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Drug Decriminalization

An integrated approach to improve health and safety outcomes



British Columbia Association of Chiefs of Police

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Introduction

The British Columbia Association of Chiefs of Police¹ (BCACP) represents approximately 9,290 police officers in the Province.² The BCACP was established to promote a high standard of ethics, integrity, honour, conduct; foster uniformity of police practices; encourage the development and implementation of efficient and effective practices in the prevention and detection of crime and effectively communicate problems and concerns to appropriate levels of authority.³

Decriminalization of personal amounts of illicit drugs in British Columbia has been a discussion point for three levels of government, law enforcement, practitioners and a segment of the general public who all agree that given the right conditions, decriminalization of small amounts of illicit drugs is supported. In October 2021 the BC Ministry of Mental Health and Addictions submitted its report, *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*, (the MMHA Proposal) to the federal government seeking decriminalization of a cumulative 4.5 grams possession of opioids (i.e., heroin and fentanyl) and central nervous system stimulant (CNS) (i.e., cocaine, crack cocaine and methamphetamines).

The BCACP supports decriminalization of personal amounts of illicit drugs as part of an integrated approach to divert persons who use drugs (PWUD) away from the criminal justice system and toward health services and pathways of care with the goal of improving health and safety outcomes for those individuals. As a stakeholder representative, the BCACP is in a position to provide further insight and perspective to inform the decision to decriminalize drugs in British Columbia. Decriminalization of personal use amounts of illicit drugs is one part of an integrated approach. The increased toxicity of the illicit drug supply (due to the introduction of fentanyl and its analogues) has led to the current public health emergency and many preventable deathsⁱ. Safer supply is a concomitant component of an integrated approach which could positively impact health and safety outcomes for PWUDs and potentially increase public safety consequent to a diminished role for organized crime in supplying illicit drugs.

The effective decriminalization of possession of personal amounts of illicit drugs was achieved by the Public Prosecution Service of Canada (PPSC) in BC through its 2020 prosecution guideline which directs prosecutors to see alternative measures and diversion from the criminal justice system for simple drug possession cases. **As part of an incremental approach, the BCACP supports a threshold amount of 1 gram of illicit drugs for personal possession and use as opposed to the proposed cumulative 4.5 grams in the MMHA Proposal.**

ⁱ On April 14, 2016, the BC Provincial Health Officer (PHO) declared a public health emergency under the Public Health Act due to an unprecedented level of overdose deaths due to the toxicity of the illicit drug supply. Since then, more than 7,953 British Columbians have died from a preventable overdose.

The BCACP also supports directed health support for PWUD's when consumption is driving criminal behaviour that puts their health or the safety of others at risk. Finally, to address public order and safety issues that arise from the consumption of illicit drugs, the BCACP recommends new provincial legislation (similar to the *Cannabis Control Act*) to provide law enforcement with the necessary tools to ensure public safety.

Effective Decriminalization - Public Prosecution Service of Canada (PPSC)

On August 17, 2020, the PPSC established guideline 5.13 related to prosecutions for personal possession of controlled substances under section 4(1) of the CDSA.⁴ This guideline recognizes that possession is a health-related issue while acknowledging that certain drug use may present particular public safety concerns. Federal prosecutors are required to consider alternatives to possession charges unless there are serious manifestations of harm that justifies a criminal prosecution. The MMHA Proposal (p.11) correctly states that between 2008 - 2017 there were 49,891 criminal possession charges in British Columbia (an average of 4,989 per year). When simple drug possession is the only offence an adult is charged with, the RCMP Data Analysis Unit reports that in 2019 there were only 50 CDSA possession convictions in British Columbia and in 2020 the number had reduced dramatically to 14 convictions.⁵ This data shows PWUD are no longer being criminalized for illicit drug possession unless there is a public safety concern or that possession is associated with other criminal conduct.

