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# BEYOND PROHIBITION

COMMUNITY ENGAGEMENT  
ON WORKERS' RIGHTS  
AND ADDRESSING  
THE DRUG TOXICITY CRISIS



**BC Health  
Coalition**



Canadian Drug  
Policy Coalition

Coalition canadienne  
des politiques  
sur les drogues





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The BC Health Coalition (BCHC) acknowledges our office is based on the unceded and stolen territories of the Coast Salish Nations of  $\text{xw}\text{m}\text{\u00e0}\text{k}\text{w}\text{\u00e4}\text{y}\text{\u00e4}\text{m}$  (Musqueam),  $\text{S}\text{k}\text{w}\text{x}\text{w}\text{u}\text{7}\text{m}\text{e}\text{s}\text{h}$  (Squamish), and  $\text{s}\text{\u00e1}\text{l}\text{i}\text{l}\text{w}\text{\u00e9}\text{t}\text{\u00e1}\text{\u00e7}$  (Tsleil-Waututh). We also acknowledge the many territories and lands across so-called British Columbia that our members come from.

We are honoured to be here as guests on this land that Indigenous peoples have cared for and continue to care for. We invite you to take a moment to think about where you presently live and honour the people of the land. Think about your relation to the place you live, work and interact. This is our inquiry to honour the past and present and to stay connected to decolonization practices.

## ABOUT THE BC HEALTH COALITION

We are a democratic, inclusive and consensus-based community of individuals and organizations that span the province of British Columbia. Together we advocate for evidence-based improvements to our public health care system, stimulate public education on health care issues, and drive positive change to our health care system through campaigns across the province.

## ABOUT THE CANADIAN DRUG POLICY COALITION

CDPC is a broad based coalition of citizens and organizations coming together to advocate for evidenced based reform to Canada's punishing drug laws. With members in every part of the country, we collaborate, motivate and activate to see an end to the legacy of suffering, ill health, and death that is the hallmark of Canada's approach to drug use.

## WITH GRATITUDE

We'd like to sincerely appreciate the dozens of our coalition members, allies, and staff in their planning and participation in this dialogue, and the production of this report. A special thanks to Melissa Kendzierski and Drawing Change for the illustrations throughout this report.

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# EXECUTIVE SUMMARY



At the direction of the BCHC Steering Committee in early 2022, a nine-month collaborative process was undertaken with our allies at the Canadian Drug Policy Coalition (CDPC), whose work includes decades of evidence-based research on drug policy, to deeply engage and educate the Health Coalition's membership around drug policy reform.

On October 3<sup>rd</sup>, 2022, this work culminated in nearly 50 members of the BC Health Coalition, including nine Steering Committee members, attending a full-day Drug Policy Dialogue educational event. The participants included provincial and local leadership from labour unions, organizers from locals, member activists, community and non-profit leadership, frontline workers, and People Who Use Drugs (PWUDs).

At the event, participants affirmed BCHC's full solidarity with PWUDs and advocated for evidence-based progressive drug policy in their group discussions.

The participants conveyed that the public view on drug use and drug policy has largely been shaped by narratives of stereotypes and stigma that has had

profound negative impacts on PWUDs, including coercing them into abstinence-based treatment models. Unregulated for-profit treatment centres were identified as particularly problematic, and it was determined that treatment must be premised on the principles of non-coercion, bodily autonomy, and prior informed consent. Participants expressed that a harm reduction framework is a better alternative to criminalized and medicalized models because it addresses the social determinants of health for PWUDs.

Participants also conveyed that criminalization puts marginalized communities at a disadvantage, and that there are a variety of limitations to the current B.C. decriminalization pilot. They identified that it is problematic for the police and other law enforcement to be referring PWUDs to health and social services, and that there should be an increase of resources for community-led programs and services that promote health and human rights.

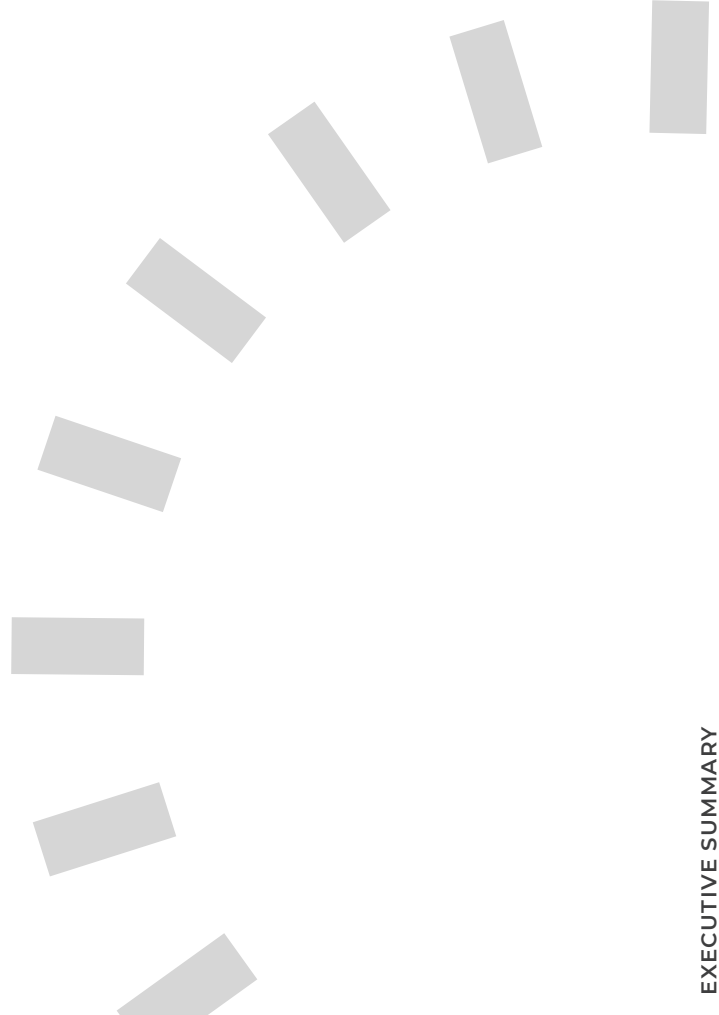
Participants discussed issues specific to workplaces, workplace policies for PWUDs, and all workers. They identified

it was problematic that workers who use drugs face stigma and discrimination in their workplaces as they are often offered only two paths under current collective agreements: take a medical leave or face disciplinary processes. Participants discussed several cases of punitive measures and employer-mandated treatment regimens that are harmful to workers, and that labour unions must support workers more through changes to collective agreement language and lobbying for governmental policy changes.

Participants identified that unregulated drug supply leads to the contamination of drugs and unknown potency and thus overdoses, expressing that mitigating this through legally-regulated access to pharmaceutical-grade drugs is a public health and social justice issue. They discussed various gaps and barriers to safe supply that exist, and that access to safe supply should be expanded through alternatives beyond the medical model. Participants also acknowledged that legal regulation of drugs is a broad term that denotes a wide range of potential regulatory models, which should be developed collaboratively with PWUDs

through community-driven solutions to prevent reproducing the inequalities embedded in medicalized and for-profit models.

A set of Principles and Policies has been derived from these group discussions.



# PRINCIPLES



## **Principle**

Equity, anti-racism, and anti-colonialism – acknowledge and account for the disproportionate and distinct harms experienced by Black, Indigenous, and People of Colour in Canada with respect to health outcomes, drug policy enforcement, and related sanctions.

