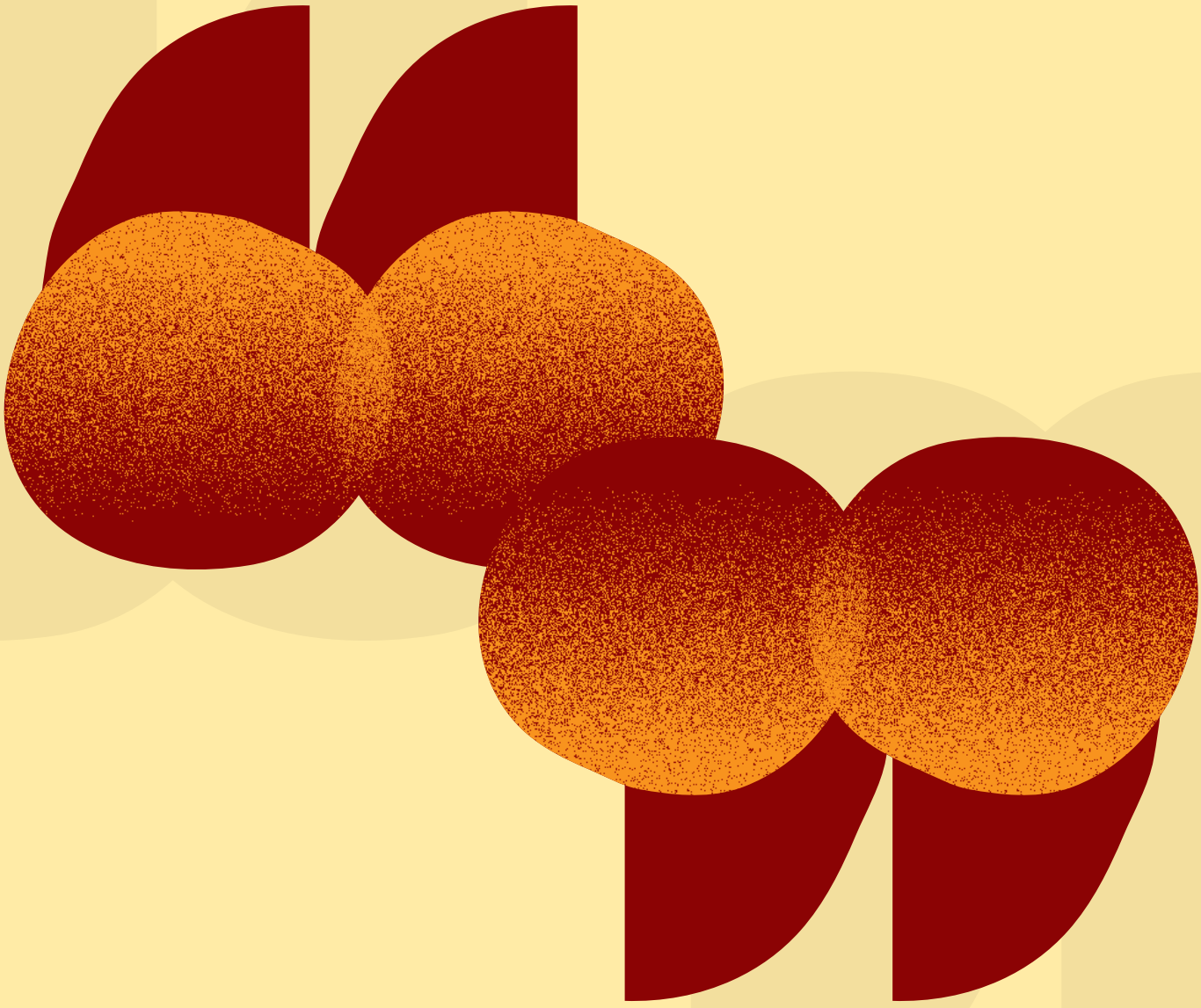
British Columbia's
Office of the Human Rights
Commissioner

A human rights-based approach to the toxic drug crisis



Commissioner's position statement

November 2025

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ISBN: 978-1-990626-23-4

This publication can be found in electronic format on the website of British Columbia's Office of the Human Rights Commissioner: bchumanrights.ca/toxic-drug-crisis

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Commissioner

The Human Rights Commissioner is grateful to the following people for their contributions to the statement: Dr. Kora DeBeck, Distinguished Professor of Substance Use and Drug Policy, School of Public Policy, Simon Fraser University; Jonathan Morris, CEO, Canadian Mental Health Association BC Division; Dr. Martin Lavoie, Deputy Provincial Health Officer, Office of the Provincial Health Officer; Dr. Danièle Behn Smith, Deputy Provincial Health Officer, Indigenous Health, Office of the Provincial Health Officer

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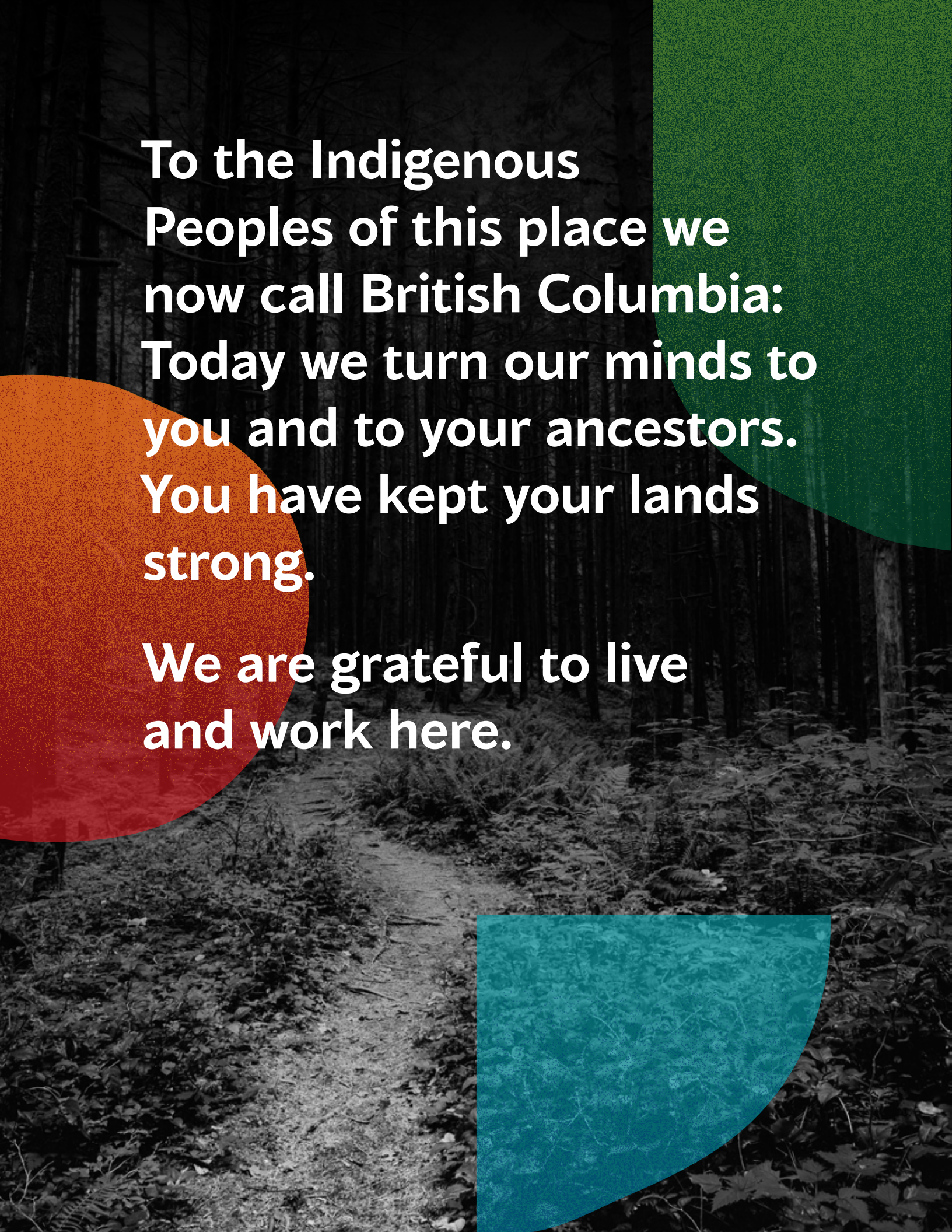
To the Indigenous Peoples of this place we now call British Columbia: Today we turn our minds to you and to your ancestors. You have kept your lands strong.
We are grateful to live and work here.

