TO END A CRISIS: VISION FOR BC DRUG POLICY

Endorsed By:

Canadian Drug Policy Coalition (CDPC)
Pivot Legal Society
British Columbia Civil Liberties Association (BCCLA)
B.C. Health Coalition
B.C. Poverty Reduction Coalition
Surrey Newton Union of Drug Users (SNUDU)
Canadian Union of Public Employees (CUPE) Local 5536
SOLID Outreach
Vancouver Area Network of Drug Users (VANDU)
Vancouver District Labour Council (VDLC)
Workers for Ethical Substance Use Policy (WESUP)
B.C. Association of People on Methadone (BCAPOM)
Coalition of Peers Dismantling the Drug War (CPDDW)
Care Not Cops
Nanaimo Community Action Team
Nanaimo Area Network of Drug Users (NANDU)
Mountainside Harm Reduction Society
Living Positive Resource Centre
Prisoners' Legal Services
Coalition of Substance Users of the North (CSUN)
Chilliwack Community Action Team
Rural Empowered Drug Users' Network (REDUN)
Harm Reduction Nurse's Association (HRNA)
Dudes Club Society
AVI Health and Community Services
Mom's Stop the Harm
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The so-called “war on drugs" originated at the intersections of settler-colonialism, racism, and class-based oppression.[1] Drug policies in BC and across Canada continue to be steeped in and reproduce these harmful structures. An overwhelming body of evidence demonstrates that prohibitionist policies function to: increase social inequalities on the bases of race, class, culture, gender, and ability;[2] exacerbate negative mental and physical health outcomes;[3] and decrease public safety.[4] Prohibition is the direct cause of thousands of fatalities every year, with drug toxicity accounting for at least 2,511 preventable deaths in BC in 2023.[5] Criminal justice and medical models alike have allowed the unregulated drug crisis to continue unabated. We assert that neither model will offer healing, justice, or liberation for communities most harmed by the war on drugs and its attendant conditions.

We call on all levels of government to urgently change course. We imagine nothing short of a sea change. This document therefore represents a significant departure from the status quo. It provides a roadmap for designing and implementing drug-related policies that are grounded in anti-racist and anti-colonial frameworks and are inspired by the principles of autonomy, choice, and compassion. We contend that contemporary drug policies must eliminate all forms of policing, coercing, medicalizing, and demonizing drug users. They must be tailored to the unique values, world-views, and material conditions of drug consumers. For too long, consumers’ basic human rights have been subordinated by an ideological agenda that was designed by the limited imaginations of a powerful few.

Our recommendations address four related areas of drug policy for immediate and substantive reform: **Drug regulation**; **Decriminalization**; **Addressing substantive equality in drug policy reform**, and; **Detox, recovery and treatment**. We conclude with a discussion of the principles and scientific evidence that inform our recommendations.

Policy, Political and Regulatory Recommendations

Drug Regulation

1. Work with the College of Physicians and Surgeons of BC to liberalize opioid and stimulant prescribing methods, as well as reduce audits targeted at physicians working within the drug toxicity crisis. Invest in education for the Regulatory Colleges about safe supply and drug regulation as mechanisms for preventing drug toxicity related deaths.

2. Remove the need for ‘Special Authority’ for all applicable substances, drugs and medications that could reduce overdose fatalities to be covered under Pharmacare Plan G.

3. Create a legal framework for the establishment of community-controlled drug use sites where patrons can also access a regulated supply of drugs on-site. Choice of substances should be wide-ranging to address autonomous decision-making around potency, route of consumption, etc.

These measures will create a safer, more communal and mutually supportive environment for people who use drugs while directly addressing the drug toxicity and overdose crisis.

Decriminalization

4. Either remove threshold amounts in their entirety, or immediately scale up the decriminalized personal possession threshold to 28 grams (1 oz) for all illicit drugs, including those currently excluded such as ketamine and benzodiazepines to remove police to the greatest degree possible from drug users' lives.

5. Introduce a civilian-run complaints pathway for those who have been impacted by police misconduct arising out of BC's new decriminalization policy, including but not limited to: unjust seizure of personal supply, improper distribution of resource cards, arrests of below threshold amounts, and street checks. The complaints pathway should be transparent, formally removed from police influence, and incorporate enforceable mechanisms for police accountability.