A survey of 72 British Columbia RCMP Detachment Commanders in October 2021 revealed that:

- a. 54% reported their police officers were not enforcing section 4(1) in the CDSA;
- b. 71% of those policing jurisdictions with a population base of 5,000 to 14,999 were not enforcing section 4(1) in the CDSA;
- c. The primary reason for stopping (or reducing) enforcement of section 4(1) in the CDSA was that the PPSC policy change resulted in charges no longer being approved.

The data show that the PPSC guideline has effectively decriminalized possession of personal amounts of illicit drugs in British Columbia.

Safer Supply and Organized Crime

A safer supply implemented by local health authorities has significant potential to reduce the health related harms associated to the illicit drug supply, reduce the violence and stigmatization that PWUD experience and potentially reduce organized crime involvement in the illicit drug market.

In August 2020 the federal Minister of Health sent a letter to Provincial and Territorial Ministers of Health encouraging them to increase access to safer, pharmaceutical-grade alternatives to the contaminated illegal drug supply for people at risk of overdose.⁶ The letter also stated that providing pharmaceutical-grade alternatives to the toxic street supply (i.e. a safer supply), both in the context of treatment or as a harm reduction measure, can support people who use drugs by reducing their risk of overdose, infection and withdrawal.

Preliminary evidence from the London InterCommunity Health Centre (LIHC) in Ontario has shown that implementing a safer supply has been effective at preventing overdose deaths, improving participants' health and helping them meet other important health and social needs.⁷ Over four years, the study followed 118 PWUD and found:

- a. Reduced illicit drug use and overdose risk;
- b. Increase engagement in primary care;
- c. Economic improvement (money spent on drugs is now spent on food and other basic necessities);
- d. Reduction in homelessness, from 62% to 38%;
- e. Reduction in survival sex work, from 68% to 20% (among women);
- f. Reduction in criminal activity to pay for drugs, from 48% to 12%.

The scaling up of a safer supply has been encouraged by the federal Minister of Health, and preliminary evidence from LIHC indicates that it is possible and can be successful in not only reducing drug-related overdose deaths but also reducing homelessness and criminal activity.

A Statistics Canada study⁸ of 13,318 people conducted to better understand the socioeconomic determinants associated with opioid overdose demonstrates the role safer supply has to play in improving health and safety outcomes. The study revealed that:

- a. 64% of those who experienced a fatal overdose were not employed at the time;
- b. 62% had visited an emergency department in the year prior to their overdose;
- c. 61% of the people had no formal contact with police in the two years prior to their overdose;
- d. 50% of the people received social assistance in the year of their overdose;
- e. The leading reasons for police to have professional interactions with PWUD (was not drug possession offences) but shoplifting (16.5%), disturbing the peace (10.9%), failure to comply with order (8.7%), and breach of probation (7.0%).

The fact that most PWUD who experienced a fatal overdose had no formal contact with police two years prior to their death points to the toxicity of illicit drugs as being a key factor to address to improve health and safety outcomes for PWUD.

Safer supply could also supplant organized crime in supplying illicit drugs. There are approximately 188 criminal groups operating in British Columbia’s illicit markets with at least 57% of organized crime networks involved in one or more aspects of fentanyl synthesis, supply, distribution, and trafficking.⁹ Absent safer supply, these groups will continue to distribute the toxic illicit drugs causing the current public health emergency and may expand operations due to the perceived reduction in risk that decriminalization offers.

In Portugal for example, drug decriminalization resulted in a marked reduction in drug trafficker sanctions. While the number of arrests for trafficking changed little, the number of individuals convicted and imprisoned for trafficking since 2001 has fallen nearly 50 percent.¹⁰ In addition to the perceived reduction in risk, the higher levels of possession may create low-level drug trafficking opportunities. For example, possession of 4.5 grams represents 45 doses of 100 mg each.

According to the United Nations more than 90% of the value added (gross profit) of cocaine and heroin is generated at the distribution stage of the illicit drug industry.¹¹ For example, cocaine can be purchased for \$35,000 a kg, sold at \$80 a gram, which represents a profit of \$45,000 per kg.

