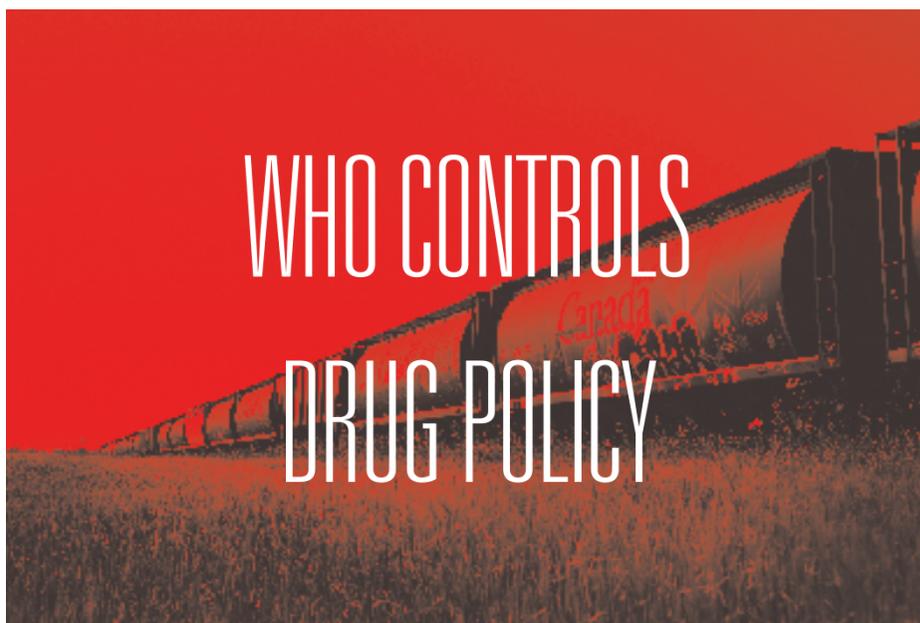


DRUG  
POLICY  
IS AIDS  
POLICY



**Canadian Drug  
Policy Coalition**

**Coalition canadienne  
des politiques  
sur les drogues**



#### **DRUG POLICY IN CANADA**

In the Canadian context, drug policy involves the interaction of many levels of government. The federal government is responsible for the Controlled Drugs and Substances Act and ensures compliance with the international treaties Canada is signatory to. Other levels are responsible for providing related services such as harm reduction and treatment services and setting priorities about implementation.

At the federal level, 11 different departments and agencies have responsibilities related to Canada's National Anti-Drug Strategy. Within most provincial, territorial or other jurisdictions, a similar range of ministries, branches and agencies are involved. At a local or regional level, the groups involved in making and administering drug policy include health authorities, school boards, municipal councils and police boards.

**DRUGPOLICY.CA**

# TEN THINGS YOUR ORGANIZATION CAN DO ABOUT DRUG POLICY ISSUES

01. Keep informed about drug policy issues. There are several excellent websites and organizations with useful resources.
02. Be aware of your own social biases about illegal drug use. Try to be critical of media claims about drug use issues.
03. **Help challenge discriminatory policies and programs that affect the lives of people who use drugs.**
04. Critically examine the overlap between drug policy issues and other social concerns like housing, poverty, and health. (We can help).
05. Examine what your organization can do to integrate drug policy issues into your policy analysis and publications. Consult local, national, and international drug policy reform organizations for help.



# 07

- 06. Participate in innovative community-based efforts to challenge negative drug policies.
- 07. **Bring a human rights perspective to your analysis of drug policy issues.**
- 08. Help support the scaling up of harm reduction services in your local areas.
- 09. When services for people who use drugs are proposed in your area, challenge NIMBYISM in all its forms.
- 10. Challenge the War on Drugs as a wasteful, ineffective and inhumane way to deal with substance use.





these thousand crosses speak  
to us resoundingly  
collectively to warn us that to abandon  
the wretched  
the miserable the scorned  
the scapegoated

these thousand crosses  
reveal a culture  
pretending to be about life  
and health and hope  
but permeated with death  
and disease and despair  
these thousand crosses bear  
witness not to a culture of  
care and freedom  
but of carelessness and  
addiction

the segregation of those who  
deserve to live and those who  
are abandoned to die  
these thousand crosses  
silently announce a social  
curse on the lives of the  
poorest of the poor in the  
downtown eastside  
they announce an assault  
on our community  
these thousand crosses  
announce a deprivation of  
possibility for those of us  
who mourn here the mothers  
and fathers and sisters and  
brothers the uncles, aunts,  
grandmothers and grandfathers  
the sons and daughters the  
friends and acquaintances  
of those members of our  
community of a thousand  
dreams of a thousand hopes  
of a thousand yearnings  
for real community  
lost to us but memorialized  
today brought finally into a  
unity here in this community  
park, this park which is the  
geographical heart of the  
downtown eastside

THESE  
THOUSAND  
CROSSES  
ARE SYMBOLS  
OF THE SOCIAL  
APARTHEID  
IN OUR  
CULTURE

*these thousand crosses of  
the contemporary martyrs  
bear witness not only to their  
drug overdose deaths  
but to the uncounted deaths  
in the downtown eastside  
deaths of drug addicts from  
suicide and AIDS*

*and so we are all abandoned  
if one is abandoned  
so we are all uncared for  
if one is not cared for*

# WHEN EAGLES CIRCLE OPPENHEIMER PARK

—Bud Osborn, Poet

when these thousand  
crosses are planted  
in this park/  
who really see them  
are awakened/  
are called forth to  
community to care/  
and who really see  
these thousand  
crosses are called  
to be hope soaring  
in the hearts of those  
for whom hope is gone/  
soaring in courage  
and blessing

will these thousand crosses  
these thousand seeds these  
thousand memorials burst  
forth into new life  
for those who will not have  
to become a martyr to our  
social madness around drug  
addiction/but will care burst  
forth in our hearts/in our lives  
in a new way for the sake of  
others and for the sake of  
ourselves? I believe these  
crosses these seeds are  
already bearing fruit/hope  
hope stands right now right  
here in this park at this moment  
hope is standing here hope in  
each cross hope in each of us

## HYPOTHESISING AN ALTERNATIVE: APPLYING THE SCIENTIFIC PROCESS TO DRUG POLICY

By Professor David Nutt, author of "Drugs—Without the Hot Air"

**I strongly believe that we should focus on public health approaches to the drug problem, and decriminalise the possession of drugs for personal use, for the following simple reason:- If users are addicted then they are ill, and criminal sanctions are an inappropriate way to deal with an illness. If they are not addicted then criminalisation will almost always lead to greater harms to the user than the effects of the drug. For example, it can severely limit career options in public service and prevent travel to some countries particularly the USA.**

However, it was clear from questions from several of the HASC committee that they are very frightened that reducing or removing the criminal penalties for drug possession will lead to greater use—and then greater harms overall. This is a reasonable hypothesis. Forming hypotheses represents the first step in thinking scientifically. Next, we should test the hypothesis against the available evidence. I think that the following evidence allows us to reject this hypothesis.