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## **Principle**

For-profit treatment centres must be regulated and accountable to the provincial government to prevent the creeping privatization of the public health care system, and to ensure treatments are informed by current evidence for best practice delivery models.

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## **Principle**

Treatment must be premised on the principles of non-coercion, bodily autonomy, and prior, informed consent, be completely voluntary, and incorporate culturally appropriate program and service delivery models.

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## **Principle**

Harm reduction is a user-developed and led philosophy of non-judgement and care. Its implementation through specific programs demonstrably improves public health and safety, reduces public costs, and leads to improved mental and physical health outcomes for people who use drugs. It should be integrated into a full continuum of health and social services, including housing and safe supply.

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## **Principle**

Police and other law enforcement must be removed as “gatekeepers” or “liaisons” between PWUDs and health and social services. Any referrals should be non-coercive and culturally appropriate, and referrals should be made by organizations led by people who use(d) drugs and skilled, trained frontline workers.





**Principle**

Employers must be accountable for properly resourcing harm reduction based treatments, including but not limited to safe supply, and other non-coercive approaches that are culturally appropriate to workers who use drugs.

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**Principle**

Harm reduction services must have the robust and emergency-level resources to ensure the safety of all frontline workers, including proper staffing levels, training, and mental health supports.

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**Principle**

Labour unions must support workers who use drugs through changes to collective agreement language that is more binding, includes a modern informed decision-making process, and provides for evidence-based alternatives to the medical or disciplinary approaches.

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**Principle**

Legally-regulated access to pharmaceutical-grade drugs is a public health and social justice issue that would mitigate many drug policy-related harms, including fatal overdose.

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**Principle**

Access to safe supply must be expanded beyond the medical model to include alternatives such as user-led compassion clubs and distribution sites. Government funding to drug user and community groups must be increased in order for them to effectively and sustainably implement these services.

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**Principle**

Legal regulation encompasses a wide range of regulatory models. Frameworks, models, and policies for legal regulation should be developed collaboratively with PWUDs through community-driven solutions to prevent reproducing the inequalities embedded in medicalized and for-profit models.

# POLICIES

- 1.** Increase investment into voluntary, non-coercive, and culturally appropriate harm reduction services, including a full continuum of health and social services that promote the safety and well-being of communities.

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- 2.** Increase emotional and material supports for PWUDs that have been released from prison, or are incarcerated due to conviction for drug-related offences.

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- 3.** Centre the voices of PWUDs and affected communities from diverse backgrounds in the entire legislative reform process, including planning, drafting legislation, implementation, and evaluation.

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- 4.** Fully decriminalize all drug possession for personal use and necessity trafficking by a full repeal of Section 4 and amendments to Section 5 of the Controlled Drugs and Substances Act (CDSA).

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- 5.** Implement automatic expungement of previous convictions for simple drug possession (including for cannabis) and an applications-based expungement process for necessity trafficking, as well as expungement of previous convictions for breaches of police undertakings, bail, probation, or parole conditions associated with charges for these acts.

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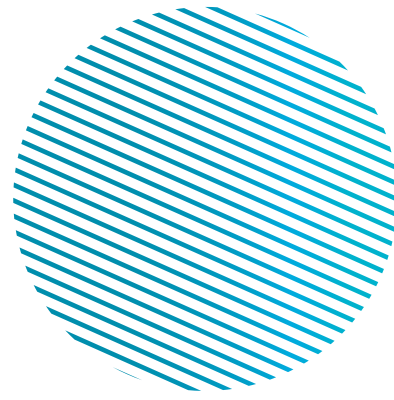
- 6.** Develop clear rules and strict limitations as to when police can stop, search, or investigate an individual for activities that are criminalized under the CDSA.

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- 7.** Develop, implement, and evaluate a comprehensive emergency response strategy to scale up access to safer alternatives to the toxic illegal drug market (safe supply) in partnership with PWUDs and the organizations that represent them.

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- 8.** Implement a single regulatory framework (legal regulation) for all psychoactive substances including alcohol, tobacco, cannabis, and other substances. This framework should aim to minimize the scale of the illegal market, bring stability and predictability to regulated markets for substances, and provide access to safer substances for those at risk of injury or death from toxic illegal substances.



# INTRODUCTION

The B.C. government declared opioid-related deaths a public health emergency on April 14<sup>th</sup>, 2016, but has failed to respond proportionately and effectively. Every day six British Columbians die as a result of the poisoned illicit drug supply. Every community in B.C. is impacted by the crisis, with a disproportionate impact on Indigenous and racialized people, people living in poverty, and people struggling with chronic pain and mental health issues.

As of the writing of this report in November 2022, the B.C. government has attempted to address this crisis by undertaking a limited provincial decriminalization pilot program. This effort has faced criticisms from frontline organizations representing People Who Use Drugs (PWUDs), namely for its cumulative threshold of 2.5 grams of a limited list of drugs for personal possession and the fact that an alternative safe supply to toxic drugs remains inaccessible. The Canadian Drug Policy Coalition (CDPC) describes this effort as a

“piecemeal approach” that leaves people behind (CDPC, 2022). They state:

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*“A cumulative threshold quantity of 2.5 grams leaves many people who use drugs behind, namely those living in rural and remote communities who already bear the disproportionate brunt of drug prohibition and the drug toxicity crisis.”*

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Our current public health emergency relating to toxic drug supplies is profoundly impacting B.C. families, draining valuable health care dollars, and devastating our communities. While this province has been going through multiple public health crises simultaneously, not all crises get equal acknowledgement.

In fact, we acknowledge that the BC Health Coalition has been missing from advocacy in this area or from supporting the advocacy work of organizations that have long been advocating through the



drug toxicity crisis. Part of the challenge has been to mobilize and educate our membership about how this particular public health crisis sits at the intersection of so much of the BCHC's work.

At the BCHC, our role is to bring together a broad cross-section of civil society to fight for public solutions to health care issues. That's why, at the strategic review process at the beginning of 2022, the BCHC Steering Committee identified that a priority for the Coalition's work would be to do internal education with our Coalition members to allow the BCHC to take positions on evidence-based progressive drug policy.

A nine-month collaborative process was undertaken with our allies at the CDPC on this work, as they have decades of evidence-based research on drug policy. As organizations, both the BCHC and the CDPC are committed to seeing evidence-based health care provisions and policies advanced in the province of B.C. Further, as democratic, non-partisan organizations our appeal is broad, and our combined reach is significant.

This process involved working with our Coalition organizational members to organize a full-day Drug Policy Dialogue educational event for their members, with the goal of learning from drug policy advocates and activists from around the province about current drug policy objectives, their reasons, and histories. Participants then engaged in group discussions on topics of drug policy reform, decriminalization, safe supply, harm reduction, and legal regulation, and developed ideas, policies, and objectives that BCHC could adopt and mobilize to enact as first steps.

