

Canada - Drug Control Data and Policies

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1. **Basic Data**

Prevalence and Trends

(Prevalence of Marijuana Use Among Canadians Aged 15 and Older, 2012) "The prevalence of past-year cannabis use among Canadians aged 15 years and older was 10.2% in 2012, unchanged from 9.1% in 2011, but lower than in 2004 (14.1%). There was an increase in past-year cannabis use among adults aged 25 years and older to 8.4% in 2012 from 6.7% in 2011, and no change from 2011 among youth aged 15 to 24 years. However, the prevalence of past-year cannabis use among youth (20.3%) remains higher than that of adults (8.4%). Youths initiated use of cannabis at an older age in 2012 than in 2011 (16.1 versus 15.6 years).

"The prevalence of past-year cannabis use in 2012 was lower than in 2004 among males (13.7% versus 18.2%), females (7.0% versus 10.2%) and youth aged 15 to 24 years (20.3% versus 37.0%), with the prevalence among males remaining twice as high as that of females (13.7% versus 7.0%, respectively). Prevalence among adults aged 25 years and older was unchanged between 2012 and 2004."

Source:

Health Canada, "Canadian Alcohol and Drug Use Monitoring Survey (CADUMS) Summary of Results for 2012" (Ottawa, Ontario: Controlled Substances and Tobacco Directorate, Health Canada, June 2013), p. 3.

http://www.hc-sc.gc.ca/hc-ps/drugs-drogues/stat/_2011/summary-sommaire-e...

2.

(Prevalence of Other Illicit Drug Use Among Canadians Aged 15 and Older, 2012) "In 2012, past-year use of the most commonly reported illicit drugs after cannabis was estimated to be about 1% for each (ecstasy (0.6%), hallucinogens including salvia (1.1%) and cocaine or crack (1.1%)). Past-year use of speed, methamphetamine or heroin is not reportable. There were no changes in prevalence of any of these drugs individually, between 2012 and 2011 or between 2012 and 2004.

"Use of at least one of five illicit drugs excluding cannabis [cocaine or crack, speed, ecstasy, hallucinogens (including salvia) or heroin] was reported by 2.0% of Canadians and is not different from 2011 (1.9%). The reported rate of such use by males (3.1%) was almost triple that reported by females (1.1%), while the rate of use by youth (6.5%) was five times higher than that reported by adults (1.2%). Rates are not comparable to 2004 because salvia was not included in the CAS [Canadian Addiction Survey].

"Users of illicit drugs were asked how easy it would be for them to get that specific drug if they wanted some "now". Most users of cannabis (84.5%) and cocaine (77.8%) said it would be easy or very easy to get. Results for other drugs are not reportable due to low numbers and small sample size."

Source:

Health Canada, "Canadian Alcohol and Drug Use Monitoring Survey (CADUMS) Summary of Results for 2012" (Ottawa, Ontario: Controlled Substances and Tobacco Directorate, Health Canada, June 2013), pp. 3-4.

http://www.hc-sc.gc.ca/hc-ps/drugs-drogues/stat/_2011/summary-sommaire-e...

3.

(Prevalence of Cannabis Use in Canada 2012, by Province) "Provincial prevalence of past-year cannabis use ranged from 8.5% in New Brunswick to 13.8% in British Columbia. There were no year-to-year changes in provincial rates of cannabis use. Each province's past-year cannabis prevalence was compared with the average prevalence for the nine remaining provinces. Of these, only British Columbia shows higher than average prevalence."

Source:

Health Canada, "Canadian Alcohol and Drug Use Monitoring Survey (CADUMS) Summary of Results for 2012" (Ottawa, Ontario: Controlled Substances and Tobacco Directorate, Health Canada, June 2013), p. 3.

<http://www.hc-sc.gc.ca/hc-ps/drugs-drogues/stat/2011/summary-sommaire-e...>

4.

(Prevalence of Selected Drugs in Canada 2004-2012)

Estimated Prevalence of Selected Drugs in Canada

Figures in Percent

Source:

CAS

CADUMS

Year

2004

2006

2009

2010

2011

2012

Cannabis Use

Cannabis - Lifetime Use

44.5

43.9

42.4

41.5

39.4

41.5

Cannabis - Past-Year Use

14.1

11.4

10.6

10.7

9.1

10.2

Other Illicit Drug Use In Past Year, By Type

Cocaine/Crack

1.9

1.6

1.2

Q

0.7

0.9

Q

1.1

Q

Speed

0.8

1.1

Q

0.4

Q

0.5 Q

0.5 Q

S

Hallucinogens (excluding salvia)

0.7

N/A

0.7 Q

0.9

0.6 Q

0.9 Q

Hallucinogens (including salvia)

--

--

0.9 Q

1.1

0.9 Q

1.1 Q

Ecstasy

1.1

1.4

0.9

Q

0.7

0.7

Q

0.6

Q

Methamphetamine/Crystal Meth

0.2

S

S

S

S

S

Alcohol Use

Lifetime Use

92.8

90.1

88.6

88.9

89.7

91.0

Past Year Use

79.3

77.3

76.5

77.0

78.0

78.4

Q: Estimate qualified due to high sampling variability; interpret with caution

S: Estimate suppressed due to high sampling variability

CAS: Canadian Addiction Survey

CADUMS: Canadian Alcohol and Drug Use Monitoring Survey

Source:

Health Canada, "Canadian Alcohol and Drug Use Monitoring Survey (CADUMS) Summary of Results for 2012" (Ottawa, Ontario: Controlled Substances and Tobacco Directorate, Health Canada, June 2013), pp. 1-2.

http://www.hc-sc.gc.ca/hc-ps/drugs-drogues/stat/_2011/summary-sommaire-e...

5.

(Prevalence of Alcohol and Cannabis Use Among Youth in Canada) "Some key findings from the report are as follows. Among students in grades 7, 9, 10, and 12 (i.e., those approximately 12–18 years old):

"□ Alcohol use is almost twice as prevalent as cannabis use (46–62% of students report alcohol use and 17–32% report cannabis use in the past year, depending on the province);

"□ 19–30% report consuming five or more drinks on a single occasion in the past month;

"□ 12–20% of Grade 12 students report driving within an hour of drinking alcohol in the past year;

"□□ 26–38% of all students report that in the past year they have been a passenger with someone that had been drinking, and 17–20% report that in the past year they have been a passenger with someone who had had 'too much' to drink;

"□ 2–5% report using cannabis daily or almost daily;

"□□ 14–21% of students in Grade 12 report driving within an hour of using cannabis, and more than 33% of Grade students report having been a passenger with someone who had used cannabis; and

"□□ Among the drugs assessed by the surveys, aside from alcohol and cannabis, ecstasy is the most prevalent drug (4–7% report lifetime use) followed by inhalants (2–4% report lifetime use)."

