences subvert important aspects of Canada's sentencing regime, including principles of proportionality and individualization and judges' discretion to impose a just sentence after hearing all the facts in the individual case.[189] A more recent study warns that mandatory minimum sentences have the potential to increase the numbers of people in prison thus exposing more people for longer periods of time to increased potential for violence and an environment characterized by mental, emotional and physical degradation.[190]

The government's own Department of Justice 2002 review of the evidence concluded that mandatory minimum sentences are "least effective in relation to drug offences" and that "drug consumption and drug related crime seem to be unaffected, in any measurable way, by severe mandatory minimum sentences."[191] Putting people in prison does not reduce levels of harmful drug use or the supply of drugs. If it did, the United States—with the highest rates of incarceration in the world, the largest proportion of which is attributable to drug offenses—would have one of the lowest levels of drug use and availability. In fact, it has one of the highest levels of use and a vast and increasing supply of illegal drugs.[192] In the U.S. where mandatory minimum sentences have been instituted, the results have been disastrous. Moreover, although rates of drug use and selling are comparable across racial and ethnic lines, blacks

and Latinos are far more likely to be criminalized for drug law violations than whites.[193]

Incarceration is costly and the introduction of mandatory minimum sentences only serves to increase these costs. Even very cautious estimates suggest that changes associated with the *Safe Streets and Communities Act* including the imposition of mandatory minimum sentences will cost the Canadian federal government about $8 million and the provinces another $137 million. These estimates fly in the face of the federal government's claim that these changes would not cost anything.[194] A study by the Quebec Institute for Socio-economic Research and Information suggests that the costs for the provinces will be much higher due to increases in the prison population—$1,676 million.[195] Already expenditures on federal corrections have increased to $2.375 billion in 2010-11, a 43.9% increase since 2005-06. The annual average cost of keeping a federal inmate behind bars has increased from $88,000 in 2005-06 to over $113,000 in 2009-10. In contrast, the daily average cost to keep an offender in the community is $80.82 or $29,499 a year.[196] Given these soaring costs, Canada's Correctional Investigator, Howard Sapers has suggested that, "at a time of wide-spread budgetary restraint, it seems prudent to use prison sparingly, and as the last resort it was intended to be."[197]

PRISON OVERCROWDING IS ALREADY A REALITY

Canada's federal prison system is already severely overcrowded, leading to increasing volatility behind bars. In the two-year period between March 2010 and March 2012, the federal in-custody population increased by almost 1,000 inmates or 6.8%, which is the equivalent of two large male medium security institutions. As of April 1, 2012 more than 17% of people in Canada's prisons are double-bunked.[198] This increase has occurred even before the imposition of mandatory minimum sentences, which will stress Canada's incarceration system even further.[199]

To accommodate increases in Canada's prison population, the federal government plans to add 2,700 cells to 30 existing facilities at a cost of $630 million. It also plans to close three federal facilities as part of its budget reduction plan. These closures will affect 1,000 people who will need to be relocated including 140 residing at the Ontario Regional Treatment Centre, a stand-alone facility at Kingston Penitentiary.

As of April 2011, 21% of federal offenders were serving a sentence for a drug crime. And 55% of people incarcerated in federal prisons have problems with substance use.[200] Despite this clear need for in-prison treatment, prison-based substance use programming is also in decline; the Correctional Service of Canada's budget for these programs fell from $11 million in 2008-09 to $9 million in 2010-11.[201]

Programs and other services inside prison that help inmates transition to life after prison are also either in decline or plagued by lack of available resources. For instance the government cancelled the safer tattooing initiative in prisons in 2006 despite the effectiveness of such programs in curbing the spread of HIV and HCV.[202] The passage of the *Safe Streets and Communities Act* follows on these and other moves by the federal government that make prisons less safe and reduce the discre-

tion of the judicial system in developing appropriate sentences for individuals convicted of drug crimes. This program recognized that tattooing takes place inside prison walls and that sharing of used equipment could potentially result in HIV and HCV infections. The Canadian Correctional Service's own evaluation of the program found positive results including: infectious disease prevention practices; potential to reduce exposure to health risks and enhance the safety of staff members, inmates and the general public; additional employment opportunities for inmates in the institution; and work skills that are transferable to the community.[203]

PRISON SENTENCES ARE INEQUITABLE

As the U.S. experience shows, the brunt of mandatory minimum sentences will be borne by people who are drug dependent, and not those involved in the higher levels of drug selling and production. Indeed, individuals who sell drugs at the street level are more often than not involved in tasks such as carrying drugs and steering buyers towards dealers; real profiteers in the drug market distance themselves from visible drug-trafficking activities and are rarely captured by law-enforcement efforts.[204] These findings undermine the 'tough on crime' approach touted by those in favour of mandatory minimum sentencing. In fact, recognizing the high financial and social costs of mandatory minimum sentences, as well as their widespread failure, the states of New York, Michigan, Massachusetts and Connecticut, have repealed these sentences for non-violent drug crimes, with other U.S. jurisdictions set to follow.[205] The overrepresentation of Aboriginal Canadians in this country's prison system is a national disgrace, made all the more disturbing by its avoidability. In 2011, approximately 4% of the Canadian population was Aboriginal, while 21.5% of the federal incarcerated population were Aboriginal. Since 2006-06, there has been a 43% increase in Aboriginal inmate population, and one in three federally sentenced women are Aborignal. In the Prairies, Aboriginal people comprise more than 55% of the total prison population at Saskatchewan Penitentiary and 60% at Stony Mountain Penitentiary in Manitoba. Provincial rates are even worse; 81% of people in provincial custody in Saskatchewan were Aboriginal in 2005.[206] A 2004 study of incarceration in Canada found that visible minority offenders are incarcerated more often for drug related offences than white offenders despite having less extensive criminal histories than white offenders.[207] The reasons for the overrepresentation of Aboriginal people in Canada's prisons are multifaceted and have to do with root historical causes discussed earlier in this report.

