Challenge and Change

A Public Health Response to Our Perplexing Relationship with Psychoactive Substances

An interactive summary of the report is available at:

Report of the Island Health Chief Medical Health Officer, 2024

November 2024

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Table of Contents

Letter from Dr. Réka Gustafson, Chief Medical Health Officer

Thank you for your interest in this report about substance use and health in Island Health. It is important to talk about psychoactive substances because they are causing preventable health harm for people in Island Health, and there are tangible steps we can take to change that.

By exploring a range of psychoactive substances, from the illegal and unregulated to the legal, promoted, and celebrated, the report hopes to show that the way we talk about and approach substances is largely rooted in history and perception, rather than evidence. While substance use is a part of the human experience, the way we use substances and how substance use affects our health is also influenced by our biology, social circumstances, experiences of trauma, and public policies.

I am grateful for the Population and Public Health (PPH) team[a] and the many colleagues who drafted, edited and provided advice on this report. I'm especially grateful for conversations with Beth Haywood, Gordon Harper, Aran Wilson, Louise Takhar and Chris Edwards, who shared the kind of wisdom, humour and insight that only those with lived and living experience can. I would like to thank Gordon for giving this report its title.

I hope that the information presented here will support constructive conversations among communities, organizations, and people who use substances in Island Health and help identify and bring about meaningful change for the better.

Sincerely,

[a] Core PPH project team includes Elyse Kornhauser, Cher Ghafari, Myrianne Richard, Maritia Gully, Jani Urquhart, Angela Reid, Sandy Shergill, Fiona Fiddick, Laura Wicki-Stordeur.

Territorial Acknowledgement

The region Island Health supports is the traditional territory of the Coast Salish, Nuu-chah-nulth, and Kwakwaka'wakw cultural families, who have been caretakers and stewards of these lands since time immemorial. It is with humility we continue to work toward building our relationship.

Rights Acknowledgement

We acknowledge with respect the inherent rights of the First Nations whose ancestral territories cover the entirety of the region served by Island Health. These inherent rights include their unextinguished land rights and rights to self-determination, health, and wellness within these territories. Laws and governance systems rooted in the land have upheld the sovereignty of these diverse Nations for thousands of years. The rights and responsibilities of First Nations to their ancestral territories have never been ceded or surrendered, and are upheld in provincial, national, and international law.

We also acknowledge that many Indigenous Peoples (First Nations, Métis, and Inuit) from elsewhere in what is now known as Canada also call these lands and waters home, and we have obligations to uphold their rights to self-determination, health, and wellness. This includes Métis Nation British Columbia and its Chartered Communities across the region served by Island Health, as well as those whose ancestral territories lie elsewhere.

Island Health Medical Health Officers recognize the need for thoughtful and intentional work to decolonize the health system. In the spirit of the United Nations Declaration on the Rights of Indigenous Peoples, the Métis Nation Relationship Accord II, and the Calls to Action of the Truth and Reconciliation Commission, Island Health works with the First Nations Health Authority, Métis Nation British Columbia, and other Indigenous partners to make programs and services more culturally appropriate and supportive of Indigenous health and wellness.

Executive Summary

Alcohol, tobacco, and illegally manufactured opioids all cause significant preventable harms to the health of people living in the Island Health region. Some of these harms are highly visible, while others are more hidden. At the same time, dialogue about substances in our communities is becoming increasingly polarized. This report explores the health consequences of a range of substances and examines the differences in our approaches as a society that might contribute to or mitigate harm.

The intention of this report is to contribute to our collective understanding and support conversations and changes in communities that lead to better health. We review data on consumption of substances and health outcomes in the context of current and historical policies and regulations, as well as dominant social narratives and norms.

It is now well recognized that the conditions in which we live shape the decisions that we make to be well and healthy. The distribution of resources and opportunities is unequal across society, concentrating conditions that make us healthy in some social groups more than others. This is why, when considering what appear to be individual choices and behaviours leading to measurable health outcomes, we must also consider the environment that created and led to these choices.

We focus on four categories of substances: alcohol, unregulated substances, tobacco and cannabis; the first three because they contribute the greatest harm within Island Health, and cannabis because enactment of the federal Cannabis Act in 2018 allows us to examine the effect of policy change on health.

Alcohol

Alcohol is a significant health concern in Island Health. Consumption is higher in Island Health than in the rest of British Columbia, and consumption is increasing. Alcohol consumption increased in 2013/14 and in 2019/20 when liquor policies were liberalized following the provincial liquor policy review and increased again during the pandemic.

Alcohol causes more hospital admissions than any other substance in Island Health and the pattern of hospital admissions mirrors consumption. Hospital admissions in Island Health have been increasing in the past decade, are higher than in B.C., higher among men than women, and higher in North and Central Island than in the South Island. Deaths attributed to alcohol are higher in Island Health than in B.C. overall.

