Protecting vulnerable communities in the midst and wake of COVID-19:
Brief to the Minister of Health and Canadian Delegation
to the United Nations Commission on Narcotic Drugs

Prepared for the 64th session of the Commission on Narcotic Drugs
by the Canadian Civil Society Working Group on United Nations Drug Policy

Introduction and Objectives

This brief is submitted to the Minister of Health and members of the Canadian delegation to the 64th session of the United Nations (UN) Commission on Narcotic Drugs (CND) by the Canadian Civil Society Working Group on UN Drug Policy (see Appendix). The Working Group was originally established in preparation for the United Nations General Assembly Special Session on the World Drug Problem in 2016. Since then, members have welcomed the opportunity to engage more regularly with Canada regarding matters coming before the CND, and to represent civil society as part of Canadian delegations to the CND.

The objective of the Working Group is to increase Canadian civil society engagement at the CND, and related UN meetings and processes, with a view to promoting international drug policy that:

- is informed by current evidence;
- adheres to international human rights agreements and other human rights norms;
- promotes the inclusion of people who use drugs and civil society stakeholders in all aspects of research, policy development and program implementation;
- reflects values that embrace ongoing critical evaluation of the impacts of drug policy on individuals, families and communities; and
- supports the achievement of the UN Sustainable Development Goals.

The following recommendations highlight priority areas in which Canada can play a leadership role in advancing evidence-informed, inclusive and effective drug policy that is grounded in a public health approach and in alignment with complementary UN initiatives, including the promotion of human rights and achievement of the Sustainable Development Goals.

The Working Group appreciates Canada's continued support for civil society participation at the CND and other UN meetings related to drugs and drug policy, as well as efforts made to increase participation – including on the Canadian delegation – over the past year. Membership on the Canadian delegation and engagement with the recommendations contained in this brief provides an opportunity to amplify the civil society voice in the international dialogue on drug policy.

Recommendations

1. Ensuring equity for people who use drugs from racialized communities, including Indigenous populations, and across genders

Repeatedly, expressly and by consensus, Canada and other Member States have directed drug control efforts to conform with the standards of international human rights.[1] Further, the 2030 Agenda for Sustainable Development lists "Leaving no one behind" as one of the fundamental aims of the Sustainable Development Goals.[2] This necessarily includes racialized communities (including Indigenous populations) and people of all gender identities. Current drug policies have had a disproportionate and discriminatory impact on women, people of diverse gender identities,[3] as well as racialized and Indigenous communities. As UN bodies, including UN human rights committees, have recognized, determinants of health such as stigma, sexism, racism, colonialism, intergenerational trauma, homophobia, transphobia, poverty, housing insecurity, pregnancy and parenting, physical and sexual violence as well as repressive laws and policies that disproportionately affect women, people of diverse gender identities and racialized communities are not sufficiently accounted for in the design of health strategies directed at people who use drugs.

The impact of punitive drug laws is gendered. Substantially more men than women are prosecuted and incarcerated for drug offences in Canada. At the same time, a higher proportion of women in prison are incarcerated for drug offences than among men in prison. Women also face barriers to treatment and harm reduction services. Despite women comprising one in three of every person who uses drugs, only one out of five people in drug treatment are women.[4] In 2016, the UN Committee on the Elimination of Discrimination against Women (CEDAW Committee) expressed concern about "the excessive use of incarceration as a drug-control measure against women and the ensuing female over-population in prison," as well as "the significant legislative and administrative barriers women face to access supervised consumption services," consequently calling on Canada to "reduce the gap in health service delivery related to women's drug use, by scaling-up and ensuring access to culturally appropriate harm reduction services" and to repeal "mandatory minimum sentences for minor, non-violent drug-related offences."[5]

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[1] For example, see *1998 UNGASS Declaration*, para. 8; CND, 53rd Session, Resolution 53/2, para 2,: http://www.unodc.org/documents/commissions/CND-Res-2000-until-present/CND53_2e.pdf; and *2016 UNGASS Outcome Document*, preamble, https://www.unodc.org/documents/postungass2016/outcome/V1603301-E.pdf.

[2] General Assembly Resolution 70/1, *Transforming Our World: The 2030 Agenda for Sustainable Development* A/RES/70/1 (25 September 2015), https://sustainabledevelopment.un.org/content/documents/21252030%20Agenda%20for%20Sustainable%20Development%20web.pdf.

