

Criminal Justice Reform related to Substance Use

Matthew Yau (University of Toronto)
Dominic Chung (University of Manitoba)
Felipe Fajardo (McMaster University)
Lorraine Hart (University of Alberta)
Jiunn-Yiing Brandom Lam (University of Ottawa)
Philip Leger (McGill University)
Julian Nguyen (McGill University)
Emma van Reekum (McMaster University)
Alexander Wong (University of Alberta)

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CFMS
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Position Paper: Criminal Justice Reform

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POSITION PAPER

Summary

This position paper provides recommendations for policy reform in the Canadian criminal justice system, with a focus on substance use disorders and drug policy. The impact of current practices in the criminal justice system, with a focus on persons who use substances, are described. The stages of the criminal justice system will be studied. Prior to incarceration, the disproportionate arrest rates for substance use in racialized populations is examined. During incarceration, the health impacts of a prison term are analyzed. After incarceration, the socioeconomic and health effects of a criminal record are described. Recommendations for each of these stages are provided to equitably support the health and wellbeing of all Canadians.

Introduction

Modern Canadian drug policy stems from the 1996 Controlled Drugs and Substances Act.¹ It classifies substances into 8 schedules with proportional punitive consequences. Amendments in 2012 included the introduction of (1) mandatory minimum sentences, which require courts to impose a minimum sentence length for certain offenses, and (2) drug treatment courts, which permit eligible offenders to engage in treatment programs in lieu of sentencing.²

The mechanism of substance use disorders is a complex phenomenon of which our understanding has evolved over the course of time. Historically, substance use disorders has been perceived as a personal failure due to moral weakness.³ Now, it is better understood as a multifactorial chronic disease caused by genetic, physiologic, psychological, and environmental factors.⁴ The DSM-5 defines substance use disorders as problematic patterns of use leading to clinically significant impairment and/or distress.⁵ A meta-analysis from 21 studies with a total of 21,370 patients found a 35% remission rate for SUDs at a 17-year follow-up, demonstrating the chronic nature of SUDs.⁶

The federal government has acknowledged the necessity of criminal justice reform, especially with regards to creating a system that is equitable and effective for individuals with substance use disorders. Minister Jody Wilson-Raybould, the former Minister of Justice, released the Criminal Justice System Review report.⁷ Containing the results of a national consultation process, this report specifically underscores the unique challenges that those with substance use disorders face within the criminal justice system. This position paper aims to expand upon and provide additional recommendations for Canada's justice system.

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Principles

The CFMS endorses the following principles with regards to criminal justice reform:

1. The criminal justice system should strive to treat all individuals equitably.
2. Criminal justice policies should reflect the classification of substance use disorders as a chronic disease, rather than as personal failure due to moral weakness.
3. The negative impacts of a criminal record should be mitigated to reduce stigma and improve health.
4. Harm reduction and rehabilitation should be central pillars of Canada's justice system.

Summary of Recommendations

Pre-Incarceration

1. That federal and provincial governments collaborate in the establishment of a commission focused on setting national policing standards with regards to collecting and releasing anonymized racial data.
2. Create a federal task force to update Canada's regulation of drugs, with a focus on examining the decriminalization of all substances for personal use.
3. Regional police forces should consult local stakeholders to develop harm reduction protocols that address substance use disorder concerns.

During-Incarceration

1. Evidence-based addiction treatment services and other rehabilitative programming should be offered to all offenders who declare alcohol or drug dependency, either onsite or as a community referral depending on duration of incarceration.
 - Safe injection supplies, including sterile needles, should be available to inmates when there is a low risk for security and self-harm.
 - Healthcare staff should have no role in punitive action for drug possession within correctional facilities and should closely monitor intoxicated patients with a low threshold for referral to authorized prescribers or offsite providers.
 - Correctional services should promote addictions education, including substance effects, withdrawal, and evidence-based theories of addiction, for all employees.
 - Pharmacological treatments for addiction, including methadone, suboxone, naltrexone, acamprosate, and acute alcohol withdrawal treatments should be available on the drug formulary within all correctional centres. Appropriate formulations, delivery methods, and prescriber education should be enforced.
 - Offenders with substance dependencies should be screened for possible mental health needs and provided with treatment, as indicated.
 - Offenders with substance dependencies who are identified as lacking stable housing or financial security upon release should be referred to social work and a local Housing First program, or equivalent, when available.
2. Healthcare services within federal, provincial, and territorial correctional centres should adhere to the United Nations Standard Minimum Rules for the Treatment of Prisoners.
 - An external review committee should be in place to identify and address deviations from this standard of care.
3. Wait times for medical interventions or services, including addictions and mental health services, should be monitored to ensure that they do not exceed wait times for the general public to access similar services.