Alcohol is a legal substance that is highly normalized in media and society. Overall, there are now fewer strategies aimed at limiting consumption of alcohol than for

cannabis and tobacco, and when a strategy is in place, it is usually applied below the level recommended by research evidence. Regulations exist around alcohol manufacturing, distribution, and sale, but accessibility and availability are very high and increasing across communities. This availability is contributing to the normalization and increased use of alcohol.

Unregulated substances

Unregulated substances include illegally produced opioids, stimulants and benzodiazepines which have highly unpredictable composition and potency and cause significant health and social harms. Poisoning by these substances was the leading cause of death for people between 19 and 59 years of age in 2023, making them responsible for more years of life lost in Island Health than any condition other than cancer. Unregulated drug deaths are higher in Central and North Island than in South Island.

In 2016, a public health emergency was declared due to the high rate of deaths due to unregulated drug poisoning in B.C. By 2019, deaths started to decline; however, after restrictions were introduced in response to the COVID-19 pandemic, deaths started to increase again. In the following months and years, unregulated substances became more highly concentrated and contaminated. Today, the death rate due to unregulated drug poisoning is nearly twice as high as it was at the declaration of the public health emergency. The burden of illness related to unregulated substances is broad and increasing; opioid- and stimulant-related hospital admissions have quadrupled in the past decade.

Tobacco

In contrast to alcohol and unregulated substances, tobacco is subject to federal, provincial and local legislation and policies with the clear goal of reducing consumption and improving health. The reduction in tobacco smoking through these evidence-based interventions is one of the greatest public health achievements of past decades.

Despite these achievements, the work to reduce harms of tobacco is not done. Although between 2007 and 2020 cigarette smoking declined in Island Health, it remains higher than the smoking rate across British Columbia. It is particularly concerning that the smoking rate was higher in North and Central Island in 2019–20 than in 2017–18.

The regulations of past decades that have successfully reduced tobacco consumption are also improving health. While tobacco remains the top cause of substance use-related premature death, this rate is declining. Hospital admissions related to tobacco

use are also decreasing, and hospital admissions related to tobacco are now lower than those due to alcohol in Island Health.

Despite progress in tobacco control, much remains to be done. The smoking rate in Island Health is well above the target of 5% by 2035 set by Canada's Tobacco Strategy and substantial inequities exist in smoking rates across the Island Health region. Continued investment in tobacco control, with attention to new and emerging products, is essential to maintain and continue to improve health.

Cannabis

Cannabis became legal and regulated in Canada with the enactment of the federal Cannabis Act in 2018. Protecting public health is a stated goal of the Cannabis Act.

While most people in Island Health do not use cannabis, 50% of young adults do, and 28% of youth in school report having tried cannabis.

Hospital admissions related to cannabis are substantially lower than hospital admissions related to alcohol, opioids, stimulants, or tobacco. However, cannabis-related hospital admissions have increased in the past 10 years. Ongoing research to inform future regulatory adjustments should focus on understanding changes in consumption and specific health outcomes associated with cannabis use, including potential impacts on mental health, addiction, and respiratory health.

Cannabis consumption and health outcomes will need ongoing monitoring to ensure the laws and regulations continue to be effective and remain focused on the goal of protecting public health.

The history of consumption and health related to these four substances highlights society's complex relationship with substances and the potential for policies, laws and regulations to influence substance consumption and health. As we learned from tobacco, the path to healthier public policies is a long and difficult one. As a first step, health needs to be a clear goal for all policies related to substances. Growing substance-related harms in our communities demand sustained action. Policymakers, health professionals, and communities need to come together to implement evidence-based and evidence-generating interventions that prioritize health and equity. Investing in prevention, creating an adequate, effective and compassionate system of care, generating high quality evidence and meaningfully engaging with Indigenous Peoples and people with lived and living experience, are actions that can make a difference today.

Introduction

Purpose

As Medical Health Officers in British Columbia, we have the responsibility to monitor and report on the health of the population and to advise on public health issues and the health promotion and protection policies, practices, and bylaws relevant to those health issues.

In this report, we examine how psychoactive substance[b] use affects the health of people in our region. We focus on four substances: alcohol, illegally manufactured opioids, tobacco,[c] and cannabis; the first three because they cause the most harm in Island Health. We included cannabis because recent changes in laws and regulations related to cannabis allow us to examine the effect of policy change. As this report does not address all substances, such as stimulants and e-cigarettes, it is not comprehensive of all experiences with substance use. However, the public health approach can be applied to substance use broadly.

