

THE DECRIMINALIZATION OF PIOIDS IN CANADA

NATIONAL DAY OF ACTION 2022



CANADIAN FEDERATION OF
MEDICAL STUDENTS

Table of Contents

Introduction/ Executive Summary	3
Part 1: Our Proposal	5
1.0 Our Asks in Support of the Decriminalization of Opioids	
1.1 Decriminalize simple possession under the CDSA	
1.2 Expunge previous criminal records for simple possession	
1.3 Develop a national strategy on substance use	
Part 2: The Current Situation	7
2.1 Current Canadian policy	7
2.2 Shortcomings of current policy	7
2.3 Subpopulations greatly impacted	8
3.0 The Move Towards Decriminalization	13
3.1 Federal Action	13
3.2 Provincial and Municipal Action	14
3.3 Organizational Action	15
Part 3: The Importance of Decriminalization in Canada	9
4.0 The Impact of COVID-19	
5.0 Cost-benefit Analysis	
6.0 Ways to Decriminalization	12
Conclusion	13
Acknowledgements	13
References	13

Introduction/Executive Summary

Canada is currently in the middle of an opioid crisis. Between July 2016 and January 2021 alone, opioid overdoses accounted for over 24,626 deaths, with 90% of these deaths occurring from the use of non-pharmaceutical opioids.¹ The majority of these deaths were amongst young males between the ages of 20 and 29.¹ The mortality rate caused by the opioid crisis has been exacerbated by the COVID-19 pandemic, likely because health facilities have been preoccupied with managing COVID-19, and individuals have been afraid of seeking healthcare due to the fear of contracting COVID-19.² Projections show that with the current Canadian strategy of managing opioid use, the number of opioid-related deaths will rise to anywhere **between 6400 and 6800 by the end of 2022.**² Rural and Northern Canadian communities, individuals experiencing poverty and/or homelessness, those experiencing incarceration, and Black, Indigenous, People of Color (BIPOC) communities are expected to face the largest relative increase.²

Opioids are substances with pain-relieving properties that are derived either from opium poppy seeds or synthetically. In Canada, opioids are commonly prescribed to treat pain, with examples such as codeine, morphine, oxycodone, hydromorphone, and tramadol.³ Opioid use, however, can also cause significant harm. Long-term use of opioids leads to adverse health outcomes including liver damage, increased tolerance (i.e., larger doses required to achieve the same response), and withdrawal symptoms such as nausea, diarrhea, insomnia, and muscle pains.³ With excessive usage, opioids can also lead to slowed breathing, unconsciousness, and ultimately death.³

These drugs are also known to elicit euphoria, prompting individuals to continue using these substances and leading to natural dependencies.³ It is the combination of their addictive properties and dreaded withdrawal symptoms that results in people experiencing difficulty quitting, especially if they do not have appropriate access to healthcare resources. Opioid dependency may also drive individuals to seek this drug illicitly, thereby increasing the chances of obtaining a supply that has been mixed with potent substances.³ One example of this is fentanyl lacing; fentanyl is an incredibly potent synthetic opioid (20-40x more potent than heroin) which can be fatal even in small doses and which accounts for a large part of fatal and non-fatal overdoses.^{4,5}

The opioid crisis is rapidly claiming the lives of Canadians across the country, and the rising mortality rate suggests that current interventions are insufficient at controlling this crisis. In Canada, drug possession results in punitive outcomes ranging from fines to a seven-year prison sentence under the Controlled Substances and Drugs Act (CDSA) of 1996.⁶ Since the implementation of this Act, there have been notable changes, including the Good Samaritan Drug Overdose Act of 2017 which legally protects drug users and bystanders who call emergency services for an opioid overdose case from criminal prosecution.⁷ While progressive, these policies have failed to control the availability of illicit drugs, the usage of drugs, and most importantly, the number of opioid-related emergencies.

Scientific evidence has resoundingly concluded that substance use and drug dependency is a medical issue that is accompanied by a psychological loss of control.⁸ Nevertheless, Canadian law still treats substance use as a purely criminal offense, and does not offer people who use opioids alternatives to

access safe use and healthcare. Indeed, alternative approaches to criminalization have been successfully implemented by other countries including supervised safe consumption sites (SCS), drug checking services, and diversion of individuals away from the criminal justice system and towards social and community services. In Portugal, for example, the possession of up to a 10 day supply of drugs is considered an administrative offense (rather than criminal, for example), and individuals have the option of receiving health services, social services for housing and employment support, or a referral to substance use clinics.⁹ The outcome of this system has included a reduction in HIV transmission, a decreased demand for criminal justice resources, and a reduction in national drug use. (r¹⁰ Most importantly, these alternative policies have been grounded in a **harm-reduction approach** which recognizes that substance use is a medical condition that should not be criminally punished.

Each year, the Canadian Federation of Medical Students (CFMS) hosts a National Day of Action (NDoA) wherein medical students across Canada advocate for a specific social and healthcare cause to Members of Parliament. This year, from many pressing topics, Canadian medical students have chosen to advocate for the decriminalization of opioids. Albeit within the first few years of our training, we have been exposed to the toll that substance use disorders (SUD) have on patients and the increasing demand that it places on the healthcare system. We are saddened and frustrated to know that patients are either unable or afraid of accessing critical care out of fear of being prosecuted for drug possession.

We hope that this important advocacy works serves as a springboard for the decriminalization of all substances in Canada. We hope to reframe substance use as a medical issue in Canada, rather than a criminal issue. Under the current criminalization model, we acknowledge and recognize that PWUD are deprived of the dignity and respect that Canada strives to provide to all people. As we progress through medical school and become providers, we hope to work in a system where people with drug dependency are able to access social and medical care, without fear of facing prosecution and discrimination.

Part 1: Our Proposal

1.0 - Our Asks in Support of the Decriminalization of Opioids

1.1 - Decriminalize simple possession under the CDSA

Criminalizing simple drug possession harms persons who use drugs (PWUD) and disproportionately targets the most vulnerable populations who require larger quantities of drugs for well-being.

The *Good Samaritan Drug Overdose Act (2017)* provides exemptions from charges of simple possession and from relative charges for individuals who call the police for a drug overdose or who are present when first responders arrive.⁷ However, this policy needs to be extended regardless of whether one is experiencing an opioid overdose, under the recognition that substance use is a chronic disorder which cannot be treated with sudden discontinuation of use (indeed, opioid withdrawal is a severe consequence of sudden opioid disuse, which can increase mortality). It is imperative to decriminalize simple possession under the CDSA which can be done by:

- a. Repealing Sections 4 and 4.1, which currently note that possession of a substance included in Schedule I and II (of which includes opioids) is guilty of an “indictable offense and liable to imprisonment for a term not exceeding five years” and/or fines (e.g., \$1000 and/or imprisonment of up to 6 months for first offense; \$2000 and/or imprisonment for up to one year for second offense)
- b. Ministerial exemption
- c. Increased threshold for possession, at either of the federal or provincial levels

1.2 - Expunge previous criminal records for simple possession

According to current policy (i.e., Section 62 of the CDSA)¹¹, previous offenses for drug possession are not expunged. Indeed, an individual can be penalized and exposed to the criminal system for a previous offense of possession. However, these legalities work to negatively impact PWUD and persons with prior drug use experience in accessing employment and housing. Expunging previous criminal records will allow for PWUD to reintegrate within society, without fear of penalty.

