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Standing Senate Committee on Legal and Constitutional Affairs
The Senate of Canada
Ottawa ON
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I. Introduction

The Canadian Drug Policy Coalition (CDPC) is a national, non-partisan organisation seeking to end the harms of Canada’s century-old regime of drug prohibition through evidence-informed drug policies. We collaborate with over 50 civil society and human rights groups across the country, focusing on public education, consultation with communities most impacted by prohibitionist drug policies, academic research, and robust engagement with diverse stakeholders. The CDPC head office is located at Simon Fraser University in Vancouver, British Columbia, in the Faculty of Health Sciences.

In December 2021, CDPC co-released a policy platform entitled “Decriminalization Done Right” (Appendix 1). It outlined reforms that would best support a public health and human rights-centred approach to drug policy and has been endorsed by over 100 organisations across Canada. CDPC also contributed to Health Canada’s “Expert Task Force on Substance Use,”¹ which recommended that Health Canada end all criminal penalties and coercive measures related to simple drug possession and begin legislating all psychoactive substances, including alcohol and tobacco, under a single public health legal framework. We appreciate the opportunity to comment on Bill C-5, *An Act to amend the Criminal Code and the Controlled Drugs and Substances Act*. We are eager to provide our input to the Standing Senate Committee on Legal and Constitutional Affairs to strengthen the Act based on existing evidence.

Our recommendations on Bill C-5 are as follows:

- Amend Bill C-5 to include a full repeal of Section 4 and amendments to Section 5 of the *Controlled Drugs and Substances Act*,
- Introduce additional amendments to the declaration of principles in Section 10.1 that recognize in most cases substance use is not problematic; interventions must be voluntary; interventions must address improving social determinants of health; criminal sanctions imposed for necessity trafficking can increase the stigma associated with drug use and are not consistent with human rights or established public health evidence; and Black, Indigenous, racialized and low-income communities have been disproportionately affected by criminal sanctions imposed by the *Controlled Drugs and Substances Act*,
- Amend Section 10.2(1) to remove any referrals made to individuals by peace officers for programs, agencies or service providers,

- Amend Section 10.2 to include the development of national guidelines for peace officers enumerating clearly defined grounds under which a peace officer can stop and question a person for simple drug possession and necessity trafficking,
- Remove Section 10.2(2) which states that any charges are valid despite the failure of a peace officer to consider options listed in Section 10.2(1) including taking no further action or warning the individual,
- Amend Section 10.4 to ensure that solely demographic information of any warnings made by peace officers will be retained, rather than the identity of that individual,
- Amend Section 10.6 to ensure that, once the sequestering system is implemented, any record of conviction under Section 4(1) is sequestered immediately rather than after two years, and
- Amend Section 10.6 to ensure that the Governor in Council adopts as soon as practicable, and within one year of the sequestration system being implemented, regulations to remove and destroy those records after sequestration, so they are no longer accessible to law enforcement and other authorities.

We provide supporting evidence for our recommendations below.

II. Full Repeal of Section 4 of the *Controlled Drugs and Substances Act* (CDSA)

The CDPC **strongly urges a full repeal of Section 4 the *Controlled Drugs and Substances Act* (CDSA)**. There is no evidence that criminalizing simple drug possession promotes individual or societal health and safety, nor does it reduce drug consumption. A 2018 report prepared for the Senate Special Committee on Illegal Drugs concluded, “*If the intention of a prohibition-based system was to protect individuals from harms inherent to substance use, then this policy approach has significantly failed to achieve this goal at an individual or population level.*”^{III} This is in part because criminalization is demonstrably linked to policing practices that deter health-promoting behaviours. The prospect of being stopped, searched, or apprehended by police compels people who use drugs (PWUD) to use in isolation^{III}, enhancing the risk of fatal overdose given the realities of a toxic, unregulated drug market. Street-level policing is also positively correlated with syringe-sharing, rushed injection, avoidance of safe consumption sites, non-adherence to opioid agonist therapy, antiretroviral therapy and safe supply programs, and fear of physical assault.^{IV} The criminalization of simple drug possession contributes to widespread health and social harms, representing a stark departure from the international human rights treaties to which Canada is a party^V, and undermining Health Canada’s Expert Task Force on Substance Use recommendation that “Health Canada end criminal penalties related to simple possession.”^I

It is also important to recognize that Canada’s drug control framework originated at the intersections of capitalism, colonialism, and anti-Black and anti-Asian racism.^{VI, VII} As an historic regime of surveillance and control, its contemporary ramifications are particularly pronounced among structurally vulnerable communities. Specifically:

- Data released in 2020 revealed that “*Black people accounted for 6.4 per cent of drug trafficking and possession charges recommended by Vancouver police since 2014*” despite

making up only one per cent of the city's population, while "*Indigenous people faced almost 18 per cent of drug charges but are just 2.2 per cent of the city's population;*"^{viii}

- Data published in 2020 demonstrated that "*Black people [in Toronto are] grossly over-represented in both cannabis and 'other' drug possession charges,*" are "*grossly over-represented in discretionary, lower-level charges,*" are "*more likely than White people to face low-quality charges with a low probability of conviction,*" and are "*significantly over-represented in all use of force cases involving the Toronto police;*"^{ix}
- Following cannabis legalization, a 2020 study nonetheless found that "*Black and Indigenous people are over-represented amongst those arrested for cannabis possession in major urban centres. It concluded that, 'Canadian cannabis legalization lacks measures to redress the racialized harms caused by the war on drugs'*"^x and;
- A study published in the International Journal of Drug Policy concluded, "*[D]rug control efforts have served to diminish the health, well-being, and self-image of Black men via discriminatory and inequitable treatment before the law.*"^{xi}

In Canada, awareness of these inequities has contributed to increasing support for decriminalization among community organisations, public health entities, professional bodies, policing forces, and the general public. In 2020, the Canadian Association of Chiefs of Police (CACP) Special Purpose Committee on the Decriminalization of Illicit Drugs conceded that, "*the application of the law is inconsistent across communities,*"^{xii} echoing positions taken by the municipalities of Vancouver and Toronto and the province of British Columbia who have pursued, successfully in the latter case, the decriminalization of simple drug possession. We urge the Committee to pay heed to the Canadian government's professed commitment to racial justice vis a vis its Anti-Racism Strategy^{xiii} and the Calls to Action outlined in the Truth and Reconciliation Commission^{xiv} by repealing Section 4 of the CDSA. Doing so is of great relevance to Canada's identity as a fair, conciliatory, and unprejudiced nation.

III. Amendments to Section 5 of the *Controlled Drugs and Substances Act* (CDSA)

Bill C-5's proposed amendments to Section 5 of the CDSA maintain that if a person contravenes Subsection (1) or (2), and if the subject matter of the offence is a substance included in Schedule I or II, they are guilty of an indictable offence and liable to imprisonment for life. These amendments pertain to necessity trafficking. As per CDPC's "Decriminalization Done Right" platform (Appendix I), **we strongly encourage the Committee to use this opportunity to amend Section 5 of the CDSA to permit "*the sharing and selling of drugs for subsistence, to support personal drug use costs, and to provide a safe supply.*"**

Contrary to prevailing narratives, necessity trafficking is not lucrative, and it is not done out of malice. Rather, it is most prevalent among impoverished, street-level PWUD who are excluded

from the formal economy and have few or no alternatives to selling drugs.^{xv} Academic research and anecdotal evidence suggest a) drug users and drug sellers are often the same people; b) drug sellers tend to have positive relationships with those they sell to; and c) drug sellers regularly participate in care practices that minimise the harms of a toxic drug supply (e.g., carrying naloxone, responding to overdose, developing rapport with buyers).^{xvi} Particularly in absence of a legal, regulated supply of drugs, it is a poor use of public resources to criminalize necessity trafficking. A more productive use of these resources would be the targeted implementation of robust poverty reduction initiatives that include viable pathways for PWUD out of the street-based economy, as well as funding for health, education, and social service initiatives.

IV. Evidence-Based Diversion Measures

A. Declaration of Principles

The CDPC has significant concerns about the proposed amendments outlined in Part I.1, “Evidence-Based Diversion Measures,” of the Bill. Namely, while the CDPC applauds the Committee for considering the introduction of rights-based Principles in Section 10.1, we wish to critically interrogate their underlying premises, potential impacts, and how they are contravened by the actual contents of the Bill, which currently do not include repealing Section 4 of the CDSA. It is crucial to recognize that **most substance use is not problematic**. The majority of PWUD, including those who consume illegal drugs, are ‘episodic’ or recreational users.^{xvii} A robust literature demonstrates that those who develop chaotic or compulsive relationships with illegal drugs do so in tandem with material deprivation and exposure to trauma, including the trauma derived from poverty, homelessness, negative encounters with police, involuntary institutionalization, and race and gender-based discrimination.^{xviii} We emphasize that a) substance use is a morally neutral activity;^{xix} and b) our current drug policy environment is a site and source of trauma, acting as a catalyst for some drug use. It is therefore more effective to alter the policies and laws that mediate individual behaviour than it is to target said behaviour.

Next, rather than reduce stigma, the a priori assumption that all PWUD require intervention, whether criminal, psycho-therapeutic or medical, can, paradoxically, exacerbate it. For example, first responders and medical service providers often perceive people diagnosed with “substance use disorders” as “dangerous,”^{xx} while interviews conducted with employers reveal low willingness to hire people who identify publicly as having experienced addiction.^{xxi} Interpersonal stigma fuels internalised stigma, as can involuntary enrolment in addiction-related treatment. In Canada, the vast majority of treatment for addiction is ideologically rooted in the “12 Steps” of Alcoholics and Narcotics Anonymous, programs designed nearly a century ago that are routinely criticised for being unsupported by contemporary evidence.^{xxii} Research on the effects of these programs suggests that enrolment contributes to viewing oneself as unstable, incompetent, and untrustworthy,^{xxiii} and that people are at significantly increased risk of non-fatal and fatal overdose immediately following discharge.^{xiv} The CDPC encourages the Committee to recognize that stereotypes about drugs and those who use them impede access to full societal participation; addressing them requires legislative and regulatory change, and that stigma gives way to discrimination when enacted by representatives of the criminal justice system. The amendments

proposed in Bill C-5 rely heavily on police and judiciary discretion. Paying heed to the disproportionate impacts of drug prohibition on Black and Indigenous communities, and in the spirit of enhancing public health, human rights, and bodily autonomy, we propose the following amendments to the Principles, with our revisions in red.

- (a) ~~problematic~~ substance use should be addressed primarily as a health and social issue;
- (b) interventions should be founded on evidence-based best practices and should aim to protect the ~~health, dignity and human rights~~, ~~dignity and health~~ of individuals who use drugs and to reduce harm to those individuals, their families and their communities;
- (c) criminal sanctions imposed in respect of the possession of drugs for personal use ~~can~~ increase the stigma associated with drug use and are not consistent with human rights or established public health evidence;
- (d) ~~criminal sanctions imposed in respect of the sale or exchange of drugs for subsistence, to support personal drug use costs, or to provide a safe supply within one's network increase the stigma associated with necessity trafficking and are not consistent with human rights or established public health evidence;~~
- (e) interventions should address the root causes of problematic substance use, ~~including by addressing structural vulnerabilities such as poverty~~ and by ~~encouraging~~ investing public resources in measures such as ~~voluntary~~ education, ~~voluntary~~ treatment, aftercare, ~~rehabilitation~~ and social reintegration;
- (f) ~~Black, Indigenous, and other racialized communities have been disproportionately affected by the criminal sanctions imposed in respect of the possession of drugs; and~~
- (g) judicial resources are more appropriately used in relation to offences that pose a risk to public safety.

B. Warning and Referrals

Given this background and context, and due to the extent to which any criminal record or government-documented history of illegal drug possession or distribution is a catalyst for stigma, discrimination, and other harms, we wholly reject the introduction of diversion initiatives that are not entirely voluntary. Short of repealing Section 4 of the CDSA, we urge the Committee to consider the following amendments to Subsections 10.2(1) through 10.6

- Amend Section 10.2(1) to remove any referrals made to individuals by peace officers for programs, agencies or service providers;

- Amend Section 10.2 to include the development of national guidelines for peace officers enumerating clearly defined grounds under which a peace officer can stop and question a person for simple drug possession and necessity trafficking;
- Remove Section 10.2(2) which states that any charges are valid despite the failure of a peace officer to consider options listed in Section 10.2(1) including taking no further action or warning the individual;
- Amend Section 10.4 to ensure that solely demographic information of any warnings made by peace officers will be retained, rather than the identity of that individual;
- Amend Section 10.6 to ensure that the Governor in Council adopts as soon as practicable, and within one year of the sequestration system being implemented, regulations to remove and destroy those records after sequestration, so they are no longer accessible to law enforcement and other authorities; and
- Amend Section 10.6 to ensure that the Governor in Council adopts as soon as practicable, and within one year of the sequestration system being implemented, regulations to remove and destroy those records after sequestration, so they are no longer accessible to law enforcement and other authorities.

We thank you for this opportunity,

Nicole Luongo, Systems Change Coordinator, Canadian Drug Policy Coalition
 Beeta Senedjani, Dialogues Program Coordinator, Canadian Drug Policy Coalition
 Donald MacPherson, Executive Director, Canadian Drug Policy Coalition

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- I. Government of Canada, Report 1: Recommendations on alternatives to criminal penalties for simple possession of controlled substances, 2021.
- II. Government of Canada, Report of the Senate Special Committee on Illegal Drugs, 2018.
- III. See, for example, L. Ti et al. (2013). "Police confrontations among street-involved youth in a Canadian setting," *Int J Drug Policy*, 24(1): 46–51; M. Bonn et al. (2020). "Addressing the syndemic of HIV, Hepatitis C, overdose, and COVID-19 among people who use drugs: The potential roles for decriminalization and safe supply," *Journal of Studies on Alcohol and Drugs*, 81(5): 556-560; B. del Pozo et al. (2021). "Police discretion in encounters with people who use drugs: operationalizing the theory of planned behavior," *Harm Reduction Journal*, 18: 132 and; J. Friedman et al. (2021). "Intersectional structural vulnerability to abusive policing among people who inject drugs: A mixed methods assessment in California's central valley," *International Journal of Drug Policy*, 87

- IV. See, for example, G. Bardwell et al. (2019). "Implementation contexts and the impact of policing on access to supervised consumption services in Toronto, Canada: a qualitative comparative analysis," *Harm Reduction Journal* 16: 30 and; P. Baker et al. (2020). "Policing practices and risk of HIV infection among people who inject drugs," *Epidemiol Rev*, 42(1): 27–40.
- V. Government of Canada, International Human Rights Treaties to which Canada is a Party. Online: <https://www.justice.gc.ca/eng/abt-apd/icg-gci/ihrl-didp/tcp.html>
- VI. In "Busted: An Illustrated History of Drug Prohibition in Canada," legal scholar and historian Susan Boyd writes, "The current and prevailing moralistic view of drugs came from the shores of Europe as British settlers arrived in Canada to eventually colonize Indigenous land. More specifically, prohibition—grounded in the idea that drugs are inherently bad and an immoral, corrupting force—evolved from the Protestant Christian ethic of the 1700s that used prohibition as a means of social control over racialized nations and communities. These communities were viewed as "other" and a threat to white European supremacy." See: S. Boyd. (2017). "Busted: An Illustrated History of Drug Prohibition in Canada," Fernwood Publishing. Online: <https://drugpolicy.ca/about/history/>
- VII. Robyn Maynard, recipient of the SSHRC Talent Award, Vanier Scholar, and author writes, "Black peoples' movement in and through public space was criminalized under slavery, which was legal and practiced in pre-Confederation Canada for over 200 years, and that the enduring surveillance of Black peoples' lives was carried forward through the practices of carding and police killings (among others). After slavery's abolition, criminalization and surveillance of Black men and women, in the form of disproportionate arrests and charges, was common in many cities throughout the twentieth century. The creation and development of drug laws, in particular, were permeated with racial tropes associating Black and Chinese communities with crime, drugs, and moral turpitude...Decriminalizing drugs, expunging records, and providing a safe supply would be lifesaving, and one means of redress for long-targeted Black, Indigenous, racialized, and poor communities, and people living with mental health issues or disabilities." See R. Maynard. (2017). "Policing Black Lives: State Violence in Canada from Slavery to the Present," Fernwood Publishing. Online: <https://www.drugpolicy.ca/about/racism/>
- VIII. D. Fumano, "New figures reveal the racial disparity in Vancouver drug charges," *Vancouver Sun*, August 7, 2020.
- IX. Ontario Human Rights Commission, *A Disparate Impact: Second interim report on the inquiry into racial profiling and racial discrimination of Black persons by the Toronto Police Service*, August 10, 2020.
- X. A. Owusu-Bempah and A. Luscombe. (2020). "Race, cannabis and the Canadian war on drugs: An examination of cannabis arrest data by race in five cities," *International Journal of Drug Policy*, 102937.
- XI. A. Khenti. (2014). "The Canadian war on drugs: Structural violence and unequal treatment of Black Canadians," *International Journal of Drug Policy* 25, 190–195.
- XII. Canadian Association of Police Chiefs (CAPC), *Decriminalisation for Simple Possession of Illicit Drugs: Exploring Impacts on Public Safety and Policing*, Special Purpose Committee, 2020.
- XIII. Government of Canada, *Building a Foundation for Change: Canada's Anti-Racism Strategy 2019–2022*.
- XIV. Truth and Reconciliation Commission of Canada: *Calls to Action*, Truth and Reconciliation Commission of Canada, 2015.
- XV. A. Stryker, *Re-thinking the Drug Dealer*, Drug Policy Alliance, 2019.

