ALTERNATIVE REPORT SUBMITTED TO THE UNITED NATIONS HUMAN RIGHTS COMMITTEE

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Violations of the International Covenant on Civil and Political Rights Related to People Who Use Drugs in Canada

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THE CANADIAN DRUG POLICY COALITION

The Canadian Drug Policy Coalition[1] (CDPC) is a national, non-partisan civil society organization working to advance drug policy grounded in evidence and human rights. CDPC collaborates with people with lived/living experience, researchers, civil society organizations, Indigenous leadership, health providers, and communities across Canada and internationally. Our work includes policy analysis, legal and human-rights advocacy, knowledge mobilization, and community engagement.

CDPC submits this alternative report to assist the Human Rights Committee in its review of Canada's compliance with the International Covenant on Civil and Political Rights (ICCPR).

This submission should be read alongside complementary reports by the HIV Legal Network[2], Tracking InJustice[3], Amnesty International Canada[4], the Joint Statement Urging Review of Canada's Position on Positive Obligations Under Article 6, and national housing and homelessness organizations[5] addressing intersecting rights violations relating to detention, health care, poverty, and housing insecurity.

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EXECUTIVE SUMMARY

CDPC's submission includes a number of detailed concerns – but at its core, it tells the story of one devastating truth: Canada's laws and government actions are driving death and life-altering injury on a mass scale.

Today, as you read this submission, an average of twenty-six people in Canada will die from drug-related toxicity[6]. An estimated 390 people will experience a non-fatal drug poisoning[7], bringing a significant risk of brain injury.

Since January 2016, more than 53,000 people have died from apparent opioid toxicity. Thousands more have died from stimulant and mixed-substance toxicity.

This is preventable. In 2025, roughly 83% of opioid-related deaths involve non-pharmaceutical, or "unregulated opioids"[*]. In 2010, the national mortality rate[8] due to accidental drug overdose is estimated to have been 6/100,000 population. By 2023, opioid-related mortality rates had skyrocketed to approximately 20/100,000 and stimulant mortality rates more than doubled, with 13,323 drug-related deaths[9] documented that year. Mortality rates surged between 2012-2023, as illegal fentanyl became increasingly prevalent in Canada's unregulated drug supply.

It is essential that the Committee examine what is driving these changes and how Canada's laws and actions are driving preventable and foreseeable death on a mass scale.

These deaths are not the result of increased rates of "addiction". Rates of drug use and substance use disorders have remained relatively stable over the last decade[10]. Drug-related mortality has risen sharply because the substances in Canada's unregulated drug supply have become increasingly unpredictable[11], varied[12], contaminated[13], and potent.

The volatility of the unregulated drug supply is a direct and foreseeable consequence of Canada's drug laws and enforcement practices[14]. Canada's approach attempts to eradicate the supply of drugs and discourage drug use by prohibiting certain drugs and the precursor chemicals used to make them, seizing drugs ("drug busts"), and increasing border security, while criminalizing and punishing certain drug-related activities including possessing drugs for personal use.

These policies and practices have not made drugs less available or addressed the demand for drugs. On the contrary, high-level enforcement at borders, ports and drug production sites, combined with low-level street policing disrupts the drug supply chain. Instead of making drugs less available, it

[*] Opioids are a class of drug that includes substances like heroin, codeine, morphine, and fentanyl. Opioids are prescribed for pain relief in medical contexts and used safely every day in hospitals across Canada. These pharmaceutical drugs are produced with strict regulations to ensure dosage and purity. Outside of medical context opioids are used recreationally, for untreated pain and trauma, and by people with physical dependencies. Often, these are produced illegally, outside of regulatory frameworks. When using "unregulated" or illegally produced drugs, dosage, purity and consistency is never assured.

often makes the illegal market more chaotic. Drug producers adapt to replace seized drugs, stretch supplies by using additives, and use more concentrated substances to evade detection. Years of drug law enforcement has led to plant-based drugs like heroin being displaced by more potent synthetic drugs like fentanyl. Prohibition has also led to the use of unpredictable additives or substitutes (e.g. benzodiazepines[15], nitazenes[16], veterinary tranquilizers[17]). The result is a more unpredictable, and often more toxic, unregulated drug supply, which increases the risk of death and harm for people who use drugs, even when their patterns of use have not changed.

This approach to illegal drugs—unlike alcohol, cannabis and prescription drugs—does not enforce any quality controls to increase safety and decrease risk. Throughout this submission we refer to the drug supply as "unregulated" because these drugs are manufactured without regulatory consumer protections to ensure people know the contents, dosage, and purity of the substances they ingest.[†]

Canada's focus on criminal enforcement pushes people to use alone and in less safe, hidden environments, because they fear punishment. This makes it more difficult for medical first responders to find them to provide life-saving care. Criminalization also drives stigma and discrimination. This discourages people from disclosing their drug use and seeking health and social supports (e.g. treatment, primary care, housing).

Under Articles 2, 6 and 26 of the ICCPR, Canada has obligations to not only refrain from arbitrary deprivation of life, but also to take reasonable and effective measures to protect life without discrimination where threats are foreseeable. Here we refer the Committee to, and endorse, the "Joint statement urging review of Canada's position on positive obligations under Article 6".

Further, drug law enforcement and punitive policies disproportionately affect Indigenous[18] Peoples[19], Black[20] and racialized communities[21], women[22], people with disabilities[23], and people experiencing poverty and homelessness[24], raising serious concerns under Articles 2 and 26.

After a decade of escalating mortality and morbidity, the threat posed by the unregulated drug supply is unquestionably foreseeable and driven primarily by Canada's drug laws and enforcement practices. Canada's continued reliance on criminalization, combined with insufficient and increasingly restricted health interventions, demonstrates a failure to exercise due diligence to protect life, and discriminates against people who use drugs, regardless of how often they use or whether they have a substance use disorder.