Source:

Young, M.M., Saewyc, E., Boak, A., Jahrig, J., Anderson, B., Doiron, Y., Taylor, S., Pica, L., Laprise, P., and Clark, H. (Student Drug Use Surveys Working Group) (2011). Cross-Canada report on student alcohol and drug use: Technical report. Ottawa: Canadian Centre on Substance Abuse, p. 3.

<http://www.ccsa.ca/Eng/topics/Monitoring-Trends/Student-Drug-Use/Pages/d...>

http://www.ccsa.ca/Resource%20Library/2011_CCSA_Student_Alcohol_and_Drug...

6.

(Age of Initiation of Cannabis and of Alcohol Use in Canada)

Average Age of Initiation of Use of Cannabis and of Alcohol for Youth Aged 15-24 in Canada, 2004-2012

CAS

CADUMS

Year

2004

2006

2009

2010

2011

2012

Cannabis

15.6 Years

15.5 Years

15.6 Years

15.7 Years

15.6 Years

16.1 Years

Alcohol

15.6 Years

15.6 Years

15.9 Years

15.9 Years

16.0 Years

16.2 Years

CAS: Canadian Addiction Survey

CADUMS: Canadian Alcohol and Drug Use Monitoring Survey

Source:

Health Canada, "Canadian Alcohol and Drug Use Monitoring Survey (CADUMS) Summary of Results for 2012" (Ottawa, Ontario: Controlled Substances and Tobacco Directorate, Health Canada, June 2013), pp. 1-2.

http://www.hc-sc.gc.ca/hc-ps/drugs-drogues/stat/_2011/summary-sommaire-e...

7.

(Prevalence of Daily Cannabis Use Among Youth in Canada) "Eight of the nine provinces with student drug use surveys ask about daily or almost daily use of cannabis in the past month. Overall, 2.2–5.3% of students report smoking cannabis every day or almost every day in the past 30 days (Table 31 and Figure 31). In four of the eight provinces, the prevalence of daily or almost daily cannabis use was significantly greater among males than females (Table 32 and Figure 32). When examined by grade, the same pattern as noted in all previous indicators emerges. In Grade 7, very few students report daily use - so few that most estimates for Grade 7 students are suppressed. In Grade 12, however, 3.3–10.0% of students report using cannabis daily or almost every day (Table 33 and Figure 33)."

Source:

Young, M.M., Saewyc, E., Boak, A., Jahrig, J., Anderson, B., Doiron, Y., Taylor, S., Pica, L., Laprise, P., and Clark, H. (Student Drug Use Surveys Working Group) (2011). Cross-Canada report on student alcohol and drug use: Technical report. Ottawa: Canadian Centre on Substance Abuse, p. 22.

<http://www.ccsa.ca/Eng/topics/Monitoring-Trends/Student-Drug-Use/Pages/d...>

http://www.ccsa.ca/Resource%20Library/2011_CCSA_Student_Alcohol_and_Drug...

8.

(Prevalence of Use of Drugs Other Than Cannabis Among Youth in Canada) "The reported prevalence of drugs (other than alcohol and cannabis) such as cocaine or heroin among students is relatively rare. That said, provinces routinely measure use of these substances. British Columbia, Alberta, Manitoba, and Ontario estimates are for lifetime use. Atlantic provinces, Québec and the YSS [Youth Smoking Survey] ask about use in the past 12 months. Therefore, the two sets of prevalence estimates are presented separately in different tables. In addition to the different time frames used in the survey questions, there is also considerable variation in the terminology used in referring to these drugs as noted where appropriate in the tables below.

"All the surveys ask about ecstasy. Estimates for ecstasy use range from 3.4–7.2% reporting past-12-month use

and 4.4–7.1% reporting lifetime use (Tables 43 and 44). Following ecstasy, inhalants are second overall in reported

use with estimates ranging from 2.6–4.4% for past-year use and 2.2–3.8% for lifetime use. However, not all surveys ask about use of inhalants; some ask about 'solvents' or 'glue'. These differences in terminology result in different prevalence estimates (Tables 45 and 46). Estimates for steroid use range from 1.4–1.7% for past-12-month use and 1.2–1.4% for lifetime use (Tables 47 and 48). Estimates for lifetime heroin use in British Columbia, Alberta, Manitoba and Ontario range from 0.8–1.3% (Table 49). Atlantic Canada does not ask students about heroin use. The YSS asks about past-12-month use of heroin [1.3% (1.0, 1.6)]."

Source:

Young, M.M., Saewyc, E., Boak, A., Jahrig, J., Anderson, B., Doiron, Y., Taylor, S., Pica, L., Laprise, P., and Clark, H. (Student Drug Use Surveys Working Group) (2011). Cross-Canada report on student alcohol and drug use: Technical report. Ottawa: Canadian Centre on Substance Abuse, p. 28.

<http://www.ccsa.ca/Eng/topics/Monitoring-Trends/Student-Drug-Use/Pages/d...>

http://www.ccsa.ca/Resource%20Library/2011_CCSA_Student_Alcohol_and_Drug...

9.

(Number of Medical Marijuana Users in Canada) "Among those who used cannabis, 17.7% (representing about 420,000 Canadians or 1.6% of the Canadian population aged 15 years and older) reported doing so for medical purposes. Prevalence of use for medical purposes was similar between male and female cannabis users (17.3% versus 18.4%, respectively), while more than one in five (21.8%) cannabis users aged 25 years and older reported using it for medical purposes, representing 1.5% of all adults in this age group. The percentage of youth who used cannabis for medical purposes is not reportable.

"Half (49.7%) of those who used cannabis for medical purposes did so mainly for chronic pain caused by conditions such as arthritis, back pain and migraines, while the remaining 50.3% used cannabis primarily for one of a variety of conditions that included insomnia, depression and anxiety. These numbers do not in any way measure or reflect enrolment in the federal Medical Marijuana Access Program."

Source:

Canadian Alcohol and Drug Use Monitoring Survey (CADUMS) Summary of Results for 2011 (online only), last accessed Dec. 12, 2012.

<http://www.hc-sc.gc.ca/hc-ps/drugs-drogues/stat/2011/summary-sommaire-e...>

10.

(Prevalence of Alcohol Use in Canada, 2012) "In 2012, 78.4% of Canadians reported drinking alcohol in the past year, a rate similar to that reported in 2011 (78.0%). There was, however, a decrease in past-year alcohol use among youth 15 to 24 years of age compared to CAS in 2004, from 82.9% to 70.0% in 2012. Similar to previous years, in 2012, a higher percentage of males than females reported past-year alcohol use (82.7% versus 74.4%, respectively) while the prevalence of past-year drinking among adults aged 25 years and older (80.0%) was higher than among youth (70.0%).

"Provincial rates of current drinking ranged from 72.3% in Nova Scotia to 82.1% in Quebec. Each province's past-year alcohol prevalence was compared with the average for the nine remaining provinces. Three provinces had lower than average prevalence (Nova Scotia, New Brunswick (73.8%) and Prince Edward Island (74.0%)) while the prevalence of past-year alcohol use in Quebec was higher than average. Prevalence of past-year alcohol use since 2011 was unchanged for all provinces."