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If you are unsure about terminology used in this report, we invite you to visit our Human Rights Glossary at: bchumanrights.ca/glossary

Issue

Since 2016, when B.C.'s Provincial Health Officer declared a public health emergency, over 16,000 people have died from drug poisonings in the province.[1] Many others are living with significant brain injuries from toxic drugs.[2] Families and communities have lost their loved ones and are seeking solutions that will prevent future deaths. While opinions on solutions vary widely, compassion for those who have died — and those who loved them — must remain at the centre of decision making.

As B.C.'s Human Rights Commissioner, I feel it is important to speak out about how this continually unfolding tragedy is a violation of human rights and the result of systemic discrimination. As we saw during the COVID-19 pandemic, any other health problem with massive fatalities would be treated with the utmost urgency, yet the toxic drug crisis continues to kill many people across the province every day for over a decade with little reprieve.

> **As we saw during the COVID-19 pandemic, any other health problem with massive fatalities would be treated with the utmost urgency, yet the toxic drug crisis continues to kill many people across the province every day for over a decade with little reprieve.**

Over the last decade, the unregulated drug supply[3] has become increasingly toxic. It is contaminated with fentanyl, benzodiazepines and other dangerous substances that are unpredictable, difficult for care providers to manage and do not always respond to life-saving efforts such as naloxone. These toxic, and often cheaper, substances are added to the drug supply to enhance potency and increase dependency.[4]

Unregulated drug toxicity is now the leading cause of death in B.C. for people aged 19 to 59.[5] As of June 2025, the number of unregulated drug deaths was equal to 4.9 deaths per day.[6] Unregulated drug toxicity refers to the addition of toxic substances that are of unknown content and potency, which denies people who use drugs the ability to make informed decisions about usage and dosage; for example, cocaine and heroin that is laced with fentanyl. While toxic drug deaths are sometimes referred to as "overdoses," this is a misnomer, as the ability of people who use drugs to use as safely as possible is compromised by illicit drug manufacturers and dealers adding unknown toxic substances and unpredictable concentrations to the drug supply.[7] Under the drug prohibition model, there are no health and safety standards or means to regulate to avoid toxic contamination when production is primarily left up to organized crime and drug cartels. Benzodiazepines and other tranquilizers mixed into the drug supply cause prolonged sedation, also contributing to increased vulnerability for people who use drugs — especially to theft, assault and health complications.

1 "Unregulated Drug Toxicity Deaths," BC Coroners Service, Government of British Columbia, April 2025, https://www2.gov.bc.ca/gov/content/life-events/death/coroners-service/statistical-reports.
2 Garam Kim, Chloé Xavier, Roshni Desai, Devon Trower, Bin Zhao, Carolyn Davison, Heather Palis and Alexis Crabtree, *Brain Injury Following Drug Toxicity Events in British Columbia*, BCCDC, February 2025), 1, http://www.bccdc.ca/Documents/20250205_KnowledgeUpdate_BI%20analyses41.pdf.
3 Unregulated drug supply refers to currently illegal psychoactive substances obtained through the illicit market.
4 "Spotlight: The evolution of Fentanyl in Canada over the past 11 years," Health Canada, 2023, https://www.canada.ca/en/health-canada/services/publications/healthy-living/evolution-fentanyl-canada-11-years.html.
5 "Mortality Context App," BCCDC, 2025, https://bccdc.shinyapps.io/Mortality_Context_ShinyApp/.
6 BC Coroners Service, "Unregulated Drug Toxicity Deaths."
7 Health Canada, "Spotlight: The evolution of Fentanyl in Canada over the past 11 years."

Unregulated drug toxicity is now the leading cause of death in B.C. for people aged 19 to 59.

At any given time, an estimated 225,000 people are using illicit drugs in B.C.[8] People who use drugs — and therefore, people who may be affected by this crisis — are from all walks of life, including people who are unhoused and stably housed, people living in cities, suburbs and small towns as well as rural and remote areas. They are in their teens, young adulthood and middle age; some use casually and infrequently, others daily and may or may not have a substance use disorder. Anyone can be impacted by toxic drugs, and too many families in B.C. understand first-hand the challenges that exist for their loved ones when seeking care and support.

When public policy on substance use and treatment of people who use drugs is based on stigma and morality, rather than evidence and respect for fundamental human dignity, harmful policies result. The health crisis facing people who use drugs is created by these bad policies, including attempts at drug prohibition.

As the UN High Commissioner for Human Rights Navi Pillay affirmed,

> "Individuals who use drugs do not forfeit their human rights. All too often, drug users suffer discrimination, are forced to accept treatment, are marginalized, and often harmed by approaches that overemphasize criminalization and punishment while under-emphasizing harm reduction and respect for human rights."[9]

While criminal law responses are sometimes justified because of public safety concerns, developing the most effective responses to the toxic drug supply not only uphold human rights standards and public health goals, but will also improve *everyone's* safety.

The toxic drug crisis is a societal and public health crisis and framing it in this way highlights the systemic discrimination endured by people who use drugs. Treating people who use drugs as if their health issues are moral failings is a violation of their human rights. We don't criminalize smokers who develop lung cancer, nor diabetics whose diets increase risk of renal disease, because we understand that people have rights to make choices about their lives based on a number of complex and personal factors and still receive comprehensive care and support for health issues flowing from those decisions.

Beyond challenges within the healthcare system, this crisis is also rooted in colonial approaches that prioritize individualism over community, wealth over health and power over empathy. A compassionate and practical approach to the toxic drug crisis requires prioritizing scientific evidence over political ideology and making every possible effort to save lives, prevent brain damage and respect fundamental human dignity.

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[8] BC Coroners Service Death Review Panel, *BC Coroners Service Death Review Panel: An urgent response to a continuing crisis* (*BC Coroners Service*, 2023) 13, https://www2.gov.bc.ca/assets/gov/birth-adoption-death-marriage-and-divorce/deaths/coroners-service/death-review-panel/an_urgent_response_to_a_continuing_crisis_report.pdf.

[9] Canadian Drug Policy Coalition, *Drug Policy and Human Rights Implications in Canada*, (Canadian Drug Policy Coalition, 2023), 3, https://www.drugpolicy.ca/wp-content/uploads/2023/07/2023_Drug-Policy-and-Human-Rights-implications-in-Canada_UNOHCHR-submission.pdf.

Background

Put simply, there are three driving forces behind the toxic drug crisis. First, an increase in people using unregulated drugs;[10] second, the rising toxicity of the unregulated drug supply;[11] and third, the failure to institute scientifically validated public policy approaches and relying on abstinence-only treatments and criminal justice responses.[12]

There are also many social factors exacerbating and complicating people's approach to self-medicating, driving up the use of unregulated drugs, including an under-resourced healthcare system, an undervaluing of mental health services, poorly integrated social supports, unresolved experiences of violence and trauma, housing instability and homelessness, poverty and a deep-rooted history of colonialism,[13] racism[14] and discrimination.[15]

Safe and adequate housing is crucial to mental health and wellness. Not only can mental health and substance use issues present barriers to finding and maintaining housing, but living in precarious housing can significantly impact one's mental health;[16] both these issues point to the need for supportive housing and Housing First treatment models for those needing integrated mental health supports. Research across Canada[17] and the U.S.[18] indicates that, compared with people in abstinence-only programs, individuals in programs structured around Housing First principles are more likely to remain housed and less likely to report using stimulants or opiates.[19] Ensuring people have access to necessary supports when they experience trauma, job loss, family-breakdown or a health crisis is key to protecting people against problematic substance use.[20] This includes income supports, social services, healthcare, counselling and housing.