6. Make a formal commitment to re-directing and reinvesting funds currently allocated to law enforcement into improving the accessibility of 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 drugs from the unregulated market, and other forms of medication and treatment to manage substance use; and other forms of healing and support for people who use drugs.

7. Eliminate “criminalization by stealth,” which includes any municipal bylaws or policies that prohibit, unreasonably limit, or create offenses for the use, possession, or distribution of substances in or near public spaces that are contrary to the spirit of the province’s decriminalization framework.

8. Directly advocate at the provincial level for the federal government to fully repeal Section 4 of the Controlled Drugs and Substances Act and Section 8 of the Cannabis Act and to automatically expunge any records of previous convictions for substance use and trafficking, including breaches of probation/bail related to these situations.

9. Formally call for the abolition of the federal-level Controlled Drug and Substances Act (CDSA) through a motion in the provincial legislature, and present this to their federal government counterparts.

These measures will decouple policing from substance use in accordance with the stated objectives of decriminalization. They will allow people who use drugs to seek formal and community-based support without fear of criminal sanctions.

Addressing substantive equality in drug policy reform

10. Non-prescriber models should be implemented through not-for-profit frameworks that directly benefit those most impacted economically and socially by prohibitionist drug policies.

11. Commit to a provincial social equity fund that administers non-repayable grants to those who have experienced disproportionate drug war-related harms such as mass incarceration or overdose as a form of competitive advantage.

12. Commit to funding programs that alleviate poverty such as social services and affordable housing, food security projects, tripling the welfare rate as recommended by other groups[6] and education.

13. Commit to funding groups led by and for people who use drugs that provide opportunities for people who use drugs to engage in their communities while being appropriately compensated for their knowledge and expertise.

14. Ensure funds are adequately distributed to the communities most affected by decades of police surveillance, profiling, violence, racism, and injustice, paying special attention to inequities between urban and remote, rural, and on-reserve communities.

15. Introduce specific funding and opportunities for voluntary support for parents who have been involved with the child welfare system. Ensure that drug use alone is not a justification for taking children into state custody and/or separating children from their families, and that decisions about state intervention are made by addressing the objective welfare of the child(ren), not stereotypes about drug use.

These measures will address some of the root social issues that create and perpetuate cycles of poverty and marginalization for people who use drugs.

Detox, recovery and treatment

16. Create a centralized provincial database of all substance use treatment services and facilities. It should clearly detail the out-of-pocket cost for individuals seeking services, the total dollar amount of government investment in each service, and the treatment modalities available. Specific, standardized, and transparent mechanisms should be designed to track each service's outcomes.

17. Develop a standardized regime of care for substance use treatment patients in collaboration with people who use drugs that is grounded in clinical best practices and contemporary evidence.

18. Develop a provincial accreditation system that includes strict regulatory oversight and assigns government representatives to intervene when treatment centers depart from expected standards of care.

19. Ensure that public funding for treatment is contingent upon regularly demonstrating that standards of care are being upheld.

20. Ensure that 12-Step programming, such as Alcoholics Anonymous meetings and access to fellowship literature (e.g., The Big Book of Alcoholics Anonymous, The 12 Steps and 12 Traditions) may be an optional component of treatment but is neither mandatory nor the sole basis through which treatment is delivered.

21. Immediately eliminate all involuntary addiction treatment. Involuntary treatment is inherently violent, disregards basic human rights to autonomy and self-determination, and is used to target racialized and marginalized communities.

These measures will ensure that people pursuing support for reducing or eliminating their drug consumption will have access to programs and services that are grounded in contemporary scientific evidence. This will in turn reduce the risk of exacerbating the trauma, social isolation, and fatal overdoses that are associated with BC's current treatment landscape.

Proclamations or Guiding Principles

Drug use is morally neutral

The meanings attached to drug use have varied cross-culturally and over time. Historically, many communities consumed drugs for pleasure, relaxation, and spiritual purposes. Conversely, drug prohibition is relatively new. It only gained significant traction in the 19th and early 20th centuries, when alcohol bans were first imposed on Indigenous populations in the 1876 Indian Act. Opium and cannabis were then purposefully linked to Chinese, Indigenous, Black, and other racialized communities. Since then, Canadian governments have leveraged the moral panics they create

about drugs and drug users to justify the displacement and criminalization of marginalized groups within and beyond the boundaries of the nation-state.