Source:

Health Canada, "Canadian Alcohol and Drug Use Monitoring Survey (CADUMS) Summary of Results for 2012" (Ottawa, Ontario: Controlled Substances and Tobacco Directorate, Health Canada, June 2013), pp. 5-6.

<http://www.hc-sc.gc.ca/hc-ps/drugs-drogues/stat/2011/summary-sommaire-e...>

11.

Crime, Courts, and Prison

(Cannabis Arrests in Canada 2012) "Unlike the Criminal Code violations discussed in previous sections, drug-related offences in Canada fall under the Controlled Drugs and Substances Act. In 2012, police reported more than 109,000 drug-related incidents, representing a rate of 314 incidents per 100,000 population (Table 6).

"Overall, fewer drug-related incidents were reported in 2012 than in 2011. The decline was due primarily to a decrease in cannabis-related incidents, which accounted for two-thirds of all drug-related incidents reported by police (Chart 14). In contrast, nearly all types of other drug offences increased. The largest increase in police-reported drug offences in 2012 was in cocaine possession (+5%), although over the previous 10-year period, the rate of possession of drugs other than cannabis and cocaine rose most, up 89%.

"British Columbia, which was the province reporting the highest overall rate of drug offences in recent years, had about 2,000 fewer cannabis-related incidents in 2012. On the other hand, the rate of cocaine-related offences in Saskatchewan has more than doubled over the past two years. As a result, Saskatchewan had the highest overall rate of police-reported drug offences in 2012, followed by British Columbia.

"Nevertheless, British Columbia continued to report the highest rates for some specific drugs, such as cannabis, heroin and ecstasy offences. It also had the second highest rate of methamphetamine (crystal meth) incidents, behind Quebec, but well above the other provinces. Overall, rates of drug-related offences were generally higher in the territories than in the provinces (Table 7)."

Source:

Samuel Perreault, "Police-reported crime statistics in Canada, 2012," Juristat (Ottawa, Ontario, Canada: Statistics Canada, July 25, 2013), catalogue no. 85-002-X, ISSN 1209-6393, p. 18.

<http://www.statcan.gc.ca/pub/85-002-x/2013001/article/11854-eng.htm?fpv=...>

<http://www.statcan.gc.ca/pub/85-002-x/2013001/article/11854-eng.pdf>

12.

(Police Seizures of Cannabis in Canada 2009) "In 2009, Canadian law enforcement seized a total of 34,391 kilograms (kg) of marihuana and 1,845,734 marihuana plants. These figures, which have remained relatively unchanged from 2008 and coupled with steady street prices in 2009, indicated an apparently stable marihuana market. As in 2008, the majority of marihuana seized was domestically produced, yet the drug continued to be imported from Jamaica, the United States, the Netherlands, and Thailand."

Source:

RCMP Criminal Intelligence, "Report on the Illicit Drug Situation in Canada - 2009," Royal Canadian Mounted Police (Ottawa, Ontario: 2010), p. 16.

<http://publications.gc.ca/site/archiv-ee-archived.html?url=http://publica...>

http://publications.gc.ca/collections/collection_2011/grc-rcmp/PS61-14-2...

13.

(Sources of Marijuana in Canada) "The amount of marihuana produced in Canada exceeded domestic demand. Reportedly, there were OC [Organized Crime] groups producing this drug specifically for export to foreign markets, the largest of which is the United States. According to the U.S. National Drug Intelligence Center (NDIC), while seizures of Canadian marihuana have declined¹³ at the Canada-U.S. border, Canada continued to be a source country for high-grade marihuana destined for U.S. illicit drug markets.^v The reported decline was believed to be due, in part, to Canadian-based Asian OC groups using their expertise to establish cannabis cultivation sites within the United States, thereby avoiding the cost of transporting drugs across the border and the risk of detection.

"Shipments of marihuana destined for Canada were smuggled through air cargo or passenger flights, and arrived primarily at Toronto Pearson International Airport. Canada Border Services Agency (CBSA) reported the seizure of approximately 1.15 tonnes of marihuana in 2009, with 60 percent of the total originating from Jamaica. Jamaican marihuana was primarily supplying a small market in Ontario and Quebec."

Source:

RCMP Criminal Intelligence, "Report on the Illicit Drug Situation in Canada - 2009," Royal Canadian Mounted Police (Ottawa, Ontario: 2010), p. 17.

<http://publications.gc.ca/site/archiv-ee-archived.html?url=http://publica...>

http://publications.gc.ca/collections/collection_2011/grc-rcmp/PS61-14-2...

14.

(Ecstasy Production in Canada, 2009) "In 2009, an abundant supply of Canadian-produced MDMA continued to meet domestic consumption requirements, as well as provide significant quantities for international markets. ⁴⁰ Domestic prices for MDMA remained at the record low levels from 2008, while purity levels of the drug remained high, or even may have increased. The nature or extent of MDMA production in Canada appeared to be unaffected by the significant shortage in the supply of MDP2P, that reportedly impacted European markets. In Europe, the shortage resulted in a decline in Ecstasy seizures and in the number of seizures of laboratories, storage, and dump sites related to large-scale MDMA production.

"Cross-border MDMA smuggling from Canada to the United States, the primary foreign market for Canadian-produced MDMA, significantly increased from 2008. As in previous years, smuggling activity at or between ports of entry (POEs) was reported in the provinces of British Columbia, Ontario, and Quebec. ⁴¹ For example, a record amount of 2.6 million dosage unit equivalents confirmed as MDMA were seized in the Pacific region in 2009. However, there was also smuggling activity across the Canada-U.S. border in other provinces, such as Manitoba. ⁴² "

Source:

RCMP Criminal Intelligence, "Report on the Illicit Drug Situation in Canada - 2009," Royal Canadian Mounted Police (Ottawa, Ontario: 2010), p. 32.

<http://publications.gc.ca/site/archiv-ee/archived.html?url=http://publica...>

http://publications.gc.ca/collections/collection_2011/grc-rcmp/PS61-14-2...

15.

Problem Drug Use and Its Correlates

(Prevalence of Injection Drug Use in Canada) "The number of Canadians reporting use of an injectable drug at some point in their life increased from 1.7 million in 1994 (7.4% overall: 10% of males, 4.9% of females) to a little more than 4.1 million in 2004 (16.1% overall: 20.8% males, 11.7% females). Of those who used an injectable drug at least once in their life-time, 7.7% (132,000) reported past-year use by injection in 1994 compared with 6.5% (269,000) in 2004. The numbers of individuals having used drugs by injection in the past year are too small to allow any analysis."

Source:

"Canadian Addiction Survey: A National Survey of Canadians' Use of Alcohol and Other Drugs: Prevalence of Use and Related Harms," Canadian Executive Council on Addictions, Health Canada, March 2005, p. 91.