> **Ensuring people have access to necessary supports when they experience trauma, job loss, family-breakdown or a health crisis is key to protecting people against problematic substance use.**

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[10] "Report and recommendations on the opioid crisis in Canada," Government Response to the Report of the Standing Committee on Health, Parliament of Canada, 2016, https://www.ourcommons.ca/DocumentViewer/en/42-1/HESA/report-6/response-8512-421-134.

[11] Health Canada, "Spotlight: The evolution of Fentanyl in Canada over the past 11 years."

[12] BC Coroners Service Death Review Panel, *BC Coroners Service Death Review Panel: An urgent response to a continuing crisis*.

[13] Jennifer Lavalley et al., "Reconciliation and Canada's overdose crisis: Responding to the needs of Indigenous Peoples," *Canadian Medical Association Journal*, 190 no. 50 (2018), https://doi.org/10.1503/cmaj.181093.

[14] "The Canadian drugs and substances strategy: The Government of Canada's approach to substance use related harms and the overdose crisis," Government of Canada, 2023, https://www.canada.ca/en/health-canada/services/publications/healthy-living/canadian-drugs-substances-strategy-approach-related-harms-overdose-crisis.html.

[15] Lavalley, J. et al., "They talk about it like it's an overdose crisis when in fact it's basically genocide," *International Journal of Drug Policy* 134 (2024), https://www.sciencedirect.com/science/article/pii/S0955395924003153.

[16] Office of the Federal Housing Advocate and Canadian Human Rights Commission, *Upholding dignity and human rights: The Federal Housing Advocate's review of homeless encampments: Final report*, (CHRC, 2024), 2, https://www.chrc-ccdp.gc.ca/sites/default/files/documents/final-report-federal-housing-advocate-s-review-of-encampments_0.pdf.

[17] "At Home," Mental Health Commission of Canada, 2025, https://mentalhealthcommission.ca/what-we-do/at-home/.

[18] Padgett DK, Stanhope V, Henwood BF, Stefancic A, "Substance use outcomes among homeless clients with serious mental illness: comparing Housing First with Treatment First programs," *Community Ment Health J.* 47(2) (2011): 227–232, https://pmc.ncbi.nlm.nih.gov/articles/PMC2916946/.

[19] National Low Income Housing Association, *The Evidence Is Clear: Housing First Works*, (NLIHA, 2024), https://nlihc.org/sites/default/files/Housing-First-Evidence.pdf.

[20] "Public Health Approaches to the Toxic Drug Crisis," Canadian Public Health Association, January 28, 2025, https://www.cpha.ca/toxic-drug-crisis.

Since the 1980s, prescription opioid use in Canada has increased dramatically. For many people in Canada, this increase has its roots in high levels of dependence to legal opioids, caused in part by misguided prescribing practices and poor education about the risks of opioid use.[21] Despite the public narrative that offering prescribed alternatives of known content and potency to reduce the use of unregulated street drugs (referred to as safer supply) has fueled the toxic drug crisis, history shows that the toxic drug crisis is rooted in prohibition policies[22] and a criminal justice system response[23] to substance use.

> **...history shows that the toxic drug crisis is rooted in prohibition policies and a criminal justice system response to substance use**

Although the circumstances are tragic, the toxic drug crisis response that began in the 1990s, and evolved considerably over the last five years, positioned B.C. at the forefront of innovative approaches to addressing drug-related deaths. B.C. was showing global leadership by establishing a human rights-based approach to substance use through harm reduction efforts.

In the 1990s, grass-roots harm reduction initiatives in Vancouver's Downtown Eastside (DTES) gained traction and provincial funding. The first safe injection site in North America, Insite, was established in the DTES and in its first 20 years has reversed close to 12,000 drug poisonings and overdoses.[24] When Insite was facing closure because it was denied a necessary federal exemption, the case went to the Supreme Court of Canada. In 2011, the Supreme Court ruled in favour of Insite, saying that denying people access to Insite's safe injection services infringed on their rights under section 7 of the *Charter of Rights and Freedoms*, the right to life, liberty and security of the person.[25]

A major shift in the toxic drug crisis occurred with the introduction of fentanyl, with illicit use rising sharply starting in 2012.[26] Fentanyl is a powerful synthetic opioid pain reliever that is 50 to 100 times more potent than morphine. It was initially used for cancer patients and others suffering debilitating pain, but its use has been broadened to include those needing moderate to severe pain management.[27]

Another factor that contributed to widespread use of more potent opioids was a shift in physician prescribing practices due to the efforts of "Big Pharma."[28] Pharmaceutical companies have allegedly

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[21] Parliament of Canada, "Report and recommendations on the opioid crisis in Canada."

[22] Kora DeBeck and Perry Kendall, "Drug Prohibition is Fuelling The Overdose Crisis: Regulating Drugs is the Way Out," *The Conversation*, July 4, 2024, https://theconversation.com/drug-prohibition-is-fuelling-the-overdose-crisis-regulating-drugs-is-the-way-out-233632.

[23] Health Canada Expert Task Force on Substance Use, *Report #1 Recommendations on Alternatives to Criminal Penalties for Simple Possession of Controlled Substances*," (Health Canada, 2021), 7, https://www.canada.ca/content/dam/hc-sc/documents/corporate/about-health-canada/public-engagement/external-advisory-bodies/reports/report-1-2021/report-1-HC-expert-task-force-on-substance-use-final-en.pdf.

[24] "Press release: Canada's first supervised consumption site celebrates 20 years of saving lives," Vancouver Coastal Health, 2023, https://www.vch.ca/en/news/canadas-first-supervised-consumption-site-celebrates-20-years-saving-lives.

[25] Joanne Csete and Richard Elliott, "Consumer protection in drug policy: The human rights case for safe supply as an element of harm reduction," *International Journal of Drug Policy* 91 (2021): 3, https://www.sciencedirect.com/science/article/abs/pii/S0955395920303145#:~:text=Safe%20supply%20initiatives%2C%20including%20but,and%20the%20right%20to%20health.

[26] Health Canada, "Spotlight: The evolution of Fentanyl in Canada over the past 11 years."

[27] "Fentanyl's path of death and destruction," Policy and advocacy blog, Canadian Public Health Association, 2016, https://www.cpha.ca/fentanyls-path-death-and-destruction.

[28] Andrew Kolodny, "How FDA Failures Contributed to The Opioid Crisis," *AMA Journal of Ethics* (2020), https://journalofethics.ama-assn.org/article/how-fda-failures-contributed-opioid-crisis/2020-08.

pursued aggressive marketing campaigns targeting physicians, which not only undersold the risks but made false and deceptive claims about opioid addiction to increase sales.[29]

For more than a decade, officials, committees, organizations, independent officers, agencies and expert panels across B.C. and internationally[30] have called upon government to urgently address the crisis by taking measures to reduce stigma, expand harm reduction services, significantly invest in prevention efforts, deliver evidence-based, accessible treatment and recovery services and address access to a legal regulated drug supply.[31]

B.C. was making progress through the introduction of prescribed alternatives and decriminalization of personal possession of small amounts of drugs. Although these programs only ran for a few years, emerging evidence suggested these interventions were having the intended impact.[32] Despite this evidence and expert advice, in 2024 the provincial government started rolling back the pilot policy initiative to decriminalize possession of small amounts of select drugs and prescribed safer supply initiatives, driving people who use drugs further into risk.[33] This decision was not supported by the evidence available; rather, it was based on unsubstantiated public perception that street disorder increased under decriminalization, of which there is no data to support.[34,35]

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Much like alcohol in the 1910s, the toxic drug crisis occurs in a prohibition model, making it clear that the crisis is not the result of safer supply policies, but rather the result of making drugs illegal. As noted by former Chief Coroner, Lisa Lapointe:

> "Despite decades of evidence suggesting otherwise, there is an implicit assumption that prohibition and criminalization have been useful and effective tools in reducing drug use

[29] "Ministers' statement on updates on battle against opioid manufacturers," Attorney general, Government of British Columbia, distributors, November 2023, https://news.gov.bc.ca/releases/2023AG0066-001850.