A 2013 report by the BC Provincial Health Officer warns that recent changes to sentencing and other justice practices brought about by the enactment of the *Safe Streets and Communities Act* will be extremely impactful on Aboriginal people. These changes will put Aboriginal people at greater risk for incarceration and the resulting consequences of incarceration, including lack of access to culturally safe services that support healing and reintegration.[208] This report also notes that the SSCA appears to conflict with other federal programs aimed at reducing prison time, specifically section 718.2(e) of the Criminal Code which requires sentencing judges to consider all options other than incarceration.[209]

An October 2012 report by the Correctional Investigator of Canada entitled, *Spirit Matters: Aboriginal People and the Corrections and Conditional Release Act* (CCRA, 1992) echoed these concerns.[210] This report speaks to the lack of resolve on the part of the Correctional Service of Canada (CSC) to meet the commitments set out in the CCRA. Sections 81 and 84 of this Act were meant to help mitigate the over-representation of Aboriginal people in federal prison, and to provide a healing path based on cultural and spiritual practices. Included among these requirements was the establishment of Healing Lodges that emphasize Aboriginal beliefs and traditions and focus on preparation for release.[211]

The report found that in BC, Ontario, Atlantic Canada and the North there were no Section 81 Healing Lodge spaces for Aboriginal Women. In addition, because Healing Lodges limit intake to minimum-security offenders 90% of Aboriginal offenders were excluded from being considered for a transfer to a Healing Lodge. The report concludes with a critique of the lack of action by the Correctional Service of Canada: "Consistent with expressions of Aboriginal self–determination, Sections 81 and 84 capture the promise to redefine the relationship between Aboriginal people and the federal government. Control over more aspects of release planning for Aboriginal offenders and greater access to more culturally-appropriate services and programming were original hopes when the CCRA was proclaimed in November 1992."[212] The report concludes by calling on the CSC to ensure that the provisions of the Act are implemented in good faith.

The implications for Canadian drug policy are clear: rising rates of incarceration of Aboriginal people, higher rates of substance use problems combined with a lack of commitment to alternative healing paths means more federally and provincially sentenced Aboriginal people will not receive the services they need.

THE FAILURES OF PROHIBITION

Rather than reducing the supply of drugs, prohibition abdicates the responsibility for regulating drug markets to organized crime groups. Though Canada's rate of incarceration in 2011 was 117 per 100,000 people, a moderate rate compared to many other nations in the world (e.g. U.S at 730 and the Switzerland at 79)[213] there are demonstrable ways in which public safety is undermined by a strictly prohibitionist approach to drugs:

Increases in Violence: Because of the lack of formal regulation used in the legitimate economy, violence can be the default regulatory mechanism in the illicit drug trade. It occurs through enforcing payment of debts, through rival criminals and organizations fighting to protect or expand their market share and profits, and through conflict with drug law enforcers. In Canada, gang violence sometimes results from turf wars over control of illegal drug markets. A "get tough" approach to crime assumes that more enforcement will eliminate the problem of gang violence. But as a comprehensive review by the International Center for Science in Drug Policy states: "Contrary to the conventional wisdom that increasing drug law enforcement will reduce violence, the existing scientific evidence strongly suggests that drug prohibition likely contributes to drug market violence and higher homicide rates."[214] Indeed the demand

for drugs means that as soon as one dealer is removed others are there to take their place.

Creation of unregulated drug markets: Drug policies that prohibit some substances actually eliminate age restrictions by abandoning controls to an unregulated market. In addition, when we prohibit rather than regulate substances, it becomes impossible to control the purity and strength of drugs. Illegally produced and supplied drugs are of unknown strength and purity, increasing the risk of overdose, poisoning and infection.[215]

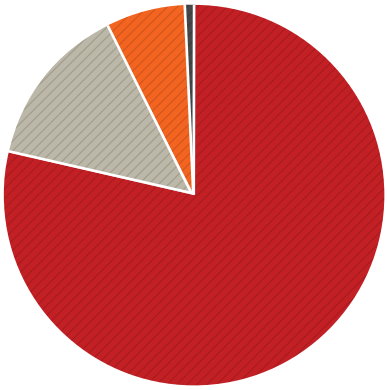
Substance displacement: As the United Nations Office on Drugs and Crime reports, if the use of one drug is controlled by reducing supply, suppliers and users may move on to another drug with similar psychoactive effects, but less stringent controls.[216] For example, studies of the effects of banning mephedrone (a cathinone analogue) in the U.K. suggest that people who used this drug before the ban either continued their use, or switched back to prohibited substances like ecstasy and cocaine, both of which are unregulated and thus of unknown purity and strength.[217]
Market displacement: Studies suggest that geographically specific enforcement practices tend to displace drug markets to other locations rather than eliminate them.[218] These findings raise serious concerns about the capacity of law enforcement strategies to completely eliminate drug supply.

Medical applications: The complete prohibition of some substances curtails their potential medical uses and benefits, as well as research into potential beneficial applications of controlled substances. An example is the use of pharmaceutical-grade heroin to treat individuals for whom other treatments have not worked. The findings of a Canadian trial of heroin-assisted treatment—the North American Opiate Medication Initiative (NAOMI) study conducted in Vancouver, BC and in Montreal, QC – were positive. Yet the continued prohibition of heroin hinders the use of this drug in treatment settings. Indeed the implementation of medical cannabis programs in Canada has been repeatedly thwarted by the prohibited status of this drug despite evidence that shows it has beneficial effects for many patients.[219]

Punitive approaches do not limit use: Comparisons between states or regions show no clear correlation between levels of drug use and the toughness of laws and penalties,[220] nor do studies tracking the effects of changes in policy show that drug use increases—for example if new laws decriminalising possession are introduced.[221] In short, any deterrence is at best marginal compared to the wider social, cultural and economic factors that drive up levels of drug use.