For more than a decade, Canada's own courts have found aspects of such laws and government actions to be a violation of the right to life, liberty and security of the person [25]. Nonetheless, Canada's drug law enforcement approaches are intensifying, often in direct opposition to the

[†] Novel or unexpected substances often cause unintended effects that increase risks and harms - for example, benzodiazepines mixed with opioids may cause the combined effects (e.g. reduced breathing) to be greater than those from either drug alone and naloxone (an opioid overdose reversal medication) does not work on benzodiazepines. This can increase the risk of death and complicates overdose response. As well, regular exposure to benzodiazepines can lead to life threatening withdrawal.

findings and recommendations of numerous government-convened expert task forces and advisory councils. Governments across Canada are:

1. Failing to protect the lives of people who use drugs by:
    1.1. Ignoring evidence and expert advice to implement quality and access controls for various prohibited drugs;
    1.2. Knowingly pursuing law enforcement practices that increase the volatility and contamination of the drug supply.
2. Prosecuting people for providing life-saving programs.
3. Expanding criminalization, police powers and health-based detention by:
    3.1. Recriminalizing drug possession in the province of British Columbia and prohibiting decriminalization in Ontario;
    3.2. Criminalizing survival activities in public spaces;
    3.3. Expanding involuntary treatment regimes and "secure" health facilities.
4. Closing and restricting essential health interventions:
    4.1. Closing supervised consumption services;
    4.2. Limiting and defunding prescription-based health programs to decrease reliance on the unregulated toxic drug supply.
5. Restricting democratic participation in drug policy decisions.

Taken together, Canada's approach constitutes a systemic human rights failure. The unregulated toxic drug crisis is not merely a health policy problem. It is a governmental failure to protect the right to life.

The Government of Canada is well aware of these concerns through regular communications with Health Canada, civil society engagement in Canada's delegation to the Commission on Narcotic Drugs, numerous law reform submissions, and a number of ongoing court cases. Despite the devastating and ongoing loss of life, and submissions made by civil society during the development of the List of Issues Prior to Reporting, this crisis has not been adequately prioritized. The Government of Canada delegation can and should be prepared to address questions from the Committee on this issue.

We ask that the Committee explicitly address drug policy within its review and issue strong recommendations requiring Canada to shift from punishment to regulation, care, and human-rights-based approaches.

SPECIFIC ISSUES AND VIOLATIONS OF THE ICCPR

ISSUE 1

Canada is failing to protect the lives of people who use drugs

Violations of Articles: 6, 2, and 26

1. Canada often justifies its approach to drug policy by asserting that it is necessary to ensure compliance with UN Drug Control Conventions[26]. This reasoning is not accurate, complete or consistent with Canada's equally important obligations under international human rights treaties. Canada has latitude under UN Drug Control Conventions, as it has demonstrated by enacting sweeping reforms to cannabis regulation. Further, UN Drug Control Conventions are not static, and are currently the subject of significant debate[27] among UN Member States, with some states formally problematizing or rejecting them in part or whole. In fact, these conventions are currently under review by an independent expert panel. Most importantly, numerous UN bodies[28] have made clear that UN Drug Control Conventions must be interpreted in light of Canada's human rights commitments including those codified in the ICCPR.[29]
2. Compliance with UN Drug Control Conventions does not justify the significant human rights concerns raised in our submission.
3. Canada's primary drug control statute, the *Controlled Drugs and Substances Act*[30] (CDSA), criminalizes possession, trafficking, importing, exporting, and production of listed substances. Penalties include imprisonment, in some cases including maximum sentencing up to life imprisonment. The CDSA is the key mechanism used by law enforcement. As outlined below, enforcement of the CDSA is a key factor driving the increasing volatility and toxicity of the unregulated drug supply.
4. The *Food and Drug Act* and *Food and Drug Regulations*[31] (FDA/FDR) are Canada's primary mechanisms to regulate ingredients, potency and access to other substances, including prescription medications. The FDA/FDR offer the legal framework that *could* but does not presently increase safety and decrease death and harm, by ensuring that the unregulated drug supply in Canada is not tainted or dangerously potent. The FDA/FDR similarly *could* but does not presently control manufacture, access/sale, or advertising of unregulated drugs.
5. In theory, the CDSA and FDA/FDR are intended to protect public health and safety by suppressing the supply of drugs, discouraging the use of drugs outside of medical/therapeutic contexts or legally authorized non-medical use (e.g. alcohol, cannabis, nicotine), and regulating access to quality-controlled drugs in some circumstances (i.e. prescription medications).
6. In practice, the CDSA/FDA/FDR framework has failed to reduce availability or use of drugs and has acted as a barrier to implementing policies that would reduce the harm caused by tainted, unregulated drugs. Ultimately, it is the government's legislative framework and the enforcement of it that has produced an unregulated drug supply characterized by extreme risk.

1.1 Canada has failed to follow evidence and expert advice to implement quality and access controls for various prohibited drugs

7. The government has ignored evidence and not acted on the recommendations[32] of the government-initiated "Expert Task Force on Substance Use" and "Expert Advisory Group on Safer Supply." Further, Canada has refused to publicly release the full findings of the Expert Advisory Group on Safer Supply, thereby reducing transparency and government accountability.
8. In 2021, Canada's Expert Task Force on Substance Use[33] called on the Canada to:

> *immediately develop and implement a single public health framework with specific regulations for all psychoactive substances, including currently illegal drugs as well as alcohol, tobacco, and cannabis. This framework should aim to minimize the scale of the illegal market, bring stability and predictability to regulated markets for substances, and provide access to safer substances for those at risk of injury or death from toxic illegal substances.*

9. Other expert bodies and human rights entities have, and continue, to advance similar demands. This includes: The UN Office of the High Commissioner for Human Rights[34],the British Columbia's Coroner Service[35], the BC Provincial Health Officer[36], the Ontario Chief Medical Officer of Health[37]– among others.
10. Canada has not responded to or implemented these calls to action despite significant data and research demonstrating the increasing diversification, toxicity and variability of the unregulated drug supply, leading to death and increased health and social harms.