- XVI. See, for example, R. Masetti, *Consider the Dealer: Supplying Drugs And Harm Reduction In The UK*, Talking Drugs, 2020; S. Kuwabara Blanchard, *Leaked FBI Report: Drug Sellers Practice Harm Reduction*, Filter Magazine, 2020 and; A. Betsos et al. (2021). “I couldn’t live with killing one of my friends or anybody”: A rapid ethnographic study of drug sellers’ use of drug checking,” *International Journal of Drug Policy* 87, 102845.
- XVII. A. K. Schlag. (2020). Percentages of problem drug use and their implications for policy making: A review of the literature. *Drug Science, Policy, and Law*, 6.
- XVIII. See, for example, V. Smye et al. (2011). Harm reduction, methadone maintenance treatment and the root causes of health and social inequities: An intersectional lens in the Canadian context, *Harm Reduction Journal*, 8(17); J. Lavalley et al. (2017). Reconciliation and Canada’s overdose crisis: responding to the needs of Indigenous Peoples. *Canadian Medical Association Journal*, 190(50) E1466-E1467; K. Milaney et al. (2021). Drug use, homelessness and health: responding to the opioid overdose crisis with housing and harm reduction services. *Harm Reduction Journal*, 18(92) and; D. J. Kinitz et al. (2022). Health of two-spirit, lesbian, gay, bisexual and transgender people experiencing poverty in Canada: a review. *Health Promotion International*, 37(1), daab057.
- XIX. For a critical interrogation of drug use, trauma, and pleasure, see, for example, S. Fraser (2008). Trauma, damage, and pleasure: Rethinking problematic drug use, *International Journal of Drug Policy*, 19(5), 410-416.
- XX. N. E. Kruis. (2021). Exploring first responders' perceptions of medication for addiction treatment: Does stigma influence attitudes? *Journal of Substance Abuse and Treatment*, 131, 108485
- XXI. A. B. Becton. *A Second Chance: Employers’ Perspectives in Hiring Individuals in Addiction Recovery, Rehabilitation and Counseling* Faculty Publications and Presentations, College of Health Professions, Spring 2017.
- XXII. J. Flanagan, *The Surprising Failures of 12 Steps*, The Atlantic, 2014
- XXIII. See, for example, J. B. Luoma. (2010). Substance use stigma as a barrier to treatment and recovery. *Addiction Medicine*, 5364, 1195-1215.
- XXIV. Government of British Columbia, BC Coroners Service Death Review Panel: A Review of Illicit Drug Toxicity Deaths, 2022

APPENDIX:

Appendix 1 - Decriminalisation Done Right: A Rights-Based Path for Drug Policy - English & French (Published December 2021)

Appendix 2 - Health Canada Expert Task Force on Substance Use - English & French (Published June 2021)

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I. Introduction

La Coalition canadienne des politiques sur les drogues (CCPD) est une organisation nationale non partisane qui a pour objectif de mettre fin aux méfaits causés par les politiques canadiennes de la prohibition des drogues, datant de plus d'un siècle, en adoptant des politiques sur les drogues fondées sur des données probantes. En collaboration avec plus de 50 groupes de la société civile et de défense des droits de la personne à travers le pays, nous privilégions l'éducation du public, la consultation avec les communautés les plus touchées par les politiques prohibitionnistes sur les drogues, la recherche scientifique et un engagement solide avec diverses parties prenantes. Le bureau principal de la CCPD est situé à l'Université Simon Fraser à Vancouver, en Colombie-Britannique, à la Faculté des sciences de la santé.

En décembre 2021, la CCPD a co-publié une plateforme politique appelée « Réussir la décriminalisation » (Annexe 1). Ce rapport décrit les réformes nécessaires à une approche de politique sur les drogues qui serait basée sur la santé publique et les droits de la personne ; cette plateforme a été appuyée par plus de 100 organisations à travers le Canada. La CCPD a également contribué au « Groupe d'experts sur la consommation de substances » de Santé Canada, qui recommande que Santé Canada élimine toutes les sanctions pénales et les mesures coercitives liées à la simple possession de drogues et adopte une législation pour toutes les substances psychoactives, incluant l'alcool et le tabac, et ce, dans un seul cadre juridique de santé publique. Nous sommes reconnaissants de cette occasion de pouvoir exprimer nos commentaires sur le projet de loi C-5, *Loi modifiant le Code criminel et la Loi réglementant certaines drogues et autres substances*. Nous sommes impatients de communiquer nos commentaires au Comité sénatorial permanent des affaires juridiques et constitutionnelles pour renforcer la Loi en nous fondant sur les preuves actuelles.

Voici nos recommandations sur le projet de loi C-5 :

- Modifier le projet de loi C-5 pour inclure une abrogation complète de la section 4 et des modifications à la section 5 de la *Loi réglementant certaines drogues et autres substances*,
- Apporter des modifications supplémentaires à la déclaration de principes de l'article 10.1, reconnaissant que, en général, la consommation de substances n'est pas problématique, les mesures d'intervention devraient être volontaires, ces mesures devraient viser à améliorer les déterminants sociaux de la santé, les sanctions pénales appliquées pour le trafic de substances de nécessité peuvent aggraver la stigmatisation associée à la consommation de drogues et ne sont pas conformes aux droits de la personne ni aux données probantes en matière de santé publique, et enfin, les communautés noires, autochtones, racialisées et

défavorisées ont été touchées de façon disproportionnée par les sanctions pénales imposées par la *Loi réglementant certaines drogues et autres substances*,

- Modifier la section 10.2(1) pour supprimer tout renvoi par les agents de la paix à des programmes, des organisations ou des fournisseurs de services,
- Modifier la section 10.2 pour inclure la formulation de directives nationales pour les agents de la paix qui énuméreront des critères clairement définis à partir desquels un agent de la paix peut arrêter et interroger une personne pour la simple possession de drogue et le trafic de substances de nécessité,
- Supprimer la section 10.2(2) qui déclare que toute accusation est valide même si l'agent de la paix n'a pas tenu compte des options énumérées à la section 10.2(1), par exemple celle de ne prendre aucune autre mesure ou de prévenir la personne,
- Modifier la section 10.4 pour garantir que seules les informations démographiques de toute mise en garde faite par des agents de la paix seront retenues, et non pas l'identité de cette personne,
- Modifier la section 10.6 pour garantir que, une fois le système de séquestration appliqué, tout dossier de condamnation en vertu de la section 4(1) est séquestré immédiatement et non après deux ans, et
- Modifier l'article 10.6 afin de garantir que le gouverneur en conseil adopte aussi rapidement que possible, et au maximum dans l'année qui suit la mise en œuvre du système de séquestration, un règlement pour enlever et détruire ces dossiers après leur séquestration, de façon à ce qu'ils ne soient plus accessibles aux forces de l'ordre et aux autres autorités.

Nos recommandations reposent sur les preuves suivantes.

I. Abrogation complète de l'article 4 de la *Loi réglementant certaines drogues et autres substances* (LRCDAS)

La CCPD **exhorte fortement à l'abrogation complète de l'article 4 de la *Loi réglementant certaines drogues et autres substances* (LRCDAS)**. La criminalisation de la simple possession de drogue ne contribue pas à promouvoir la santé et la sécurité des individus ou de la société, et ne réduit pas la consommation de drogue. Un rapport de 2018 préparé pour le Comité spécial du Sénat sur les drogues illicites a conclu que si le système de prohibition avait pour objectif de protéger les individus contre les méfaits inhérents à la consommation de substances, il n'a pas réussi à atteindre cet objectif au niveau individuel ou collectif. ^{II} La criminalisation est liée de manière évidente à des pratiques policières qui nuisent aux habitudes qui favorisent la santé. Le risque d'être arrêté, fouillé ou appréhendé par la police force les personnes qui consomment des drogues à consommer de manière isolée, ^{III} ce qui amplifie le risque de surdose mortelle dans le contexte d'un marché de drogues toxiques et non réglementé. De plus, il y a une forte corrélation entre la présence de la police dans les rues et le partage de seringues, les injections rapides, la réticence à fréquenter les lieux de consommation sécuritaire, la réticence à suivre un traitement aux agonistes opioïdes, un traitement antirétroviral ou un programme d'approvisionnement sûr, ainsi que la crainte d'une agression physique. ^{IV} La criminalisation de la possession simple de drogues entraîne des préjudices étendus sociaux et de santé, allant à l'encontre des traités internationaux sur les droits de la personne auxquels le Canada est parti, ^V et contrecarrant la recommandation du Groupe d'experts sur la consommation de substances de Santé Canada qui propose que « Santé Canada mette fin aux sanctions pénales liées à la possession simple ». ^I

Il faut également reconnaître que le cadre canadien de contrôle des drogues est le fruit du capitalisme, du colonialisme et du racisme contre les personnes noires et asiatiques.^{VI, VII} Ce régime historique de surveillance et de contrôle a des effets néfastes particulièrement marqués sur les communautés vulnérables. En particulier :

- Des données publiées en 2020 ont révélé que les personnes noires représentaient 6,4 % des accusations de trafic et de possession de drogue recommandées par la police de Vancouver depuis 2014, et ce, bien qu'elles ne représentent qu'un pour cent de la population de la ville. Les personnes indigènes ont été impliquées dans près de 18 % des accusations de drogue, alors qu'elles ne représentent que 2,2 % de la population de la ville ;^{VIII}
- Des données publiées en 2020 ont révélé que « Les personnes noires [à Toronto] sont largement surreprésentées dans les statistiques sur les accusations discrétionnaires de faible gravité et elles sont plus susceptibles que les personnes blanches d'encourir des accusations ayant peu de chances d'aboutir à une condamnation » et « sont considérablement surreprésentées dans tous les cas de recours à la force impliquant la police de Toronto » ;^{IX}
- Après la légalisation du cannabis, une étude réalisée en 2020 a conclu que les personnes noires et indigènes sont surreprésentées parmi les personnes arrêtées pour la possession de cannabis dans les grands centres urbains. Cette étude a également conclu que la légalisation du cannabis au Canada ne prévoit pas de mesures visant à réparer les préjudices racialisés causés par la guerre contre la drogue,^X et ;
- Une étude publiée dans l'*International Journal of Drug Policy* a conclu que les efforts de contrôle de la drogue ont contribué à diminuer la santé, le bien-être et l'image de soi des hommes noirs par un traitement discriminatoire et inéquitable devant la loi.^{XI}

Au Canada, la sensibilisation à ces inégalités a conduit à un plus grand soutien en faveur de la décriminalisation des drogues parmi les organisations communautaires, les organismes de santé publique, les organismes professionnels, les forces de police et le grand public. En 2020, le Comité spécial sur la décriminalisation des drogues illicites de l'Association canadienne des chefs de police (ACCP) a admis que l'application de la loi varie d'une collectivité à l'autre,^{XII} ce qui correspond aux déclarations des municipalités de Vancouver et de Toronto et de la province de la Colombie-Britannique qui ont poursuivi, avec succès dans ce dernier cas, une décriminalisation de la simple possession de drogues. Nous exhortons le Comité à prendre en compte la déclaration du gouvernement canadien sur son engagement envers la justice raciale, conformément à sa Stratégie antiraciste^{XIII} et aux appels à l'action définis par la Commission de vérité et de réconciliation^{XIV} en abrogeant l'article 4 de la LRCDas. Cette mesure est essentielle pour préserver l'identité du Canada en tant que nation juste, conciliante et sans préjugés.

II. Modifications à l'article 5 de la Loi réglementant certaines drogues et autres substances (LRCDas)

Les modifications proposées par le projet de loi C-5 à l'article 5 de la LRCDas stipulent que si une personne contrevient au paragraphe (1) ou (2), et si la substance en question est une substance

inscrite à l'annexe I ou II, elle est coupable d'un acte criminel et risque l'emprisonnement à vie. Ces modifications concernent le trafic de substances de nécessité. En accord avec la plateforme « Réussir la décriminalisation » de la CCPD (annexe I), **nous encourageons fortement que le Comité profite également de cette occasion pour modifier l'article 5 de la LRCDas afin de permettre le partage et la vente de drogues pour la subsistance, pour soutenir les coûts de consommation personnelle de drogues et pour assurer un approvisionnement sûr.**

Au contraire des idées courantes, le trafic de substances de nécessité n'est pas une activité lucrative, et il n'est pas motivé par la malveillance. C'est plutôt une activité largement prévalente parmi les personnes qui consomment de la drogue dans la rue, qui sont appauvries, exclues de l'économie formelle et n'ayant que peu ou pas d'alternatives à la vente de drogue.^{xv} Selon des recherches académiques et des preuves anecdotiques, a) les personnes qui consomment de la drogue et celles qui la vendent sont souvent les mêmes ; b) les vendeurs de drogue ont souvent des relations positives avec ceux à qui ils vendent ; et c) les vendeurs de drogue participent généralement à des pratiques de soins qui minimisent les effets néfastes d'un approvisionnement en drogue toxique (par exemple, porter de la naloxone, répondre à une surdose, développer des relations avec les clients).^{xvi} En particulier en l'absence de sources légales et réglementées d'approvisionnement en drogues, la criminalisation du trafic de substances de nécessité représente un gaspillage des ressources publiques. La mise en œuvre des mesures de réduction de la pauvreté, qui comprendraient des voies d'accès efficaces pour sortir les personnes dépendantes de la drogue du marché de la rue, ainsi que le financement des initiatives en matière de santé, d'éducation et de services sociaux, serait plus efficace.

III. Mesures de déjudiciarisation fondées sur des données probantes

A. Déclaration de principes

La CCPD a de grandes inquiétudes quant aux amendements proposés dans la partie I.1, « Mesures de déjudiciarisation fondées sur des preuves », du projet de loi. En particulier, bien que la CCPD approuve la décision du Comité de mettre en place des principes fondés sur les droits dans la section 10.1, nous voulons poser une question critique sur les prémisses sous-jacentes, les impacts potentiels et la façon dont ils sont contredits par le contexte actuel du projet de loi, qui ne prévoit pas l'abrogation de l'article 4 de la LRCDas. Il est essentiel de souligner que **la majorité de la consommation de substances n'est pas problématique**. La plupart des personnes qui consomment des drogues sont des consommateurs « occasionnels » ou récréatifs.^{xvii} Il existe de nombreuses publications qui démontrent que ceux qui développent un usage problématique ou compulsif de la drogue sont souvent victimes de privations matérielles ou de traumatisme, notamment de la pauvreté, de l'absence de logement, de confrontations négatives avec la police, de l'institutionnalisation involontaire et de la discrimination liée à la race ou au genre.^{xviii} Nous insistons sur le fait que : a) la consommation de substances est une activité moralement neutre ;^{xix} et b) notre environnement politique actuel en matière de drogues est une source et un site de traumatismes, catalysant la consommation de certaines drogues. Ainsi, il est plus utile de modifier les politiques et les lois qui influencent les comportements individuels que de les attaquer.

Ensuite, plutôt que de réduire la stigmatisation, la supposition que toutes les personnes qui consomment de la drogue ont besoin d'une intervention, qu'elle soit criminelle, psychothérapeutique ou médicale, peut, paradoxalement, la renforcer. Par exemple, les premiers intervenants et les fournisseurs de services médicaux considèrent souvent que les personnes souffrant de troubles liés à la consommation de substances sont dangereuses,^{xx} et les employeurs sont peu enclins à embaucher des personnes qui s'identifient publiquement comme ayant eu une dépendance.^{xxi} La stigmatisation sociale renforce la stigmatisation interne, tout comme une inscription involontaire à un traitement lié à la dépendance. Au Canada, la plupart des traitements pour la dépendance sont idéologiquement ancrés dans les 12 étapes des Alcooliques et des Narcotiques Anonymes, des programmes conçus il y a environ un siècle et qui sont régulièrement critiqués parce qu'ils ne sont pas soutenus par des données contemporaines.^{xxii} La recherche sur ces programmes suggère que la participation à un tel programme conduit à se voir comme quelqu'un d'instable, d'incompétent et d'indigne de confiance,^{xxiii} et que les personnes qui y participent sont exposées à un risque considérablement accru de surdose non fatale et fatale immédiatement après leur sortie.^{xiv} La CCPD demande au Comité de reconnaître que les stéréotypes concernant les drogues et les personnes qui les consomment sont un obstacle à une participation complète à la société et qu'il est nécessaire d'apporter des changements législatifs et réglementaires pour y remédier, et enfin, de reconnaître que la stigmatisation conduit à la discrimination lorsqu'elle est mise en œuvre par des représentants du système de justice pénale. Les modifications proposées dans le projet de loi C-5 s'appuient fortement sur le pouvoir discrétionnaire de la police et de la justice. Étant conscients des impacts disproportionnés de la prohibition des drogues sur les communautés noires et autochtones, et toujours dans le but d'améliorer la santé publique, les droits de la personne et l'autonomie corporelle, nous vous proposons les modifications suivantes aux Principes, présentées en rouge.

