Facing up to an epidemic: drug policy in Canada

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for
Moving Harm Reduction Policy Forward
Kiev, Ukraine

4-6 October 2004
Drug users are citizens: they include our sons, daughters, brothers and sisters and, increasingly, our parents. They deserve humane responses; let us not wage war on them.¹

The Problem

Canada is facing a public health crisis with respect to injection drug use.² Rates of blood borne infections among people who inject drugs increased during the 1990s at an alarming rate. By 1996, almost half of all new HIV diagnoses were in people who inject drugs.³ Since 1997, the proportion of new HIV infections annually that are attributable to people who inject drugs has decreased slightly; by 1999, the number had dropped to 26 percent.⁴ However, HIV and AIDS infection remain a major problem. Overall, the number of adult AIDS cases related to injection drug use has increased to 21.7 percent of all new reported AIDS diagnoses in 2001, up from 8.3 percent of new AIDS cases in 1995.⁵ As noted by Health Canada, the “absolute number of infections in this group is still unacceptably high.”⁶

Rates of infection with hepatitis C (HCV) are also high. Among Montréal street youth, 35 percent of injection drug users have the virus,⁷ while 88 percent of participants in the Vancouver Injection Drug User Study (VIDUS) are infected.⁸ More recent data found that rates of HCV infection among injection drug users reach 85 percent in Vancouver and 70 percent in Montréal, with annual incidence rates of 26 percent and 27 percent respectively.⁹

⁴ Ibid.
⁶ HIV/AIDS Among Injecting Drug Users in Canada, supra note 3.
The prevalence of HIV among injection drug users is on the rise in larger Canadian cities. In Montréal, HIV prevalence among people who inject drugs was 19.5 percent in 1997, nearly four times what it was in 1988. In Toronto, HIV prevalence among injection drug users was 8.6 percent in 1997-1998, up from 4.8 percent in 1992-1993. Similar trends have been observed in Québec City, Winnipeg, and Ottawa. The available (limited) data also shows that the HIV epidemic among injecting drug users is increasingly being seen outside major urban areas. The mobility of people injecting drugs and their interactions with people who do not use suggest that the problem is not limited to cities or to injection drug users, but rather affects all of Canadian society. Further, the problem of drug use among Aboriginal communities has been the subject of increasing concern.

The problems are most apparent in Vancouver. The city’s Downtown Eastside is Canada’s poorest urban neighbourhood. Street-based drug use is rampant in this area, and HIV prevalence among injection drug users was estimated to be between 23 to 30 percent in 2000. The prevalence of HCV was even higher, at approximately 88 percent in the same year. While fatal overdoses and other health concerns related to drug use have been observed in the area since the 1970s, they have increased dramatically. There have been more than 2000 overdose

10 HIV/AIDS Among Injecting Drug Users in Canada, supra note 3.
15 HIV/AIDS Among Injecting Drug Users in Canada, supra note 3.
deaths in British Columbia since 1992, and it has been the leading cause of death among people aged 30 to 49 for five years in a row. Among those participating in the Vancouver Injection Drug User Study, overdose is the leading cause of death, regardless of HIV status.

There are many reasons for the escalating problem of drug use and overdose in Canada. These include a rise in the number, variety and potency of drugs that are produced, sold and used on streets, a decline in the street cost of drugs, and the fact that people using drugs are beginning to do so at a younger age. Users who inject quickly in order to reduce the risk of being detected and arrested are also more likely to inject in an unsafe fashion. The shift from heroin to cocaine use also contributes to the escalation, as cocaine users may inject as many as 20 times a day. A greater frequency of injection, and the incentive to inject quickly, increases the likelihood that individuals will share needles and other equipment, putting themselves at risk for HIV and HCV infection.

**Drug Policy and Strategy in Canada: From Prohibition to Harm Reduction?**

Criminal laws to control illicit drugs and their use have been in place in Canada since the early 1900s. The current statute, the *Controlled Drugs and Substances Act (CDSA)*, enacted in 1996 and brought into force in 1997, consolidated several preceding acts.