[3] Center for American Progress, *Unjust: How the broken criminal justice system fails transgender people* (Report, Movement Advancement Project, 2016), 8.

[4] United Nations Office on Drugs and Crime (UNODC) (2020), *World Drug Report 2020* (United Nations Publication, Sales No. E.20.XI.6), https://wdr.unodc.org/wdr2020/field/WDR20_BOOKLET_1.pdf.

[5] UN Committee on the Elimination of Discrimination against Women, *Concluding observations on the combined on the combined eighth and ninth periodic reports of Canada*, UN Doc. CEDAW/C/CAN/CO/8-9, November 18, 2016, paras. 44-45.

Similarly, the UN Committee on the Elimination of Racial Discrimination (CERD) in 2017 expressed concern at the disproportionately high rate of incarceration of black and Indigenous peoples and called for "evidence-based alternatives to incarceration for non-violent drug users."[6]

The United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP) affirms that "Indigenous individuals have an equal right to the enjoyment of the highest attainable standard of physical and mental health."[7] Further, approaches founded on Indigenous knowledge and culture ensure a more holistic approach to drug use and control.

Notwithstanding general rhetorical affirmations of human rights, attention to specific human rights concerns in the context of drug policy remains contentious at the CND.[8] In Canada, Black and Indigenous communities are disproportionately charged, prosecuted and incarcerated for drug offences.[9] Drug policies affecting Indigenous populations remain largely based on colonial norms, laws and customs, leading to disproportionate rates of incarceration and police persecution. While accounting for only 5% of the population in Canada as a whole, as of January 2020, Indigenous prisoners made up 30.4% of the total federal prison population — an increase of 43.4% since 2010. [10] Furthermore, 40% of federally incarcerated women in Canada are Indigenous, and Indigenous women are more likely than white women to be imprisoned for drug offences.[11] At the same time, almost 20% of Black federal prisoners are incarcerated for a drug offence,[12] and Black women in particular are more likely than white women to be in prison for that reason.[13]

For drug policy to create greater equity for Indigenous peoples, it must support access to and availability of resources to enable an Indigenous-specific public health approach, guided by Indigenous knowledge. Focused attention and equitable capacity to address the Indigenous

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[6] UN Committee on the Elimination of Racial Discrimination, *Concluding observations on the combined twenty-first to twenty-third periodic reports of Canada*, UN Doc. CERD/C/CAN/CO/21-23, September 13, 2017, paras 15 and 16(d).

[7] United Nations General Assembly. (2007). *United Nations Declaration on the Rights of Indigenous Peoples.* Retrieved from Department of Economic and Social Affair Indigenous Peoples: https://www.un.org/development/desa/indigenouspeoples/declaration-on-the-rights-of-indigenous-peoples.html.

[8] Human Rights Council (4 September 2015), *Study on the Impact of the World Drug Problem on the Enjoyment of Human Rights: Report of the United Nations High Commissioner for Human Rights*, UN Doc. A/HRC/30/65, http://www.ohchr.org/EN/HRBodies/HRC/RegularSessions/Session30/Documents/A_HRC_30_65_E.docx; Human Rights Council (14 September 2018), *Implementation of the Joint Commitment to Effectively Addressing and Countering the World Drug Problem with Regard to Human Rights: Report of the Office of the United Nations High Commissioner for Human Rights*, UN Doc. A/HRC/39/39, https://www.ohchr.org/EN/HRBodies/HRC/RegularSessions/Session39/Documents/A_HRC_39_39.docx.

[9] Commission on Systemic Racism in the Ontario Criminal Justice System, *Report of the Commission on Systemic Racism in the Ontario Criminal Justice System*, 1995; J. Rankin and S. Contenta, 'Toronto marijuana arrests reveal 'startling' racial divide,' *Toronto Star*, July 6, 2017; A. Owusu-Bempah and A. Luscombe, 'Race, cannabis and the Canadian war on drugs: An examination of cannabis arrest data by race in five cities,' *International Journal of Drug Policy* (2020), 102937; D. Fumano, 'New figures reveal the racial disparity in Vancouver drug charges,' *Vancouver Sun*, August 7, 2020.