(a) la consommation ~~problématique~~ de substances doit être abordée principalement comme un enjeu social et de santé ;

(b) les interventions doivent reposer sur des pratiques exemplaires fondées sur des données probantes et viser à protéger ~~la santé, la dignité et les droits de la personne, la dignité, et la santé~~ des consommateurs de drogues ainsi qu'à réduire les méfaits pour ceux-ci, leurs familles et leurs collectivités ;

(c) l'imposition de sanctions pénales pour la possession de drogues à des fins de consommation personnelle ~~peut~~ ~~accroître~~ la stigmatisation liée à la consommation de drogues et est incompatible avec les données probantes établies en matière de santé publique ;

(d) les sanctions pénales appliquées à la vente ou à un échange de drogues à des fins de subsistance, pour couvrir les frais personnels liés à la consommation de drogues ou pour assurer un approvisionnement sûr au sein de son réseau accroît le stigma associé avec le trafic de nécessité, et sont contraires aux droits de la personne ou aux données probantes établies dans le domaine de la santé publique ;

(e) les interventions doivent cibler les causes profondes de la consommation problématique de substances, **notamment en s'attaquant aux vulnérabilités structurelles telles que la pauvreté et en favorisant consacrant des ressources publiques à** des mesures comme l'éducation **volontaire**, le traitement **volontaire**, le suivi, **la réhabilitation**, et la réintégration sociale ;

(f) les communautés de personnes noires, autochtones et les autres communautés racialisées ont été frappées de manière disproportionnée par les sanctions pénales imposées pour la possession de drogues ; et

(g) l'utilisation de ressources judiciaires est plus indiquée dans le cas des infractions qui présentent un risque pour la sécurité publique.

B. Avertissements et renvois

Dans ce contexte, et parce que tout casier judiciaire ou tout antécédent de possession ou de distribution illégale de drogue documenté par le gouvernement contribue à la stigmatisation, à la discrimination et à d'autres préjudices, nous nous opposons fermement à l'introduction d'initiatives de déjudiciarisation qui ne sont pas entièrement volontaires. À défaut d'abroger la section 4 de la LRCDas, nous appelons le Comité à examiner les modifications suivantes aux sections 10.2 (1) à 10.6.

- Modifier la section 10.2 (1) pour supprimer tout renvoi par les agents de la paix à des programmes, des organisations ou des fournisseurs de services ;
- Modifier la section 10.2 pour inclure la formulation de directives nationales pour les agents de la paix qui énuméreront des critères clairement définis à partir desquels un agent de la paix peut arrêter et interroger une personne pour la simple possession de drogue et le trafic de substances de nécessité ;
- Supprimer la section 10.2 (2) qui déclare que toute accusation est valide même si l'agent de la paix n'a pas tenu compte des options énumérées à la section 10.2 (1), par exemple celle de ne prendre aucune autre mesure ou de prévenir la personne ;
- Modifier la section 10.4 pour garantir que seules les informations démographiques de toute mise en garde faite par des agents de la paix seront retenues, et non pas l'identité de cette personne ;
- Modifier l'article 10.6 afin de garantir que le gouverneur en conseil adopte aussi rapidement que possible, et au maximum dans l'année qui suit la mise en œuvre du système de séquestration, un règlement pour enlever et détruire ces dossiers après leur séquestration, de façon à ce qu'ils ne soient plus accessibles aux forces de l'ordre et aux autres autorités ; et

- Modifier l'article 10.6 afin de garantir que le gouverneur en conseil adopte aussi rapidement que possible, et au maximum dans l'année qui suit la mise en œuvre du système de séquestration, un règlement pour enlever et détruire ces dossiers après leur séquestration, de façon à ce qu'ils ne soient plus accessibles aux forces de l'ordre et aux autres autorités.

Nous vous remercions pour cette opportunité,

Nicole Luongo, Coordinatrice du changement des systèmes, Coalition canadienne des politiques sur les drogues

Beeta Senedjani, coordonnatrice du programme des Dialogues, Coalition canadienne des politiques sur les drogues

Donald MacPherson, directeur général, Coalition canadienne des politiques sur les drogues

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 - V. Gouvernement du Canada, Traités internationaux en matière de droits de la personne auxquels le Canada est partie. Site internet : <https://www.justice.gc.ca/fra/apd-abt/gci-icg/didp-ihrl/tcp.html>
 - VI. Dans son livre « *Busted : An Illustrated History of Drug Prohibition in Canada* », Susan Boyd, juriste et historienne, écrit : « C’est avec les colons britanniques de l’Europe, qui sont arrivés au Canada pour coloniser les terres indigènes, qu’est née la mentalité moraliste actuelle et dominante à l’égard des drogues. Ce principe provient de la philosophie chrétienne protestante des années 1700, où la prohibition était un moyen de contrôle social sur les nations et les communautés racialisées. Ces communautés étaient considérées comme < autres > et inférieures par les suprémacistes blancs européens. »

Voir : S. Boyd. (2017). *“Busted: An Illustrated History of Drug Prohibition in Canada,”* Fernwood Publishing. Site internet : <https://drugpolicy.ca/fr/about/lhistoire-des-politiques-sur-les-drogues-au-canada/>

- VII. Robyn Maynard, récipiendaire du Prix Talent du CRSH, chercheuse-boursière Vanier et auteure, explique que les déplacements des personnes noires dans les espaces publics ont été criminalisés pendant l’esclavage, qui a été légal et pratiqué dans le Canada pré-Confédération pendant plus de 200 ans, et le contrôle permanent de la vie des personnes noires a été perpétué par le profilage et les meurtres commis par la police (entre autres). Après l’abolition de l’esclavage, la criminalisation et le contrôle des hommes et des femmes noirs, par des arrestations et des accusations excessives, sont restés communs dans de nombreuses villes tout au long du vingtième siècle. En particulier, la conception et l’élaboration des lois sur les drogues ont été influencées par des stéréotypes raciaux associant les communautés noires et chinoises à la criminalité, à la drogue et à la turpitude morale... La décriminalisation des drogues, la suppression des dossiers et la fourniture d’un approvisionnement sûr permettraient de sauver des vies et offriraient un moyen de réparation aux communautés noires, indigènes, racialisées et pauvres, ainsi qu’aux personnes souffrant de problèmes de santé mentale ou de handicaps, groupes qui ont longtemps été victimes de cette politique. Voir R. Maynard. (2017). *“Policing Black Lives: State Violence in Canada from Slavery to the Present,”* Fernwood Publishing. Site internet : <https://www.drugpolicy.ca/about/racism/>
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- XIII. Gouvernement du Canada, Construire une fondation pour le changement : La stratégie canadienne de lutte contre le racisme 2019–2022.
- XIV. Commission de vérité et réconciliation du Canada : Appels à l’action, Commission de vérité et réconciliation du Canada, 2015.
- XV. A. Stryker, *Re-thinking the Drug Dealer*, Drug Policy Alliance, 2019.
- XVI. Voir, par exemple, R. Masetti, *Consider the Dealer: Supplying Drugs And Harm Reduction In The UK*, Talking Drugs, 2020; S. Kuwabara Blanchard, *Leaked FBI Report : Drug Sellers Practice Harm Reduction*, Filter Magazine, 2020 et ; A. Betsos et al. (2021). “*I couldn’t live with killing one of my friends or anybody*”: A rapid ethnographic study of drug sellers’ use of drug checking,” International Journal of Drug Policy 87, 102845.
- XVII. A. K. Schlag. (2020). *Percentages of problem drug use and their implications for policy making: A review of the literature.* Drug Science, Policy, and Law, 6.

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- XIX. Pour une interrogation en profondeur sur la consommation de drogues, le traumatisme et le plaisir, voir, par exemple, S. Fraser (2008). *Trauma, damage, and pleasure: Rethinking problematic drug use*, International Journal of Drug Policy, 19(5), 410–416.
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DECriminalIZATION DONE RIGHT:

A Rights-Based Path for Drug Policy

We acknowledge that the land on which we live and work is traditionally known as Turtle Island and home to many diverse First Nations. We are called to honour the Calls to Action of the Truth and Reconciliation Commission in our work and must do our part to address the ongoing injustices faced by Indigenous Peoples who suffer the disproportionate impacts and harms of punitive drug policy. We are actively committed to this effort, working in collaboration with our Indigenous colleagues and others.

Mission

To protect and advance the health, human rights, and dignity of people who use drugs by:

- abolishing criminal and other laws, policies, and practices that control, stigmatize, pathologize, and punish people who use drugs; and
- securing the redistribution of resources into programs and services, including those that are community-led, that uphold and promote people's health and human rights, and create safety and security. This includes a safe alternative source of drugs to the contaminated, unregulated drug supply, and greater access to health and harm reduction services, income, housing, reparations for the effects of drug prohibition, food security, and other social determinants of health.

Civil Society Platform on Drug Decriminalization

A CALL TO PUT HEALTH AND HUMAN RIGHTS FIRST

Punitive drug laws and policies purported to deter drug use have failed — and worse, they have done catastrophic harm. They have fueled deadly stigma; epidemics of preventable illness and death; poverty; homelessness; and widespread, systematic, and egregious violations of human rights. They are rooted in, and have reinforced, sexism, racism, and colonialism. They have destroyed lives, torn families apart, and undermined communities' well-being and safety. They have wasted inordinate sums of public money to cause terrible damage.

Recognizing the many lives that have been lost and ruined to the state-sanctioned “war on drugs,” we must act to end the harm. We must stop stigmatizing drug use and pointlessly punishing people who use drugs. We must expand harm reduction programs; ensure access to non-coercive, evidence-informed treatment and supports; scale up safe supply measures; and ensure that policies, programs, and services protect and promote health and socio-economic wellbeing. At the heart of these reforms must be efforts focused on reducing poverty; ensuring access to housing; and combatting violence, sexism, racism, discrimination, and implementing the Calls to Action in the Truth and Reconciliation Commission report and the Calls to Justice in the report of the Missing and Murdered Indigenous Women and Girls Inquiry, and other commitments.

Decriminalizing personal drug possession and necessity trafficking are fundamental, necessary steps towards a more rational and just drug policy, and away from our current anti-drug policies. It is a change that is long overdue.

We call on the Government of Canada to adopt an anti-racist, anti-colonial, human rights–based approach to drug policy that does not rely on criminal, administrative, and medical interventions that maintain the goal of dissuading drug use, and under which people who use drugs continue to be oppressed, coerced, and silenced. Among other measures, our proposed drug policy includes:

1. **Fully decriminalizing all drug possession for personal use, as well as the sharing or selling of drugs for subsistence, to support personal drug use costs, or to provide a safe supply.** This requires the removal of criminal sanctions and all other penalties (administrative or otherwise) as follows:
 - A full repeal of section 4 of the *Controlled Drugs and Substances Act* (CDSA) and section 8 of the *Cannabis Act*;
 - Amendments to section 5 of the CDSA, which criminalizes trafficking and possession for the purpose of trafficking, to permit the sharing and selling of drugs for subsistence, to support personal drug use costs, and to provide a safe supply (i.e. “necessity trafficking”);
 - Removal of all sanctions and interventions associated with simple drug possession, or with necessity trafficking, including:
 - ▷ administrative penalties, including but not limited to fines, “health assessments,” or dissuasion commissions;
 - ▷ confiscation of substances, paraphernalia, or medical supplies;
 - ▷ geographic, drug use, or personal contact restrictions or curfews;
 - ▷ drug treatment courts as a coercive alternative to criminal sanctions; and
 - ▷ other coerced or involuntary treatment or other health interventions.
 - Automatic expungement of previous convictions for simple drug possession (including for cannabis) and an applications-based expungement process for necessity trafficking, as well as expungement of previous convictions for breaches of police undertakings, bail, probation, or parole conditions associated with charges for these acts;
 - Clear rules and strict limitations relating to when police can stop, search, and investigate a person for drug possession; and
 - Removal of police and other law enforcement as “gatekeepers” or “liaisons” between people who use drugs and health and social services, to be replaced by organizations led by people who use(d) drugs or skilled and trained frontline workers.
2. **Redistributing resources from the enforcement of these harmful drug laws** to non-coercive, voluntary policies, programs, and services that protect and promote people’s health and human rights, including health, education, housing, and social services that support people who use drugs, have been released from prison or are incarcerated due to conviction for drug-related offences, and promote the safety and well-being of communities.

THE CURRENT STATE OF THE LAW

Offences

Substances scheduled under the CDSA

In Canada, the unauthorized possession of various drugs (“controlled substances”) for personal use (“simple drug possession”) is a crime under section 4(1) of the *Controlled Drugs and Substances Act* (CDSA):

4(1) Except as authorized under the regulations, no person shall possess a substance included in Schedule I, II or III.

“Trafficking” of a (broader range of) controlled substances is also a crime under section 5 of the CDSA, as is “possession for the purpose of trafficking”:

5(1) No person shall traffic in a substance included in Schedule I, II, III, IV or V or in any substance represented or held out by that person to be such a substance.

5(2) No person shall, for the purpose of trafficking, possess a substance included in Schedule I, II, III, IV or V.

“Trafficking” is defined (in section 2) as including any act of selling, administering, giving, transferring, transporting, sending, or delivering a controlled substance — or offering to do any of these things — unless authorized by a regulation, whether for a profit or for free.

The CDSA also criminalizes the act of importing any scheduled substance (in section 6) and any production of substances (in section 7, for substances on Schedules I through V), even if the substance is for personal use. (There is a separate offence for unauthorized exporting.)

Cannabis

Cannabis is no longer regulated under the CDSA. Instead, the *Cannabis Act*, in force since October 2018, legalizes the possession, and also the production and sale (i.e. trafficking), of cannabis within certain parameters, but imposes criminal penalties for any activities outside these parameters. It is not a crime to possess up to 30g of legally obtained, dried cannabis (or its equivalent in non-dried form, such as 150g of fresh cannabis) or to share this amount with other adults. However, a person under the age of 18 is criminalized for possessing more than 5g of dried cannabis or its equivalent.

It is a crime to possess more than 30g of dried, legal cannabis (or its equivalent in some other form), or to possess any amount of cannabis that a person knows is “illicit” (i.e. was sold, produced, distributed, or imported contrary to the federal *Cannabis Act* or any provincial law), without legal authorization. It is also a crime to produce, import, or export cannabis without a federal authorization, and to distribute or sell cannabis products outside of what is allowed under a province’s regulations. Providing cannabis to a person under the age of 18 is also crime.

Which drugs are illegal under the CDSA?

Schedule I	includes a wide range of opioids (including opium, heroin, hydromorphone, methadone, buprenorphine, oxycodone, diacetylmorphine, and various fentanyl), cocaine and other coca derivatives, amphetamines (including methamphetamine and MDMA), and various other synthetic drugs (including GHB, PCP, and ketamine).
Schedule II	includes various synthetic cannabinoids (such as “spice” or “K2”).
Schedule III	includes stimulants such as methylphenidate (sold under the brand name Ritalin™) and cathinone, sedatives such as methaqualone (Quaalude™), and psychedelics such as LSD, psilocybin (“mushrooms”), mescaline, ayahuasca, and the synthetically similar dimethyltryptamine (DMT).
Schedule IV	includes barbiturates, benzodiazepines, steroids, and the psychedelic salvia.
Schedule V	is currently empty, listing no substances.
Schedule VI	includes various precursors used in the manufacture of other controlled substances.

Penalties

For substances controlled under the CDSA, the maximum penalty upon conviction for *simple possession* is seven years in prison (for a Schedule I substance), five years (for a Schedule II substance), and three years (for a Schedule III substance). It is not a crime to possess substances on the other schedules.

The maximum penalty upon conviction for *trafficking*, or *possession for the purpose of trafficking*, is life in prison (for a Schedule I or II substance), ten years (for a Schedule III or V substance), and three years (for a Schedule IV substance). There are also minimum penalties in some circumstances. The penalty in a given case depends on:

- the substance involved (see the text box for the scheduling of some common substances);
- whether the prosecution treats the offence as *indictable* (more serious) or prosecutes by way of *summary conviction* (less serious). Trafficking (and possessing for the purpose of trafficking) any Schedule I or II substance is always an indictable offence; and
- a number of other factors, such as whether it is a first or a subsequent conviction, and in the case of trafficking offences, factors such as the quantity of drugs, the presence of violence, whether a weapon or children were involved, and whether the offence was committed for or in association with a “criminal organization.” The law also requires that, in the case where a person convicted of an offence is Indigenous, a court must consider any systemic factors that may have played a part in the person being charged, and what type of sentence may be appropriate in the circumstances because of that person’s Indigenous heritage or connection.

Under the *Cannabis Act*, possessing more than the allowable quantity carries a penalty ranging from a ticket for small amounts to up to five years in prison. Illegal distribution or sale carries a penalty ranging from a ticket to up to 14 years in prison depending on amounts. Providing cannabis to a person under the age of 18 carries a maximum penalty of 14 years in prison.

In addition to formal criminal penalties associated with drug possession and trafficking, a host of informal consequences for drug-related activities play a tremendous role in furthering the punishment of people who use drugs. Criminal sanctions that arise from possessing and trafficking drugs, including prosecution, incarceration, and having a criminal record, give rise to stigma and discrimination that can directly impede one’s access to housing, child custody, employment, and health and social services. When and if a policy of decriminalization has properly been implemented, it will still be necessary to combat residual stigma and discrimination against people who use drugs via public education and committed enforcement of human rights legislation and the *Canadian Charter of Rights and Freedoms*.

THE HARMS OF CRIMINALIZATION

A growing body of evidence indicates that criminalizing drug possession is ineffective in reducing the use and availability of drugs, is a waste of public funds, and is taking a terrible human toll on people who use drugs and their loved ones. It is also an unjustifiable infringement on personal liberty and security of the person. Criminalizing drug possession puts people who use drugs at increased risk of harm, including the risk of overdose. Criminalizing drug use impedes people's access to health and social services and emergency care in the case of overdose, as well as contributing to new HIV and hepatitis C infections. In Canada, criminalization has led to more potent and dangerous drugs, hampered efforts to scale up safe supply programs, and contributed to a drug poisoning crisis that has resulted in almost 23,000 overdose deaths nationwide between January 2016 and March 2021.