On October 3<sup>rd</sup>, 2022, this work culminated in the attendance of nearly 50 members of the BC Health Coalition, including 9 Steering Committee members. The participants included provincial and local leadership from labour unions, member activists and organizers from locals, community and non-profit leadership, frontline workers, and People Who Use Drugs (PWUDs). The following coalition organizational members were represented at the dialogue:

- BC Federation of Labour
- BC Federation of Students
- BC General Employees' Union
- Canadian Centre for Policy Alternatives BC
- Community Action Initiative
- Canadian Union of Public Employees BC
- Hospital Employees' Union
- Health Sciences Association
- United Food and Commercial Workers 1518
- Council of Canadians
- Poverty Reduction Coalition

The following report is a summary of the dialogue that took place between these participants. Included in each section is a set of recommendations for principles derived from these group conversations, as well as a set of corresponding evidence-based policies from the extensive work of our allies at CDPC (CDPC 2021, Health Canada Expert Task Force on Substance Use 2021).

Our hope is that non-coalition allies and coalition members alike can use these principles and policies to guide their future advocacy on addressing the drug toxicity crisis.

# HARM REDUCTION

MOVING BEYOND ABSTINENCE  
AND COERCION



Harm reduction at its core acknowledges the risks associated with drug use and reduces the negative consequences of drug use by meeting people where they are at without judgement. Harm reduction is an evidence-based public health approach that is deeply rooted in social justice with the belief that People Who Use Drugs (PWUDs) are human beings who deserve to be treated with safety, compassion, and the utmost dignity and respect. Harm reduction is common sense and stops people from getting injured and dying from things that are preventable. For example, we practice harm reduction in our daily lives, such as wearing sunscreen, driving the speed limit, wearing a seat belt, and using an oven mitt.

When it comes to discussions around drug use and drug policy, coalition members understand that public view has largely been shaped by narratives of stereotypes and stigma. The narratives surrounding drug use are produced in part by prohibitionist policies dating back to the early 1900s and the North American (and indeed worldwide) history of governments, police, and media representation of drug use as inherently “bad” and “immoral”. Central to these narratives are a set of values and assumptions that cause a broad set of harms to drug users, particularly marginalized communities (i.e., visibly racialized, visibly poor), and form the basis of our current approaches to drug policy.



**Principle:** Equity, anti-racism, and anti-colonialism – acknowledge and account for the disproportionate and distinct harms experienced by Black, Indigenous, and People of Colour in Canada with respect to health outcomes, drug policy enforcement, and related sanctions.

Judged through a “criminal lens”, PWUDs are treated with distrust, suspicion, and a lack of care for their personal safety. Additionally, assumptions made around “proper amounts” of drug possession were specifically identified by participants as harmful to those in rural areas and Indigenous communities, where access is often limited. Lastly, a criminalized approach makes no allowance for “necessity trafficking”, which is the sharing or selling of drugs for subsistence, to support personal drug use costs, or to provide a safe supply (CDPC, 2021). Participants identified this as particularly unjust as there is an assumption of an intention of harm on the part of these PWUDs.

Judged through a “medical lens”, PWUDs are treated in a paternalistic manner that undermines their ability to govern their own health care and body. There’s also a distrust and a lack of respect for their autonomy and bodily sovereignty by medical professionals who rely on surveillance measures, such as drug tests to find out someone’s history rather than using dialogue. Participants with frontline health care experience shared that this stigma is furthered through a view that drug use *“is seen as a clear choice that can be snapped out of and is not afforded the same respect from the medical field as other illnesses.”*

In the current climate, abstinence may be expected for PWUDs due to the stigma associated with drug use, along with accompanying socio-political and cultural factors.

# RISKS AND LIMITATIONS TO ABSTINENCE-BASED TREATMENT MODELS

A narrow approach to drug use and treatment or rehabilitation might assume that abstinence-based treatment “cures” people. This “old-school addictions medicine” (Wyton, 2022) approach tends to be rooted in twelve-step dogma that may pathologize the individual without taking into consideration the central impacts of social determinants of health.

Participants identified various risks and limitations involved in abstinence-based treatment models, including lack of access that proved to be a main barrier. They described instances where individuals had to call detox and treatment programs daily to check in, even though they may not have access to a reliable phone plan. Additionally, long wait times for detox and treatment programs result in disappointment and discouragement, as often times the window of “being ready” for help is short.

Another risk identified by participants included the inflexible, one-size-fits-all approach to treatment models. One major safety concern in mandated abstinence-based treatment is that the

risk of overdose following discharge is high due to the unknown potency of drugs in the unregulated illicit market (Ledberg & Reitan, 2022). This risk is particularly relevant in programs that require individuals to attend detox and stabilize prior to treatment, as the gap between stabilization and treatment is a terrible danger zone. Additionally, some people may want to attend treatment for only one drug they are using, such as opioids, however they are required to stop using all drugs to access treatment. Lastly, some treatment centers may not allow folks to take certain types of medications, including methadone, suboxone, benzodiazepines, and safe supply. One participant stated:

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*“The way recovery is run right now is almost like incarceration. It is coercive, not comfortable and safe for people, which is astounding because people are already in discomfort when they are seeking treatment.”*

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# PRIVATE FOR-PROFIT TREATMENT CENTRES

At present, many publicly and privately funded addiction treatment centres are unregulated. There is an urgent need to implement regulatory oversight and a standardized accreditation process for these institutions. Participants noted that because some employers have direct financial agreements with treatment centers, they are incentivized to recommend that employees attend inpatient treatment or engage with outpatient services. This leads to employees being coerced into making deleterious choices about their healthcare to preserve their employment status.

Mandated treatment can lead to significant harms. For example, group members of Workers for Ethical Substance Use Policy (WESUP) reported that workplace policies related to substance use had a detrimental impact on their mental health and led some employees to exiting the workforce involuntarily (OHRN, 2021). Employees were required to attend abstinence-based inpatient treatment and had no choice

as to their treatment goals (OHRN, 2021). They were structurally prohibited from accessing publicly funded programs and were denied other, potentially beneficial treatment options such as harm reduction services, opioid replacement therapy, withdrawal management, or mental health support (OHRN, 2021).

Though abstinence-based treatment centres are regarded as appropriate avenues for care, it is important to recognize that much drug use is episodic or recreational. The central risks associated with drug use are derived from the dangers of acquiring drugs from an unregulated, street-based market and related criminal sanctions.

**Principle:** For-profit treatment centres must be regulated and accountable to the provincial government to prevent the creeping privatization of the public health care system, and to ensure treatments are informed by current evidence for best practice delivery models.





# HUMAN RIGHTS AND PUBLIC HEALTH APPROACHES TO TREATMENT AND “RECOVERY”

“Recovery” is not a linear process and everyone’s journey through recovery is different. When someone enters treatment, regimes must be tailored to the unique desires and circumstances of each person, and will not be successful if imposed coercively. Embedded in the call for non-coercive, user-led approaches to healthcare are the tenets of full, prior informed consent and bodily autonomy. People must be able to choose a regime of care for their bodies and minds that meet their specific needs. As one participant stated:

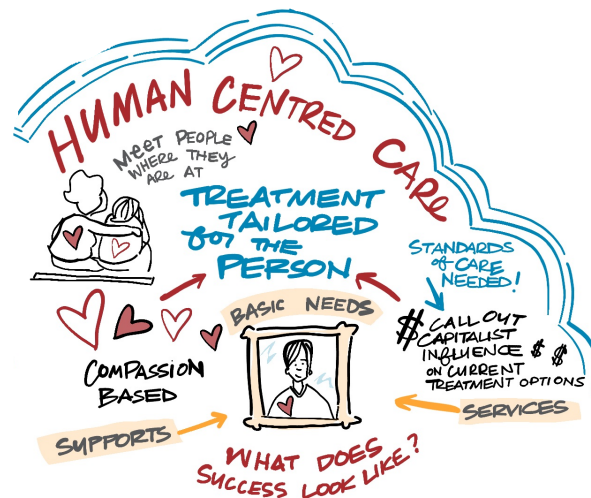
*“Heroin is my medicine. I found it after seeking every approach to well-being I could and having all of them fail. As an adult I can make a decision, I can do the research and find that it does not do that much harm to my body, but we are told that they are bad and drug use is bad.”*

**Principle:** Treatment must be premised on the principles of non-coercion, bodily autonomy, and prior, informed consent, be completely voluntary, and incorporate culturally appropriate program and service delivery models.