1.3 - Develop a national strategy on substance use

Canada does not currently have a national strategy on substance use. It is imperative that the federal, provincial, and municipal governments work in concert to create national policies that work to curb the opioid crisis.

This strategy needs to be multifaceted and should incorporate:

- a. Input from **key stakeholders** within the field of decriminalization and which includes individuals with lived experiences including persons who use drugs (PWUD), harm reduction workers, advocacy organizations, healthcare providers, and experts in substance use and misuse
- b. Increasing **funding** for pilot safe supply projects across the country
- c. Ensuring **universal and low-barrier access** to recovery, treatment, and harm reduction services include safe supply of medically regulated substances
- d. Implementation of **evidence-based prevention programs** that address the underlying social and economic factors that contribute to substance use disorder and problematic substance use
- e. Consultations with **key organizations** that focus on the intersectionality between opioid use and racialized and marginalized communities (e.g., Indigenous communities, BIPOC, LBGTQ+ populations etc.). Particularly imperative within this point is the need for the respect of the sovereign rights of Indigenous peoples and their governments in supporting them to make appropriate treatments and interventions for their communities.

Part 2: The Current Situation

2.1 - Current Canadian Policy

The Controlled Drugs and Substances Act (CDSA) is the primary Canadian policy document regarding the regulations, punishments, and exceptions to drug and opioid use.¹¹ The CDSA classifies opioids as a Schedule I drug, for which the possession outside of authorized use can have substantial consequences, depending on whether it is classified as an indictable or a summary offense. A Schedule I indictable offense can lead to imprisonment for a maximum of 7 years while a first offense summary conviction can lead to a fine of \$1000 and/or 6 months imprisonment (fine of \$2000 and/or 1 year imprisonment for subsequent offenses). It is important to note that these are the punitive consequences for *simple* possession and there are separate sections detailing the punishments for possession for purposes of trafficking, exporting, production, and/or sale.¹¹

There are some limited exemptions in the CDSA which prevent individuals from being charged or convicted for the possession of unauthorized opioids. This includes any individual who is seeking medical or law enforcement assistance due to suffering from a medical emergency or if they are a person at the scene of someone seeking emergency medical assistance. These individuals cannot be charged for the possession of opioids, even if the possession is a violation of a pre-trial release or probation orders. However, it does not protect these individuals from other outstanding charges or from charges related to production or exporting of drugs. This has been referred to as the Good Samaritan Drug Overdose Act of 2017.¹¹

The CDSA states that the purpose of this act and its punishments is to “contribute to the respect for the law and the maintenance of a just, peaceful and safe society while encouraging rehabilitation, and treatment in appropriate circumstances, of offenders and acknowledging the harm done to victims and to the community.”¹¹ However, the criminalization of possession of Schedule I substances, particularly substances classified as opioids, does not meet its stated objectives. These policies are not effective in mitigating the prevalence and adverse events associated with problematic substance use, and instead disproportionately harm populations made vulnerable by historical and systemic inequities.¹² Moreover, this act does not encourage the rehabilitation and treatment of offenders due to a lack of healthcare access and the significant obstacles in returning to daily life that come with imprisonment and a criminal record.¹²

2.2 - Shortcomings to Current Policy

2.2.1 Current policy does not encourage rehabilitation and treatment of offenders

One of the stated goals of the CDSA is the treatment and rehabilitation of offenders. However, recent data from British Columbia suggests that this objective is not met.¹³ This 2019 study demonstrated that 34% of people who died from illicit substances in British Columbia between 2011 and 2016 had some sort of contact with police in the preceding 2 years.¹³ Within this population, 15% had more than 3 contacts in the

2-year period. However, it would be expected that if contact with the criminal justice system were meant to be rehabilitative, it would not be associated with such high levels of overdose-associated mortality so soon after police contact. It may even be argued that incarceration and police contact worsens one's road to rehabilitation. Indeed, in the two weeks post-release, an incarcerated individual's risk for overdose is 56x higher than that of the general population.¹⁴ It has also been shown that those who had police contact have significantly less total income and less consistent employment compared to their counterparts who did not have police contact.¹⁴

Moreover, therapy for problematic opioid use is not widely available within correctional facilities. Opioid agonist therapy (OAT) is considered first-line therapy with buprenorphine–naloxone for those with problematic opioid use, and has been shown to be beneficial in abstinence from illicit opioid use.¹⁵ Further, it has been shown to reduce mortality and even reduce future likelihood of contact with the criminal justice system and imprisonment.¹⁶ Despite the strong high-quality evidence, however, this treatment has not been made widely available within correctional facilities for individuals with a past history of problematic opioid use.¹⁷ For example, in Nova Scotia, only those already receiving OAT prior to admission continue to receive this therapy in prison.¹⁷ This policy leads to OAT-receiving prisoners to be targeted by those who didn't receive this therapy. There is an expectation to divert the medication by vomiting and straining it through a sock for someone else to use and in the case that these individuals may not be willing to divert the medication, they are often subject to violence.¹⁷ However, if they are found to be diverting, their OAT is discontinued by correctional facility officers.¹⁷ Hence, such restrictive rules on the use of OAT and other opioid therapies in prisons, especially when this therapy can be life-changing, does not encourage the supposed rehabilitation of offenders as stated in CDSA.