Potential profits from illicit drug sales.¹²

Drug	Purchase at the KG level	Sell at the gram level	Income per 1,000 grams in sales	Profit from each KG
Heroin	\$68,000	\$140 per gram	\$140,000	\$72,000
Fentanyl	\$70,000	\$160 per gram	\$160,000	\$90,000
Cocaine	\$35,000	\$80 per gram	\$80,000	\$45,000
Crack Cocaine	\$35,000	\$80 per gram	\$80,000	\$45,000
Methamphetamine	\$10,000	\$30 per gram	\$30,000	\$20,000

The illicit drug economy is inextricably linked to numerous acts of violence, including homicides, attempted homicides, kidnapping, assaults, arson, and human trafficking. Many violent acts associated to organized crime’s involvement in the illicit drug trade occur in public spaces putting the public at risk of serious injury or death. The increase in violence associated to gang-related homicides and attempted homicides is, in part, related to money owed for failed drug transactions, drug debts owed, and inter-gang rivalry and conflict as groups compete for territory. Many, if not all, of the victims of gang-related homicides and attempted homicides, are involved in some aspect of the illicit drug economy. Since 2006, there have been more than 850 gang-related homicides and attempt homicides across British Columbia (CFSEU-BC, 2021).

The absence of a legal safer supply puts vulnerable PWUD in contact with drug traffickers and organized crime groups. In 2011, 14.5% of all PWUD reported experiencing some form of violence.¹³

Health Care System Readiness and Pathways of Care

In 2019, approximately 760,000 British Columbians (17.7% of population) did not have a family doctor or other primary care provider.¹⁴ The majority of BC's population of 5,147,712 people live in densely populated cities with an overburdened health care system but many live in small communities (11.7%) and rural areas (13.6%) where access to substance abuse treatment is non-existent.¹⁵ ¹⁶ The Public Health Agency of Canada found that people who have died of drug-related overdose deaths often did not have a comprehensive and coordinated health care and social service follow-up¹⁷ and the current patchwork of waitlists and referrals is leaving most adults without any supports for mental health and substance use harms until they become much worse or reach a crisis.¹⁸

Frontline police officers are often the first point of contact with persons who use drugs 24-hours a day, and report that there is a significant lack of immediately available treatment services to accept people with a substance use disorder, which leads to the continued cycle of crime, criminal justice system involvement, and perpetuation of addiction.¹⁹ ²⁰ Pathways for PWUD need to be established, particularly in the small and rural communities, in order for police to quickly connect PWUD to a range of evidence-based treatment and other social services (such as housing and employment) as needed.²¹

In October 2021 a survey regarding decriminalization was conducted among RCMP Detachment Commanders across British Columbia.²² Analysis of the results determined that:

- a. 67% of RCMP jurisdictions in Metro Vancouver have street-based outreach programs, however; that number drops to 47% on Vancouver Island and to 41% in the North District;
- b. Nearly two-thirds (64%) reported their communities do not have drug rehabilitation or treatment programs available;
- c. 80% of respondents in the North District reported that rehabilitation or treatment programs were not available within their jurisdictions and their communities did not have the resources required to develop or implement these services or programs.

The MMHA Proposal discusses health system readiness (p.26) by stating the provincial health system is being strengthened; however, it does not indicate the current capacity/availability of treatment or rehabilitation programs across the province. The BCACP believes that pathways to care for PWUD need to be established well in advance of drug decriminalization so there is no delay between wanting and receiving treatment.