The *CDSA* prohibits the import or export of illegal drugs, as well as drug possession and trafficking. Trafficking of drugs is defined to include providing, administering, transferring, and selling illegal substances. The *CDSA* also prohibits the *unauthorized* possession of equipment intended for ingesting drugs into the human body, or meant for the production of such substances, if it contains traces of a prohibited drug; therefore, possessing used injection equipment is itself a crime.

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26 SC 1996, c 19 (hereinafter *CDSA*).

27 *CDSA*, s 2(1).

28 *CDSA*, s 2(2)(b)(ii). The *CDSA* uses the definition of possession found in the *Criminal Code*, RSC 1985, c C-46, s 4(3).
The current legal status of syringes distributed to drug users is also somewhat uncertain. Needles are produced and sold for medical purposes and therefore technically qualify as “devices” under the *Food and Drugs Act (FDA)*. However, the *Criminal Code* prohibits the promotion or sale (which includes free distribution) of “instruments for illicit drug use”, which is defined as including anything “intended under the circumstances” for ingesting illegal substances.

There are several negative consequences that flow from pursuing strictly prohibitionist policies. They encourage users to inject quickly, out of fear of police apprehension. Zero tolerance also produces an underground market for drugs, with associated crime and corruption. Further, drug users are often compelled to use unclean equipment or to inject in unsafe or unhygienic circumstances (particularly in the case of street-based injecting), increasing the risk of contracting infections. Riley notes that a zero-tolerance model creates a culture of marginalized and stigmatized people who are difficult to reach with educational messages about safe practices or treatment. This is the product of a “drug war” mentality, abstinence-based morality, and the fact that “AIDS and other drug-related harms are sometimes viewed as just deserts [sic]” for drug users. The prohibitionist mindset undermines community caring, by fostering “public attitudes that are vehemently anti-drug, and the view that drug-users do not care about their own lives.”

Put simply, prohibition alone, as a public health strategy, is not a success. Wodak and Owens note that “[p]rohibition is increasingly regarded as flawed in principle and a resounding failure in practice.” They conclude that increasing the health, social, legal and economic costs of drug use in order to minimise the number of people who use drugs, the very basis of prohibition, produces more net harm to individuals and society than accepting the inevitability of some drug use … Authorities around the world are increasingly recognising

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29 RSC 1985, c F-27, s 2 (hereinafter *FDA*).
30 *Criminal Code*, s 462.1.
33 Kerr, *supra* note 18 at 24.
that most problems associated with illegal drugs are caused by prohibition rather than being the inevitable result of their pharmacological properties.  

A large number of policy-makers and community members in Canada as in many other countries have recognised that strictly prohibitionist policies are ineffectual in stopping drug use, and can have damaging consequences, as outlined above.  A policy of “harm minimisation” or “harm reduction” has been recommended by many. The philosophy underlying harm reduction is the desire to reduce the negative consequences associated with drug use. It tolerates (but does not condone) drug use, and accepts that abstinence from drugs is not realistic for some users. Drug use is acknowledged as a fact of life, and effort is directed to diminishing the harmful consequences of drug use on the user and the community.  

Following a harm reduction approach, drug addiction and the risk of the spread of disease are understood as public health issues. The Joint United Nations Programme on HIV/AIDS (UNAIDS) observes that if comprehensive, wide-ranging harm reduction programs are implemented to combat the spread of HIV among injecting drug users — including education, promotion of condom use, drug treatment and needle exchanges — infections can be contained at a low level.  It emphasises that this is particularly the case “in the many countries where drug injection is a major driving force for the spread of HIV.”

As indicated by Riley, “[o]ne of the main barriers to the adoption of non-prohibitionist policies is idealism. Adopting harm reduction means accepting that some harm is inevitable.” It is an admission that a zero-tolerance approach based on abstention has failed. A harm reduction approach acknowledges that the police cannot eliminate illicit drug use and, in particular, the problems associated with street-based injecting.

The Canadian federal government’s stated position for two decades has been that “[t]he criminal law should be employed to deal only with that conduct for which other means of social control are inadequate or inappropriate, and which interfere with individual rights and freedoms only to

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38 Ibid, at 7-8.
40 Riley, *supra* note 31 at C3-4.
42 Ibid 77.
the extent necessary for the attainment of its purpose.”44 Such a position lends support to proposals for a drug policy based on harm reduction principles.