While policies in some jurisdictions do endorse OAT delivery in some correctional facilities, without appropriate resources, access has remained limited.¹⁸ There remain important gaps in initiating and maintaining OAT, concerns about safety, and the lack of continuity of care with linkage to community-based providers and the Ministry of Community Safety and Correctional Services policy.^{18–20}

2.2.2 Current policies are not effective in mitigating the prevalence and adverse events associated with problematic substance use

Moreover, while the CDSA states that one of its goals is to maintain a peaceful society and to acknowledge the harms done to victims and community, current data shows that criminalization has failed to meet this goal. There have been roughly 25,000 deaths in Canada between January 2016 and June 2021 due to opioids.^{1,21} Even more worrisome is the upward trend in opioid-related deaths over the years. For example, Canadian opioid-related deaths had increased from 7.8 deaths per 100,000 people in 2016 to 19.1 in 2021 (ref). Further, April to June in 2019 saw 1038 deaths, whereas the same time period in 2020 and 2021 saw 1680 and 1720 deaths, respectively.² Modeling data suggests that if our current health interventions remain the same and with a similar level of fentanyl in the drug chain, we can continue to expect 1600 to 1700 deaths quarterly. However, if we are able to change interventions towards those that limit opioid-related deaths (i.e., through prevention, harm-reduction, and treatment approaches), Canada has a projected possibility of decreasing deaths to 1100 to 1200 every quarter.² It is important to further note that about 60% of all accidental opioid-related deaths also involved a stimulant, indicating the polysubstance nature of the opioid overdose crisis.² Taken together, there is an immediate need for a

paradigm shift in the way that society interacts with individuals who experience problematic substance use to prevent further morbidity and mortality.

2.3 - Subpopulations Greatly Impacted

2.3.1 - Populations with Low Socioeconomic Status (SES)

Lower socioeconomic status is a well-documented health determinant and is especially relevant in the setting of opioid-related harms. A population-based descriptive study in Ontario, for example, found significant opioid-related harms within the lowest income neighborhoods as compared to other quintiles.²² Indeed, these neighborhoods exhibited more opioid-related deaths, hospital admissions, emergency department visits, and neonatal abstinence syndrome.²² Strikingly, the rates of opioid-related harms in the lowest income quintile were at least double that of the highest income quintile within all of these categories.²²

Moreover, there was an inverse relationship between opioid-related harms and increasing neighborhood incomes.²² This finding has also been supported by a 2018 Statistics Canada study that reported on the social and economic demographic factors of those hospitalized for opioid poisonings in Canada.²³ Between 2011 and 2016, hospitalizations related to opioid poisoning were 23.4 per 100,00 individuals in the lowest household income quintiles as compared to 6.6/100,00 in the highest income quintile. The report further revealed increased hospitalization rates in those who were unemployed or out of the workforce, lived in lone-parent homes, and/or spent greater than 50% of their household income on housing.²³ Not only does opioid-related harms disproportionately impact individuals of lower SES, but it is also these same individuals who have greater police contact, highlighting the intersectionality between income level and criminal oppression.²³ Multiple other studies have demonstrated similar relationships between socioeconomic marginalization and opioid-related overdoses and harm unearthing the dire need for resources targeted towards low SES populations for problematic substance use.²⁴⁻²⁶

2.3.2 - LBQTQ+ Communities

While a culture of stigma associated with substance use and Lesbian, Gay, Bisexual, Transgender, Questioning (LGBTQ) communities make it difficult to ascertain the true effects of opioid harms within LGBTQ communities, several studies have shown marked difference between LGBTQ people and their heterosexual counterparts.²⁷ For example, it has been shown that LGBTQ people are more likely to use substances, with these trends emerging as early as adolescence.²⁸ Shockingly, studies have highlighted a five-fold increase in fatal drug overdose linked to sexual orientation.²⁹

Unfortunately, many data collection efforts do not collect information regarding sexual and gender identities which make it difficult to report the effect of opioid harms on Canadian LGBTQ people. As such, many organizations, including the 2019 Lancet edition, have called to action organizations such as Canadian Institute of Health Research (CIHR) and the US National Institute of Health to better characterize the effects of overdose on LGBTQ individuals through adopting standard metrics of sexual and gender identities within their large-scale health surveys.³⁰ This will be an important step for LGBTQ

individuals who face significant barriers, including bullying, rejection from family, and homophobia which place them at an increased risk of problematic substance use alongside other health concerns.

2.3.3 - Women

Women have often been overlooked in opioid-use research and data due to a historically higher rate of men who use substances as compared to women.³¹ However, recent data now demonstrates that women and girls have unique risk factors when it comes to substance use. A study by the National Centre on Addiction and Substance Abuse at Columbia University, for example, identified the following risk factors to be unique to and/or more serious for girls and young women^{32*}:

- Sexual and physical abuse, which are more often experienced by women. Women who have been sexually abused are more likely to use substances, use them earlier, more often, and in greater quantities
- Greater vulnerability to the physical health impacts of substance use, making women more vulnerable to addiction and the associated health problems related to substance use
- Women tend to use substances to improve mood, increase confidence, reduce tension, cope with problems, lose inhibitions, enhance sex, and/or lose weight. These emotional and relational reasons can keep them in a destructive cycle in the absence of more adaptive supports

**The study collected data on people who were biologically female and may not reflect the characteristics of all people who identify as female.*

Women are also more vulnerable to and exposed to interpersonal violence before adulthood, and which often continues into adulthood.^{33,34} Indeed, the struggle with substance use for many women stems from ongoing trauma and intimate partner violence throughout development.³³ In addition to these risk factors, it has been shown that women who heavily use substances will typically use more than one substance³¹. US data shows that emergency room visits related to opioid use among women doubled between 2004-2010 and the percentage increase in overdose deaths since 1999 was significantly greater among women (151%) than men.³⁵

Women also face more barriers when it comes to treatment for substance use. A review of best practices in Canada found that women experience a greater stigma attached to substance abuse than men, as well as greater resistance from family/friends when accessing treatments, particularly if they have children.^{31,36} Further barriers to treatment include family responsibilities, lack of child care, job loss, anger from spouse, and loss of friends. There are also disparities in screening and access to treatment amongst certain groups of women.^{31,36} Indeed, research has demonstrated that women of low SES and women of color were often more frequently screened for substance use when accessing perinatal care, compared to middle class and Caucasian women.³¹ This has the effect of creating discrepancies on two levels: women outside of these categories do not receive the screening that they need and women within these categories bear undue stigmatization leading to distrust of care providers.

When developing treatment and harm reduction services, it is important to create welcoming, accessible, relevant, and safe services for all women. Future research and services must be trauma-informed and needs to recognize burdens that biological sex and gender place amongst women who use drugs.