1.2 Canada knowingly pursues law enforcement practices that increase the volatility and contamination of the drug supply

11. When law enforcement pressures increase, illegal drug manufacturers adapt:
    - Substances become more potent and compact to evade detection (e.g. the shift from heroin to synthetic drugs like unregulated fentanyl[38]);
    - Novel and often more potent substances proliferate (e.g. emergence of highly potent analogues like carfentanil and addition of other substances like veterinary tranquilizers and benzodiazepines);
    - Production becomes more sophisticated or clandestine and lacks safeguards to ensure consistent potency and to protect against cross-contamination.
12. This phenomenon is well documented internationally and in Canada through drug checking services[39] and Health Canada's own monitoring systems[40].
13. Ultimately, consumers are not able to access adequate information that would give them knowledge of the potency or contents of the substances they ingest. And, shifts in the contents and potency of the drug supply reliably increase the foreseeable risk of death.
14. Police enforcement (e.g., drug seizures) increases the volatility of the drug supply and recent research shows that drug deaths increase significantly[41] for up to three weeks after police drug

seizures[42]. Fear of police and criminalization also deters people from accessing health and social services, and incarceration is correlated with increased risk of death upon release.

15. According to UN experts[43], this approach "undermines health and social wellbeing and wastes public resources while failing to eradicate the demand for illegal drugs and the illegal drug market."
16. Put plainly, when police enforce drug laws – people are at greater risk of death[44].
17. Under General Comment No. 36, Article 6 requires States to address "general conditions in society that may give rise to threats to life." Canada's drug policy framework and enforcement practices predictably produce tens of thousands of preventable deaths; this cannot be reconciled with Canada's obligations under Article 6. The continued reliance on prohibition despite overwhelming evidence of harm demonstrates a failure of due diligence by the Government of Canada.
18. This failure is compounded by discriminatory impacts of police enforcement. Enforcement disproportionately targets Indigenous peoples, Black communities, and people living in poverty. Thus, Canada's drug law enforcement not only fails to protect life but does so inequitably, engaging Articles 2 and 26.
19. The scale, duration, and predictability of Canada's drug toxicity crisis demand recognition as a systemic violation of the right to life. The Canadian Drug Policy Coalition recommends that:

The Committee find that:

1. Canada's drug laws (CDSA, FDA, FDR) are a significant contributor to the volatility and toxicity of the unregulated drug supply, constituting a violation of the right to life under Article 6;
2. Canada has failed to take reasonable and effective measures to protect life without discrimination where threats are foreseeable by failing to respond to and work towards implementation of the recommendations of the Expert Task Force on Substance Use in violation of Articles 2, 6 and 26.

The Committee call on Canada to:

1. Publicly release the full findings and reports of the Expert Advisory Group on Safer Supply;
2. Within 1 year, complete an arms-length review of the impacts of drug law enforcement on the volatility of the drug supply, and discriminatory practices and effects of such enforcement. This should be led by an independent committee of qualified interdisciplinary evaluators and people with lived/living experience with meaningful engagement from civil society;
3. Implement the recommendation of the Expert Task Force on Substance Use to create "a single public health framework with specific regulations for all psychoactive substances" including a commitment to specified goals and timelines, processes for lived/living experience and civil society engagement, and human rights accountability mechanisms to ensure that reasonable and effective measures are taken in a timely manner.

ISSUE 2

Prosecuting people for providing life-saving programs: The Drug User Liberation Front Compassion Club

Violations of Articles: 2, 6, 9, and 26

20. CDPC is mindful that the issue described herein is still before both the Supreme Court of British Columbia and the Federal Court of Canada. CDPC wishes to emphasize that nothing in this submission should be interpreted to increase risk of harm and death for members of the Drug User Liberation Front (DULF) compassion club nor the security of the person or liberty of the founders of the DULF compassion club who are currently challenging criminal convictions[45] for their involvement in the compassion club.

21. In 2016, the province of British Columbia declared the toxic drug crisis a public health emergency[46]. The crisis, however, is not limited to British Columbia; it is devastating families and communities across the country.

22. In this context, between August 2021 and June 2022 the founders of DULF sought authorization[47] from the Government of Canada to establish a compassion club for people at significant and foreseeable risk of death due to unregulated drugs. Their request was supported by academic experts and the local Medical Health Officer. Even the Vancouver Police Department was informed of DULF founders' plan and agreed to work with them if the government authorized the compassion club.

23. DULF wanted to act lawfully; they asked the government for help. The government rejected their request in July 2022. Faced with what one founder described as a "horror beyond words"[48] in their community, DULF's founders were compelled to act, even without government authorization.

24. DULF sourced heroin, methamphetamine and cocaine online, tested the drugs using the best available technologies, packaged and labeled them with ingredient lists and health warnings, and carefully selected compassion club members who were all at least 18 years of age and currently using unregulated drugs. Drugs were sold at-cost and without any profit to the founders.

25. The compassion club opened in August 2022. They operated transparently; police, government, and health authorities were all informed as to their operations. Highly experienced researchers were evaluating DULF's compassion club's operations and outcomes.

26. And, **it worked**. During the year that the club operated[49], members experienced significantly reduced risk of non-fatal overdose, and, of the club's 47 members, one died *prior* to ever accessing the club and only two people declined to attend follow up interviews required as part of the club's evaluation. No overdoses occurred on DULF's premises.

27. In 2023, numerous politicians mounted a public campaign targeting DULF. In an increasingly politicized environment characterized by misinformation, DULF was raided by police, its founders were arrested and the compassion club was shut down.

28. At the time of their arrest, even the Vancouver Police Department agreed that their arrests could "absolutely"[50] result in drug users who rely on the compassion club's services consuming more dangerous substances. The Premier of British Columbia acknowledged that DULF had been doing "life-saving work"[51].

29. In 2025, the DULF founders were each found guilty of three drug trafficking offences. The maximum punishment for these crimes is imprisonment for life.

30. The members of the compassion club lost access to lifesaving supports and were left without reasonable options other than once again using drugs from the unregulated supply. One club member, whose drug use was more stable when the club was in operation, has publicly admitted that after it was shut down he returned to using unregulated drugs, was exposed to fentanyl for the first time, and during the two months after the club closed, he overdosed "at least once a day"[52].

31. DULF's founders are now challenging the lawfulness of the CDSA on the basis that a portion of the law violates Canada's *Charter of Rights and Freedoms* because it unjustifiably violates rights to life, liberty, security of the person and protection against discrimination. The founders are not currently in custody; they have been released into the community while the Supreme Court of British Columbia hears their court challenge.