<http://www.ccsa.ca/Resource%20Library/ccsa-004028-2005.pdf>

16.

(Sharing of Injection Equipment in Canadian Prisons) "Seventeen percent (17%) of inmates reported recently injecting drugs. A substantial proportion of these inmates increased their risk of acquiring a blood-borne infection (BBI) by using someone else's used injecting equipment (see Table 4 for gender-specific estimates). Of those who recently injected drugs, 37% of inmates reported sharing a needle with a person with a positive or unknown BBI status and 42% reported using someone else's works after they had used them. Additionally, men were more likely than women to report using someone else's used needle, 55% vs. 41%, $\chi^2(1, n=438) = 6.22, p < 0.05$ and sharing works with a person with a positive or unknown BBI status, 33% vs. 23%, $\chi^2(1, n=397) = 4.40, p < 0.05$."

Source:

Thompson, Jennie, Zakaria, Dianne, and Jarvis, Ashley, "Use of bleach and the methadone maintenance treatment program as harm reduction measures in Canadian Penitentiaries 2010," Correctional Service of Canada, Research Report R-210, August 2010.

<http://www.csc-scc.gc.ca/text/rsrch/reports/r210/r210-eng.shtml>

17.

(Injection Drug Use in Prisons) "Infectious disease management can be a challenge in correctional settings due to the high rates of BBIs, and risky behaviours such as injection drug use (IDU), tattooing and piercing among people entering the correctional system (PHAC, 2008b). While jurisdictions prohibit IDU, tattooing and piercing within their facilities some inmates continue to engage in these activities with escalated risk of infection due to the need to share equipment. For example, among Canadian studies, the reported level of IDU ranges from 5% to 28% in federal institutions and 1% to 8% in provincial correctional centres (Alary, Godin & Lambert, 2005; Calzavara & Burchell, 1999; Calzavara et al., 2003; Calzavara, Myers, Millson, Schlossbert, & Burchell, 1997; Dufour et al., 1996; Ford, 1999; Ford et al., 2000; Martin, Gold & Murphy, 2005; PASAN, 2003; Poulin et al., 2007; Price Waterhouse, 1996; Rehman, 2004; Small et al., 2005). These rates are higher when capturing ever injecting in prison (8% to 28%) compared to shorter periods of time such as the past 12 months (1% to 11%)."

Source:

Thompson, Jennie, Zakaria, Dianne, and Jarvis, Ashley, "Use of bleach and the methadone maintenance treatment program as harm reduction measures in Canadian Penitentiaries 2010," Correctional Service of Canada, Research Report R-210, August 2010.

<http://www.csc-scc.gc.ca/text/rsrch/reports/r210/r210-eng.shtml>

18.

(Injection Drug Use In Prison by Drug Type) "Overall, 87% of inmates who recently injected drugs in a penitentiary reported opiates as one of their three most used drugs. Although the number of inmates who reported injecting only non-opiate drugs was small, comparisons between this group and opiate users suggests that injecting opiates may be associated with the use of someone else's used equipment (see Table 9). Inmates who recently injected opiates were more likely, than those who recently injected non-opiates, to use someone else's used needle, 81% vs. 48%, $\chi^2(1, n=251) = 13.92, p < 0.05$, and works, 59% vs. 36%, $\chi^2(1, n=236) = 3.98, p < 0.05$."

Source:

Thompson, Jennie, Zakaria, Dianne, and Jarvis, Ashley, "Use of bleach and the methadone maintenance treatment program as harm reduction measures in Canadian Penitentiaries 2010," Correctional Service of Canada, Research Report R-210, August 2010.

<http://www.csc-scc.gc.ca/text/rsrch/reports/r210/r210-eng.shtml>

19.

(Number of People in Canada Living with HIV, by Transmission Method) "HIV/AIDS remains an issue of concern for Canada. The number of people living with HIV (including AIDS) continues to rise, from an estimated 64,000 in 2008 to 71,300 in 2011 (an 11.4% increase) (Table 1, Figure 1). The increase in the number of people living with HIV is due to the fact that new infections continue at a not insignificant rate which is greater than HIV-related deaths, as new treatments have improved survival. The estimated prevalence rate in Canada in 2011 was 208.0 per 100,000 population (range: 171.0–245.1 per 100,000 population). Nearly half (46.7%) of those living with HIV were men who have sex with men (MSM). Those who

acquired their infection through heterosexual contact and were not from an HIV-endemic region comprised the next largest group (17.6%), followed by those who acquired their infection through injection drug use (IDU) (16.9%) and those exposed through heterosexual contact and were also from an HIV-endemic region (14.9%)."

Source:

"Summary: Estimates of HIV Prevalence and Incidence in Canada, 2011" (Ottawa, Ontario: Public Health Agency of Canada, Centre for Communicable Diseases and Infection Control, 2012), p. 1.

<http://www.phac-aspc.gc.ca/aids-sida/publication/survreport/estimat2011-...>

<http://www.phac-aspc.gc.ca/aids-sida/publication/survreport/assets/pdf/e...>

20.

(Estimated Number of New HIV Infections, by Transmission Method) "Although estimates of the number of new HIV infections are uncertain, the number of new infections in 2011 was estimated at 3,175 (range between 2,250 and 4,100) which was about the same as or slightly fewer than the estimate in 2008 (3,335; range of 2,370 to 4,300) (Table 2, Figure 2). In terms of exposure category, MSM continued to comprise the greatest proportion (46.6%) of new infections in 2011, which was slightly higher than the proportion they comprised in 2008 (44.1%). In 2011, the proportion of new infections among IDU was lower than in 2008 (13.7% compared to 16.9%). The proportion of new infections attributed to the heterosexual/non-endemic and heterosexual/endemic exposure categories were about the same in 2011 compared to 2008 (20.3% vs 20.1% and 16.9% vs 16.2%, respectively) (Figure 3)."

Source:

"Summary: Estimates of HIV Prevalence and Incidence in Canada, 2011" (Ottawa, Ontario: Public Health Agency of Canada, Centre for Communicable Diseases and Infection Control, 2012), p. 2.

<http://www.phac-aspc.gc.ca/aids-sida/publication/survreport/assets/pdf/e...>

21.

(Reported Drug Harms) "The most commonly reported drug-related harm involves physical health, reported by 30.3% of lifetime and 23.9% of past-year users of illicit drugs excluding cannabis, and 15.1% of lifetime and 10% of past-year users of any illicit drug. Following physical health, a cluster of harms, represented somewhat equally, includes harms to one's friendships and social life (22.3% and 16.4% of users excluding cannabis, 10.7% and 6.0% of any illicit users), home and marriage (18.9% and 14.1% excluding cannabis, 8.7% and 5.1% of any illicit users), work (18.9% and 14.2% excluding cannabis, 9.2% and 5.1% of any illicit users) and financial position (19.6% and 18.9% excluding cannabis, 8.4% and 6.5% of any illicit users)."