Also important is to challenge the narrative that recovery is synonymous with abstinence. While some people may choose to abstain from all alcohol and illegal drug use while in recovery, some people prefer to adopt approaches that prioritize reductions in their drug use and/or safer drug use through harm reduction principles.

Both criminal and individual medical responses to drug use and policy seek to eliminate the use of drugs. Conversely, harm reduction frameworks accept that some people will continue to use drugs and should be provided with the tools



to mitigate risk. This includes people having the autonomy to make decisions about their own life, such as the choice to use drugs, and that decision is respected instead of challenged.

In one study, most PWUDs did not support mandatory treatment, instead emphasizing the need to improve voluntary services and address social determinants of health and illness. (Chau, et al. 2021). Some significant changes that PWUDs identified includes control and autonomy in treatment decisions and goals, peer advocacy in decision-making, and the removal of involvement of police and the criminal justice system in treatment encounters (Chau, et al. 2021).

**Principle:** Harm reduction is a user-developed and led philosophy of non-judgement and care. Its implementation through specific programs demonstrably improves public health and safety, reduces public costs, and leads to improved mental and physical health outcomes for PWUDs. It should be integrated into a full continuum of health and social services, including housing and safe supply.



A proper harm reduction approach means that PWUDs must be meaningfully engaged and consulted in decision-making related to human rights and public health based approaches to treatment and recovery. It means increasing accountability measures for treatment centers and ensuring they are operated based on evidence, as well as addressing and removing punitive measures in existing programs and services.

## HARM REDUCTION POLICIES

1. Increase investment into voluntary, non-coercive, and culturally appropriate harm reduction services, including a full continuum of health and social services that promote the safety and well-being of communities.
2. Increase emotional and material supports for PWUDs that have been released from prison, or are incarcerated due to conviction for drug-related offences. (CDPC, 2021)
3. Centre the voices of PWUDs and affected communities from diverse backgrounds in the entire legislative reform process, including planning, drafting legislation, implementation, and evaluation. (CDPC, 2021)



# DECRIMINALIZATION

## NORMALIZING A JUST FUTURE FOR DRUG USERS

Punitive drug laws and policies have failed, and instead fuelled deadly stigma, violated human rights, and created an epidemic of drug poisoning deaths. Drug prohibition is deeply rooted in colonialism, sexism and racism, and has caused catastrophic harm to individuals, families, and communities, in addition to wasted public funds.

Marginalized communities are at a disadvantage because legal approaches tend to shuffle them into the criminal justice system, whereas more advantageous groups, such as white people in a position of privilege are shuffled into medical trajectory. One participant with a public health background stated:

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*“If we’re still in a system of many inequalities like poverty [and] racism, then we will see the same things play out in other aspects of our healthcare system.”*

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Another participant discussed the long-term impacts of criminalization. They stated:

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*“So if we have a recreational or episodic user of drugs, and their drugs are seized and [they] get a criminal charge, then they will have a criminal record [and be] excluded from [the] legal job market, [resulting in] economic insecurity, alienation, loss of housing, relationships, etc.”*

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# LIMITATIONS TO THE B.C. DECRIMINALIZATION PILOT

The main limitation to the provincial pilot is that **decriminalization does not address the lethal drug supply**, so PWUDs will continue to die at unprecedented rates. Decriminalization is only available to adults aged 18 and over and completely disregards one's right to bodily autonomy. Participants argued that purchasing and selling drugs is a consensual agreement between both parties, and that the state should not interfere with this process. PWUDs should be able to choose what they consume and be in control of their own bodies if it is not impacting other people around them. One participant noted:

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*“If [decriminalization is] not meeting people where they need to be met, it causes many issues and is already not providing the support needed at that base level.”*

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Another drawback identified by participants to the provincial pilot involves the **low threshold amounts**. The 2.5-gram cumulative threshold is not evidence-based and there will be many unintended negative consequences for marginalized groups of people. The low threshold can be particularly challenging for folks who travel for work and are not always in the city to obtain a sufficient supply to be okay and maintain stability. In contrast, focusing solely on the threshold amount of 2.5 grams prevents expanding conversations about decriminalization.

Currently there is no distinction between legal definitions of possession for personal use vs. trafficking (i.e., amount limits). This is because different people may have the need for different amounts of drugs in their possession. There is a concern that the limit of 2.5 grams will become a threshold for police to use as a definition between amounts for personal use vs. trafficking.

Participants identified that the presence of police at the table advocating for increased funding for police is problematic. Police are providing resources and referrals when interacting with PWUDs, but those people do not want to engage with the police. This is an inappropriate role for police and serves to inflate their budgets, while simultaneously minimizing community services. There needs to be dialogue about increasing budgets and resources for community organizations and health services, in addition to improving access to relevant services in rural areas that are extremely under-resourced.

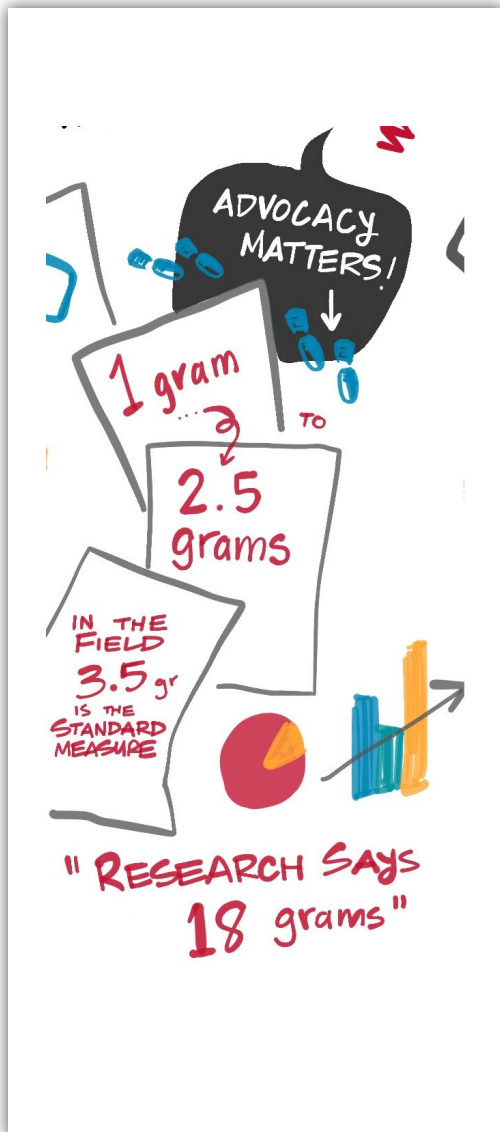
**Principle:** Police and other law enforcement must be removed as “gatekeepers” or “liaisons” between PWUDs and health and social services. Any referrals should be non-coercive and culturally appropriate, and referrals should be made by organizations led by people who use(d) drugs and skilled, trained frontline workers.