Drug prohibition harms Indigenous, Black, and other racialized, marginalized, and low-income communities, who are profiled and disproportionately arrested and incarcerated for drug offences, and who are disproportionately subjected to child apprehension orders. More broadly, criminalization perpetuates stigma, discrimination, and the over-incarceration of people who use drugs, and has been used to enact human rights violations towards entire communities. In carceral settings, access to harm reduction and other health services is also drastically curtailed, and there is ample evidence showing a heightened risk of overdose following release from prison or after any compulsory abstinence, including involuntary detoxification and treatment.

While rates of drug use remain consistent among different racial groups, research shows that Indigenous, Black, and racialized populations are incarcerated for drug offences at far higher rates than white populations. The illegal status of drugs is used as justification to take children into state custody and separate children from their families, contributing to an overrepresentation of Indigenous, Black, and racialized children in state care. The harms of drug policy affect not only those individuals who are incarcerated or apprehended by the state, but extend intergenerationally through whole families and communities, compounding the marginalization these groups face.

The harms of criminalization follow people for the rest of their lives, with criminal records limiting employment and housing opportunities, affecting child custody, and restricting travel. Once branded as a person who uses drugs or who engages in a criminalized drug-related activity (either as the result of a criminal record or by association), a person faces discrimination and exclusion. Criminalization can leave people feeling ashamed, angry, and reactive, and can exacerbate consumption. The harms also go beyond the individual and affect families and communities who face stigma, social isolation, negative health outcomes, and financial burdens because of the criminalization of their loved one.

Enforcing drug offences consumes billions of dollars annually. There is significant evidence from other countries that removing criminal sanctions for simple drug possession can result in direct savings — funds that can be redirected toward more effective, evidence-based services and interventions that can promote healthier communities.

The continued emphasis on drug prohibition over the years has failed to decrease the use and availability of drugs, while worsening the risks and harms of using drugs and the violence associated with criminalized markets. Movements to defund police and challenge abusive police practices, including the overly broad use of the criminal law, are gaining momentum. The time to decriminalize drug possession and necessity trafficking, scale back the “war on drugs,” and redistribute enforcement resources to communities is long overdue.

SUPPORT. DON'T PUNISH.

It is time for Canada to adopt a human rights–based approach to drug policy, which includes, among other things, decriminalizing all drug possession for personal use and selling and sharing drugs for subsistence, to support personal drug use costs, and to provide a safe supply.

Decriminalizing simple possession

Most drug use is social, and most people who use drugs that are deemed illegal do so for relaxation, socialization, pleasure, spirituality, self-medication, and connection and without developing dependence. Decriminalizing possession of drugs for personal consumption is necessary to respect human rights, including the rights to dignity, personal privacy, liberty, and autonomy.

Important precedents have been set demonstrating that exceptions to the criminal prohibition on possession must be made in order to protect health and safety — including the decriminalization of cannabis (first for medical use, then more broadly); exemptions from the CDSA for supervised consumption, overdose prevention, and drug checking services; exemptions for the medically supervised prescription of controlled substances; and exemptions under the *Good Samaritan Drug Overdose Act* giving immunity (to a degree) to anyone who calls 911 to report an overdose. Jurisdictions in Canada are requesting exemptions decriminalizing the possession of drugs within their boundaries; others may follow. In 2021, the Federal Expert Task Force on Substance Use recommended decriminalization. While these are good starting points, a fundamental change in drug policy is required — one that removes entirely the criminalization of people for possessing a substance for their own personal consumption or for selling or sharing in situations where the transfer of drugs is done to support one's own drug use or subsistence, or to reduce the risk of others by providing a safer supply of substances to them.

Decriminalization must include the removal of criminal sanctions and all other penalties for simple drug possession for all people. This begins with a full repeal of section 4 of the CDSA, which makes simple drug possession a crime. But it must go further and include an end to all sanctions and coercive measures for simple possession, including fines and administrative penalties; the confiscation of substances, medical supplies, or paraphernalia; geographic, drug use, or personal contact restrictions or curfews; the imposition of drug treatment courts (DTCs) as a coercive alternative to criminal penalties (see text box); and any form of coerced or involuntary treatment.

In a human rights–based approach to decriminalizing simple drug possession, it is important that any services offered to individuals be completely voluntary and with their informed consent and be culturally appropriate. This includes participation in a health assessment, addiction treatment services, psychosocial and mental health services, and harm reduction or support services. Because services offered as a condition of diversion from criminal punishment are not voluntary, they should not be used as such. This also means removing police and other law enforcement from the equation by which people who use drugs access services and supports. When a person is known to possess drugs, that fact should not attract the involvement of police, other law enforcement, or government actors; rather, a range of appropriate evidence-based services and supports need to be scaled so people can access them if they want. Moreover, individuals' privacy must be respected and there should be no record of contact with law enforcement related to simple possession and no sharing of any related information with other government agencies. At the same time, there should be strong protections against “net widening” or “up-charging,” a scenario in which police lay charges for drug trafficking or possession for the purposes of trafficking because they are no longer able to proceed with simple possession charges.

A closer look at Drug Treatment Courts

Studies by the federal Department of Justice have revealed that Drug Treatment Courts (DTCs) are not only ineffective (demonstrating no statistically significant reductions in re-arrests) but are also, in some circumstances, directly harmful to participants and their families. In addition, DTCs present serious problems with accessibility, including the inability of such courts to engage women, Indigenous people, sex workers, racialized people, and youth, as well as difficulties in retaining them once they have entered. More broadly, the coercive characteristics of the DTC system result in encroachment on the substance use treatment sphere and can contort the judicial protections of defendants to the point of undermining health and infringing on human rights.

Multiple human rights concerns are raised by DTCs, which typically require an individual to first plead guilty to an offence to be admitted to the program. For the program's duration, participants are subject to frequent random urine screening, a rigorous treatment regime, highly intrusive judicial supervision, and the potential for sanctions (including jail time) for drug use, breach of conditions, or missed treatment sessions, urine tests, or court appearances.

Courts impose numerous onerous conditions on participants that are often impossible to adhere to, such as urine drug screens, curfews, attendance at meetings, restrictions on travel, and mandatory health appointments. Those who cannot comply may be expelled from the program or receive conditional sentencing orders. Participants who "graduate" from the program may receive a non-custodial sentence, usually a period of probation, restitution, and/or fines. Those who are expelled from or do not complete the program (and may have already pled guilty to enter the DTC program) face the traditional criminal sentencing process, often with no credit for the time spent in the DTC program.

DTC treatment counsellors are given powers of enforcement and judgment that are often guided by discretionary decision-making without any avenue for review. Treatment counsellors can recommend that participants be sanctioned if they do not follow treatment suggestions, blurring their roles and responsibilities from therapeutic to disciplinary, and undermining the therapeutic relationship. Participants are also required to sign release of confidentiality forms upon entry into the DTC, resulting in each participant's treatments being discussed with the DTC team and in open court. This raises concerns about the right to confidentiality between participants and health professionals. Requiring the disclosure of personal information in return for their continued freedom from incarceration not only constitutes an affront to DTC participants' dignity, it also undermines their right to privacy, which can lead to resistance to participation.

Decriminalizing selling and sharing of drugs for subsistence, to support personal drug use costs, and to provide a safe supply (necessity trafficking)

Decriminalizing the selling and sharing of a controlled substance for subsistence, to support personal drug use costs, and to provide a safe supply (“necessity trafficking”) is also in line with a human rights and public health–based approach to drug policy. It is common for people to sell limited quantities of drugs to others in their network as a means of livelihood, to support their own independent use, or to provide a safe supply. It is a poor use of public resources to criminalize selling or sharing in these circumstances. Instead, focus should be put on improving accessibility of harm reduction, treatment services, education, access to a safe supply of substances, and other supports and any law enforcement efforts focused exclusively on more serious offences within and outside the drug trade.

Section 5 the CDSA currently criminalizes “trafficking” and “possession for the purpose of trafficking,” regardless of the quantity of substance and the circumstances. It should be amended to permit selling or sharing of drugs for subsistence, to support personal drug use costs, and to provide a safe supply. As with decriminalizing simple drug possession, decriminalizing necessity trafficking requires an end to all sanctions and coercive measures.

The Controlled Drugs and Substances Act

Section 6(1) of the *Controlled Drugs and Substances Act* prohibits importing controlled substances into Canada, while section 7(1) prohibits their production. Penalties for these offences include a range of prison sentences and mandatory minimum sentences, which vary depending on circumstances such as the type and quantity of drug involved. In Canada, a significant proportion of women — and particularly Black women — serving a federal prison sentence (i.e. a sentence of 2+ years) for a drug offence are incarcerated for drug importation, many of whom were carrying drugs across borders as a way to alleviate their situations of poverty, including some who have reported being forced into these activities with threats of violence to their children and/or families. As with the prohibition on selling and sharing of a controlled substance for subsistence, to support personal drug use costs, and to provide a safe supply, criminalizing the import and production of controlled substances is a poor use of public resources, which should instead be invested in programs to address the root causes of poverty.

Additional considerations to ensure faithful implementation of decriminalization

- There must be clear rules and strict limitations relating to when police can stop, search, and investigate a person for drug possession.
- Police should receive mandatory training on these reforms and on forms of necessity trafficking, to prevent “net widening” and the inappropriate use of police discretion.
- Federal, provincial, and municipal governments must establish and resource effective civilian police complaint and oversight mechanisms that are accessible to people who use drugs and ensure accountability for police officers.

- People who use drugs should have access to legal advice and representation to help them know and defend their rights.
- No one should be in pre-trial detention for drug possession or necessity trafficking while the process is going forward.
- To reduce racial and other disparities, people who use drugs and affected communities from diverse backgrounds must be included in the entire process: planning, drafting legislation, and implementation. An external research body should be established and funded to coordinate collection of baseline data on age, race, disability, sexual orientation, gender identity and expression, spiritual and religious affiliation, income, and substance use (without personal info) during police stops and to track impact of law reform.
- That evaluation of the success of decriminalization reforms should prioritize criminal justice and social welfare outcomes.

Undoing the harms of prior criminalization

Criminal prosecution and penalties do long-lasting harm; this must also be addressed. Decriminalization must include automatic expungement of previous convictions for simple drug possession, including for cannabis, and an applications-based expungement process for necessity trafficking, as well as for all breaches of conditions flowing therefrom to mitigate the numerous harmful consequences of a criminal conviction.

Redistributing resources to protect and promote health and equity

Funds saved from decriminalizing drug possession and necessity trafficking must be adequately distributed to the communities most affected by decades of police surveillance, profiling, violence, racism, and injustice. These resources must be invested into non-profit community-based organizations, including groups led by and for people who use drugs, that support people who use drugs, including by providing health services to prevent and treat overdose, HIV, HCV, and other infections; mental health services; harm reduction services such as supervised consumption, drug checking, and needle and syringe programs; health services such as opioid agonist therapy (OAT) (including injectable forms), safe supply programs to provide quality-controlled alternatives to toxic drugs from the unregulated market, and other forms of medication and treatment to manage substance use; and other forms of healing and support.

Resources should also be reinvested into social services and affordable housing, food security projects, income support, as well as education and employment opportunities, including in a drug-related industry. Supports need to be in place where connections are informed and led by people with lived and living expertise of drug use. Additional support should be incorporated for parents who have been involved with the child welfare system. Culturally appropriate initiatives and practices need to be implemented to ensure that these supports will have the desired outcomes for individuals who have been failed by the system in the past.

Resources should specifically be available for people leaving incarceration for drug-related offences, regardless of whether they continue to use substances or not. To avoid the social inequities that occurred when the *Cannabis Act* was passed where women and Indigenous and Black people were vastly underrepresented in the new legal industry, governments should adopt social equity programs that work to prevent the perpetuation of the racial and class inequalities as decriminalization is implemented. Not only do people who use drugs need drug decriminalization and a safe supply of drugs, they need equitable and meaningful opportunities to engage in their communities and be compensated for their knowledge and expertise.

Resources and additional information

Act Now! Decriminalizing Drugs in Vancouver

(Pivot Legal Society, 2020)

[LEARN MORE](#)

A New Approach to Managing Illegal Psychoactive Substances

(Canadian Public Health Association, 2014)

[LEARN MORE](#)

Count the Costs

(Transform Drug Policy Foundation)

[LEARN MORE](#)

Decriminalizing People who Use Drugs: Making the Ask, Minimizing the Harms — A Primer for Municipal and Provincial Governments

(HIV Legal Network, 2020)

[LEARN MORE](#)

DrugDecrimCanada.com

(Canadian Association of People Who Use Drugs)

[LEARN MORE](#)

Drug Decriminalisation Across the World (interactive map)

(Talking Drugs, Release & International Drug Policy Consortium, 2020)

[LEARN MORE](#)

E-tool: Comparing models of drug decriminalisation

(International Drug Policy Consortium)

[LEARN MORE](#)

International Guidelines on Drug Policy and Human Rights

(International Centre on Human Rights and Drug Policy et al., 2019)

[LEARN MORE](#)

Is Decriminalisation Enough? Drug User Community Voices from Portugal

(International Network of People who Use Drugs, 2018)

[LEARN MORE](#)

Letter to Canadian Government: Decriminalize Simple Drug Possession Immediately

(190+ Civil Society Organizations, May 2020)

[LEARN MORE](#)

Reports of the Expert Task Force on Substance Use

(Government of Canada, 2021)

[LEARN MORE](#)

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4. BC Centre on Substance Use
5. British Columbia Civil Liberties Association
6. CACTUS Montréal
7. Canadian Association of People Who Use Drugs
8. Canadian Drug Policy Coalition
9. Canadian Students for Sensible Drug Policy
10. Cannabis Amnesty
11. Centre on Drug Policy Evaluation
12. Community-Based Research Centre
13. Drug User Liberation Front
14. Harm Reduction Nurses Association
15. HIV Legal Network
16. MAPS Canada
17. Moms Stop the Harm
18. Pivot Legal Society
19. South Riverdale Community Health Centre
20. Thunderbird Partnership Foundation
21. Toronto Overdose Prevention Society

Health Canada Expert Task Force on Substance Use

Report #2

Recommendations on the Federal Government's Drug Policy as Articulated in a Draft Canadian Drugs and Substances Strategy (CDSS)

Final

June 11, 2021

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Message from the Co-Chairs

June 11, 2021

Shannon Nix, Associate Assistant Deputy Minister
Controlled Substances and Cannabis Branch, Health Canada

Dear Associate Assistant Deputy Minister,

We are pleased to submit this second report from the Health Canada Expert Task Force on Substance Use which gives recommendations on the Federal Government's substance use policy as articulated in the draft Canadian Drugs and Substances Strategy.

We are honoured to have been given the responsibility of Co-Chairing this Task Force and we are conscious of the historical opportunity this represents to contribute to the discussion on how to improve the way controlled substances are managed and regulated in Canada.

We see this as a pivotal time for policies that aim to decrease harms from substance use. Our Expert Task Force met virtually during COVID-19 and with seemingly weekly reminders of how historical and current systemic racism, social inequalities, and policy decisions are fuelling substance use harms.

The Expert Task Force was given specific questions to answer about the CDSS and has answered them in the report but felt a need to go further and signal clearly that bold action is needed to address the urgent problem of rising overdoses and other harms from substances in Canada.

It is time for a paradigm shift in policy. The reception of the cannabis legalization and more recent public opinion surveys suggest that there is an appetite for Canada to move to twin increased investment in a comprehensive network of services and supports for those who use substances with newer strategies such as regulation of controlled substances, the decriminalization of simple possession and drug use, and the expansion of safer supply. The evidence supports these policy alternatives as ways to decrease substance use harms according to groups such as the Global Commission on Drug Policy as well as the presentations and written submissions the Expert Task Force received from Canadian community groups, organizations representing people with lived and living experience, clinicians, and academics.

We are thankful to all those who shared their knowledge and wisdom. They have helped the Expert Task Force develop its thinking and build recommendations based on the best evidence.

It has been a privilege to work with the diverse group of experts who made up the Task Force. Each member brought a unique perspective to our collective effort, and all have contributed to a rich dialogue that has resulted in the recommendations we present to you today.

Finally, our thanks go to the Secretariat and to the report-writer who have so skillfully supported us through this work.

Sincerely,



Carol Hopkins



Dr. Kwame McKenzie



Mike Serr

Co-Chairs, Health Canada Expert Task Force on Substance Use

Truth and Reconciliation in Canada's Drugs and Substances Strategy

The children emerge in 2021 to tell the truth, will the truth be heard this time?

During the mandate of the Expert Task Force, 215 Indigenous children were discovered in an unmarked grave at the largest residential school in Canada, located at Tk'emlúps te Secwépemc, Kamloops, British Columbia. A reminder to Canada of the intergenerational trauma carried by the many families who survived the residential school system is a root cause of problematic substance use. From a spirit centred Indigenous worldview, it is said the Great Spirit and our Mother the Earth ensured the children would be found at this time. A reminder that while the world begins to emerge from the pandemic, we cannot ignore the truth and must act to ensure Drug Policy includes attention to trauma.