Why this report and why now? Alcohol, tobacco, and illegally manufactured opioids all cause significant health harm for the people of Island Health today. Some of these harms are highly visible, while others are more hidden. At the same time, dialogue about substances in our communities is becoming increasingly polarized. Here we report on the health consequences of a range of substances and examine the differences in our approaches that might contribute to or mitigate harm. We consider substances not as bad or good but simply causes of preventable health harm.

The intention of this report is to contribute to our collective understanding and support conversations and changes that lead to better health. This report was written with humility and the recognition that harms related to substance use are strongly influenced by the social, structural, and commercial determinants of health, and that the social and health burdens of substance use are inequitably distributed. In particular, there are historical and ongoing consequences of substance use policy for Indigenous Peoples in the communities served by Island Health. Recognizing Indigenous Peoples as rights and title holders, and specifically their right to self-determination and jurisdiction over their health, is a key action reflected in this report.

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[b] *Psychoactive substances* are legal or illegal substances that affect mental processes and range from caffeine and nicotine products to illegally manufactured fentanyl.

[c] For this report, *tobacco* specifically refers to commercially produced tobacco or nicotine-containing products used for recreational purposes. This does not include tobacco used by First Nations, Inuit, and Métis communities for traditional and sacred practices, which differ in their composition, production, and usage.

The Role of Dominant Narratives

How we talk about issues matters. We reflect and reinforce individual and societal beliefs about a topic by the words we use and the stories we choose to tell. Collective stories are woven into what experts call dominant public narratives that influence how society (including decision-makers) views the world and what is believed to be common sense, and that often predetermine what solutions are considered.[1]

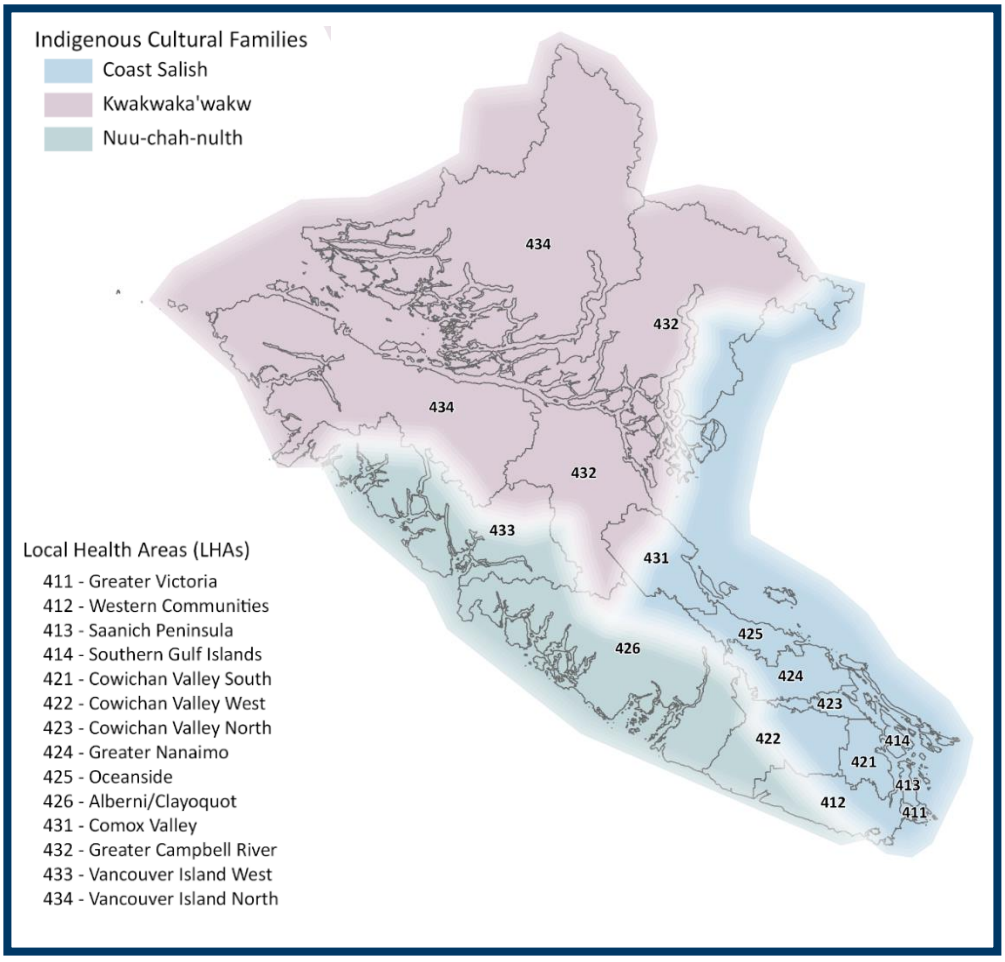
There is a long and complex history of policies related to psychoactive substances in Canada. An understanding of this history helps contribute to the collective understanding of the current context and how to work with communities to address the health harms experienced today. This report considers data in the context of the history of policies on psychoactive substances in Canada and how the various public narratives around substance use influenced policies and approaches related to substance use.