2.3.4 - Sex Workers

Sex workers represent a particularly vulnerable group among people who use opioids due to the overlap between street-based drug use and sex work scenes^{35,37–39}. Although both men and women sex workers who use opioids, women are more likely to be involved in survival sex work compared to men.⁴⁰ At baseline, sex workers suffer a high burden of poverty, disease, and violent victimization that is often exacerbated by opioid use.⁴¹ A study on opioid use in a cohort of sex workers in Vancouver, Canada indicated that nearly one fifth of sex workers in Metro Vancouver used non-medical prescription opioids.^{35,37–39} Likewise, Goldenberg et al. (2020) found that almost one in three sex workers who use drugs in Vancouver experience at least one non-fatal overdose over a 7.5-year period.⁴² Opioid use among sex workers has statistically associated with exchanging sex while high, exchanging sex for drugs, police harassment/arrest, having a drug injecting intimate partner, and recent physical/sexual intimate partner violence.^{35,37–39}

Moreover, sex workers face significant barriers in accessing adequate care including stigma and police enforcement strategies. In particular, current policing practices have been shown to exacerbate drug and sexual-related harms. Injection drug use among sex workers has been independently associated with police sexual coercion, potentially through increased visibility and/or police targeting of this vulnerable sub-population.^{35,37–39} Sex workers may face enhanced targeting, harassment, surveillance, and arrest, in part due to their overlapping engagement in both sex work and drug use.⁴² Enforcement policies have negatively impacted sex workers' ability to screen clients, negotiate safer sex transactions with clients, access health and social services, and report violence to police^{35,37–39,42}. Currently, there is a lack of evidence-based policies to improve treatment outcomes for this population in Canada, which has serious implications for health and safety. One model that can potentially facilitate harm reduction and opioid overdose prevention support is the model implemented in San Francisco's St. James Infirmary, a peer-based occupational health and safety clinic that supports trauma-informed and gender-sensitive care, advocacy, and social justice for sex workers.⁴²

2.3.5 - Indigenous Populations

There are many systemic factors that are related to opioid use in Indigenous communities, including racism, intergenerational trauma, inequities created by residential schools and other forms of colonization, and reduced access to social supports, medical care, and harm reduction services.⁴³

The health impact of the opioid crisis on Indigenous people can be seen in opioid-related hospitalizations and deaths. A 2018 Statistics Canada analysis, for example, showed up to 5-fold greater opioid-related hospitalizations among Indigenous people compared to non-Indigenous people.²³ Moreover, a report from the First Nations Health Authority shows that 15% of opioid-related deaths in BC in 2020 were in First Nations people, who account for 3.3% of BC's population, a rate 6 times higher than other residents of the province.⁴⁴ Indigenous women in BC have a rate of opioid-related deaths 10 times greater than other women in the province.⁴⁴

The COVID-19 pandemic has exacerbated these disparities through restricted travel and closure of health centers and harm reduction sites, making it more difficult for Indigenous populations to access harm reduction services, naloxone, and in-person treatments. A report from The Chiefs of Ontario demonstrated

that the number of opioid-related deaths in First Nations people increased by 132% from pre-pandemic levels, compared to a 68% rise among non-First Nations people.⁴⁵ This was accompanied by a rise in opioid poisonings from unregulated fentanyl, which was found to contribute to 87% of opioid-related deaths, a trend seen in both First Nations and non-First Nations people.⁴⁵

The war on drugs has also led to a high incarceration rate of Indigenous people, reflecting the ongoing oppression of those who use drugs. According to Correctional Services of Canada, Indigenous people are more likely to be admitted into correctional facilities after receiving a mandatory minimum sentence of imprisonment related to drug possession or import/export. The conviction rate increased from 1% of all federal offenders in 2007 to 12.5% in 2017.⁴⁶ During this time period, Indigenous people accounted for only 4-5% of the Canadian population. Indeed, Indigenous people now comprise over 30% of the Canadian federal inmate population, including 42% of the female population.⁴⁷

Part 3: The Move Towards Decriminalization

Advocacy and movement towards the decriminalization of opioids can largely be categorized as federal, provincial (including municipal, as there is often considerable overlap), and advocacy on the part of other non-governmental organizations. In recent work, decriminalization has almost unilaterally focused on the legalization of all or most substances, and not just opioids. Much work has also recognized the need for better support of persons who use drugs, as well as how the current system of criminalizing PWUD is both ineffective and disproportionately impacts equity-seeking communities. In fact, almost all petitions recognize that decriminalization is only one aspect of the solution and increased healthcare and other supports are also critical. To varying degrees, different organizations have acknowledged disproportionate representation of equity-seeking communities in prisons, as well as the possibility of expunging previous criminal offenses for substance use or possession.

Important recent advocacy, campaigning, and work towards legalization are described categorically below.

3.1 - Federal action

Various federal parties have weighed in on the topic of decriminalization, both in the form of statements and parliamentary bills.

One of the first statements related to this advocacy work was in September 2019 by the Green Party of Canada, which called for the for broad decriminalization of substances, and particularly focused on safe screened supply and medical support for PWUD. ([Greens call on federal government to ...](#)) In February 2021, the new leader of the Green Party, Annamie Paul, again called on the federal government to respond to the opioid epidemic in another public media statement (see *Decriminalization, Safe Supply and Supports - Annamie Paul and Green Party Call on Government to Urgently Respond to the Opioid Epidemic within the Life of This Parliament* 2021). ([Decriminalization, safe supply and su...](#)) This support reiterated the need for a national safe supply program, and also included support for the BC government and other communities seeking exemption under the CDSA. The Green Party has since made several other statements with a common theme of a national safe supply program complementing decriminalization ([Greens call on federal government to ...](#)),

The NDP has also recently weighed in on decriminalization with the creation of Bill C-216 (*Health-based Approach to Substance Use Act*) (NDP Health Critic Introduces Legislation to Decriminalize Drug Use 2021). Written by Don Davies and introduced in April 2021, Bill C-216 was intended to decriminalize drug use at large and change the treatment of substance use to a health issue rather than a legal one. Similar to the requests of the Green Party, this would include harm reduction and treatment resources (such as reducing barriers to accessing safe supply). Bill C-216 includes clauses for expunging existing

criminal records for possession. This was a private members' bill and since the first reading in April of 2021 is currently in progress and outside the order of precedence (*Bill C-216, 2021*).

The current Liberal government has introduced a bill with some similarities to that of the NDP, but with other important changes. Bill C-5 was introduced on December 7, 2021, and proposed to repeal mandatory minimum penalties for drug offenses in addition to requiring police and prosecutors to *consider* using diversion in response to possession of an illegal drug (*Bill C-5: Mandatory Minimum Penalties to Be Repealed, 2021*). Of note, Bill C-5 applies to many criminal offenses, including weapons-related offenses, and is not specifically about decriminalization so much as adjusting the criminal code in multiple domains to address the disproportionate effects of law-enforcement on marginalized communities (particularly Indigenous and Black Canadians). It should also be acknowledged that diversion is distinct from decriminalization, and refers to the maintenance of criminal penalties with the *option* of alternatives, such as admission to treatment programs.

Relative to the Greens and NDP, the Liberal bill ultimately focuses on maintaining public safety while also making responses to criminal conduct, in their words, more fair. Bill C-5 was specific in that it would repeal mandatory minimum penalties for 14 offenses in the criminal code and the CDSA relating to substance use or possession (*Federal Actions on Opioids to Date 2022*), but the emphasis was on over-incarceration of certain populations, an issue often closely linked to decriminalization. Bill C-5 completed its second reading on March 31, 2022 and will be moving on to committee consideration (*An Act to Amend the Criminal Code and the Controlled Drugs and Substances Act* n.d.).