01. There is good evidence that decriminalisation does not radically increase drug use and can reduce some measures of harm, as shown by a balanced review of the first ten years of the Portugal experience of decriminalisation. The collapse of society predicted by some did not occur; they had slight increases in drug use followed by slighter falls, which compares favourably with the trends in the neighbouring countries and the rest of the EU over the same period. More importantly, young people growing up under this system used fewer drugs, and harms and deaths from heroin went down as a result of a treatment-centred attitude replacing a punishment-centred approach. Remarkably, young people who have grown up in the Netherlands, where cannabis use is decriminalised, are less likely to be users of the drug than young people in Britain, the US and many other countries which criminalise young users. Perhaps the cachet of illegality here promotes some use.
02. An increase in the availability of some drugs may actually lead to a reduction in the use of other more harmful drugs, so reducing net harms to society. We saw a noteworthy example of this in the past few years with the advent of the stimulant mephedrone. As this became popular, cocaine users seem to have switched to mephedrone and cocaine deaths fell by almost a quarter. Mephedrone gives a strong high and has potential to harm and kill, but seems much less likely to kill than cocaine. By switching, cocaine users reduced their risk of dying. It appears that the mephedrone phase caused the first significant impact on the steady rise of cocaine deaths we had seen in 20 years. It seems to have been a major – if unplanned and temporary—public health success. Relatively fewer young people progress to problematic drug use in the Netherlands than in most comparable Western countries. There is evidence that the legalization of medical cannabis in some states of the USA has been associated with a considerable reduction in fatal road traffic accidents, comparable with the benefits of laws requiring

seatbelts. This, the authors of the study show, is mostly due to the large drop in the number of fatal crashes involving alcohol as people appear to substitute cannabis for drinking.

03. Regulating access to drugs such as cannabis as in the Dutch model reduces the need for users to go to dealers. So it minimises their exposure to people whose main goal is to get their clients onto the most addictive substances such as heroin and crack. Indeed this was the main reason why the Dutch initiated the coffee shop model in the first place and it has been successful; by separating the markets of cannabis and heroin they have among the lowest rates of heroin use in young people in Europe. The Netherlands is now in the process of restricting tourists' access, on a city by city basis, to coffeeshops, making them primarily for Dutch residents. As drug tourism was never the aim of the coffeeshop policy, this change is not without logic, however, given that there is already a mature market for cannabis that may now be pushed into the illicit market with a correlating effect on street disorder and crime, as has already been seen in Maastricht.
04. Approaches to dealing with addicted users which swap punishment for healthcare have been successful. In 1994, despite strong resistance from the UN, Switzerland began a program which allowed long-term treatment-resistant addicts to take clean pharmaceutical heroin under medical supervision. This has been criticized for maintaining rather than ending addictions, but it has stabilised chaotic lives, allowing users to be socially reintegrated, getting homes and sometimes jobs, and as well as removing the health harms associated with polluted, inconsistent street drugs. Addicts in this treatment get fitter, they virtually never overdose, and very few die. Unlike those in other regimes, most stay in treatment, allowing some to progress later to abstinence. It isn't just the addicts who benefit; crime fell enormously once users could access heroin from the State rather than profiteering dealers. The State, and taxpayers don't lose out in this arrangement, the expensive program more than pays for itself in healthcare and law enforcement savings.
05. Approaches which explicitly reject an evidence-based public health approach, but instead focus on incarceration and criminalisation of addicts, continue to utterly fail, at enormous financial and human cost. The Global Commission on Drugs Policy have just published a new evidence-rich report, well worth reading, which focuses on the effect of different approaches to drug users on the HIV/AIDS pandemic. The spread of disease cannot be considered a wholly natural, biological phenomenon, it is also social, economic and very political. Political choices determine whether a huge majority or a small minority of new HIV infections are caused by injecting drug use. In Russia, where organisations trying to help heroin addicts look after

their health have been persecuted, a million people are HIV positive, over 80% of them through their drug habit. In comparison, here in the UK, Margaret Thatcher, the only PM we've had with a science degree, heeded her scientific advisors, brushed off moralising critics, and instituted a needle-exchange programme. Since then, UK policy has at least accepted the need for harm-reduction alongside punishment, and less than 2% of new HIV infections in 2010 were caused by injecting drugs. In the US, where incarceration rates are high, but harm-reduction measures (like distributing clean hypodermics) is politically taboo, unfunded or even illegal, HIV spreads in prisons where syringes carrying heroin and HIV are passed around. Whilst use of prescription heroin in a clean needle rarely harms anyone besides the user, these preventable HIV infections across the world in injecting drug users cause infections in their sexual partners and continually infuse HIV into wider society.

06. Treating addicts with more humanity doesn't make drug use look more appealing. The idea that less punitive approaches would encourage drug use is again a reasonable hypothesis, but science demands that hypotheses are tested against the evidence. The Swiss evidence shows that rather than making heroin more popular, numbers of people becoming addicts have steadily fallen. It has been suggested that whilst heroin use can appear rebellious where the focus is on punishment (think of Pete Doherty photographed with an entourage of police, or sashaying in and out of court), in Switzerland, young people think of addicts as simply ill, which deters use. It is no surprise that Switzerland's policy has won broad democratic support and has inspired similarly successful projects in other European countries, including small trials here in the UK. It's also no surprise that much of the world remains strongly opposed to this approach despite such strong evidence that it works.