# WAYS TO STRENGTHEN THE PROVINCIAL DECRIMINALIZATION POLICY

To strengthen the provincial decriminalization policy, participants advised that there must be meaningful consultation with PWUDs, including listening to their knowledge and expertise, specifically VANDU's request for an 18-gram threshold, rather than police's advocacy to have a dismally low 1-gram threshold.

Participants identified strengthening mental health supports and community services by increasing funding as a main way to improve the provincial decriminalization policy, which aligns with the *Decriminalization Done Right: A Rights-Based Path for Drug Policy* platform. This platform strongly encourages the redistribution of resources from enforcement of harmful drug laws to protect and promote health and equity (CDPC, 2021). Resources should be reinvested into community-led programs and services that promote health and human rights, including healthcare, overdose prevention, housing, harm reduction, education, safe supply, mental health, social services, and food security (CDPC, 2021).





Participants also discussed having open conversations about decriminalization to combat stigma and discrimination against PWUDs as a way to reinforce the provincial decriminalization policy. This

includes public education and committed enforcement of human rights legislation and the Canadian Charter of Rights and Freedom (CDPC, 2021).

## DECRIMINALIZATION POLICIES

1. Fully decriminalize all drug possession for personal use and necessity trafficking by a full repeal of Section 4 and amendments to Section 5 of the Controlled Drugs and Substances Act (CDSA). (CDPC, 2021)

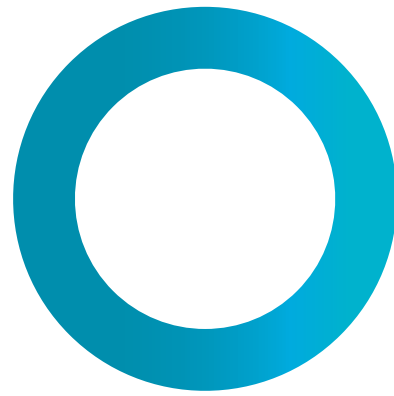
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2. Implement automatic expungement of previous convictions for simple drug possession (including for cannabis) and an applications-based expungement process for necessity trafficking, as well as expungement of previous convictions for breaches of police undertakings, bail, probation, or parole conditions associated with charges for these acts. (CDPC, 2021)

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3. Develop clear rules and strict limitations as to when police can stop, search, or investigate an individual for activities that are criminalized under the CDSA. (CDPC, 2021)





# NO DRUG WAR ON THE SHOP FLOOR

Drug decriminalization should impact workplace policies. Employers tend to view drug use as something to be punished and shamed for, even though they may play a contributing factor to why an employee may resort to drugs as a coping mechanism for oppressive conditions, such as long hours and non-union environments.

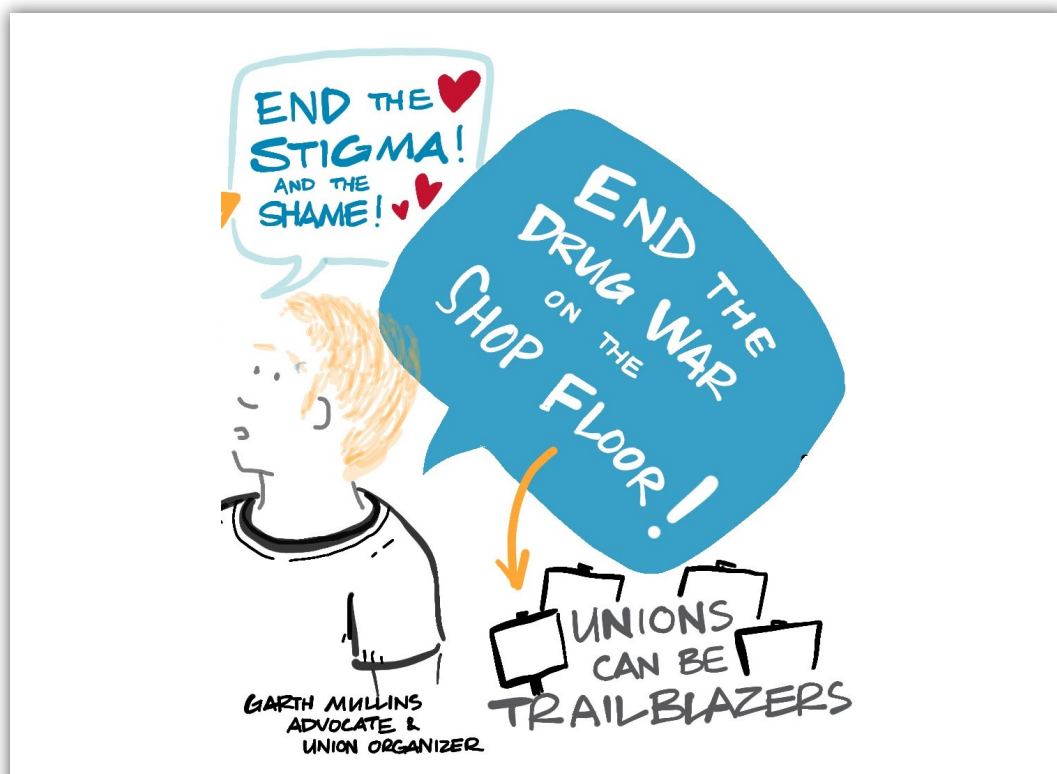
In the workplace, the implications might be that an employee can return to work after completing an abstinence-based treatment program, which assumes that an abstinent worker is a better worker. However, drug users are not necessarily

impaired when using drugs, and using drugs should not mean a person cannot work. One participant shared the following example:

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*“An employee might come to work with a case of beer to go to a party after work. Having a case of beer at work is not normally an issue, so why should that be any different if an employee brings drugs to use when they leave work?”*

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# HARMFUL PRACTICES IN THE WORKPLACE

Participants identified several cases of punitive measures being taken in the workplace that they had observed. In instances involving “Safety-Sensitive Positions”, the classifications in these positions are ultimately used as a weapon where employees are terminated if an incident occurs due to zero tolerance policies for drug use. In other cases, “Last Chance Agreements” are served to employees where they are given one last chance to do their job, with failure resulting in termination. This old policy and practice is stigmatizing and prevents empathetic employers in providing adequate support to their employees.

Participants also noted that peer support employees who are hired for their lived and/or living experience often get reprimanded for drug use, which sets them up for failure at their place of employment. This goes against employee rights and collective agreement rights because employees should be protected like they would be for any other illness. For instance, if someone sustains a physical injury such as a cut on their foot, they would be provided with crutches and accommodations, whereas with drug use the employee is stigmatized.

Employer-mandated treatment regimens may include mandatory urinalysis or other drug/alcohol testing, which impacts workers’ rights, and workplace health and safety. This is an approach used in the federal system of drug treatment courts, which has been criticized as intrusive, coercive, ineffective, and a form of surveillance (CDPC, 2021). It involves

employees paying for the drug test at their own cost and loss of work time to travel to the nearest drug testing site. Drug/alcohol testing can detect substances that were used up to a month ago and does not tell the employer if someone is actively using at work or how impaired they may or may not be.