32. Canada's drug laws failed to support the DULF compassion club, despite its demonstrable success in reducing overdose and related harm to its members. Government and police actions caused foreseeable and significant risk of death of club members. Prosecutors charged DULF's founders without properly considering whether it was in the public interest to do so.

33. The result is a devastating violation of ICCPR obligations to protect life without discrimination contrary to Articles 2, 6 and 26, and arrests and convictions that are manifestly disproportionate, unjust, unpredictable and discriminatory[53] contrary to Article 9. The Canadian Drug Policy Coalition recommends that:

The Committee find that:

1. Canada's failure to legally authorize the DULF compassion club violates Article 6;
2. Government and police actions to close the DULF compassion club and prosecute the DULF founders violate Articles 6 and 9.

The Committee call on Canada to:

1. Stay all criminal charges and expunge the criminal records of the DULF founders for their involvement in the compassion club;
2. Immediately undertake a review of section 5 of the CDSA and relevant sections of the FDA/FDR and, within 1 year, bring forward amendments to these laws to ensure non-medicalized safer supply programs such as DULF's compassion can operate lawfully.

ISSUE 3

Expanding criminalization, police powers and health-based detention

Violations of Articles: 2, 6, 9, 26

34. In the devastating context described above, Canada's actions are increasing foreseeable risk of death, harm and criminalization of impacted communities by rescinding harm-reducing policies, increasing criminalization of people who use drugs and lack housing, and abandoning evidence-based health services while enacting involuntary treatment laws and policies.
35. Canada is acting in a manner contrary to long-established human rights standards. Such violations were succinctly described by the UN High Commissioner for Human Rights, Navi Pillay, in 2009[54]:

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

3.1 Recriminalizing drug possession in the province of British Columbia and prohibiting decriminalization in Ontario

36. "Decriminalization" refers to policy that removes criminal sanctions[55] related to drug use. Models of decriminalization vary widely around the world, and the impact of these policies depend on design, implementation, and alignment with rights-based principles. Poorly designed models risk perpetuating harms, while strong models can advance public health, social justice, and human rights[56].
37. The province of British Columbia (B.C.) implemented a limited decriminalization policy in January 2023 through an exemption granted by the Government of Canada under the CDSA. The policy removed criminal sanctions for people 18 years and older for possession of up to combined total of 2.5 grams of opioids, methamphetamine, cocaine and MDMA for personal use.
38. B.C.'s stated purpose[57] for implementing decriminalization was to reduce the stigma associated with seeking care for substance use and to support people to access health and social services by treating substance use as a health matter, not a criminal justice issue. Criminal justice involvement for drug use[58] is tied to a number of negative health and social outcomes, and people are at significantly higher risk of drug-related death in the days and weeks after release from jail[59].
39. Despite significant concerns[60] and limitations[61] of B.C.'s decriminalization model, preliminary evaluation data indicate its beneficial impacts[62] including: significant decreases in police interactions[63] (called "offences") and police seizures of small amounts of drugs; increased comfort seeking health and social services; decreased ambulance calls; and no observed increase in substance use disorder diagnoses.

40. The B.C. and federal governments failed support the success of decriminalization. Governments did not conduct evidence-based public education in local communities, governments or police, failed to make parallel investments in health services and housing, and adopted language in public announcements that entrenched stigma. All of which set the stage for public misunderstanding and backlash.

41. Amidst growing politicization of the decriminalization policy, B.C. attempted to enact a law targeting homeless people who use drugs (outlined below at 3.2) in November 2023, and eventually recriminalized drug possession in public spaces in May 2024. Almost immediately, possession "offences" rebounded to rates nearly as high as pre-decriminalization. This change impacted people living in poverty, homeless people, and people without access to health and social services and safe places to consume drugs indoors. Notably, this change disproportionately harms racialized communities and Indigenous people who are disproportionately experiencing homelessness.

42. B.C. abandoned decriminalization[64] as of January 31, 2026. It is now once again a crime to possess small amounts of drugs for personal use.

43. Decriminalization cannot mitigate the harms caused by government failures to address the unregulated drug supply. That said, its abandonment increases the foreseeable risk of death by increasing criminal justice involvement amongst people who use drugs and driving people to use drugs in isolation to avoid police surveillance. These impacts disproportionately impact and discriminate against Indigenous, Black and racialized communities, people without housing, and people living with disabilities.

44. Government failures to support proper implementation and education about decriminalization in B.C. has impacted other regions in Canada. Toronto, Ontario requested a CDSA exemption to decriminalize drug possession in 2022; their request was rejected[65] by the Government of Canada in May 2024.

45. The province of Ontario went a step further in 2024, introducing a law[66] that prohibits municipalities and local health boards from applying for any form of decriminalization exemption.

3.2 Criminalizing survival activities in public spaces

46. In Canada, most public space is regulated through municipal bylaws and other provincial, territorial or federal land use legislation. These overlapping laws and policies frequently criminalize activities related to drug use that occur at the intersection of poverty and homelessness. Rights violations against people living in encampments are more fully outlined in the "Right to Life & Ending Homelessness in Canada"[67] civil society submission.

47. Due to the increasing toxicity and unpredictability of unregulated drugs, public spaces can be the safest place to use drugs[68] to ensure proximity to others and access to emergency health care, outreach services, and harm reduction support in the event of a drug poisoning. People with no housing or shelter access live their lives in public spaces and may have nowhere else to use.

48. Provincial laws and Municipal bylaws increasingly seek to criminalize drug use and survival activities in public spaces. People without housing can be fined, displaced, detained, or have

property seized as a result of such activities. Under some laws, people convicted of a public space offence can face incarceration. These measures force people to use drugs in isolated areas where overdose risk increases as emergency response is unavailable.

49. CDPC and Pivot Legal Society voiced many of these concerns[69] with the United Nations Office of the High Commissioner on Human Rights in 2023. Despite this, provinces and municipalities continue to implement new laws and bylaws that drive harm.

50. Notably, a in B.C. that sought to prohibit drug use in numerous public spaces and create offences and punishments (including fines and possible incarceration) was stopped from being implemented by the Supreme Court of British Columbia[70]. The Court found that "the unregulated nature of the illegal drug supply is the predominant cause of increasing death rates in British Columbia" and that in this context "irreparable harm will be caused if the Act comes into force" – including increased risk of death. The Court acknowledged "it is apparent that public consumption and consuming drugs in the company of others is oftentimes the safest, healthiest, and/or only available option for an individual, given a dire lack of supervised consumption services, indoor locations to consume drugs, and housing."

