Decriminalization in BC: S.56(1) Exemption

Request for an exemption to Health Canada from the *Controlled Drugs and Substances Act* (CDSA) pursuant to Section 56(1) to decriminalize personal possession of illicit substances in the Province of British Columbia

October 2021

Acknowledgements

BRITISH COLUMBIA | Ministry of Mental Health and Addictions

We acknowledge with respect that the work we do throughout B.C. takes place on the traditional lands of Indigenous peoples. The Ministry of Mental Health and Addictions is deeply committed to true and lasting reconciliation with Indigenous peoples in B.C.

This submission was drafted by the BC Ministry of Mental Health and Addictions with input from the Ministry of Public Safety and Solicitor General, Ministry of Health, Ministry of Children and Family Development, Ministry of the Attorney General, and the Office of the Provincial Health Officer, as well as our external partners that came together to form the Decriminalization Core Planning Table (CPT).

We would like to express our gratitude for the contributions of CPT members who shared their time, experiences, expertise, and data with us, engaging enthusiastically and in good faith even when perspectives diverged. The recommendations put forth in this submission may not always represent the views of all members. Member organizations include:

BC Association of Aboriginal Friendship Centres
BC Association of Chiefs of Police
BC Centre for Disease Control
BC Centre on Substance Use
BC First Nations Justice Council
BC/Yukon Association of Drug War Survivors
City of Kamloops
City of Vancouver
First Nations Health Authority
Métis Nation BC
PIVOT Legal Society
RCMP "E" Division
Rural Empowered Drug Users Network
Society for Narcotic and Opioid Wellness
SOLID Victoria
Union of BC Municipalities
Vancouver Area Network of Drug Users
Vancouver Police Department

This submission was also informed by conversations with additional organizations and experts, including health authorities, the Canadian Mental Health Association (CMHA-BC), Moms Stop the Harm (MSTH), the Canadian Drug Policy Coalition, the South Asian Mental Health Alliance (SAMHAA), the Rainbow Heath Cooperative, the Support Network for Indigenous Women and Women of Colour (SNIWWOC), and others.

TABLE OF CONTENTS

1 INTRODUCTION

Since 2016, British Columbia has been under a public health emergency. This emergency is arising out of unprecedented numbers of illicit drug poisoning deaths, primarily due to increasing toxicity and unpredictability of the illicit drug supply with increasing concentrations of fentanyl and its analogues. The emergency has been exacerbated by the COVID-19 pandemic, which has significantly impacted social determinants of health, reduced access to harm reduction and treatment services, incentivized the manufacturing of more potent street drugs as a result of international supply disruptions, and driven people at risk of a fatal or non-fatal illicit drug toxicity poisoning to use drugs alone in dangerous situations.

BC has taken action to address the illicit drug poisoning crisis, including rapid scale-up and implementation of life-saving initiatives such as the Take-Home Naloxone program, access to medication-assisted treatments and prescribed safer supply, and expanded supervised consumption, overdose prevention, and harm reduction services and improvements in treatment and recovery. While these initiatives have saved lives and underscore the widely accepted notion that substance use should be approached as a public health issue, they are undermined by the continued criminalization of illicit substance use under Canada's *Controlled Drugs and Substances Act* (CDSA). Criminalization of simple possession remains a significant impediment to BC's ability to implement a comprehensive public health response to the illicit drug poisoning crisis.

This submission is intended to start an iterative dialogue with Health Canada regarding how BC's approach to decriminalization can satisfy the expectations of both governments, leading to the granting of a s.56(1) exemption.

To meaningfully address the illicit drug poisoning crisis, including the widespread stigma that can lead people who use drugs (PWUD) to avoid life-saving health services and use alone, the Premier's 2020 Mandate Letter to Minister Sheila Malcolmson directs the Ministry of Mental Health and Addictions (MMHA) to work with the Ministry of Public Safety and Solicitor General and the Ministry of Attorney General to pursue the decriminalization of personal possession of illicit substances in BC.

Public support for the decriminalization of personal possession of illicit substances is strong, with 66 percent of British Columbians in favour of the move, according to a February 2021 poll conducted by the Angus Reid Institute.[1] This represents the highest level of support for decriminalization of any Canadian province. There have also been calls for decriminalization from the Canadian Association of Chiefs of Police,[2] the Health Officers Council of BC, BC's

[1] https://angusreid.org/opioid-crisis-covid/

[2] https://www.cacp.ca/index.html?asst_id=2189

Provincial Health Officer, several BC municipalities, Health Canada's own Expert Task Force on Substance Use,[3] the First Nations Health Authority,[4] and a variety of organizations representing people with lived experience of substance use.

With this widespread support **BC is formally asking the federal Minister of Health, in consultation with the federal Minister of Mental Health and Addictions to exercise their authority under Section 56(1) of the CDSA to exempt all persons in British Columbia 19 years of age or older from the application of Section 4(1) on the condition that the amount of any controlled substance in their possession does not exceed the thresholds for "personal possession" set out in a Schedule.** This Schedule would be based on evidence of personal use patterns. This submission includes BC's recommendations for a personal use Schedule for opioids (including heroin and fentanyl), crack and powder cocaine, and methamphetamine.

BC submits that this proposed exemption meets the test under s.56(1). It is necessary for a medical purpose, namely combatting the public health emergency of drug poisoning deaths. In addition to saving lives, this proposed exemption is in the public interest to mitigate the harms to PWUD (i.e., unnecessary involvement in the criminal justice system) and to society of the attendant costs, harms, and reduced effectiveness of public health interventions. It also reflects the *Charter* values at stake in a proportionate way.

This document describes the overarching principles, objectives, and other key details of BC's proposed decriminalization framework. This submission represents the culmination of intensive stakeholder and partner engagement, which will continue into the implementation planning and post-implementation phases. **This submission is intended to support ongoing dialogue with Health Canada regarding how BC's approach to decriminalization can satisfy the expectations of both governments, leading to the granting of a s.56(1) exemption.** It is recognized that details of the proposed framework may change as a result of these future discussions.

2 Background and Rationale

Since the declaration of the public health emergency in April of 2016, over 7,700 British Columbians have died from illicit drug poisoning. Numbers of fatal illicit drug poisoning initially peaked at 1,549 in 2018, at an average of 4.2 deaths per day. Following a 36 percent decrease in illicit drug poisoning deaths between 2018 and 2019 (984, for an average of 2.7 deaths per

[3] Health Canada. Expert Task Force on Substance Use. (2021). Recommendations on the Federal Government's Drug Policy as Articulated in a Draft Canadian Drugs and Substances Strategy (CDSS). https://www.canada.ca/en/health-canada/corporate/about-health-canada/public-engagement/external-advisory-bodies /expert-task-force-substance-use/reports/report-2-2021.html#a3

[4] https://www.fnha.ca/Documents/FNHA-harm-reduction-policy-statement.pdf

day), deaths reached a new high in 2020, with 1,733 deaths, or 4.7 per day – an increase that the BC Centre for Disease Control (BCCDC) linked, in part, to the ongoing COVID-19 public health emergency.[5] Deaths have continued to climb in 2021 with 1,204 suspected illicit drug toxicity deaths in the first seven months and are on track to exceed the previous annual high.[6] Illicit drug poisoning is now the leading cause of death amongst British Columbians aged 19 to 39—people in the prime of their lives. For men, the toxic drug crisis has been so severe that overall life expectancy at birth for males has declined in recent years in BC.[7]

The BC Coroners Service reports that this year has seen an increase in deaths in which extreme fentanyl concentrations were present.[8] Regional Health Authorities, overdose prevention service providers, and researchers[9] also continue to issue alerts and raise concerns regarding increased presence of benzodiazepines in the illicit drug supply, which is causing severe and complex drug toxicity presentations. While no British Columbians have died of illicit drug poisoning at overdose prevention or safe consumption sites, the scientific and medical literature[10,11,12] supports what we have been told by PWUD, namely that drug law enforcement pushes PWUD to deliberately avoid these kinds of lifesaving services. Criminalization and stigma lead many to hide their use from family and friends and to avoid seeking treatment, thereby creating situations where the risk of drug poisoning death is elevated. The BC Coroners Service reports that between 2018 and June 2021, most illicit drug toxicity deaths occurred in private residences (55.7 percent) or other residences, such as social housing sites or shelters (26.3 percent), where residents are more likely to use alone.

---

[5] http://www.bccdc.ca/resource-gallery/Documents/Statistics%20and%20Research/Statistics%20and%20Reports/Overdose/2021.04.16_Infographic_OD%20Dashboard.pdf

[6] https://www2.gov.bc.ca/assets/gov/birth-adoption-death-marriage-and-divorce/deaths/coroners-service/statistical/illicit-drug.pdf

[7] The Daily — Life tables, 2016/2018 (statcan.gc.ca)

[8] https://www2.gov.bc.ca/assets/gov/birth-adoption-death-marriage-and-divorce/deaths/coroners-service/statistical/illicit-drug.pdf

[9] Laing, M. K., Ti, L., Marmel, A., Tobias, S., Shapiro, A. M., Laing, R., Lysyshyn, M., & Socías, M. E. (2021). An outbreak of novel psychoactive substance benzodiazepines in the unregulated drug supply: Preliminary results from a community drug checking program using point-of-care and confirmatory methods. International Journal of Drug Policy, 93, 103169. https://doi.org/10.1016/j.drugpo.2021.103169

[10] Kerr, T., Small, W., & Wood, E. (2005). The public health and social impacts of drug market enforcement: A review of the evidence. *International Journal of Drug Policy*, 16(4), 210–220. https://doi.org/10.1016/j.drugpo.2005.04.005

[11] Collins, et al. (2019). Policing space in the overdose crisis: a rapid ethnographic study of the impact of law enforcement practices on the effectiveness of overdose prevention sites. *Journal of International Drug Policy, 73*, 199-207.

[12] Small, W., Kerr, T., Charette, J., Schechter, M.T., and Spittal, P.M. (2006). Impacts of intensified police activity on injection drug users: Evidence from an ethnographic investigation. *International Journal of Drug Policy*, 17(*2*), 85-95.

This data indicates that, while the purpose of the *Controlled Drugs and Substances Act* is to protect public health, it is in fact undermining it by contributing to the conditions that make fatal and non-fatal illicit drug poisonings more likely. An exemption to enable decriminalization within BC is necessary and warranted in order to disrupt these conditions, as it meets the s.56(1) criteria of serving a medical purpose and being in the public interest. It is supported by scientific research and it will directly support BC's response to the illicit drug poisoning crisis, which will ultimately save lives.