Criminalization increases the negative effects of drug use: The reality is that making some drugs illegal does not stop people from using substances as is evident from the United Nations data demonstrating increasing levels of drug use over the past three decades.[222] Criminalization of substance use further stigmatizes people who use drugs, making it more difficult to engage people in health care and other services. Criminalization also increases marginalization and encourages high-risk behaviours among people who use drugs, such as injecting in unhygienic environments, poly-drug use and binging. Evidence from other countries suggests the stigma

FIGURE 4: CANNABIS INCIDENTS REPORTED BY THE POLICE IN 2011



380 IMPORT & EXPORT

5,280 PRODUCTION

10,898 TRAFFICKING

61,406 POSSESSION

Source: Statistics Canada. Table 252-0051—Incident-based crime statistics, by detailed violations.

and fear of arrest deter people from seeking treatment, and it is more effective to divert users into treatment without harming their future prospects with a criminal record for drug use.[223]

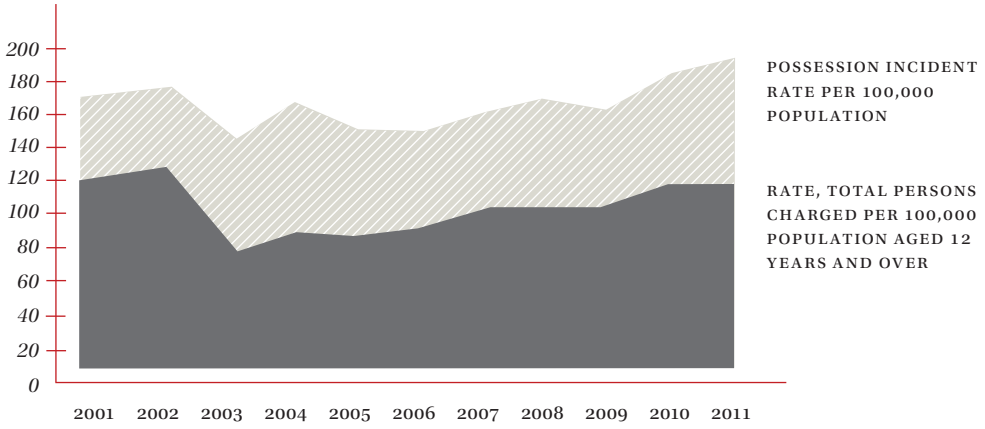
Trying to manage drug use through incarceration diverts law enforcement away from efforts to improve community safety with crime prevention programs. Funding prisons and police also takes away precious resources from services like adequate housing and family income, and robust educational programs, all of which have the potential to address the root causes of crime.[224] None of these strategies is at the forefront of the approach taken by Canada's current federal government.

Despite the well-documented failures of prohibition, Canada still pursues a strictly prohibitionist approach to many drugs and has in fact, scaled-up this approach in recent years.

CANNABIS AS A CASE IN POINT

Numerous drug use surveys in Canada report that next to alcohol and tobacco, cannabis is the most often used substance. Cannabis control policies, whether harsh or liberal, appear to have little or no impact on the prevalence of its consumption.[225] Though heavy use of cannabis can have negative health impacts, the overall public health impacts of cannabis use are low compared with other illicit drugs such as opioids or with alcohol, especially given that risk of overdose is very low, as is the risk from cannabis-related accidents.[226] A review of the harms of various substances published in the highly respected medical journal *The Lancet* found that alcohol was the most potentially harmful drug over even heroin and cocaine. Of the 20 drugs assessed by this study cannabis was ranked at eight in terms of harmfulness behind most major illegal substances.[227]

FIGURE 5: CANNABIS POSSESSION, INCIDENT AND CHARGE RATE, 2001 - 2011



Source: Statistics Canada, Table 252-0051 —Incident-based crime statistics, by detailed violations, annual.

In addition, police reports suggest that Canada has a robust underground cannabis industry. For example, the RCMP reported that in 2009, police agencies seized a total of 34,391 kilograms of cannabis and 1,845,734 cannabis plants. Police drug seizures only tell us part of the story. The most recent estimates of the size of the underground cannabis economy in Quebec peg it at 300 tonnes in 2002; in BC estimates of the size of the economy suggest it could reach as high as $7 billion annually.[228] A recent study estimated that annual retail expenditures on cannabis by British Columbians was $407 million and daily users accounted for the bulk of the cannabis revenue, with a median estimated expenditure of approximately $357 million.[229]

These data suggest that cannabis remains a popular drug, but the potential financial benefits of a regulated and taxable product like cannabis are completely lost to the federal and provincial treasuries.[230] In addition, the costs of criminalizing cannabis including policing, courts and corrections are borne by governments and Canadian taxpayers. In 2011 for example, there were 61,406 incidents reported to police involving possession of cannabis, a rate of 178 per 100,000 population for the whole of Canada. Police reported incidents of cannabis possession are far higher than any other illegal drug (21 for cocaine possession and a rate of 30 for all other illegal drugs combined). Indeed, police reported incidents of cannabis possession have increased 16% between 2001 and 2011. Of these police reported incidents, 28,183 were charged for possession of cannabis in 2011.[231]

A recent study in British Columbia suggests that charges for possession of cannabis in BC have doubled between 2005 and 2011 despite low public support for the imposition of a criminal conviction for this conduct. This study also found that charges for cannabis possession vary considerably between police

departments and between municipal police and RCMP detachments. The RCMP are responsible for an overwhelming majority of the charges in BC. The study's author conservatively estimates that it costs about $10 million annually in BC alone to enforce criminal prohibition against cannabis possession. Given the relatively low impact cannabis has on public health compared to other drugs, and the significant limitations placed on people with criminal convictions (employment and travel restrictions), the study's author suggests that our current policies likely do more to undermine collective respect for the law and law enforcement, than they do to protect public health.[232]

CHANGES TO CANADA'S MEDICAL CANNABIS ACCESS PROGRAM

The federal government has operated a Medical Marihuana (Sic) Access Program since 2001 prompted by court rulings that upheld the right to access cannabis for serious and chronic medical conditions.[234] That program is currently undergoing a major overhaul and in December 2012, the federal government released a set of proposed new regulations for the program.[235] The *Marihuana for Medical Purposes Regulations* (MMPR) will require patients to obtain a prescription-like document from a physician or nurse practitioner, rather than applying for an Authorization to Possess through Health Canada. The elimination of the very cumbersome application process and the addition of nurse practitioners as authorized health care practitioners prescribers are welcome moves. But in Canada too few physicians currently know enough about the benefits and risks of cannabis for medical purposes to make sound medical judgments and recommend it to their patients, nor are enough physicians sufficiently aware of the appropriate use of cannabis for medical purposes.[236] More education of physicians is needed to ensure that patients will have adequate access to the program. In the meantime, Health Canada must take proactive steps to establish fair and timely access to the program.

