A COMPREHENSIVE PUBLIC HEALTH RESPONSE TO THE PROBLEM OF ILLICIT INJECTION DRUG USE

recommendations developed by the Health Officers Council of British Columbia, May 1998

Several hundred people die annually in British Columbia from illicit drug overdoses.[1] Rates of communicable diseases such as hepatitis C and HIV among injection users and their sexual partners are soaring.[2] Property crime rates in Vancouver are twice those in other Canadian cities.[3] These are some of the well-documented consequences of our current approach to the injection drug use problem. The resulting individual and social costs justify a new, comprehensive strategy, including legal reform.

ASSUMPTIONS:

This paper is written with the following assumptions, which are supported by a number of local, national, and international studies and reports:

1. The health and social impacts of current policy are now so devastating that a fundamental change in policy and approach by government and public agencies is urgently required.[4 5] It is time to change the paradigm

2. The current legal structure, with its enforcement strategy, does not deter drug use, and enables a dangerous black market in illicit substances.[6]

3. The health of users and the safety of the community are affected adversely by enforcement of our current laws against possession.[7]

4. The situation is worsened by inadequate supports and services for addicts, such as a lack of treatment alternatives, housing, employment, and community support for persons with mental illnesses.[8 9 10]

5. The best way to change the hopeless, reactive culture surrounding illicit drug use in B.C. is to adopt a creative, comprehensive strategy, including not only legislative and enforcement change, but also a support and service structure providing life options and reducing health risks for injection users.[11]

An effective strategy must be comprehensive, including a number of initiatives already proven to be effective and in use in several other countries.

The required elements of an effective approach are:

1. A legal context enabling a (non-punitive) health enhancing approach to all addictions, including addictions to injection drugs.

2. Prevention and education, targeting both the public at large and vulnerable populations, i.e. children and youth

3. Accessible, high quality addiction management programs for injection users

Because of the significant negative public health consequences of current policy, the Health Officers Council of British Columbia has developed the following recommendations and discussion.

RECOMMENDATION SUMMARY

1. *The government of British Columbia should mandate and fund the immediate implementation of comprehensive health and addiction management programs accessible to injection users throughout the province. This action should be coupled with a commitment to primary prevention programming, including a broad public education campaign.*

2. *The federal, provincial, and municipal governments should support the immediate development of a multi-centre trial of a comprehensive addiction management program, including prescription of various opiates and other drugs. The trial should assess impacts on health, risk behaviours, employment, and criminal behaviour of enrolled users.*

3. *The federal government should amend the Controlled Substances Act to provide for controlled legal availability of certain Schedule I drugs in a tightly controlled system of medical prescription within a comprehensive addiction management program. Possession of small quantities of controlled drugs should be decriminalized. Importing and trafficking offences should remain, and enforcement of them be improved.*

I. CHANGING THE SOCIAL/SUPPORT CONTEXT

RECOMMENDATION: *The government of British Columbia should mandate and fund the immediate implementation of comprehensive health and addiction management programs accessible to injection users throughout the province. This action should be coupled with a commitment to primary prevention programming, including a broad public education campaign.*

BACKGROUND

Addiction management services for injection users in British Columbia are fragmented, and are often inadequate and inaccessible. For example, in the Downtown Eastside, injection users have access to needle exchange and a limited number of substance abuse counsellors. Detox services have been very limited, and relatively inaccessible and inappropriate for injection users and for particular sub-populations, for example women. Methadone prescription is provided to relatively few addicts, and

almost always without supportive counselling. Longer term counselling and support programs are essentially unavailable to the majority of users. Recent funding initiatives through the health board may provide a few more counselling options, and there will soon be a short term detox option for some. However, the general approach is still piecemeal. [12] [13]

While the Ministry of Health and the Vancouver/Richmond Health Board have declared the health problems of injection users in the Downtown Eastside as an emergency, the major provincial funder for alcohol and drug services, the Ministry for Children and Families, has not identified this issue as a high priority. Local M.C.F. officials are working with the health board within significant provincial policy and funding constraints.

Access to addiction management services in other areas of the province is even more limited and inconsistent. However, it is clear from a variety of studies and reports such as the 1994 Cain report, the BCCDC enhanced HIV surveillance initiative, and the VIDUS study[14], that injection drug use and its associated health risks are significant problems in many areas of the province.