2.1 Substance Use and Criminalization Harms

Before discussing the harms associated with substance use, it is necessary to acknowledge that substance use occurs on a continuum, ranging from beneficial to harmful. Some people experience minimal health-related harms from substance use. However, the harms caused by criminalization of substance use affect many, regardless of whether their substance use is beneficial, neutral, or problematic for their health. For those whose substance use could be characterized as problematic, criminalization is an ineffective deterrent and serves to compound harms.[13] Dr. Bonnie Henry, BC's Provincial Health Officer, highlights this in her 2019 report, *Stopping the Harm: Decriminalization of People Who Use Drugs in BC*:

> If the intention of a prohibition-based system was to protect individuals from harms inherent to substance use, then this policy approach has significantly failed to achieve this goal at an individual or population level. Evidence shows that this approach has had the opposite effect and has substantially increased harms.[14]

In terms of quantifiable economic harms, the Canadian Centre for Substance Use and Addiction[15] has estimated that licit and illicit substance use in BC costs over $6.6 billion per year:

- $1.9 billion in costs to the health care system (e.g., hospitalizations and emergency room visits);
- $3.1 billion in lost economic productivity;
- $1.2 billion in costs from the criminal justice system (e.g., policing and court system); and

[13] Ibid.
[14] Henry, B. (2019). "Stopping the Harm: Decriminalization of People Who Use Drugs in BC." Office of the Provincial Health Officer. Retrieved from https://www2.gov.bc.ca/assets/gov/health/about-bc-s-health-care-system/office-of-the-provincial-health-officer/reports-publications/special-reports/stopping-the-harm-report.pdf.
[15] https://www.ccsa.ca/canadian-substance-use-costs-and-harms Canadian Substance Use Costs and Harms, 2015-2017

- $483 million in other direct costs (e.g., property crime).[16]

These costs include the increased healthcare expenses and lost economic productivity experienced by people with acquired brain injury due to drug poisoning events. Although the diagnosis of neurological injury and associated long-term impairment is complex and population prevalence is challenging to measure, recent research conducted by the BCCDC found a high occurrence of such injuries in the Provincial Overdose Cohort.[17] The long-term impacts of acquired brain injury are varied, and can include physical and cognitive impairments, diminished motor skills, and significant behavioural changes—all of which can pose significant challenges for individuals, their families, and provincial health and social services.[18]

Harms associated with substance use are exacerbated by criminalization and the stigma faced by individuals who use substances. In some cases, substance use can lead to social harms such as job loss, housing insecurity, loss of driver's license, and/or damaged interpersonal relationships. In other cases, these harms may be primarily caused by the issuance of criminal penalties for substance use, and the related structural stigma that individuals who use substances face. Many people who use substances also face stigma and discrimination in interactions with the healthcare system, leading to a lack of trust in health care services and providers, and poorer health outcomes.[19] Even in the absence of criminal charges or penalties, fear of drug seizure prevents people from accessing life-saving services, from calling police when in unsafe situations, and from calling emergency services during overdose events.

In addition to the harms caused by criminalization, there is also evidence that it does little to deter illicit substance use. According to a study of injection drug users in Vancouver by Werb et al (2008), the majority of individuals whose drugs were seized by law enforcement purchased a replacement supply within 10 minutes.[20]

Beyond the harms experienced by people who are criminalized for substance use, there are also major impacts on those around them, including family members, friends, and dependents.

---

[16] This includes both licit and illicit substances. Provincial data is not available broken down by substance.

[17] http://www.bccdc.ca/Health-Professionals-Site/Documents/Harm-Reduction-Reports/Neurological%20Injury_ODC_2020_01_03.pdf

[18] https://www.canada.ca/en/health-canada/services/opioids/opioid-related-hospitalizations-anoxic-brain-injury.html

[19] Public Health Agency of Canada. (2019). "Addressing Stigma: Towards a More Inclusive Health System: The Chief Public Health Officer's Report on the State of Public Health in Canada 2019." Retrieved from https://www.canada.ca/content/dam/phac-aspc/documents/corporate/publications/chief-public-health-officer-reports-state-public-health-canada/addressing-stigma-what-we-heard/stigma-eng.pdf.

[20] Werb, D., Wood, E., Small, W., Strathdee, S., Li, K., Montaner, J., and Kerr, T. (2008). "Effects of police confiscation of illicit drugs and syringes among injection drug users in Vancouver. *International Journal of Drug Policy,* 19(4), p. 332-338.

These harms include social, emotional, relational, and financial impacts when an individual who uses substances is fined, arrested, charged, incarcerated, and/or loses their job. It is also felt by children who come to be involved with the child welfare system because of a parent or guardian's substance use.

MMHA urges Health Canada and the federal Ministers of Health and Mental Health and Addictions to consider these harms in the context of the *Charter* rights of PWUD in our province. Under Section 7 of the *Charter,* everyone has a right to life, liberty, and security of the person and a right not to be deprived thereof except in accordance with the principles of fundamental justice. One fundamental implication of this is that criminal laws with the purpose of promoting public health and safety should not unintentionally make the risk of death–or serious mental or physical harm—worse. Section 15(1) guarantees equality, including without discrimination based on mental or physical disability. While the illicit drug poisoning crisis affects all PWUD, people with substance use disorders–a recognized disability–are disproportionately affected. All levels of government therefore have an obligation to minimize the mortality and morbidity risks of their policies and to not exacerbate any pre-existing inequities. This decriminalization framework strikes a careful and proportionate balance between those rights—particularly under sections 7 and 15—and the primary purposes of the *CDSA*: to preserve and protect public health and safety.

2.2 Addressing Inequities

Indigenous Peoples come from resilient communities with strong traditional wellness practices. However, due to the ongoing impacts of colonization and racism and healthcare inequities, Indigenous Peoples in BC are over-represented among those experiencing substance use related harms and criminalization. In 2020, First Nations people died of illicit drug poisoning at 5.3 times the rate of other BC residents.[21] First Nations women are disproportionately represented among illicit drug toxicity deaths, dying at 9.9 times the rate of other women in BC in 2020.[22]

Indigenous Peoples are also over-represented in the criminal justice system. In 2017/2018, Indigenous adults accounted for 35 percent of admissions to adult custody, while representing only approximately six percent of the Canadian adult population.[23] Indigenous women accounted for 42 percent of all women admitted to custody. During the same period, Indigenous youth (aged 12-17) made up 43 percent of admissions to correctional services in

[21] https://www.fnha.ca/AboutSite/NewsAndEventsSite/NewsSite/Documents/FNHA-First-Nations-in-BC-and-the-Toxic-Drug-Crisis-January-December-2020-Infographic.pdf
[22] Ibid.
[23] https://www.justice.gc.ca/eng/rp-pr/jr/gladue/p2.html

nine reporting jurisdictions, while representing only about eight percent of the Canadian youth population.

Current federal drug laws pertaining to simple possession also create significant and disproportionate harms for Black communities, evident in high rates of police stops, arrests, and incarceration for drug use or suspected drug use. In 2010-11, nine percent of the Canadian federal prison inmate population was Black, even though Black people account for just 2.5 percent of Canada's overall population.[24] In 2014, 12 percent of prisoners incarcerated for *drug-related* crimes in Canadian prisons were Black,[25] an inequity stemming in part from racialized enforcement of the CDSA. Other marginalized communities also experience additional and intersecting harms related to illicit substance use. This has been documented within the LGBTQ2S+ community, particularly for trans women and men who have sex with men.[26,27] Negative outcomes are amplified for individuals experiencing multiple axes of marginalization, such as People of Colour who also identify as LGBTQ2S+.

2.3 Decriminalization to Enable a Public Health Response

In 2019, the Government of BC launched *A Pathway to Hope: A roadmap for making mental health and addictions care better for people in British Columbia.*[28] The roadmap lays out a 10-year vision and three-year action plan for mental health and addictions, with an emphasis on supporting well-being, addressing problems early on, and transforming care for children, youth, and young adults. Initiatives in the three-year action plan include promoting early childhood social emotional development, expanding services for youth and young adults, and Indigenous-led mental health and wellness initiatives as part of the *Memorandum of Understanding: Tripartite Partnership to Improve Mental Health and Wellness Services*. Other cross-government initiatives that address root causes of substance use and support prevention of mental health and substance use problems include a poverty reduction strategy, affordable childcare, and housing affordability plans.

---

[24] Wortley, S., & Owusu-Bempah, A. (2011). The usual suspects: police stop and search practices in Canada. Policing and Society, 21(4), 395-407.

[25] Solomon, E. (2017, April 4th). "A Bad Trip: Legalizing pot is about race," *Maclean's*, http://www.macleans.ca/politics/ottawa/a-bad-trip-legalizing-pot-is-about-race/.

[26] Fendrich, M., Mackesy-Amiti, M. E., & Johnson, T. P. (2008). Validity of self-reported substance use in MSM: Comparisons with a general population sample. *Annals of Epidemiology, 18*(10), 752-759. doi:10.1016/j.annepidem.2008.06.001

[27] Hughes, T. L., & Eliason, M. (2002). Substance use and abuse in lesbian, gay, bisexual and transgender populations. *The Journal of Primary Prevention, 22*(3), 263-298. doi:10.1023/A:1013669705086

[28] Government of BC. (2019. A Pathway to Hope. https://www2.gov.bc.ca/assets/gov/british-columbians-our-governments/initiatives-plans-strategies/mental-health-and-addictions-strategy/bcmentalhealthroadmap_2019web-5.pdf

The Province has developed a comprehensive approach to responding to the illicit drug poisoning crisis, led by MMHA's Overdose Emergency Response Centre (OERC). BC's emergency response includes a comprehensive package of essential evidence-based supports and services, including the Take-Home Naloxone program, overdose prevention and supervised consumption services, drug checking services, opioid agonist treatment and prescribed safer supply, acute overdose risk case management, and enhancements to the treatment and recovery system of care[29]. According to modelling conducted by the BCCDC, BC's harm reduction services averted more than 6,100 deaths between 2016 and 2020 – a number which has almost certainly increased since, with new healthcare initiatives coming on board.

Ultimately, the goal of each component of the comprehensive package for responding to the illicit drug poisoning crisis is to prevent illicit drug toxicity-related events and deaths and to improve health and social outcomes for PWUD. One of the biggest impediments to maximizing the benefits of these interventions is the stigma and criminalization that PWUD continue to experience. As noted previously, stigma and criminalization prevent people from accessing critical health and social services and impacts social determinants of health like employment, income security, and housing.