The proposed MMPR will also eliminate the Personal Use Production Licenses (PUPL) and thus the ability of people to grow their own cannabis. This is of concern for several reasons. Many people choose to produce their own supply because current prices of available cannabis are prohibitive.[237] Producing their own also enables them to select the strain(s) that work best for them. Health Canada's proposal to centralize the cultivation of cannabis for medical purposes in the hands of licensed commercial producers will increase the costs substantially as stated in the Regulatory Impact Analysis Statement which accompanies the proposed MMPR.[238] The elimination of the PUPL responds to concerns expressed by law enforcement and others about the cultivation of medical cannabis in residential homes.[239] Rather than eliminating this option, the MMPR could address these concerns through routine inspections and certification of home gardens.

The proposed regulations also exclude currently existing medical cannabis dispensaries in the supply and distribution system. These dispensaries play a key role in disseminating information about cannabis, and they offer a range of cannabis strains, products and services such as peer counseling and referrals to other services. Including medical cannabis dispensaries in the distribution system would

address some of the barriers to access to cannabis for medical purposes that Canadians currently experience.

If the goals of our current laws are to reduce cannabis production and consumption clearly these laws are not effective. Young people in Canada use cannabis extensively (depending upon the province, 30% to 53% of grade 12 students reported using cannabis during their lifetime).[240] In fact, a recent report from UNICEF suggests that Canada has the highest rate of youth cannabis use among developed countries, but one of the lowest rates of tobacco use.[241] Yet there are no regulatory controls such as age restrictions on cannabis as there are on tobacco. Nor can purchasers reliably determine the dose (i.e. level of THC) or the origin of this substance. When it comes to tobacco use, a regulatory system that includes age restrictions on purchase, prohibiting lifestyle marketing, and focusing on clean air initiatives has been effective in making Canada safer and healthier. Recognizing the unique challenges presented by cannabis policies, and the potential of a public health regulatory framework to control the use and availability of this drug, the Union of British Columbia municipalities recently endorsed a motion to encourage the BC provincial government to support the decriminalization and regulation of cannabis.

Motion Passed at the 2012 Conference of the Union of British Columbia Municipalities

WHEREAS marijuana prohibition is a failed policy which has cost millions of dollars in police, court, jail and social costs; AND WHEREAS the decriminalization and regulation of marijuana would provide tax revenues: THEREFORE BE IT RESOLVED that UBCM call on the appropriate government to decriminalize marijuana and research the regulation and taxation of marijuana.

Recent polls also suggest that a majority of Canadians are prepared to legalize and regulate cannabis (57%). In British Columbia, 77% of respondents to a poll indicated support for cannabis law reform.[243] They are not alone. In an effort to stem the damage that underground drug markets create, leaders in Central and South America have called for changes to the way cannabis is regulated. In 2011, the Global Commission on Drug Policy encouraged governments to experiment with the regulation of cannabis with the goals of safeguarding health and safety of all citizens.[244]

ALTERNATIVES TO PROHIBITION: WHAT ARE THEY?

It is time to consider an approach that helps to contain the negative effects of drug use, provides a variety of treatment modalities and harm reduction services, and avoids criminalizing those who choose to use drugs.

New models for addressing drug related problems are also emerging across the globe. In fact, in 2012 and 2013 the international consensus on prohibition seems to be coming apart. Countries are beginning to experiment with approaches that show more promise for achieving the health and safety goals for their communities. At least 25 jurisdictions around the world are currently deploying some form decriminalization of drugs.[245] Portugal, Uruguay, Guatemala, Colombia, the

ONE OF THE KEY PRIORITIES OF THE CDPC IS TO ELIMINATE THE CRIMINALIZATION OF DRUG USE. DRUG USE IS A HEALTH, NOT A CRIMINAL MATTER, AND SHOULD BE TREATED AS SUCH. PROHIBITION DOES NOT DELIVER ON ITS INTENDED GOALS, BUT IT DOES RESULT IN THE MARGINALIZATION OF WHOLE GROUPS OF PEOPLE AND, IN SOME CASES, THEIR DEATHS.

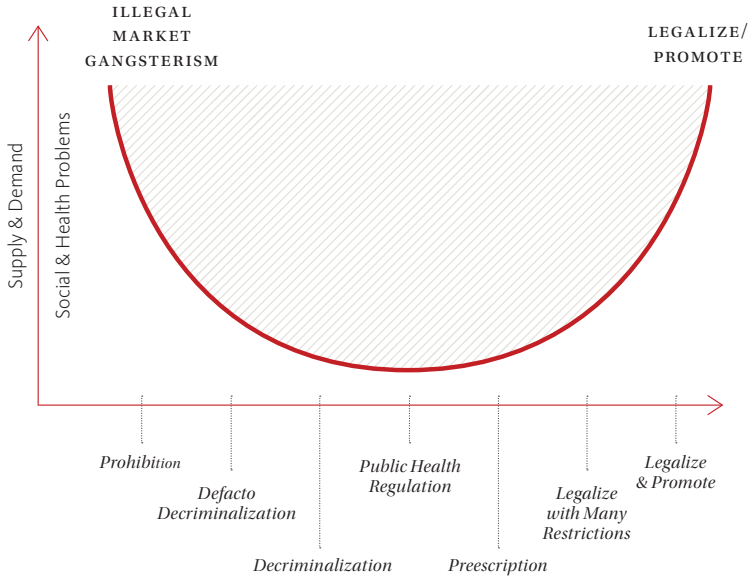
Czech Republic, as well as some U.S. states, are among the jurisdictions experimenting with either decriminalization or legal regulation of some drugs. Portugal decriminalized all illegal drugs in 2001. The Czech Republic has ventured down this same road. The Czech Republic decided to decriminalize all drugs in 2010 after undertaking a cost-benefit analysis of their policies that found that despite drug prohibition, 1. Penalization of drug use had not affected the availability of illegal drugs; 2. Increases in the levels of drug use had occurred; 3. The social costs of illicit drugs had increased considerably. After decriminalization and similar to Portugal, drug use has not increased significantly but the social harms of drug use have declined. In Portugal decriminalization has had the effect of decreasing the numbers of people injecting drugs, decreasing the number of people using drugs problematically, and decreasing trends of drug use among 15 to 24 year olds.[246]