There is evidence that the Canadian drug strategy has shifted, if slowly and not always consistently,45 towards a harm reduction philosophy, with an emphasis on initiatives such as needle exchange and methadone programs. Canada’s Drug Strategy adopted in 1998 by the federal government states that its long-term goal is to reduce the harm associated with drugs to individuals, families and communities.46 The Strategy also states that because “substance abuse is primarily a health issue rather than an enforcement issue, harm reduction is considered to be a realistic, pragmatic, and humane approach as opposed to attempting solely to reduce the use of drugs.”47

In April 2000, a Special Senate Committee on Illegal Drugs was established with a goal to “develop a national harm reduction policy in order to lessen the negative impact of illegal drugs in Canada [and to] study harm reduction models adopted by other countries and determine if there is a need to implement them wholly or partially in Canada.”48 As well, Health Canada has indicated that programs aimed at HCV prevention should adopt a harm reduction approach.49

In September 2001, Canada’s federal, provincial and territorial ministers of health “acknowledged” a report jointly prepared by several inter-governmental advisory committees that set out a harm reduction approach and a framework for action.50 The ministers tasked a working group of the committee with examining the feasibility of establishing a safe injection facility as a scientific, medical research project.

Also welcome is the indication of Allan Rock, then federal Minister of Health, that more steps would be taken in the direction of harm reduction in the future. In Health Canada’s public response to the Final Report of the Canadian HIV/AIDS Legal Network on Injection Drug Use and HIV/AIDS: Legal and Ethical Issues, the Minister acknowledged that “a comprehensive


45 See the commentary by Fischer, *supra* note 25.


47 Ibid.


50 *Reducing the Harm Associated with Injection Drug Use in Canada*. Report of the Federal/Provincial/Territorial Advisory Committee on Population Health, 2001. The document was prepared in conjunction with: the F/P/T Committee on Alcohol and Other Drug Issues; the F/P/T Advisory Committee on AIDS; the F/P/T Heads of Corrections Working Group on HIV/AIDS; and a multi-disciplinary committee of senior Justice and Health officials.
response to IDU requires a partnership approach involving other disciplines and jurisdictions.”

The Minister pledged his commitment to “support efforts to reduce injection drug use-related harm in correctional settings.”

According to Health Canada’s response, Health Canada recognizes that “changes are needed to existing legal and policy frameworks - both national and international - in order to effectively address IDU as a health issue.” Health Canada continues by saying that “the required changes are complex and must be developed collaboratively over time.” However, in the interim Health Canada advocates a harm reduction approach within the current frameworks. For example, the response refers to needle exchange programs as an important harm reduction measure as well as an example of “strong co-operation between the health and law enforcement sectors.”

A Multi-faceted Response: the “Four-Pillar Approach”

In November of 2000, the City of Vancouver released the draft discussion paper *A Framework for Action: A Four-Pillar Approach to Drug Problems in Vancouver*. The paper establishes a framework for action to “appropriately and effectively deal with city-wide substance misuse and associated crime.” The approach is based on the “four pillars” of prevention, treatment, enforcement, and harm reduction:

- **Prevention** focuses on education regarding substances, as well as on building awareness about the reasons behind drug abuse and what can be done to avoid addiction.
- **Treatment** involves numerous interventions and support programs, including detoxification, counselling, social programs, and medical care.
- **Enforcement** consists of a “redeployment of officers” in the Downtown Eastside to combat organized crime and drug dealing, and to strengthen ties with health services and similar agencies.
- **Harm Reduction** is a “pragmatic approach that focuses on decreasing the negative consequences of drug use for communities and individuals.” The paper draws upon successful harm-reduction initiatives undertaken in other parts of the world.

Following the document’s release, the public was consulted on the various aspects of the proposal. In general, the public was supportive of the framework, including harm reduction measures. In many ways, this four-pillar approach has become the basis for drug policy not only in Vancouver, but in all of Canada.

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52 Ibid.
53 Ibid, at 3.
Harm Reduction Strategies: An Ethical Imperative

The criminal approach to drug use was ostensibly designed to decrease the various health and social problems that result from the use of and addiction to various substances. However, many Canadian experts have pointed out that this approach has simply failed to achieve its objectives. Rather than solving problems, the model both exacerbates existing dilemmas and creates new ones. The criminal approach has been characterized as failing to achieve the goals for which it is designed and promoted; excluding those who inject drugs from the community; misusing limited resources; “stimulating the rise to power of socially destructive and violent empires;” and fuelling the “decline of humanity that is essential to civilized societies.”