[30] Global Commission on Drug Policy, *Beyond punishment: from criminal justice responses to drug policy reform*, (Global Commission on Drug Policy, 2024), https://globalcommissionondrugs.org/wp-content/uploads/2025/01/GCDP_Report2024_EN_forweb.pdf.

[31] BC Coroners Service Death Review Panel, *BC Coroners Service Death Review Panel: An urgent response to a continuing crisis,* 15.

[32] Amanda Slaunwhite et al., "Effect of Risk Mitigation Guidance opioid and stimulant dispensations on mortality and acute care visits during dual public health emergencies: retrospective cohort study," *BMJ* (2024), https://pubmed.ncbi.nlm.nih.gov/38199614/.

[33] Government of British Columbia, *Decriminalization Data Report to Health Canada February 2023 – January 2025*, (Government of British Columbia, 2025), https://www2.gov.bc.ca/assets/gov/overdose-awareness/data_report_to_health_canada_may_2025.pdf.

[34] "Incident-based crime statistics, by detailed violations, Canada, provinces, territories, Census Metropolitan Areas and Canadian Forces Military Police," Statistics Canada, 2025, https://www150.statcan.gc.ca/t1/tbl1/en/tv.action?pid=3510017701&pickMembers%5B0%5D=1.36&pickMembers%5B1%5D=2.105&cubeTimeFrame.startYear=2020&cubeTimeFrame.endYear=2024&referencePeriods=20200101%2C20240101.

[35] According to Statistics Canada, based on police crime statistics, rates for "disturbing the peace" in B.C. remained about the same between 2022-2023 (from 910 instances in 2022 to 918 in 2023 per 100,000 population), but declined in 2024 (from 918 to 820 per 100,000 population); Statistics Canada, "Incident-based crime statistics, by detailed violations, Canada, provinces, territories, Census Metropolitan Areas and Canadian Forces Military Police."

and associated harms.

Those who deride decriminalization, harm reduction and/or pharmaceutical alternatives to unregulated drugs simply ignore the fact that Canada's drug toxicity crisis began and continues to flourish under a criminalization/drug prohibition model."[36]

While the benefits of prohibition remain highly questionable, many of the harms are clear: a thriving drug trade fueling organized crime and related violence; decreased safety for people who use drugs; and reinforcing stigma against people who use drugs, impeding their access to effective health care and social supports.

Positions

The toxic drug crisis is a human rights violation

A human rights-based approach and applicable laws

Key principles of a human rights-based approach include indivisibility,[37] inalienability and universality of rights,[38] intersectional equality and non-discrimination,[39] meaningful participation, inclusion and empowerment, transparency and accountability and the rule of law.[40] In the immediate term, taking a human rights-based approach to the toxic drug crisis means implementing evidence-based tools to reduce harms and deaths as a first priority, focusing on dismantling stigma in favour of honouring human dignity. This entails recognizing that people who use drugs are no less worthy of government support, or equitable access to health care and adequate housing, than others. In the longer term, we must also work to prevent the situations that lead people to use unregulated drugs, by preventing trauma; adequately responding to trauma; and ensuring accessible, acceptable and appropriate health services, including mental and substance use related health services. Drug policy is not only a matter of public health, it is a human rights issue.

> **In the immediate term, taking a human rights-based approach to the toxic drug crisis means implementing evidence-based tools to reduce harms and deaths as a first priority...**

A human rights-based approach also demands that we not violate the rights of one group in favour of another, nor prioritize certain rights above others. Everyone has the right to health regardless of substance use and governments are obligated to uphold that right.

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[36] Lisa Lapointe, "We need to monitor all aspects of the drug emergency," *Victoria Times Colonist*, April 12, 2025, https://www.timescolonist.com/opinion/comment-we-need-to-monitor-all-aspects-of-the-drug-emergency-10515094.

[37] All human rights have equal status and cannot be positioned in a hierarchical order. Denial of one right invariably impedes enjoyment of other rights. Thus, the right of everyone to an adequate standard of living cannot be compromised at the expense of other rights, such as the right to health or the right to education.

[38] Human rights are universal and inalienable. All people everywhere in the world are entitled to them. The universality of human rights is encompassed in the words of Article 1 of the Universal Declaration of Human Rights: "All human beings are born free and equal in dignity and rights."

[39] All individuals are equal as human beings and by virtue of the inherent dignity of each human person. No one, therefore, should suffer discrimination on the basis of race, colour, ethnicity, gender, age, language, sexual orientation, religion, political or other opinion, national, social or geographical origin, disability, property, birth or other status as established by human rights standards.

[40] B.C.'s Office of the Human Rights Commissioner, *From Hate to Hope: Report of the Inquiry into Hate in the COVID-19 Pandemic*, (BCOHRC, 2023),185, bchumanrights.ca/wp-content/uploads/BCOHRC_Hate-in-the-pandemic.pdf.

Governments have an obligation under international human rights law,[41] and under constitutional law,[42] to protect the right to life and security of the person (against threats to physical and mental health and safety) and promote the health of individuals in their jurisdictions. This includes removing life-threatening risks to individuals in consumer products.[43] The UN *Declaration on the Rights of Indigenous Peoples* (UNDRIP), adopted in B.C. through the *Declaration on the Rights of Indigenous Peoples Act* (DRIPA), upholds the right to health and culturally appropriate services.[44] B.C.'s *Human Rights Code* prohibits discrimination on the basis of disability, which includes mental illness and substance use disorders.[45]

The International Covenant on Economic, Social and Cultural Rights (ICESCR) establishes the right to the highest attainable standard of health. The ICESCR oversight body asserts that governments should see this right as "embracing a wide range of socio-economic factors that promote conditions in which people can lead a healthy life," including measures to prevent and reduce "exposure to harmful substances."[46]

Under section 7 of the *Canadian Charter of Rights and Freedoms*,[47] individuals have the right to life, liberty and security of the person. These rights are engaged when government policy contributes to preventable death, such as by denying access to harm reduction services. In my view, inadequately addressing underlying factors such as trauma and mental health conditions, over the course of decades, is a failing of provincial and federal social policy to uphold rights.

> **Under section 7 of the *Canadian Charter of Rights and Freedoms*, individuals have the right to life, liberty and security of the person. These rights are engaged when government policy contributes to preventable death, such as by denying access to harm reduction services.**

Disproportionate impacts

While the crisis impacts all of us and people who use drugs span the socio-economic spectrum, it is crucial to recognize the significantly disproportionate impacts of the toxic drug crisis to effectively address the reasons that certain population groups are at greater risk and require targeted health care solutions. Those impacted by the toxic drug crisis are disproportionately male, Indigenous and

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[41] "International Covenant on Economic, Social and Cultural Rights," United Nations, 1966, https://www.ohchr.org/en/instruments-mechanisms/instruments/international-covenant-economic-social-and-cultural-rights.
[42] "Section 7 – Life, liberty and security of the person," The Canadian Charter of Rights and Freedoms, Government of Canada, 1982, https://www.justice.gc.ca/eng/csj-sjc/rfc-dlc/ccrf-ccdl/check/art7.html.
[43] Joanne Csete and Richard Elliott, "Consumer protection in drug policy: The human rights case for safe supply as an element of harm reduction," 3.
[44] United Nations, *United Nations Declaration on the Rights of Indigenous Peoples*, (UN, 2007), https://www.un.org/development/desa/indigenouspeoples/wp-content/uploads/sites/19/2018/11/UNDRIP_E_web.pdf.
[45] "*Human Rights Code*," Government of British Columbia, 1996, https://www.bclaws.gov.bc.ca/civix/document/id/complete/statreg/00_96210_01.
[46] Office of the High Commissioner for Human Rights, *CESCR General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12)*, (OHCHR, 2000), https://www.ohchr.org/sites/default/files/Documents/Issues/Women/WRGS/Health/GC14.pdf.
[47] The Canadian Charter of Rights and Freedoms, "Section 7 – Life, liberty and security of the person."