In Uruguay legislators are considering a proposal to create a legally regulated and state controlled regime for cannabis. In November 2012, the U.S. states of Washington and Colorado voted to create regulated markets for cannabis for adults, and legislation to do the same has been introduced in eight other state legislatures. These events follow on a long history of decriminalization of cannabis including the Dutch coffee shop model, and the decriminalization of cannabis in several Australian and U.S. states. One of the key priorities of the CDPC is to eliminate the criminalization of drug use. Drug use is a health not a criminal matter and should be treated as such. Prohibition does not deliver on its intended goals, but it does result in the marginalization of whole groups of people and in some cases their deaths.

Canada has contributed some of the best thinking in the world when it comes to offering alternatives to prohibition. Since 1998, the Health Officers Council of British Columbia has created a series of discussion papers that recommend an end to prohibition and its replacement with a regulated market for all substances based on the principles of public health.[247] The latest of these papers published in 2011 describes how public health-oriented regulation of alcohol, tobacco, prescription and illegal substances can better reduce the harms that result both from substance use and substance regulation, compared to current approaches.

A model for legalizing and regulating cannabis draws on a public health approach which includes price controls through taxation, restriction of advertis-

FIGURE 6: THE PARADOX OF PROHIBITION



Adapted from: Health Officer's Council of BC, 2011

ing and promotion, controls on age of purchaser, driving restrictions, limited hours of sale, labeling that contains information on potency and health effects, plain packaging and licensing guidelines for producers of cannabis. Taxation has been shown to decrease levels of alcohol and tobacco use; similar approaches could be taken to cannabis to balance the need to limit use but avoid recreating an illegal market for contraband.[248] The U curve depicted (Figure 6) illustrates the relationship between how we control or regulate drugs and what happens to supply and demand. The left hand of the curve shows what happens when a substance is fully prohibited and thus controlled by an underground market. The right side of the curve similarly depicts what happens when a substance is legalized and promoted without regard for public health impacts. From the perspective of public health, the ideal mode of regulation sits in the middle of the curve at its lowest point. This is the point where a substance is available in a regulated market with appropriate age and other controls and appropriate programs that address the harms and benefits of substance use.

This discussion paper draws on a strong evidence base and focuses on the prevention of illness, injury, and mortality. As the image above illustrates, this paper recognizes that careful thought must be put into all aspects of a regulatory model for drugs. It also recognizes that changing how we control substances requires a robust governmental response to provide adequate health care and other

supports. In particular, a public health approach proposes that the supply chain for drugs would be under comprehensive societal control in order to maximize control over availability and accessibility and reduce consumer demand. [249]

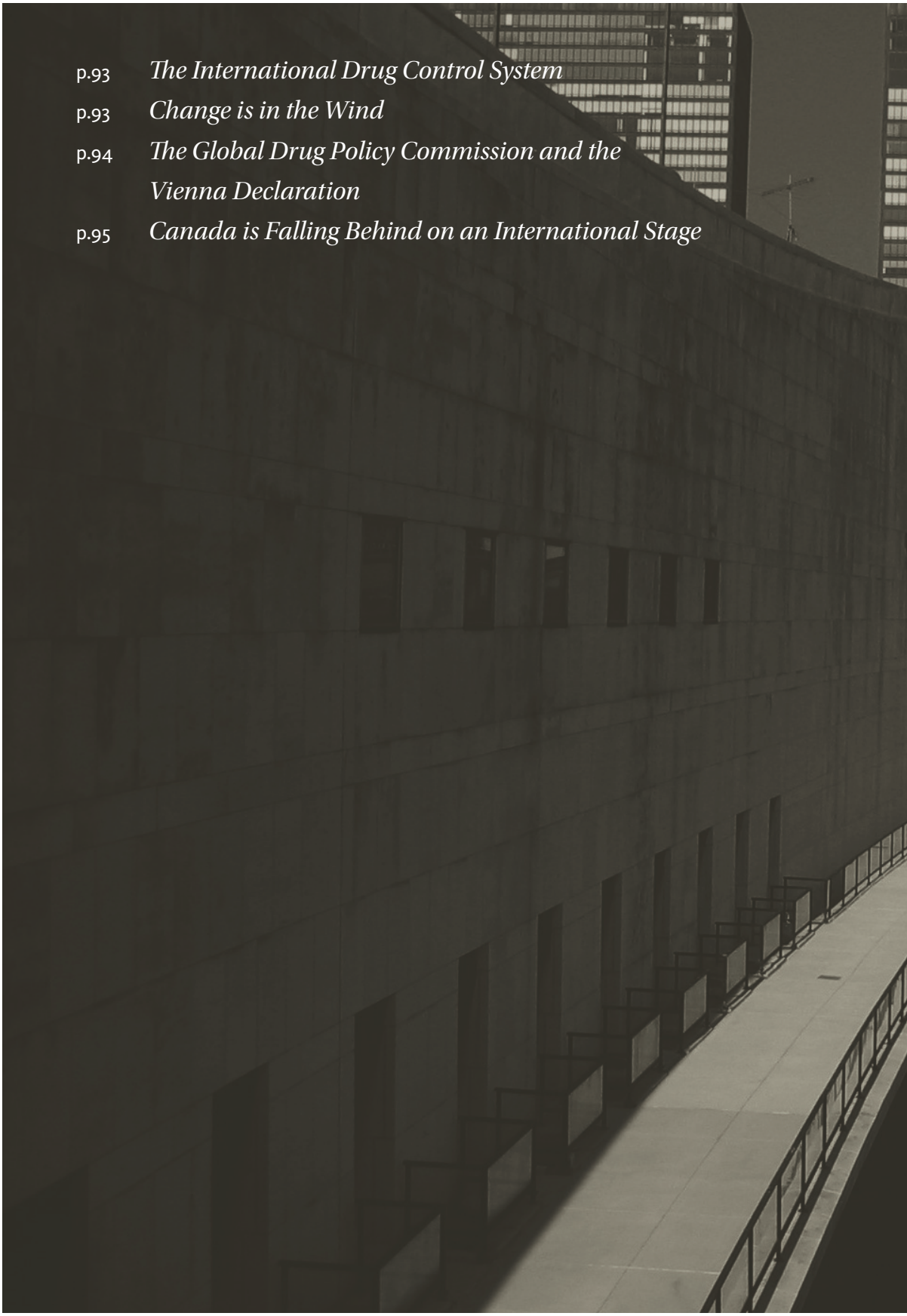
CASE STUDY
Waterloo Crime Prevention Council