Background and Context

The Island Health Region

Island Health is one of five regional health authorities in British Columbia. Island Health provides health care to over 900,000 people across a widely varied geographic area of approximately 56,000 square kilometres. This area includes Vancouver Island, the Gulf and Discovery Islands, and part of the mainland opposite northern Vancouver Island. The communities served by Island Health range from urban centres like Victoria and Nanaimo to many rural and isolated communities such as Kingcome, Gilford, and Tahsis, accessible only by water or air.

There are 50 First Nations in the Island Health service area, belonging to three First Nations cultural families:[d] Coast Salish (largely on the South Island, as far north as Comox); Nuu-chah-nulth (all along the west coast of Vancouver Island); and Kwakwaka'wakw (Strathcona/Campbell River and North Island area).



[d] This map has been adapted from the First Peoples' Map of BC. It is intended to be used as a general reference that reflects the regional diversity of First Nations People served by Island Health. It is not intended to delineate territorial boundaries.

There are also six Métis Chartered Communities within the Island Health region, and six Friendship Centres, which are multiservice urban Aboriginal centres providing support and services to Indigenous Peoples who live in urban locations on Vancouver Island.

In order to facilitate health care planning and delivery, Island Health is divided into three Health Service Delivery Areas (HSDAs): North Island, Central Island, and South Island. These are further subdivided into 14 Local Health Areas (LHAs) and 43 Community Health Service Areas that are classified according to population size as metro (over 190,000), urban/rural (40,001–190,000), rural (10,001–40,000), or remote (0–10,000).

Social and Structural Determinants of Health – Creating Environments That Support Health and Wellness

Since individual behaviours directly influence health, health promotion efforts often focus on individual choices to improve health. This is particularly true for substance use.

However, it is now well recognized that the conditions in which we live, or the ***social determinants of health (SDOH),*** shape the decisions that we make to be well and healthy. The SDOH include income, housing, education, early childhood development, access to health services, and more. These determinants are often interrelated and together create the conditions of daily life that affect health and well-being.

The ***structural determinants of health*** **(or *structural drivers of health*)** are the structures that create the SDOH and the access to resources necessary for health. Examples of these structural determinants of health include economic, political, cultural, and social structures such as budgets, taxation regimes, laws, and policies that determine access to resources and opportunities.[2,3]

The distribution of resources and opportunities is unequal across society, concentrating conditions that make us healthy in some social groups more than others.[4] This is why, when considering what appears to be individual choices and behaviours leading to measurable health outcomes, we must also consider the environment that created and led to these choices. For example, Indigenous-specific racism is a structural determinant of health that has had, and continues to have, a profound impact on the health of Indigenous Peoples in Island Health.

"It is my experience that people's vulnerability to problematic use of substances, including the use of illicit drugs is exacerbated by their prevalence to poverty, homelessness, mental illness and racism. I believe having access to regulated drugs, (like what is available for people who use, rely on alcohol, cigarettes, cannabis, etc.), is essential to reducing and preventing drug related crimes, accidental overdose and deaths."

- Louise Takhar, a person with lived experience

Spectrum of Substance Use

While psychoactive substances can harm one's health, these substances have been widely used by individuals and communities throughout human history and continue to be commonly used today. People use substances for a variety of reasons, such as for ceremonial purposes, for personal enjoyment, and to deal with stress, trauma, or pain. Substance use can be understood as a spectrum, beginning with non-use, beneficial use, lower-risk use, higher-risk use, and potentially leading to substance use disorder. Each of these points on the spectrum has different levels of benefits and harms, and people may move back and forth between them over time or remain at one point on the spectrum. Only a small proportion of people who use substances develop a substance use disorder.[5]

What Is Healthy Public Policy?

Healthy public policy aims to improve population health by centring health and equity within all policy development. This approach recognizes that many conditions that contribute to good health lie outside of the direct actions of the health sector and, therefore, health is a collective societal effort.

"Nobody knows more about drug addiction than we ourselves do. We are the ones doing the drugs, living the life. Most people don't understand it. A lot of us have been through pretty horrible traumas. For me, drugs were a way to numb out so I didn't have to feel."