51. Despite this court decision, Ontario implemented[71] a similar – though more punitive – law in 2025. Under Ontario's law, anyone who is suspected to be consuming an illegal substance in a public space can be directed by a police officer to leave the area (this includes a dwelling or tent), can have their drugs seized and, if convicted of an offence, can be fined of up to $10,000 and/or imprisoned for up to six months.

52. The resulting displacement, incarceration, and police seizure of drugs or drug use equipment can lead to increased overdose risk and mortality[72], directly engaging the right to life. The broad police discretion authorized under these laws to detain or remove individuals based on suspicion of drug use also raises concerns of arbitrary detention under Article 9 and discriminatory enforcement under Article 26.

3.3 Introducing involuntary treatment regimes and "secure" health facilities

53. Canadian provinces already have laws allowing people to be detained against their will for mental health reasons causing danger to oneself or others. While these laws may require reform to ensure they respect rights and bodily autonomy, they do have mechanisms to allow people to request review of their detention and they *should* be used in only the most serious of circumstances based on reliable information and informed by best available evidence. People who use drugs are already increasingly detained under these laws, often when experiencing a combination of mental health symptoms and unregulated drug-related intoxication. These laws are intended as a last resort for the treatment of serious mental health conditions – not for addictions treatment.

54. In the last two years, some provinces have begun prioritizing policies to detain people and force them into drug treatment[73] without their consent. These treatment programs often require abstinence, prohibit people from accessing effective and safe medical supports like methadone, and increase the risk of overdose upon discharge[74]. This policy shift towards "involuntary treatment" is being driven by political discourse, not evidence.

55. To understand the dangers and human rights violations caused by involuntary treatment, it is important to understand that "addiction" does not have an agreed upon scientific definition[75] and how a person's drug use is treated varies significantly depending on economic and social status, race and gender. Systemically marginalized communities are more likely to receive poor-quality treatment or none at all.

56. Further, the current patchwork of "addiction treatment" systems in Canada fails to meet[76] the needs of far too many people who seek support. For addiction treatment to be safe and effective, it should be accessible, high-quality, culturally responsive, upholding of human rights[77], and voluntary. A significant portion of addiction treatment in Canada is run by privately-operated service providers, some of which are for-profit companies[78]. Canada does not have national standards for addiction treatment to ensure services are safe and effective. With the exception of Québec[79], provincial accreditation systems for residential facilities, where they exist at all, do not meaningfully enforce expected standards of care[80]. This means that most places in Canada, privately-run treatment providers operate without meaningful government oversight around staff training or certification, standards of care, or what treatment they offer. Residential addiction treatment centres are not required to track service user outcomes or publicly share reports of abuse or deaths. Voluntary treatment is not readily available. People seeking treatment may have to wait months or years[81] for services depending on where they live and many people die while they wait.

57. Rather than improving access to voluntary treatment services that people want and need, some provinces are prioritizing involuntary treatment. Both Alberta[82] and B.C.[83] are building involuntary drug treatment facilities rather than investing public funds in improving evidence-based voluntary services.

58. There is limited evidence to suggest that involuntary substance use treatment is safe[84] or effective[85]. While, coercion may keep people in a treatment facility longer, the evidence does not demonstrate that they will exit treatment healthier, happier, more stable, or with reduced[86] substance[87] use[88]. On the contrary, involuntary treatment is linked to increased risk of fatal and non-fatal overdose after being[89] discharged[90]. Many people who have been treated involuntarily also associate it with persistent trauma and severe violations of their health and safety, largely because there are even fewer safeguards[91] in place to prevent abuse for involuntary patients than there are for voluntary patients[92]. People who have been subjected to involuntary treatment may be less willing to engage with voluntary health services in the future, worsening their health and social outcomes, as well as the health and social outcomes of communities overall[93].

59. The province of Alberta[94] has passed a deeply concerning involuntary treatment law – this law is not yet in force and should be stopped from ever being implemented due to the foreseeable harms and serious human rights abuses it poses. The Alberta law allows police to apprehend and involuntarily detain people who use drugs even when they have been deemed to have capacity to make decisions about their care[95]. The law's criteria for apprehension[96] focus on whether a person has a history of overdose, is struggling with daily activities, is experiencing deteriorating health, is demonstrating severe intoxication, among others. *None* of the criteria in the law justify the violation of bodily autonomy[97] and foreseeable risk to life and health caused by involuntarily detaining a person due to drug use. Further, none of these criteria take the unregulated and

variable drug supply into consideration in assessing the reasons why a person has a history of overdose, appears severely intoxicated or is experiencing deteriorating health.

60. People experiencing poverty and housing instability are disproportionately impacted by coercive treatment policies as a way to remove visibly homeless people from their communities rather than working to provide safe and adequate housing for all community members. Governments in Canada have failed to adequately invest in voluntary, evidence-based treatment, while concurrently neglecting their obligations to address structural determinants of health, such as housing and poverty. In the resulting context, provinces are deploying forced treatment to clear homeless encampments[98] and displace people deprived of housing out of public view.

61. Involuntary detention cannot be used as a substitute for voluntary, accessible, high-quality health care, housing, meaningful poverty reduction initiatives.

62. Unionized workers are also impacted by coercive treatment policies. Workers can be forced into treatment programs that are harmful to them, can lose their employment for refusing to see a doctor chosen by their employer, and can be ordered to maintain 24/7 abstinence and undergo regular drug testing for months or years – at their own expense – even if there is no reasonable employment-related justification for these measures.

63. In sum, involuntary addictions treatment is linked to an increased risk of death and harm contrary to Article 6. These laws and policies discriminate against people who use drugs, especially those without housing and experiencing poverty, contrary to Articles 2 and 26. The widespread use of involuntary treatment is not supported by evidence and disregards informed consent raising concerns that these policies also violate Article 7 guarantees that "no one shall be subjected without his free consent to medical or scientific experimentation" and Article 9 protections against arbitrary detention.