Participants also identified concerns about mandated treatment being a perceived solution because this type of healthcare is not evidence-based and impacts workers’ rights, workplace health, and safety. Studies show that mandatory treatment for employees to retain their jobs does not work and results in more deaths. For example, in Sweden, a study followed people for six months after discharge from mandatory treatment. The results demonstrated that the risk of dying immediately after completing treatment is very high, particularly for young people (Ledberg & Reitan, 2022). Also, the risk of death is much higher in men vs. women and rises with age (Ledberg & Reitan, 2022). These findings indicate that mandatory treatment is ineffective and treatment options should align with evidence-based measures to prevent further loss of life due to the drug poisoning crisis.

Giving people agency over the path they will take is important. Treatment plans should involve employees in the decision-making process and take into account what is going to work best for them. For instance, if an employee is seeking help with substance use by accessing evidence-based treatment, including



safe supply or compassion clubs, then employers should not force the employee to take an abstinence-based route. The decision should be left to the discretion of the employee.

The systems currently available do not allow people to make their own informed decisions regarding treatment, opting for coerciveness instead. For example, employer-tied healthcare benefits, which may offer a limited choice of treatment options for employees, could create conditions of shame for those seeking treatment, and result in them seeking alternatives in the street-based market instead. Additionally, under the current medicalized approach at workplaces, there is a lack of empathy and adequate support for employees who still need help after discharge from treatment facilities and/or upon returning to work after a sick leave related to drug use, which puts people at higher risk for overdose if they do relapse.

people in their direct communities. A big gap identified was the lack of mental health support for workers who are dealing with drug toxicity deaths in their work and communities. In some cases, workers are only given a mental health phone line as a form of support from their employers.

**Principle:** Harm reduction services must have the robust and emergency-level resources to ensure the safety of all frontline workers, including proper staffing levels, training, and mental health supports.



**Principle:** Employers must be accountable for properly resourcing harm reduction based treatments, including but not limited to safe supply, and other non-coercive approaches that are culturally appropriate to workers who use drugs.

Lastly, participants also suggested that under-resourced harm reduction approaches in the workplace actually lead to harms for all the workers involved. Frontline workers identified being short-staffed and overworked, as well as lacking comprehensive trainings to support the

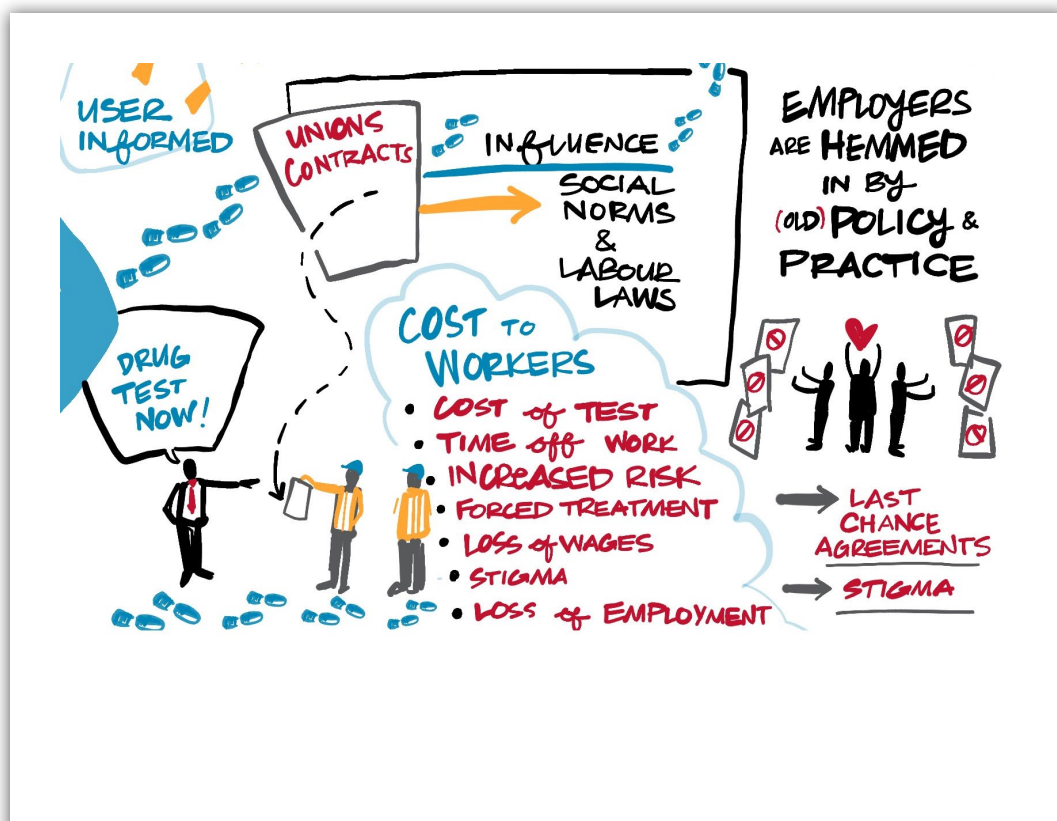
# A THIRD WAY NEEDED

When drug use emerges in the workplace, workers who use drugs are often offered only two paths under collective agreements: take a medical leave or face disciplinary processes. This reflects predominantly constrained ways of thinking about drug policy in terms of solely medicalized or criminalized terms. Drug use does not necessarily fit under these two pathways, and there needs to be another option.

Political will and influence from the labour movement, in tandem to solidarity with community groups like drug user movements, can facilitate impactful

change to collective agreements. Participants acknowledged that union contracts have historically been used to influence social norms and labour laws, such as the introduction of parental leave laws that were fought for by unions. As one participant stated:

*“Overdose fatalities is a working class issue in Canada and the labour movement must be at the front and centre of this.”*





Unions can support workers who use drugs and do a lot more through changing the language in collective agreements to be more binding, protect workers who use drugs, and include a modern informed decision-making process around drug policy at work. This should ideally be achieved through negotiating collective agreement language that supersedes other regulations of laws that have an impact on the workplace.

Participants conveyed that labour unions need to think about how the provincial decriminalization policy will impact the workplace and how to educate themselves as union leaders and workers. Unions should also lobby for labour standards to be changed, so employees are not discriminated against or criminalized because of their drug use and cannot lose their jobs for using drugs.

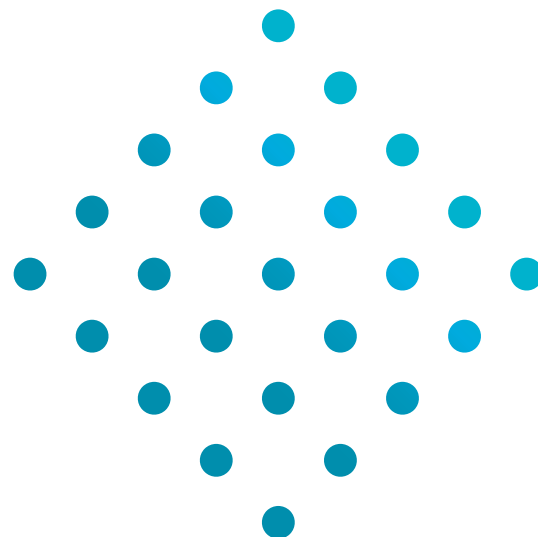
For effective changes to happen, lawyers, PWUDs, and employees who are directly impacted by these policies must draft contract language for evidence-based alternatives that are not based on assumptions, stereotypes, and stigma.