Indigenous People

Indigenous people comprise 3.3% of British Columbia's population yet disproportionately account for almost 15% of toxic drug related deaths.²³ Indigenous people often do not receive adequate treatment for substance use or other medical needs due to ongoing discrimination in the health care system.²⁴ A 2020 study found 84% of Indigenous peoples experienced racism and discrimination in the health care system which discouraged them from seeking necessary care.²⁵ Furthermore, many have been dissuaded from treatment due to excessively long wait times or because the treatment programs were grounded in a faith they did not share.²⁶

According to the First Nations Health Authority, in October 2021, 19 Indigenous communities were under drinking water advisories in BC.²⁷ Further, in October 2021, 11 First Nations Chiefs declared a state of emergency to bring the lack of funding for opioid treatment services and aftercare to the attention of the provincial government.²⁸ The BCACP suggests that the MMHA proposal include an analysis on how decriminalization would affect health supports in Indigenous, northern and remote communities. This could include a consideration of Indigenous communities and governments setting their own threshold amounts thereby empowering them to address local needs consistent with principles in BC's *Declaration on the Rights of Indigenous Peoples Act*.²⁹

At present, it appears that the British Columbia health system is not in a position to provide wide spread treatment options related to heroin, fentanyl, cocaine, crack cocaine, and crystal methamphetamine in all communities across the province. This further highlights the need for an incremental approach to thresholds while a more comprehensive health care infrastructure is established. Based on our discussion with a sampling of First Nations leadership and Councils, more robust discussions are required.

Threshold Amounts

Assessment of a number of factors can inform threshold amounts to eliminate criminality for possession of personal amounts of illicit drugs while facilitating improved health and safety outcomes. Such factors include the toxicity levels of illicit drugs, thresholds set by other countries implementing decriminalization and purchasing and consumption data.

Toxicology

To provide a context within which to consider the thresholds proposed in the MMHA Proposal the BCACP retained Mr. Wayne Jeffery (M.Sc., Pharm.), a registered pharmacist, an analyst designated for the *Controlled Drugs and Substances Act*, and instructor at both the University of British Columbia (UBC) Faculty of Pharmacy and the Forensic Nursing Program at the British Columbia Institute of Technology (BCIT). Over the last 42 years, Mr. Jeffery has published 29

articles and qualified as an expert witness in court in BC, Alberta, Yukon, and Northwest Territories in relation to the pharmacology and toxicology of licit and illicit drugs.

In relation to opioids and CNS stimulants, Mr. Jeffery advises that:

- a. These drugs are consumed in milligram doses;
- b. They are both physically and psychologically addicting;
- c. Lethal doses occur at far below the proposed threshold of 4.5 grams;
- d. CNS stimulants can cause psychotic episodes, violence and excited delirium.

Opioids

Heroin	MMHA proposes up to 4.5 grams
Street dose	0.1 gram (100 mg)
Daily heavy user	0.5 to 1 grams per day
Lethal dose	0.25 to 0.5 grams
Fentanyl	MMHA proposed up to 4.5 grams
Street dose	0.1 gram (100 mg)
Daily heavy user	0.001 to 0.005 grams (1-5 mg)
Lethal dose	0.002 gram (2 mg)

CNS Stimulants

Cocaine powder	MMHA proposed up to 4.5 grams
Street dose	0.1 gram (100 mg)
Daily heavy user	1 to 2 grams
Lethal dose	1 to 1.5 grams
Cocaine IV	MMHA proposed up to 4.5 grams
Street dose	0.05 to 0.1 grams (50-100 mg)
Daily heavy user	1 gram
Lethal dose	0.8 gram
Crack cocaine	MMHA proposes up to 4.5 grams
Street dose	0.1 to 0.3 grams (rock)
Daily heavy user	1 to 3 grams (10 rocks)
Lethal dose	1 to 4.5 grams in a 24 hr period
Methamphetamine	MMHA proposes up to 4.5 grams
Street dose	0.1 gram
Daily heavy user	0.25 to 0.3 grams
Lethal dose	0.15 to 1.5 grams

Notes:

4.5 grams (4,500 mg) = 45 doses of 100 mg each. Accidental absorption of fentanyl can occur through wet skin. A heavy user of meth on a limited duration 'speed run' can consume 1 to 1.5 grams per day. A lethal dose of fentanyl at 2 mg represents a dose of pure fentanyl, which is why a street dose amount (not pure) is higher than the lethal dose.