The Canadian Drug Policy Coalition recommends that the Committee call on Canada to:

1. Within 1 year, complete an arms-length review of existing decriminalization policies throughout the world and craft recommendations to amend section 4 of the CDSA (prohibition of drug possession). To be led by an independent committee of qualified interdisciplinary researchers and people with lived/living experience with meaningful engagement from civil society;
2. Amend federal, provincial and territorial human rights laws to protect people against discrimination on the basis of social status, including housing status;
3. Rescind laws that target people who use drugs and rely on public spaces for the necessities of life and invest in housing and health and social services to provide dignified alternatives to homelessness and public drug use;
4. Rescind involuntary addictions treatment laws and invest in publicly administered, not-for profit, voluntary addictions treatment that is high-quality, accessible and culturally responsive;
5. Establish national standards for addictions treatment including client redress mechanisms, quality assurances, mandatory evaluation of outcomes and reporting of deaths and injuries.

ISSUE 4

Closing and restricting essential health interventions

Violations of Articles: 6, 2, 26

64. Given the scale of the current crisis, Canada must take stronger actions to prevent death and mitigate harm now. Harm reduction is the last line of defence for people at risk of imminent death from unregulated drugs. "Harm reduction" describes not only a suite of health and social services; it is also a principle for interpreting law[99] and policy and an ethos of mutual aid and care. Many harm reduction services that are now officially authorized and touted by Canada's government emerged out of community-level action by-and-for people who use drugs and their allies.

65. These proven life-saving and health-benefitting services are now under attack. Political actors[100] have launched misinformation campaigns[101], used a Parliamentary Committee studying the "Opioid Epidemic and Toxic Drug Crisis"[102] on health to spread misinformation[103] and encourage discrimination against people who use drugs, and laws and government decisions are shutting down services people rely on every day. Harm reduction services are being blamed for social inequities, structural and systemic problems, and service-design flaws that they did not cause and do not have power to solve.

66. CDPC recognizes that neither of the services described below (supervised consumption sites and prescription-based safer supply) can be scaled to a population level, nor are they a solution to the systemic unregulated drug crisis driven by the CDSA/FDA/FDR legal framework. They are not intended to be complete solutions, are not appropriate or available to people who only use unregulated drugs occasionally, and, to-date, have been implemented with significant limitations that decrease their potential efficacy, such as geographic barriers.

67. They do, however, save lives daily. For the thousands of people who use unregulated drugs and can access these services, they create safety and connect people to systems of care.

4.1 Closing supervised consumption services

68. Canada has historically been a leader in advancing supervised consumption services (SCS), having opened InSite, the first sanctioned SCS in North America, in 2001. In 2011, the Supreme Court of Canada declared that the government's refusal to extend the authorization InSite needed to operate was unconstitutional because it violated the right to life and security of the person. Despite this, in the last year over half of the SCS in Ontario have been forced to close and sites in other locations are under threat.

69. The Government of Canada describe these services[104] as:

> *Supervised consumption services save lives and benefit communities. Supervised consumption sites provide a safe, clean space for people to bring their own drugs to use, in the presence of trained staff. This prevents accidental overdoses and reduces the spread of infectious diseases, such as HIV. Supervised consumption sites may offer a range of evidence-based harm reduction services, such as drug checking*.

70. SCS operate as a low-barrier drop-in health and social service. They are not intended or designed to act as comprehensive treatment services. By welcoming clients without expectation that they seek abstinence, SCS can connect with many people who are not connected to other health and social services. They provide safety and overdose response in the moment, and over months and years build relationships to help people connect with health and social supports.

71. SCS are busy, and they save lives. Between January 2017 to May 2025, SCS[105] in Canada were visited 5,394,643 times, serving 531,495 people. SCS staff have responded to more than 65,977 overdoses. Data gathered since 2020 shows that there have been 0 confirmed overdose fatalities in Canada's SCS.

72. Over the last two years many SCS have been forced to close. Many have been defunded, new provincial laws are forcing services to close due to new requirements that they not be within 200 metres (Ontario: *CCRA*, 2024[106]) or 150 meters (Quebec *Bill 103*, 2025[107]) of schools, daycares. In Ontario, municipalities and local health boards are prohibited from applying for or supporting applications to operate SCS without permission from the Ontario government. It is clear the government has no intention of offering that permission. In the words of Ontario's Minister of Health, Sylvia Jones: "There will be no further safe injection sites in the province of Ontario under our government"[108].

73. Some provincial governments justify the closure of these services by inaccurately alleging that SCS increase crime and violence in their local communities. The data don't support that story. Findings suggest that with the exception of break and enters, SCS in Toronto were associated with neutral to positive improvements in local crime trends[109] and SCS implementation was not associated with increased homicide rates but, instead, a reduction in monthly incidence near SCS[110].

74. The data do show that many SCS clients lack housing[111], are experiencing extreme poverty, and are often coping with a number of health conditions and trauma. Many clients do not have a home or indoor place to go when SCS are closed, and some rely on poverty-driven minor crimes like shop lifting or other theft to meet their most basic daily needs.

75. SCS are now being forced to close or told to take responsibility to ensure people experiencing homelessness and poverty are not seen sleeping or loitering near an SCS. Governments ask SCS to provide more and more crime data when reporting on their services. It is not reasonable for small, often under-resourced SCS to be held responsible for systemic government failures to address homelessness and poverty. Governments are shifting the blame for their failures and asking too much from frontline workers who are already helping people in crisis and saving lives every day.

76. Governments are also intentionally limiting how SCS operate, leaving many people unable to benefit from them. In the last few years, there has been an unprecedented shift from injecting to smoking[112] unregulated drugs across North America. In B.C. smoking-related overdose deaths increased from 29% (2016) to 65% (2023), yet less than half of supervised consumption sites offered a safe place for people to smoke. In Ontario, opioid toxicity deaths where inhalation was the only mode of drug use almost doubled (2017-2021)[113] and, since 2020, approximately half of opioid toxicity deaths had evidence of inhalation[114]. Despite this, Ontario has never funded inhalation services.

77. This is not accidental: it is a government choice that is causing increased foreseeable risk of death. Beyond the significant risk of death for people who inhale drugs, this government failure is also being used against existing SCS who are regularly blamed when members of the public witness a person smoking/inhaling drugs outside an SCS. SCS providers would provide safer indoor spaces for these people, if government allowed and resourced them to do so.