3.2 - Provincial and municipal action

British Columbia has become a forerunner in the work against drug criminalization, largely due to advocacy work conducted in Vancouver. Other voices within the province have also advocated for decriminalization, including the Provincial Health Officer, Dr. Bonnie Henry, who authored a report in April 2019 entitled, “**Stopping the Harm. Decriminalization of People who use Drugs in BC**”. This report addressed the reality that criminal-justice based approaches to drug use do not address what is primarily a health issue, and in fact, results in harm to people who are otherwise law-abiding and non-violent (*Controlled Drugs and Substances Act (S.C. 1996, C. 19), 2022*). It recommended decriminalization via revisions to the provincial Police Act – an initiative unlike other federally-oriented bills which address the CDSA, Canada’s federal statute. (Henry, 2019). The report included provisions for the police force to avoid expending resources on enforcement of simple possession.

In November 2020, the Vancouver City Council turned their attention towards federal legislation and approved a motion asking the Federal Government for an exemption to the Criminal Code provisions on simple drug possession (*Request for an Exemption to Health...2019*). Specifically, anyone in possession of substances less than the threshold value would not face criminal, financial, or administrative penalties for 15 common illicit drugs. The final proposal was submitted to Health Canada on June 1 (*Request for an Exemption to Health...2019*).

Vancouver was the first such jurisdiction to ask for such an exemption, and in doing so, created a precedent. As such, numerous mayors from various communities across BC have also signed a letter in

support of Vancouver's ask, including Victoria, Saanich, Nanaimo, Burnaby, New West, Port Coquitlam, and Kamloops ("B.C. Mayors Lend Support to Vancouver's Drug Decriminalization Plan" 2021). Most of these jurisdictions did not advocate for similar exemptions for themselves, but rather felt that Vancouver would be an appropriate test for the model's efficacy (that could presumably be later extended to other jurisdictions).

In October of 2021, BC revisited advocacy for decriminalization, building on the work of the City of Vancouver. An exemption request was sent to Health Canada for the CDSA (section 56(1)) which would effectively decriminalize possession of illicit substances in the province of BC if under a certain amount (Government of British Columbia Mental Health and Addictions, 2021). In a historic step, this exemption request was approved by Health Canada and will take place for a 3-year period starting January 31, 2023 until January 31, 2026. This makes BC the first and only province to have received such an exemption. This exemption signifies that while substances remain illegal, those who have less than 2.5 grams of some illicit drugs will not be arrested, charged or have the substances seized. Instead, police will direct these individuals to appropriate health and social supports as well as assist with necessary referrals if requested. (ref)

After the initial work of the Province of BC and the City of Vancouver, Toronto has also petitioned the Federal government to decriminalize possession of small quantities of drugs. A report in November 2021 from the Toronto Board of Health included a multi-sectoral consultation and requests for more federal and provincial funding in critical health and social supports (such as for prevention, harm reduction, and treatment services), a national framework to decriminalize simple possession of all drugs for personal use, and maintenance of legal penalties associated with drug trafficking (Kirthana Sasitharan 2021). If granted, the request would have similar ramifications to the exemption request of the city of Vancouver where individuals found in possession of drugs for personal use, at least under a certain amount, would not be subject to criminal penalties. Drug trafficking, however, would remain illegal and subject to penalties under the CDSA ("Toronto Public Health Moves Forward on Comprehensive Approach to Drug Poisoning Crisis in Toronto" 2021).

3.2 - Organizational action

Law enforcement has also begun to take a rational view on substance use, recognizing that policing and arrests for possession are outdated, ineffective, and harmful responses that need to be revised.

In July 2020, for example, the Canadian Association of Chiefs of Police recommended that enforcement be replaced with healthcare resources (Azpiri 2020). The Ontario Association of Chief of Police (OACP), via the Substance Advisory Committee (OACP SAC), recently supported this statement and called on the Ontario Ministry of Health to establish treatment programs and support services, referencing Portugal and the concept of escalating sanctions if treatment for substance is refused (i.e., instead of immediately jumping to punitive measures such as jail time) (*Ontario Association Chief of Police Statement Decriminalization for Simple Possession of Illicit Drugs* 2020). Importantly, the role of education, rehabilitation, and recovery were emphasized instead of pure decriminalization, using resources such as supervised consumption sites, diversion, and safe supply under a physician care model (*Ontario Association Chief of Police Statement Decriminalization for Simple Possession of Illicit Drugs* 2020).

Ontario's Big City Mayors (OBCM) – similar to the collection of mayors in BC who signed a letter supporting the City of Vancouver – have also vocalized support for the Chiefs of Police and health leaders in calling for decriminalization (Review of *Ontario's Big City Mayors Call for Action on Ambitious Mental Health and Addictions Plan* 2021). In June 2021, they also asked for the creation and funding for Mental Health Crisis Responses Units that would pair trained mental health professionals with police officers to respond to low risk crisis calls and wellness checks. This sentiment has been echoed by the Expert Task Force on Substance Use, part of Health Canada (*Report 1: Recommendations on Alternatives to Criminal Penalties for Simple Possession of Controlled Substances* 2021). The task force met to address the harms of criminalization such as stigma and the disproportionate impacts of populations impacted by structural inequity. In addition to the expected recommendations of ending criminal penalties for simple possession, the task force recommended a presumption of innocence and recommended expunging records for previous offenses related to simple possession. This task force also explicitly recognized the sovereign rights of Indigenous peoples, and the need for appropriate support for their governments (*Report 1: Recommendations on Alternatives to Criminal Penalties for Simple Possession of Controlled Substances* 2021).

Among First Nations organizations, The British Columbia First Nations Health Authority (FNHA) is notable for its advocacy of decriminalization (*FNHA Policy on Harm Reduction* 2017). Their goal is to engage with First Nations communities and Health Systems to ensure policies around this are advanced in ways that are responsive to the needs and preferences of First Nations people – in other words, ensuring autonomy in making health-related decisions such as those related to substance use, as well as recognizing Indigenous sovereignty (*FNHA Policy on Harm Reduction* 2017). This report also recognizes the disproportionate impacts of illegal drug markets and the prison system on First Nations people, and thus how decriminalization may be an important step in preventing future undue harms. The FNHA also supports harm reduction through the distribution of naloxone kits, sterile harm reduction supplies, and directly providing services like for supervised safe consumption (*FNHA Policy on Harm Reduction* 2017).