[10] Office of the Correctional Investigator (2020), '*Indigenous People In Federal Custody Surpasses 30% - Correctional Investigator Issues Statement And Challenge*,' (Press Release) 2020, https://www.oci-bec.gc.ca/cnt/comm/press/press20200121-eng.aspx.

[11] Office of the Correctional Investigator (2018), Office of the Correctional Investigator Annual Report 2017-2018. (Ottawa: Government of Canada), http://www.ocibec.gc.ca/cnt/rpt/annrpt/annrpt20172018-eng.aspx.

[12] Office of the Correctional Investigator, *A Case Study of Diversity in Corrections: The Black Inmate Experience in Federal Penitentiaries Final Report,* 2014.

[13] Office of the Correctional Investigator of Canada*, Annual Report 2014–2015 of the Office of the Correctional Investigator*, 2015.

determinants of health (colonialism and its ongoing racism, social exclusion, denial of cultural continuity, political and territorial sovereignty as well as self-determination) are essential to reduce harms from drugs and drug policy. Additionally, cultural connection and access to culturally relevant services are identified as key sources of resilience for Indigenous people, including those struggling with issues related to their drug use and those who are vulnerable to or living with HIV.

Canada has advocated strongly for international drug policies which reduce stigma towards drug use and people who use drugs, including leading a resolution on *Promoting non-stigmatizing attitudes to ensure the availability, access and delivery of health, care and social services for drug users*[14] adopted at the 61st session of the CND in 2018. Criminalized drug possession is one of the main driving factors behind both individual and systemic stigma and discrimination affecting people who use drugs. This stigma and discrimination perpetuates widespread human rights violations, while also preventing people from seeking and accessing vital services. Criminalization of drug possession disproportionately impacts Indigenous peoples, people of colour and women. The decriminalization of drug possession for personal use has been called for expressly by 12 UN agencies (including the World Health Organization, UNAIDS and the Office of the UN High Commissioner for Human Rights) in their 2017 Joint Statement on Ending Discrimination in Healthcare Settings[15] and by all agencies of the UN system in a common position released in early 2019.[16] Importantly, administrative sanctions such as fines, mandatory referrals to treatment or the confiscation of drugs must not be introduced as an alternative to criminal sanctions, as this would authorize law enforcement to continue to surveil and police people who use drugs — a practice that will have a disproportionate impact on Indigenous, Black and other marginalized communities.

We urge Canada to promote recognition and advance discussions among Member States, including in statements delivered at the CND, of the negative impacts of current drug policies on women, people of diverse gender identities as well as racialized and Indigenous communities, and to support accessible, gender-sensitive and culturally appropriate treatment, harm reduction and other health services that are tailored to meet their specific needs.

We also urge Canada to express support for the full decriminalization of possession of scheduled substances for personal use, the prohibition of all forms of racial profiling by law enforcement and the creation of participatory roles for Indigenous peoples and people who use drugs in treatment and prevention measures.

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[14] CND, 61st Session, Resolution 61/11, *Promoting non-stigmatizing attitudes to ensure the availability, access and delivery of health, care and social services for drug users* https://www.unodc.org/documents/commissions/CND/CND_Sessions/CND_61/CND_res2018/CND_Resolution_61_11.pdf .

[15] World Health Organization (2017), *Joint United Nations statement on ending discrimination in health care settings,* https://www.who.int/news/item/27-06-2017-joint-united-nations-statement-on-ending-discrimination-in-health-care-settings

[16] UN Chief Executives Board, *Summary of Deliberations: Segment 2: common United Nations system position on drug policy*, UN System, 2nd regular session of 2018, UN Doc CEB/2018/2, January 18, 2019; United Nations Chief Executives Board, *United Nations system common position supporting the implementation of the international drug control policy through effective inter-agency collaboration*, UNCEB, 2nd Session, Annex 1, UN Doc. CEB/2018/2, January 18, 2019.

We also urge Canada to acknowledge the unique experiences and needs of people who use drugs from racialized communities, including Indigenous populations, and across genders, in its own proposed resolution, while advocating for the inclusion of the above-mentioned groups in other resolutions.

Finally, we urge Canada to model and promote Member States' harmonization of domestic laws and policies with international human rights standards, especially those protecting racialized and Indigenous communities as well as people of all gender identities.