Moreover criminalisation produces many perverse consequences that actually increase the harms of drugs and costs to society. Criminal networks coalesce around drug supply; America in the era of alcohol prohibition was the heyday of organised crime. The lack of quality control in illegal drug markets leads to wholly unnecessary harms like deadly outbreaks of anthrax in heroin injectors. Dealers with concerns only for their profits adulterate and misdescribe drugs, for example selling the much more potent and riskier drug PMMA as the less risky ecstasy. Badly enacted prohibition also severely limits research so denies the possible therapeutic benefits of drugs such as MDMA for treating PTSD and psilocybin for treating depression and the anxiety of cancer.

**It is now time to begin to introduce a more rational evidence-based approach to drug policy to minimise harms. We must consider all drugs, including alcohol, as part of the problem to be tackled. I hope that the Select Committee will recommend a more progressive approach than the current one of interdiction and punishment which has, and will continue to fail.**



## WHY PEOPLE SHOOT UP

By Dan Gardner, *The Ottawa Citizen*, author of "Future Babble"

The United Nations and national governments the world over, including Canada's, are actively promoting an epidemic. They are infecting people by the tens and hundreds of thousands. God knows how many will die.

A report released this week by the Global Commission on Drug Policy isn't quite that blunt, but it comes close. "The global war on drugs is driving the HIV/AIDS pandemic among people use who drugs and their sexual partners," it concludes. "Throughout the world, research has consistently shown that repressive drug law enforcement practices force drug users away from public health services and into hidden environments where HIV risk becomes markedly elevated. Mass incarceration of non-violent drug offenders also plays a major role in increasing HIV risk.... The war on drugs has also led to a policy distortion whereby evidence-based addiction treatment and public health measures have been downplayed or ignored."

Among most drug policy researchers and public health officials, that paragraph is no more controversial than saying smoking causes lung cancer. But the members of the Global Commission include former presidents of Brazil, Mexico and Colombia. And George Schultz, the U.S. secretary of state in the Reagan administration. And Paul Volcker, the near-legendary former chairman of the U.S. Federal Reserve. And Canada's Louise Arbour, a former Supreme Court justice and former UN High Commissioner for Human Rights. It's extraordinary to have people of that background and stature agreeing in public that, as the report put it, "the war on drugs has failed and millions of new HIV infections and AIDS deaths can be averted if action is taken now."

But excellent as the report is, it omits a critical piece of the puzzle.

Why do users take drugs by intravenous injection?

After all, drugs can be swallowed, inhaled, or smoked. Each of these methods is inherently more pleasant than sliding a sliver of cold steel into a vein. What's more, each of these methods is less likely to result in overdose. Each is less likely to result in abscesses or bacterial infections of the heart. And each involves little or no risk of transmitting blood-borne diseases like hepatitis and HIV.

So why do people use the most unpleasant and dangerous method?

If you look around today, you would say it's just part of the illicit drug culture. If you hook up with someone who injects, that's how you learn to take drugs, and, in time, you become habituated to it. Users may even come to feel affection for the little rituals involved in preparing the needle. So that's why they do it.

But that answer simply pushes the question back a little further: When and why did the most unpleasant and dangerous method of taking drugs become widespread?

In the 19th century, currently illicit drugs were legal. Sometimes people mixed them with alcohol or tea and drank them. Sometimes they smoked them. And occasionally they injected drugs, especially morphine, a more-potent derivative of opium.

But drugs weren't injected into the veins. Instead, following the medical practice of the day, these were subcutaneous (below the skin) injections. "No one seems to have injected morphine intravenously until the 20th century," writes historian Richard Davenport-Hines in *The Pursuit of Oblivion: A Global History of Narcotics*.

We know roughly where and when it started. It was 1925. In Terre Haute, Indiana. That's the earliest known account of intravenous drug use. From there, the habit spread like a virus. In 1935, almost half the addicts admitted to an American drug-treatment hospital were doing it. By the early 1950s, injection had become so routine that when a heroin panic swept North America—immortalized by Frank Sinatra in *The Man With The Golden Arm*—the needle symbolized the threat.

# WHAT CAUSED THIS DRAMATIC CHANGE IN USERS' BEHAVIOUR?

## DRUGS WERE CRIMINALIZED.

So what caused this dramatic change in users' behaviour? Drugs were criminalized.

Banning drugs didn't wipe them out. It merely shifted their sale to the black market. That had two immediate effects.

First, the available drugs tended to come in more potent forms, for the simple reason that smuggling a highly potent drug is easier than smuggling the same drug in less potent form. Imagine having to choose between smuggling a case of vodka or several kegs of beer and you get the idea. As a result, opium was increasingly replaced by morphine and its even more potent chemical cousin, heroin.

The other thing the switch to the black market did was raise the price, by as much as 10 times or more. Inevitably, users became very concerned about the efficiency of the method by which they took the drug: They had to get the "the most bang for the buck." So forget eating or drinking the drug. That's the most inefficient method. Smoking is better. So is inhaling.

But the most efficient method of all, by far, is intravenous injection.

Out went opium smoking and the other, safer 19th-century methods of drug consumption. In came heroin injection.

Something like this pattern can be seen whenever drugs were banned.

Opium had been smoked in Thailand for centuries. But in 1959, at the insistence of the United States, the Thai government banned it. Heroin injection appeared and spread almost immediately, so when AIDS arrived in the 1980s, it raced from one needle to another, producing one-third of new infections.

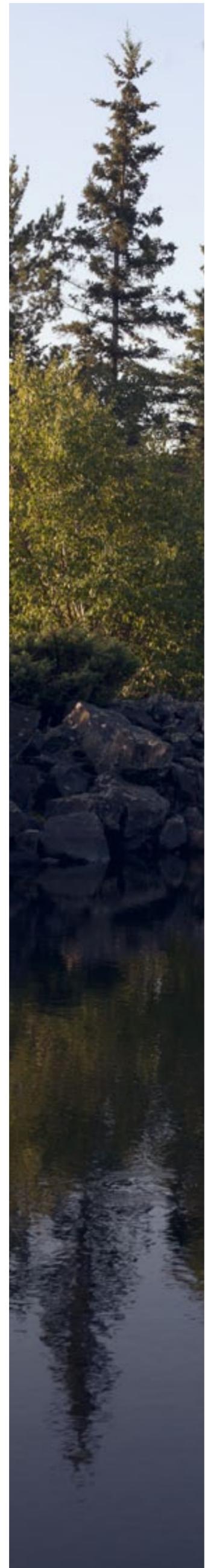
Now, I have to confess that I've plagiarized myself here. I wrote almost everything in this column a decade ago. But that underscores the point, doesn't it?