Despite attempts at de facto decriminalization in municipalities such as Vancouver, as well as the BC Solicitor General's request that police adopt a harm reduction approach to simple possession, the application of such policies is inconsistent and many PWUD continue to be criminalized for personal possession. Between 2008-2017, there were 49,891 criminal drug possession charges in BC. [30] There is wide variation between regions in BC when it comes to drug arrests. For example, in 2018 the rate of drug arrests in Kelowna was roughly twice that of Vancouver.[31] In addition, some measures of criminalization have increased in recent years. RCMP data shows a 49% increase in total drug seizures between 2018 and 2020, with small quantities (below thresholds proposed by City of Vancouver in their 2021 section 56(1) exemption request) making up the majority of the additional seizures.[32]

To better ensure that all British Columbians who use substances can access health and social services without fear of criminalization, and that drug laws are applied evenly and equitably in a way that maximizes positive public health outcomes, a province-wide approach to

[29]See the full list of comprehensive interventions and details of the OERC structure at: https://www2.gov.bc.ca/assets/gov/overdose-awareness/bg_overdose_emergency_response_centre_1dec17_final.pdf

[30] BC Ministry of Public Safety and Solicitor General. British Columbia crime trends, 2008 - 2017. Victoria, BC. Available from: https://www2.gov.bc.ca/assets/gov/law-crime-and-justice/criminal-justice/police/publications/statistics/bc_crime_trends_2008-2017.pdf

[31] Boyd, S. (2018). *Drug Arrests in Canada, 2017*. Report prepared for the Vancouver Area Network of Drug Users.

[32] RCMP "E" Division Criminal Operations Core Policing. (2021). *Illicit Street and Pharmaceutical Drug Occurrences & Total Drug Possession Charges "E" Division (20118-2020).*

decriminalization is needed. That is why the Province is requesting a section 56(1) exemption from the federal *CDSA* to decriminalize personal possession of small amounts of illicit substances. Not only would a section 56(1) exemption allow the Province to better align its response to the illicit drug poisoning crisis with a public health approach, but it would also enable police to improve the nature of interactions between law enforcement and PWUD and emphasize other public safety priorities, like violence, property crime, drug trafficking, and organized crime.

2.4 Decriminalization in the Context of Public Safety

Saving and improving the lives of PWUD remains the overarching goal of BC's response to the illicit drug poisoning crisis. It is within this context that we are pursuing decriminalization of personal possession of illicit substances. Complementary to this goal, the Province remains committed to ensuring the safety of the entire public and combatting serious drug-related crimes remain priorities. As such, the BC Minister of Public Safety and Solicitor General has received a mandate to "work with police to address serious crime in BC communities, including cracking down on those who distribute toxic drugs."[33]

The Canadian Association of Chiefs of Police has emphasized the need to prioritize public safety alongside public health, noting in its report recommending decriminalization that police must continue to fight organized crime and disrupt the illicit drug supply into communities through enforcement of laws pertaining to the trafficking, production, and importation of illicit substances. This would require continued enforcement activities related to these more serious drug-related crimes alongside moves to decriminalize personal possession.

While decriminalization would allow police to shift resources away from enforcement of laws pertaining to simple possession and toward more serious crime such as trafficking and importation of illicit substances, it is anticipated that, in many cases, frontline law enforcement officers would continue to interact with people in possession of personal amounts of drugs at times. We recognize that for many PWUD, interactions with police have the potential to perpetuate trauma. Within this context, decriminalization offers an opportunity to improve interactions and build trust between police and PWUD.

3 British Columbia's Approach

MMHA established a collaborative process to develop a comprehensive framework for decriminalization in BC. Consultation with key partners and stakeholders has informed all

[33] https://www2.gov.bc.ca/assets/gov/government/ministries-organizations/premier-cabinet-mlas/minister-letter/farnworth_mandate_2020_mar_pssg.pdf

components of the framework, including key principles, implementation and evaluation planning, risk identification and mitigation, and public education, training, and communications.

3.1 Partners and Stakeholders

MMHA has undertaken engagement in a variety of ways to inform all elements of the full s.56(1) exemption request, including through a cross-government Project Team, a Core Planning Table made up of key stakeholders, and focused engagement with Indigenous partners and other impacted groups.

3.1.1 Cross-Government Project Team

MMHA has convened a Project Team inclusive of leadership staff from the Ministries of Health, Public Safety and Solicitor General, Attorney General, and Children and Family Development, as well as the Office of the Provincial Health Officer. Project Team members have been working with MMHA to ensure BC's approach to decriminalization is supported by and reflects the perspectives of all relevant arms of government and public health.

3.1.2 Core Planning Table

MMHA established a Decriminalization Core Planning Table (CPT) to support the development of the policy framework that serves the basis of BC's s.56(1) exemption request. Participating members represent a variety of partners and stakeholders.[34] Feedback from members was generated through professionally facilitated workshops on key topic areas, discussion at regular CPT meetings, surveys, and one-on-one conversations. Participants were provided with materials in advance of meetings to help facilitate focused discussions on iterations of s.56(1) exemption application drafts.

3.1.3 Indigenous Partners and Leaders

MMHA is taking a distinctions-based approach to engaging with Indigenous partners and leaders in BC, seeking input from both First Nations and Métis leadership based on their preferred methods and tables of engagement. In addition to the inclusion of representatives from the First Nations Health Authority, Métis Nation BC, BC Association of Aboriginal Friendship Centres, and the BC First Nations Justice Council on the CPT, MMHA has engaged with governance organizations to seek input on the framework and guidance on how they would like to be involved moving forward. MMHA is also committed to undertaking further engagement to determine how or if the s.56(1) exemption could or would be applied to First Nations reserves in BC, or whether individual First Nations could choose to opt out of implementing decriminalization on reserve lands.

[34] See appendix A for a more detailed list of organizations represented at the Core Planning Table.

3.1.4 Additional Engagement

Focused engagement has also been undertaken to generate feedback from additional stakeholders not represented at the CPT or Project Team. This has included discussions on key decriminalization policy issues with a variety of stakeholders, such as:

- Regional Health Authorities and other health and social service providers;
- Law enforcement and justice sector partners;
- Municipal governments;
- People with lived and living experience and family/caregiver groups; and
- Advocacy organizations, including drug policy advocacy organizations and organizations representing racialized communities in BC.

3.2 PRINCIPLES

The following principles have been developed and endorsed by CPT members to guide the development of BC's decriminalization framework.

1. **Do No More Harm:** Drug prohibition creates significant harms for PWUD and broader society, contributing to institutionalized stigma and discrimination, overdose deaths, communicable disease, violence, incarceration, and barriers to effective health and harm reductions services. The provincial decriminalization framework should seek to reduce harms caused through its policies and programs.
2. **Choice and Autonomy**: The provincial decriminalization framework must ensure that PWUD be treated with dignity and respect, including when interacting with the criminal justice and healthcare systems. To this end, the framework should support PWUD to define their own personal goals when it comes to their health and ensure that information is provided to support PWUD to access timely health and social support.
3. **Trauma-Informed and Person-Centred:** Many PWUD have experienced trauma and violence. The provincial decriminalization framework must ensure that alternatives to criminalization (e.g., referrals to health and social services) are trauma-informed and person-centred.
4. **Anti-Racism:** Recognizing that drug prohibition has disproportionately harmful impacts on racialized people, including Indigenous Peoples, the development of a framework for decriminalization should take an anti-racist approach, creating conditions of greater inclusion, equity, and justice.
5. **Reconciliation and Decolonization**: BC's approach to decriminalization should also be informed by the understanding that colonialism is inherent in the province's criminal justice

system, thus the framework must be designed in a way that removes the unique and disproportionate impacts of drug prohibition on Indigenous Peoples.

6. **Cultural Safety**: BC's decriminalization framework should ensure that alternatives to criminalization are culturally safe and do not reproduce trauma, racism, or discrimination.
7. **Equal Voice:** Recognizing that pre-existing power imbalances exist, BC's decriminalization framework must consider the perspectives of all voices equally.
8. **Value Lived Experience:** The provincial decriminalization framework must reflect ongoing engagement with PWUD throughout policy development, implementation, monitoring, and evaluation.
9. **Public Health and Health Equity (including Gender-based Analysis +)**: Our work must seek to understand and address social inequities and social determinants of health faced by diverse populations of PWUD and take into consideration how varying identity factors such as gender, race, ethnicity, age, and disability may impact how people experience policies and initiatives related to decriminalization.
10. **Public Safety**: The provincial decriminalization framework must recognize law enforcement's role in protecting society by combatting organized crime and disrupting the supply of illegal substances into BC communities through enforcement of laws pertaining to the trafficking, production, and importation of illicit substances.
11. **Comprehensiveness**: BC's framework for decriminalization should provide protection and benefits for as many PWUD as possible, in a variety of contexts and situations. This includes recognizing the community and social contexts of drug use, and that not all PWUD require or desire treatment interventions.

4 A Framework for Decriminalization in BC

This full s.56(1) exemption request builds upon a previous outline submitted to Health Canada by providing additional details regarding the proposed approach to decriminalization in BC. MMHA has worked with partners inside and outside of government to ensure that this submission comprehensively addresses the key components flagged for inclusion by Health Canada. This submission is intended to form the basis for ongoing dialogue with Health Canada, wherein revisions and/or additions may be made to satisfy the requirements and expectations of both the Province of BC and the federal government.

4.1 Goals and Objectives

The overarching goal of British Columbia's decriminalization framework is the decriminalization of personal possession of small amounts of illicit substances in BC. Criminalization and associated stigmatization for substance use have a significant and negative impact on the social environment and wellbeing of people who use drugs by contributing to self-stigma, social isolation, lack of economic opportunity, reduced access to health and social services, and societal exclusion, all leading to increased vulnerability to substance use harms including illicit drug toxicity-related poisoning events and deaths. As part of a comprehensive strategy to save lives, this framework and policy seeks to address criminalization as a social determinant of health, reducing harms caused by criminalization and removing structural barriers to support for people who use drugs and who are at high risk of drug poisoning death.

Decriminalization is expected to support the following long-term objectives:

- Reduce illicit drug poisoning events and deaths;
- Reduce barriers to accessing health services experienced by PWUD;
- Reduce structural and societal stigma;
- Reduce health, social, and economic harms associated with the criminalization of substance use;
- Reduce PWUD reliance on toxic illicit drugs, and increase access to health and social services, including safer supply;
- Increase engagement and retention in treatment and support services for people with substance use disorders;
- Improve interactions between law enforcement and PWUD;
- Increase PWUD trust in law enforcement and criminal justice system;
- Improve ability of law enforcement and criminal justice system to prioritize serious crime; and
- Increase socio-emotional well-being of PWUD.