Adopting an ethic of harm reduction acknowledges that prohibitionist approaches to drug use have not worked. A harm reduction approach does not identify abstinence as the necessary goal of any intervention. It is deemed unethical to demand from someone something of which they are physically or mentally incapable. That said, proponents of harm reduction measures would certainly recognize abstinence as being a worthwhile goal for some people. “While harm reduction approaches do not preclude abstinence as a worthwhile goal, they question the long established notion that abstinence is the only acceptable drug policy or program outcome.”

The harm reduction ethic emphasizes pragmatism in dealing with the problems associated with drug use: for instance, the utilization of methadone treatment programs to combat heroin addiction, or the establishment of needle exchange facilities to reduce the sharing of needles and associated spread of disease. The emphasis is on keeping those who choose to use drugs alive and disease-free, with rehabilitation open as a possibility. Moralizing about the intrinsic evils of drugs and drug use is avoided, recognizing that many of the ills associated with drug use result from the approach we as a society use to deal with these individuals.

Harm Reduction Strategies: A Legal Imperative

In Canada, it has been convincingly argued that there are not only ethical, but also legal obligations to undertake harm reduction initiatives, such as the establishment of safe injection facilities. In particular, it has been argued that international law demands that such initiatives be undertaken, as part of the international legal obligation to provide Canadians with the highest standard of health possible.

Furthermore, it has been shown that international drug conventions do not prevent such initiatives. Canada is a party to:

56 Kerr, supra note 18 at 7.
• the 1961 Single Convention on Narcotic Drugs (as amended by the 1972 Protocol Amending the Single Convention on Narcotic Drugs);
• the 1971 Convention on Psychotropic Substances; and
• the 1988 United Nations Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances.  

It is often incorrectly assumed that these treaties require signatory countries to adhere strictly to a criminal prohibitionist approach to drug use. In reality, they incorporate provisions permitting various health-based approaches, including harm reduction measures. Indeed, a 1972 UN conference led to the adoption of a Protocol Amending the [1961] Single Convention which “highlights the need for treatment and rehabilitation of drug addicts.”

Several articles in the international drug control treaties can be interpreted as permitting or even supporting harm reduction efforts, requiring states to implement particular policies that are not concerned with criminal penalty. Importantly, Article 38(1) of the 1961 Single Convention, entitled “Measures Against the Abuse of Drugs,” states:

The Parties shall give special attention to and take all practicable measures for the prevention of abuse of drugs and for the early identification, treatment, education, after-care, rehabilitation and social reintegration of the persons involved and shall co-ordinate their efforts to these ends.

In addition, the vagueness of the conventions permits parties to look to state practice to help determine how to interpret the provisions. In global terms, state practice is undeniably inconsistent. This lends support to the argument that responses to harms associated with injection drug use should be left to the discretion of states, which can, on their own terms, assess the best way of serving their communities. The conventions themselves concede a degree of latitude to a state’s “prevailing conditions,” “constitutional limitations” and “legal system and domestic law.” In fact, these important provisions allow for the undertaking of harm reduction initiatives.

Four Examples of Pragmatic Canadian Drug Policy

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57 The full text of the Conventions can be found via the website of the International Narcotics Control Board at www.incb.org.
Needle Exchange Programs
A cornerstone of HIV prevention for IDUs in Canada has involved making sterile syringes available through needle exchange programs (NEPs). The first NEPs were opened unofficially in Toronto in 1987 and officially, with government funding, in Toronto and Vancouver in 1989.61 By the end of 1990, eight publicly funded NEPs existed in Canada. Today, needle exchange programs operate with government funding in all provinces with the exception of Prince Edward Island (a remote island with a small population), and it is estimated that there are hundreds of locations at which needles are exchanged or distributed. Syringes are distributed to IDUs in various ways, including through fixed locations, outreach workers, mobile units (e.g., vans), and vending machines.