78. SCS closures have significant impacts for people who use drugs as well as a chilling effect on harm reduction service providers. A site in Lethbridge Alberta was the busiest in the world until the Alberta government forced its closure in 2020[115]. A study[116] looking at the potential closure of SCS in Toronto estimated that "a large proportion of people – almost 50% in some scenarios – would lose access to an intervention with a strong evidence base for improving their health and well-being." Since this study, over half the sites in Toronto were forced to close.

79. SCS cannot save everyone who is at risk of death. They have, however, prevented tens of thousands of possible deaths in the last decade. Closing them is a clear violation of Article 6. Government's justifications for these closures are grounded in and perpetuate discrimination and stigma against people who use drugs, lack housing and live in poverty contrary to Articles 2 and 26.

4.2 Limiting and defunding prescription-based health programs to decrease reliance on the unregulated toxic drug supply

80. As outlined throughout this submission – Canada's preventable drug-related death crisis is being driven by the unregulated drug supply. In this context, pharmaceutical-grade alternatives to unregulated illegal drugs are an effective intervention to prevent death and injury, and to improve community safety.

81. Programs like this are commonly referred to as "safe supply" or "safer supply". Safer supply includes both prescription-based services and non-medicalized compassion club models such as the model that DULF tried to implement. The goal of these programs is to reduce people's reliance on unregulated and unpredictable drugs that are causing fatal and non-fatal overdose without requiring that people become abstinent (sober). They are designed to prioritize immediate safety and to support longer-term wellness and stability while also decreasing a person's likelihood of being arrested and imprisoned for drug and poverty related crimes. The Government of Canada defines these programs[117] as:

> *Safer supply refers to providing prescribed medications as a safer alternative to the toxic illegal drug supply to people who are at high risk of overdose. Safer supply services can help prevent overdoses, save lives, and connect people who use drugs to other health and social services*.

82. Currently, the Government of Canada has only authorized limited prescription-based models. In variations of this model, a prescriber provides controlled access to pharmaceutical alternatives to the unregulated drugs that put people at risk of dying.

83. This model creates significant limitations. Most people at risk of dying do not have access to a medical prescriber, and these programs have never been scaled up or designed to properly meet people's needs. For example: in April 2024, 15 programs in Ontario[118] were providing life-saving care to about 1,500 people – a fraction of the number of people that could potentially have

benefited from it. 2,224 people died of opioid toxicity in Ontario in 2024. In November 2023 in British Columbia, approximately 3,500 people[119] were accessing safer supply, compared to an estimated 225,000 people[120] who access the unregulated drug supply each year.

84. Further, the pharmaceutical alternatives available through prescriber-based safe supply do not meet the needs of all clients[121], limiting their efficacy. For example, prescribing hydromorphone (Dilaudid) to someone who has been regularly exposed to much stronger opioids like fentanyl can be inadequate. Additionally, some people have become physically dependent on benzodiazepines when unexpectedly exposed through contaminated unregulated drugs, but benzodiazepines are not offered in some programs. Rather than improve prescription safer supply programs, governments have used these design failures as reasons to restrict or end safer supply services.

85. Despite these limitations, people accessing safer supply[122] are exposed to far less risk of death and injury, they are less likely to be hospitalized due to drug overdose, commit fewer poverty-related crimes, and are more likely to maintain stable housing and achieve better social outcomes such as employment. Communities also benefit from safer supply programs because emergency and other health care services are less overwhelmed.

86. Between 2017 and March 2025, Health Canada funded 31 prescription-based safer supply projects across the country. Despite data showing positive outcomes, that funding was time-limited and expired on March 31, 2025. Rather than working to scale up and improve these programs, Canada has abandoned them both by failing to renew their funding and, in some regions, passing legislation and policies that make these services nearly impossible to implement.

87. Every person who loses access to a safer supply program is put at immediate and longer-term foreseeable risk of death because they are being forced back into the toxic unregulated drug supply. In December 2023, more than 130 experts[123] in substance use called on the Canadian government to continue to support and scale-up safer supply programs. They noted:

> *Due to the complexity of their needs, there is a strong danger that people who lose access to safer supply programs will not only lose access to a source of regulated, prescribed opioids, but will also lose access to the comprehensive primary care they have been receiving through [federally]-funded programs. This will result in poor health outcomes and even death for many people currently receiving safer supply.*

88. A 2025 study[124] supports their call to action, finding that closure of these programs:

> *…may force them back into an increasingly dangerous unregulated market, ultimately putting their lives at risk, along with reversing the many benefits programs provided, such as connections to essential health and social services. By replacing harm reduction programs with treatment services, the government is not reducing the demand for opioid use; instead, it forces a return to the unregulated drug market, ultimately putting individuals at risk of overdose.*

89. By failing to fund, improve and scale up these programs, Canada is ignoring evidence and recommendations from its own Expert Advisory Group on Safer Supply, and recommendations from researchers, clinicians, public health officials and civil society organizations.

90. Canceling life-preserving health services and forcing people into withdrawal (whether immediately or forcing someone to taper off their medications) can be dangerous to life and health contrary to Article 6, and disrespects patient autonomy, informed consent, and the right to health and continuity of care. All of which undermines trust and can push people toward unsafe alternatives, compounding stigma and harm rather than reducing it.

The Canadian Drug Policy Coalition recommends that the Committee call on Canada to:

1. Commit to sustaining and scaling up the number of supervised consumption services (SCS) in Canada, including by providing adequate funding for these services and ensuring that provincial laws and policies do not prohibit or unreasonably restrict SCS;
2. Create national standards for inhalation services in SCS and fund the establishment and operation of inhalation services in SCS anywhere where data indicate need for them;
3. Immediately re-instate funding for safer supply programs and ensure that provincial laws and policies do not prohibit or unreasonably restrict safer supply programs;
4. Implement expert recommendations for improving the accessibility and efficacy of prescription-based safer supply programs;
5. Establish national standards for non-prescription-based safer supply programs that can be implemented under the current CDSA/FDA/FDR legal framework.