Fatal doses of carfentanil (approximately 100 times more potent than fentanyl) can occur at the microgram level (1 microgram = 0.000001 gram). A recent BC Medical Journal article provides an anecdotal example suggesting that some PWUD are intentionally moving toward carfentanil because they are looking for even-higher-potency opioids.³⁰ So far, in 2021, fentanyl has been detected in 87% of overdose deaths.³¹ Furthermore, carfentanil has been detected in 137 suspected illicit drug toxicity deaths in 2021 (Jan-Sept).

International Thresholds

The Strategic Research Office (CFSEU-BC) conducted a jurisdictional scan of drug possession thresholds that have been adopted in other countries. The results of this scan indicate that the proposed cumulative threshold of 4.5 grams (of heroin, methamphetamine and cocaine) is more than the average of most countries.

Countries that have decriminalized/depennalized amounts of illicit drugs:

Location	Heroin (grams)	Meth (grams)	Cocaine (grams)	Crack (grams)	Cumulative all drugs (or cumulative total of heroin, meth, cocaine, and crack cocaine for countries using drug-specific totals)*
Czech Republic	1.5	1.5	1.0	0.2	4.2
Ecuador	0.1		1.0		1.1
Germany	1.0	5.0	3.0		9.0
Latvia	0.001	0.02			0.2
Mexico	0.05	0.04	0.5		0.6
Oregon, USA	1.0	2.0	2.0		5.0
Paraguay	2.0		2.0		4.0
Peru	1.0	1.0	2.0		4.0
Portugal	1.0		2.0		3.0
Russia	0.5		0.5		1.0
Spain	3.0		7.5		10.5
				Meanⁱⁱ	3.9
				Modeⁱⁱⁱ	4.0
				Median^{iv}	4.0

Notes:

Colombia was excluded as an extreme outlier, which would have skewed the average upward.

*This is a gross under-estimation of the actual cumulative total for many countries, because this relies on only the three “main” drug types, and not all drug types listed in each country’s legislation. Moreover, some countries either do not list a threshold for methamphetamine, or they list their threshold in “day’s supply” rather than a fixed weight.

Most countries did not consider fentanyl when they established their decriminalization thresholds.

Germany’s thresholds vary across the country. Some Länder (states) use a judicial discretion model, while others use fixed thresholds. The specific alternative measure applied also depends on the jurisdiction. Among those using fixed thresholds, heroin is set at 1 gram, cocaine ranges from 1-3 grams, and methamphetamine is subject to a federal court interpretation whereby 5 grams and over is considered a “non-small amount”, while anything under that is a “small amount” which qualifies for local alternative measures.

ⁱⁱ Mean is the average number found by adding all data points and dividing by the number of data points.

ⁱⁱⁱ Mode is the most frequent number (occurs the highest number of times).

^{iv} Median is the middle value in a list from smallest to largest.

Many countries have opted for separate possession limits for each drug. The cumulative threshold in the MMHA Proposal will still permit the possession of 4.5 grams of any one illicit drug, which is more than the average threshold of individual drugs that most countries have established.

While the BCACP has been publicly supportive of the decriminalization of small amounts of illicit drugs for personal use, the MMHA Proposal (p.23) accurately states, “policing partners expressed concern that the recommended levels were too high.” Portugal implemented a decriminalization model 20-years ago and their threshold for heroin has remained at 1.0 gram (representing 10 doses of 100 mg). It should also be noted that Portugal has not been impacted by illicit fentanyl and its analogues. The BCACP submits that the proposed 4.5 grams (representing 45 doses of 100 mg) cumulative threshold is not consistent with other countries or in the best interest of a public health model. Decriminalization of opioids and CNS stimulants (at the same time) with different pharmacological properties, different use/dose levels, different lethal dose levels, and different physical/psychological addictive properties has the potential to negatively affect health and safety outcomes.

To provide a visual representation of the proposed threshold amount the three photographs below depict 45 doses of 100mg of fentanyl – the proposed possession threshold of 4.5 grams.