Measurable progress towards outcomes above is unlikely to be achieved through decriminalization alone. Progress also relies on other complementary system change initiatives, such as expanding and improving health and social services to support PWUD and addressing other social determinants of health such as poverty, housing, and systemic racism.

Shorter term objectives include:

- Increase PWUD awareness of and comfort with accessing health and social services;
- Increase voluntary and appropriate connections between PWUD and health and social services;
- Increase public awareness of decriminalization and its role in reducing stigma;

- Increase public understanding of substance use as a public health issue;
- Increase law enforcement awareness and understanding of decriminalization policy and health and social services;
- Improve interactions between law enforcement and PWUD regarding personal possession of illicit substances, including providing law enforcement with information to support PWUD to access health and social services;
- Reduce seizures, arrests, charges, penalties, and criminal records for simple possession;
- Decrease existing racial disparities in enforcement of federal law regarding simple possession; and
- Reduce police and court time and resources spent on enforcement or prosecution of personal possession.

Measurable progress on these objectives is expected within 1-5 years of implementation.

Appendix B contains a logic model summarizing the key inputs, outputs, and intended outcomes of BC's decriminalization framework. This model will continue to be refined through engagement with stakeholders, including research and evaluation experts, and PWUD.

4.2 Eligibility

At this time, BC's decriminalization framework will apply to adults at the provincial age of majority (19 years and older) within the geographic boundaries of British Columbia. Further work will address how decriminalization could be applied appropriately for youth and young adults aged 12 to 18. BC recognizes that youth are vulnerable to substance use-related harms and is committed to developing an evidence-based and equitable approach to addressing the needs of youth within its decriminalization framework. It is also necessary to undertake appropriate steps to reconcile the potential inclusion of youth with existing federal and provincial legislation and regulations governing youth justice. Any approach to addressing youth substance use within a provincial decriminalization framework will be developed with the participation of youth with lived and living experience and designed to ensure that any penalties for youth possession are no more punitive than those for adults.

MMHA will also continue to work with First Nations, Indigenous partners, and governance organizations to determine how decriminalization could apply on individual First Nations reserves.

4.3 Defining Personal Possession

Section 4(1) of the *CDSA* makes it an offence to possess a controlled substance. A charge under s.4(1) is often referred to as "simple possession" in contrast to a charge of possession for the purposes of trafficking under s.5(2) of the *CDSA.* The *CDSA* does not have a concept of

"personal possession", which is what BC is asking the federal Ministers of Health and Mental Health and Addictions to decriminalize.

In order to decriminalize personal possession, it is necessary to first define it. In BC's decriminalization framework, the exemption will only apply if the quantity of the substance possessed qualifies as an amount for "personal use". Those amounts will be set out as specified quantities in a Schedule. The definition will also provide PWUD clarity regarding criteria under which the exemption applies to them. A robust public education campaign will support dissemination of clear public-facing messages regarding the exemption.

MMHA has worked closely with the CPT to determine an approach to defining personal possession. This includes examining much of the available evidence on substance use and personal possession patterns in BC and exploring options for a discretionary model or a model of binding thresholds based on available data regarding personal use patterns. A dedicated workshop was held with the CPT to review available evidence and discuss options for defining personal possession, followed by a focused discussion regarding proposed threshold amounts. While CPT members did not come to complete consensus on a recommendation for defining personal possession, BC recommends binding thresholds.

4.3.1 Considerations

Guided by the overarching framework principles identified in section 4.2, the CPT identified several key considerations for defining personal possession. The following questions were developed to help determine options.

- Is the model clear and easy to communicate to PWUD, police, and the public?
- How do we account for people who use larger amounts (e.g., those with severe substance use disorders)?
- How do we account for people who use more than one type of illicit substance?
- People often purchase or use substances within a social context, such as purchasing on behalf of or to share with friends and/or family. This usually occurs without intent for profit. How do we account for "social supply" within the definition of personal possession?
- What guidance do law enforcement need to limit discretion?
- Individuals who live in or travel to rural areas, where illicit drugs may not be as readily available, may routinely purchase larger amounts of drugs that are intended as a multi-day supply. How can a definition of personal possession account for regional variation and multi-day supply?
- How do we ensure the proposal meets the needs of Indigenous Peoples, People of Colour, and people of low socio-economic status (e.g., unhoused people)?

- In what cases will people still be arrested? In what cases will people have their drugs seized?

Three approaches to defining personal possession were considered and discussed with the CPT, based on a review of approaches in other jurisdictions and careful consideration of strengths and limitations of possible options within this s.56(1) exemption:

- Indicative Threshold: A flexible, suggested threshold range of an illicit substance that an individual can possess for personal use. This option would allow for some discretion and consideration of individual circumstances by law enforcement.
- Binding Threshold: A firm threshold indicating the maximum amount of an illicit substance than an individual can possess for personal use. Discretion could still be exercised by law enforcement for those in possession above thresholds (i.e., it does not automatically indicate a charge such as trafficking). In this definition, binding thresholds should be considered a floor, not a ceiling.
- No Thresholds: No recommendations on what constitutes a "personal amount" of a substance. This allows for maximum law enforcement discretion.

Based on the principles and considerations identified above, most CPT members indicated a preference for binding thresholds, assuming threshold levels accommodate for current patterns of possession and consumption. Binding threshold floors also offer the advantage of having the greatest ease of communication to PWUD, law enforcement and members of the public. This option also limits police discretion below the threshold, thereby reducing the likelihood of biased and discriminatory application of the exemption, while still allowing for consideration of unique circumstances for people in possession above the threshold. Although MMHA considered the option of pursuing an exemption without established thresholds, it was determined that such a model would provide too much discretion and likely fail to achieve desired short- and long-term objectives.

4.3.2 Data and Evidence

For thresholds to be effective, they must be set to reflect actual patterns of use and possession. Otherwise, many PWUD will continue to possess amounts over the threshold limit and remain at risk of criminalization. Thresholds that are too low have been found to be ineffective and diminish progress overall on the objectives of decriminalization. For example, in Mexico, because binding thresholds were set extremely low, rates of drug-related arrests and criminal proceedings have continued to rise,[35] as have the numbers of people charged with trafficking.[36] Russia has also set low thresholds that, combined with a punitive enforcement culture, have

[35] Talking Drugs. Drug Decriminalization Across the World.
[36] Office of the Provincial Health Officer, pg. 26

resulted in a lack of real drug policy reform. Conversely, setting thresholds too high may impede law enforcement's ability to conduct trafficking investigations.[37]

To help inform the potential development of threshold levels for decriminalization, researchers (DeBeck., et al) developed a methodology for estimating drug consumption volumes based on self-reported data from existing research studies of PWUD in Vancouver.[38] Due to study limitations, including measurement limitations and the timeframe of data (current to 2018 only), the researchers emphasize that the estimates produced from this methodology are conservative and expected to underestimate the current volumes of drug consumption. They are also focused on only a few classes of drugs (i.e., opioids and stimulants), and thus do not provide guidance on other substances, such as psychedelics.

Estimated Volume of Drugs Consumed and Projections for Multiday Supply Scenarios

Substance		Estimated Volume of Drugs Consumed per Day	3 Day Supply	5 Day Supply	10 Day Supply
Opioids*	Median	**0.33 g**	0.98 g	1.63 g	3.25 g
	Upper Quartile	**0.65 g**	1.95 g	3.25 g	6.50 g
	Max	**4.39 g**	13.16 g	21.94 g	43.88 g
Cocaine	Median	**0.50 g**	1.50 g	2.50 g	5.00 g
	Upper Quartile	**1.06 g**	3.19 g	5.31 g	10.63 g
	Max	**4.75 g**	14.25 g	23.75 g	47.50 g
Crack cocaine	Median	**2 rocks****	6 rocks**	10 rocks**	20 rocks**
	Upper Quartile	**4 rocks**	12 rocks	20 rocks	40 rocks
	Max	**75 rocks**	225 rocks	375 rocks	750 rocks
Amphetamine	Median	**0.21 g**	0.63 g	1.05 g	2.10 g
	Upper Quartile	**0.45 g**	1.35 g	2.25 g	4.50 g
	Max	**6.45 g**	19.35 g	32.25 g	64.50 g

*Opioids = heroin, fentanyl, and other powder street opioids; ** 1 rock = one point, 0.1 g

Figure 1: DeBeck et al estimated drug consumption volumes

In addition to the research conducted by DeBeck et al., in early 2021 the Vancouver Area Network of Drug Users (VANDU) partnered with a local researcher to conduct a rapid survey of PWUD to generate additional information regarding daily use and purchasing patterns. VANDU recommended threshold amounts based on average daily purchase amounts and 90-95 percent coverage (respondents not vulnerable to arrest for possession under these thresholds).[39] It

[37] Canadian Association of Chiefs of Police (CACP). Decriminalization for Simple Possession of Illicit Drugs: Exploring Impacts on Public Safety and Policing. Special Purpose Committee on the Decriminalization of Illicit Drugs. (2020). https://www.cacp.ca/index.html?asst_id=2189

[38] DeBeck, K., et al. Methodology to Estimate Drug Consumption Volumes to Inform Threshold Determinations (September 2021) [Powerpoint Slides].

[39] VANDU. VANDU Decrim Study Results (May 2021) [PowerPoint Slides].

should be noted that the VANDU survey did not address polysubstance use or cumulative possession and purchasing patterns. While other regional drug user groups and researchers are interested in surveying PWUD in their communities on local purchasing and consumption patterns, current data reflects PWUD in Vancouver only. Consultation with provincial stakeholders suggests that PWUD outside of the Vancouver (particularly those living in rural or remote parts of BC) are likely to purchase and carry a multi-day supply for personal use due to limited local availability of drugs for purchase, transportation issues, and in some cases higher income and ability to purchase more supply at a given time.

Drugs	Use quantities per day (average – max range)	Purchase quantities at one time (average-max range)	**Recommended thresholds: 95% Coverage**	**Recommended thresholds: 90% coverage**
Fentanyl	0.75 - 5.0g	0.5-3.5g	10.00	4.50
Heroin	0.40 - 3.5g	0.5-3.5g	5.00	3.25
Cocaine	0.61 – 7.0g	0.5-2.0g	6.00	4.00
Crack	1.0 -14.0g	0.5-3.5g	6.00	4.00
Methamph -etamine	0.5 -7.0g	0.5-3.0g	28.00	10.00

Figure 2: VANDU estimated drug consumption and purchase volumes

The Vancouver Police Department (VPD) has published data provided in response to a Freedom of Information (FOI) request on drug seizures from May 2019 to June 2020.[40] This data includes drug type and quantity seized by the VPD over the period. [41] For the purposes of this submission, the RCMP "E" Division has also provided a report to the BC Government on drug seizure occurrences, quantities, and charges for possession from 2018 to 2020. [42] This data provides additional context for drug quantities commonly held and seized by police in BC.