**Principle:** Labour unions must support workers who use drugs through changes to collective agreement language that is more binding, includes a modern informed decision-making process, and provides for evidence-based alternatives to the medical or disciplinary approaches.



# SAFE SUPPLY

## THINKING BEYOND PROHIBITION



The cascading consequences of drug prohibition, which include but are not limited to criminal sanctions, social exclusion, difficulty acquiring and maintaining formal employment and housing, and stigma, can contribute to chaotic or compulsive patterns of drug use. In these and other ways, the criminalized status of drug use exacerbates the likelihood of addiction. Decriminalization would reduce interactions with courts, police and jails, as well as child apprehensions and termination of employment.

The unregulated illicit drug supply leads to contamination of drugs and unknown potency and thus overdoses as people are uncertain of what's in their drugs or how strong they are. Accessible safe supply would very quickly end the phenomena of mass overdose deaths.

Prohibitionist drug policy instills assumptions that all use of currently illicit drugs carries the signifier of

'addict'. Community-led safe supply advocates for choice-making around people's relationships with drugs such as drug options, dosages, methods of access, and in extension, increased options and access to supports for holistic well-being. As one participant noted:

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*“With legal drugs, [we] would have more of a capacity to choose for ourselves whether our relationship with drugs is considered addiction and needs intervention, or not.”*

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**Principle:** Legally-regulated access to pharmaceutical-grade drugs is a public health and social justice issue that would mitigate many drug policy-related harms, including fatal overdose.



# GAPS AND BARRIERS TO SAFE SUPPLY

Participants noted that current legislation, such as section 56 of the CDSA, limits safe supply procurement through medical models, where some drugs are accepted while others are not based on stigma. Approaches that rely solely on a medical model can create barriers, such as rigid protocols, limited number of prescribers, stigma associated with drug use, and may not meet everyone's needs.

Under this model, there is a limited number of prescribers compared to the number of people who need a safer supply and prescribers may prescribe a limited dosage or not have the drug options needed. Insufficient drug options and dosages can mean that people still need to rely on an unregulated drug market in order to maintain daily stability and prevent from feeling sick. Rigid protocols, such as surveillance and punitive measures (i.e. urine screening), punish these people and can result in unreliable and inconsistent access to a safer supply for them.

Additionally, accessibility of medicalized safe supply falls short for people living in rural communities where they may have an even greater shortage of prescribers compared to urban areas, as well as limited access to social and healthcare services. Lastly, accessibility is limited for people who work 9-5 jobs and can't pick up prescriptions outside their work hours.

Participants identified a wide array of environments in which there are policy gaps and barriers to the implementation of safe supply. Within the child welfare system, parents who access a medicalized safe supply fear being reported to child welfare. People who are in detox or treatment facilities may not be able to take a safe supply of drugs while admitted to these services. Further, gaps exist with emergency shelters which may not be willing or able to securely store certain types of safe supply medications. Generally, participants noted the lack of political will and urgency from all levels of government to address the toxic drug supply.



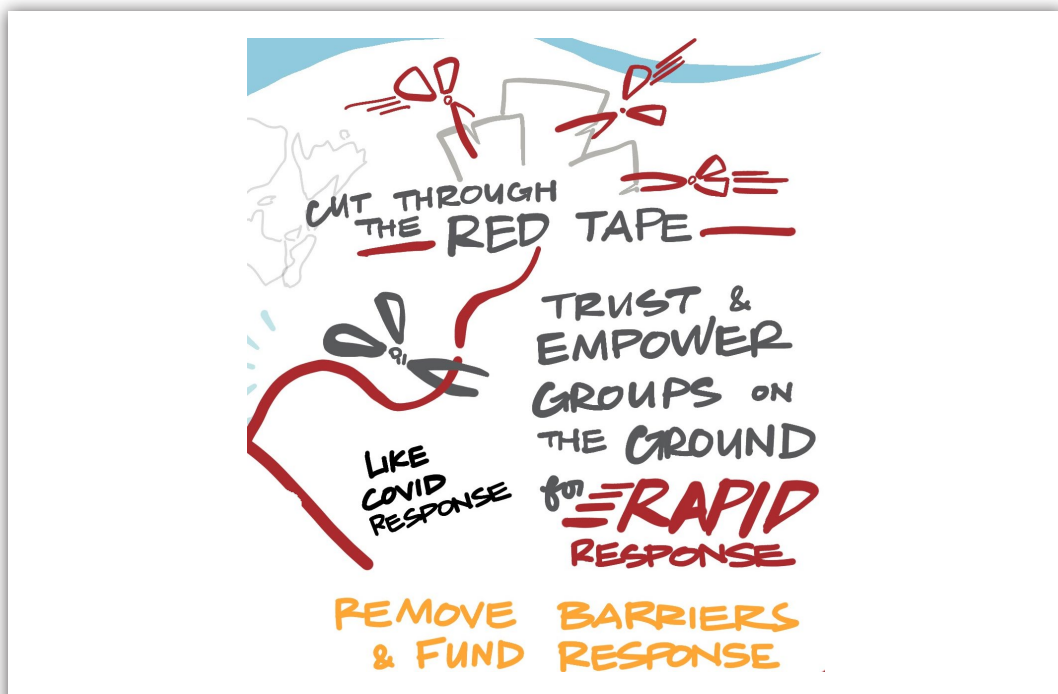
# WAYS TO IMPROVE ACCESS TO SAFE SUPPLY

Access to safe supply can be improved by removing geographic, organizational and governmental policy barriers for people who need this service. Participants noted that the government can enact emergency legislation given the severity of the crisis in ways that they have seen being done to fight the spread of COVID-19. There is a need to address and remove punitive measures embedded within restrictive medicalized safe supply models. This can include improving accessibility by having safe supply available 24 hours a day in the pharmacy and increasing the range of professionals that can prescribe safe supply (i.e. nurses).

Importantly, improvements to access must expand to include safe supply models beyond a medical model, such as compassion clubs and safe supply clinics that offer wrap-around support, including peer patient navigator, outreach worker,

and assistance with transportation. This will require increased funding for drug user groups and other community groups who are best placed to effectively implement these harm reduction services. Safe supply must also expand beyond urban centers and include rural communities.

**Principle:** Access to safe supply must be expanded beyond the medical model to include alternatives such as user-led compassion clubs and distribution sites. Government funding to drug user and community groups must be increased in order for them to effectively and sustainably implement these services.