ISSUE 5

Restricting democratic participation in drug policy decisions

91. Finally, amidst this crisis and the significant harmful changes to policy and services outlined in this submission, CDPC has identified a decrease in transparency and accountability in government decision making. Life-altering decisions are being made without appropriate opportunities to provide input. Where opportunities do exist, it is increasingly unclear if or how expert opinion and civil society submissions are taken into consideration in government decision-making.
92. We are not asserting that Canada is acting in direct violation of Article 25. Rather, the violations of articles 2, 6, 7, 9, and 26 asserted in our submissions could be significantly mitigated if government decision-making was conducted more transparently and properly considered the submissions of experts and civil society groups that put significant effort into articulating the life, health and human rights implications of numerous law, regulatory and policy reforms pursued by government.
93. Taking reasonable and effective measures as required under the ICCPR requires that Canada conduct its legislative and regulatory functions in a manner that allows civic engagement and ensures that government policy is grounded in reliable evidence and compliant with human rights standards.

The Canadian Drug Policy Coalition recommends that the Committee call on Canada to:

1. Review legislative, regulatory and federal committee processes to ensure they are transparent, provide adequate opportunity for civic engagement, that evidence submitted in such processes is properly considered, and that human rights standards and *Charter* obligations taken into consideration.

SUMMARY OF RECOMMENDATIONS PART 1

Recommendations to mitigate death and harm caused by the unregulated drug supply:

1. Immediately undertake a review of section 5 of the CDSA and relevant sections of the FDA/FDR and, within 1 year, bring forward amendments to these laws to ensure non-medicalized safer supply programs such DULF's compassion club are able to operate lawfully;
2. Within 1 year, complete an arms-length review of the impacts of drug law enforcement on the volatility of the drug supply, and discriminatory practices and effects of such enforcement. To be led by an independent committee of qualified interdisciplinary evaluators and people with lived/living experience with meaningful engagement from civil society;
3. Implement the recommendation of the Expert Task Force on Substance Use to create "a single public health framework with specific regulations for all psychoactive substances" including a commitment to specified goals and timelines, processes for lived/living experience and civil society engagement, and human rights accountability mechanisms to ensure that reasonable and effective measures are taken in a timely manner.

Recommendations to decrease risk of dying, criminalization and arbitrary detention of people who use drugs and who provide life-saving services:

1. Stay all criminal charges and expunge the criminal records of the DULF founders for the involvement in the compassion club;
2. Within 1 year, complete an arms-length review of existing decriminalization policies throughout the world and craft recommendations to amend section 4 of the CDSA (prohibition of drug possession). To be led by an independent committee of qualified interdisciplinary researchers and people with lived/living experience with meaningful engagement from civil society;
3. Amend federal, provincial and territorial human rights laws to protect people against discrimination on the basis of social status, including housing status;
4. Rescind laws that target people who use drugs and rely on public spaces for the necessities of life and invest in housing and health and social services to provide dignified alternatives to homelessness and public drug use;
5. Rescind involuntary addictions treatment laws and policies and invest in publicly administered, not-for profit, voluntary addictions treatment that is high-quality, accessible and culturally responsive.

SUMMARY OF RECOMMENDATIONS PART 2

Recommendations to ensure effective, evidence-based health services are available without discrimination:

1. Establish national standards for addictions treatment including client redress mechanisms, quality assurances, mandatory evaluation of outcomes and reporting of deaths and injuries;
2. Create national standards for inhalation services in SCS and fund the establishment and operation of inhalation services in SCS anywhere where data indicate need for them;
3. Implement expert recommendations for improving the accessibility and efficacy of prescription-based safer supply programs;
4. Establish national standards for non-prescription-based safer supply programs that can be implemented under the current CDSA/FDA/FDR legal framework;
5. Commit to sustaining and scaling up the number of supervised consumption services (SCS) in Canada, including by providing adequate funding for these services and ensuring that provincial laws and policies do not prohibit or unreasonably restrict SCS;
6. Immediately reinstate funding for safer supply programs and ensure that provincial laws and policies do not prohibit or unreasonably restrict safer supply programs.

Recommendations for government transparency and accountability:

1. Publicly release the full findings and reports of the Expert Advisory Group on Safer Supply;
2. Review legislative, regulatory and federal committee processes to ensure they are transparent, provide adequate opportunity for civic engagement, that evidence submitted in such processes is properly considered, and that human rights standards and *Charter* obligations taken into consideration.

A NOTE ON TERMINOLOGY:

Canada's illegal drug supply has shifted significantly over the past decade and the language different stakeholders use has evolved over time. While there are overdose deaths associated with legal (e.g. alcohol) and prescription drugs, the vast majority of drug-related acute deaths and injuries result from people consuming illegal drugs from the "unregulated drug supply," sometimes referred to as a "toxic drug supply." Many community groups, researchers, academics and health care providers refer to Canada's ongoing crisis as the "unregulated drug crisis" to foreground the reality that it is the lack of legal regulation that is driving the vast majority of death and injury.

In this submission we generally use the term "unregulated", however, other interchangeable terminology such as overdose, drug poisoning, toxic drug death, drug-related death crisis also appears. These variations reflect the different terms adopted in the research, government records, and other sources.

"Overdose" is still commonly used to refer to unregulated drug-related harms but is not entirely accurate. "Overdose" refers to when there is too much of a drug in a person's body, which causes them to experience severe, sometimes life-threatening health impacts. Overdoses can be fatal and non-fatal. The term "overdose" can inadvertently imply that someone is aware of what a dose should be and has knowingly ingested more than that dose. In earlier decades (pre-2010), the unregulated drug supply was less volatile in Canada. At that time, the unregulated heroin supply was relatively stable, uncontaminated and less varied; however, dosage was not easy to measure and sometimes the amount a person took overwhelmed the body.

Today, dosage is still hard to measure, but the contents of drugs are far more unpredictable and varied - often with more potent and unknown adulterants, substitutes, or contaminants. This is why the terms "contaminated," "tainted," "poisoned," and "toxic" are used more frequently. The issue is less that someone has knowingly taken a higher dose ("overdose") and more likely that they believe they are purchasing a specific drug with specific dosing, but are often unknowingly consuming other substances that cause significant unintended negative effects.

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