Source:

"Canadian Addiction Survey: A National Survey of Canadians' Use of Alcohol and Other Drugs: Prevalence of Use and

Related Harms," Canadian Executive Council on Addictions, Health Canada, March 2005, p. 56.

<http://www.ccsa.ca/Resource%20Library/ccsa-004028-2005.pdf>

22.

Harm Reduction

(Participation in Methadone Maintenance in Prisons) "At the time of the survey, 7% of all inmates reported being on MMTP. An additional 9% of all inmates reported not being on the program but previously trying to get on it at CSC. The remaining 84% of inmates reported never trying to join the program (63%), never using drugs (20%), and no longer needing the program (<1%).

"Participation in MMTP was associated with drug use in penitentiaries. Of inmates who were on MMTP, 60% reported not using opiates recently in a penitentiary; however, 40% did (see Table 10). Similarly, of those who were not on CSC's MMTP but had tried to get on the program, almost equal proportions reported no drug use in a penitentiary (45%) and recent opiate use a penitentiary (44%). Conversely, the majority of inmates who never tried to get on MMTP at CSC reported no recent opiate use in a penitentiary (87%) and a minority (12%) reported recent opiate use in a penitentiary."

Source:

Thompson, Jennie, Zakaria, Dianne, and Jarvis, Ashley, "Use of bleach and the methadone maintenance treatment program as harm reduction measures in Canadian Penitentiaries 2010," Correctional Service of Canada, Research Report R-210, August 2010.

<http://www.csc-scc.gc.ca/text/rsrch/reports/r210/r210-eng.shtml>

23.

(Cost-Effectiveness of Proposed Supervised Injection Facility in Montreal, Canada) "The model used here [18], predicted the number of new HIV and HCV cases prevented based on the needle sharing rate. This included the impact of behavioral changes in injection activities outside of the SIF. The behavioral change, according to Table 2 and Table 3, was only considered twice (once for the first SIF and later for the second SIF)—this modeling decision is apparent in the marginal number of new HIV cases averted in Tables 3, 4 and 5. This calculation of behavioral impact is based on a conservative odds-ratio that falls within the limit specified by Kerr et al. (2005) [40].

"As expected, the results presented in Table 2 and Table 3 show that increasing the scope of SIFs through site expansion would result in a decrease of HIV infection cases. The model predicts: 14–53 fewer HIV cases and 84–327 fewer HCV cases annually, with the marginal range being much smaller: 5–14 fewer HIV cases and 33–84 fewer HCV cases annually.

"This range disparity, as outlined in Table 2 and Table 3, translates into substantial differences between the economic evaluation of SIFs with respect to the cumulative versus marginal estimates: the total effect of establishing SIFs and the effect of establishing each subsequent SIF, respectively.

"For example, according to Table 3, the cumulative annual estimates of new HIV cases averted, translates into a cost savings for society ranging from \$0.764 million (benefit) for the first SIF to -\$4.1 million (loss) for the seventh SIF. Benefit-cost ratios range from 1.35 to 0.73, and cost-effectiveness values range from \$155,914 to \$288,294 (cost per lifetime treatment). The cumulative annual estimates of new HCV cases averted translate into a cumulative cost savings that range from \$0.769 million (benefit) for the first SIF to -\$3.7 million (loss) for the seventh SIF. Benefit-cost ratios range from 1.35 to 0.73, and incremental cost-effectiveness values range from \$25,986 to \$46,727 (cost per lifetime treatment).

"In contrast, the marginal estimates of Montreal's SIF expansion translate into a much smaller return. This is particularly true with respect to its benefit-cost and cost-effectiveness ratios. For instance, the marginal benefit-cost ratio varies from 1.35 to 0.77 for HIV and 1.35 to 0.76 for HCV. The marginal cost-effectiveness value for HIV ranges from \$155,914 to \$436,560 (cost per life-time treatment). The HCV marginal cost-effectiveness value ranges from \$25,986 to \$66,145 (cost per lifetime treatment)."

Source:

Jozaghi et al., "A cost-benefit/cost-effectiveness analysis of proposed supervised injection facilities in Montreal, Canada." *Substance Abuse Treatment, Prevention, and Policy* 2013 8:25. doi:10.1186/1747-597X-8-25

<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2683812/pdf/1747-597X-4-7.pdf...>

24.

Economics

(Annual Cost of Substance Use) "Measured in terms of the burden on services such as health care and law enforcement, and the loss of productivity in the workplace or at home resulting from premature death and disability, the overall social cost of substance abuse in Canada in 2002 was estimated to be \$39.8 billion. This estimate is broken down into four major categories in Figure 1. This overall estimate represents a cost of \$1,267 to every man, woman and child in Canada, as indicated according to substance in Figure 2.

"Tobacco accounted for about \$17 billion or 42.7% of that total estimate, alcohol accounted for about \$14.6 billion (36.6%) and illegal drugs for about \$8.2 billion (20.7%) (see Table 2).

"Productivity losses amounted to \$24.3 billion or 61% of the total, while health care costs were \$8.8 billion (22.1%). The third highest contributor to total substance-related costs was law enforcement with a cost of \$5.4 billion or 13.6% of the total."

Source:

J. Rehm, D. Baliunas, S. Brochu, B. Fischer, W. Gnam, J. Patra, S. Popova, A. Sarnocinska-Hart, and B. Taylor, "The Costs of Substance Abuse in Canada 2002 - Highlights" (Ottawa, Ontario, Canada: Canadian Centre on Substance Abuse, March 2006), p. 1.

<http://www.ccsa.ca/Resource%20Library/ccsa-011332-2006.pdf>

25.

(Cost of Substance Abuse in Canada) "In 2006 a team of researchers published estimates of the social costs of substance abuse in Canada across several domains based on 2002 data (Rehm et al., 2006). Total costs of substance abuse for all substances (including tobacco) were estimated to be \$39.8 billion in 2002, which translates into \$1,267 per capita. Of this, approximately 39% are direct costs to the economy associated with health care, enforcement, prevention/research and 'other costs' ⁶, and 61% are indirect costs associated mainly with productivity losses resulting from premature death and disability. Figure 2 depicts the estimated direct social costs associated with alcohol, illicit drugs and cannabis in 2002.

"Important findings from Figure 2 include the fact that (1) total direct social costs associated with alcohol (\$7,427.5 million) are more than double those for all illicit drugs combined (\$3,565.5 million); (2) direct alcohol-related health care costs (\$3,306.2 million) are nearly three times as high as for all illicit drugs, excluding cannabis (\$1,061.6 million), and over 45 times higher than the direct health care costs of cannabis (\$73 million); and (3) annual direct costs for health care (\$4,440.7 million) are 31 times higher, and annual direct costs for enforcement (\$5,407.7 million) are 36 times higher than annual costs for prevention and research (\$147.6 million)."

Source:

Thomas, Gerald and Davis, Christopher G., Comparing the Perceived Seriousness and Actual Costs of Substance Abuse in Canada: Analysis drawn from the 2004 Canadian Addiction Survey," Canadian Centre on Substance Abuse (Ottawa, ON: Canadian Centre on Substance Abuse, March 2007), pp. 2-4.