MMHA has also consulted with clinical experts to inform the development of appropriate thresholds. Addictions medicine physicians around the province have observed that tolerance levels have increased in recent years due to higher concentrations of illicit fentanyl, leading to higher consumption quantities, particularly for opioids. Although use varies widely, consumption for people with substance use disorders can be as high as 3.5g/day.

[40] Vancouver Police Department. Records Access Request. (July, 2020). https://vpd.ca/wp-content/uploads/2021/06/seized-illicit-substances-may-17-2019-to-june-9-20.pdf

[41] MMHA team is grateful to researcher Dr. Geoff Bardwell for translating the seizure data from a PDF to a workable spreadsheet, and to Erica McAdam, a graduate student at Simon Fraser University for sharing her analysis of seizure quantities against varying threshold levels.

[42] RCMP "E" Division Criminal Operations Core Policing. (2021). *Illicit Street and Pharmaceutical Drug Occurrences & Total Drug Possession Charges "E" Division (20118-2020).*

4.3.3 Recommendation

Based on the available data and extensive consultation, ***BC seeks to establish a cumulative binding threshold quantity at 4.5g, with no drug seizures, arrests, or charges for simple possession at or below this amount*.** Phase one of BC's exemption request seeks to set a threshold for those substances most commonly involved in illicit drug poisoning deaths; however, MMHA is committed to working with Health Canada and CPT stakeholders to develop appropriate thresholds for other illicit substances (e.g., MDMA and psilocybin) in phase two. We recognize that those who use multiple substances may possess higher cumulative quantities than people who primarily use one type of substance, and that polysubstance use is common. A common example of this is co-use of crystal methamphetamine with opioids. Crystal methamphetamine was the most commonly used substance among clients of harm reduction sites in BC in 2018 and 2019, and was frequently used concurrently with opioids.[43] As such, we will seek to work with Health Canada, researchers, and people with lived experience to evaluate any disproportionate impact of a cumulative threshold on polysubstance users and adjust our approach if required. We propose an annual review (at minimum) of the proposed threshold quantity alongside monitoring and evaluation data, which could result in either a change in the cumulative binding threshold floor or the setting of thresholds for individual substances.

Substance	Cumulative Binding Threshold Floor for Personal Use
Opioids (including heroin and fentanyl)	**4.5g**
Powder cocaine and crack cocaine	
Methamphetamine	

This cumulative, binding threshold will be simple and clear to communicate to the public, PWUD, and police agencies operating in the province. The threshold quantity is a floor, below which nobody found in possession would be subject to confiscation of drugs, arrest, or charge for simple possession. This model limits police discretion and reduces the risk of inequitable application of the exemption based on bias and discrimination. Above the threshold, law enforcement will continue to exercise discretion regarding whether to confiscate drugs or arrest an individual for simple possession. Officers may still choose not to seize drugs or arrest for amounts above the threshold floor if they feel that the individual circumstances do not warrant such a response. Police discretion would continue to be governed by federal guidelines which advise the Public Prosecution Service of Canada to avoid pursuing charges for simple possession except in the most serious cases when there is a risk to the public. Due to variations

[43] Papamihali, K., Collins, D., Karamouzian, M., Purssell, R., Graham, B., & Buxton, J. (2021). Crystal methamphetamine use in British Columbia, Canada: A cross-sectional study of people who access harm reduction services. PLoS ONE 16(5): e0252090. https://doi.org/10.1371/journal.pone.0252090

in drug purchasing and possession patterns in rural and remote areas, it is expected that law enforcement will use appropriate discretion for amounts for personal use that are above the cumulative binding threshold floor. Similar discretion will be recommended to accommodate individuals with severe substance use disorder and/or polysubstance use.

BC's exemption request does not seek to exempt individuals from the charge of possession for the purpose of trafficking (PPT) under the CDSA. Therefore, police will maintain their authority under current law to arrest and/or seize drugs where evidence of an intent to traffic exists, even if amounts of substances in possession are below threshold quantities.

Informed by available data from DeBeck et al and VANDU, a cumulative 4.5g threshold floor would likely accommodate multi-day supply for many PWUD who primarily use one substance (e.g., opioids or crystal methamphetamine), as well as some limited amounts of "social supply" (i.e., substances possessed with intention to share with another individual where there is no motivation to profit). Based on drug seizure data provided by VPD and RCMP, there is evidence that eliminating seizures for personal possession below recommended threshold amounts could reduce overall seizures significantly.[44] When an individual who is living in poverty and struggling with substance use disorder has their drugs seized, they are often put into desperate and unsafe situations when seeking to replace their drugs. This includes incurring drug debts, and/or turning to property crime or survival sex work. Therefore, by significantly reducing the numbers of drug seizures, BC's decriminalization framework has the potential to reduce harms by decreasing property crime, increasing safety of PWUD, and improving interactions between police and PWUD. While data on consumption and possession patterns outside of Vancouver is limited, this approach would also provide coverage for some degree of regional variation.

4.3.4 Summary of Stakeholder Feedback

CPT members, partners and stakeholders were not all aligned in their recommendations for threshold amounts. While PWUD, clinical experts, researchers, and Indigenous partners advocated for thresholds to be set at recommended levels based on available evidence, guiding principles, and the perspectives of people with lived experience of substance use, policing partners expressed concern that the recommended levels were too high.

The majority of CPT members were opposed to confiscation of personal amounts of illicit substances under recommended thresholds. However, support for exempting drug seizures was mixed amongst law enforcement agencies, as some perceived potential risks and liabilities in allowing individuals to remain in possession of toxic illicit substances.

MMHA will work with BC's Ministry of Public Safety and Solicitor General to mitigate any risks and concerns associated with limiting drug seizures below the thresholds, including a legal

[44] MMHA will work with policing partners to quantify this impact as part of our evaluation plan.

review of potential liabilities, a comprehensive change management approach, and rigorous monitoring and evaluation.

4.4 Alternatives to Criminal Penalties

Many jurisdictions that have pursued decriminalization have put in place a range of administrative sanctions as alternatives to criminal penalties. These sanctions sometimes include fines, confiscation of drugs, mandatory education or treatment, and/or confiscation of documents. Widespread confiscation of drugs has also continued in areas of BC where forms of *de facto* decriminalization exist, such as the City of Vancouver.

MMHA held a workshop with CPT members and others on September 10, 2021 to discuss and formulate recommendations on alternatives to criminalization. This workshop revealed widespread opposition to inclusion of administrative sanctions or any alternatives that could be perceived as coercive, as these may contribute to further criminalization, stigma, discrimination, and a lack of trust in the health and social service system for PWUD.

As such, ***BC's framework proposes to exclude alternative administrative sanctions and penalties such as fines, seizure of documents, or mandatory referral to education or treatment.***

In keeping with Canada's obligations under international human rights and drug treaty conventions to which it is a signatory, and by recommendation of the CPT, BC is committed to offering alternative health and social service pathways to people found in possession of drugs meeting the criteria for personal possession.[45]

BC's decriminalization framework proposes that, as an alternative to criminalization, all individuals found in possession of personal amounts of substances at or below the threshold will be provided with information regarding local health and social services, as well as additional assistance to connect with services if desired. Harm reduction supply provision may also be provided where appropriate.

4.4.1 Provision of Information and Harm Reduction Supplies

Police will, at a minimum, provide people found to be in possession of small amounts of illicit substances for personal use with information about how to access local health and social supports.

[45] Including, but not limited to, the Universal Declaration on Human Rights (1948), the Single Convention on Narcotic Drugs (1961), the Convention on Psychotropic Substances (1971), and the Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances (1988).

Provision of information would take the form of a pamphlet or card with a standardized preamble as well as Health Service Delivery Area (HSDA)[46]-specific information on available treatment, safer supply options, harm reduction and supervised consumption sites, drug checking services, peer-led services, social services, Indigenous-specific services, and traditional treatment approaches. Individuals would not be required to follow up with any of these services but could choose to self-refer. When an individual requests it of them, police could assist with a referral. An example of the types of services that could be included in these lists is included in Appendix D. If this submission is approved, MMHA will work with Health Authorities, social service providers and people with lived and living experience to develop resource lists for all HSDAs and ensure that they are safe, relevant, up to date and inclusive of peer-led supports as available.

Subject to funding and necessary policy arrangements, BC will also equip RCMP detachments and municipal and First Nations police departments with harm reduction supplies such as Take-Home Naloxone kits and drug checking supplies to offer to individuals.

4.4.2 Voluntary Referrals

Stakeholder opposition to mandatory referrals to addiction treatment or other services was near-unanimous. Members of the CPT stated that mandatory referrals are rarely effective, perpetuate the belief that all substance use requires treatment interventions, and further stigmatize PWUD. Regional Health Authorities have also suggested that because clinicians take a patient-centred, trauma-informed approach to supporting PWUD, there would be little support for any model wherein referrals would be perceived as mandatory or coercive in nature.

BC has taken a nuanced approach to defining “voluntary referrals”. Police will not proactively refer individuals to health or social services, as PWUD may feel obligated to accept a referral from a member of law enforcement. However, assistance may be provided to those who would like a referral or require assistance to initiate a referral. Under this arrangement police would not collect health information such as a BC Personal Health Number, although collection of minimal identifying information such as name and birthdate may be required. Other intermediaries such as peer support or outreach workers could also fulfill this role during their own interactions with PWUD.

In addition to preserving the choice and autonomy of PWUD, the inclusion of voluntary referrals to a range of services under BC’s decriminalization model represents an

[46] Each Regional Health Authority contains three geographically bounded Health Service Delivery Areas (HSDAs), which are in turn divided into a number of Local Health Areas. HSDA boundaries are used for administrative purposes such as demographic data analysis and to group and classify the community-level health services provided within them.

acknowledgement that treatment is not indicated for everyone who uses illicit substances. According to the BC Coroners Service Illicit Drug Overdose Death Review Panel findings, at least 10 percent of those who died of illicit drug poisoning were not regular users, meaning that they would not meet the criteria for substance use disorder.[47] Furthermore, as noted by BC's Provincial Health Officer, substance use occurs along a continuum, with one end representing beneficial and/or cultural use. For individuals engaging in forms of non-problematic substance use, any harms are primarily associated with the potential contamination of their drugs as a result of BC's poisoned illicit drug supply.[48] Although referral to overdose prevention, drug checking, or other harm reduction services may be beneficial for these individuals, treatment interventions are not necessary.