Benefits of NEPs62
NEPs have been found to reduce risk behavior, HIV and hepatitis C incidence, and be associated with substantial savings in health care expenditures.63 The specific biologic action of NEPs is a form of vector control, by reducing the time that needles spend in circulation.64 NEPs are generally regarded as the single most important factor in preventing HIV epidemics among IDUs.65 An international investigation of NEPs found that in cities with needle exchange or distribution programs HIV seroprevalence decreased by 5.8 percent per year, while HIV prevalence increased by 5.9 percent per year in cities without such programs.66 NEPs have also been found to increase access to various health care programs, including addiction treatment and voluntary HIV testing.67 Several studies have also demonstrated that the implementation of NEPs have not lead to increases in drug use locally.68

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61 Canadian Centre on Substance Abuse. Needle exchange programs FAQs (frequently asked questions. Available via www.ccsa.ca.
66 Ibid.
**Misinterpretation of a Canadian study**

In some circles, two Canadian studies demonstrating an association between HIV infection and use of NEPs have been misinterpreted and misused by people opposed to NEPs. The studies did create confusion, albeit primarily among politicians and not scientists. Some have claimed that the Vancouver study demonstrates a causal relationship between HIV infection and syringe exchange, despite the fact that the study merely demonstrated an association between frequent use of syringe exchange and HIV prevalence. The authors of the paper stated that “our study was not intended to evaluate the effectiveness of NEP…the fact that frequent NEP attendance was associated with HIV prevalence should not be interpreted as causal” (p. F64).

Given the confusion created by the study, the relationship between frequent syringe exchange attendance and HIV incidence or infection was studied in a follow-study titled “Do Needle Exchange Programmes Increase the Spread of HIV Among Injection Drug Users? An Investigation of a Vancouver Outbreak”. The paper, published in the prestigious journal *AIDS*, demonstrates that the previously observed association between syringes exchange attendance and HIV prevalence reflected a “selection bias” – meaning that syringe exchanges do not cause HIV infection, but rather high risk individuals are the people most likely to frequently attend a syringe exchange program. Consistent with this, the authors of the second paper pointed out that frequent syringe exchange attendees were more likely than non-frequent syringe exchange attendees to live in unstable housing, to inject frequently, inject cocaine, work in the sex trade, inject in “shooting galleries” and to have recently been incarcerated. These characteristics have previously been found to be associated with HIV infection in several studies, and the authors calculated that the rate of HIV infection found among frequent syringe exchange attendees was at the level that would be expected given their risk profile. The authors did investigate the unlikely explanation that syringe exchange prompted increases in risk behaviour, but found no evidence to support this explanation. The authors also ruled out the explanation that syringe exchange prompted the formation of social networks.

**Summary**

In summary, the evidence to date indicates that NEPS are the most effective HIV prevention intervention that can be offered to IDUs. A wealth of scientific studies suggests that NEPs have been associated with significant declines in HIV incidence, as well as higher uptake of health services, including drug treatment. As well, investigation has shown that many of the concerns expressed in regard to NEPs (NEPs prompting increases in drug use) have proven to be unfounded and in some cases contrary to empirically-derived evidence.

Therefore, NEPs have an important place in Canada’s response to HIV/AIDS and to IDU.

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70 Strathdee, note 67.

Methadone Maintenance Treatment
Methadone remains the only opioid approved for long-term treatment of opiate dependence in Canada.

The safety and effectiveness of methadone maintenance treatment (MMT) has been documented in scientific and medical publications. MMT programs have been credited with decreasing opioid use, reducing criminality, and improving the general health of the drug user. Moreover, MMT reduces individual mortality and morbidity. Another important benefit of MMT is that it helps decrease the spread of HIV, as methadone is typically administered orally rather than by syringe. MMT has thus become a “critical resource in the struggle against injection drug use and AIDS.” Methadone clinics are also potentially excellent sites for disease prevention and education. Patients can be offered screening and counselling for transmissible diseases; and can be provided information on safe sex, on the dangers of sharing needles, and on methods for cleaning syringes.