All of this has been known for years. Even decades. The science writer Edward Brecher laid out much of it in 1972.

But entire generations of politicians have simply refused to examine the evidence and reconsider their policies. Even on something as relatively simple as the efficacy of Insite, the Vancouver injection site, Stephen Harper, Dalton McGuinty, Jim Watson, and a long list of other politicians have steadfastly refused to take a serious look the evidence and talk about it. It's hard to imagine any of them having the intellectual honesty and political courage to call for a royal commission into the whole bloody mess.

But who knows? Sometimes, even when it's least expected, change happens. Maybe the Global Commission on Drug Policy is a straw in the wind.

I sure hope so. Nothing would be more depressing than writing this column again a decade from now.



SUPPORT FOR A GLOBAL  
DRUG WAR HAS HAD A PROFOUND  
IMPACT ON THE SPREAD OF HIV AND  
ASSOCIATED AIDS DEATHS.

staunchly “tough on crime” approach to drugs, it’s estimated that fully 50 per cent of the country’s thousands of injection drug users are now HIV-positive.

These horrifying statistics aren’t the unfortunate side effects of an otherwise effective program to control drugs, and they’re not isolated incidents. Despite deep international commitment to the war on drugs, it has failed on a colossal level. Even as drug enforcement funding has increased over the past two decades, the global drug supply has steadily increased. Meanwhile, countries that are primary consumers of drugs, such as Canada and the United States, have seen drug prices tumble to new lows while drug purity has increased dramatically.

# CANADA’S ADDICTION TO THE WAR ON DRUGS HAS UGLY SIDE-EFFECTS

By *Dan Werb*, Co-Founder, *International Centre for Science in Drug Policy*

At the Summit of the Americas in Colombia, Harper said: “I think what everyone believes and agrees with, and to be frank myself, is that the current approach is not working, but it is not clear what we should do.”

It was a surprising and refreshing admission, coming as it did from Stephen Harper, one of the hemisphere’s most committed warriors in support of the war on drugs. Embedded in this admission of failure was a pleading for clarity about what to do next, and how to implement viable and effective solutions to the drug problem. This is why the recent release of the Global Commission on Drug Policy’s report, titled “The War on Drugs and HIV/AIDS: How the Criminalization of Drug Use Fuels the Global Pandemic” represents such a bombshell for Canada and other nations stuck in the fruitless, endless and self-perpetuating war on drugs.

The commission itself is made up of a who’s who of international leaders

including former U.S. Federal Reserve chair Paul Volcker, Canadian Supreme Court Justice Louise Arbour, Virgin Group founder Richard Branson, and the former presidents of Mexico, Colombia and Brazil. Their report represents a damning indictment of the global war on drugs by laying bare its true cost and staggering level of failure.

As the report outlines, support for a global drug war has had a profound impact on the spread of HIV and associated AIDS deaths. In Russia, which has outlawed clinically proven addiction treatment options such as methadone, the number of HIV-positive individuals has soared from close to zero in 1994 to almost one million in 2009.

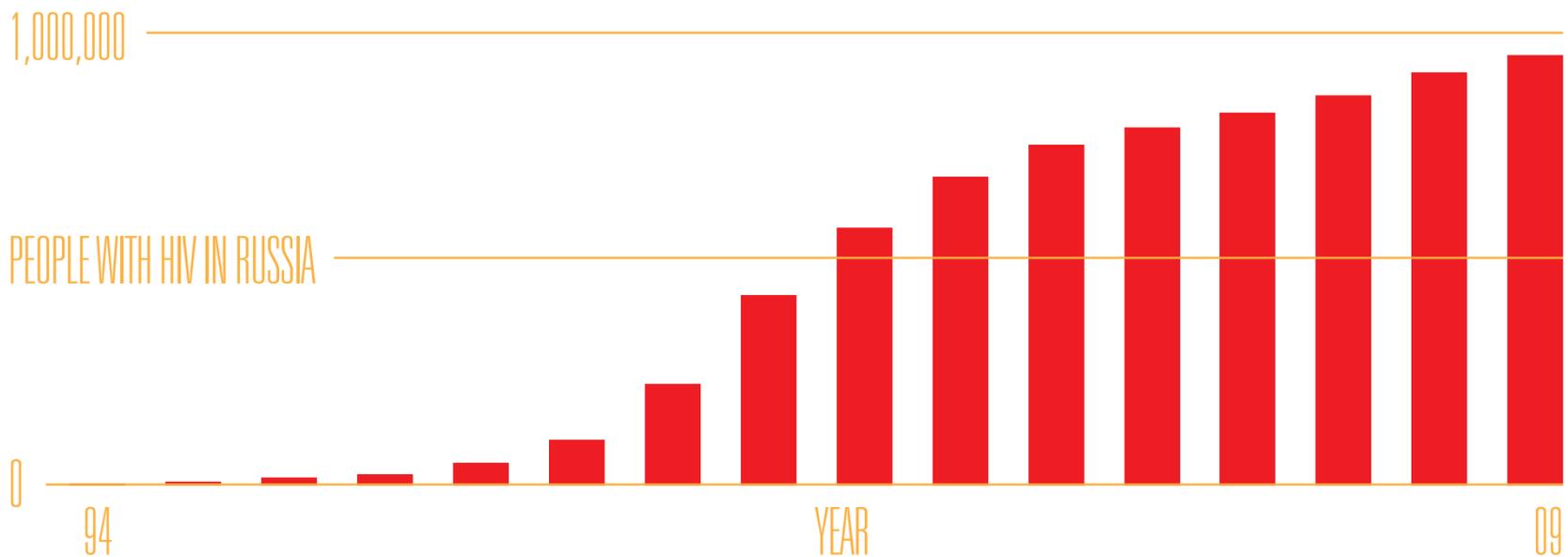
Not surprisingly, Russia’s growing epidemic is concentrated among its increasing number of injection drug users. In Thailand, which sanctioned the extrajudicial killing of Thai drug users in a brutal drug war in 2003 and continues to take a

“THE CURRENT APPROACH IS NOT WORKING, BUT IT IS NOT CLEAR WHAT WE SHOULD DO.”