4.5 Health System Readiness

While significant work is underway to build up BC's substance use system of care, our Regional Health Authorities offer a continuum of substance use services, which range from specialized treatment to harm reduction programming and novel safer supply programs that provide pharmaceutical alternatives to the illicit drug supply. BC is continuing to strengthen the substance use system of care and is currently developing a framework that would bring together these and other services in a coordinated and comprehensive way.

The following is a high-level list of services that are available in all BC health regions and are continuing to be scaled up by Regional Health Authorities in partnership with the Ministry of Health and MMHA:

- Harm reduction services: Take-Home Naloxone, harm reduction supplies, drug checking services, and overdose prevention and supervised consumption sites (including supervised inhalation);
- Medication-assisted treatment: Expanded access to evidence-based medications for substance use disorders (including through nurse prescribing) such as buprenorphine/naloxone, methadone, and Kadian™ (opioid agonist treatment) and acamprosate for alcohol use disorder;
- Community-based treatment and recovery: Access to community-based mental health and substance use treatment and support, including psychosocial supports, group counselling, and intake/referral to specialized treatment programs through regional and local community clinics;
- Injectable opioid agonist treatment (iOAT)

[47] BC Coroners Service. (2018.) https://www2.gov.bc.ca/assets/gov/birth-adoption-death-marriage-and-divorce/deaths/coroners-service/death-review-panel/bccs_illicit_drug_overdose_drp_report.pdf

[48] Office of the Provincial Health Officer, p. 4.

- Prescribed safer supply: Programs and policies are aimed at increasing available pharmaceutical alternatives to toxic illicit drugs;[49]
- Enhanced harm reduction services, including managed alcohol programs for people with alcohol use disorder, and contingency management for people with stimulant use disorder;
- Bed-based services, including withdrawal management, treatment, and recovery;
- Mental health and substance use supports for youth, including Foundry centres and bed-based treatment and recovery care for youth and young adults; and
- Community outreach programs for people at risk of overdose, including Overdose Outreach Teams, Intensive Case Management Teams, and Assertive Community Treatment Teams.

4.6 Regional Considerations

BC's population is spread across many municipalities, unincorporated areas, and First Nations. Overall, BC has 162 municipalities and 198 distinct First Nations. Seven of the top 10 most populated municipalities are in the Metro Vancouver area, with a combined population accounting for roughly half of BC's overall population.[50]

Under the *Police Act*, municipalities with populations of 5,000 and over must provide law enforcement by forming their own police department, contracting with an existing department, or contracting with the provincial government for RCMP police services. Twelve municipalities have their own police forces and 63 have contracts with the Province for RCMP services. The Stl'atl'imx Tribal Police Service is the only Tribal Police Service in BC, providing policing services to St'at'imc Nation communities. Several other agencies and integrated teams provide supplemental or dedicated policing. These include the Metro Vancouver Transit Police, an enhanced police force at the Vancouver International Airport, and integrated teams throughout the province.

The Ministry of Health and MMHA partner with the Provincial Health Services Authority, five Regional Health Authorities, and the First Nations Health Authority (FNHA) to provide health services across BC. This regionalized approach allows for services to be planned and delivered in ways that meet the unique needs of specific regions and communities. These benefits are evident in the range of innovative community-based substance use services that have been developed across the province in response to the illicit drug toxicity crisis. Regional Health

[49] https://news.gov.bc.ca/releases/2021MMHA0035-001375
[50] https://www2.gov.bc.ca/assets/gov/data/statistics/people-population-community/population/pop_subprovincial_population_highlights.pdf

Authorities, the Ministry of Health and MMHA use sixteen geographic Health Service Delivery Areas[51] to plan and provide health program delivery and services to BC's population.

FNHA represents a new relationship between First Nations, the Province of BC, and the Government of Canada. FNHA aims to improve health outcomes for First Nations people in British Columbia. FNHA is responsible for:

- Planning, managing, delivering and funding First Nations health programs and services previously provided by Health Canada's First Nations and Inuit Health Branch;
- Working with BC's Ministry of Health and health authorities to address service gaps and improve health outcomes for First Nations in BC; and
- Improving the quality, accessibility, delivery, effectiveness and cultural appropriateness of health-care programs and services for First Nations.

MMHA is engaging with representatives from FNHA, the Union of BC Municipalities and its members, Regional Health Authorities, municipal police, and the RCMP to ensure that BC's decriminalization framework is implemented in a safe and effective way to meet its core goals and objectives.

4.6.1 Rural and Remote Considerations

Although most of the population in BC is concentrated in large and medium-sized municipalities, a significant proportion of the population, including many Indigenous Peoples, reside in rural and remote environments with unique barriers for timely health and social service delivery. These barriers are the result of a variety of factors, including geographic remoteness, low population density, challenges in recruitment and retention of health and social service providers, limited mobile network coverage and access to internet services, and inclement weather conditions affecting transportation and telecommunications. BC's approach to decriminalization will consider the needs of people living in rural and remote areas by working with Regional Health Authorities to identify services able to support PWUD in each HSDA. As evidenced by the approach to defining simple possession and alternative pathways, BC is also actively engaged with municipal partners, and drug user advocacy groups to understand and respond to the specific needs of PWUD in rural and remote communities.

BC also recognizes that for PWUD living in rural and remote regions of the province, purchasing patterns of illicit substances may differ from those living in urban centres. Furthermore, some of the barriers to accessing treatment and services in rural and remote areas (e.g., transportation issues) also impact drug purchasing patterns. These factors can lead PWUD living or working in rural and remote areas to purchase larger, multi-day supplies of illicit substances, likely in excess of 4.5g. As such, future phases of implementation may wish to consider higher

[51] https://catalogue.data.gov.bc.ca/dataset/health-service-delivery-area-boundaries

threshold quantities for these regions. This would require significant data collection and stakeholder consultation activities, including with First Nations located in rural and remote areas.

4.7 Approach to Unique Populations (GBA+)

BC's decriminalization framework has been developed using gender-based analysis plus (GBA+) to assess how diverse groups of people may experience and be affected by the policies and approaches taken. This analysis goes beyond sex and gender and includes the examination of a range of intersecting identity factors (e.g., Indigeneity, age, education, language, race, ability, class etc).

4.7.1 Youth

BC's decriminalization framework seeks alignment with existing federal and provincial legislation and regulations. BC's decriminalization framework proposes to define youth in a way that is consistent with the age of majority (19 years of age) used in provincial regulation of legal psychoactive substances like alcohol and cannabis. However, it is recognized that individuals 18 years of age are adults under the CDSA. Under the *Youth Criminal Justice Act* (YCJA), youth aged 12 to 17 who have committed a criminal offense may be dealt with through alternative or extrajudicial measures rather than pursuing criminal charges. If the offence is nonviolent (e.g., personal possession of controlled substances) and the youth has no previous offences, a police officer must consider this route. This may involve taking no further action, or, in the case of possession of illicit substances, may include referral to community or health services. In cases of multiple or more serious offences, Crown counsel may approve an extrajudicial sanction such as participation in counselling as an alternative to a criminal charge.

Given the separate legislation governing youth justice and additional safety concerns, as well as the fact that individuals 18 years of age are no longer subject to the YCJA and are treated as adults under federal drug law, further discussion with Health Canada is needed to determine how a decriminalization framework may apply to youth/young people. MMHA is also liaising with leadership from the Ministry of Children and Family Development, and other stakeholders to explore all options and determine if special considerations are required to meet the needs of youth/young people under BC's decriminalization framework.

4.7.2 Indigenous Peoples

MMHA has taken a distinctions-based approach to consulting with Indigenous partners and leaders in BC, seeking input from Indigenous leadership based on their preferred methods and tables of consultation. A key area of policy development in the implementation planning phase will focus on determining how or if the s.56(1) exemption could or would be applied to First Nations reserves in BC. BC is committed to ensuring that alternative pathways identified as

appropriate for inclusion in BC's decriminalization framework are culturally safe and trauma-informed.

4.7.3 Other Identity Factors

As part of engagement with the CPT, as well as discussions with other stakeholders, several other identity factors have been identified as having an impact on how an individual may experience criminalization for substance use, or, conversely, decriminalization. If BC's submission is approved, MMHA will continue to work with partners and stakeholders to address and respond to these factors where possible and mitigate unintended consequences for specific groups of people. These include:

- Racialized people/People of Colour who face systemic racism in the criminal justice and health care systems;
- Immigrants, refugees, and international students who may fear that accessing health and support services for substance use will jeopardize their legal status;
- Women and gender-diverse individuals who engage in sex work, who may be more vulnerable to experiencing violence and may fear seeking assistance from police due to substance use and fear of criminalization;
- LGBTQ2S+ individuals who use substances may have longstanding distrust of police and health systems due to experiences of discrimination;
- Parents who fear investigation and loss of custody due to substance use;
- People who work in labour and trade industries who are disproportionately represented among people poisoned by illicit drugs, and who may work in remote locations for extended periods and purchase substances in higher quantities; and
- People with disabilities, including chronic pain, who may have unique reasons for seeking illicit substances and face unique barriers to accessing appropriate health and social supports.

4.8 Approach to Unique Circumstances

MMHA has undertaken work with government partners and the CPT to address intersections between the decriminalization framework and other existing legislation and regulation, including public safety concerns regarding personal possession while operating a motor vehicle, local government bylaws and regulations surrounding consumption in public places, considerations related to child welfare, and mental health and safety concerns.

4.8.1 Personal Possession in a Motor Vehicle

Under Canadian and BC legislation and regulations, adults can operate a vehicle with alcohol or cannabis in it as long as the product is contained in its unopened original packaging, or not readily accessible to the driver and any passengers (e.g., in the trunk). During the implementation planning phase, MMHA will work with the CPT and government partners to

determine a clear policy for how BC's decriminalization framework will approach possession of personal amounts of other drugs while operating a motor vehicle.

Section 320.14(1) of the *Criminal Code* makes operating a motor vehicle while impaired by any psychoactive substance a criminal offence. Police presently possess a variety of enforcement tools to manage public safety concerns regarding impaired driving, regardless of the psychoactive substance used. This will not be affected by the exemption application. The Province does not anticipate that its application for a s.56(1) exemption for personal possession will lead to increased rates of impaired driving but we will be monitoring closely for this potential impact.