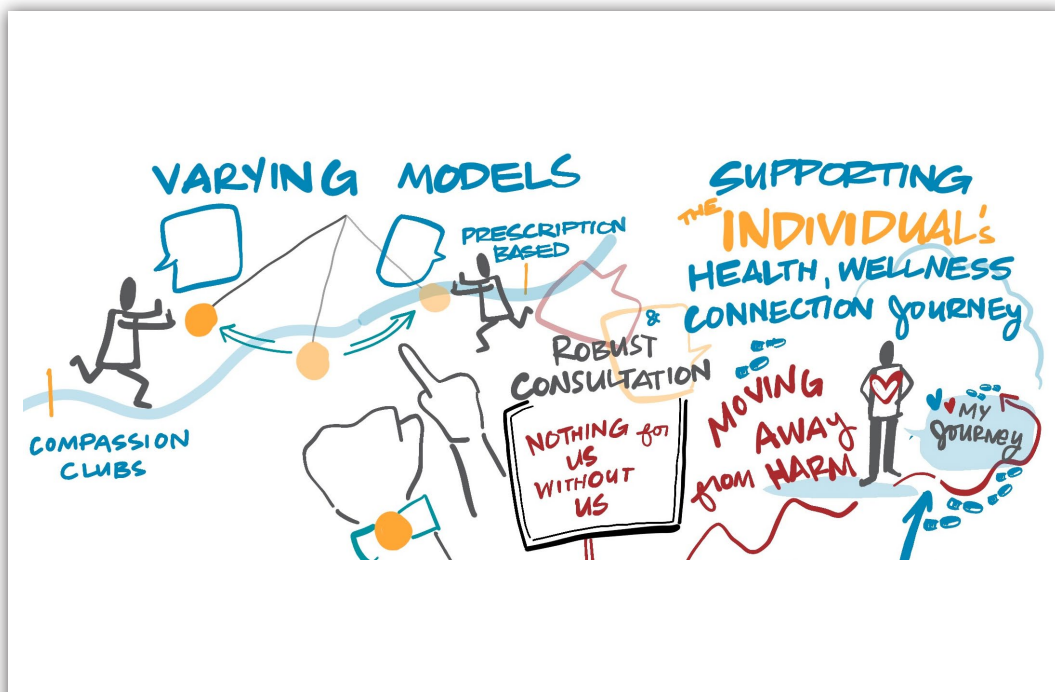


# LEGAL REGULATION

Participants acknowledged that legal regulation is a broad term that denotes a wide range of potential regulatory models. For example, while safe supply in its current form is legally regulated, its efficacy is limited by the rigidity through which it is made available to consumers. Participants discussed the benefits and drawbacks of less restrictive regulatory models, including user-owned and operated compassion clubs. Community driven models developed collaboratively with PWUDs could reduce many of the barriers to entry that exist with medicalized safe supply. One participant described accessible safe supply as:

*“...where someone can go and have agency to ask for what they know they need and be given it in a non-judgemental way and it would be safe.”*

Participants expressed that legal regulation is a public health and social justice issue, and discussed models for a legally regulated drug market through a consumer protection lens, drawing parallels to the ways in which alcohol, cannabis, and tobacco are legalized and how these consumer goods are protected against contamination. However, participants acknowledged the limitations and drawbacks of a consumer model playing out within the cannabis industry where for-profit monopolies have formed, inflating prices and making it inaccessible for people.





**Principle:** Legal regulation encompasses a wide range of regulatory models. Frameworks, models, and policies for legal regulation should be developed collaboratively with PWUDs through community-driven solutions to prevent reproducing the inequalities embedded in medicalized and for-profit models.

It's necessary to centre and listen to the perspectives of PWUDs at decision and policy making tables, and further acknowledge the emotional labour involved with sharing their personal stories. Additionally, framing the issue as a drug poisoning crisis can further reduce the stigma as the illegal drug supply can affect anyone, including first time, recreational, and seasoned users.

## SAFE SUPPLY POLICIES

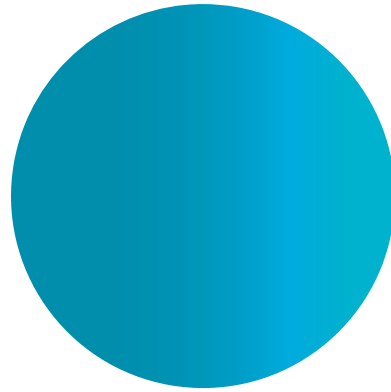
- 1.** Develop, implement, and evaluate a comprehensive emergency response strategy to scale up access to safer alternatives to the toxic illegal drug market (safe supply) in partnership with PWUDs and the organizations that represent them.

(Health Canada Expert Task Force on Substance Use, 2021)

- 2.** Implement a single regulatory framework (legal regulation) for all psychoactive substances including alcohol, tobacco, cannabis, and other substances. This framework should aim to minimize the scale of the illegal market, bring stability and predictability to regulated markets for substances, and provide access to safer substances for those at risk of injury or death from toxic illegal substances.

(Health Canada Expert Task Force on Substance Use, 2021)





# CONCLUSION

Through this collaborative process with our partner, Canadian Drug Policy Coalition, our members were able to deeply engage with and collectively build our capacity to support evidence-based drug policy reform. Discussions centred around the need for harm reduction to move beyond abstinence and coercion to a human rights and public health approach to treatment and recovery. Participants further discussed normalizing a just future for drug users and ways to strengthen decriminalization policy.

Thinking beyond prohibition to legal regulation, participants explored user-led alternatives and affirmed the need to centre people with lived experiences in decision making tables to address the toxic drug supply.

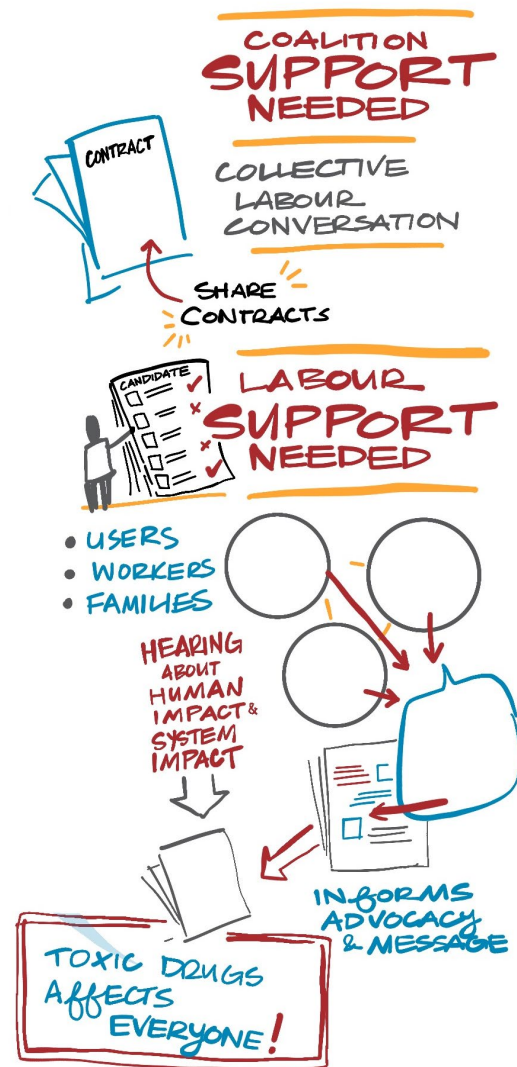
To collectively tackle this public health crisis and address harmful practices in the workplace, participants expressed the need to take the conversations during this dialogue back to their workplaces and organizations.



*“In the now, we have to be willing to take these conversations back to our workplace [and] to start informing our members and employers about this.”*

To protect workers in the toxic drug crisis, a third way beyond solely medicalized or criminalized approaches is critical.

The principles and policies borne out of these conversations serve as a pathway to mobilize and engage our membership in this public health care crisis that sits at the intersection of so much of BCHC’s work, including primary care reform and public solutions to improving our health care system.



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The logo for BC Health Coalition, with 'BC' in red and 'Health Coalition' in black.

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