racialized, working in trades,[48] living in poverty, homeless or experiencing housing precarity,[49] people living with childhood trauma including exposure to the child welfare system[50] and/or living with a mental illness.[51] Mental illness and substance use disorders are the leading causes of disability in Canada.[52]

In 2024, First Nations people died from toxic drugs at 6.7 times the rate of other B.C. residents. First Nations women died at 11.6 times the rate of other women in B.C.[53] For Indigenous people, colonialism and Indigenous-specific racism — and the intergenerational trauma flowing from these experiences — has wide-reaching impacts on connection to family, community, culture, language and land, as well as traditional and community approaches to mental health.[54]

Human rights violations through deliberate policies, such as the residential school system, approaches to child apprehension and the child welfare system, inadequate and inequitable access to education and health care, and reserve land policies have directly contributed to the disproportionate rates of substance use and toxic drug deaths for Indigenous people.[55]

Statistics also show that a disproportionate number of men in trades have died from toxic drugs, often due to injuries on the job that required pain management medication, which led to opioid use.[56] In fact, national data shows that men account for nearly three out of four opioid toxicity deaths, and 30 to 50 per cent of those who were employed at the time of death were employed in trades.[57] It's important to recognize how stigma and patriarchal norms, including feelings of shame, can impact men's ability and willingness to seek help for substance use and mental illness.[58]

In addition to highlighting these disproportionate impacts, it is also important to note that the toxic drug crisis knows no boundaries. Not all people who use drugs — or die from toxic drugs — struggle with substance dependence. In fact, analyses of overdose fatalities indicated that the majority of individuals in B.C. who died from drug poisonings did not have a diagnosed opioid use disorder or use opioids on

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[48] Canadian Public Health Association, "Public health approaches to the toxic drug crisis."
[49] BC Coroners Service Death Review Panel, *BC Coroners Service Death Review Panel: An urgent response to a continuing crisis,* 14.
[50] Lake S, Hayashi K, Milloy MJ, Wood E, Dong H, Montaner J, Kerr T, "Associations between childhood trauma and non-fatal overdose among people who inject drugs," *Addict Behav.* (2015), https://pubmed.ncbi.nlm.nih.gov/25588793/.
[51] "Mental Illness and Addictions: Facts and Statistics," Centre for Addiction and Mental Health, 2021, https://www.camh.ca/en/driving-change/the-crisis-is-real/mental-health-statistics.
[52] Ibid.
[53] First Nations Health Authority, *First Nations and the Toxic Drug Poisoning Crisis In BC*, (FNHA, 2024), https://www.fnha.ca/Documents/FNHA-First-Nations-and-the-Toxic-Drug-Poisoning-Crisis-in-BC-Jan-Dec-2024.pdf.
[54] Office of the Provincial Health Officer, *Alternatives to unregulated drugs: another step in saving lives*, (OPHO,2024), 7, https://www2.gov.bc.ca/assets/gov/health/about-bc-s-health-care-system/office-of-the-provincial-health-officer/reports-publications/special-reports/alternatives_to_unregulated_drugs.pdf.
[55] Lavalley J, Kastor S, Valleriani J, McNeil R, "Reconciliation and Canada's overdose crisis: responding to the needs of Indigenous Peoples," *CMAJ 190(50)* (2018). https://pmc.ncbi.nlm.nih.gov/articles/PMC6291395/.
[56] "News release: BC Coroners Service shares unregulated drug toxicity data for May, June 2025," Government of British Columbia, https://news.gov.bc.ca/releases/2025PSSG0039-000729.
[57] "Communications toolkit for employers of men in trades," Government of Canada, 2025, https://www.canada.ca/en/services/health/campaigns/men-construction-trades-overdose-crisis-canada/toolkit-reduce-stigma-harms-substance-use/powerpoint.html.
[58] Gupta M, Madabushi JS, Gupta N, "*Critical Overview of Patriarchy, its Interferences with Psychological Development, and Risks for Mental Health*," Cureus (2023), https://pmc.ncbi.nlm.nih.gov/articles/PMC10332384/.

a daily basis.[59] Many people who have died are people who come from varying degrees of privilege. For example, for young people, social media has presented new avenues for obtaining unregulated toxic drugs. While peer pressure is nothing new, the amplification through social media presents unique challenges—but also presents opportunities for dismantling stigma and opening important avenues for education and public awareness. As the number one cause of death for people in their youth to their middle age, this crisis touches us all.

Centering lived expertise and experience

Solutions to the toxic drug crisis must engage people who use drugs. Nothing about us without us, the concept that decision-making must include those impacted by the decisions, should guide policymakers. No one understands the complexities of substance use and intersecting challenges such as homelessness, income inequality and discrimination better than people with lived expertise and experience. Foundational to a human rights-based approach is ensuring substantive equality for people who use drugs and ensuring policy decisions are informed by the best available evidence, including lived experiences.

> **No one understands the complexities of substance use and intersecting challenges such as homelessness, income inequality and discrimination better than people with lived expertise and experience.**

The toxic drug crisis requires a public health response

The Office of the Provincial Health Officer (OPHO) succinctly describes the public health emergency as a "culmination of policy failures, across several dimensions and over many decades."[60] Contributing to these policy failures is a significant stigma associated with mental illness and substance use. This stigma is reinforced through prohibition policies which have led to substantial experiences of discrimination for people who use drugs. When substance use is criminalized, individuals are less likely to seek help, use supervised consumption services or disclose substance use to care providers.[61]

Access to harm reduction services is also hindered by policing efforts.[62] Gentrification, particularly in the DTES, has resulted in a greater police presence around key harm reduction services such as overdose prevention sites. This increase in policing drives people into isolation, indoors and away from social services, thereby increasing the risk of death.[63] The rationale for this approach often centres around perceptions of community safety, which place priority on the comfort of select vocal businesses and housed residents without proper consideration for those experiencing extreme vulnerabilities such as homelessness, mental illness and substance dependence. This approach also ignores what the evidence says about effectively addressing the crisis and improving community safety for all. Treating

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[59] Office of the Provincial Health Officer, *A review of prescribed safer supply programs across British Columbia: recommendations for future action*, (OPHO, 2023), 21, https://www2.gov.bc.ca/assets/gov/health/about-bc-s-health-care-system/office-of-the-provincial-health-officer/reports-publications/special-reports/a-review-of-prescribed-safer-supply-programs-across-bc.pdf.

[60] Office of the Provincial Health Officer, *Alternatives to Unregulated Drugs*, 11.

[61] Collins AB, Boyd J, Mayer S, Fowler A, Kennedy MC, Bluthenthal RN, Kerr T, McNeil R., "Policing space in the overdose crisis: A rapid ethnographic study of the impact of law enforcement practices on the effectiveness of overdose prevention sites," *Int J Drug Policy* (2019) https://pmc.ncbi.nlm.nih.gov/articles/PMC7147938/.

[62] Canadian Public Health Association, "Public health approaches to the toxic drug crisis."

[63] Ibid.

people who use drugs as criminals, forcing them out of public sight and into dangerous conditions, increases stigma and takes away their autonomy.