—STEPHEN HARPER

These findings are just the tip of the iceberg. The commission's report carefully illustrates how the drug war has doomed hundreds of thousands to incarceration, persecution, and HIV infection despite its clear failures to affect drug supply. For that reason alone it should be required reading for Prime Minister Harper, as it offers him what he seems to be asking for: a clear set of steps to undo the damage of the failed status quo. And he doesn't have to look far to find solutions. In the report, the commissioners highlight the success of British Columbia, which aggressively advanced a public health approach to tackling drug harm, and as a result has seen the number of new HIV cases among injection drug users drop almost 90 per cent since 1996.

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CANADA AND THE UNITED STATES HAVE  
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Unfortunately, instead of celebrating this made-in-Canada success, our federal government seems intent on alternately vilifying it and litigating against it while doubling down on a tough-on-crime approach. If these policy failures affected only Canadians, they would be damaging enough. What the commission's report outlines, though, is the way in which policies in drug consumer countries like Canada can devastate other regions.

In the case of Canada and the United States, our addiction to the war on drugs, coupled with an insatiable demand for drugs themselves, has proved a deadly cocktail for those countries unlucky enough to exist along the supply chain. In Mexico, for instance, an all-out drug war has claimed the lives of over 50,000 since its inception in 2006. Rather than stifle drug supply, it appears to have fueled it, as estimates suggest that Mexican heroin production has increased 340 per cent since the drug war was launched. The

report clearly shows **this is not a Mexican failure but a regional one**, and that Canadians should recognize their own government's complicity in supporting enforcement policies that do untold damage far beyond our borders.

Prime Minister Harper's recognition of the futility of Canada's drug policies represents a potential turning point, and he should be supported in seeking a viable alternative to the broken status quo. In this regard, the commission's report provides him with the answers he needs to move towards effective drug policies. Though it confirms some of our worst fears about the impact of the war on drugs, the report also outlines evidence-based ways to overcome them. Let's hope our prime minister finds in it the path forward that he seeks.

## TAKE ACTION AND JOIN THE COALITION NOW!

Join us in forming the future of drug policy in Canada.

We are currently engaging in a series of national dialogues and actions – listening, learning, and informing each other as we work together to create a new approach to drug policy in Canada and internationally. Become a member and help us rethink Canada’s drug policy.

## IT’S TIME TO CHART A NEW PATH: THE CDPC ENVISIONS A NEW DRUG POLICY FOR CANADA

The current approach to Canada’s “drug problem” is not working. It relies far too heavily on the criminalization of people and punitive policies. It’s expensive, wasteful, ineffective and damaging to those who are most in need. It is time for innovative solutions.

The Coalition advances policy and program innovations that will have a profound impact on reducing the harms related to substance use in Canada.

We will address issues of equity of access to health care for people who use drugs, stigma, and the legislative changes needed to end the criminalization of people who use drugs. We will put forward new ideas for developing an alternative regulatory scheme for all drugs in line with public health and human rights principles that will improve community health and safety.

## THE CANADIAN DRUG POLICY COALITION WILL:



- *Build a Social Movement to Change Canadian Drug Policy:* The coalition is working to connect with Canadians to build a movement for change. Our goal is a safe, just and healthy Canada where the rights of all persons are valued and enhanced.
- *Develop Collaboration and Partnerships in Canada:* The Canadian Drug Policy Coalition (CDPC) works with other NGOs to produce policy position papers, sponsor public dialogues and develop a coordinated communications capacity on drug policy issues.
- *Report on and Advocate for a More Just Drug Policy for Canada:* In February 2012 the Coalition issued *Changing the Frame: A New Approach to Drug Policy in Canada*. This document sets the stage for a principled, evidence driven, pragmatic and humane reform of Canada’s drug laws and policies. During 2012 the Coalition will produce a series of policy briefs tailored to politicians and policy makers at all three levels of government. In February 2013, the Coalition will issue a report card on

Canadian drug policy that will begin the process of building a framework for evaluating Canadian drug policy.

- *Liaise/Advocate with Governments:* The CDPC advocates for changes to Canada’s national drug policy to respect the principles outlined above. In particular, the Coalition will work with all levels of government to expand health and social services for people who use drugs and work to end the inhumane War on Drugs.
- *Engage at the International Level:* Through international events, UN processes and partnerships with international NGOs, the Coalition will work on transnational efforts to limit the negative effects of drug policy, particularly prohibition, and foster and support human rights based approaches to drug policy.

THE **CDPC** ENVISIONS A SAFE,  
HEALTHY AND JUST **CANADA** IN WHICH  
DRUG POLICY AND LEGISLATION AS  
WELL AS RELATED INSTITUTIONAL  
PRACTICE ARE BASED ON **EVIDENCE**,  
HUMAN RIGHTS, SOCIAL INCLUSION  
AND PUBLIC **HEALTH**.

# THE

## CHANGING THE FRAME

### KEY POLICY PRINCIPLES OF THE CDPC:

*The Coalition is focused on five key policy areas:*

#### **A Comprehensive Health Social and Human Rights Approach**

A comprehensive strategy takes a “population health” and human rights approach, which aims to improve the health and social well-being of the entire population and to reduce health inequities among population groups. A population health approach also explicitly acknowledges that to reduce health inequities in society a reduction in social and material inequities is required.

#### **Scaling Up Harm Reduction**

‘Harm Reduction’ refers to policies, programs and practices that aim to reduce the negative health, social and economic consequences of using legal and illegal psychoactive drugs, without necessarily reducing drug use. Harm reduction benefits people who use drugs, their families and their communities. Harm reduction values the human rights of people who use drugs and affirms that they are the primary agents of change for reducing the harms of their drug use. CDPC believes a harm reduction approach is essential to developing innovative strategies to deal with Canada’s drug problem.