Note: Photographs reduced in size to fit this page.



Purchasing and Consumption Data

The BCACP is not aware of any existing theoretically based, empirically tested framework that can inform the development and evaluation of the decriminalization of illicit drug possession.³² Although there has been research on frequency of use and drugs used in the DTES,^{33 34} the BCACP is not aware of any research that sheds light on purchase quantities, consumption patterns, and possession quantities of opioids and CNS stimulants across the province to inform an evidenced-based threshold amount.

According to a 13-year old study (MMHA Proposal p.8), drugs can be purchased in Vancouver within 10 minutes.³⁵ Although the BCACP is not aware of any current studies indicating the time it takes to access illicit drugs in remote communities, we suggest that illicit drug prices and drug availability research be conducted to better inform purchase quantities and purchase frequency across the province.

Drug prices in British Columbia have remained relatively stable over the past few years.³⁶

Drug	Purchased at the 0.1 gram level	Purchased at the gram level	Price if purchased at the ounce level	Price if purchased at the kg level
Heroin	\$20	\$140-\$160	\$3,000-\$5,000	\$68,000-\$72,000
Fentanyl	\$20	\$160	\$2,800-\$3,600	\$70,000-\$80,000
Cocaine	\$10	\$80	\$1,400-\$1,600	\$35,000-\$45,000
Crack cocaine	\$10	\$80-\$100	\$1,600-\$1,800	\$40,000-\$50,000
Crystal Meth	\$10	\$30-\$50	\$400-\$600	\$10,000-\$15,000

The BCACP suggests that the self-reported consumption or “rapid survey” data (MMHA Proposal p. 20-21) is not a strong evidence base to establish a drug possession threshold across the province. When the purchase price of drugs is compared to the self-reported consumption, it indicates the cost to consume opioids would be from \$60 to \$620 per day or \$21,900 to \$226,300 per year.

Drug		Median daily use in grams	Approx. daily median cost	Approx. yearly cost
Opioids	Median	0.33	\$60	\$21,900
	Upper Quartile	0.65	\$120	\$43,800
	Max	4.39	\$620	\$226,300
Cocaine	Median	0.50	\$50	\$18,250
	Upper Quartile	1.06	\$80	\$29,200
	Max	4.75	\$320	\$116,800
Crack Cocaine	Median	0.2	\$20	\$7,300
	Upper Quartile	0.4	\$40	\$14,600
	Max	7.5	\$600	\$219,000
Amphetamine	Median	0.21	\$20	\$7,300
	Upper Quartile	0.45	\$45	\$16,425
	Max	6.45	\$190	\$69,350

Note: Quantities under the gram level were priced as 0.1 gram level and quantities over 1 gram were priced at the gram level. Crystal methamphetamine prices were substituted for amphetamine prices.

If a PWUD purchased fentanyl at the gram level (4.5 grams a day or 1.64 KG a year) it would cost approximately \$262,800 per year. At these levels of consumption, it would cost the PWUD approximately \$1.3 million dollars over five years.

Drug	Grams per day	Cost to purchase per day	Cost to purchase per year	Cost to purchase over 5 years
Opioids	4.5	\$720	\$262,800	\$1,314,000
Cocaine	4.5	\$360	\$131,400	\$657,000
Crack Cocaine	4.5	\$360	\$131,400	\$657,000
Methamphetamine	4.5	\$135	\$49,275	\$246,375

The MMHA proposal (p.22-23) states the 4.5 grams possession threshold would account for some limited amounts of “social supply” whereby substances are possessed with the intention to share with another individual where there is no motivation to profit. There is emerging research on social supply,^{37 38 39 40} however; the BCACP believes “social supply” would meet the definition of trafficking (section 5(1) in the CDSA), which is beyond the scope of a section 56(1) exemption request that applies to section 4(1) of the CDSA. Furthermore, the MMHA proposal does not explain how social sharing would reduce drug overdoses or promote a public health approach when the drugs being shared are from the illicit and toxic market.