<http://www.ccsa.ca/Resource%20Library/ccsa-011350-2007.pdf>

26. **Laws & Policies**

(National Anti-Drug Strategy) "The National Anti-Drug Strategy is a horizontal initiative of 12 federal departments and agencies, led by the Department of Justice, with new and reoriented funding⁴ covering activities over a five-year period from 2007/08 to 2011/12. The goal of the Strategy is to contribute to safer and healthier communities through coordinated efforts to prevent use, treat dependency, and reduce production and distribution of illicit drugs. Illicit drugs are defined in the Controlled Drugs and Substances Act (CDSA) to include opiates, cocaine and cannabis-related substances (including marijuana) as well as synthetic drugs such as ecstasy and methamphetamine. The Strategy encompasses three action plans: Prevention, Treatment and Enforcement:

"□ The objectives of the Prevention Action Plan are to prevent youth from using illicit drugs by enhancing their awareness and understanding of the harmful social and health effects of illicit drug use; and to develop and implement community-based interventions and initiatives to prevent illicit drug use.

"□ The objective of the Treatment Action Plan is to support effective treatment and rehabilitation systems and services by developing and implementing innovative and collaborative approaches.

"□ The objective of the Enforcement Action Plan is to contribute to the disruption of illicit drug operations in a safe manner, particularly targeting criminal organizations.

"The Strategy's action plans are expected to contribute to a reduction in the supply of, and demand for, illicit drugs, which ultimately contributes to safer and healthier communities."

Source:

Government of Canada, "National Anti-Drug Strategy Implementation Evaluation - Final Report" (Ottawa, Ontario, Canada: Evaluation Division, Office of Strategic Planning and Performance Measurement, Dept. of Justice, May 2012), p. 1.

<http://www.justice.gc.ca/eng/rp-pr/cp-pm/eval/rep-rap/12/nas-sna/index.h...>

<http://canada.justice.gc.ca/eng/rp-pr/cp-pm/eval/rep-rap/12/nas-sna/nas-...>

27.

(Federal Role in Canadian Drug Control Policy) "The role of the federal government is described in key legislation and international conventions and protocols in areas relevant to the Strategy's activities. The federal government role in the Strategy is grounded in its authorities under the Constitution Act (1867) as well as key legislation, including CDSA; Criminal Code of Canada; Canada Health Act; Proceeds of Crime (Money Laundering) and Terrorist Financing Act; and Youth Criminal Justice Act. Departmental legislative authorities of relevance include Canada Revenue Agency Act; Canada Border Services Agency Act; Corrections and Conditional Release Act; Department of Foreign Affairs and International Trade Act; Department of Health Act; Department of Justice Act; Department of Public Safety and Emergency Preparedness Act; Department of Public Works and Government Services Act; Director of Public Prosecutions Act; and Royal Canadian Mounted Police Act. International conventions and protocols of relevance include the United Nations Narcotic Drug Conventions and other multilateral processes such as the OAS, the G8, the Paris Pact, and the Dublin Group.

"The federal government plays a critical role in addressing illicit drug issues at the broad policy level. For example, the Department of Justice led on introducing Bill C-10, which included mandatory minimum penalties for serious drug crime, and received royal assent on March 13, 2012. HC [Health Canada] is responsible for amendments under the CDSA to control the movement of certain substances in and out of Canada. This is particularly relevant for controlling and preventing the movement of illicit drugs as well as precursor chemicals which are used to make synthetic drugs (e.g. methamphetamine)."

Source:

Government of Canada, "National Anti-Drug Strategy Implementation Evaluation - Final Report" (Ottawa, Ontario, Canada: Evaluation Division, Office of Strategic Planning and Performance Measurement, Dept. of Justice, May 2012), p. 37.

<http://www.justice.gc.ca/eng/rp-pr/cp-pm/eval/rep-rap/12/nas-sna/index.h...>

<http://canada.justice.gc.ca/eng/rp-pr/cp-pm/eval/rep-rap/12/nas-sna/nas-...>

28.

(Perception of Seriousness of Substance Abuse Problems) "Our analyses suggest that public perceptions of the relative seriousness of substance abuse problems are incongruent with the actual costs they impose on Canadian society. In particular, the total social costs associated with alcohol are more than twice those for all other illicit drugs in 2002, yet the public

consistently rated the overall seriousness of illicit drugs as higher at the national, provincial and local levels in the Canadian Addiction Survey (2004). Interpreting these findings it is possible to suggest that perceptions of the seriousness of illicit drugs are relatively *amplified* while perceptions of the seriousness of problems associated with alcohol are relatively *attenuated* in Canadian society."

Source:

Thomas, Gerald and Davis, Christopher G., Comparing the Perceived Seriousness and Actual Costs of Substance Abuse in Canada: Analysis drawn from the 2004 Canadian Addiction Survey," Canadian Centre on Substance Abuse (Ottawa, ON: Canadian Centre on Substance Abuse, March 2007), p. 4.

<http://www.ccsa.ca/Resource%20Library/ccsa-011350-2007.pdf>

29.

(Medical Marijuana) The Canadian government in 2001 established regulations to expand the use of marijuana as a medicine. According to an editorial in the *Canadian Medical Association Journal* , "The new regulations promise more transparency in the review of applications to grow or possess medicinal marijuana, a broader definition of medical necessity, and greater latitude for physicians in determining the needs of individual patients."

Source:

"Marijuana: federal smoke clears, a little," Canadian Medical Association Journal, Vol. 164, No. 10, May 15, 2001, p. 1397.

<http://www.cmaj.ca/cgi/reprint/164/10/1397.pdf>

30.

(Prison-Based Methadone Maintenance Programs) "Ensuring that offenders have access to interventions that address their substance abuse issues allows the Correctional Service of Canada (CSC) to support the safe reintegration of offenders into society. The treatment needs of offenders with opioid dependence are met through CSC's Methadone Maintenance Treatment (MMT) Program. ¹

Some of the objectives of CSC's MMT program include reducing relapse to opioid drug use and the incidence of drug-related criminal activity; improving the offender's general health and quality of life; and assisting and motivating offenders to gradually desist from all illicit drug use."

Source:

Johnson, S., Farrell MacDonald, S., & Cheverie, M. (2011). Research at a Glance: Characteristics of participants in the Methadone Maintenance Treatment (MMT) Program. Research Report R253. Ottawa, Ontario: Correctional Service Canada. Last accessed on the web Dec. 12, 2012.

<http://www.csc-scc.gc.ca/text/rsrch/smmrs/rg/rg-r253/rg-r253-eng.shtml>

31.