For First Nations:

- ❖ Who have a history of trauma, the odds of using opioids in a harmful way are 2.9 times greater than those who do not have a history of trauma.
- ❖ Who are experiencing grief and loss, the odds of using opioids in a harmful way are 2.8 times greater than those who did not experience grief or loss.

Canada's colonial policies and systems cause harm to First Nations, Inuit, and Métis people, families, and communities by disconnecting them from the strengths held within their nationhood, language, land, and culture. For far too long, policies and resource allocations to First Nations, Inuit, and Métis people have been constrained by deficit-based decision-making, inadequate funding formulas, and an epistemic racism that seeks to erase the value of Indigenous and sacred knowledge.

This systemic racism has perpetuated the legacy of intergenerational trauma and entrenched a public mindset that Indigenous people are incapable of managing themselves and their own programs and communities. Furthermore, because of this denial of equitable resourcing and of mechanisms to address jurisdictional chasms and erase the perceived "option" for responding to the needs of Indigenous people, these communities have been left without relevant resources to answer the acuity of need related to drugs and alcohol.

The UN Sustainable Development Goals, the UN Declaration on the Rights of Indigenous People, and the Truth and Reconciliation Calls to Action all express the importance of the social determinants of health, promote the right to mental health and well-being, with equity and access to quality health care as the means to extend life expectancy for Indigenous peoples of Canada.

- ❖ First Nations who have positive role models or mentors in their life, are 2.9 times less likely to use opioids in a harmful way than for those who do not have these meaningful relationships in their life.

- ❖ First Nations who believe that their cultural identity matters are 2.3 times less likely to use opioids in harmful way than for those who do not hold this belief.

Reconciliation for First Nations, Inuit, and Métis people, families and communities in Canada requires equitable resource capacity to ensure access to distinctions-based services that are culture- and land-based; a trauma informed continuum of care; harm reduction services; and evidence informed by people who use drugs and alcohol. Reconciliation also requires availability and access to the right services for Indigenous people within the criminal justice system, Indigenous women and gender diverse individuals, Indigenous people living with HIV, economically disadvantaged Indigenous individuals, Indigenous youth and elderly, Indigenous people with disabilities such as FASD, and Indigenous people who are disproportionately impacted by environmental emergencies which detach them from safety. Indigenous people are disproportionately represented in each of these circumstances because of inter-generational trauma, transmitted through social factors and possibly epigenetic changes¹, that has at its source harmful policies without adequate resources to respond. Harmful policies are not limited to drug policies, they encompass the full spectrum of colonialist policies, most notably the Indian residential school system whose harms continue to reverberate through First Nations, Inuit, and Métis communities to this day.

Immediate, comprehensive policy change is needed to redress the historical and ongoing harms to First Nations, Inuit, and Métis people, families, and communities. This change must be supported with resources commensurate with the needs. Every day lost is another day of potentially irreparable harms. Progress on this comprehensive policy change will require meaningful measurements of change, and must ensure high-quality, culturally relevant, disaggregated and distinctions-based data is available and accessible to Indigenous communities.

¹ Catalyst, [Passing down history: How our biology may play a role in the transmission of trauma](#)

Executive Summary

This report presents the conclusions and recommendations from the second part of the mandate of the Health Canada Expert Task Force on Substance Use. The Task Force met, heard presentations, reviewed documents, and deliberated on recommendations on the Federal Government's Drug Policy as articulated in a draft *Canadian Drugs and Substances Strategy* (CDSS) from May 5th to June 9th, 2021.

The Task Force considered six specific questions relating to how the draft CDSS articulates the problem of substance-use harms in Canada; its overall goals, principles and objectives; its four pillars of prevention, treatment, harm reduction, and enforcement, and the evidence base; its priority areas; how to better support populations most at-risk; and any other issues or areas that should be included. The Task Force used the questions to structure its discussions, then selected a broader, more strategic approach to presenting its recommendations.

The Task Force wishes to emphasize five key messages related to Canada's substance strategy:

1. Canadian policy on substances must change significantly to address and remove structural stigma, centre on the health of people who use substances, and align with current evidence.
2. Bold actions are urgently needed, including decriminalization, the development of a single public health framework which regulates all substances, and the expansion of safer supply.
3. We need made-for-Canada solutions that are tailored to the specific historical, cultural, social, political, and geographic contexts of Canada's diverse population groups.
4. National leadership is essential to ensure that there are standards for the array of supports and services that people in Canada who use substances should be able to access.
5. Canada must make new and significant investments so that the impacts of substance use can be adequately addressed.

The Task Force's recommendations in response to the specific questions it was asked about the CDSS are divided into two sections: recommendations on how to articulate the problem of substance-use harms in Canada, and recommendations on the way forward.

The Task Force recommendations on how to articulate the problem are as follows:

Policy-Related Harms

- ☐ Provide more context on policy-related harms, the impacts of social determinants of health, and historical harms and their persistent, intergenerational effects.
- ☐ Describe the impact of inadequate regulation of pharmaceuticals, tobacco, alcohol, cannabis, and illegal substances on Canada's substance issue, and acknowledge that alcohol currently causes more harms than the substances covered by the CDSA.

Substance-Related Harms

- ☐ Broaden the definition of substance-related harms.
- ☐ Acknowledge and describe the disproportionate and distinct harms experienced by the Black population of Canada.

Substance Use and People Who Use Substances

- ☐ Consider and describe the full spectrum of substance use to provide a more complete and nuanced understanding of the situation.
- ☐ Recognize the many profiles of people who use substances and avoid language that reinforces stigma.

Underfunding and Lack of Services

- ☐ Acknowledge and describe the lack of resources and services for people who use substances or who have a substance use disorder.

The Task Force recommendations on the way forward are the following:

Legal Regulation

- ☐ Include as a core priority of the CDSS to immediately develop and implement a single public health framework with specific regulations for all psychoactive substances, including currently illegal drugs as well as alcohol, tobacco, and cannabis. This framework should aim to minimize the scale of the illegal market, bring stability and predictability to regulated markets for substances, and provide access to safer substances for those at risk of injury or death from toxic illegal substances.

Safer Supply

- ☐ Include as an urgent priority of the CDSS developing, implementing, and evaluating a comprehensive emergency response strategy to scale up access to safer alternatives to the toxic illegal drug market in partnership with people with lived and living experience and the organizations that represent them.

Funding

- ☐ Provide sufficient and ongoing funding for the strategy.

Reducing Stigma

- ☐ Include an objective related to reducing stigma.
- ☐ Define the role of enforcement as a means to clearly support the aims of the public health framework and legal regulation by focussing on criminal organizations and the illegal toxic drug supply.

Equity

- ☐ Make equity a core principle and equity, anti-racism and anti-colonialism a priority area in the new CDSS.

National Leadership

- ☐ Include as an objective the implementation of national standards for providing supports to people who use substances, including harm reduction services, and describing the role of Provinces and Territories in our system and how Health Canada will work to ensure supports meet national standards across the country.
- ☐ Include an objective related to assessing, acknowledging, reducing, and addressing policy-related harms.

An Integrated Approach

- ☐ Remove the notion of “pillars” from the strategy and replace it with a more holistic and integrated approach that better represents the interconnectedness of the different areas for action.
- ☐ Frame the overall aim of the strategy as a health promotion approach to substance use and minimizing harms.
- ☐ Articulate harm reduction as an effective, evidence-based, non-judgemental public health approach for individuals who use substances, integrated into a full continuum of health and social services including housing.
- ☐ Include a full continuum of harm reduction, treatment and recovery care and services.
- ☐ Include labour-market measures as part of an integrated approach to support certain populations.
- ☐ Align and integrate Canada's international policy with its domestic policy on substances.

Introduction

This is the second of two reports prepared by the Health Canada Expert Task Force on Substance Use, established to provide Health Canada with independent, expert advice and recommendations on:

- potential alternatives to criminal penalties for the simple possession of controlled substances, with the goals of reducing the impacts of criminal sanctions on people who use drugs, while maintaining support for community and public safety; and
- the federal government's drug policy, as articulated in a draft *Canadian Drugs and Substances Strategy* (CDSS), with the objectives of further strengthening the government's approach to substance use.

The Task Force convened for the first time on March 10, 2021 and submitted its first report to the Associate Assistant Deputy Minister, Controlled Substances and Cannabis Branch of Health Canada on May 6, 2021. Key findings and recommendations highlighted in the first report of the Task Force should particularly be kept in mind when reading this second report. Specifically, the Task Force found that criminalization of simple possession causes harms to Canadians and needs to end. The Task Force was mindful of five core issues when making recommendations: stigma; disproportionate harms to populations experiencing structural inequity; harms from the illegal drug market; the financial burden on the health and criminal justice systems; and unaddressed underlying conditions.

The Task Force also considered Canada's obligations under international treaties, lessons learned in other jurisdictions, the important issue of safety, supports for community, recent developments under the *Controlled Drugs and Substances Act* (CDSA), and the broader Canadian legal framework.

The Task Force made four recommendations related to decriminalization and regulation, and four related recommendations (See Appendix C). In addition to recommending an end to criminal penalties and coercive measures for simple possession and consumption of substances, the Task Force recommended that all substances – including substances currently under the CDSA, tobacco, cannabis, and alcohol – be integrated under a single public health framework of legally regulated substances. This recommendation has profound implications for a new CDSS, which will be examined further in this report.

This second report presents the recommendations and advice of the Task Force to strengthen the government's approach to substance use. Although it can be read independently, it builds on the first report and should be interpreted within the context of that first report.

Task Force Members

The following people participated as members of the Task Force. Bios of Task Force members are provided in Appendix A.

Carol Hopkins (Co-Chair), CEO of the Thunderbird Partnership Foundation (a division of the National Native Addictions Partnership Foundation)

Dr. Kwame McKenzie (Co-Chair), CEO of Wellesley Institute, Director of Health Equity at the Centre for Addiction and Mental Health, Full Professor in Psychiatry at the University of Toronto and consultant with the World Health Organization

Mike Serr (Co-Chair), Chief Constable, Abbotsford Police Department; Chairperson of the Drug Advisory Committee, Canadian Association of Chiefs of Police (CACP), and Chair of the CACP's Special Purposes Committee on the Decriminalization of Illicit Drugs

Serge Brochu, PhD, Professor, École de criminologie at the Université de Montréal

Deirdre Freiheit, President and CEO, Shepherds of Good Hope (SGH) and Shepherds of Good Hope Foundation

Gord Garner, Executive Director, Community Addictions Peer Support Association

Charles Gauthier, President and CEO, Downtown Vancouver Business Improvement Association

Cheyenne Johnson, Executive Director, British Columbia Centre on Substance Use (BCCSU)

Harold R. Johnson, Elder, Advisor and Ambassador, Northern Alcohol Strategy Saskatchewan, Former Crown Prosecutor

Damon Johnston, Chair, Addictions Foundation of Manitoba, and President, Aboriginal Council of Winnipeg

El Jones, Spoken Word Poet, Educator, Journalist, and a Community activist living in African Nova Scotia

Mae Katt, Primary Health Care Nurse Practitioner, Thunder Bay and Temagami First Nation

Robert Kucheran, Chairman of the Executive Board, Canada's Building Trades Unions

Frankie Lambert, Communications Officer, AQPSUD (Association Québécoise pour la promotion de la santé des personnes utilisatrices de drogues / Québec Association for Drug User Health Promotion)

Anne Elizabeth Lapointe, Executive Director, Maison Jean Lapointe and Addiction Prevention Centre

Dr. Shaohua Lu, Addiction Forensic Psychiatrist, Clinical Associate Professor, University of British Columbia

Donald MacPherson, Director, Canadian Drug Policy Coalition

Akwasi Owusu-Bempah, PhD, Assistant professor, Department of Sociology, University of Toronto

Hawkfeather Peterson, President of BCYADWS (BC/Yukon Association of Drug War Survivors), Regional Peer Coordinator of the Northern Health Authority in BC

Dan Werb, PhD, Executive Director, Centre on Drug Policy Evaluation, MAP Centre for Urban Health Solutions, Li Ka Shing Knowledge Institute of St. Michael's Hospital, Assistant Professor, University of Toronto Institute of Health Policy, Management and Evaluation, and Assistant Professor, University of California San Diego Division of Infectious Diseases and Global Public Health

Approach / Methodology

Overview

The Task Force was provided with a draft *Canadian Drugs and Substances Strategy* (CDSS) document for its review and feedback. The version of the CDSS that was reviewed by the Task Force was dated August 2020.

The Task Force was asked to respond to six specific questions about the CDSS:

- 1. Do we have the right articulation of the problem regarding substance-use harms in Canada?*
- 2. Does the CDSS have the right overall goals, principles and objectives?*
- 3. Are there any gaps across the four pillars of the strategy (prevention, treatment, harm reduction, and enforcement) and the evidence base?*
- 4. Do we have the right priority areas moving forward?*
- 5. How can we better support populations most at-risk of substance use harms through the CDSS?*
- 6. Are there any other issues or areas we should include in the CDSS?*

The Task Force structured many of its discussions based on these questions but agreed in the end to present a broader set of recommendations that are not all specifically tied to the questions or to the draft CDSS provided by Health Canada.

The work took place over a series of six meetings, on May 5, 12, 19 and 26 and June 2 and 9, 2021. Meetings lasted between two (2) and five (5) hours and were held using an online web conferencing tool. The Task Force Secretariat prepared records of proceedings of each of the meetings for the use of Task Force members.

Various documents and briefs were shared with Task Force members and reviewed before meetings. Task Force members also collaborated and exchanged asynchronously between meetings using email and the Government of Canada's GCcollab platform.

Presentations and Submissions

The following organizations and individuals presented to the Task Force in this second part of its mandate:

May 5, 2021

- Health Canada
- Thunderbird Partnership Foundation

May 19, 2021

- Dr. Jeffrey Turnbull, Ottawa Inner City Health
- BC Yukon Association of Drug War Survivors Women's Committee

May 26, 2021

- Community Addictions Peer Support Association (CAPSA)
- Black Health Alliance

June 2, 2021

- Dr. Elaine Hyshka

Key Messages

Building on the Task Force recommendations in its first report, the Task Force would like to emphasize the following key points about Canada's substance-related policies and strategy:

1. **Canadian policy on substances must change significantly to address and remove structural stigma, centre on the health of people who use substances, and align with current evidence.** People who use substances are not the problem. Social, historical, and political systemic forces (including colonisation, social inequity, and racism) and inadequate policies (such as criminalization of simple possession, an extremely toxic unregulated illegal drug market, and inadequate regulation of alcohol) are the fundamental drivers behind toxicity deaths and many other substance use harms. New solutions, beginning with legal regulation, should focus on the social determinants of health, public health, and the human rights of people who use substances. The development and implementation of these solutions must involve people with lived and living experience and the organizations that represent them, given that they are the ones that will be most affected.
2. **Bold actions are urgently needed.** The war on drugs has led to what ends up looking like a war on people who use drugs. People are dying every day, and the situation in Canada, already particularly deadly², is getting worse, not better³. Canada has the fastest growing rate of overdose mortality in the world. This is despite the fact that Canada also has a broad

² WorldAtlas, [Highest Overdose & Drug Related Death Rates In The World](#), 2021

³ Government of Canada, [Opioid- and Stimulant-related Harms in Canada](#), March 2021

set of overdose prevention interventions that are legally available, including naloxone distribution, drug checking services, and supervised consumption sites. While these may account for the fact that Canada's overall rate of overdose mortality is slightly lower than the United States (which has the highest rate in the world), the modest successes that these interventions have achieved to date are dwarfed by the fact that Canada's overdose epidemic is worsening at an alarming rate⁴. Canada's current drug policies are failing to keep people alive and must be immediately transformed through decriminalization, the development of a single public health framework which regulates all substances, and the expansion of safer supply.

3. **We need made-for-Canada solutions that are tailored to our specific historical, social, political, and geographic contexts.** Although we can learn from other jurisdictions, Canada must develop its own solutions, ones that recognize the sovereign rights of Indigenous peoples and support their governments in providing appropriate prevention, harm reduction, treatment, and recovery approaches; that ensure equitable protections and outcomes for other groups disproportionately impacted by substance use harms, including but not limited to women, Black populations, and racialized populations; and that take into consideration our country's size and the distribution of our population between North and South, urban and rural.
4. **National leadership is essential.** The government of Canada must take the lead to reach across political and jurisdictional boundaries and develop a consensus on national standards for the continuum of equitable, people-centred services and resources needed to ensure that all people in Canada who use substances have access to comprehensive and appropriate protections and supports.
5. **Canada must make new and significant investments to address this issue.** These should be a distinct funding stream separate from mental health, to reinforce the importance and urgency of this issue.

More specific recommendations are included in the following sections related to how the problem should be articulated in the strategy, and where in a new *Canadian Drugs and Substances Strategy* (CDSS) should focus moving forward.

Articulation of the Problem

Although the articulation of the problem in the draft CDSS appropriately frames the issue as broad and systemic, the Task Force found some important gaps and challenges that must be addressed. The CDSS needs to balance clear, concise statements to facilitate understanding with recognizing the complexity of the issue and the importance of an integrated approach.

The Task Force was particularly concerned about the strategy's silence on policy-related harms, and the manner in which the draft CDSS discusses substance related harms, substance use, and people who use substances.

⁴ Government of Canada, [Opioid- and Stimulant-related Harms in Canada](#), March 2021

Policy-Related Harms

Recommendation: Provide more context on policy-related harms, the impacts of social determinants of health, and historical harms and their persistent, intergenerational effects.