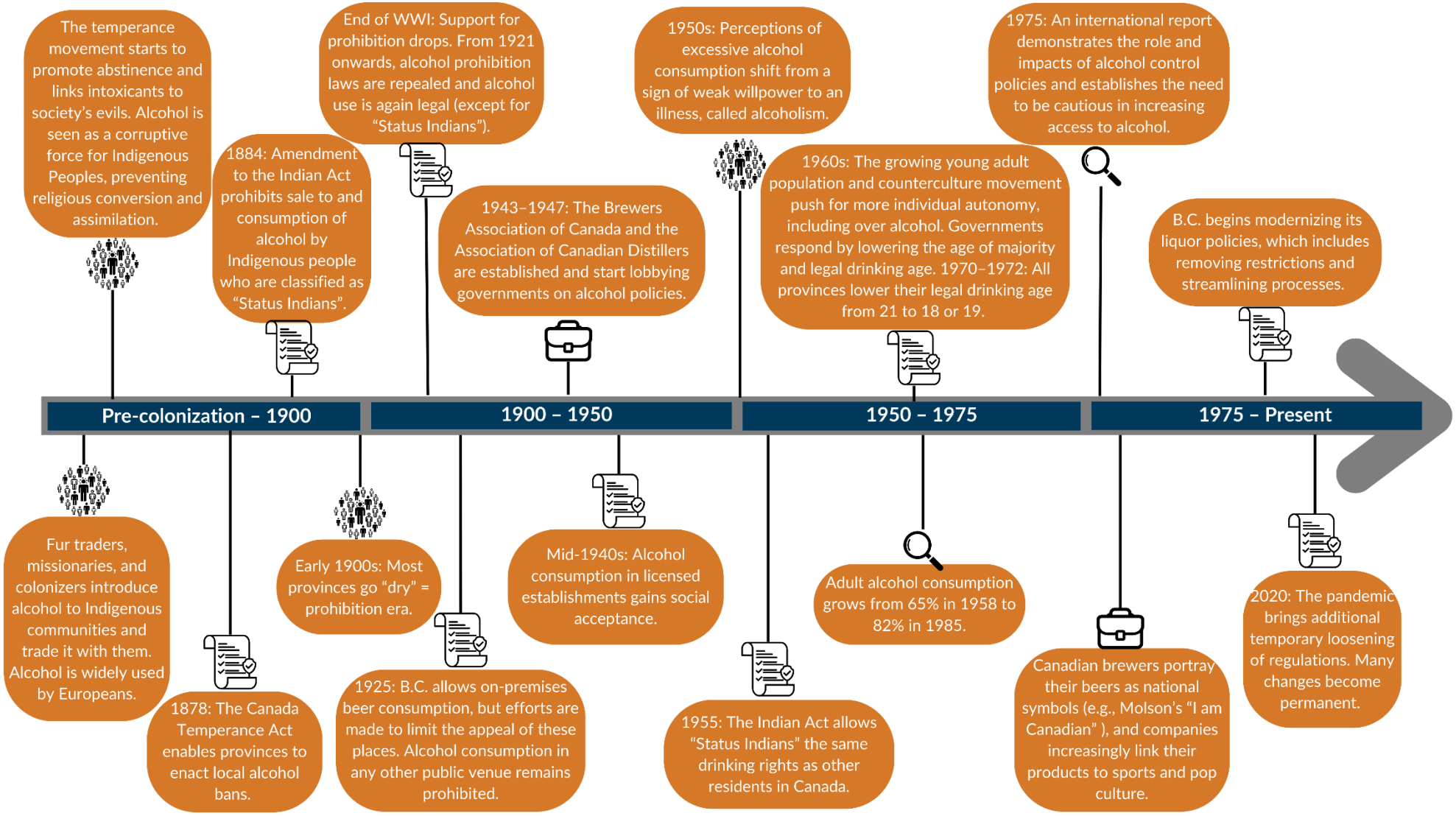
– Beth Haywood, a person with lived experience

A Brief History of the Role of Policies on Psychoactive Substances in Canada

Policies are structural drivers that play a crucial role in shaping health and health disparities. In the context of substance use, by influencing access, price, convenience, social norms, and legal consequences, policies and laws can both promote health and create substantial harm.[6] The following timelines outline some of the significant events in the history of policies pertaining to psychoactive substances in Canada. These timelines are not exhaustive, but they do aim to illustrate how policies, laws, industry influence, and dominant social narratives and norms have created the current landscape of substance use in Canada. More detailed timelines can be found in the Appendix.