The legacy of prohibition's racist origins is still observable when drugs such as fentanyl are framed by the media and politicians as a "foreign invader." This narrative implies that immigrant groups are a corrupting force that have introduced it into the drug supply. On the other hand, alcohol is now legally regulated, socially acceptable, and a source of enormous profit for the private sector. Canada and BC's ever-shifting legal and regulatory frameworks for substances say little about the chemical composition of drugs; rather, they are mapped onto prevailing (White) cultural attitudes and dominant class interests.

Many harms that are commonly attributed to drug use are derived from prohibitionist drug policy environments

All drug use is associated with some risk. However, the majority of harms linked to illegal drug use are derived from prohibitionist drug policy environments. The Iron Law of Prohibition posits that the more intensely a substance is criminalized, the more manufacturers, transporters, and distributors adulterate it to evade detection, and the more potent, unpredictable and dangerous it becomes.[7] There are strong correlations documented between enhanced enforcement efforts, transnational organized criminal activity, and supply chain fluctuations that increase drug toxicity. This culminates in thousands of needless deaths every year in Canada alone.[8]

In addition to increasing the toxicity of the illegal drug market, the twin policy models of drug criminalization and medicalization promote stigma, discrimination, and societal exclusion.[9] Both models undermine user autonomy, promote negative interactions with police, the medical system, and other social institutions, and encourage isolated drug use. This triggers a cascade of consequences in the realms of health, housing, employment, criminal justice, and interpersonal relationships. We contend that policy responses to drug use should be moved firmly outside the confines of the criminal justice and medical systems. The elimination of institutional coercion would allow people to speak frankly and transparently about their drug consumption patterns without fear of reprisal. It would also reduce taxpayer burden by saving costs on enforcement, emergency response, and untreated injuries[10] while improving public health and safety for everyone.[11]

Types of personal drug use varies greatly

It is a myth that all illegal drug use is problematic. As with alcohol, many if not most people use illegal drugs episodically or recreationally. Seventy to 90 percent of people who use stigmatized drugs do not ever meet the formal criteria for a substance use disorder (SUD),[12] a statistic that is replicated among populations who are highly marginalized and subjected to prolonged and intensive institutionalized surveillance (e.g., incarcerated or formerly incarcerated groups).[13]

Patterns of chaotic or compulsive use tend to develop in response to regimes of austerity and neoliberalism that drive poverty, homelessness, and related forms of oppression. For example, evictions are strongly linked to disruptions in drug use patterns and the use of methamphetamine to stay alert while navigating extreme hardship.[14]

Increased drug use and is also correlated with exposure to stigma and discrimination within the employment, education, medical, criminal-judicial, and family welfare systems.[15] The academic literature on stigma emphasizes that negative perceptions of oneself as an "addict" are reified through processes of interpersonal interaction; people are more likely to report "spontaneous remission" from addiction when they do not engage with the medical system, a fact that highlights the extent to which societal scripts about drug use are imbued with value judgements that shape drug-related behaviours.[16] It is imperative that people who use drugs be empowered to decide for themselves whether their use constitutes a problem and, if it does, to pursue forms of voluntary care that are suited to their unique needs and circumstances. Most importantly, housing, employment, and other opportunities for full social participation should never be contingent upon permanently abstaining from all drug use.

Medical institutions can create harms that parallel those of the criminal justice and legal systems

The fields of medicine and public health have been complicit in the surveillance and disempowerment of drug users. The perception of medicine as a "kinder, gentler" agent of social control has enabled inpatient and outpatient addiction treatment to evade substantive regulatory oversight, sometimes with disastrous results.[17] This is because substance use interventions rarely account for personal patterns of use, cultural values and beliefs, or the social determinants of health[18] and because most are administered through a rigid and outdated "one size fits all" model that overwhelmingly encourages abstinence.[19] Medical programs that rely on simplistic assumptions about individual motivation and behavioural change often adopt policies that blur the line between encouragement and coercion.[20] Many service users report that medical interventions for drug use are distinct from the criminal justice and legal interventions in name only.[21]