Policy-related harms, and specifically the harms resulting from criminalization of simple possession, need to be acknowledged as a significant part of the problem. International expert groups have shown that the prohibition of certain drugs has led to increased criminal activity and a very robust and unregulated highly toxic drug market. Prohibition has also promoted stigma and discrimination and undermined the human rights of people who use substances. The policy of prohibition has been identified as a major source of harm to people who use drugs.⁵

The articulation of the problem should also more clearly acknowledge and describe the historical, intergenerational, and persistent harms resulting from historical and ongoing structural racism in Canada.

Recommendation: Describe the impact of inadequate regulation of pharmaceuticals, tobacco, alcohol, cannabis, and illegal substances on Canada's substance issue, and acknowledge that alcohol currently causes more harms than the substances covered by the CDSA⁶.

In addition to the harms caused by the highly toxic illegal drug market, significant harm has been caused by the over-prescription or aggressive marketing of currently legal substances as healthy and beneficial. Access to pharmaceutical alternatives for the toxic drug supply is part of safer access, but more access does not necessarily equate with fewer harms overall, as evidenced, for example, by Canada's experience with alcohol⁷.

Substance Related Harms

Recommendation: Broaden the definition of substance-related harms.

The full scope of substance-related harms must be understood to create a solid foundation for the strategy. These harms go well beyond substance-related disorders as defined by the American Psychiatry Association (APA) DSM 5. Substance-related harms encompass a much wider range of harms than individual health consequences directly linked to substances. They include, for example, stigma, disproportionate harms to populations experiencing structural inequity, violence related to the illegal drug market, a high financial burden on the health and criminal justice system, and unaddressed underlying conditions.⁸

⁵ Transform Drug Policy Foundation, [The War on Drugs: Are we paying too high a price?](#)

⁶ Canadian Institute for Substance Use Research and the Canadian Centre on Substance Use and Addictions, [Canadian Substance Use Costs and Harms 2015–2017](#), 2020

⁷ Canadian Institute for Substance Use Research, [Strategies to Reduce Alcohol-Related Harms and Costs in Canada: A Review of Federal Policies](#), 2019

⁸ Health Canada's Expert Task Force on Substance Use, Report #1, Recommendations on Alternatives to Criminal Penalties for Simple Possession of Controlled Substances, May 2021

Recommendation: Acknowledge and describe the disproportionate and distinct harms experienced by Black people and Black communities.

The draft CDSS makes no mention of Black populations in Canada even though Black people have a higher rate of drug-related persecution than other populations, despite not using drugs more than these other populations. The term anti-Black racism was coined in Canada to capture the systemic nature of the disproportionate exposure to, and impacts of, negative social determinants of health on Black people in Canada. The colonial history of our country, the transatlantic slave trade, and racial discrimination in institutions, public services, policy, and laws explain why Black people in Canada are less likely to be in the boardroom, are more likely to live in poverty, are less likely to perform well at school, have higher rates of unemployment, receive lower rates of pay for comparable skills, are more likely to live in precarious housing, and have higher rates of contact with the criminal justice system. While the Black population in general have increased risks of substance use harms, different social inequities may intersect and increase risks of specific harms for groups within the Black populations. For instance, criminalization of drug use leads to Black women being disproportionately policed in child welfare as well as globally being the fastest growing incarcerated population⁹, and Black 2SLGBTQQI people face high rates of trauma, stigma, and policing.

Substance Use and People Who Use Substances

Recommendation: Consider and describe the full spectrum of substance use to provide a more complete and nuanced understanding of the situation.

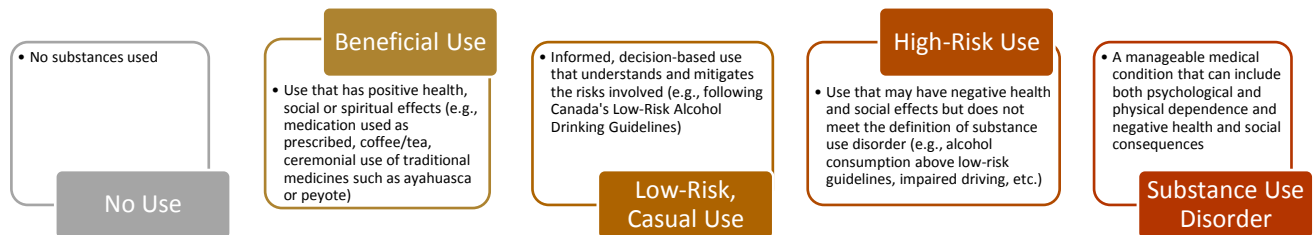
In the draft CDSS, the language describing substance use as problematic sometimes seems to centre on use being chronic or habitual, which is not an accurate portrayal of problematic substance use. The document presents an oversimplified picture of the range of substance use situations by differentiating solely between low-risk and high-risk use.

The Task Force recommends that the CDSS include and be based on a more nuanced understanding of the full spectrum of substance use, as depicted in the following graphic adapted from *A Public Health Approach to Drug Control in Canada*¹⁰. It should also account for the reality that people can move from one type of use to another, that they do not do this in a sequential way, and that the threshold for considering different types of use low or high risk may vary for different substances.

⁹ Feminist Review, [selling black bodies: black women in the global prison industrial complex](#), 2005

¹⁰ Health Officers Council of British Columbia, [A Public Health Approach to Drug Control in Canada](#), 2005

Figure 1: Spectrum of substance use



Recommendation: Recognize the many profiles of people who use substances and avoid language that reinforces stigma.

“People who use substances” is a broad category that encompasses a wide range of situations and experiences. A key to success is to include in the scope of the strategy all people who use substances – in other words, most of the Canadian population¹¹.

Among people who use substances, there is a relatively small subset with substance use disorders and high acuity needs, a larger number of people who are at risk and seeking formal care, an even larger population that is at risk but not seeking formal care, and finally a healthy population with no risk factors and no need for care. A comprehensive strategy must recognize all these sub-populations in order to adequately address their different situations and needs.

In addition, it is important to note that stigma is fed by language¹², and by the idea that an individual’s drug use, in and of itself, is causing harm to others. When discussing substance-related harms, the strategy should use explicit language that focuses on the harms themselves and does not stigmatise people who use substances. Likewise, when describing problematic substance use, it is important to keep the focus on problems related to use, not on individuals who use, or how they use.

¹¹ Harm Reduction International, [Regional Overview – North America](#), 2021

¹² Community Addictions Peer Support Association, [There Is an Urgent Need to Reduce Substance Use Stigma](#), 2019

Underfunding and Lack of Services

Recommendation: Acknowledge and describe the lack of resources and services for people who use substances or who have a substance use disorder.

Services for people who use substances are typically categorized under “mental health and addiction services” and these services are chronically underfunded^{13,14}. With the system struggling to meet the more acute needs, access to services for people with substance use disorder is inadequate, and services for people at risk but not diagnosed with a disorder are almost non-existent. People who want to talk to an expert about their substance use have nowhere to turn, and there is a lack of accessible information and guidelines on substance use.

The Way Forward

The draft CDSS reviewed by the Task Force included goals, principles, objectives, pillars, and priority areas. While the document contains many useful ideas and strategies, the Task Force considers that it will require significant change because the draft assumes that the status quo, prohibiting certain substances by making them illegal under the CDSA, will continue.

Given the scale, scope, and urgency of the problem, the Task Force wishes to highlight two core priorities, legal regulation and a scaled up safer supply emergency response, in addition to a number of other goals, priorities, and principles that should be included in a comprehensive federal strategy for a public health approach to psychoactive substances in Canada.

Legal Regulation

Recommendation: Include as a core priority of the CDSS to immediately develop and implement a single public health framework with specific regulations for all psychoactive substances, including currently illegal drugs as well as alcohol, tobacco, and cannabis. This framework should aim to minimize the scale of the illegal market, bring stability and predictability to regulated markets for substances, and provide access to safer substances for those at risk of injury or death from toxic illegal substances.

Given the evidence of increasing toxicity within the illegal drug market, particularly since 2015, and the tens of thousands of Canadians from all walks of life who have lost their lives as a result¹⁵, there is clear urgency for this work. The work should be undertaken in close collaboration with people with lived and living experience and the organizations that represent them, civil society organizations, and other key stakeholders.

¹³ Canadian Mental Health Association, [Ending the Health Care Disparity in Canada](#), 2018

¹⁴ Thunderbird Partnership Foundation, [NNADAP Funding Parity Report: Ontario Region Case Study - Executive Summary](#), National Native Addictions Partnership Foundation, Inc., 2018

¹⁵ Government of Canada, [Opioid- and Stimulant-related Harms in Canada](#), March 2021

Effective regulation must strike the right balance between the extremes of prohibition and complete deregulation, which are both associated with increased social and health harms¹⁶.

This regulatory framework should^{17,18,19}:

- Engage those most impacted by current approaches that criminalize people who use drugs.
- Focus on protecting and promoting public health by stabilizing drug markets and clearly establishing regulations for access.
- Emphasize using effective policy levers to limit harmful patterns of use and avoid inducing demand.
- Encourage shifting use to lower potency products.
- Enhance public health surveillance and intervention options.
- Limit commercial interests and prioritize non-profit models of delivery.
- Apply best practices and rigorous evidence to develop specific and effective regulations for each class of substances—including alcohol, tobacco, cannabis, pharmaceutical drugs, and the range of currently illegal drugs—within a public health framework.

In developing and implementing this new framework, the Government of Canada should consider how to redirect and reallocate resources currently dedicated to the criminal prosecution related to drug possession. It should also use its influence with other countries to increase pressure for the evolution of international agreements to facilitate regulation.

Safer Supply

Recommendation: Include as an urgent priority of the CDSS developing, implementing, and evaluating a comprehensive emergency response strategy to scale up access to safer alternatives to the toxic illegal drug market in partnership with people with lived and living experience and the organizations that represent them.

An expert committee should be convened within three months of this report to lead the design of a national safer supply program, with the goal to increase access to safer supply for up to one (1) million Canadians at risk of death from drug toxicity. This expert committee could:

- Develop new pathways for outreach, screening, and drug distribution, and work to implement them. Services including all pathways to support optimum health must be visible and readily available for those seeking these additional supports.
- Develop strategies to use existing health infrastructure as sites for safe supply distribution including pharmacies, public health clinics, harm reduction services, and other appropriate service locations.

¹⁶ Waterloo Region Crime Prevention Council's Working Group on Cannabis Legalization-Regulation, [An Ounce of Prevention](#), 2018

¹⁷ Global Commission on Drug Policy, [Regulation - The Responsible Control of Drugs](#), 2018

¹⁸ Canadian Public Health Association, [A New Approach to Managing Psychoactive Substances in Canada](#), 2014

¹⁹ Health Officer's Council of British Columbia, [Public Health Perspectives for Regulating Psychoactive Substances: What we can do about Alcohol, Tobacco and Other Drugs](#), 2011

- Develop a plan for deploying an expanded health response with resources commensurate with those allocated to responding to other emergencies such as COVID-19.
- Identify legal changes that need to take place to enable acceleration of safer supply dispensing to Canadians.
- Determine the most effective regulatory and legal changes necessary to quickly respond to the toxic poisoning crisis including Section 56 exemptions and new regulations where needed.
- Initiate a process to engage people with lived and living expertise in using criminalized substances and harm reduction to substantively collaborate on all aspects of the emergency safer supply strategy.^{20,21,22,23}

Funding

Recommendation: Provide sufficient and ongoing funding for the strategy.

Funding should be equivalent to the scope of the issues, should be allocated to various sectors commensurate with evidence of impact, and it should be recurring so that supports continue even when governments change. Current policies are currently costing Canada huge amounts. In 2017, the estimate of healthcare costs in Canada related to the use of opioids and other depressants and cocaine and other stimulants was one billion dollars²⁴, and the cost of policing and legal proceedings related to drug possession exceeded six billion dollars²⁵. Although a significant initial investment will be required to reshape the system and address the drug toxicity crisis, costs can be expected to decrease over time as the impact of new, more effective policies is felt.

Reducing Stigma

Recommendation: Include an objective related to reducing stigma.

In its first report, the Task Force identified stigma as a core issue that multiplies harms and increases the risk of negative outcomes. Reducing stigma takes time and sustained effort because it requires changing underlying beliefs that have been built and reinforced over many

²⁰ [International Journal of Drug Policy, Consumer protection in drug policy: The human rights case for safe supply as an element of harm reduction](#), 2021

²¹ [Journal of Studies on Alcohol and Drugs, Addressing the Syndemic of HIV, Hepatitis C, Overdose, and COVID-19 Among People Who Use Drugs: The Potential Roles for Decriminalization and Safe Supply](#), 2020

²² [Public Health in Practice, 'Safer opioid distribution' as an essential public health intervention for the opioid mortality crisis – considerations, options and models towards broad-based implementation](#), 2020

²³ [Canadian Medical Association Journal, A safer drug supply: a pragmatic and ethical response to the overdose crisis](#), 2020

²⁴ [Canadian Institute for Substance Use Research and the Canadian Centre on Substance Use and Addictions, Canadian Substance Use Costs and Harms 2015–2017](#), 2020

²⁵ [Canadian HIV/Aids Legal Network, Decriminalizing drug possession for personal use in Canada: Recent developments](#), 2020

years. Implementing laws that make it unlawful to discriminate against people who use substances can accelerate the process by providing incentives for behaviour change. Changing public messaging and use of language are also important, and public education more generally can also play a role. Efforts to reduce stigma should draw on work on stigma reduction for other health conditions, for example HIV/AIDS, and on anti-oppression work such as that of Anne Bishop²⁶.

Recommendation: Define the role of enforcement as a means to clearly support the aims of the public health framework and legal regulation by focussing on criminal organizations and the illegal toxic drug supply.

Enforcement can be an effective tool in supporting equitable, evidence-based regulations and policies, however it has historically been associated with the policing and criminal prosecution of low-level offences, leading to significant harms for people who use substances. With the implementation of a legal regulation framework for all substances, the focus of enforcement will naturally shift to inspecting legal institutions to ensure that regulations are enforced, and to reducing the importation, manufacture, and trafficking of currently illegal substances and their precursors.

Equity

Recommendation: Make equity a core principle and equity, anti-racism and anti-colonialism a priority area in the new CDSS.

Given the disproportionate harms to specific populations, and particularly Indigenous, Black, and racialized people, there is significant, urgent work to be done to improve equity of access to quality supports and services.

Several approaches could help facilitate increased equity:

- Undertake a racial equity impact assessment of substance use policies and develop a mitigation strategy to decrease any unintended inequitable impacts. Require that all services funded by the Federal government have undertaken a health equity audit and needs assessment and act on the outcomes to ensure that supports better serve communities.
- Require that all services funded by the Federal government collect appropriate data that so they can demonstrate to their funder that they are meeting the needs of their population.
- Require that Federal policies and federally funded services be developed in partnership with Black communities, with First Nations, Inuit, and Métis leadership, and include the voices of people with lived and living experience of substance use.
- Invest in programs created and run by communities to prevent substance-related harms. Empower communities to develop and manage programs that work for them, with the understanding that communities are not monolithic, experience multiple intersecting axes

²⁶ Anne Bishop, [Becoming an Ally – Breaking the Cycle of Oppression in People](#), 2015

of oppression, and require leadership and programs that integrate and utilize intersectional approaches.

- Increase funding for prevention and harm reduction for traditionally underserved populations.
- Require the collection, analysis and dissemination of racially disaggregated data on substance use at the population level as collected by existing government surveys (e.g. Canadian Tobacco, Alcohol and Drugs Survey (CTADS)/ Canadian Student Tobacco, Alcohol and Drugs Survey (CSTADS).
- Require the collection, analysis and dissemination of racially disaggregated data on criminal justice contact resulting from drug offences.
- Implement an equitable and inclusive research and evaluation program that specifically recruits, involves, and builds capacity in marginalized populations to build, gather and use evidence. This program should aim to improve access to socio-demographic data and improve our understanding of the needs and approaches that promote equitable services and supports and improved health outcomes for marginalized populations.
- Support an accreditation standard for services which includes a requirement that services have the capacity to offer equitable access and outcomes of services for the population – this could include training in Anti-Black racism and protocols and processes within organizations that promote authentic community engagement and community governance.
- Make protection of the rights and freedoms of all people who use substances a central goal or principle.

Increasing equity will help keep communities safe, by keeping community members who use substances healthy and safe, and by giving communities a voice in defining what safety means for them.

National Leadership

Recommendation: Include as an objective the implementation of national standards for providing supports to people who use substances, including harm reduction services, and describing the role of Provinces and Territories in our system and how Health Canada will work to ensure supports meet national standards across the country.

Provincial and Territorial governments are responsible for addressing the needs of their populations, and of First Nations, Inuit, and Métis people in particular, but the current system does not provide sufficient accountability. Strong national leadership and support is needed to ensure that all parties meet their obligations, and that all people who live in Canada benefit from equitable access to supports and services and health outcomes.

National standards should acknowledge the strengths in First Nations, Inuit and Métis culture and language that are protective and facilitate wellness, and should include cultural and land-based practices.

Standards will require implementing and reporting on key metrics to support accountability in the system. The implementation of national standards should also include plans and resources for the education and training of health care professionals.

This federal leadership role would best be accomplished by establishing a separate, properly funded Branch with a sole focus on substance use health (see glossary), separate from mental health, that has within its mandate all substances, including tobacco, alcohol, cannabis, and the substances currently under the CDSA. Such an organization would be responsible for knowledge mobilization and evidence-based action, collecting and coordinating national data, translating and sharing it, and creating policy recommendations based on this evidence.