- Sufficient funding and employee recruitment procedures should be maintained to prevent unreasonable wait times.
- 4. Given the lack of recent Canadian data, research efforts and funding should be targeted to address the knowledge gap in the field of correctional healthcare provision and inmate health.
 - Healthcare authorities within provincial, territorial, and federal correctional institutions should prioritize collection, interpretation, and publication of service utilization and epidemiological data in order to further shape inmate health policy.

Post-Incarceration

1. Undergraduate and graduate medical education programs within Canada should encourage learning opportunities in addictions, inmate health, and care for former inmates.
 - Learners should be educated about incarcerated populations and their unique health needs as a sub-group under the category of marginalized and/or underserved populations.
 - Medical programs should develop and/or promote thoughtful experiential learning opportunities to work with incarcerated populations and individuals with criminal records.
2. An accessible route for complete, non-revocable amnesty for criminal records relating to the simple possession of cannabis should be established.
 - One key consideration should include the possibility of an automatic amnesty process to reduce accessibility requirements.

Pre-Incarceration

This section focuses on aspects of the criminal justice system that occur prior to incarceration, including the legality of drugs and the enforcement of drug laws.

Background:

Drug Crime in Canada:

Drug-related offences are crimes related to the manufacture, sale, possession, or transportation of substances illegal under Criminal Code of Canada.¹ In 2017, the number of drug-related offences hit its lowest point since 2003, with the rate of drug-related offences being 246.88 per 100 000 residents nationwide.² According to the 2017 Canadian Tobacco, Alcohol, and Drugs Survey (CTADS), 15.7% of Canadians have used an illicit drug within the past year. The most common drug used was cannabis with 14.8% usage, then crack/cocaine with 2.5% usage.³

In 2016, the federal government adopted Canada's drugs and substances strategy (CDSS), which centered on four pillars: prevention, treatment, enforcement, and harm reduction.⁴ The strategy's stated goal is to address "illicit drug production, supply and distribution".⁵

The *Cannabis Act* permits the recreational possession and use of up to 30 grams of cannabis. Despite being introduced in the House of Commons in April 2017 (and passed in June 2018),

42% of all drug arrests in 2017 were for cannabis possession. Drug possession remains the most common type of drug offence, with 72% of all arrests being for possession.⁶ In addition, arrest rates for methamphetamine and opioid use have increased significantly. In 2010, there were 464 arrests for heroin possession, rising to 2,219 in 2017. In 2010, there were 1,523 arrests for methamphetamine possession, rising to 8,996 arrests in 2017. This increase in arrest rates indicates that criminalization remains a mainstay in addressing what has been described as the “worst illegal drug overdose death crisis” in Canadian history.⁶

The Racial Impact of Drug Crime:

A Toronto Star investigation analyzing cannabis arrests in Toronto between 2003 and 2013. For the 11,299 people arrested for possession of up to 30 grams of marijuana, whose skin colour was recorded and who had no prior convictions, 25.2% were black, 52.8% were white, 15.7% were brown, and 6.3% were categorized as other.⁷ The arrest rate for the black population was 3 times higher compared to the proportion of black individuals in Toronto (8.4% of the city), while the arrest rate for the white population aligned with the proportion of white individuals in Toronto (53.1% of the city).⁷ This is despite scant evidence showing a difference in marijuana usage rates between black and white youth.⁸ A VICE News investigation published in April 2018 established disproportionate arrest rates as a national issue.⁹ In its analysis of arrest data from 6 major cities in Canada, the investigation revealed stark differences in arrests for cannabis possession among racial groups. For example, Indigenous individuals in Regina were almost 9 times more likely to be arrested than whites. Black people in Halifax were 5 times as likely to be arrested than white people.