(Seizure of Children from Drug Producing Homes) "In 2006, the province of Alberta passed the Drug Endangered Child Act,¹⁷ which authorized the state (child welfare authorities or the police) to seize children from drug-producing homes, even if based on suspicion alone.¹⁸ Often these children, and even the parents, might not know about the drugs. More troubling is that there may not even be illicit substances present, but rather the chemicals used to create such substances, and this may be deemed sufficient for apprehension of the children. To add to the equation, the Motherisk Laboratory at the Hospital for Sick Children receives hair samples to be analyzed for drugs of abuse from thousands of parents implicated in child-protection matters each year from across the country, and they are analyzed for drugs of abuse. Based on consultations with child protection workers or the respective authorities, children are rarely removed from drug-using parents' care until substantial evidence of child safety issues is built. Among our cohort of children presented here, however, the majority of the parents were not known to be using illicit substances themselves and, on the basis of our clinical assessments, appear to be able to parent their children adequately. It is not likely that the production of drugs, particularly marijuana, hinders effective parenting much more than actual drug use, yet the differences in the ways these cases are handled suggest that police and child protection agencies perceive the former to be of greater concern with respect to child safety than the latter."

Source:

Moller, Monique; Koren, Gideon; Karaskov, Tatyana; and Garcia-Bournissen, Facundo, "Examining the Health and Drug Exposures among Canadian Children Residing in Drug-Producing Homes," *The Journal of Pediatrics* (Cincinnati, OH: July 2011), p. 4.

<http://www.ncbi.nlm.nih.gov/pubmed/21784455>

32.

(Canada/United States Border Enforcement Cooperation) "Through successful binational fora such as the Cross-Border Crime Forum (CBCF) and Project North Star, the United States and Canada have increased intelligence-sharing and joint training opportunities for law enforcement officials. Investigative cooperation has also been expanded, through the establishment of new Integrated Border Enforcement Teams and notable enforcement initiatives such as Operation Sweet Tooth/Project O'Skillet and Operation Triple Play/Project O'Slider. The result: greater success in seizing illicit drugs crossing the U.S.-Canada border and apprehending those that traffic them.

"Despite our best efforts, drug trafficking still occurs in significant quantities in both directions across the border. The principal illicit substances smuggled across our shared border are MDMA (Ecstasy), cocaine, and marijuana."

Source:

Government of the United States and the Government of Canada, "United States - Canada Border: Drug Threat Assessment 2007" (March 2008), p. vii.

<https://www.publicsafety.gc.ca/cnt/rsrscs/pblctns/archive-brdr-drg-thrt-s...>

33.

(Public Health and Drug Control Policy in Canada) "Public health oriented regulation has much potential to reduce the health, social and fiscal harms associated with all psychoactive substances.

"In addition, public health oriented regulation is supportive of Canadians human rights as established by the pre-eminence of the Charter of Rights and Freedoms 7 i.e. the "right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice." (section 7), "subject only to such reasonable limits prescribed by law as can be demonstrably justified in a free and democratic society" (section 1)."

Source:

"Public Health Perspectives for Regulating Psychoactive Substances: What We Can Do About Alcohol, Tobacco, and Other Drugs," The Health Officers Council of British Columbia (Victoria, British Columbia: November 2011), p. 9.

<http://drugpolicy.ca/wp-content/uploads/2011/11/Regulated-models-Final-N...>

34. **North American Opiate Medication Initiative (NAOMI)**

"The North American Opiate Medication Initiative (NAOMI) is a carefully controlled (clinical trial) that will test whether medically prescribed heroin can successfully attract and retain street-heroin users who have not benefited from previous repeated attempts at methadone maintenance and abstinence programs.

"The NAOMI study will enroll 470 participants at three sites in Vancouver, Montreal and Toronto. The Toronto and Montreal sites are expected to begin recruitment this spring.

"Each site will enroll about 157 participants. About half of these volunteers will be assigned to receive pharmaceutical-grade heroin (the experimental group) and half will receive methadone (the control group). The prescribed heroin will be self-administered under careful medical supervision within a specially designed clinic. Those in the heroin group will be treated for 12 months then transitioned, over three months, into either methadone-maintenance therapy or another treatment program. The researchers expect a 6-9 month recruitment period, so that the total time to complete the study will be 21 to 24 months."

Source:

Health Canada News Release, "North America's First Clinical Trial Of Prescribed Heroin Begins Today," (Vancouver: February. 9, 2005).

<http://dev.cihr.ca/e/26516.html>

35.

18. What was NAOMI?

"NAOMI was North America's first-ever clinical trial of prescribed heroin that took place from 2005 to 2008.

"It was led by researchers from PHC and UBC, and tested whether medically prescribed heroin (diacetylmorphine) was more effective than methadone therapy for individuals with chronic heroin addiction who were not benefiting from other conventional treatments.

"19. Who participated in the NAOMI study?

"NAOMI enrolled 251 chronic, heroin dependent participants (192 in Vancouver and 59 in Montreal)."

" **24. What did NAOMI find?**

"The NAOMI Trial results, published in the prestigious medical publication the New England Journal of Medicine, showed that participants treated with diacetylmorphine reported improved physical and mental health, were 62 per cent more likely to remain in addiction treatment and 40 per cent less likely to take illegal drugs and commit crimes to support their habit than were those treated with methadone.

"After a year, 88 per cent of those treated with diacetylmorphine remained in treatment, compared with 54 per cent in the methadone group.

"Data from NAOMI and other long-term studies with medically prescribed heroin show that many of the patients of these studies also transition from injection to oral treatments, detox programs and abstinence."

" **25. What happened to the NAOMI participants after they completed the study?**

"Doctors were unable to secure approval from the federal government to give patients diacetylmorphine.

"All participants who received injection medication were encouraged to switch to methadone.

"Providence agreed to provide interim funding for the continued operations of a methadone program at the clinic site. SALOME was designed to continue the work of NAOMI."

Source:

"SALOME Clinical Trial Questions and Answers," Providence Healthcare, Vancouver, British Columbia, last accessed March 3, 2017.

<http://www.providencehealthcare.org/salome/faqs.html>

36.

(Findings from the North American Opiate Medication Initiative) "Our study had two primary findings. First, we found that most study participants were motivated for treatment, despite not accessing it in at least the past 6 months (as per trial entry criteria). This may be the result of a lack of accessible or attractive treatment options available to them. Second, we found that baseline motivation for treatment did not predict retention in either HAT [heroin assisted treatment] or MMT [methadone maintenance treatment], however motivated patients receiving HAT were more likely to achieve response than unmotivated patients. While HAT is likely to retain patients regardless of motivational status, success in treatment, in terms of decreases in illicit drug use and crime, is more likely among motivated patients, as measured in our study. Further, HAT was statistically significantly more effective than MMT on each of the outcomes assessed."

Source:

Nosyk, Bohdan; Geller, Josie; Guh, Daphne P.; Oviedo-Joekes, Eugenia; Brissette, Suzanne; Marsh, David C.; Schechter, Martin T.; Anis, Aslam H., "The effect of motivational status on treatment outcome in the North American Opiate Medication Initiative (NAOMI) study," *Drug and Alcohol Dependence* (Philadelphia, PA: College on Problems of Drug Dependence, September 2010), pp. 3-4.