Later sections of this document discuss various legal changes that would enable a more comprehensive approach to the problems associated with illicit drug use. Changing the legal status of illicit drugs offers potential benefit only in the context of a comprehensive strategy, including adequate and appropriate addiction management resources, public education and evidence-based prevention programming. In other words, enabling physicians to prescribe narcotics in the absence of accessible addiction management and a better educated public is unlikely to have significant impact on the public health problems posed by injection use. In a way, we have tried this experiment in B.C. with our current methadone strategy. A large number of physicians are now licensed to prescribe methadone in their private practices. Those who practise in the highest risk areas are very much aware of the futility of this policy in the absence of counselling, and other basic social supports.

INTERNATIONAL MODELS

Examples of more comprehensive approaches to injection drug use policy development, legal change, and program delivery are available in many other countries.

Switzerland has perhaps the most well-developed national strategy for injection drug use. In 1991, it adopted a package of measures to tackle problems caused by drug use. The program includes "basic measures", i.e. both primary prevention activities and care and treatment (including both social support and addiction management) , and "accompanying measures", i.e. training, evaluation, and research. The program is co-ordinated under an inter-departmental "working party". Addiction management includes not only addiction reduction treatment, but also needle exchange, and safe fixing within designated health sites. In 1993, a major research study of a narcotics prescription program was initiated, and results of that study are now being published. This complex study has shown very positive outcomes such as increased employment and reduced criminal activity in a group of study participants on controlled heroin administration. [15] [16]

Australia has conducted extensive discussion and study over the last 15 years to determine the feasibility of alternate prescription, including heroin, for opiate-addicted individuals. This very long

term project has had broad input, including both federal and regional politicians. Legal and criminology consultants determined that " a trial would not place Australia in breach of international treaties", although Australian laws would have to be changed to allow it. The National Centre for Epidemiology and Population Health also reported that there was considerable public support for a prescription program, and that such a program would "provide the possibility of significantly strengthening treatment options." [17] A national plan to provide prescription heroin was approved by state ministers of health, with broad support from medical and policing authorities, but has so far been overridden by the Prime Minister on political grounds.

Seattle, Washington, has a comprehensive methadone treatment program, which has been developed in the very strict American legal context, with its emphasis on methadone replacement. The Evergreen Treatment Centre is licensed to maintain a maximum of 700 clients on methadone. There are approximately 40 full time staff working in various parts of this program, which includes assessment, dispensing and monitoring, acupuncture, substance abuse counselling, and mental health support. Persons accessing the Seattle Needle Exchange can obtain "vouchers" which support their full participation in the program for 6 months. [18]

Other countries such as Germany, the Netherlands, and the United Kingdom may also provide helpful examples and experience with a variety of programming.

II. PILOTING CHANGE: EVIDENCE DEVELOPED IN THE CANADIAN CONTEXT

RECOMMENDATION II: The federal, provincial, and municipal governments should support the immediate development of a multi-centre trial of a comprehensive addiction management program, including prescription of various opiates and other drugs. The trial should assess impacts on health, risk behaviours, employment, and criminal behaviour of enrolled users.

BACKGROUND

The discussion of decriminalization and legalization of illicit drugs is not new in this century or in this country. There are many issues regularly raised as points in favour of, and against, changing the current legal approach.

Points cited in favour of change are : the failure of current policy and practice, the urgency of the HIV epidemic, the inadequacy of (legally) available options, the lack of logic (alcohol is legal; heroin is not), and recently mounting evidence of individual and community benefit from harm reduction approaches.

Points against change are: lack of political commitment and resources for the current policy, the need to regulate social behaviour through sanctions, potential for prescription to facilitate addiction and draw addicts from other jurisdictions, creation of increased community risk, and a belief that because methadone is a sufficient response, exploring alternatives would divert needed funds inappropriately.

Except for the Swiss experiment, and a number of smaller feasibility and case control studies, there is very little research that informs this discussion. Fortunately, the Swiss prescription study, conducted within the context of a co-ordinated national program, provides an example of how we can gather our own information about the application of the health paradigm within the Canadian context.

A CANADIAN STUDY

There has been interest expressed in Vancouver, Montreal, and Toronto in designing and implementing a multi-centre addiction management trial within Canada.[19] The Addiction Research Foundation has drafted the protocol for such a study, which could include any of a variety of treatment modalities including oral and injectable methadone, morphine, longer-acting agents such as LAAM, and possibly heroin. Such a trial could be implemented within the context of a comprehensive addiction management program, or could itself form the "nidus" around which a full program could be developed. A multi-centre research design would enable evaluation of success in a variety of community settings, urban and rural.

There is increasing interest across North America in studying this issue. For example, in the summer of 1998 the New York Academy of Medicine in association with Beth Israel Medical Center, Columbia School of Public Health and the Yale University Center for Research on AIDS will be sponsoring international conferences on heroin maintenance and expanded pharmacotherapies for the treatment of opiate dependence.