2. Recognizing the impacts of COVID-19 on people who use drugs

The global COVID-19 pandemic has increased the already significant risks facing people who use drugs, who are at higher risk of both contracting and dying from the disease.[17] Additionally, people who use drugs face greater barriers to accessing treatment for COVID-19 in both public and private healthcare systems, which the pandemic has already stretched to their limits.

The global drug markets having been disrupted by the pandemic and resulting restrictions on transnational movement, which has increased the volatility of the unregulated drug supply, due to the limited availability of essential chemicals in the manufacturing processes of many currently scheduled substances.[18] This has worsened the hardship and dangers faced by people who use drugs.[19]

Disruptions also appear to have created serious price fluctuations in in the unregulated market, resulting in increased financial hardship for people who use drugs. Some have also been forced to engage in dangerous behaviour to obtain drugs that are now more costly.

Lockdown and physical distancing measures implemented by many Member States have decreased the ability of people who use drugs to access harm reduction and treatment services, as well as disrupted the work of organizations seeking to facilitate harm reduction measures such as overdose prevention sites and supervised consumption services. When these harm reduction measures are either suspended entirely, or run at a reduced capacity, limited access means people who are already isolated from peers, social services and the community, which lockdowns and physical distancing necessarily require, end up having no other choice but using alone, thereby increasing their risk of fatal overdose. Ontario saw a 38.2% increase in opioid-related deaths in the first 15 weeks of the COVID-19 pandemic compared to the 15 weeks before the pandemic.[20] Similarly, in the first 8 months of the pandemic, British Columbia surpassed the total number of overdose-related deaths of 2019,

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[17] John Marsden and others, 'Mitigating and learning from the impact of COVID-19 infection on addictive disorders,' Addiction, vol. 115, No. 6 (June 2020), pp. 1007-1010.
[18] United Nations Office on Drugs and Crime (UNODC) (2020), *World Drug Report 2020* (United Nations Publication, Sales No. E.20.XI.6), https://wdr.unodc.org/wdr2020/field/WDR20_BOOKLET_1.pdf.
[19] UNODC (2020), *COVID-19 and the Drug Supply Chain: from Production and Trafficking to Use* (Research Brief), https://www.unodc.org/documents/data-and-analysis/covid/Covid-19-and-drug-supply-chain-Mai2020.pdf.
[20] Ontario Drug Policy Research Network and others, (2020) *Preliminary Patterns in Circumstances Surrounding Opioid-Related Deaths in Ontario during the COVID-19 Pandemic,* (Ontario Drug Policy Research Network) https://www.publichealthontario.ca/-/media/documents/o/2020/opioid-mortality-covid-surveillance-report.pdf?la=en.

with deaths reaching 1,716 by the end of 2020.[21] Importantly, there was a significant increase during the pandemic in opioid-related deaths in neighbourhoods with higher ethno-cultural diversity in Ontario.[20] In British Columbia, Indigenous people have also borne a disproportionate burden of overdose deaths.[22]

People who use drugs face higher risks of comorbidities that can lead to severe negative health outcomes if they become infected with COVID-19, such as death from other respiratory illnesses.[23] Despite this, people who use drugs, especially those who live with HIV, hepatitis C and/or other blood-borne infections, must overcome more barriers to accessing treatment and healthcare services — a problem that has been exacerbated by the additional strain placed on public healthcare by the pandemic.

Canada and other Member States have implemented some positive measures to alleviate the negative impacts of the COVID-19 pandemic. These include the greater availability of take-home doses for opioid agonist therapy, fast-tracking of exemption processes for overdose prevention sites and the wider availability of "urgent public health need" sites. Given the lifesaving impact these initiatives have had, it should be ensured that they are retained even after widespread vaccination and the containment of the COVID-19 virus. There is also a need to identify and reduce remaining barriers to implementation.

The COVID-19 pandemic has also led to the introduction of virtual meetings at the international level, including in the context of the CND. While this digitization has created greater opportunities for civil society engagement with international drug policy processes than was previously available when meetings ran only in-person, such formats have not been leveraged by all stakeholders to ensure equivalent and enhanced civil society engagement. Moreover, such remote, virtual engagement is in no way an adequate substitute for in-person engagement, including by civil society; in the longer-term, it should be seen as an opportunity to extend accessibility to the CND, but as an *adjunct* to in-person civil society participation, including on the Canadian delegation.