The Centre of Addiction and Mental Health (CAMH) in Toronto later produced a statement in September 2021 also acknowledging both the disproportionate harms of criminalization to some populations (particularly racialized communities) as well as the overall harms to health (*CAMH Statement on the Decriminalization of Substance Use* 2021). CAMH not only recommended that the federal government nationally decriminalize all drugs (and crimes connected to substance use) and establish personal possession thresholds to prevent criminalization without increasing prevalence, but also advocated for a greater investment in the social determinants of health and ongoing evaluation of measures of decriminalization and their efficacy (*CAMH Statement on the Decriminalization of Substance Use* 2021).

Indeed, various organizations have placed pressure on the Trudeau government with regards to decriminalization. A letter was written in October 2021 by the Association des intervenants en dépendance du Québec, the Canadian Association of People who Use Drugs, the Canadian Drug Policy Coalition, and the HIV Legal Network (Association des intervenants en dépendance du Québec (AIDQ) et al. 2021). Here, the writers urged for an evidence-based federal drug policy. In addition to decriminalization of drug possession and elimination of criminal sanctions, this letter also recognized the need for resources to facilitate low-barrier access to safe supply. The list of signatories in this letter was

more than 65, representing numerous organizations (Association des intervenants en dépendance du Québec (AIDQ) et al. 2021).

Doctors for Decriminalization is another coalition of clinicians in Canada that recognize and advocate against the harms of criminalization disproportionately impacting equity-seeking populations. It asks for responsible and evidence-based drug and substance policy for Canadians, recognizing that drug prohibition and criminalization has failed to decrease the use and availability of drugs while worsening the associated harms. Doctors for Decriminalization advocates for funding used for criminalization of substance use be transferred for policies and programming to promote health, equity, social stability, and safety (“Doctors for Decriminalization ABOUT US” n.d.).

These advocacy efforts on multiple platforms and institutions highlight several key themes, and two broad approaches. One approach is exemplified by the Province of BC and the City of Vancouver who sought exemptions to existing criminal code. In light of the ongoing acute overdose crisis in Vancouver, whereby more than 21,000 people have died since 2014 (City of Vancouver 2019), asking for an exemption is likely the fastest way to navigate the current system. The other approach focuses on directly changing the criminal code; however, while forward thinking (e.g., Bill C-216), these changes are often slow to be processed or get stalled in legislative bureaucracy. Other important themes unveiled include that many of these organizations advocate for the broad legalization of all substances. Many have also identified the disproportionate harms that criminalization has on marginalized groups such as Indigenous and Black Canadians, and thus the importance of trauma-informed approaches to treatment.

Part 3: The Importance of Decriminalization in Canada

4.0 - The Impact of COVID-19

COVID-19, caused by the coronavirus SARS-CoV-2, first emerged in December 2019 and has since caused widespread effects on individuals' physical and mental health. Among the 4.39 million cases in Canada, 46,972 individuals have died of this illness, with many more living with long-lasting effects of the virus.⁴⁸ The effects of COVID-19 have gone beyond just health - the pandemic also came with immense challenges and rippling effects for almost every sector of society, including public health, education, businesses, and legislation to name a few.⁴⁹⁻⁵¹

In the context of the opioid crisis within Canada, COVID-19 has had a detrimental impact on PWUD and further highlighted the gaps within our system. An increase in opioid-related deaths was seen in many provinces across Canada. In 2020, there were 2,426 opioid related deaths in Ontario, an increase of 60% and 64% from 1,517 deaths in 2019 and 1,475 opioid-related deaths in 2018, respectively. In BC, opioid-related deaths have far outpaced those by COVID-19; the overdose crisis killed 3,000 people in B.C. between January of 2020 and July of 2021, compared to the 1,800 who died from COVID-19 in the same time period. By the end of 2020, the BC Coroner Service reported 1716 illicit drug toxicity deaths, which was the largest single year-over-year increase since 2010. Additionally, the rates of emergency medical services (EMS) for suspected opioid overdose increased by 57% and the rates of fatal opioid overdose increased by 60% in Ontario since the onset of the COVID-19 pandemic in March 2020.

There are many factors that resulted in this increase of opioid-related harm across the country, the first being physical distancing measures enacted during the pandemic. Physical distancing measures were established in many provinces to reduce the transmission of COVID-19 and included limitations and restrictions to indoor gatherings, social events, as well as access to recreational activities (such as movie theaters and gyms). These measures significantly increased social isolation; indeed, physical distancing alone was seen to “increase the likelihood of using opioids alone, reduce individuals' ability to safely access drugs, leading to increased periods of abstinence, and to increase stockpiling behavior to prevent periods of abstinence.” (ref)

In conjunction with these measures, COVID-19 has also resulted in worsening mental health and an increase in feelings of stress, anxiety, depression, and despair, further increasing the risk of using substances, both regulated and unregulated.⁵²⁻⁵⁴ This increased stress can be caused by a multitude of factors that were exacerbated with the pandemic, including reduced social support, worry about COVID-19 transmission, and an increased financial burden, to name a few. According to one study, compared to 2018 estimates, fewer people aged 15 and older reported excellent or very good mental health during the peak of the COVID-19 pandemic from March 30 to April 2, 2020. This same survey also found younger adults (aged 15 to 24) to have a significant decrease in their mental health. In 2018,

62% of young adults reported excellent or very good mental health, whereas in the pandemic, this number decreased to 42%.

Another factor that resulted in an increase of opioid-related harm during the COVID-19 pandemic was the decreased access to safe consumption sites (SCSs) and other resources for people who use drugs. During the initial few months of the pandemic, many SCSs and outreach services were running on reduced capacity (limited hours and/or number of clients they were able to serve at a time) or had to close altogether. This resulted in a significant reduction in individuals being able to use these services, and especially in Toronto, BC, and Alberta.. In Alberta, for example, from April to June 2020, there were 40,755 visits to SCSs in Edmonton, Calgary, Lethbridge and Grande Prairie, and to the overdose prevention site in Red Deer. This represents a decrease of 65% compared to 114, 430 visits in January to March 2020. In Toronto, monthly visits to The Works, a local supervised injection service, dropped from 3,853 in February 2020 to only 127 in April 2020, and has only gone up to 790 visits in July 2020. In BC, monthly visits to overdose prevention sites and safe consumption sites declined from just under 60,000 in February 2020 to approximately 20,000 in April 2020, and has only increased to about 23,000 in July 2020.