III. CHANGING THE LEGAL CONTEXT

RECOMMENDATION 3. The Controlled Substances Act should be amended to provide for controlled legal availability of certain Schedule I drugs in a tightly controlled system of medical prescription within a comprehensive addiction management program. Possession of small quantities of controlled drugs should be decriminalized. Importing and trafficking offences should remain, and enforcement of them be improved

BACKGROUND:

Use of addictive substances is associated with many health problems regardless of the legal status of the drug. "Legalized" drugs such as alcohol, tobacco, and prescription medications, all have negative consequences both for individuals and for the greater community. However, enforcement of current laws against users of injection drugs such as heroin and cocaine significantly worsens the drug-associated health and social problems. [20]

The purpose of legislative change with respect to "illegal" drugs is to reduce the negative health, social and economic impacts of enforcement against users. For example, an important enforcement strategy is

to attempt visible control of street trade in illicit drugs. This activity targets addicts and results in behaviours and conditions that increase health risks, such as shooting up in filthy alleys as quickly as possible to avoid detection and being caught with the drug, purchasing unknown potencies and mixtures of drugs from unregulated sources, and developing "shooting galleries" in decrepit hotels. An ironic additional consequence of current legislative and enforcement policy is the prevalence of unsafe drug use, and its attendant health risks, in the prison population.

In Canada, Bill C-8, the Controlled Substances Act of 1996, defines the control of "certain drugs, their precursors, and other substances", specifying criminal offences for possession, trafficking, and manufacturing of various drugs, as well as the punishments for those infractions.[21] In general, possession offences are punished less stringently than trafficking, and punishments for "lesser" drugs, such as cannabis or prescription drugs, may be less than those for illicitly acquired opiates or cocaine. However, possession, production, and trafficking are all defined as serious criminal offences, subject to very stiff fine and/or lengthy incarceration.

This law, like its precursors, has been written in the context of international agreements such as the Single Convention on Narcotic Drugs (1961), the Convention on Psychotropic Substance (1971) and the Convention Against Illicit Traffic in Narcotic Drugs and Psychoactive Substances (1988). In general, these conventions require participating countries to enact criminal legislation to control illicit drug use, production and traffic, although there may be some flexibility with respect to sentencing (or diversion), and some ambiguity about the need to convict for possession. The fact that countries such as the United Kingdom, Switzerland, and Australia are now using diversion to a treatment system with legalized prescription, indicates that impediments offered by these agreements can be overcome. Full discussions of these agreements are available elsewhere. [22]

Other Canadian laws which are important in the discussions about potential legislative change are the Contraventions Act and the Alternative Sentencing Law. The former provides mechanisms for converting criminal offences to civil offences; the latter specifies potential options for "diversion" from jail sentencing.

DEFINITIONS AND POTENTIAL IMPLICATIONS:

Potential changes in legislative, enforcement, and sentencing policies regarding drug possession can be categorized under the following terms: depenalization, diversion, decriminalization and/or legalization.[23] [24]

The term "**depenalization**" is used to mean a reduction in severity of penalty for possession. In several jurisdictions, a depenalization policy has reduced the penalty for cannabis possession from imprisonment and/or significant fine, to a modest fine.

Diversion refers to the use of sentencing alternatives to fine or imprisonment. Sentencing options may include community service or mandatory compliance with a treatment program. Interestingly, the LeDain Commission recommended replacement of the incarceration option with mandatory treatment.[25] Forms of diversion are in use in European countries, where addicts may avoid prison by registering with an addiction management program.

Decriminalization is used to mean removal of the offence of possession (of small, defined amounts) of specified drugs from the criminal law. Some jurisdictions practise *de facto* decriminalization of cannabis use through changes in enforcement priorities without legislative reform. This may already be the case in some parts of Canada: cannabis possession offence rates are much lower in Quebec than in British Columbia, and vary greatly among urban centres. [26] [27]

Legalization is used to mean provision of a legal source of supply. In Canada, alcohol is legalized, i.e. its provision is controlled under government regulation. Similarly, methadone is a legalized, addictive, drug in Canada and in many other countries. In Switzerland, a national referendum has recently supported a national drug strategy which includes legalized prescription of opiates such as heroin within a broader context of addiction management.

Each of these categories includes a range of options; each has its advantages and disadvantages.