We urge Canada to promote recognition at the CND and among Member States of the devastating impacts of the COVID-19 pandemic on people who use drugs.

We also urge Canada to emphasize to Member States the need to designate all substance use services, including harm reduction (e.g., needle and syringe programs, overdose prevention, supervised consumption and drug checking services), community residential and non-residential treatment, peer support and recovery services as essential services and ensure that these services have adequate access to personal protective equipment, infection control, training and testing for staff, peers, clients and visitors.

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[21] Sheila Malcolmson (2020), *Minister's Statement on BC Corners Service's illicit drug toxicity deaths report*, (Ministry of Mental Health and Addictions Communications), https://news.gov.bc.ca/releases/2021MMHA0005-000239.

[22] C. Bellrichard, '93% spike in First Nations overdose deaths recorded in B.C. during COVID-19,' *CBC News*, July 6, 2020.

[23] UNODC (2020), *COVID-19 and the Drug Supply Chain: from Production and Trafficking to Use* (Research Brief), https://www.unodc.org/documents/data-and-analysis/covid/Covid-19-and-drug-supply-chain-Mai2020.pdf.

We also urge Canada to emphasize to Member States the importance of "Leaving no one behind," and to endorse responses to the pandemic which are inclusive and supportive of people who use drugs.

Finally, we urge Canada to lead by example in retaining the positive policies and programs put in place during the pandemic, including with respect to harm reduction and treatment services as well as civil society engagement at the CND, and to encourage other Member States to adopt or continue such approaches.

3. Promoting safe supply

The current system of international scheduling reinforces the "Iron Law of Prohibition," which dictates that as law enforcement becomes more intense, the potency of prohibited substances increases.[24] Moreover, the observed displacement/replacement effect indicates that the scheduling of substances is routinely followed by the emergence of new substances often posing greater harms from consumption. The continued reliance on scheduling and law enforcement crackdowns fuels harms experienced by people who use drugs, including the steadily increasing rate of overdoses around the world. Such approaches would benefit from undertaking risk assessments and considering the optimal sequencing of interventions before scheduling new substances.

The rate of opioid overdose deaths as part of the ongoing overdose crisis has rapidly increased in 2020, with an average of 17 people dying in the overdose crisis per day in Canada.[25] Most of these deaths were related to fentanyl and its analogues, which adulterate the unregulated market. However, other adulterants found by drug checking services in Canada have included cocaine, methamphetamines and even plaster and other building materials.[26] The UN Office on Drugs and Crime's *World Drug Reports* have consistently identified an increase in both drug manufacturing and consumption year to year, despite the estimated cost of enforcing current drug laws exceeding USD100 billion per year.[27] This demonstrates that the current system of prohibition has failed to reduce, or even stabilize, the consumption of currently scheduled substances. The current system of prohibition has also failed to protect those most vulnerable in our communities from the dangers of an adulterated, unregulated drug supply.

Canada has, in recent years, promoted a public health approach to drug policy, and safe supply forms an integral part of any public health approach, as part of the wider evidence-based movement towards the regulation of currently prohibited drugs.[28] This is because safe supply guarantees substances for people who use drugs that are of known quality and

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[24] Clayton J Mosher & Scott Atkins (2007). '*Drugs and Drug Policy: The Control of Consciousness Alteration.*' (SAGE E-Books). pp. 308–09.

[25] Special Advisory Committee on the Epidemic of Opioid Overdoses (2020) *Opioids and stimulant-related harms in* Canada (Ottawa, Public Health Agency of Canada), https://health-infobase.canada.ca/substance-related-harms/opioids-stimulants.

[26] KW Tupper and others, (2018), 'Initial results of a drug checking pilot program to detect fentanyl adulteration in a Canadian setting,' *Drug & Alcohol Dependence,* 190: 242–5.

[27] Mark Tyndall, (2020), 'Safe opioid distribution in response to the COVID-19 pandemic,' *International Journal of Drug Policy,* 83: https://doi.org/10.1016/j.drugpo.2020.102880.