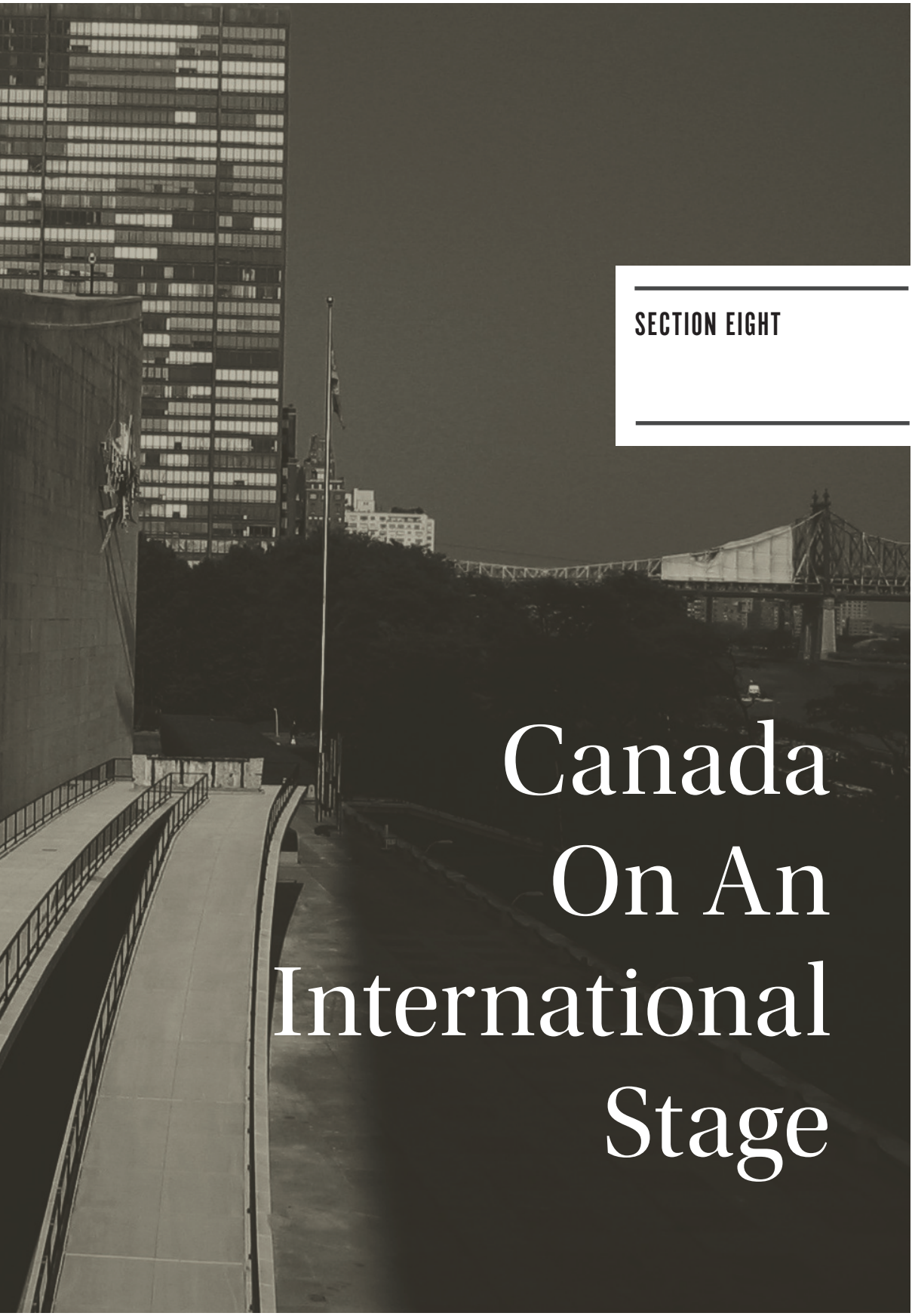
The Waterloo Region Crime Prevention Council (WRCPC) has been a Canadian model for crime prevention through social development since 1995. The Council's mission is to prevent and reduce crime, fear of crime and victimization—and always in partnership with community, including those most affected by program/policy design and delivery.

The WRCPC addresses the root causes of crime, fear of crime and victimization by acting as a catalyst, educator, connector, resource and supporter through evidence-informed practice and the wisdom of local community. For several years the Council has been involved with community and systems-wide issues related to alcohol, prescription and currently illicit substance use.