> **Treating people who use drugs as criminals, forcing them out of public sight and into dangerous conditions, increases stigma and takes away their autonomy.**

The stigma associated with substance use and with mental illness is also a big barrier to seeking care and support. Despite increased awareness of mental health, a Canadian survey found 75 per cent of respondents would be reluctant or would refuse to disclose a mental illness to their employer or coworkers.[64] The top reasons were fear of negative consequences, such as job loss and not wanting to be treated differently due to stigma. Another study of street-involved youth in Vancouver found that 95 per cent of participants reported high levels of internalized stigma, including feelings of shame and worthlessness, which led to a reluctance to seek help for substance use.[65]

As the Canadian Mental Health Association of BC (CMHA BC) asserts, "stigmatizing and dehumanizing people living with mental health or substance use health-related illnesses has deadly consequences."[66]

Harm reduction and regulated alternatives to toxic drugs save lives and improves community conditions

Available evidence

Both B.C.'s Chief Coroner[67] and B.C.'s Provincial Health Officer[68,69] have issued extensive evidence-based reports calling for regulated and/or prescription-free alternatives to the toxic drug supply to immediately prevent deaths. The reports include several calls to action, such as expanding harm reduction services, redirecting policing priorities, creating regulated dispensing models and rapidly scaling safer supply programs. I note that these recommendations align with a human rights-based approach to addressing B.C.'s toxic drug crisis, stressing investment in multiple methods of harm reduction and safer supply, and a shift away from punitive tactics.

In March 2020, B.C. launched its safer supply pilot program, becoming the first jurisdiction in Canada to implement a province-wide opioid supply policy. It provided free prescribed pharmaceutical-grade opioids, primarily hydromorphone and sustained-release morphine, to individuals deemed "high-risk of drug poisoning or other harms due to reliance on unregulated drug supply."[70] The program became permanent in July 2021 and expanded to include injectable fentanyl.[71]

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[64] Centre for Addiction and Mental Health, "Mental Illness and Addictions: Facts and Statistics."
[65] Karamouzian M, Cheng T, Nosova E, Sedgemore K, Shoveller J, Kerr T, Debeck K, "Perceived Devaluation among a Cohort of Street-Involved Youth in Vancouver, Canada," Subst Use Misuse (2019), https://pubmed.ncbi.nlm.nih.gov/30526206/.
[66] "Resisting stigma: a call for a compassionate public health approach to drug policy and services," Canadian Mental Health Association BC, 2024, https://bc.cmha.ca/news/toxic-drug-crisis-public-use/.
[67] BC Coroners Service Death Review Panel, *BC Coroners Service Death Review Panel: An urgent response to a continuing crisis*.
[68] Office of the Provincial Health Officer, *Alternatives to unregulated drugs*.
[69] Office of the Provincial Health Officer, *A review of prescribed safer supply programs across British Columbia*.
[70] Ibid.
[71] Bohdan Nosyk et al., "Evaluation of Risk Mitigation Measures for People with Substance Use Disorders to Address the Dual Public Health Crises of COVID-19 and Overdose in British Columbia: A Mixed-Method Study Protocol," *Bmj Open* 11, no. 6 (2021): e048353; Nguyen, Hai V., Shweta Mital, Shawn Bugden, and Emma E. McGinty, "British Columbia's Safer Opioid Supply Policy and Opioid Outcomes," *JAMA Internal Medicine* 184, no. 3 (2024): 256–64.

Regulated alternatives to toxic drugs, including but not limited to the provision of legally regulated medical-grade heroin or hydromorphone in non-stigmatizing ways, are well justified by the state obligations to protect the right to life and the right to health.[72] Safer supply represents an opportunity for replacing potentially lethal street drugs with a more predictable alternative. An established body of research has shown that when administered in the right ways, with the right considerations, safer supply programs can have significant positive impacts for those accessing these programs.[73] This is also true for impacts to community safety. When someone has an alternative space to use drugs there is less public substance use.[74] When someone can access a regulated supply of drugs, they aren't funding organized crime.[75] If someone receives prescribed drugs, they aren't facing the prospect of poverty or theft to get money for drugs.[76]

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Through 10 pilot projects, Health Canada studied safer supply and noted significant positive impacts for participants, including: improved well-being and reduced stress; an increase in stable housing; better health outcomes, including addressing chronic disease and mental health; greater job retention; no longer engaging in survival sex; improved family and friend relationships; less reliance on street drugs while having access to safer supply; and feeling hopeful for the future.[77]

A series of studies in Ontario also found a strong correlation between a reduction of drug poisonings with safer supply programs.[78,79] One study focused on a treatment program that offered various harm reduction measures including injectable opioids, mental health supports, housing and Opioid

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[72] Joanne Csete and Richard Elliott, "Consumer protection in drug policy: The human rights case for safe supply as an element of harm reduction."

[73] Slaunwhite, "Effect of Risk Mitigation Guidance".

[74] Wood E, Kerr T, Small W, Li K, Marsh DC, Montaner JS, Tyndall MW, "Changes in Public Order after the Opening of a Medically Supervised Safer Injecting Facility for Illicit Injection Drug Users," *CMAJ* (2004), https://pmc.ncbi.nlm.nih.gov/articles/PMC517857/.

[75] Canadian Psychological Association, *The decriminalization of illegal substances in Canada*, (Canadian Psychological Association, 2023), https://cpa.ca/docs/File/Position/Decriminalization%20Position%20Paper%20EN%202023-Final.pdf.

[76] Ibid.

[77] "Early findings from safer supply pilot projects," Government of Canada, 2022, https://www.canada.ca/en/health-canada/services/opioids/responding-canada-opioid-crisis/safer-supply/early-findings-safer-supply-pilot-projects.html.

[78] For this study local harm reduction and safer supply groups collaborated with a 92-bed emergency men's shelter and a volunteer-run safer use space (SUS), in Hamilton, Ontario. It included an on-site safer supply, opioid agonist treatment and harm reduction supply programs. The results were a significant decrease in overdoses, from 0.93 to 0.17 per 100 nights of shelter bed occupancy. Notably, zero overdoses occurred in the SUS. See Lew et al., "The Impact of an Integrated Safer Use Space and Safer Supply Program on Non-Fatal Overdose among Emergency Shelter Residents during a COVID-19 Outbreak: A Case Study," *Harm Reduction Journal* 19, no. 1 (December 2022): 29, https://doi.org/10.1186/s12954-022-00614-8.

[79] Ibid.

Agonist Treatment.[80,81] Another study, examining a program that paired safer supply provisions with comprehensive health and social supports, found a significant reduction in emergency room visits, hospital admissions and health care costs.[82,83]

These studies join a growing body of evidence that shows significantly declining rates of emergency department visits, hospital admissions and general health care costs after entry into safer supply programs.[84] Access to safer supply connects people who use drugs to other crucial health and social supports.

These studies join a growing body of evidence that shows significantly declining rates of emergency department visits, hospital admissions and general health care costs after entry into safer supply programs.

It is also important to recognize the key challenges associated with safer supply to ensure programs do not inadvertently cause harm. The OPHO has noted that the limited availability and coverage of approved medications for opioid use disorder (for example, injectable hydromorphone and diacetylmorphine) results in people continuing to use street fentanyl.[85] This limited availability of approved medications may also be a driver of diversion, as people are motivated to sell prescribed opioids to purchase higher potency unregulated opioids to better meet their needs.[86]

A Canadian study comparing B.C.'s safer supply program to provinces without such a program, found an association between the introduction of safer supply and an increase in hospitalizations for opioid poisonings, but no increase in deaths.[87] However, the researchers note this increase may also have been impacted by external factors at the time, such as reduced access to harm reduction services due to COVID-19 restrictions. From this study, it is unresolved whether increased hospitalizations were caused by access to safer supply, or whether these numbers merely correlated in time. Expanding initiatives to provide regulated alternatives to the toxic drug supply in B.C. should be implemented in a way that proactively monitors and responds to unintended consequences and adjusts policies to mitigate potential negative impacts for those participating in the program.