The current scheme of criminalizing drug use disproportionately impacts Indigenous communities. Despite comprising only 3% of the Canadian population, Indigenous peoples accounted for 28% of inmates from 2015-2016, which can be partially attributed to the inconsistent application of drug enforcement.¹⁰ Indigenous peoples are “very frequently stopped, questioned, searched and detained” because of stereotypes associating them with criminal behavior.¹¹ In addition, as a high proportion of the Indigenous population experiences homelessness, individuals can resort to using substances in public spaces, increasing likelihood of arrest.¹²

Given the disproportionate impact that drug policies have on racialized individuals, the scarcity of racial demographics collected and released by police departments is quite troubling. In 2009, racial demographic data was missing for 80% of the Uniform Crime Reports sent to Statistics Canada, despite the presence of a race field on forms.¹³

Drug Enforcement in Canada:

Intense enforcement of drug laws has been associated with adverse health outcomes, risky behaviour of people who use intravenous drugs (PWID), decreased ability for health services to provide outreach care, and displacement of PWID, without evidence of significant impact on the price of drugs and the frequency of use.¹⁴ In a study published in the *International Journal of Drug Policy*, Small et al. observed the effects of the implementation of a large-scale police initiative aimed at cracking down on the open air drug market of Vancouver’s Downtown Eastside.¹⁵ This increased police activity led to riskier activities, such as rushed injections or injecting in unsafe locations, improper disposal of syringes, displacement of PWID across a

larger geographical area, exposing at-risk individuals from other neighbourhoods to intravenous drug use, and hampering the efforts of community healthcare workers. In a review article published by the same group at the British Columbia Centre for Excellence on HIV/AIDS, the authors advocate for alternative policing models, such as fostering partnerships between public health agencies and police forces, or having police connect PWID to harm reduction services.¹⁶

Forceful drug law enforcement is unlikely to reduce drug market violence. Werb et al. found that high homicide rates and gun violence were a likely consequence of forceful drug law enforcement, without any evidence of reducing drug supply.¹⁷ The authors theorize that disrupting a drug market may create power vacuums where competing groups vie for market control via violent means. Rather than reducing access to substances, drug prohibition forces people to obtain drugs from the black market, generating “an illicit business worth billions of dollars run by drug traffickers.”

Analysis:

The criminalization of drug possession creates a judicial space where discrimination against marginalized populations is perpetuated. A growing body of evidence demonstrates the adverse health effects of enforcing a “tough on crime” approach, while also finding an absence of beneficial impact on the drug market. The use of public funds to enforce drug laws which can potentially harm communities diverts resources from initiatives targeted at tackling the social determinants of substance use. As such, a profound re-examination of the most effective method of approaching the regulation of substance use is necessary.

The decriminalization of substances is an example of an alternative drug policy to criminalization that places an emphasis on harm reduction. Decriminalization declassifies the personal use of illegal substances as a criminal charge, opting for non-criminal penalties instead. Various public health institutions have supported a decriminalization approach, including the boards of public health in Toronto, Montreal, and Vancouver, the Canadian Centre on Substance Use and Addiction, the Canadian Mental Health Association, the World Health Organization, and the United Nations.¹⁸⁻²³

The impact of the decriminalization of drugs in Portugal is often cited as evidence of the policy’s success. Portugal decriminalized drug possession in 2001.²⁴ A report by Glenn Greenwald presents a review of the impacts of decriminalization in Portugal, finding that “by virtually every metric, the Portuguese decriminalization framework has been a resounding success”.²⁵ A 17% reduction in new HIV cases occurred between 1999 and 2003. The number of drug related deaths dropped from 281 in 2000 to 133 in 2006. There was a 147% increase in the number of people in substitution treatment programs. The usage rates for most drugs drastically decreased, despite a slight increase in the 19-24 age group. In 2006, usage rates were below the European Union average. From 2001-2005, Portugal had the lowest usage rate of cannabis in the European Union, and had one of the lowest usage rates of cocaine.

Recommendations:

1. That federal and provincial governments collaborate in the establishment of a commission focused on setting national policing standards with regards to collecting and releasing anonymized racial data.

2. Create a federal task force to update Canada's regulation of drugs, with a focus on examining the decriminalization of all substances for personal use.
3. Regional police forces should consult local stakeholders to develop harm reduction protocols that address substance use disorder concerns.

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During Incarceration

This section centres on the health concerns faced by inmates, as well as the complex relationship between health and justice ministries aimed towards the delivery of healthcare in these contexts.