History of MMT in Canada
In 1959, Vancouver physician Dr Robert Halliday obtained approval from the federal Department of Health to conduct a study of methadone as a method of treating opiate-dependent persons. Dr Halliday was successful in establishing that methadone maintenance was a legitimate form of treatment for drug-dependent persons. By 1972, two dozen methadone treatment programs existed in Canada. The Commission of Inquiry into the Non-Medical Use of Drugs, known as the Le Dain Commission, stated in the early 1970s that methadone “is the cheapest and most effective weapon we have for dealing with large-scale heroin dependence.” The Commission recommended that methadone maintenance be available to persons dependent on opiates throughout Canada.

Possible misuses of methadone became a concern of the federal government in the early 1970s. In 1972, the government passed regulations to the Narcotic Control Act that stated that no doctor or pharmacist could prescribe, administer, give or sell methadone to any person unless so authorized by the federal government. The regulations had a drastic impact on the methadone programs that existed in Canada. Between 1972 to 1975, methadone prescribers as well as patients involved in methadone programs decreased by one-third.

In the mid-1990s, the federal government transferred licensing and control of methadone programs to the provinces. Some provinces have delegated to the College of Physicians and Surgeons the responsibility of regulating the methadone maintenance programs. It is still necessary for physicians to obtain federal authorization to prescribe and administer methadone to their patients. However, since the mid-1990s, access to MMT has been vastly expanded in Canada, and today MMT is considered as an essential component of Canada’s response to HIV/AIDS and IDU.

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Safe Injection Facilities

Another partial solution to the crisis of injection drug use, HIV/AIDS, and HCV (as well as overdoses) that has more recently been introduced in Canada by way of a scientific trial is the establishment of safe injection facilities (SIFs – also known as “supervised injection facilities” or “sites”).

SIFs are places in which drug users are able to inject using clean equipment under the supervision of medically trained personnel. The drugs are not provided by anyone at the facility, but are brought there by the drug users. The professional staff do not help to administer the drugs, but assist users in avoiding the consequences of overdose, blood borne diseases or other negative health effects (such as abscesses) that may otherwise result from using unclean equipment and participating in unsafe injecting practices.

SIFs also help direct drug users to treatment and rehabilitation programs, and can operate as a primary health care unit. Facilities provide free sterile equipment, including syringes, alcohol, dry swabs, water, spoons/cookers, and tourniquets. The facilities are intended to reduce incidents of unsafe use of injection drugs and to prevent the negative consequences that too often result from unsafe injection. They are not “shooting galleries,” which are not legally or officially sanctioned and are often unsafe because they do not offer hygienic conditions, access to sterile injection equipment, supervision and immediate access to health-care personnel, or connections to other health and support services.

There are three main ways in which SIFs can be effective at improving public health: (1) preventing fatal overdoses, (2) preventing the spread of blood borne diseases and other injuries caused by unsafe injecting, and (3) acting as a gateway to education, treatment and rehabilitation.

The debate

Before the first trial was authorized in Canada, some suggested that establishing SIFs would send the wrong message to the community – namely, that injection drug use is acceptable and has official support. It was argued that this would contribute to increased use. In fact, in cities in Europe that have SIFs the total number of drug users has decreased.

Another concern was that the introduction of SIFs would increase the concentration of drug users in the area in which the SIF is located, thereby affecting the quality of life in the neighbourhood. In reality, SIFs are expected to reduce nuisance and visibility problems: crime, violence, loitering, drug dealing and property damage could be diminished, and many needles would be disposed of safely rather than discarded on the streets. European studies support this contention, with police reporting declines in street robbery, car break-ins, and heroin trafficking and related offences after the introduction of injection facilities.

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Other countries’ experiences
SIFs can be established. This is demonstrated by their successful implementation as pragmatic, practical and effective harm reduction strategies in one Australian and many Swiss, German and Dutch cities. SIFs have been instituted in places where high-level public drug scenes existed with typically associated harmful consequences, such as deteriorating health conditions and increasing public nuisances. SIFs now appear to be accepted in those jurisdictions, despite some initial opposition.