#### **Removing the Stigma of Criminalization**

Criminalization is one of the major barriers to accessing health and social supports for people who use drugs. Criminalization marginalizes, stigmatizes and seriously affects the self-worth of people who use drugs especially those at the lower end of the socio-economic scale including the mentally ill and homeless. It separates, segregates and pushes people to the margins of society. Removing the burden of criminalization from people who use drugs is an essential first step to

enabling their full participation in efforts to attain their health and well-being.

#### **Moving Beyond Prohibition**

It’s time to examine the evidence about our current policies and explore new and innovative strategies for addressing problems associated with substance use, our drug laws and the illegal drug trade.

#### **Promoting International Human Rights**

Drug policies, and the accompanying enforcement practices, often entrench and worsen systemic discrimination against people who use drugs and communities in drug-producing countries. The result is marginalization, stigmatization and widespread, varied and serious human rights violations. Drug policy at home and throughout the globe should protect the rights of people and support public health approaches.

### OUR VISION FOR DRUG POLICY IN CANADA

The CDPC envisions a safe, healthy and just Canada in which drug policy and legislation as well as related institutional practice are based on evidence, human rights, social inclusion and public health.

The CDPC aims to achieve a society that understands the complexity of substance use and embraces a policy framework that recognizes that problem drug use is a complex social, economic, cultural and health issue.

We want to reshape the way Canadian health, social and legal policies respond to drug-related problems. We need policies that empower people to play a role in creating their future as equal participants in their learning and healing and to receive the support and compassion they need to get there. Drug policies need to contribute to individual and community health and safety and be evaluated on these measures.



COALITION





## THE SITUATION IN CANADA

WHEN IT COMES TO DRUG POLICY CANADA IS A PLACE OF BOTH PROMISING PRACTICES AND CHALLENGES:

### Promising Practices

- **Supervised Consumption Site:** Canada is home to North America's first legal supervised injection site—Insite—located in Vancouver, British Columbia. Insite recently scored a major victory. The federal government lost its appeal to the Supreme Court of Canada to close this facility and was ordered to keep Insite open. Several Canadian cities are in the process of discussing the implementation of supervised injection sites including Victoria, Montreal, Ottawa, Toronto and Quebec City.
- **Scaled up Harm Reduction in Some Places:** In some places in Canada, harm reduction supplies are readily available. The Province of Ontario, for example, has 180 sites where harm reduction supplies are distributed. British Columbia has 247 sites offering harm reduction supplies.
- **Declining rates of HIV in some Populations:** The number of new positive HIV tests among people who inject drugs has declined considerably in British Columbia since 2002.
- **Overdose Prevention:** There is growing activity in Canada around the implementation of overdose death prevention through the delivery of naloxone programs. Several provinces are considering programs and working with NGOs to work out the details of implementation.
- **Integrated Municipal Drug Policies:** some Cities like Vancouver and Thunder Bay, Ontario, have eschewed simplistic war on drugs policies and

have set about developing their own approaches that focus not only on the needs of businesses and police, but on the needs of people who use drugs.

- **Medical Cannabis:** Canada has a Medical Marijuana Access Program.
- **User Groups are Being Organized Across Canada:** VANDU, (Vancouver Area Network of Drug Users) in Vancouver (British Columbia), is the largest, best funded and most well known. SOLID is a very active group in Victoria (British Columbia), as is TODUU in Toronto (Ontario). The B.C./Yukon Association of Drug War Survivors and AAWARE in Alberta are regional groups.

### Challenging Issues:

- **National "Anti-Drug" Strategy:** In 2007, the Canadian federal government released its "Anti-Drug Strategy" signaling a major shift in its orientation to drug policy. This policy explicitly omits harm reduction from its mandate and emphasizes prevention, treatment and enforcement, though the bulk of funding goes toward enforcement.
- **Mandatory Minimum Prison Sentences:** In March 2012, the federal government passed into law changes that implement mandatory minimum sentences for some drug crimes. The impact of these changes will be to incarcerate a greater number of citizens for longer time periods, limiting their access to early release and to pardons. These changes combined with a lack of syringe exchange programs in prisons means that more HIV infections are likely.
- **Increasing Number of Overdoses in Canada:** Recent research indicates that overdoses are on the rise including alcohol overdose. There is an urgent