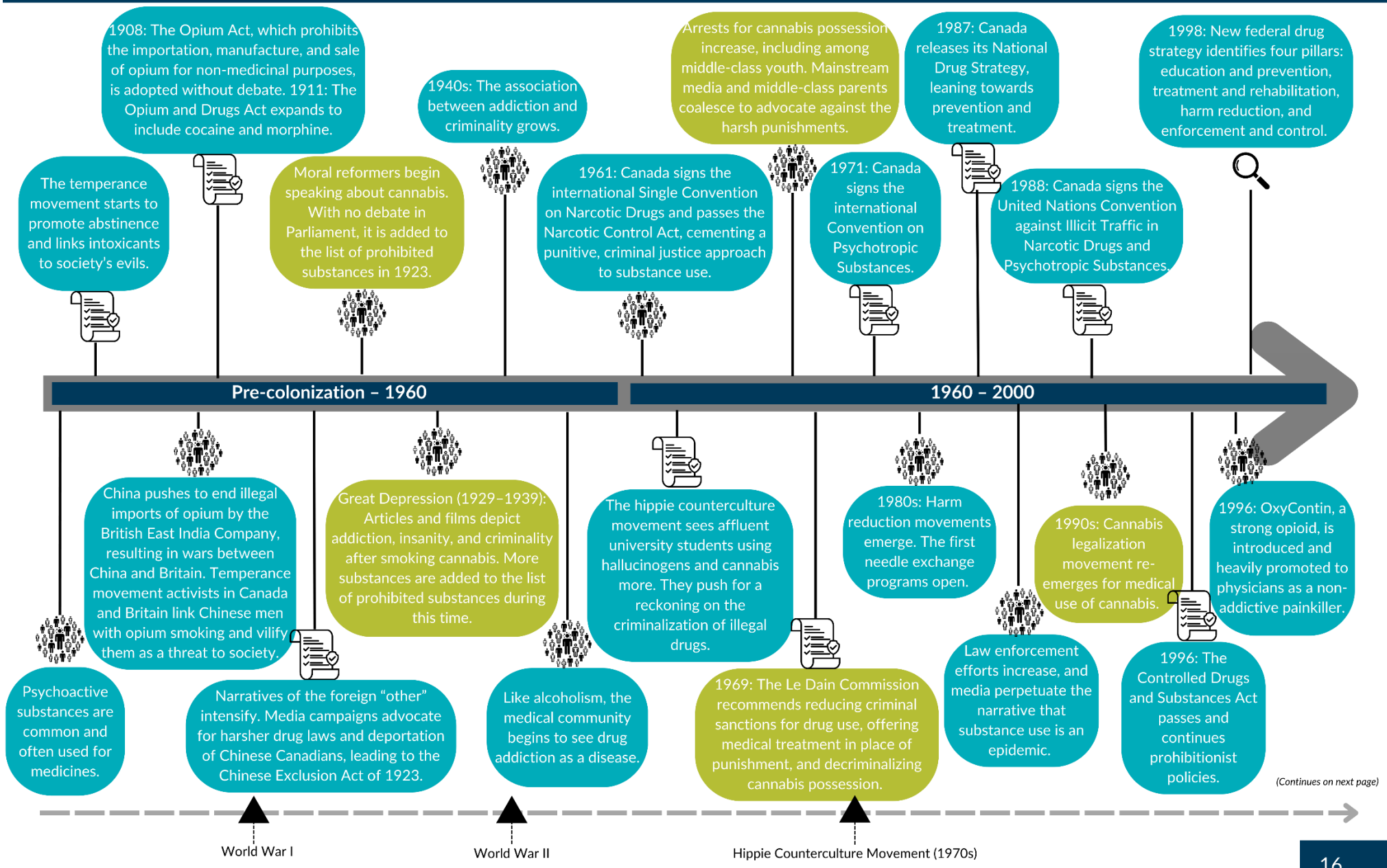
People around the world have been using psychoactive substances for a very long time. Many societies have used and continue to use substances to alter the mind, create art, participate in ceremonies or religious rituals, and enhance social activities, or simply for the individual experience.[5,7–9]

Alcohol



This timeline is not exhaustive but does aim to illustrate how policies, laws, industry influence, and dominant social narratives and norms have created the current landscape of psychoactive substance use in Canada.