Background:

Health Concerns Within Incarceration

The incidence of infectious disease is higher in incarcerated populations. A 2016 literature review exploring the burden of disease within incarcerated population found that hepatitis C affects 30% of women and 15% of men in provincial correctional facilities, as well as 30% of men within the federal inmate population. HIV rates ranged from 1-2% in men and 1-9% in women. Sharing needles and piercing materials while in custody contributes to increased incidence of these blood-borne infections.¹

Canadian inmates face significantly higher rates of mental health disorders compared to the general Canadian population and nearly half of Canadian inmates report a history of childhood trauma such as physical, sexual, or emotional abuse.¹ 73% of federally incarcerated male inmates have a current mental health disorder that meets DSM criteria.² Moreover, substance use disorders are common in these populations, with over 50% of all federal male offenders meeting DSM criteria for an alcohol and substance use disorder.²

Incarceration aggravates these mental health vulnerabilities through policies such as segregation. In the 2014-15 fiscal year, 26.3% of male federal offenders and 46.3% of female offenders spent a period of time in segregation. The average length of stay in segregation was 27 days.³ Greater than 16% of placements into federal administrative segregation lasted 30-60 days and 3.5% of placements lasted over 120 days.⁴ Furthermore, 86.6% of federal inmates with a history of self-injury and 63.2% of those with a history of mental health had been subject to segregation.⁵

The use of illicit drugs within correctional centres is not uncommon. The Edmonton Remand Centre recently reported eight opioid overdoses in a single weekend during July of 2018, and four overdose deaths between May and July of that year.⁶ A punitive approach to substance use disorders can foster an environment where inmates are reluctant to declare or address substance use disorders. This can lead to increased illicit drug use and more serious health complications. In contrast, when housed in a comprehensive inpatient addictions treatment unit, Canadian inmates with substance use disorders have lower rates of recidivism.⁷ In the 2016-17 fiscal year, operating expenditures for Canadian adult correctional services totaled \$4.7 billion, with yearly institutional expenditures ranging between \$77,639 (provincial/territorial) and \$105,286 (federal) per offender.⁸ Therefore, reducing offender admissions through providing intensive addictions treatment either as an alternative to incarceration for lesser offences, or as part of a comprehensive incarceration sentence to reduce recidivism, would yield positive social and financial impacts.

Analysis:

The Office of the Correctional Investigator has described correctional centres as a “dysfunctional and toxic workplace” in which healthcare must be delivered.⁹ Within Canadian

correctional centres, healthcare is largely delivered via internally-hired medical staff, rather than contracted to external agencies. In many jurisdictions, including Ontario and federal correctional centres, these healthcare staff are employed by the justice department rather than the local health authority. Medical staff rely on correctional service officers for safety, facilitation of daily tasks, and to convey information to and from inmates. Therefore, healthcare personnel may feel compelled to modify their clinical practice to align with correctional pressures rather than patient needs. For example, physicians may feel obligated to perform body cavity searches without medical indication. In addition, correctional institutional policies impact the way in which healthcare is delivered. Physicians' ability to prescribe effective medications can be constrained due to restrictive drug formularies.¹⁰ Furthermore, time conflicts may prioritize court dates over medical appointments and long wait lists may limit access to services such as addictions treatment.

Despite the existence of protective mandates such as the UN Standard Minimum Rules for the Treatment of Prisoners, the Office of the Correctional Investigator has indicated that Canadian Correctional Services has provided no objective evidence to demonstrate that inmates receive the "same standards of health care that are available in the community... without discrimination on the grounds of their legal status" or that federal correctional centres are adhering to the other components of these UN standards.^{10,11} After the Canadian Federation of Medical Students published a Policy Statement on Solitary Confinement and Health Delivery in Canadian Correctional Facilities, the federal government legislated Bill C-83 to begin addressing matters such as segregation, body cavity searches, and healthcare provider autonomy.^{12,13} However, this legislation is only applicable within federal correctional centres and therefore does not provide protections to over 95% of Canadian inmates admitted into provincial or territorial custody.¹⁴

Lastly, due to factors such as loss of income while incarcerated, lack of employment availability and/or continuity after release, strained relationships, and social stigma, incarceration may increase an inmate's risk of homelessness upon release. Therefore, social work support and connection to harm reduction programs which provide permanent housing (such as Housing First) are essential to promote successful reintegration into society.¹⁵

Recommendations:

1. Evidence-based addiction treatment services and other rehabilitative programming should be offered to all offenders who declare alcohol or drug dependency, either onsite or as a community referral depending on duration of incarceration.
 - Safe injection supplies, including sterile needles, should be available to inmates when there is a low risk for security and self harm.
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 - Sufficient funding and employee recruitment procedures should be maintained to prevent unreasonable wait times.
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 - Healthcare authorities within provincial, territorial, and federal correctional institutions should prioritize collection, interpretation, and publication of service utilization and epidemiological data in order to further shape inmate health policy.