Specialized substance use services, which offer withdrawal and outpatient treatment alongside group therapy, also saw reduction in their capacity, resulting in a decrease in new registrations and longer wait times. Between the first week of March and the first week of April 2020, Ontario reported over a 70% decrease in the total number of admissions (new registrations) to services across the province from 1,850 per week to 701 per week. Furthermore, the need for physical distancing and social isolation have also made it difficult for those receiving treatment with additional challenges. As quoted by one anonymous addictions social worker in a report by the Canadian Centre for Substance Use and Addictions: “Struggle is real for our members, they come in for treatment and if they show any signs or symptoms we need to isolate them in another building on site. We provide all meals and services until a negative COVID test comes back and then they can return to the building. In early recovery it is very challenging as they often feel they are not “doing” recovery. Therefore they want to leave and we continue to maintain support and encouragement to keep them safe. I find they often struggle mostly to feeling like outcasts due to their addictions and now in recovery when we promote connection they feel like they are being outcasts again.”

5.0 - Cost-benefit analysis

There is a lack of data as to the costs that criminalization costs to either the provincial or federal governments. However, this data can be estimated based on available data.

Indeed, the rates of opioid-related offenses in Canada are rising. In 2019, there were a total of 4766 opioid-related offenses in Canada, representing a 48% rate increase as compared to 2018. Notably this increase was due to possession of substance rather than trafficking offenses rather the offenses related to importation/exportation decreased). These rates are reported to be the highest in BC (38 per 100,000 population), and especially within the cities of Leowna, Lethbridge, and Vancouver. Western Canada

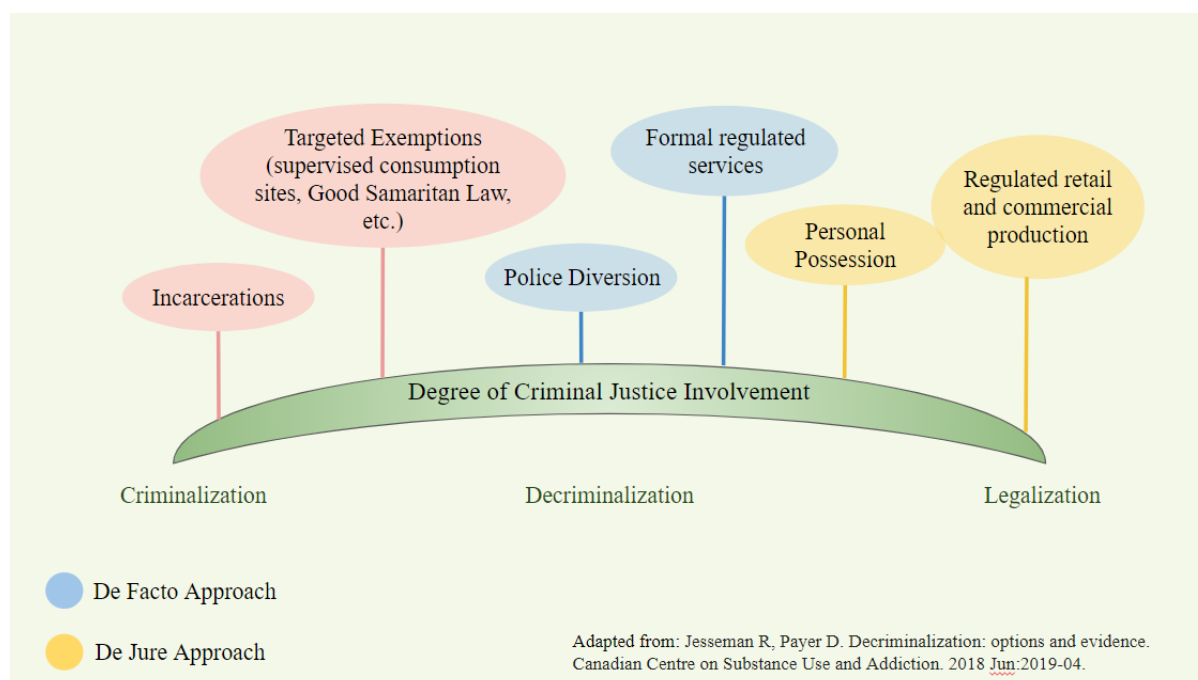
continues to be the most impacted province, although the 2020 report by the Special Advisory Committee on the Epidemic of Opioid Overdoses notes that the rate in other provinces/regions continues to increase.

As such, the police system continues to see an increase in the number of police cases, court visits, and prisons that are occupied with drug-related crimes, and which do nothing to curb the current opioid epidemic. Moreover, the costs to the healthcare system also continue to increase. It was reported that there were more than 30, 600 Emergency Medical Services (EMS) responses to suspected opioid-related overdoses from January to September 2021, based on available data from nine provinces and territories. For a similar time frame in 2019 before the pandemic, there were 17,443 EMS responses (a 76% increase). As noted, the COVID-19 has disproportionately impacted PWUD; with our current system of criminalization, we do little to support the opioid epidemic (ref below).

While there is little data to demonstrate the cost-effectiveness of decriminalization in Canada, data from other countries can be used as a good analogy. The Czech Republic, for example, shifted to a decriminalization approach for substance use in 1999 and noted decreased economic burden on social and enforcement costs.⁵⁵ Portugal decriminalized personal possession of all drugs as a part of a wider re-orientation policy towards a health-led approach to substance use. Substance use no longer results in criminal records or its associated stigma, and if found to be under possession, individuals are redirected to counseling and treatment services rather than correctional facilities. This police diversion approach led to a fall of the proportion of prisoners sentenced for drugs from 40% to 15%, and a continuous decrease in the rates of drug use and drug-related related deaths to be below the EU average since the beginning of the century. Indeed, further research from Australia, the US demonstrate that police diversion programs, when compared to criminal charges, reduce criminal justice system costs and adverse social and economic consequences to the individual (refs).

7.0 - Ways to Decriminalization

The regulation of controlled substances occurs along a continuum of categories:



There are 2 main approaches to substance regulation: De facto and De jure. While the de facto approach follows non-legislative or informal guidelines, the de jure approach is through formal policy or legislation. Under these approaches, there are three main categories to approach substance use: criminalization, decriminalization, and legalization.

There have been many recent examples of decriminalization efforts across the world that provide data on programs that work. Although there are still gaps in this data, it can be used as a starting point to help Canada choose a decriminalization method that may work to help the drug-using community.

Listed below are some methods, examples, and their associated advantages and disadvantages to approaching substance use, using either de facto and de jure approaches (1,2).