[28] Global Commission on Drug Policy (2018). *Regulation: The Responsible Control of Drugs. https://www.globalcommissionondrugs.org/wp-content/uploads/2018/09/ENG-2018_Regulation_Report_WEB-FINAL.pdf.* See also: Canadian Association of People who Use Drugs (2019). *Safe Supply Concept Document.* https://vancouver.ca/files/cov/capud-safe-supply-concept-document.pdf.

quantity – and hence contributes to the realization of the human right to the highest attainable standard of health, among other rights.[29] Having been trialled in Canada at the provincial level with support from the federal government, safe supply is effective both at saving lives and at reducing illegal drug use. Participants in these programs are more likely to benefit from safe supply options as opposed to traditional treatments, when measured by the metrics of client retention, lowering participants' use of illegal drugs and improving overall quality of life.[30] For example, heroin maintenance trials in Vancouver involving more than 200 participants had retention rates of over 80% after a year on treatment, and those remaining on treatment had drastic reductions in their illegal opioid use. In comparison, in British Columbia retention rates of new clients on methadone are under 35% a year.[31]

North America has some of the highest rates of opioid and stimulant use in the world, with a growing number of accidental opioid- and stimulant-related overdose deaths. In the face of the current overdose crisis in North America, safe supply has proven to be a lifesaving initiative; London Intercommunity Health Centre's "Safer Supply" program has proven highly successful and effective in reducing the risks and harms facing people who use drugs who are involved in the program.[32] The supply of drugs in known quantity and quality such as prescription heroin programs and heroin agonist treatment, implemented in a treatment context in Vancouver, decreased overdose related deaths by 50% from April 2016 to December 2017.[33] The success of safe supply initiatives in Canada has been fostered and supported by provincial and federal governments, as well as the tireless work of civil society organizations. Moreover, civil society organizations in Canada continue to advocate for safe supply initiatives outside the medicalized approach employed to date.[29]

As noted above, Canada has advocated strongly for international drug policies which reduce stigma towards drug use and people who use drugs. Prohibition has functioned as a tool of stigma, painting marginalized communities as immoral for their choice to consume drugs. Conversely, safe supply changes this narrative by respecting the agency of people who use drugs and removing connotations of "immorality" which surround drug use. The provision of a safe supply is a necessary step towards ending stigmatization of and discrimination against people who use drugs.

We urge Canada to acknowledge the shortcomings and risks of a reliance on scheduling and law enforcement interventions to address the unregulated drug supply and associated harms.

We also urge Canada to reiterate its previously stated commitment to safe(r) supply in statements at the CND.

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[29] Joanne Csete & Richard Elliott (2020). 'Consumer protection in drug policy: The human rights case for safe supply as an element of harm reduction ,' *International Journal of Drug Policy,* 102976, DOI: **https://doi.org/10.1016/j.drugpo.2020.102976**

[30] Canadian Association of People who Use Drugs (2019), *Safe Supply Concept Document.* https://vancouver.ca/files/cov/capud-safe-supply-concept-document.pdf.

[31] 'Sustained Release Oral Morphine, Injectable Hydromorphone, and Prescription Diacetymorphine for Opioid Use Disorder: Clinical and Cost-effectiveness, and Guidelines' (Ottawa: CADTH, April 2017). (CADTH rapid response report: summary of abstracts).

[32] https://www.cbc.ca/news/canada/london/prescribing-opioids-to-drug-users-1.5351329

[33] Tyndall, 'Safe opioid distribution.'

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Appendix: Supporting Members of the Canadian Civil Society Working Group on UN Drug Policy

Organization	Representatives
Canadian Association of People who Use Drugs	Frank Crichlow Natasha Touesnard
Canadian Centre on Substance Use and Addiction	Rebecca Jesseman Rita Notarandrea
Canadian Drug Policy Coalition	Daniel Gates Donald MacPherson Scott Bernstein
Canadian Students for Sensible Drug Policy	Heath D'Alessio Alex Betsos
Centre on Drug Policy Evaluation	Nazlee Maghsoudi
Community Addiction Peer Support Association	Richard Blute Randy Harwood Gord Garner
Health Officers Council of British Columbia	Betsy MacKenzie
HIV Legal Network	Sandra Ka Hon Chu Richard Elliott
Moms Stop the Harm	Petra Schultz