For example, **depenalization**, or a fine-only approach has the advantage of a simplified enforcement system, i.e. ticketing, thus reducing court costs and the impacts on users if they can pay the fine. It *may* also be achievable under existing (Canadian) legislation. However, importing, cultivating, manufacture and trafficking remain as problems. The substitution of a civil offence punishable by fine for the criminal offence of cannabis possession has been accomplished, and its benefits documented, in several American states and a variety of countries including Australia and the Netherlands. However, there have been no similar initiatives with heroin or cocaine. [28]

Diversion, or alternative sentencing, keeps the user out of jail, but still requires policing and court processes. Assumptions about treatment effectiveness are often naive, unfortunately, and treatment may be unavailable, inappropriate, and not what the addict wants. Re-offence is likely, and the police must still enforce; sentencing for repeat offences would probably be imprisonment.

Decriminalization, repeal of the possession offence for small quantities for personal, private use, has the potential to reduce many harms related to the unsafe injection of illicit drugs, and to facilitate public health initiatives with addicts. The policing and individual costs of enforcement against users would be reduced, presumably allowing a greater emphasis by the police on reducing supply. However, the potential increase in drug use could result in a growth of the illegal supply, which would remain difficult to control.

Legalization, provision of a legal source of supply, would enable increased government control of supply and distribution, provide quality control (reducing potential for overdose deaths), reduce demand for illegal supply, and provide a source of government revenue. However, legalization in the absence of a comprehensive service and support strategy and close monitoring may lead to an increase in drug use, and more health problems.

[1] Cain JV, *Report of the Task Force into Illicit Narcotic Overdose Deaths in British Columbia*. British Columbia Ministry of the Attorney General, 1994
[2] Strathdee S, Patrick D et al, *Needle Exchange is Not Enough: Lessons from the Vancouver Injection Drug Use Study*, AIDS, Vol 11, F59-F65
[3] Poulin C, *Canadian Community Epidemiology Network on Drug Use, Inaugural National Report*, NHRDP project No. 6606-6022-703, May, 1997 (CCSA)
[4] Cain, *op cit*
[5] Hankins, *op cit*
[6] Cain, *op cit*
[7] Hankins K, *HIV/AIDS and Injection Drug Use: A National Action Plan, May 1997*, ISBN 1-896323-22-7 (CCSA)
[8] Single E, et al, *The Costs of Substance Abuse in Canada*, Ottawa, Canadian Centre on Substance Use, 1996, 532 pp
[9] Hammersley R et al, *The Relationship between Crime and Opioid Use*, British Journal of Addiction 82 (1989), 1029-1043
[10] Archibald C et al, *The Point Project: A Study of Risk Factors for HIV Infection among Vancouver's Injection Drug Use Community*, April 1996
[11] Cattaneo M et al, *Evaluation of the Federal Measures to Reduce the Problems Related to Drug Use, Phase 1 (1990-1992)*, Insitut Universitaire de medicine social et preventative Lausanne, (Switzerland)
[12] Parry P, *Something to Eat, A Place to Stay, and Someone who gives a Damn*, Consultant's report prepared for the B.C. Ministry of Health and the Vancouver/Richmond Health Board, September, 1997; available from Vancouver/Richmond Health Board
[13] Kotani N & committee, *Review of Alcohol and Drug Services in Vancouver, May 1997* (sponsored by the Vancouver Regional Office, Ministry for Children and Families, and the Vancouver/Richmond Health Board
[14] Vancouver Injection Drug Use Study, personal communication with Dr. David Patrick, Associate director, B.C. Centre for STD/AIDS Control
[15] Uchtenhagen A, *Programme for a Medical Prescription of Narcotics, Summary of the Synthesis Report*, Swiss Federal Office of Public Health, July, 1997
[16] Cattaneo *op cit*
[17] Bammmer G, *Report and Recommendations of Stage 2, Feasibility Research Into the Controlled Availability of Opioids*, National Centre for Epidemiology and Population Health, Australian Institute of Criminology, June, 1995
[18] Ron Jackson, personal communication, December, 1997
[19] personal communication with Dr. Perry Kendall
[20] Hankins, *op cit*
[21] Revised Statutes of Canada, 1996, Chapter 19, *The Controlled Substances Act*
[22] Single e, *Issues and options Regarding Illicit Drugs in Canada*, A policy discussion paper commissioned by the Attorney General of British Columbia, 1997
[23] Hankins et al, *op cit*
[24] Single E, *op cit (13)*
[25] LeDain Commission, *Report of the Commission of Inquiry Into the Non-medical Use of Drugs*, Ottawa, Queen's Printer, 1972
[26] Poulin *op cit*
[27] Whynot E. *Canadian Community Epidemiology Network on Drug Use, Vancouver, 1995*
[28] Single E, *op cit*