The WRCPC facilitated the Waterloo Region Harm Reduction Network in 2005 and later, the Ontario Network of Municipal Drug Strategy Coordinators. The WRCPC established the "KW Drug Users Group" as a safe place for people who use illicit drugs to meet and talk with each other about important issues. At any level, change always starts with dialogue. In the absence of interest from any sector, the WRCPC undertook primary research on the extent and typology of accidental drug overdoses, the third cause of accidental death in Ontario. They subsequently facilitated the establishment of Preventing Overdose Waterloo Wellington (POWW), a unique peer and service provider effort to train citizens and providers in overdose prevention and intervention. In 2012, the WRCPC published "Between Life and Death: Barriers to Calling 9-1-1 During an Overdose Emergency", a report unique in Canada which demonstrates a clear reluctance of OD witnesses to call 9-1-1, primarily out of fear of police attendance.

p.93 *The International Drug Control System*
p.93 *Change is in the Wind*
p.94 *The Global Drug Policy Commission and the Vienna Declaration*
p.95 *Canada is Falling Behind on an International Stage*





SECTION EIGHT

Canada On An International Stage

THE INTERNATIONAL DRUG CONTROL SYSTEM

As in Canada, policies and laws that prohibit and punish the use of certain substances have been the mainstay of the international approach.[250] The current United Nations drug control system is based on international treaties including the 1961 Single Convention on Narcotic Drugs, the 1971 UN Convention on Psychotropic Drugs and the 1988 Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances. This drug control system requires member states to take measures to prevent the non-medical use of a wide range of drugs through restrictions on production and supply and by suppressing demand for drugs. Canada participates in international forums and agencies that monitor the implementation of these treaties including the Commission on Narcotics Drugs and the International Narcotics Control Board (INCB). One of the key problems with international drug control is that bodies involved in shaping drug policy like the INCB have historically emphasized law enforcement and operate in isolation from the UN agencies that deal with the health and social consequences of drug markets (WHO, World Bank, UNAIDS, UNDP) and the UN bodies that focus on human rights issues. The INCB for example, operates as a guardian of drug prohibition and chastises member states for policy developments it considers to be inconsistent with the international treaties.

Recently the Board voiced its concern about the outcome of referenda in Washington and Colorado that effectively legalized simple possession of cannabis by adults.[251] And in its most recent report, the INCB chastised the Canadian Supreme Court for ruling in favour of the Insite, Vancouver's Supervised Injection facility. The INCB takes the position that supervised injection facilities contravene the international drug control conventions, despite their excellent record of preventing the harms of drug use.[252]

These comments by the INCB reflect its support for harsh policing and its tendency to use its reports as a mechanism to criticize states that deviate from repressive and supply-oriented international drug policies. While criticizing innovative and effective public health programs, the INCB overlooks the most heinous and repressive of drug policy developments around the globe including human rights abuses. Drug control cannot operate in isolation from international law including human rights law; nor can it be unconnected from the concerns of public health or medical ethics.[253]

CHANGE IS IN THE WIND

But despite these international bodies, the current system of drug control is under considerable pressure to change. Some national governments have begun to chart their own paths when it comes to drug control. Some countries do not suppress socially and culturally embedded uses of controlled drugs like cannabis, opium and coca leaf chewing. Other governments have introduced pragmatic measures based on public health that focus on reducing the harms associated with drugs (i.e. needle exchanges, etc.) And a number of governments have introduced de-penalization or decriminalization of some or all drugs to move away from the mass incarceration of people who use drugs.[254]

2012 was a monumental year for drug policy reform around the world. Cannabis legalization is now a reality in the U.S. with the passing of voter initiatives in Colorado and Washington State. Sitting politicians are beginning to speak out and call for dialogue on alternative approaches. Leaders throughout Latin America have begun to openly denounce the war on drugs and table reforms. The Organization of American States has begun a formal review process of the hemisphere's drug policies. There is an emerging consensus that the global war on drugs has been a catastrophic failure. Nowhere has this been made more evident than with the situation in Mexico, where the drug war has claimed the lives of 40,000 people over the past six years.[255]

THE GLOBAL COMMISSION ON DRUG POLICY AND THE VIENNA DECLARATION

One of the key events that helped turn the tide was the release of the Global Commission on Drug Policy's first report in June 2011. The 19-member panel, including current and former heads of state and former United Nations Secretary General Kofi Annan among others, and Canada's Louise Arbour, criticized global prohibition and recommended that policies be based on evidence of what works to protect the health and safety of citizens. The Global Commission called on countries to end the criminalization, marginalization and stigmatization of people who use drugs but who do no harm to others and called for wide-ranging changes in drug policies. Some of these recommendations include: experiment with models of legal regulation of drugs to undermine the power of organized crime; make available a variety of approaches to health, harm reduction and treatment services; abolish abusive practices associated with treatment such as forced detention; invest in effective prevention activities that avoid simplistic 'just say no' messages and 'zero tolerance' policies in favour of educational efforts grounded in credible information and programs that focus on social skills and peer influences; focus repressive actions on violent criminal organizations, to undermine their power and reach while prioritizing the reduction of violence and intimidation; and replace drug policies and strategies driven by ideology and political convenience with fiscally responsible policies and strategies grounded in science, health, security and human rights.[256]

In 2010 the International AIDS Conference endorsed the Vienna Declaration. The Declaration affirms the body of research that demonstrates that the criminalization of drugs and enforcement efforts at the international and national level are costly and ineffective when it comes to curbing substance use. The Declaration also outlined the unintended consequences of drug law enforcement and the criminalization of people who use drugs including rising rates of HIV, the undermining of public health approaches to substance use, and human rights abuses among others. The Vienna Declaration has been endorsed by thousands of people and organizations including the Canadian Public Health Association and the Urban Public Health Association, which represents the medical health officers of Canada's 18 largest cities.[257]

CANADA IS FALLING BEHIND ON AN INTERNATIONAL STAGE

Meanwhile, Canada's federal government, once a leader in the field of drug policy, has fallen behind and embraced punitive policies, such as mandatory minimums for drug offences, which have already proven to be ineffective in curbing drug use and detrimental to society at large. Despite evidence to the contrary, Canada is continuing to address the harms of its large underground drug economy by expanding a war on drugs approach that other countries are beginning to question.