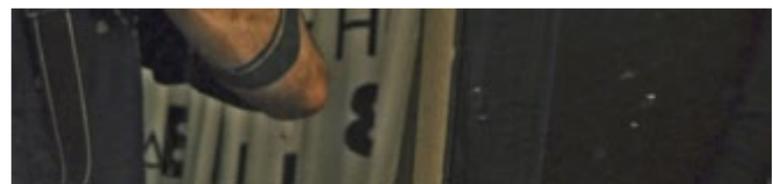
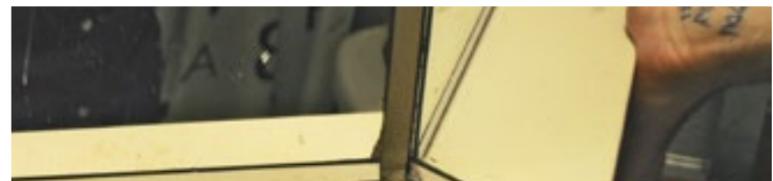
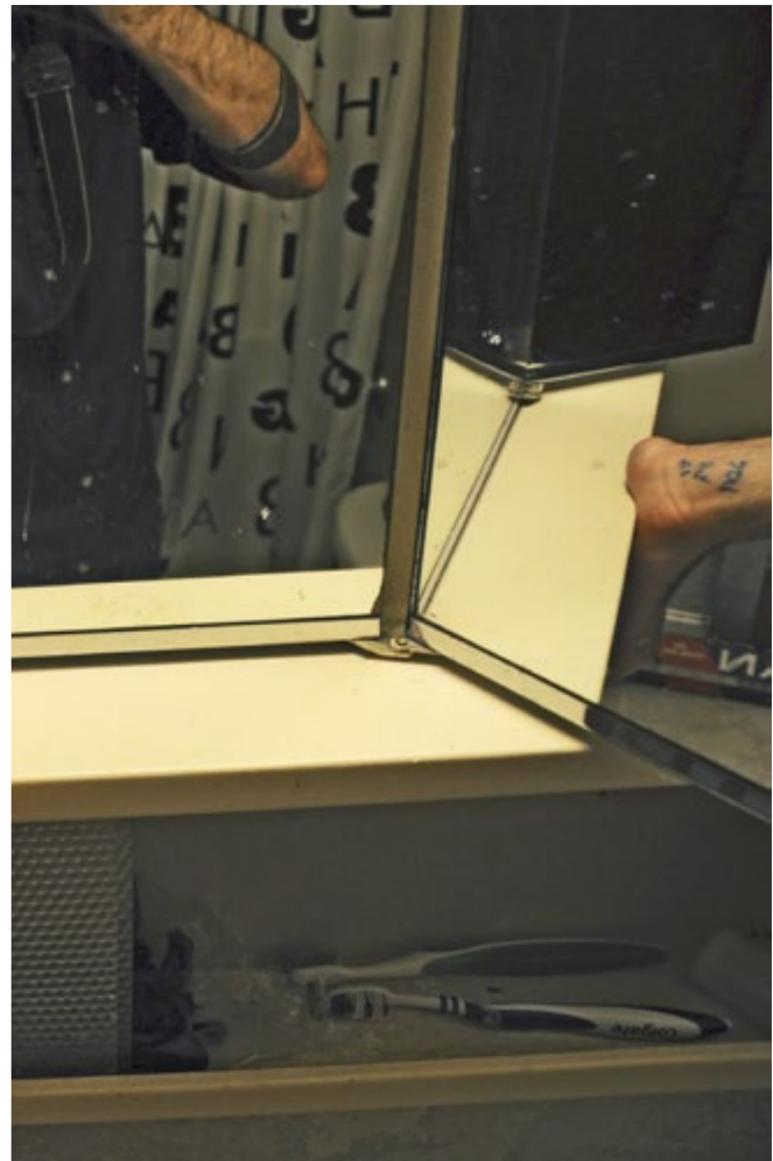
need for scaled up services to prevent overdose deaths. Recent changes that limit prescribing of Oxyneon (in the wake of the discontinuation of Oxycontin) have increased the potential for overdose as dependent users turn to illegal drugs of unknown dose and purity.

- **Patchwork of Harm Reduction Services:** Though several provinces have scaled up harm reduction services, many areas, particularly rural and remote locations are without sufficient access to harm reduction supplies. Public controversy about the distribution of crack kits means that these supplies are distributed on a very limited basis.
- **"Legal Highs":** The number of new psychoactive drugs is increasing as more synthetic chemicals make their way into markets for recreational drug use. The Canadian federal government recently announced its intention to put MDPV into Schedule I of the Controlled Drugs and Substances Act. This means that the harshest drug law penalties will apply to possession, production and trafficking of this substance, further criminalizing and stigmatizing people who use drugs.
- **NIMBYISM:** ("Not in my backyard") This phenomenon remains a force in Canada. Community-based objections to methadone clinics and the continuing use of municipal bylaws to zone out harm reduction services are just a few examples of the difficulties facing services that meet the needs of people who use drugs. NIMBYISM is supported by entrenched discriminatory ideas about people who use illegal drugs.

Canadian ngos wanting to do something about drug policy need to first become informed about the complex issues, the players and the mechanisms. Until now we have lacked the capacity to provide ngos with easy access to relevant information from a Canadian perspective. Some excellent networks do exist, but these tend to focus on specific issues or lack capacity to provide the needed breadth. Those ngos in Canada that have been engaged in drug policy issues have tended to depend on international networks for information. While these networks are helpful, Canadian ngos have expressed the need for more robust Canadian organization.

# BEYOND PROHIBITION





### CANADIAN NURSES LEAD THE WAY IN HARM REDUCTION

By Irene Goldstone, retired former Director, Special Education and Care Evaluation at BC Centre for Excellence in HIV/AIDS

Nurses from across the country will be gathering in Vancouver at the Canadian Nurses Association Biennial Convention this week. As part of the occasion Insite and the Dr Peter Centre are each hosting special sessions on June 17th, providing opportunities for knowledge exchange on harm reduction policies and nursing practice.

Canadian nurses recognize that substance use, both legal and illegal, is an enduring feature of human existence and that abstinence is not always a realistic goal. As such, nurses focus on reducing adverse consequences and building non-judgmental, supportive relationships for the health and safety of individuals, families and communities.

There is a risk that the image of nurse-supervised injection is limited to a nurse hovering over a client while the injection takes place and nothing more occurs. I want to dispel this image.

The nurses of Insite have articulated their framework of nursing practice. Nursing care is client-centred with the focus on relationship building, maintaining dignity and respect, and creating an environment of cultural safety and empowerment. Primary nursing care at Insite includes safer injection education, needle-syringe exchange, first aid, wound care, overdose management, addiction treatment, reproductive health services and communicable disease prevention. These services are delivered as comprehensive harm reduction and health promotion programming nested in partnerships with the health and social service systems and community agencies.

In 2011 the Canadian Nurses Association released a discussion paper on Harm reduction and currently illegal drugs: implications for nursing policy, practice, education and research, which was endorsed by the Canadian Association of Nurses in AIDS Care. The values of harm reduction are consistent with the values guiding professional ethical nursing

practice articulated in CNA's Code of Ethics for Registered Nurses for the provision of safe, ethical, competent and compassionate nursing care; for the promotion of health and well-being; for the promotion of and respect for informed decision-making; for the preservation of dignity in which care is provided on the basis of need; and for the promotion of justice.

Considering this it really shouldn't come as a surprise that Canadian nurses support harm reduction services. The origins of outreach nursing have been attributed to the Grey Nuns, founded by Marguerite d'Youville in Montreal, who by the mid 1700's, were known for their care to the destitute. Inequity of access to health care and the basic determinants of health has led to "street nursing" practices in many urban centres.

In Vancouver, after World War II nurses led a major effort to reach marginalized people who would not attend hospitals for the treatment of sexually transmitted diseases. In 1988 the BC Centre for Disease Control established the AIDS Prevention Street Nurse Program with a focus on needle and syringe exchange. With the epidemics of overdose deaths and the dramatic outbreak of HIV that Vancouver experienced in the 1990's, the street nurses were some of the first to advocate for bringing injecting from the alleys into the safety of a supervised injection health service.