<http://www.ncbi.nlm.nih.gov/pubmed/20510549>

37. **Study to Assess Longer-Term Opioid Medication Effectiveness (SALOME)**

"What is the SALOME clinical trial?"

"The Study to Assess Longer-term Opioid Medication Effectiveness [SALOME] is a clinical trial that will test whether diacetylmorphine, the active ingredient of heroin, is as good as hydromorphone (Dilaudid®), a licensed medication, in benefiting people suffering from chronic opioid addiction who are not benefiting sufficiently from other treatments. Also, this study will test if those effectively treated with injectable diacetylmorphine or hydromorphone can be successfully switched and retained to the oral formulations of the medications."

Source:

"SALOME Clinical Trial Questions and Answers," InnerChange Foundation (Vancouver, British Columbia: 2010), p. 1.

http://www.innerchangefoundation.org/pdf/SALOME_FAQs_v4.pdf

38.

"How are SALOME and NAOMI trials related?"

"In the NAOMI study, a small group of patients received hydromorphone (Dilaudid®) instead of diacetylmorphine in a double-blind basis (nor the patients or staff knew which drug they were receiving), for the purpose of validation of self-reported use of street heroin in urine toxicological tests. An unexpected finding was that injection patients could not accurately discriminate whether they were receiving diacetylmorphine or hydromorphone."

Source:

"SALOME Clinical Trial Questions and Answers," InnerChange Foundation (Vancouver, British Columbia: 2010), p. 1.

http://www.innerchangefoundation.org/pdf/SALOME_FAQs_v4.pdf

39.

Vancouver's Insite

(Support for Insite) "Since its inception, Insite has been subject to an independent review by a team of physicians and scientists put in place to provide an 'arm's length' evaluation of the program. The results of this scientific evaluation have been published in peer-reviewed academic journals and have indicated that Insite has reduced unsafe injection practices, public disorder, overdose deaths and HIV/Hepatitis while increasing uptake of addiction services and detox [8]. To date, there have been over three-dozen peer-reviewed papers evaluating Insite published making it one of the most evaluated healthcare programs in the history of Canada [9-38]. In light of the evidence, the program has garnered widespread support from Canadian physicians, scientists and healthcare professionals."

Source:

Small, Dan, "An appeal to humanity: legal victory in favour of North America's only supervised injection facility: Insite," Harm Reduction Journal (London, United Kingdom: October 2010), Vol. 7, p. 3.

<http://www.harmreductionjournal.com/content/pdf/1477-7517-7-23.pdf>

40.

(Insite's Goals) "Insite opened on 21 September of 2003 under an exemption granting it status as a scientific pilot study until 12 September 2006. The primary goals of the program are: (1) to reach a marginalized group of IDUs with healthcare and supports who would otherwise be forced to use drugs in less safe settings (2) to reduce dangerous injection practices (syringe sharing) thereby reducing the risk of infectious diseases like HIV and HCV; and (3) to reduce fatal overdoses in the population

of people that use the facility. The program also aims to provide referrals to treatment and detoxification, reduce public disorder (public injection) and validate the personhood of a deeply stigmatized target population."

Source:

Small, Dan, "An appeal to humanity: legal victory in favour of North America's only supervised injection facility: Insite," Harm Reduction Journal (London, United Kingdom: October 2010), Vol. 7, p. 1.

<http://www.harmreductionjournal.com/content/pdf/1477-7517-7-23.pdf>

41.

(Insite Evaluations) "The British Columbia Centre for Excellence in HIV/AIDS was commissioned to evaluate Insite. A study published in 2006 showed that there was an increase in uptake of detoxification services and addiction treatment.¹³ Another study published that year showed that Insite did not result in increased relapse among former drug users, nor was it a negative influence on those seeking to stop drug use.¹⁴ Results of studies using mathematical modelling showed that about one death from overdose was averted per year by Insite.¹⁵ A subsequent study estimated 2–12 deaths averted per year.¹⁵ Although these studies did not have sufficient power to detect any difference in incidence of blood-borne infections, Kerr and colleagues did find that Insite users were 70% less likely to report needle-sharing than those who did not use the facility.¹⁶ Before the opening of Insite, those same individuals reported needle-sharing that was on par with cohort averages. As for public order, Wood and colleagues found that there was no increase in crime following the opening of the facility.¹⁷ In fact, there had been statistically significant decreases in vehicle break-ins and theft, as well as decreases in injecting in public places and injection-related litter."

Source:

Dooling, Kathleen and Rachlis, Michael, "Vancouver's supervised injection facility challenges Canada's drug laws," Canadian Medical Association Journal (Ottawa, Ontario: September 21, 2010), Vol. 182, Issue 13, p. 1441.

<http://www.ncbi.nlm.nih.gov/pubmed/20805208>

<http://www.cmaj.ca/content/182/13/1440.full>

42.

(Reduced Overdose Mortality) "In this population-based analysis, we showed that overdose mortality was reduced after the opening of a SIF [supervised injecting facility]. Reductions in overdose rates were most evident within the close vicinity of the facility—a 35% reduction in mortality was noted within 500 m of the facility after its opening. By contrast, overdose deaths in other areas of the city during the same period declined by only 9%. Consistent with earlier evidence showing that SIFs are not associated with increased drug injecting (panel),^{38,39} these findings indicate that such facilities are safe and effective public-health interventions, and should therefore be considered in settings with a high burden of overdose related to injection drug use."

Source:

Marshall, Brandon D L; Milloy, M-J; Wood, Evan; Montaner, Julio S G; Kerr, Thomas, "Reduction in overdose mortality after the opening of North America's first medically supervised safer injecting facility: a retrospective population-based study," *The Lancet* (London, United Kingdom, April 2011), p. 7.

<http://www.communityinsite.ca/injfacility.pdf>

43.

(Insite Users and Other Drug Use) In an evaluation of the Vancouver supervised injection facility Insite, researchers concluded that: "Although there was a substantial increase in the number of participants who started smoking crack cocaine, it is unlikely that the facility, which does not allow smoking in the facility, prompted this change. These findings are relevant to a recent review of supervised injection facilities by the European Monitoring Centre on Drugs and Drug Addiction, which highlighted concerns that these facilities could potentially 'encourage increased levels of drug use' and 'make drug use more acceptable and comfortable, thus delaying initiation into treatment.'"

Source:

Kerr, Thomas, Jo-Anne Stoltz, Mark Tyndall, Kathy Li, Ruth Zhang, Julio Montaner, Evan Wood, "Impact of a medically supervised safer injection facility on community drug use patterns: a before and after study," *British Medical Journal*, Vol. 332, Jan. 28, 2006, p. 222.

<http://www.ncbi.nlm.nih.gov/pubmed/16439401?dopt=abstract>

<http://www.bmj.com/content/332/7535/220>

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