Complementary Supports for Decriminalization

Police Liability

The MMHA Proposal (p.23) accurately captures police concerns with the, “potential risks and liabilities in allowing individuals to remain in possession of toxic illicit substances.” The MMHA proposal could include a liability exclusion for police in relation to the non-seizure of illicit drugs. Returning drugs (under threshold amounts) that result in a fatal overdose death may trigger an Independent Investigations Office of BC (IIO) investigation and/or potential lawsuit from family members if the PWUD fatally consumes the drugs that were returned to them by police.

Public Safety

The MMHA Proposal (p.21) states there will be no drug seizures, arrests, or charges for simple possession at or below the cumulative binding threshold of 4.5 grams, however; the BCACP believes there will be cases where it would be appropriate to seize drugs. For example:

- a. To prevent the continuation of a criminal offence such as driving while impaired;
- b. When there are concerns surrounding the nature and location of public consumption including use that endangers the safety of children;
- c. To prevent death or injury when an overdose occurs requiring medical intervention or a PWUD becomes ill or violent in public after consumption;
- d. In cases where the age of majority cannot be determined;
- e. When a person is apprehended under the *Mental Health Act*;
- f. When a person is arrested and transported to a police facility.

The MMHA Proposal (p.23) states drug seizures could be reduced by 60-80% if this decriminalization proposal is approved however, if police stop seizing drugs in limited situations where there is a clear nexus to public or personal safety, without the establishment of clear pathways to health especially in rural and small communities, an unintended consequence could be an increase in the number of drug-related overdose deaths.

Pathways of Care

The MMHA Proposal (p.23) accurately states that many jurisdictions that have pursued decriminalization have put in place a range of administrative sanctions as alternatives to criminal penalties. The BCACP believes that drug decriminalization will create a need for social and structural interventions that best enable police to fulfil public safety and public order objectives without negatively impacting health outcomes for PWUD. The BCACP suggests that decriminalization must be accompanied by a framework of diversion program options⁴¹ to provide front line police with established pathways to refer PWUD to health, rehabilitation, and recovery support.⁴² This cannot simply be accomplished by providing local police with information regarding the nearest health, treatment and support resources available in the area which frontline officers can provide to PWUD.

Other jurisdictions which have pursued decriminalization have implemented models directing PWUD with problematic substance use to connect with health practitioners. The BCACP believes that diverting PWUD to dissuasion or compassion commissions, health or peer supports will provide better health outcomes and reduce overdose deaths.

Public Consumption

The MMHA Proposal (p.30-31) accurately states, “police have ongoing concerns regarding potential impacts to public consumption.” Rural and remote communities may not have bylaws or the ability to fund bylaw offence prosecutions.

Research is needed to determine the dangers that second-hand illicit drug smoke could pose to the public. A limited number of animal studies in controlled environments have shown that exposure to methamphetamine smoke can result in a positive drug test for those exposed⁴¹ and that exposure to crack cocaine smoke can increase plasma levels to those similar to users.⁴³

Other harmful aspects of public consumption include litter, discarded needles and other biohazard material, vandalism, property crime, public nuisance complaints, as well as other unpredictable behaviour. As previously stated, CNS stimulants can cause psychotic episodes, violence and excited delirium, and other medical emergencies, which may put the public as well as the localized health services at risk.

In November 2021, the City of Vernon, Mayor Victor Cummings, stated in a media release that he would like to see safer supply become a priority and that police need tools to easily, and readily manage PWUD in public places.⁴⁴ Police agencies across the province are routinely called upon to address concerns of public consumption of illicit drugs which impact youth and the perception of community safety. In the absence of a robust public health response being established, police will continue to be called to address these concerns. The BCACP recommends that appropriate legislation be developed to support communities and provide police agencies with the tools to address concerns around public consumption.