Just over one year ago, professional associations—Canadian Nurses Association, Registered Nurses Association of Ontario and Association of Registered Nurses of British Columbia and BC Nurses Union each acted as intervenors in support of Insite at the Supreme Court of Canada. Nurses across Canada cheered when the Supreme Court ruled in favour of Insite remaining open.

Look for nurses to be leaders in advocating for the expansion of supervised injection services locally, nationally and globally!

## THE HISTORIC INSITE DECISION IN A NUTSHELL

By Scott Bernstein, *Pivot Legal Society*

Unless you've been hiding with the radio and TV off and avoiding the web, you've already heard the Supreme Court of Canada decision on Insite—North America's only sanctioned safe injection facility. In short, this morning we won a remarkable victory that will allow Insite to continue to operate and save lives, prevent disease, provide access to health care and recovery services and a host of other proven benefits. It was an important victory of evidence-based science over ideology. Importantly, we're hopeful that this historic decision may open the doors to similar services throughout Canada and possibly into the United States where the results of the SCC are being watched by harm reduction advocates.

In May, I attended the Supreme Court of Canada as one of four lawyers representing PHS Community Services, Dean Wilson and Shelly Tomic—the three parties who began the legal action in BC Supreme Court in 2007 when faced with threats from the federal government to close down Insite. Sitting in the Ottawa airport, I blogged about the journey that took me through this case, first as a law student and then a lawyer. As my first trip to the Supreme Court of Canada, I was thrilled and honoured to be a part of this important case that affects so many people and to assist the talented senior lawyers who put so much passion into

this case, Joseph Arvay and Monique Pongracic-Speier.

The media, of course, have been reporting on the decision this morning with gusto. But, understandably, there has been some confusion in the reporting of the actual legal decision that was handed down by the Court. For the record, let me give a brief explanation of what was decided (and what wasn't) by the SCC:

In this case, we made two big arguments. The first was that Insite was health care and health care is a "protected core" of provincial power. As a protected core, health care decisions (like creating Insite) couldn't be negated by a federal law (the Controlled Drugs and Substances Act CDSA). This constitutional doctrine is termed "interjurisdictional immunity" (impress your friends with this if you dare) and has been relied on by the courts less and less frequently in recent times and has never worked in favour of provincial powers, only federal ones to date. We lost this argument in the BC Supreme Court, and then surprisingly won it in the Court of Appeal. In the Supreme Court of Canada, we lost it again. The SCC said in this case to "apply it here would disturb settled competencies and introduce uncertainties for new ones." So, when the media say that the SCC decision found that health care was in the purview of the province and can't be ousted by the criminal law, that's



# THE WAR ON DRUGS HAS FAILED

—Dr. Evan Wood, *BC Centre for Excellence in HIV/AIDS*

not really true. The SCC says that—absent any Charter issues—the CDSA applies and can oust health care because of another constitutional doctrine: paramountcy.

The second argument, though, relied on the Charter. We said that the CDSA sections were unconstitutional because they violate the Section 7 rights to not be deprived of life, liberty or security of the person without being in accord with the "principles of fundamental justice" (continue impressing your friends). OR, the Minister's failure to continue an exemption of the CDSA was a Section 7 infringement. In the end, the SCC found that while the prohibition on possession of drugs (but not trafficking) does engage life, liberty and security of the person, it wasn't contrary to those principles because there was a mechanism in place where the Minister could grant an exemption for purposes of science, research, etc. But, because the Minister refused to grant an exemption, this was contrary to the Charter Section 7 because this decision was arbitrary (undermining the purposes of the CDSA) and grossly disproportionate. So, in the end, the Court ordered the Minister ("an order in the nature of mandamus"—if you still have friends left after the first two, try this one out) to issue the exemption forthwith.

And, that's the decision in a nutshell.

As for what the Insite decision means for the Minister allowing other facilities in Canada and what steps Pivot will take in the future in this area, I'll leave that for

a future blog post. But, the SCC seems to have left open a door or at least a crack (paragraphs 152 and 153):

The dual purposes of the CDSA—public health and public safety—provide some guidance to the Minister. Where the Minister is considering an application for exemption for a supervised injection facility, he or she will aim to strike the appropriate balance between achieving the public health and public safety goals. Where, as here, the evidence indicates that a supervised injection site will decrease the risk of death and disease, and there is little or no evidence that it will have a negative impact on public safety, the Minister should generally grant an exemption.

The CDSA grants the Minister discretion in determining whether to grant exemptions. That discretion must be exercised in accordance with the Charter. This requires the Minister to consider whether denying an exemption would cause deprivations of life and security of the person that are not in accordance with the principles of fundamental justice. The factors considered in making the decision on an exemption must include evidence, if any, on the impact of such a facility on crime rates, the local conditions indicating a need for such supervised injection site, the regulatory structure in place to support the facility, the resources available to support its maintenance, and expressions of community support or opposition.



**CANADIAN DRUG  
POLICY COALITION (CDPC)**  
Simon Fraser University  
2400-515 West Hastings Street  
Vancouver BC, V6B 5K3





# THE GLOBAL **WAR** ON DRUGS IS DRIVING THE HIV/ AIDS PANDEMIC AMONG PEOPLE WHO USE **DRUGS** AND THEIR SEXUAL PARTNERS.

“The global war on drugs is driving the HIV/AIDS pandemic among people who use drugs and their sexual partners. Today, there are an estimated 33 million people worldwide living with the human immunodeficiency virus (HIV), and injecting drug use accounts for approximately one-third of new HIV infections occurring outside sub-Saharan Africa. While the annual number of new infections has been falling since the late 1990s, HIV incidence increased by more than 25 percent in seven countries over this time span, largely as a result of HIV transmission related to intravenous drug use. Five of these countries are in Eastern Europe and Central Asia, where the war on drugs is being aggressively fought and, as a result, the number of people living with HIV in this part of the world has almost tripled since 2000.”

—The Global Commission on Drug Policy

**DRUGPOLICYXAIDS.COM**

Check out our Aids 2012 liveblog to keep up with all drug policy-related events and ideas throughout the conference.