Conclusion
In 2003, Canada recognized that SIFs are an important component of a comprehensive harm reduction strategy. Canada’s first government-funded safe injection site opened in Vancouver. The provincial Ministry of Health is supporting the operations costs and the federal Ministry of Health is providing funding to support the scientific evaluation of the three-year pilot research project. After one year of operation, first results are positive. Among other things, a study in the Canadian Medical Association Journal confirms that the Vancouver SIF has resulted in substantial reductions in public disorder related to injection drug use. In this study, the authors compared rates of public drug use, discarded syringes, and drug-related litter before and after the opening of the Vancouver SIF. After considering the influence of police presence and rainfall, the SIF was found to be associated with substantial declines in each of the indicators of public disorder.74

Decriminalization of Small Amounts of Marijuana

Making good on a promise made in December 2002, the Canadian federal government tabled a bill that would decriminalize possession of small amounts of marijuana (up to 15 grams) and cannabis resin (hashish, up to one gram) on 27 May 2003 in the House of Commons. Reports from committees of the Senate and the House of Commons had all recommended this, concluding that treating cannabis possession as a criminal offence has expended enormous judicial resources to little effect and that cannabis is not harmful enough to merit serious legal sanction. Because of elections that took place in Canada in June 2004, the Bill did not proceed, but the new government has made it clear that it will re-introduce it.

The Way Forward

Despite the above-mentioned examples of how Canada’s drug policy has become more pragmatic, many feel that much remains to be done.

In particular, most of the government resources still go towards supply-reduction initiatives that have limited effectiveness, while spending on effective harm reduction measures remains comparatively low. In 2001, a report by Canada’s Auditor General stated that 95 percent of the federal government’s expenditures related to illicit drugs was used for supply-reduction initiatives. A great part of expenditures by the Royal Canadian Mounted Police (RCMP) on illicit drug issues are related to complex and resource-intensive operations aimed at reducing organized crime and the supply of illicit drugs. The available evidence suggests that supply-reduction activities such as those undertaken by the RCMP have little if any impact on illicit drug supplies and community drug-use patterns. For example, one study from Australia found no evidence that heroin seizures affected the price, purity, or perceived availability of heroin. Similarly, analyses conducted by the United Nations Office for Drug Control and Crime Prevention suggest that a maximum of five percent of the global illegal drug flow is seized by law enforcement. For this reason, heroin purity has increased and prices have decreased since the late 1980s, despite massive expenditures on drug interdiction efforts.

Several experts have presented compelling arguments suggesting that the current emphasis on prohibitionist drug laws, and the related practices of enforcement and incarceration, have made the problem of injection drug use and HIV/AIDS worse. It has been well established that a prohibitionist response produces a black market, which results in increased crime, violence, corruption, and harm to individuals who use drugs and to the greater society. The impact of enforcement approaches and incarceration on HIV/AIDS treatment and prevention has been demonstrated empirically. For example, incarceration has been found to be an independent predictor of HIV infection and interruption of antiretroviral treatment. In terms of prevention, a recent study found police intervention to be a barrier to sterile-needle acquisition – a disturbing finding, given that difficulty accessing needles has been found to be independently associated with syringe sharing.

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76 Ibid.
83 E Wood et al. Unsafe injection practices in a cohort of injection drug users in Vancouver: could safer injecting
A further problem relates to the fact that Canada’s drug policy does not adequately address the broad determinants of illicit drug use and the associated harms. It appears there has been little if any coordinated effort to address key determinants of injection drug use such as poverty, homelessness, childhood abuse, and cultural dislocation. Any meaningful change in drug policy will necessarily require simultaneous changes in social policy. Until such action is taken, Canada’s approach to illicit drug use will remain a “band-aid” approach.

In conclusion, while Canada’s drug policy has been on the right path, further considerable changes in policy and law are needed to reduce the harms associated with injection drug use. The federal government will have to recognize that it is no longer acceptable to invest a majority of its resources in supply-control strategies. Acknowledging the limitations of the current prohibitionist approach, the government must focus on promoting public health approaches to dealing with problems of illicit drug use. Among other things, in addition to methadone maintenance treatment programs, needle exchange programs in the community, the trial safe injection facility in Vancouver, and moves towards the decriminalization of the possession of small amounts of marijuana, there is an urgent need for federally funded pilots of programs such as heroin maintenance and prison-based needle exchanges, and a need for additional safe injection facilities. As a further step in the right direction, the government has provided funding to conduct a multi-city trial of heroin maintenance, expected to begin in Vancouver in January 2005. Beyond this, much investment and coordination are needed to address the complex needs of current injection drug users as well as the factors that lead to injection drug use in the first place.

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