Canada possesses a wealth of public health expertise, drug researchers, scientists and activists to help lead the country toward a more humane and just drug policy. Unfortunately this expertise has not translated into national policy. Despite signs of progress in other countries, Canada's approach to drug policy has taken significant steps backwards since 2006. Before that time, the Canadian government participated in the growing movement towards reforming drug policy to incorporate a public health approach. In the past, Canada attempted to decriminalize minor cannabis possession and supported some innovative harm reduction and treatment programs for injection drug users, including supervised consumption services and heroin-assisted treatment.

CANADA ALSO OPPOSED THE RECENT UN RESOLUTION TO HOLD A SPECIAL SESSION ON DRUG POLICY GLOBALLY, NOW SCHEDULED FOR 2016. THE RESOLUTION WAS CO-SPONSORED BY 95 COUNTRIES INCLUDING COUNTRIES IN LATIN AMERICA AND THE CARIBBEAN AND IN THE EUROPEAN UNION, AS WELL AS JAPAN, CHINA, AUSTRALIA, AND THE UNITED STATES.

Three federally funded reports, the 1973 Le Dain Commission, the Report of the Senate Special Committee on Illegal Drugs and the House of Commons Special Committee on Illegal Drugs report, have all recommended various versions of drug policy reform.[258] But since 2006, Canada has ceased to be a leader in innovative drug policies on an international stage.

Canada on the International Stage: On an international stage, Canada recently expressed its opposition to Bolivia's reservation to the 1961 Single Convention on Narcotic Drugs. In 2011, Bolivia proposed an amendment to article 49, deleting the obligation that "coca leaf chewing must be abolished." The coca leaf has been chewed and brewed for tea for centuries in the Andean region and produces a mild stimulant effect similar to caffeine. Without any objections, Bolivia's request would have been approved automatically. When its attempt to amend the Single Convention failed in 2011, Bolivia left the Convention with the intent to rejoin with a new reservation designed to align its international obligations with its constitution, which protects indigenous rights including the right to chew coca leaves.[259] Coca chewing is part of traditional and Indigenous practice in Bolivia and has many important social and health ben-

efits. With the support of 169 countries Bolivia re-entered the Convention in 2013 with the reservation in place, though the exportation of coca internationally remains prohibited. Only 15 countries objected to Bolivia's reservation, including Canada.[260] Bolivia's actions are part of a rising tide of efforts to assert unique national perspectives on the regulation of drugs and to affirm respect for traditional Indigenous use of these substances.

Canada also opposed the recent UN resolution to hold a special session on drug policy globally, now scheduled for 2016. The resolution was co-sponsored by 95 countries including countries in Latin America and the Caribbean and in the European Union, as well as Japan, China, Australia, and the United States.[261] This resolution was initially brought forward by the leaders of Mexico, Colombia and Guatemala, three countries suffering some of the worst harms of global drug policies that focus on enforcement to the exclusion of human rights and health concerns. Support for this resolution was an acknowledgement of a deepening crisis in the hemisphere. Canada's refusal to support this resolution signals its approach: to keep to the status quo and to refuse to acknowledge that a vigorous discussion about the harms of drug prohibition is taking place around the globe.

Canada's increasing involvement in the war on drugs: Canada, has also scaled up its involvement in drug enforcement around the world.

Since 2006, the Canadian Forces have joined with other countries in an unprecedented increase in military involvement in drug interdiction in Latin America. Canada, for example, participates in ongoing counter-narcotics missions in the Caribbean Sea and the eastern Pacific. Canadian warships and aircraft have acted as eyes and ears for the U.S.-led Joint Interagency Task Force—South (JIATF-S) to prevent transport of drugs and money by air and sea between South America, Central America, the Caribbean islands and North America.[262] Canadian military aircraft and warships have been involved in interdiction efforts in the Caribbean Sea including assisting the U.S. Coastguard to board vessels and seize illegal drugs. Canadian military aircraft have been involved in surveillance sorties in the region.[263]

These moves signal a renewed emphasis on a repressive approach both at home and internationally.[264] The rationale for the Canadian military's involvement in the war on drugs is built on a series of faulty premises. Firstly—that military might and securitization can defeat drug cartels. One need only look to Mexico, which saw an explosion in violence after President Calderón declared war on the drug cartels in 2006, to see how woefully dangerous an idea this is. Secondly, regardless of the Canadian military's interdiction efforts, the supply of illegal drugs to Canadian consumers has remained the same. As with all attempts over the last forty-plus years to control the flow of narcotics into Canada, as long as a demand exists, the supply will continue. No counter-narcotic activity, no matter how costly or logistically sophisticated, has ever managed to halt the flow of drugs across Canadian borders.

Given Canada's unique geopolitical position, it is time for Canada to again become a global leader in drug policy reform.

LIST OF ACRONYMS

· BBV	Blood-borne virus
· CADUMS	Canadian Alcohol and Drug Use Monitoring Survey
· CCRA	*Corrections and Conditional Release Act*
· CDSA	*Controlled Drugs and Substances Act*
· CND	UN Commission on Narcotic Drugs
· CSC	Correctional Service of Canada
· CCSA	Canadian Centre on Substance Abuse
· DOCAS	Drugs and Organized Crime Awareness Service (RCMP)
· DTC	Drug Treatment Court
· HCV	Hepatitis C virus
· HAT	Heroin-Assisted Treatment
· HIV	Human Immunodeficiency Virus
· INCB	International Narcotics Control Board
· MDMA	Methylenedioxymethamphetamine (sometimes known as ecstasy though ecstasy does not necessarily contain MDMA)
· MMT	Methadone Maintenance Therapy
· NADS	National Anti-Drug Strategy
· NNDAP	National Native Alcohol and Drug Abuse Program
· RCMP	Royal Canadian Mounted Police
· *SSCA*	*Safe Streets and Communities Act*
· TDS	Toronto Drug Strategy
· UNODC	United Nations Office on Drugs and Crime
· VANDU	Vancouver Area Network of Drug Users
· WRCPC	Waterloo Region Crime Prevention Council
· WHO	World Health Organization

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