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[80] This study evaluated a program involving 26 participants with histories of concurrent psychiatric illness and offered both injectable and oral opioid treatments, as well as housing support. Over half of participants experienced no overdoses (a notable improvement, as all had reported overdosing in the year before joining), with no deaths among those who remained enrolled. 45 per cent stopped using non-prescribed opioids. 96 per cent connected to behavioral health services. 73 per cent reconnected with estranged families. 31 per cent started work, vocational or educational programs. Two participants died from overdoses shortly after leaving the program. See Harris et al., "Outcomes of Ottawa, Canada's Managed Opioid Program (MOP) Where Supervised Injectable Hydromorphone Was Paired with Assisted Housing," *International Journal of Drug Policy* 98 (2021), https://www.sciencedirect.com/science/article/abs/pii/S0955395921003054.

[81] Ibid.

[82] This study sought to evaluate the impact of a safer opioid supply program in London, Ontario that began in 2016, on health services utilization and health care costs for, where clients are prescribed pharmaceutical opioids and provided with comprehensive health and social supports. The study found rates of emergency department visits, hospital admissions, health care costs (not related to primary care or outpatient medications) declined significantly after entry into the SOS program (n = 82), with significant declines in the year following cohort entry; Tara Gomes et al., "Clinical Outcomes and Health Care Costs among People Entering a Safer Opioid Supply Program in Ontario," *CMAJ* 194, no. 36 (2022), https://doi.org/10.1503/cmaj.220892.

[83] Ibid.

[84] Gagnon et al., "Impact of Safer Supply Programs on Injection Practices: Client and Provider Experiences in Ontario, Canada," *Harm Reduction Journal* 20, no. 1 (June 28, 2023): 81, https://doi.org/10.1186/s12954-023-00817-7.

[85] Office of the Provincial Health Officer, *A review of prescribed safer supply programs across British Columbia.*

[86] Centre for Addiction and Mental Health, "Mental Illness and Addictions: Facts and Statistics."

[87] Nguyen, Hai V., "British Columbia's Safer Opioid Supply Policy and Opioid Outcomes," 256–64.

> **Expanding initiatives to provide regulated alternatives to the toxic drug supply in B.C. should be implemented in a way that proactively monitors and responds to unintended consequences and adjusts policies to mitigate potential negative impacts for those participating in the program.**

While how to address the toxicity of the drug supply is one important research and policy question, targeting effective treatment options for substance dependence is another. Importantly, there is no data to support the assertion that abstinence-only treatment options (as opposed to supported treatment and recovery centres where more comprehensive approaches are implemented) are effective in addressing dependence on substances or the root causes of the toxic drug crisis. Research on the outcomes of abstinence-only treatments—and incorporation of those findings and the existing research on criminal law approaches—is desperately required to support the significant public investment in these responses and the ways in which these approaches undermine resources and will to invest in harm reduction policies and programs.

Policy must follow the evidence to be human rights compliant. For example, where the evidence points to comprehensive, multi-modal treatment options as being most effective, that is where public investment should flow. In other words, a rights-based response to this crisis requires that people dealing with substance dependence have access to effective treatment.

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Expert advice

In 2023, B.C.'s Chief Coroner convened a third death review panel of over 20 specialists, emphasizing the need for a comprehensive strategy and prioritizing short-term actions to reduce preventable deaths. The report was clear: "In the short term, the fastest way to reduce deaths is to reduce dependence on the unregulated toxic drug supply, which requires access to a quality-controlled, regulated supply for those at risk."[88]

In 2023, B.C.'s OPHO released a report reviewing prescribed safer supply programs across B.C., which stated that, based on available evidence, a safer supply policy can be ethically defended and prioritized. The report also made key recommendations that included monitoring the effectiveness of safer supply programs, implementing strategies to address and reduce diversion without disrupting benefits and ensuring these strategies meet the unmet needs of people involved in diversion.[89] Some experts have also noted that diversion still increases the percentage of drugs in distribution that are not toxic, and

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[88] BC Coroners Service Death Review Panel, *BC Coroners Service Death Review Panel: An urgent response to a continuing crisis*, 6.

[89] Office of the Provincial Health Officer, *A review of prescribed safer supply programs across British Columbia.*

may still improve outcomes for people who use drugs.[90] These recommendations are also consistent with findings from the Global Commission on Drugs.[91]

I note that providing access to regulated alternatives to toxic drugs doesn't preclude ensuring that people who use drugs have options when they choose to seek help to address substance dependence; in fact, it requires it. This means far more access to voluntary mental health and addiction services, which are free, accessible, culturally appropriate and available as soon as someone needs them.

A significant concern about regulated alternatives is diversion to the street market; however, both B.C.-based reports stress that there is no evidence supporting claims that diversion is increasing overdose deaths or leading increased rates of youth to become substance dependent. Given young people and others without substance dependence may be tempted to experiment with opioids regardless of preventative steps taken, and these communities are unlikely to have access to prescription safe supply, it is much less likely to result in death if the substance they are taking is of known content and potency.

> **There is no evidence supporting claims that diversion is increasing overdose deaths or leading increased rates of youth to become substance dependent**

In 2024, B.C.'s Auditor General reported on an audit that assessed whether the provincial government effectively monitored the initial province-wide rollout of prescribed safer supply. Findings showed that government developed a data collection framework, monitored and adjusted funding and initiated an evaluation of the program.[92] However, there were no strategies to address major implementation barriers, and there was ineffective public reporting on program performance. The audit concluded that government did not effectively monitor the program's initial implementation. As a result of these failures, the provincial government could not adequately communicate the effectiveness of programs and therefore was more susceptible to political critiques about the risks of safer supply, such as diversion.

In 2025, leaked information claimed a number of pharmacies (60 out of 1400) were involved in diverting prescription opioids.[93] As a result, the Ministry of Health quickly backtracked on their efforts and ended B.C.'s safer supply pilot program, especially given weakening public support for the program. Notably, there is no evidence to suggest that the problems of diversion were inherent in the safer supply program rather than a problem of illegal action taken by individuals within an otherwise legitimate public health effort.

The reality is that diversion is a far easier issue to tackle than the toxic drug crisis itself. Given the

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[90] National Safer Supply Community of Practice, *Reframing diversion for health care providers*, (National Safer Supply Community of Practice, 2022), https://www.substanceusehealth.ca/sites/default/files/resources/ReframingDiversionForHealthCareProviders.pdf.

[91] Global Commission on Drug Policy, *Beyond punishment*.

[92] Office of the Auditor General of British Columbia, *B.C.'s Toxic Drug Crisis: Implementation of Harm Reduction Programs*, (OAG, March 2024), https://www.oag.bc.ca/app/uploads/sites/963/2024/07/OAGBC-20240320-OAGBC-BCsToxicDrugCrisis-Report-March2024.pdf.

[93] Marcy Nicholson, "B.C. investigating 'significant' prescribed opioid diversion," *Global News*, February 5, 2025, https://globalnews.ca/news/11005999/bc-safe-supply-diversion/.

promising testimonies and peer-reviewed studies that suggest overall positive social and economic outcomes of safer supply, my position is that the sensible and measured approached — in line with a human rights lens — is to focus on improving the problem of diversion rather than abandoning the safer supply program altogether.

> **Focus on improving the problem of diversion rather than abandoning the safer supply program altogether.**

Involuntary care is not an evidence-based method for addressing substance use

In September 2024, Premier Eby announced an expansion of involuntary care for people with concurrent mental health and substance use disorders.[94] The challenges of diversion of prescribed alternatives to toxic drugs, coupled with a renewed public safety narrative leading up to the 2024 provincial election, led to a policy shift away from harm reduction and toward punitive tactics.[95]

Since government announced the expansion of involuntary care, several experts and advocates including the former Chief Coroner,[96] BC Civil Liberties Association,[97] CMHA BC,[98] Health Justice[99] and Community Legal Assistance Society[100] have expressed strong concerns. These organizations have resoundingly emphasized the need for greater investments in comprehensive voluntary care for those who are seeking help, services that have been grossly underfunded and under resourced, as well as the need for robust oversight to ensure access to justice and recourse for rights violations.