Moreover, the proliferation of substance use disorder" (SUD) designations in recent years may undermine progress. SUDs are defined through highly contentious debates within the medical and scientific communities. There is widespread disagreement among researchers and clinicians about the appropriateness of relying on self-reporting for making diagnoses.[22] Diagnostic questionnaires emphasize legal, employment, or interpersonal problems related to substance use, the responses to which are shaped by one's network relationships, neighborhood characteristics, and the drug policy environment they are embedded in.[Ibid] What is more, the utility of SUD labels for reducing drug-related stigma is contested.[23] Paradoxically, research demonstrates that in contexts where SUDs are broadly considered mental illnesses, as awareness of drug-related stigma increases, so too does drug-related stigma.[24] This finding can be partially explained by SUD's associations with irrationality and unpredictability.[25] Several studies have found that biological causal explanations

of drug use invoke stereotypes of dangerousness, instigate rejection tendencies among the public, and promote artificial divisions between "healthy" non-drug users and "sick" drug users.[26]

Against this backdrop, clinicians and prescribers wield immense power. This is partly due to the fact that SUD diagnoses are a prerequisite to acquiring prescription-based alternatives to the legal drug supply ("safe supply"), and because those seeking safe supply are subjected to the human biases of prescribers.[27] Cultural norms within medicine that encourage front-line personnel to view drug users with suspicion also prevent therapeutic rapport-building between patients and providers and may incentivize drug users to exaggerate or conceal information about their personal patterns of use.[28] For the medical system to be truly health-promoting, actors therein must acknowledge their limitations, and relinquish their role as gatekeepers to a safe and regulated drug supply.

Policing and criminalization have no place in drug policy

Drug use should not be a crime, and the development of drug policies should be wholly decoupled from policing and the criminal justice system. Criminal justice and public health paradigms are mutually exclusive, ideologically and practically. The continued involvement of police and prosecutors in drug policy design and implementation contradicts concurrent efforts to frame drug use as a public health issue. There is no evidence to suggest that criminalization benefits drug users or the public. Rather, decades of research traces the multi-causal pathways through which criminalization fuels anti-drug-user stigma, exacerbates class, race, culture, and gender-based oppression, and erodes public trust in democratic institutions. We envision a renewed commitment from governments to creating a drug policy environment that is endorsed by those with relevant expertise; namely, drug users, their allies, and those who possess the skills, knowledge, and relationships to foreground health and safety absent of police or prosecutorial input.

Policy responses to drug use must be grounded in contemporary best practices and empirical evidence

Drug policy making is a contested space. It is complicated by the need to balance competing values and weigh contradictory interpretations of what constitutes "evidence." However, this is not an excuse for government responses to drug use, addiction, or harms linked to the unregulated drug supply to be informed solely by ideology or anecdotes. Decision-making processes are marred when the desire to generate support for one's political party usurps the results of empirical research, a trend that has characterized drug-related policy making since the introduction of prohibition. Sufficient scientific knowledge exists to make drug policy choices that will predictably achieve their stated public health and safety goals. Debates about drug policy reform should therefore proceed systematically and transparently, with a concerted effort made by policymakers and government actors to institutionalize processes of stakeholder interaction that foreground contemporary evidence.

Government spending on drug-related policies must be transparent, traceable, and accompanied by publicly available outcome evaluations

It is imperative that all levels of government clearly indicate where and how public funds are being spent on drug-related initiatives and programming. This includes policies in the domains of addiction treatment, decriminalization, front-line crisis response, and safe supply. The public must trust that state resources are not being used to sustain administrative and bureaucratic bloat, or to prolong interventions that are disproportionate to the scale and scope of the drug toxicity crisis. Provincial budgets must not merely boast substantial investment in mental health and addictions, they must also delineate precisely which services are being funded, over what duration, and the anticipated outcomes for people who use drugs.[29]

People who use drugs are best suited to describe their needs and must be meaningfully foregrounded at every stage of policy development, implementation, and evaluation

Robust inclusion of people who use drugs in the making of drug policies is a prerequisite for successful policy reform. All drug-related policies should be developed by foregrounding the perspectives and experiential expertise of people who use drugs. BC is fortunate to count a diverse network of urban and rural drug user groups among its community members. Their life-saving work must be celebrated, and their insights weighted above institutional actors for whom drug use is merely political or theoretical. Policies are more likely to be effective, comprehensive, and equitable when they are led by impacted communities and fully honour the rallying cry, "Nothing about us without us."

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