4.8.2 Public Consumption

Health Canada has previously indicated that a s.56(1) exemption request for decriminalization should consider the risk of increased public consumption of illicit substances. A systematic review of all available evaluation studies of the impacts of decriminalization on subsequent drug use trends found that, in the majority of jurisdictions that have implemented some form of decriminalization, drug use did not increase following implementation.[52] This includes Portugal, which remains the most highly studied example of decriminalization of personal possession of illicit substances globally.[53] As such, the Provincial Government does not anticipate that our decriminalization framework will increase overall population prevalence of substance use, or public consumption. Although police have ongoing concerns regarding potential impacts to public consumption, officers will continue to have enforcement tools, including laws prohibiting trespassing and public intoxication. Risk mitigation strategies to limit the likelihood of increased public consumption will need to balance public safety risks with the need to ensure that PWUD are not subject to increased enforcement and driven to use drugs alone, where risk of illicit drug toxicity death is elevated.

4.9 Implementation

To realize the objectives of decriminalization, policymakers must pay significant attention to how BC's decriminalization framework will be implemented on the ground in communities.

4.9.1 Implementation at Different Stages of the Criminal Justice System

CPT members have raised questions concerning how an exemption would apply to people who have an active criminal case file regarding a charge for simple possession in BC, and whether

[52] Scheim, A.I., Maghsoudi, N., Marhsall, Z., Churchill, S., Ziegler, C., and Werb, D. "Impact evaluations of drug decriminalisation and legal regulation on drug use, health and social harms: a systematic review." *British Medical Journal Open* 2020, 10:e035148. doi: 10.1136/bmjopen-2019-035148

[53] Hughes, C.E. and Stevens, A. (2010). "What can we learn from the Portuguese decriminalization of illicit drugs?" *The British Journal of Criminology*, 50(6), pp. 999-1022.

previous criminal records for simple possession could be expunged. MMHA is committed to working with Health Canada and its partners in the criminal justice system to explore these questions.

4.9.2 Police Training

If granted an exemption from the CDSA, MMHA will work with its policing partners and Health Authorities to develop a range of training resources to support knowledge and full implementation of the decriminalization framework amongst front-line police officers across BC. The BCCDC has expertise in this area, having worked with police forces to develop resources to support officer knowledge and application of the *Good Samaritan Drug Overdose Act*. Examples of training resources are included in Appendix C.

4.9.3 Public Education

MMHA has a public engagement team and a dedicated annual budget to develop and run public campaigns supporting overdose awareness. These existing resources will be leveraged to launch an education and awareness campaign to inform British Columbians about the decriminalization framework. The public engagement team has expertise in social marketing, production of web- and television-based advertisements, and can draw on a network of branding and communications agencies. The team is also committed to working with PWUD to ensure that messages resonate with those most impacted by the illicit drug poisoning crisis.

Workplaces represent a specific context in which education will be particularly relevant, both for employers and employees. MMHA will work with its partners inside and outside of government to support employers in developing workplace policies on personal possession of illicit substances, where required.

4.10 Monitoring and Evaluation

If a s.56(1) exemption is approved, MMHA will lead the oversight, monitoring, and evaluation of BC's decriminalization framework, including working with internal and external evaluation partners to monitor progress toward objectives, intended outcomes, unintended consequences, and other issues, risks, and risk mitigation strategies on an ongoing basis.

BC is home to public universities and research institutions that are world leaders in substance use research, uniquely positioning the province to develop a significant body of research literature and implementation science regarding the Province's decriminalization policy. A comprehensive evaluation plan will require partnerships with various research institutions, law enforcement agencies, and people with lived experience of substance use. It will also require access to a range of provincial administrative datasets from health and justice stakeholders, as well as qualitative data generated in partnership with people with lived and living experience, and policing partners.

MMHA has convened a Decriminalization Research and Evaluation Committee with leading researchers and experts, including representatives of the BCCDC, BC Centre on Substance Use (BCCSU), Canadian Institute for Substance Use Research (CISUR), FNHA, as well as members with lived and living experience of substance use. The committee will develop key indicators, explore the use of administrative data to track progress on indicators, and determine key qualitative research needed to support comprehensive evaluation. If a s.56(1) exemption is granted, BC will submit a detailed evaluation plan to Health Canada. Below are a few examples of indicators and data sources that will be explored.

Intended Outcomes	Indicators (draft examples only)	Potential Data Sources
Reduction in illicit drug poisoning events and deaths	# of deaths officially attributed to illicit drug poisoning # of illicit drug poisoning-related calls responded to by BC Emergency Health Services	BC Coroners Service data BC Emergency Health Services data
Reduction in arrests and charges for simple possession	# of criminal cases with simple possession as the most serious offence (MSO)	Statistics Canada data on adult criminal cases and charges
Reduction in drug seizures under the threshold for personal possession	# of drug seizure events under threshold quantities	Municipal police department data RCMP data
Increased voluntary and appropriate health service referrals	# of connections with health services where police were cited as the referral/information source	Health Link BC Health Authorities
Law enforcement awareness and understanding of decriminalization policy, health and social services	# of police officers that have attended training/information sessions on decriminalization # of police officers that report implementing decriminalization policy in practice	Attendance/participation data on new training/information sessions Participant Survey (TBD)
Increased public awareness of decriminalization and its role in reducing stigma	# of people reached by decriminalization awareness campaign materials	BC Stats Survey (TBD)

5 CONCLUSION

BC has faced a public health emergency relating to high rates of illicit drug toxicity deaths since 2016, with over 7,500 lives lost in the past five years, and countless others impacted by non-fatal illicit drug poisonings, stress and burnout from crisis response efforts, and the pain of

bereavement. The Province is committed to using every tool at our disposal to bring this crisis to an end. BC has a history of bold and innovative drug policy, but further action is urgently needed. Therefore, under an urgent public health need, the Province is pursuing a s.56(1) exemption to decriminalize personal possession of illicit substances in BC. Decriminalization will help to address the stigma that prevents so many from reaching out for the services and support they need.

BC's decriminalization framework seeks to complement a comprehensive response to the illicit drug poisoning emergency. This submission was developed with input from key partners and stakeholders, including people with lived and living experience, clinical leaders, public health experts and practitioners, drug policy experts, law enforcement, Indigenous partners, Regional Health Authorities, and municipalities.

This submission expands upon an initial outline provided to Health Canada by detailing key details of BC's plan for the decriminalization of personal possession. These include intended outcomes, eligibility, a definition of what constitutes "personal possession", alternatives to criminal penalties, and a plan for implementation including training and public education. The framework considers the nuances of how decriminalization would work in different regions, for specific populations (including Indigenous Peoples), and in unique circumstances. Finally, the framework commits to strong monitoring and evaluation to ensure that intended outcomes are realized and to support evidence-based adjustments to our approach throughout the implementation phase. Given the significant public support for decriminalization, BC's proposal provides the federal government with an opportunity to generate a timely body of implementation science to support drug policy reform elsewhere in the country and world.

This submission is intended to inform ongoing dialogue between Health Canada and MMHA leading to a s.56(1) exemption. MMHA is committed to ensuring that our approach meets the requirements of the federal government and we look forward to continuing to work together on this important act of drug policy reform.

6 APPENDIX A

Core Planning Table Member Organizations
Peer Organizations
Vancouver Area Network of Drug Users
Society of Living Illicit Drug Users (Victoria)
Coalition of Substance Users of the North (Quesnel)
Society for Narcotic and Opioid Wellness (Dawson Creek)
Rural Empowered Drug Users Network (Nelson / Grand Forks)
BC Yukon Association of Drug War Survivors (province-wide)
Indigenous Partners
First Nations Health Authority
Métis Nation BC
BC Association of Aboriginal Friendship Centres
BC First Nations Justice Council
Police
RCMP
BC Association of Chiefs of Police
Vancouver Police Department
Municipalities
Union of BC Municipalities

City of Vancouver
City of Kamloops
Additional Partners
BC Centre on Substance Use
BC Centre for Disease Control
Pivot Legal Society

Government Members/Secretariat	
Ministry of Mental Health and Addictions	Ally Butler, Executive Director of Substance Use and Strategic Initiatives (Co-Chair) Chris Van Veen, Senior Director (Co-Chair) Meg Emslie, Director
	Secretariat Support Stephanie Taylor, Senior Policy Analyst Danielle Parish, Senior Policy Analyst
Ministry of Health	Kenneth Tupper, Director of Substance Use Prevention and Harm Reduction
Office of the Provincial Health Officer	Dr. Daniele Behn-Smith, Deputy Provincial Health Officer, Indigenous Health Dr. Brian Emerson, A/Deputy Provincial Health Officer
Ministry of the Attorney General	
Ministry of the Solicitor General and Public Safety	Brian Sims, Executive Director of Policing and Security Matt Brown, Director of Policing Operations
Ministry of Children and Family Development	Wendy Norris, Manager, Strategic Child Welfare and Reconciliation Policy Rose Anne Van Mierlo, Director, Youth Justice Program Support

7 APPENDIX B

The following logic model summarizes inputs, outputs, and immediate and longer-term outcomes of our proposal.

Inputs	Outputs	Short-Term Outcomes	Long-Term Outcomes[54]
Section 56(1) exemption	Definition of simple possession / thresholds *Policy restricting seizures under threshold amounts	Reduced police and court time and resources spent on enforcement of personal possession Reduction in seizures, arrests, charges, criminal penalties, and criminal records for simple possession for PWUD	Reduction in illicit drug poisoning events and deaths Reduction in health, social, and economic harms associated with criminalization of substance use
Stakeholder input into policy design	Health and social service referral pathways and resources	Decreased racial and other disparities in enforcement of simple possession Increased voluntary and appropriate connections between PWUD and health and social services	Reduction in PWUD reliance on toxic illicit drugs and increase access to health and social services
	Guidelines and training for law enforcement	Law enforcement awareness and understanding of decriminalization policy, health, and social services Reduced and improved interactions between law enforcement and PWUD regarding personal possession	Reduction in barriers to accessing health services experienced by PWUD Increased engagement and retention in treatment and supports for people with substance use disorders Improved interactions between law enforcement and PWUD Increased PWUD trust in law enforcement and criminal justice system

[54] Long term objectives of decriminalization are unlikely to be achieved through decriminalization alone. Progress on these objectives is expected to take years and relies on other complementary system change initiatives, such as expanding and improving health and social services to support PWUD and addressing social determinants of health such as poverty, housing, and systemic racism.