Unregulated Substances & Cannabis



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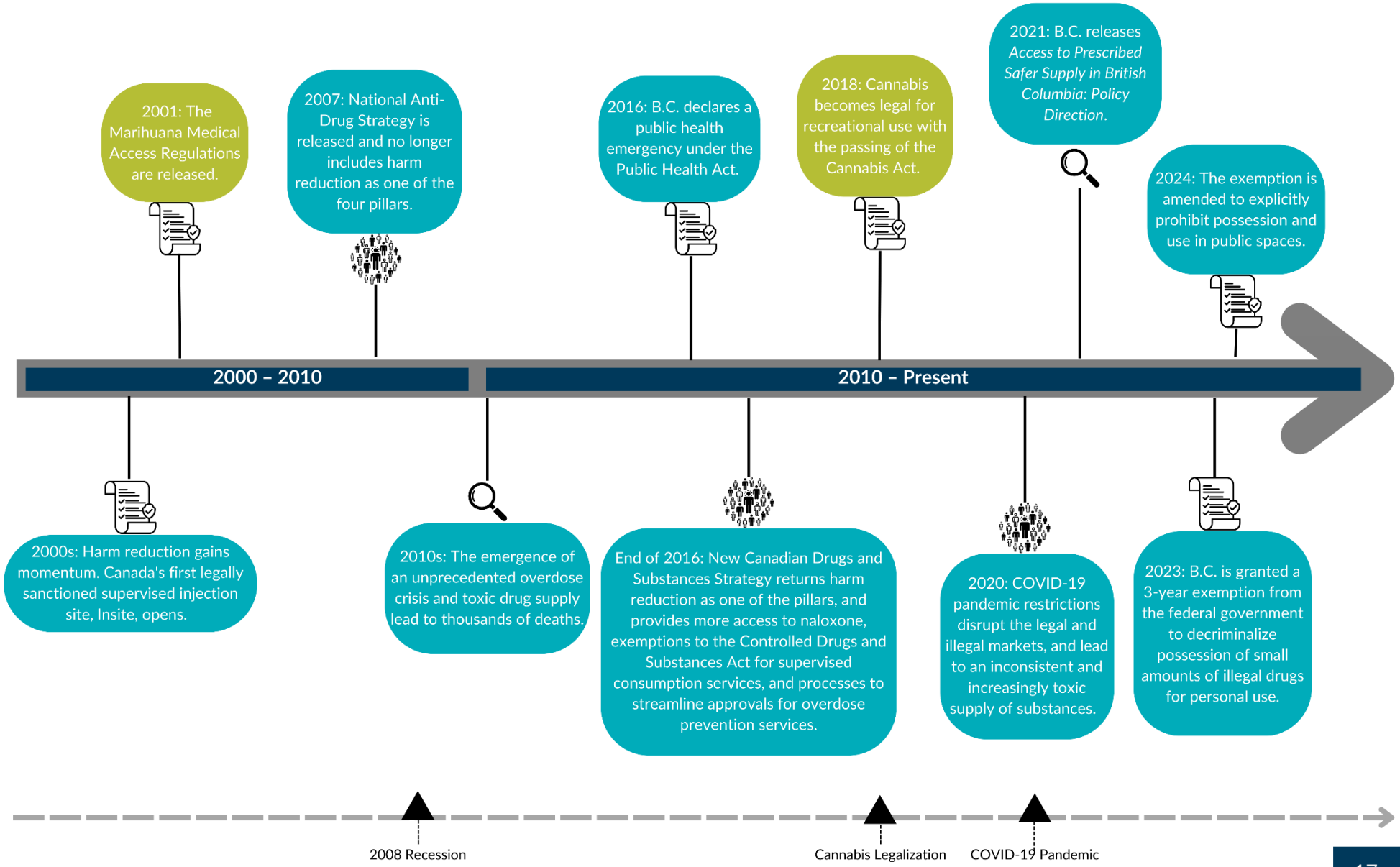