Recommendation: Include an objective related to assessing, acknowledging, reducing, and addressing policy-related harms.

There is a vast body of research on policy related harms, and the federal government should take a leadership role in acknowledging and addressing them. Potential wording for such an objective could be “The significant harms that stem from current policy frameworks are assessed and acknowledged, and measures to minimize and redress those harms have been implemented in collaboration with people with lived and living experience and other key stakeholders.”

This work should not stop at correcting past harms, it is also important to put measures in place to detect and rapidly correct any unintended harmful consequences of new policies.

An Integrated Approach

Recommendation: Remove the notion of “pillars” from the strategy and replace it with a more holistic and integrated approach that better represents the interconnectedness of the different areas for action.

The framing of the draft strategy as pillars – prevention, treatment and recovery, harm reduction, and enforcement – with a supporting evidence base, suggests discrete components that can work independently, and the “pillars” themselves are more closely tied to a criminal justice approach than a population health approach. The substance use health model adopted by CAPSA²⁷ and the First Nations Mental Wellness Continuum Framework²⁸ are examples of circular presentations shared with the Task Force that reflect and reinforce how all the dimensions of a strategy must work together for success. Other approaches the Task Force discussed could be to present the main thrusts of the strategy as intersecting circles as in a Venn diagram, or to borrow the population health approach framework of primary, secondary, and tertiary prevention²⁹. This latter approach could enable a stronger focus on the social determinants of health and facilitate better integration of prevention, harm reduction, and treatment and recovery into a continuum of supports and services.

²⁷ Community Addictions Peer Support Association (CAPSA), Presentation to the Task Force, May 2021

²⁸ Government of Canada and Assembly of First Nations, [First Nations Mental Wellness Continuum Framework](#), 2015

²⁹ Government of Canada, [Implementing the Population Health Approach](#), 2013

Recommendation: Frame the overall aim of the strategy as a health promotion approach to substance use and minimizing harms.

There is increasing evidence that taking a problem-centred approach is less effective than focusing attention and energy on a positive goal. This has already been recognized in other domains like physical health and mental health, where health promotion is a central element of the overall strategy.

Public education will be required to minimize harms and achieve longer-term goals of substance use health. Public education should include educating the public about substances and their risks, and the toxic substances circulating in the illegal market.

Recommendation: Articulate harm reduction as an effective, evidence-based, non-judgemental public health approach for individuals who use substances, integrated into a full continuum of health and social services including housing.

Harm reduction supports both social justice for people criminalized for their substance use and an evidence based public health response to substance use in the community. Harm reduction must shift from exemptions to existing policy to an accepted and central intervention with a full continuum of supports and care.

Evidence shows that harm reduction does not increase or encourage substance use. Harm reduction strategies and services can lessen the negative consequences associated with substance use, including social, physical, emotional, or spiritual concerns. It has been shown that people who engage in harm reduction services are more likely to engage in ongoing treatment following access to these services. Some harm reduction initiatives have also been successful in reducing blood-borne diseases such as HIV/AIDS and hepatitis C and in decreasing death rates from drug overdoses.³⁰

Because harm reduction requires that interventions and policies designed to serve people who use drugs reflect the specific needs of individuals and communities, there is no universal formula for implementing harm reduction. Successful implementation requires that we invest in community-created and community-run harm reduction programs and empower communities to develop and manage programs that work for them, knowing that communities are not monolithic, that they experience multiple intersecting axes of oppression, and that they need leadership and programs that incorporate and use an intersectional approach (e.g., 2SLGBTQQI, Black communities, Indigenous communities, sex workers).

Recommendation: Include a full continuum of harm reduction, treatment and recovery care and services.

Substance-use disorder is a condition with many manifestations that presents a high likelihood of reoccurrence, and for those who want support there will be a need for access to treatment and recovery programs that go from short-term, controlled used, to abstinence-based

³⁰ British Columbia Ministry of Health, [Harm Reduction - A British Columbia Community Guide](#), 2005

programs, to long term follow up and supports. Different treatment options should be available depending on the presence and severity of concurrent disorders. This treatment and recovery-oriented system of care should be widely available, covered for all, and provide quality services aligned with evidence. It should also draw on the wisdom of Indigenous people, who have created cultural and land-based programs that are successful in dealing with the root causes of substance use.

Recommendation: Include labour-market measures as part of an integrated approach to support certain populations.

Where employment intersects with substance use, stigma plays a big role in preventing people from seeking help for substance use disorders. This is particularly the case for health care workers, for people who work in the criminal justice system, and people who work in physically demanding occupations such as construction workers. The current system of addiction care is neither well understood nor well integrated. There are also cultural and labour market barriers to obtaining needed supports, for example a lack of paid sick days or protections like seniority.

Current care is not consistent with Canada's health principle of universality and equal access. Access to quality treatment and recovery programs is uneven, private industry programs are expensive, there is too much focus on residential programs, and there are long waiting lists for publicly funded programs. A full spectrum is needed, with standards across the spectrum, and related measures that facilitate access to appropriate supports.

Recommendation: Align and integrate Canada's international policy with its domestic policy on substances.

Canada could play a significant role in advancing evidence-informed harm reduction internationally and in supporting the implementation of more equitable and effective practices around the world. Advancing these issues on the international stage would also facilitate mutual support with other jurisdictions.

Appendix A – Task Force Member Bios

Carol Hopkins (Co-Chair)

Carol Hopkins is the Chief Executive Officer (CEO) of the Thunderbird Partnership Foundation (a division of the National Native Addictions Partnership Foundation) and is of the Lenape Nation at Moraviantown, ON. Carol was appointed an Officer of the Order of Canada in 2018. In 2019, she was recognized with an honorary Doctor of Laws degree from Western University.

Carol has spent more than 20 years in the field of First Nations addictions and mental health. She has co-chaired national initiatives known for best practice in policy review and development, resulting in the: First Nations Mental Wellness Continuum Framework, the Honouring Our Strengths: A Renewed Framework to Address Substance Use Issues Among First Nations in Canada, the Indigenous Wellness Framework, and the Native Wellness Assessment.

Carol holds both a Master of Social Work degree from the University of Toronto and a degree in sacred Indigenous Knowledge (equivalent to a Ph.D. in western-based education systems).

Kwame McKenzie (Co-Chair)

Dr. Kwame McKenzie is the CEO of Wellesley Institute, Director of Health Equity at the Centre for Addiction and Mental Health, a Full Professor in Psychiatry at the University of Toronto and a consultant working with the World Health Organization.

Kwame is a member of the National Advisory Council on Poverty, a member of Canada's Expert Advisory Panel on COVID-19 and Mental Health and the Minister of Health's COVID-19 Testing and Tracing Advisory. Kwame is an international expert on the social causes of mental illness, suicide and the development of effective, equitable health systems. He has published over 250 papers, 5 books. His works have been recognised by numerous awards including African Canadian Achievement Award for Science, Dominican of Distinction Award, Don Wasylenski Award for Global Health, CAMH 150 Difference Makers in Mental Health, Harry Jerome Award and the Pioneers for Change Social Impact Award.

Kwame has served as a Human Rights Commissioner for Ontario and Chair of the Research and Evaluation Advisory Committee of Ontario's Basic Income Pilot.

He holds a medical degree from University of Southampton, and is a Fellow of the Royal College of Psychiatrists (UK).

Mike Serr (Co-Chair)

Mike Serr has been serving as a police officer for 30 years in British Columbia. He became the Chief Constable for the Abbotsford Police Department in September 2018.

The majority of Mike's operational experience is in the field of gang and drug suppression. He has worked for the British Columbia Organized Crime Agency, Integrated Gang Task Force, and British Columbia Municipal Undercover Program.

Mike is active locally and nationally in committee work and is currently the Chairperson of the Drug Advisory Committee for the Canadian Association of Chiefs of Police (CACP), as well as the Chair of the CACP's Special Purposes Committee on the Decriminalization of Illicit Drugs. He is also the Co-Chair of the British Columbia Drug Overdose Task Groups, has established the Abbotsford Opioid Working Group, is a member of the Advisory Council for Drug Free Kids Canada, the Character Abbotsford, and the Abbotsford Community Development Council.

Mike has a Bachelor of Arts in Criminology from Simon Fraser University.

Serge Brochu

Serge Brochu, PhD (psychology) has been a professor at the École de criminologie of the Université de Montréal since 1986. After serving in many administrative capacities, including Director of the International Centre for Comparative Criminology, Associate Dean of Management and Human Resources, Associate Dean of Faculty Affairs in the Faculty of Arts and Science, and Associate Vice Rector, Research, Creation and Innovation, he is now Professor Emeritus. He actively participates, through his writings and conferences in Canada and abroad, in the public policy debate on the social and judicial control of drug addiction. Over the course of his career, he has published more than 300 lectures, 146 scientific articles, 67 book chapters and 17 books. His work has earned him recognition as a Fellow of the Royal Society of Canada and as Honorary President of the International Society of Criminology.

Serge Brochu holds a doctorate in Psychology from l'Université de Montréal

Deirdre Freiheit

Deirdre Freiheit is President and CEO of Shepherds of Good Hope (SGH) and Shepherds of Good Hope Foundation, located in Ottawa, Ontario. SGH is a dynamic, innovative organization that cares for the needs of adults experiencing homelessness and who live with mental health challenges, substance use disorders and trauma. SGH operates a large homeless shelter, soup kitchen and five supportive housing residences.

Deirdre has been a leader in the not-for-profit sector for almost 30 years, having previously been the Executive Director of the Health Charities Coalition of Canada and CEO of the Canadian Lung Association. She is a former member of the Institute Advisory Board for Nutrition, Metabolism and Diabetes of the Canadian Institutes of Health Research, a lay reviewer on the Heart and Stroke Foundation research grant review panels and is a passionate advocate for marginalized populations.

Deirdre is a graduate of Atlantic Business College in New Brunswick.

Gord Garner

Gord Garner is the Executive Director of the Community Addictions Peer Support Association. He is a national speaker on addressing stigma and the resulting discrimination towards people who use(d) drugs and trainer on using Person-First Language. He is living well with his own substance use disorder at the time of this writing. He is dedicated to removing the barriers of

stigma from across the four pillars, to enable policy writers, academics, researchers and people with experience of substance use disorders active or in remission to take evidence-based actions to improve the lives of all Canadians concerning substance use. His work is informed by his 38 years of active addiction and by those who helped him.

Charles Gauthier

Charles Gauthier is the current President and CEO of the Downtown Vancouver Business Improvement Association, leading this organization since 1992. He also still presently serves on the board of the International Downtown Association. He is a dedicated, life-long non-profit society professional, focused on building strategic partnerships and collaborating with like-minded individuals to further mutual goals. Previous to this role, Charles served as the Community Economic Development Officer and Business Improvement Area Coordinator for the Summerland Economic Development Commission, and as the Economic Development Officer and General Manager for the Eastman Regional Development Corporation. Additionally, as a member of various local associations, he previously served on the Board of the International Downtown Association and Canadian Society of Association Executives, British Columbia. Charles was the recipient of Business in Vancouver's prestigious "40 Under 40 Achievement Award" (1996) and the Downtown Vancouver Association's President's Award (2009).

Charles has a Bachelor of Arts (Political Studies) and a Master of City Planning degree from the University of Manitoba.

Cheyenne Johnson

Cheyenne Johnson is Saulteaux (Ojibwe) and mixed Settler ancestry. She is a displaced status member of the Tootinaowaziibeeng Treaty 4 Reserve (Valley River) in western Manitoba. She is a Registered Nurse who works in addiction and substance use care in Vancouver. She is currently the Co-Interim Executive Director at British Columbia Centre on Substance Use (BCCSU) and is the founding Director of the BCCSU's Addiction Nursing Fellowship Program. She is passionate about providing public education to reduce stigma and improve the addiction system of care in BC. She is also an Adjunct Professor at the School of Nursing at University of British Columbia and actively collaborates with interdisciplinary clinicians, educators and researchers across Canada. She is currently Board of Director at the Association for Multidisciplinary Education and Research in Substance Use and Addiction. Cheyenne is the committee Co-Chair at Provincial Opioid Addiction Treatment Support Program. She has co-authored many articles related to addiction medicine and addiction nursing.

Cheyenne Johnson obtained her Master of Public Health from Simon Fraser University.

Harold R. Johnson

Semi retired from the Northern Alcohol Strategy Saskatchewan, Harold Johnson now acts as that agency's elder, advisor and ambassador. He was a Provincial Crown Prosecutor for ten years and private practice before that. Before a twenty-year career in law, he worked in heavy

industry, beginning as a marine engineer in the Canadian Navy, then as an heavy equipment operator, miner, logger, commercial fisher, trapper, mechanic, and firefighter across northern and western Canada. Harold is the published author of five works of fiction and five non-fiction books. He will publish a fiction book in October 2021 and a non-fiction book in January 2022. His book *Firewater: How alcohol is killing my people (and yours)* was nominated for a Governor General's award in 2016.

Harold has a Bachelor of Laws degree from the University of Saskatchewan and a Master's Degree in Law from Harvard University, where he graduated in 1996.

Damon Johnston

Damon Johnston is the current Chair of the Addictions Foundation of Manitoba. He has also served on the Board of Directors of the Canadian Mental Health Association for the last eight years. He served in the Royal Canadian Navy from 1966 to 1968. He is a member of the Fort William First Nation in Thunder Bay, Ontario. Damon has been serving as President of the Aboriginal Council of Winnipeg since 2007. He was a member of the Illicit Drug Task Force in Winnipeg, established by the federal, provincial and municipal governments. Damon's role as an Indigenous community leader in Winnipeg provides him the opportunity to be well versed in a variety of public consultation and advisory processes. He is currently on the Advisory Committee to the Health Transformation Initiative launched by the Government of Manitoba.

Damon graduated in 1970 from Confederation College in Thunder Bay, Ontario, with a Diploma in Administrative Management.

El Jones

El Jones is a spoken word poet, an educator, journalist, and a community activist living in African Nova Scotia. She was the fifth Poet Laureate of Halifax. In 2016, El was a recipient of the Burnley "Rocky" Jones human rights award for her community work and work in prison justice. She is a co-founder of the Black Power Hour, a live radio show with incarcerated people on CKDU that creates space for people inside to share their creative work and discuss contemporary social and political issues. She is a board member of East Coast Prison Justice Society and of Wellness Within which advocates for the health of women, Trans, and non-binary people who are criminalized. El served as the 15th Nancy's Chair of Women's Studies at Mount Saint Vincent University for the 2017-2019 term. El is a two-time Atlantic Journalism gold award winner for her work with the Halifax Examiner. El would like to pay tribute to the many nameless and unrecognized women whose work makes it possible for her to be here today.

El is completing her PhD at Queen's University in Cultural Studies and is an assistant professor in the department of Political and Canadian Studies at Mount Saint Vincent University in Halifax.

Mae Katt

Mae Katt is a member of Temagami First Nation and a Primary Health Care Nurse Practitioner. Her diverse nursing career includes mental health and substance use, adolescent health, maternal/child health and community health. She has a strong health policy and research background in community development, youth suicide, early psychosis, cancer care, health human resources and acquired brain injury.

She is a member of the Nishnawbe Aski Nation (NAN) COVID-19 Task Team advising leadership on pandemic planning and responses. Mae has spent 4 years on the NAN Health Transformation Advisory Council that focuses on improving health care for northern Ojibway, Cree and Oji-Cree members in 49 remote & rural First Nations. She has been providing primary health care at the Dennis Franklin Cromarty High School for 18 years.

Mae holds an Honours Bachelor of Science degree in Nursing, Master of Education (Curriculum Specialty) and an Honorary Doctorate of Laws degree from Trent University.

Robert Kucheran

Robert Kucheran was raised in Port Arthur, (now Thunder Bay) Ontario. He left home at 16 years of age to play hockey in the Ontario Hockey League where he played for the Oshawa Generals for 5 years. After the OHL, he attended York University on a hockey scholarship. He became a member of the International Union of Painters and Allied Trades (IUPAT) in April 1985 working as a summer student at the Port Arthur Ship Building Company in Thunder Bay. After graduation, he became the Business Manager of Local 1671 in Thunder Bay. During this time, he was elected Secretary to the local building trades. He was also a Director with the Superior North Apprenticeship Board.

In 2000, Robert and his family located to Caledonia, Ontario when he took the position as Organizer with Local 205 Hamilton. He was appointed General President's Representative in the fall of that same year. As GPR, he attended the Harvard University Trade Union Program in 2001. He was appointed General Vice President in 2005 and in 2009, was elected to that position in 2014 and 2019. He sits on the General Executive Board of the IUPAT. He is a trustee to the IUPAT, Finishing Trades Institute, the Labor Management Cooperation Initiative, the IUPAT Industry Pension Fund, and the IUPAT Industry Pension Fund Canada. In 2012, he was elected as the Chairman of the Executive Board for the Canada's Building Trades and remains in that position today.

Robert earned a Diploma in International Business at Confederation College in 1992.