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Post Incarceration

This section centres focuses on the lasting health, economic, and social impacts of incarceration.

Background

Health Impact of a Criminal Record

A criminal record can carry stigma, resulting in unjust treatment and discrimination within healthcare institutions. The World Health Organization recognizes a criminal record as an area of discrimination in healthcare settings.¹ A study in California found that 42% of individuals with a criminal record reported discrimination by healthcare professionals, specifically within the emergency room.² Discrimination within the healthcare setting carries significant negative consequences. One study in British Columbia found that patients who had not been to jail recently were 1.98 times more likely to receive a family physician appointment compared to patients who were recently incarcerated.³ Decreased usage of preventative health services stemming in part from discrimination due to a criminal record can result in worse health outcomes for patients, and higher healthcare costs.

Socioeconomic Impact of a Criminal Record

Healthcare is not the only institution in which discriminatory attitudes are present. The barriers that those with criminal records face are enshrined not only in discriminatory policies, but also within society. There is no law requiring landlords to request a criminal record prior to renting their property. In fact, asking about a criminal record is perceived by some as discriminatory.⁴ However, this practice is commonplace, and is a significant barrier for those with a record to find a home. This injustice stems from popular perception rather than from a by-law, and is more difficult to modify.

Another crucial benefit of removing the inequities that those with criminal records face is that it will reduce recidivism. The city of Los Angeles has cited reduced recidivism as a result of increased employment due to providing amnesty for cannabis related offences. According to their data, the average overall recidivism rate in California is 65%, while the average rate for those with employment after release is 3%.⁵ Selbin et al. measured the impact of clearing criminal records, and found that amnesty boosts employment rates and increases earnings.⁶ The lengthy, costly process of obtaining a record suspension has a profound impact on Canada's economy. In Toronto, 15% of people on social welfare in their prime working age cited "Need for a Record Suspension" as a key barrier to employment.⁷

The consequences of a criminal record are powerful and varied. The Canadian Bar Association lists a number of potential effects: deportation, inability to volunteer, inability to travel, inability to receive full social assistance.⁸ⁱ Due to the lasting impact of a criminal record, the John Howard Society deems any criminal record to be "a lifetime sentence".⁹ In 2016, Public Safety Canada estimated that around 3.8 million Canadians have a criminal record.¹⁰

Analysis

The impact of a criminal record on an individual's health and socioeconomic status cannot be overstated. Given the number of Canadians estimated to have a criminal record, a method of mitigating the negative effects of a criminal record is necessary. One policy option that is currently provided is applying for a record suspension. If an application for a record suspension is successful, the criminal record is withheld from police databases and federal agencies. The current process for involves waiting 5-10 years after a sentence has been concluded, and paying \$631 to apply for a record suspension, without knowing if their application will be successful.¹¹

The federal government has recently tabled Bill C-93 - An Act to provide no-cost, expedited record suspensions for simple possession of cannabis. This act is a step in the right direction in mitigating the unconstructive negative impacts of a criminal record. However, while Bill C-93 effectively reduces barriers towards applying for a record suspension, significant challenges still remain. According to Cannabis Amnesty, record suspensions can be revoked by the Parole Board of Canada, or by a subsequent government. The expungement of criminal records is a more effective alternative. Expungement involves the deletion of the criminal record - it can never be revoked.

The political environment is ripe for change - a recent Parliamentary study with members from the Liberal, Conservative, and New Democratic parties concluded with a request, "That the

Government examine a mechanism to make record suspensions automatic in specific and appropriate circumstances.”¹² Progress achieved by several states in the United States have demonstrated the feasibility of amnesty reform. California and Delaware have already passed legislation facilitating amnesty for cannabis possession, while Vermont, Seattle, New Jersey, Pennsylvania, and Colorado are considering future policies.^{13,14}

Recommendations:

1. Undergraduate and graduate medical education programs within Canada should encourage learning opportunities in addictions, inmate health, and care for former inmates.
 - Learners should be educated about incarcerated populations and their unique health needs as a sub-group under the category of marginalized and/or underserved populations.
 - Medical programs should develop and/or promote thoughtful experiential learning opportunities to work with incarcerated populations and individuals with criminal records.
2. An accessible route for complete, non-revocable amnesty for criminal records relating to the simple possession of cannabis should be established.
 - One key consideration should include the possibility of an automatic amnesty process to reduce accessibility requirements.

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