Targeted Exemptions:

Method	Examples	Description	Advantages	Disadvantages
Targeted Exemptions	Supervised Consumption Sites	Location where people can use drugs in clean, safe environment, with trained health professionals	First established in 1986 and now in many locations across Europe and in Canada. Large body of evidence proving efficacy, especially when offered in conjunction with integrated health/social services, treatment, and housing	May be inaccessible depending on personal factors (location, mental health, stigma, etc.)
	Drug Checking Services	Street drugs analyzed to minimize risk of hazardous contaminants.	Established in Europe over 25 years ago, outcomes show that these services can influence	May be inaccessible depending on personal factors

			drug use risk behaviors, provide intervention/education/referral opportunities, monitor local drug supply and inform public health, decrease contaminated drugs in local market	(location, mental health, stigma, etc.)
	Prescription Maintenance Programs	Provide medically supervised access to controlled substances	Results show increased treatment retention, decreased illicit opioid use, improved social function, decreased criminal activity	Access to care may be an issue since the program requires medical supervision and prescription
	Good Samaritan Laws	Protection from arrest/prosecution of individuals who call for assistance for an overdose/witnessed overdose	Remove fear of criminal repercussions as barriers to calling first responders	Limited data on the impact of these laws; must ensure there is awareness of this policy among drug users

De Facto Approaches:

Method	Examples	Description	Advantages	Disadvantages
Police Diversion	Bristol Drugs Education Programme (UK)	Option to attend half-day drug education course if caught possessing drugs; individuals can only participate once; those who complete course have charges dropped	Pilot showed high rates of program uptake and 80% completion rate. Also showed improved relationships among police, PWUD, and community service agencies	Police officers hesitated to apply program to individuals using heroin/crack; also discrepancies in determining personal use vs intent to traffic
	The Council of Australian Government-Illicit Drug Diversion Initiative	Police diversion programs usually with therapeutic focus but also with warnings, confiscations, civil penalties, since 1999	Provided national framework, best practice guidelines, expansion of treatment services. Promising evidence of diversion programs in reducing rates of re-offense.	“Net widening” effects of increasing number of people involved in criminal justice system.
	Seattle Law Enforcement Assisted Diversion	Bypass police and direct individuals arrested for low level drug and prostitution crimes to comprehensive case management and community supports	Harm reduction approach without having abstinence as a condition of participation	Est. in 2011, unsure if there is enough data to support effectiveness of program

National Approaches	Netherlands' Opium Act Directive (1976)	Regulated coffee-shop market for cannabis and small amounts of other drugs	Supposedly prevent cannabis users from using more harmful drugs.	Unable to determine if policy has affected trends of drug usage and overdose
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De Jure Approaches:

Method	Examples	Description	Advantages	Disadvantages
National Approaches	Portugal's Law 30/2000	Use of illicit drug or possession of up to 10-day supply is an administrative, not criminal, offense (2000). Individuals apprehended under this law approach a commission formed of legal, health, and social service perspectives. Responses of the commission can include: warning, referral to health/social services, referral to substance use treatment, fines, community service.	Reductions of social harms of drug use: public drug use, HIV/AIDS transmission, lost productivity and demands on criminal justice resources. No marked increase in the drug market and drug prices were not decreased.	Some indications of increase in rates of use after strategy implementation but these are comparable or lower than trends in other EU countries.
	Czech Republic's administrative offense approach	Drug possession for personal use as an administrative offense (1990)	Opened up room for more reform of decriminalization programs	Threshold of amount of drugs considered as "personal use" hard to determine
	Mexico's 2009 "narcomenudeo"	Individuals apprehended with small amounts of drugs referred to health authorities, up to the third apprehension. Afterwards, they would be required to enter treatment.	Offers a way to receive treatment and healthcare help and also a police record that states "no penal action"	Implementation limited due to little/no police training and education to support new legislation. Thresholds qualifying for personal possession very low.
Legalisation and Regulation	Uruguay 2013	Full legalization of non-medication cannabis through home production,	Decreased demands on criminal justice resources	No data yet on health, economic, and social impacts

		licensed co-operatives, licensed pharmacies		
	Canada 2018 (3-5)	Legalized cannabis to keep cannabis away from youth, not profit criminals, protect public health and safety. Possession thresholds of up to 30g dried legal cannabis allowed, obtained from home growth, provincially licensed retailer.	2017 showed almost 48,000 cannabis related drug offenses reported to police. 80% were possession offenses. Allowing production and possession of legal cannabis for adults reduces burden on courts. Increased monitoring of cannabis products and sales. Increased use of cannabis from legal sources.	Increased number of users, particularly among persons 25 years and older; use among 15-17 year olds declined. - Increased concerns on driving after cannabis use

Provided with the data of these initiatives and more, there are a number of pillars Canada can build on when developing its own substance regulations policies. According to the Canadian Centre on Substance Use and Addiction, these are among the key considerations that Canada should use to guide future policy and practice (1):

1. There is no evidence to support an association between decriminalization and increased rates of drug use or other harms
2. Continuity and integration of care increases positive health and social effects. For example: Co-location of health and addiction treatment services with supervised consumption sites.
3. Community capacity is necessary to provide health and social resources needed to support police diversion programs that address individual risks and needs.
4. Threshold quantities should not be set too low (limits eligibility) and provide some flexibility to allow for consideration of other factors, such as individuals consumption levels.
5. Avoid diversion procedures that increase administrative/resource requirements on police without necessary support, as it results in lower uptake and reduced impact.
6. Clear communication to both police and the public can reduce net widening by defining the objectives of diversion and educating the public on program requirements and the impacts of non-compliance. (Note that net widening is an increase in the number of people caught up in criminal justice processes following a diversion program, usually occurring when there are incentives for police to issue higher numbers of sanctions or there are sanctions for non-compliance).
7. Clear guidelines and training for the police are required for program implementation, consistency, and equity.
8. Consider legislative and regulatory context to ensure successful program implementation. For example, avoiding blanket policies that lead to ineffective practice.
9. Involve people with lived experiences in developing policy and practice to address substance use.

De Jure vs De Facto:

As illustrated by the success of the Portuguese model, the De Jure option can be a highly successful and far-reaching decriminalization method. In Canada, a De Jure model would remove criminal penalties

associated with certain drug-related offenses such as possession from the CDSA. This change would be enacted at the federal level and impact provincial, territorial, and municipal police, courts, and health and social services. This legislative change would only be the beginning of a comprehensive approach requiring time and investment, as seen in Portugal (1).

In contrast, De Facto options may be implemented faster than De Jure options as programs can be created and put into practice at the provincial, territorial, and municipal levels. However, these programs would require careful training, administration, and resource planning to avoid net widening and ensure equity of application (1).

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Conclusion

Multiple

As Canada moves to consider decriminalization methods, it is important to recognize that decriminalization is not a single model or approach. Instead, the decriminalization effort should be tailored based on the problem, context, and resources available - one that reflects the complex issue of substance use and is comprehensive enough to cover public health and safety, social issues, and the economy. Canada needs to move towards the creation of a national decriminalization strategy that not only takes into account prior experiences of other nations, but also empowers its own communities and enlists the help of persons with lived experiences to better support PWUD.