Frankie Lambert

Currently living in Tiohtià:ke (Montreal, Quebec), Frankie Lambert (he/they) is a 24-year-old Haitian transnational adoptee. He is currently working as a communications officer for the AQPSUD (Association Québécoise pour la promotion de la santé des personnes utilisatrices de drogues [Quebec association for the promotion of the health of drug users]). A provincial organization, which, in accordance with the philosophy of harm reduction and empowerment,

brings together people who use drugs and who aspire to promote their health, prevent sexually transmitted and blood-borne infections, and improve their living conditions. Frankie also contributed to the editorial board of the UPHNS (Urgent Public Health Need Sites) blog, a pan-Canadian project that promotes the exchange of knowledge, resources and information on harm reduction and overdose prevention in UPHNSs and emergency shelters set up in response to the COVID-19 crisis. Lastly, Frankie is also part of the Defund the SVPM Coalition, and the activist group Black Lives Matters. As a drug user, Frankie lives by the philosophy of harm reduction and transformative justice.

Anne Elizabeth Lapointe

Anne Elizabeth Lapointe is the Executive Director of the Maison Jean Lapointe and of the Addiction Prevention Centre.

Ms. Lapointe has 20 years of experience in the field of addictions including 15 years in prevention. She has contributed to the development and evaluation of the Maison Jean Lapointe and the CQLD's prevention programs. These programs reach 100,000 young people yearly in Quebec. Ms. Lapointe is actively involved in the community and sits on several round tables and expert committees. She has given countless conferences pertaining to her field of expertise and continues to share her knowledge within the community. Her proficiencies include behavioral addictions, such as problem gambling as well as prevention and treatment of all addictions.

Ms. Lapointe holds a Bachelor's degree in Communications, a Diploma in Management, a Certificate and a Graduate Diploma in Addiction and Ethics.

Shaohua Lu

Dr. Shaohua Lu is an addiction forensic psychiatrist with over 20 years of experience in clinical psychiatry. He is currently a member of the Prescription Review Panel at the College of Surgeons and Physicians of BC. Shaohua is a clinical associate professor at the University of British Columbia where he helped to develop the addiction psychiatry and chronic pain management program. He continues to teach residents and medical students.

Shaohua has been a consulting psychiatrist in the Vancouver General Hospital and the BCOSI clinic, a federal program that assesses and treats Canadian Armed Forces Veterans and RCMP officers. He has worked extensively with patients with complex medical psychiatric and addiction needs.

Shaohua had served on the Board of Director for the Doctors of BC, Canadian Academy of Psychosomatic Medicine, and the Pacific Rim College of Psychiatrist. He had served on various policy and administrative committees at Vancouver Coastal Health Authority. Shaohua chaired the 2009 BC Medical Association's addiction care policy paper Stepping Forward, which supported a full spectrum care for individuals with addiction. He has published in peer reviewed journals on addictions, PTSD and other research projects.

Shaohua completed his addiction psychiatric fellowship at Harvard University.

Donald MacPherson

Donald MacPherson is the Director of the Canadian Drug Policy Coalition based at the Faculty of Health Sciences at Simon Fraser University. Formerly, he was North America's first Drug Policy Coordinator at the City of Vancouver where he worked for 22 years and is the author of Vancouver's ground-breaking Four Pillars Drug Strategy in 2001.

His publications include the books *Raise Shit! Social Action, Saving Lives* (2009) and *More Harm than Good: Drug Policy in Canada* (2016). In 2007, he received the Kaiser Foundation National Award of Excellence in Public Policy in Canada. In 2009 he was awarded the Richard Dennis *Drug Peace Award* for Outstanding Achievement in the Field of Drug Policy Reform by the Drug Policy Alliance in the US.

In 2019, Donald was given a Lifetime Achievement Award from the BC Centre on Substance Use and an Honorary Degree from Adler University in Chicago/Vancouver for his contribution to social justice in the field of drug policy.

Akwasi Owusu-Bempah

Akwasi Owusu-Bempah is an Assistant professor in the Department of Sociology at the University of Toronto. He also holds a status appointment at the Centre for Criminology and Sociological Studies. Trained as a criminologist, his research focuses on racial and other forms of inequity in the context of law, criminal justice and social policy. His recent work has examined the history of North American drug policy and its contemporary impacts on Black and other racialized populations. Cannabis continues to be a key focus of this work.

Akwasi's peer-reviewed research on race, cannabis use and cannabis law enforcement has been published in the *International Journal of Drug Policy*, the *Journal of Ethnicity in Substance Abuse*, and the *Canadian Journal of Criminology and Criminal Justice*. He also writes widely on these topics for popular outlets and is a frequent media commentator. He is an Affiliate Scientist at the Centre for Addiction and Mental Health, Direct or Research for the Campaign for Cannabis Amnesty, and Racial Equity Lead at the Centre on Drug Policy Evaluation.

Akwasi holds Ph.D. and M.A. degrees in criminology from the University of Toronto, and a B.A. from Carleton University.

Hawkfeather Peterson

Hawkfeather Peterson (pronouns are they/them) lives and works in British Columbia. They are the current President of the BCYADWS (BC/Yukon Association of Drug War Survivors) and the Regional Peer Coordinator of the Northern Health Authority in BC. Hawkfeather has worked with a passionate focus directed towards protecting the rights of mothers and birthing parents who are substance users. They work directly with the Provincial Perinatal Substance Use Project and BC's Women and Children's Hospitals Overdose Task Force. Hawkfeather also serves as a Frontline VCH (Vancouver Coastal Health) Outreach Worker in their home community.

For over a decade, Hawkfeather has worked with multiple levels of governments and various organizations. All of this work comes from the lens of a person with living experience as a substance user and with loving dedication to supporting their beautiful community of drug users.

Dan Werb

Dan Werb is a scientist with the MAP Centre for Urban Health Solutions in the Li Ka Shing Knowledge Institute of St. Michael's Hospital. He holds assistant professor appointments at the Institute of Health Policy, Management and Evaluation at the University of Toronto and in the Division of Infectious Diseases and Global Public Health at the University of California San Diego. For the last 6 years, he is also the Executive Director of the Centre on Drug Policy Evaluation at MAP, which conducts extensive epidemiologic, implementation and policy research on addictions and drug policy, and works closely with governments, affected communities and civil society to guide effective and evidence-based policy responses to substance use.

Dan has published over 85 studies on issues related to addictions, drug policy, and HIV, with a focus on preventing the transition of street youth into injection drug use, as well as on identifying the impact of policy and public health interventions on marginalized drug-using populations.

Dan is the recipient of a Trailblazer Award in 2017 from the Canadian Institutes of Health Research and was named by the Canadian Broadcasting Corporation (CBC) as one of 13 young Canadians changing our country for Canada's 150th anniversary celebration.

Dan received his Ph.D. and M.Sc. in Epidemiology and Biostatistics from the University of British Columbia.

Appendix B – Recommendations from the First Report of the Expert Task Force on Substance Use

In its first report, dated May 6, 2021, the Expert Task on Substance Use made the following recommendations on alternatives to criminal penalties for simple possession of controlled substances and related issues.

Decriminalization and Regulation

1. Elimination of all penalties and coercive measures

Recommendation: The Task Force unanimously recommends that Health Canada end criminal penalties related to simple possession and most also recommend that Health Canada end all coercive measures related to simple possession and consumption.

It is our expert opinion that penalties of any kind for the simple possession and use of substances are harmful to Canadians. Substance use should be managed as a health and social priority, with a focus on the social determinants of health, and not through criminal or civil sanctions.

As to coercive measures, the evidence on mandatory, coerced or forced treatment, including drug treatment courts, is mixed, and success rates are typically low³¹³². Furthermore, decriminalization or regulation may be less effective and may amplify structural inequities if conditions and penalties are such that people who use drugs are at risk of being criminalized for non-compliance with civil penalties.

This does not preclude offering support or voluntary treatment as options in addition to or instead of penalties under other Acts.

Implementation and pathways for youth and school-age children and their families need to be further explored and developed to ensure the necessary supports are in place for this population.

2. Legislative change

Recommendation: Most Task Force members also recommend that the Government of Canada immediately begin a process of legislative change to bring the *Controlled Drugs and Substances Act* (CDSA), the *Tobacco and Vaping Products Act* (TVPA), the *Cannabis Act*, and any other relevant federal legislation **under a single public health legal framework with regulatory structures that are specific to different types of substances.**

Regulation of drugs will have the greatest impact on ending the drug toxicity death crisis and minimizing the scale of the unregulated drug market. It will address key drivers of substance toxicity injury and death and facilitate a health promotion approach to substance use.

³¹ Justice Research and Policy Journal, [Drug Treatment Courts: A Quantitative Review of Study and Treatment Quality](#), 2012

³² Department of Justice Canada, [Drug Treatment Court Funding Program Evaluation](#), 2017

Regulatory structures that are specific to different types of substances will be important to address varying levels of substance toxicity, as well as the unique health and social outcomes of each type of substance.

Bringing all substances together under a single Act will also provide an opportunity to harmonize the regulation of all substances with potential for harm, including alcohol, tobacco, and cannabis, and potentially mitigate harm more effectively through a more consistent and coherent approach.

3. Thresholds

Recommendation: The Task Force recommends that thresholds for simple possession be based on presumption of innocence, and that they be set high enough to account for the purchasing and consumption habits of all people who use drugs.

People who use drugs have different consumption needs and patterns. Some people with substance use disorders need to use more than others because of high tolerance. Some people on low, fixed incomes tend to purchase monthly or biweekly supply when they are paid, which also leaves them in possession of larger than “average” amounts. And individuals relying on the illegal drug market may also purchase larger amounts to minimize their exposure to potential violence. Threshold determinations are of critical importance and processes to consider threshold amounts should be co-led with people with lived and living experience of using drugs.

4. Expungement

Recommendation: As part of decriminalization, the Task Force recommends that criminal records from previous offenses related to simple possession be fully expunged. This should be complete deletion, automatic, and cost-free.

Criminal records expose people who use drugs to discrimination and makes it hard for them to be gainfully employed, which leads to further stigma and marginalization.

Related Recommendations

The measures recommended above, while important, will not be sufficient. Further measures are needed to mitigate the harms experienced by people who use substances, and to avoid unintended consequences as policy changes are implemented.

5. Supports for people who use drugs or substances or who are in recovery

Recommendation: The Task Force recommends that Canada make significant investments in providing a full spectrum of supports for people who use drugs or substances or who are in recovery.

Supports could include supervised consumption sites, an array of treatment options, pharmaceutical grade alternatives to illegal street drugs, housing, drug checking services, and other social supports. Access to these supports should be equitable and universal.

There is an urgent need for a safe supply of pharmaceutical grade alternatives to reduce people's exposure to the toxicity of illegal street drugs.

The need for more supervised consumption services, including supervised injection, snorting, smoking, and accommodating assisted injection for those who are unable to inject themselves, is also urgent.

6. Evidence and monitoring

Recommendation: The Task Force recommends the implementation of a more comprehensive and responsive system to rapidly and effectively gather, use, and disseminate evidence about substance use, its effects, and the impacts of government policies on the health and wellbeing of Canadians.

Systems must be in place to monitor the impacts of policies and enable rapid responses to changing circumstances. This is critical to ensure that Canadian substance-related policies are grounded in the best available evidence while also being responsive, adaptive, and effective. The focus of evidence-gathering to date appears to be mostly on substance use harms rather than a health promotion approach to substance use. Correcting this bias is important to ensure that policies are as effective as possible in meeting the needs of Canadians.

More targeted research is needed with marginalized populations, including Indigenous people, Black people, racialized people, and newcomer communities. This will require capacity building in these populations for this work. More also needs to be done to disaggregate existing data on these populations and to publish disaggregated data consistently at the national level and across all provinces and territories.

The evidence collected should be used to strengthen public education, health promotion, prevention, treatment, and protection from contaminated substances.

7. Rights of Indigenous Peoples of Canada, First Nations, Métis, and Inuit

Recommendation: The Task Force strongly urges Health Canada to respect the sovereign rights of the Indigenous Peoples of Canada and support their governments in providing appropriate prevention and treatment approaches.

Whatever changes are implemented must not encroach on Indigenous rights, and First Nations, Métis, and Inuit should be able to self govern and apply their knowledge, culture, and traditional responses to substance use.

Furthermore, legislation and regulation must recognize the authority and sovereignty of First Nations, Métis and Inuit and support them in righting the disproportionate harms that have been inflicted on their people from current policies.

8. Further Consultation

Recommendation: The Task Force recommends that Health Canada convene a new committee that centres people with lived and living experience of substance use to provide advice on the implementation of its recommendations.

People with lived or living experience of substance use have unique expertise on substance use and they will be directly impacted by any policy decisions about substance possession and use. Future consultations should ensure that their diverse voices are strongly and equitably represented, including those of specific groups such as Indigenous women, Black people, racialized people, those who are incarcerated, migrants and people without status.

Consultation should also be broadened to include a wider range of voices and perspectives generally, to maximize the potential for successful implementation of eventual decisions.

Appendix C – Glossary of Terms

Addiction	A treatable chronic illness involving complex interactions among brain circuits, genetics, the environment, and an individual's life experiences (see substance use disorder).
Decriminalization	<p>Removal of criminal penalties for an activity.</p> <p>De facto approaches are ones that do not require any changes to the laws or regulations.</p> <p>De jure approaches involve changing the laws or regulations.</p>
Drug	For the purposes of this report, "drug" means an illegal or unauthorized psychoactive substance.
Drug toxicity	<p>A poisonous quality of a drug that can cause functional, biochemical, or structural damage to the human body.</p> <p>Toxicity can be acute or chronic; toxicity can cause temporary or permanent physical, cognitive, or psychological injuries, up to and including death.</p>
Equity	The absence of avoidable or remediable differences among groups of people, whether those groups are defined socially, economically, demographically, or geographically. (WHO)
Harm	A negative consequence to an individual, family, community, or society at large, including direct, indirect, and intergenerational or epigenetic physical and mental health, social, and economic and financial impacts.
Harm reduction	<p>Harm reduction is a public health approach that uses practical strategies and approaches to reduce harms related to substance use.</p> <p>The range of harm reduction strategies includes safer use, managing use, abstinence, addressing the conditions of use in addition to the use itself, and meeting people who use substances "where they're at" not only in terms of substance use but also geographically (e.g., rural and remote communities), socially, culturally, and on their life journey.</p>
People with lived and/or living experience of substance use	People who currently consume or have in the past consumed substances, or their family or community members collectively and directly impacted by the consumption of substances.

People who use drugs	People who consume illegal or unauthorized psychoactive substances.
Recovery	<p>Recovery is a process of change through which people improve their health and wellness, live self-directed lives, and strive to reach their full potential. There are four major dimensions that support recovery:</p> <ul style="list-style-type: none"> • Health—overcoming or managing one’s disease(s) or symptoms and making informed, healthy choices that support physical and emotional well-being. • Home—having a stable and safe place to live. • Purpose—conducting meaningful daily activities and having the independence, income, and resources to participate in society. • Community—having relationships and social networks that provide support, friendship, love, and hope. <p>(Substance Abuse and Mental Health Services Administration)</p>
Regulation	Government oversight of production, manufacture, importation, distribution, product promotion, and sale.
Safer supply	A legal and regulated supply of drugs that are traditionally only accessible by medical prescription or through the illegal drug market.
Simple possession	<p>This refers to possession as defined in section 4(3) of the Criminal Code of Canada and referenced by the CDSA:</p> <p>(a) a person has anything in possession when he has it in his personal a) a person has anything in possession when he has it in his personal possession or knowingly</p> <ul style="list-style-type: none"> (i) has it in the actual possession or custody of another person, or (ii) has it in any place, whether or not that place belongs to or is occupied by him, for the use or benefit of himself or of another person; and <p>(b) where of two or more persons, with the knowledge and consent of the rest, has anything in his custody or possession, it shall be deemed to be in the custody and possession of each and all of them.</p>

Social determinants of health	Social and economic factors that influence people’s health, such as social status, income, education, employment and working conditions, equitable and timely access to health services and care, the experience of discrimination or racism, etc. These factors are largely outside of an individual’s control. For Indigenous populations, determinants of health also include processes of colonization, culture, language, and land.
Stigma	A negative social, political, and cultural attitude toward a group or individual with a distinguishing attribute or behaviour, founded on a deeply held set of false beliefs, and involving overt and covert judgement, oppression, and discrimination. Common causes of stigma are stereotypes, fear, colonizing norms, unequal power dynamics, lack of awareness, and misinformation. Policies and laws often entrench and exacerbate stigma (see structural racism).
Structural racism	A system of public policies, institutional practices, cultural representations, and other norms that work in various, often reinforcing ways to advantage white people and perpetuate inequity toward people of colour.
Substance	Except when referring to the <i>Controlled Drugs and Substances Act</i> (CDSA) and its provisions, substance in this report is defined more broadly as a psychoactive substance, i.e., “chemicals that cross the blood-brain barrier and affect mental functions such as sensations of pain and pleasure, perception, mood, motivation, cognition, and other psychological and behavioral functions” (CPHA), and includes controlled substances under the CDSA as well as other unauthorized substances, alcohol, tobacco, and cannabis.
Substance use disorder	A diagnosable, treatable health condition that is categorized from mild, to moderate to severe. Substance use disorders are diagnosed by assessing a complex pattern of symptoms including impaired control, social impairment, risky use, and pharmacological indicators.
Substance use health	An expression adopted by organizations of people with lived and living experience to focus attention on the unique, unmet health service and support needs of people who use substances, which should be considered and addressed in the same way as mental health or physical health needs.

Treatment	Services to identify and address substance use disorders through withdrawal management, pharmacological interventions and/or psychosocial interventions.
Unregulated drug market	The sale and purchase of substances that escapes oversight by the Canadian legal and regulatory system.