The administrative province-wide decriminalization legislation could parallel some of the offences in the *Cannabis Control and Licensing Act*,⁴⁵ which addresses harms associated with:

- a. Consumption in public places such as skating rinks, sports fields, parks, swimming pools, playgrounds, skate parks, workplaces, meeting rooms, common areas in condominium or dormitories;
- b. Consumption on school property, abutting school property, or health board property;
- c. Operating a vehicle or boat knowing that another person on board is consuming illicit drugs;
- d. Operating a vehicle while in possession of illicit drugs;
- e. Illicit drugs stored in a way that could create access for a youth;
- f. Allowing a youth to be in an area where illicit drugs are being consumed (smoked or injected).

If the MMHA Proposal applies province-wide then it would be logical to apply a province-wide administrative system that could be consistently applied and capture data to support the monitoring and evaluation of the MMHA Proposal.

Conclusion

The BCACP supports decriminalization of personal amounts of illicit drugs as part of an integrated approach to divert persons who use drugs (PWUD) away from the criminal justice system and toward health services and pathways of care with the goal of improving health and safety outcomes for all British Columbians. Most countries which have implemented decriminalization pursued a lower drug possession amount for heroin and have implemented a range of administrative sanctions as alternatives to criminal penalties.

The BCACP ardently believes that health pathways for PWUD need to be established, particularly in rural and remote communities, to connect PWUD with a range of evidence-based health care and treatment supports as well as other key supports such as employment and housing. At present, nearly two thirds (64%) of RCMP detachments in the province report that the communities they serve do not have drug rehabilitation or treatment programs available.

The data used to develop the proposed thresholds for personal possession are predominantly consumption data from Vancouver's Downtown Eastside which cannot be extrapolated province wide and fail to capture existing purchasing patterns reported by groups representing PWUD as typically occurring at the 0.5 gram level (the proposed threshold is nine times this amount).

Setting thresholds at the level proposed by the MMHA Proposal will likely have a negative effect on public safety by:

- a. Not addressing the role of organized crime in the supply of illicit drugs;
- b. Creating low-level drug opportunities (e.g., an adult possessing 45 doses of 100 mg);
- c. Not creating provincial legislation to address problem possession and use that could also capture data to support the monitoring and evaluation of MMHA Proposal.

The BCACP believes additional consultation is needed with mayors, band councils, and community leaders across the Province to fully understand the implications of the MMHA Proposal. The BCACP supports a lower threshold of 1 gram of opioids as part of an incremental approach which includes safer supply and fully resourced health supports. The BCACP supports a lower threshold to fully understand the implications to community safety across rural and urban communities in BC.

The current public health emergency caused by the increased toxicity levels of the illicit drug supply requires an integrated approach. Decriminalization (which has already been effectively achieved by the PPSC's charge approval policy) on its own is not sufficient. To have a direct and dramatic effect on health and safety outcomes the BCACP supports safer supply, prescribing pharmaceutical grade alternatives to the toxic illicit drug supply. Medically prescribing drugs has the potential to significantly reduce overdose deaths, stigmatization and the public safety consequences of illicit drugs supplied by organized crime.

The BCACP hopes that the insight and perspective it brings will help inform the MMHA Proposal. As a stakeholder representative, the BCACP will continue to advocate for an integrated approach to divert PWUD found in possession of small amounts of illicit drugs away from the criminal justice system and towards health services and pathways of care while ensuring the safety of all British Columbians.

¹ The BCACP is an association representing the senior police leadership of both the RCMP and Municipal Police agencies within British Columbia.

² Number of police officers in Canada in 2019, by province or territory. Statista. Available at: <https://www.statista.com/statistics/530608/number-of-police-officers-in-canada-by-province/>

³ Information related to the British Columbian Association of Chiefs of Police is located at: <https://www.bcacp.ca/about-us>

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⁵ Number provided by Tara Haarhoff, Manager of the RCMP E Division Data Analysis Unit. The numbers relate to occurrences where possession is the only offence coded by police and possession charges resulted in conviction. Email to Sgt. Holmquist dated September 29, 2021.

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