Indeed, the evidence to support compulsory treatment for substance dependence is lacking.[101] Worse, research shows increased rates of drug poisoning deaths — of up to 3.5 times higher — for people who use drugs who were forced into treatment compared to those not forced into treatment.[102] Overall, there is a lack of high-quality evidence to support or refute the effectiveness of involuntary treatment for substance use disorder.[103,104,105]

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[94] "News release: New beds improve care for incarcerated people with mental-health, addiction issues," Government of British Columbia, April 24, 2025, https://news.gov.bc.ca/releases/2025HLTH0035-000373.
[95] Brenna Owen, "Ex-Coroner Says B.C.'s Drug Policy Overhaul Looks like 'Impulsive Political Decision,'" *CBC News*, February 21, 2025, https://www.cbc.ca/news/canada/british-columbia/lisa-lapointe-drug-policy-overhaul-1.7465012.
[96] Lapointe, L., "Involuntary care will not end the drug crisis," *Victoria Times Colonist*, September 25, 2024, https://www.timescolonist.com/opinion/comment-involuntary-care-will-not-end-the-drug-crisis-9568580.
[97] Isabella Zavarise, "Critics slam B.C. premier's involuntary care announcement, cite lack of evidence," *CTV News Vancouver*, September 16, 2024, https://www.ctvnews.ca/vancouver/article/critics-slam-bc-premiers-involuntary-care-announcement-cite-lack-of-evidence/.
[98] "Involuntary care already exists in BC, but is it working?," Canadian Mental Health Association of BC, 2024, https://bc.cmha.ca/news/involuntary-care-in-bc/.
[99] "BC's Mental Health Act overview," Health Justice, 2024, https://www.healthjustice.ca/fast-facts-mha#Involuntary-Treatment-Facts-2024.
[100] Love, K., "Involuntary care doesn't work. What BC should do instead," The Tyee, September 24, 2024, https://thetyee.ca/Opinion/2024/09/24/Involuntary-Care-What-BC-Should-Do-Instead/.
[101] Canadian Drug Policy Coalition, *Drug Policy and Human Rights Implications in Canada*.
[102] Ibid.
[103] Bahji, A., et al, "Effectiveness of involuntary treatment for individuals with substance use disorders: a systematic review," *The Canadian Journal of Addiction* (2023), https://journals.lww.com/cja/fulltext/2023/12000/effectiveness_of_involuntary_treatment_for.2.aspx.
[104] Pilarinos, A., Kendall, P., Fast, D., DeBeck, K., "Secure care: more harm than good," *Canadian Medical Association Journal* (2018), https://www.cmaj.ca/content/cmaj/190/41/E1219.full.pdf.
[105] Canadian Centre on Substance Use and Addiction, "Evidence brief: Involuntary treatment for severe substance use disorders," (CCSA, 2025), https://www.ccsa.ca/en/involuntary-treatment-severe-substance-use-disorders.

> **Overall, there is a lack of high-quality evidence to support or refute the effectiveness of involuntary treatment for substance use disorder.**

B.C.'s Representative for Children and Youth (RCY) notes "mental health detentions are among the most intrusive measures that a state can impose on people,"[106] which is particularly concerning for young people, who are often not informed of or appropriately supported to exercise their rights under the *Mental Health Act*.[107] In a 2021 report, RCY found a significant rise in the number of children and youth who are receiving involuntary mental health services — an increase of 162 per cent between 2008/09 and 2017/18.[108] As of 2023, there were more young people in involuntary care than in voluntary care in hospitals in B.C.[109] This suggests the voluntary, community-based system of mental health services is currently inadequate and requires substantial investment by government before increasing the capacity of involuntary care.

> **This suggests the voluntary, community-based system of mental health services is currently inadequate and requires substantial investment by government before increasing the capacity of involuntary care.**

There are significant human rights related risks of involuntary care: compulsory treatment violates the most basic human rights of self-determination and autonomy and has historically been used to target racialized and marginalized communities.[110] In 2019, the UN Special Rapporteur on the rights of persons with disabilities stated that involuntary hospitalization and treatment for substance dependence contravenes article 14 and 15 of the Committee on the Rights of Persons with Disabilities (CRPD).[111]

Due to the lack of evidentiary support and the significant human rights issues at stake, it is my position that compulsory treatment for mental illness should be used as a last resort and where urgently required to prevent imminent harm, should only be used where aligned with evidence-based treatment approaches, should not be used in situations where substance use disorders exist alone (where they are not concurrent with mental illness) and must be accompanied by strong oversight when used. In order to get to the point in which compulsory treatment could be in alignment with human rights standards (again, only under the conditions listed above), the *Mental Health Act* must be amended to remove the unique and problematic provisions providing for deemed consent (which deems everyone with involuntary status to have consented to all forms of psychiatric treatment, without safeguards like an assessment of their capacity to make treatment decisions).

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[106] Representative for Children and Youth, *Detained: rights of children and youth under the Mental Health Act*, (RCY, 2021), https://rcybc.ca/wp-content/uploads/2021/01/RCY_Detained-Jan2021.FINAL_.pdf.
[107] Ibid.
[108] Ibid.
[109] Representative for Children and Youth, *Detained: Rights of children and youth under the Mental Health Act RCY Annual Review Year* 2, (RCY, 2024), https://rcybc.ca/wp-content/uploads/2024/04/2024.03.25-Detained-Year-2-Progress-Assessment-FINAL.pdf.
[110] Canadian Drug Policy Coalition, *Drug Policy and Human Rights Implications in Canada*.
[111] "A/HRC/40/54: Rights of persons with disabilities - Report of the Special Rapporteur on the rights of persons with disabilities," United Nations Human Rights Office of the High Commissioner, 2019, https://www.ohchr.org/en/documents/thematic-reports/ahrc4054-rights-persons-disabilities-report-special-rapporteur-rights.

Compulsory treatment for mental illness should be used as a last resort and where urgently required to prevent imminent harm, should only be used where aligned with evidence-based treatment approaches, should not be used in situations where substance use disorders exist alone (where they are not concurrent with mental illness) and must be accompanied by strong oversight when used.

The lack of evidence of effectiveness is key to the human rights analysis: where the treatment is likely to be either ineffective or cause harm, the violation of liberty rights cannot be justified. Access to voluntary treatment — for both mental illness and substance dependence — must be the primary investment for government. Until these services actually meet demand, using evidence of the tragic harms of the toxic drug crisis to support violating people's liberty rights not only lacks credibility, but also seriously undermines human rights protections.

Conclusion

As Human Rights Commissioner, I strongly believe in applying a human rights-based approach to the toxic drug crisis, thereby centring compassion and evidence-based policy, and largely shifting from a criminal justice response to a public health one. Inadequate social policy, rooted in ableism, classism and racism and developed by colonial governments, coupled with inaccessible mental health supports and pervasive stigma, are the drivers of this crisis. Using punitive tactics by criminalizing people who use drugs and doubling down on prohibition policies have proven to be ineffective and harmful for decades. B.C.'s leading experts have been issuing clear, evidence-based recommendations for a decade, and yet the provincial government has acted in contradiction of those recommendations at the expense of those most marginalized in our province. As Commissioner, I support their calls to action.

Government's obligation is to save lives, reduce harm and improve quality of life for those who have been marginalized, while working toward greater equity for everyone. This means respecting the rights of people who use drugs, reducing stigma, preventing the circumstances that lead to substance use and dependence and developing effective services and programs based on evidence rather than ideology. Effective human rights-based drug policy is, first and foremost, the right approach for the rights and wellbeing of people who use drugs; secondarily, but not unimportantly, it is also the most effective means of addressing the impacts of the toxic drug crisis on the broader community.

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