			Improved ability of law enforcement and criminal justice system to prioritize serious crime
	Public awareness campaign	Increased public awareness of decriminalization and its role in reducing stigma Increased public understanding of substance use as a public health issue	Reduced stigma experienced by PWUD Increased socio-emotional well-being of PWUD

8 APPENDIX C

The following list contains examples of BC-specific resources developed to promote police officer education and awareness of the federal *Good Samaritan Drug Overdose Awareness Act*.

'Test Your Knowledge' Quiz:
https://towardtheheart.com/assets/uploads/1618262317VlUle50ZLLqMaxqcobmVNfdFeBC95WjEqYhrOwV.pdf

Training Slide Deck:
https://towardtheheart.com/assets/uploads/1625680068BGJmmCAyxkIwZo8vENGBQElBc6OssoL0teYImdz.pdf

GSDOA Poster:
https://towardtheheart.com/assets/uploads/1505411688Qgm0PwNT8IxIogPhlnwYhaFnm6NpIcikCfb2EY2.pdf

GSDOA Wallet Cards:
https://towardtheheart.com/assets/uploads/1526595325dttSdJc37OH9Y8aecNPDo1PlR5KsP2h7KaWZcgE.pdf

9 APPENDIX D

The following tables include examples of provincial and Health Service Delivery Area (HSDA) resources that could be included in service information cards provided by police to people found in possession of personal amounts of illicit substances. The formatting may look different in the final information products.

Table 1: Provincial Services

Provincial Services

Type	Service	Contact Information (all services 24/7 unless otherwise stated)
Supervised Consumption & Harm Reduction	Lifeguard App *Safer use smart phone app with timer and automatic emergency responder contact if no response following use*	https://lifeguarddh.com/products/lifeguard-app/
	Toward the Heart *Information on harm reduction services including take home naloxone training and harm reduction supply locations*	https://towardtheheart.com/
Crisis Support	Crisis Lines BC *Emotional support, crisis and suicide assessment/intervention and resource information*	Suicide support line: 1-800-784-2433 Mental Health Support Line: 310-6789 Seniors Distress Line: 604-872-1234 Youth Chat: www.YouthInBC.com (noon-1am) Adult Chat: https://crisiscentrechat.ca/ (noon-1am) Local crisis lines: https://www.crisislines.bc.ca/mapcrisis-lines
	Hope for Wellness Help line: (nationwide) *24 hr immediate mental health counselling and crisis intervention for all Indigenous people across Canada*	1-855-242-3310
	Kuu-Us Crisis Line Society – *Indigenous-focused crisis support located on Nuu-Chah-Nulth Territory, but provides crisis support to Indigenous people across BC*	Adults/Elders line: 250-723-4050 Youth line: 250-723-2040 Toll free: 1-800-588-8717
Overnight Shelter and Drop In	BC211 *Connection to Shelter and Street Help Line, shelter availability (Lower mainland only)*	2-1-1 http://shelters.bc211.ca/bc211shelters (updated daily with availability)
	BC Housing Emergency Shelter and Drop In *List and map of all shelters and drop-in services supported by BC Housing*	https://www.bchousing.org/housing-assistance/homelessness-services/emergency-shelter-map
Access to treatment and information about health services	Health Link BC / 8-1-1 *Health service navigators can help find health information or health services, or connect you with a nurse, dietitian, or pharmacist.*	8-1-1 https://www.healthlinkbc.ca/
	BC211	2-1-1 https://bc211.ca/

	Community resource navigation and link to specialized help lines including Alcohol and Drug Information and Referral Line	info@bc211.ca Phone, text, email and webchat available
	Wellbeing *B.C.'s official resource for mental health, substance use, and addictions support*	https://wellbeing.gov.bc.ca/
First Nations and Indigenous-specific Services	First Nation's Virtual Doctor of the Day *Virtual doctor appointments for First Nations people in BC*	1-855-344-3800 Monday to Sunday 8:30am to 4:30pm
	Native Courtworker and Counselling Association of British Columbia *Culturally appropriate justice and health related services according to need*	Call toll free: 1-877-811-1190 Email: nccabc@nccabc.net Website: https://nccabc.ca/
	Indian Residential School Survivors Society *Wellness and healing services to Indian Residential School Survivors and intergenerational Survivors throughout B.C.*	1-800-721-0066

Table 2: HSDA 23-233 Fraser South: Surrey

HSDA 23-233 Fraser South: Surrey

Type	Service	Hours of Operation	Address, Telephone No
Supervised Consumption & Harm Reduction	SafePoint *Supervised consumption (Injection)*	Monday to Sunday 7:00 am to 1:00 am No appointment needed	2- 10681 135a St, Surrey 604-587-7898
	Smoke n' Go *Supervised consumption (inhalation)*	Monday to Sunday 9:00 am to 9:00 pm No appointment needed	2- 10681 135a St, Surrey 604-587-7898
	Surrey North Community Health Clinic *Harm Reduction Supplies incl Naloxone Distribution, drug checking, medical clinic.*	Monday to Friday 8:30 am to 4:30 pm	10697 135A Street Surrey 604-589-8678
	Lookout Mobile Harm Reduction *Delivery of supplies including drug checking to Delta, White Rock, Surrey, Ladner, Langley*	Monday to Friday 8:30 am to 4:30 pm Call for delivery.	604-328-7610
Crisis Support	Fraser Health Crisis Line *Free & confidential emotional support, crisis intervention, community resource information*	24/7	604 – 951 - 8855 Toll-free 1-877-820-7444
	Surrey Women's Centre *Medical emergency support, trauma counselling, transportation to hospital*	Support worker available 24/7 by phone	604-583-1295
Overnight Shelter and Drop-In	Gateway Shelter and Resource Centre (Lookout Society)	24/7 Walk-in's welcome	10667 135A Street Surrey 604-589-7777
	Year-round and Emergency Shelters *(multiple, including women's-only shelters)*	Most are 24hr, intake hours vary	http://shelters.bc211.ca/bc211shelters (updated daily with availability)

	Quibble Creek Sobering Centre *Place to recover from intoxication, supervised consumption, harm reduction supplies*	Monday to Sunday 24 hours per day Walk-in's welcome	13670 94A Avenue, Surrey 604-580-4969
Access to Treatment	Regional Access to Addiction Care Clinic, Fraser South *Access to addiction care and treatment*	Monday to Friday 8:30 am to 4:30 pm No appointment needed	13740 94a Ave, Surrey 604-587-3755
	Surrey Urgent Care Response Centre *Access to Mental Health care and treatment*	Monday to Sunday 8:30 am to 8:30 pm No appointment needed	Charles Barham Pavilion 13750 96 Ave Access through 94a Ave, Surrey 604-953-6200
	Quibble Creek Substance Use Services *Substance use counselling services*	Monday to Friday 8:30 am to 4:30 pm Walk-in's welcome	13670 94A Avenue, Surrey, BC 604-580-4950
Indigenous-specific supports	Fraser Region Aboriginal Friendship Centre Association (FRAFCA) *Harm reduction, outreach, counselling, housing support*	Monday to Friday 8:30 am to 5:00 pm	101-10095 Whalley Blvd, Surrey, BC 604-283-3293 https://frafca.org/

Table 3: HSDA 43-432 North Vancouver Island: Campbell River

HSDA 43-432 North Vancouver Island: Campbell River

Type	Service	Hours of Operation	Address, Telephone No
Supervised Consumption & Harm Reduction	Overdose Prevention Service *Harm reduction supplies, witnessed consumption, education, referrals*	Monday-Sunday 9:00 am- 7:00 pm	1330 Dogwood Street, Unit #5 Campbell River 250-287-9969
	AVI Campbell River *Harm reduction services and supports, referral to services, systems navigation, outreach*	Monday - Thursday 9:00 am - 4:00 pm Friday: 11:00 am - 3:00pm	1371 c. Cedar Street, Campbell River BC 250-830-0787 Info line: 1-800-665-2437
Crisis Support	Vancouver Island Crisis Society *Crisis line, incl. supports for substance use*	24/7	1-888-494-3888
Overnight Shelter and Drop-In	Salvation Army Evergreen House *Low barrier shelter with housing transition support*	24/7 Walk-in's welcome	690 Evergreen Road Campbell River 250- 287-3791
	Sobering and Assessment Centre *Safe, supportive environment for overnight sobering*	24/7 Walk-in's welcome	#6 - 1330 Dogwood Street Campbell River 250-287-9969
	Campbell River Women's Resource Centre and Transition House *Drop-in counselling and resource centre and emergency transition house*	Resource Centre: Monday-Thursday 10:00 am – 3:00 pm	1330 Dogwood Street, Unit #5 Campbell River 250-287-3044 24 hr help line: 250-286-3666 24 hr text line: 250-895-1773
	Kwesa Place *Drop-in services, free laundry, showers, clothing, and snacks*	10am-4pm Monday to Friday	1342 Shoppers Row Campbell River
Access to Treatment	Island Health Mental Health and Substance Use Services Intake Services *Assessment, short term counselling, referrals*	Monday-Friday 8:30 am – 4:30 pm (closed 12-1)	#207–1040 Shoppers Row Campbell River 250-850-2620

	Foundry Campbell River *Mental Health and Substance use supports for youth aged 12-24*	Mon, Fri 830-430 Tues, Wed, Thurs 8:30 am-6:00 pm	140 10th Avenue, Campbell River 250-286-0611
	Columbia Coast Medical Services *Medical management of opiate dependency, methadone, counselling, pain assistance (private clinic: fees may apply)*	Monday – Friday 8:30 am - 4:30 pm Call to make an appointment	1371B Cedar St Campbell River 250-287-4822
	North Island Survivors Healing Society *Trauma and abuse counselling centre*	Call for options and to make an appointment	625 D 11th Avenue, Campbell River 250-287-3325
Indigenous-specific supports	Kwakiutl District Council Health (KDC Health) *First Nations and Indigenous intervention and counselling, screening, treatment, education*	Monday -Friday 8:30 am - 4:30 pm	1400A Drake Rd Campbell River 250-286-9766
	Laichwiltach Family Life Society *Holistic services (cultural, mental, emotional, spiritual, physical) for Indigenous people and families*	Monday to Friday 8:30 am to 4:30 pm	441 4 Ave, Campbell River, BC 1-250-286-3430
	Tsow Tun Lelum Society *Confidential outreach services such as counselling and cultural support*	Monday to Friday 9:00am- 4:00pm	1-888-403-3123