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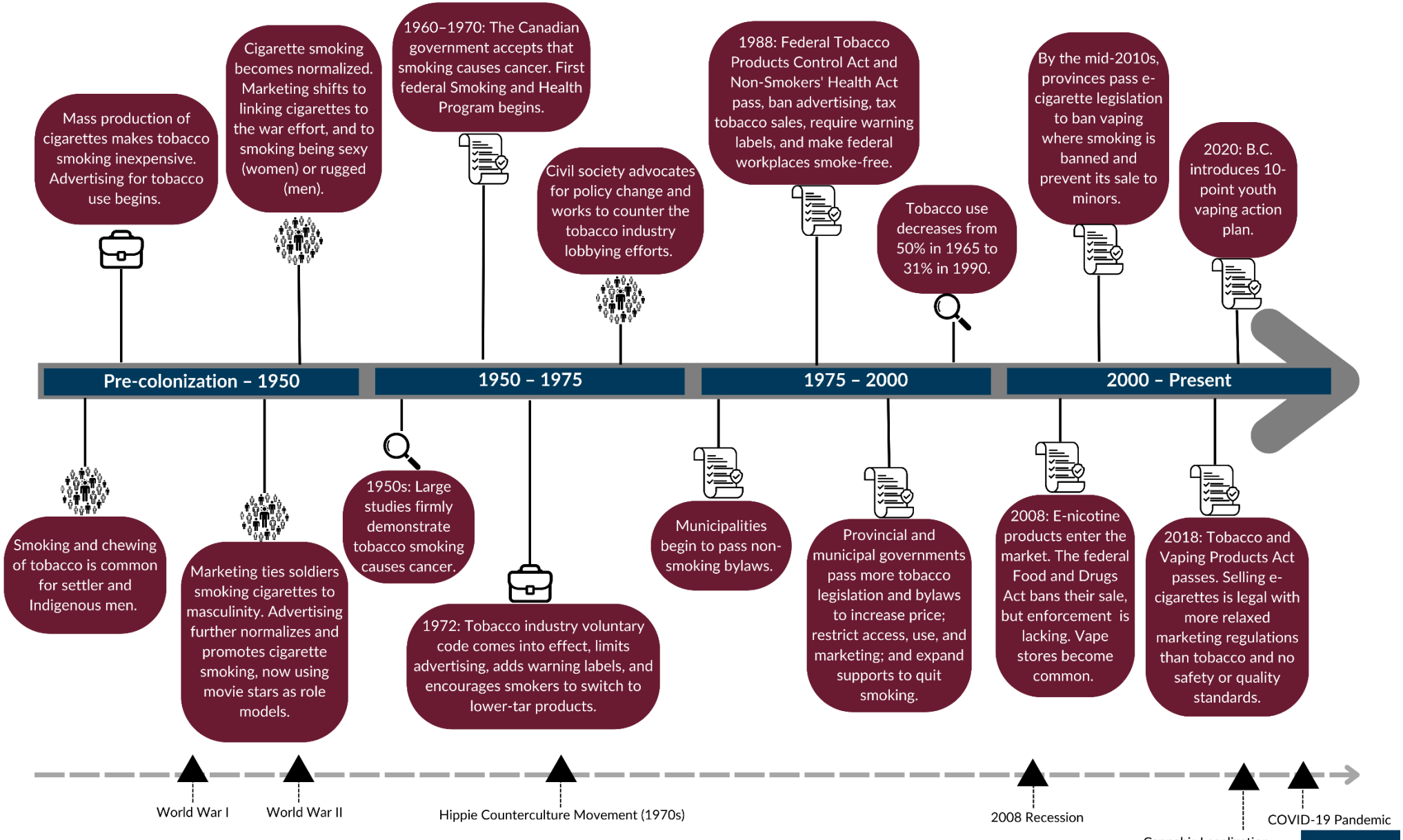
Tobacco



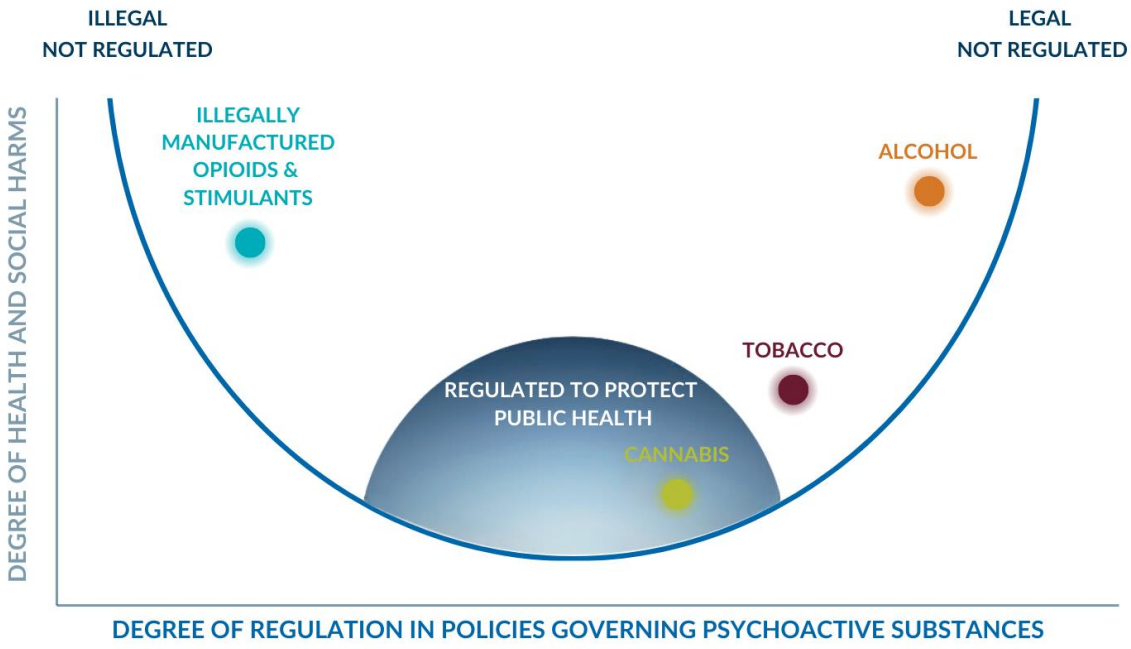
This timeline is not exhaustive but does aim to illustrate how policies, laws, industry influence, and dominant social narratives and norms have created the current landscape of psychoactive substance use in Canada.

Drug Policy Approaches

Over the past 250 years, shifts in the public perception of psychoactive substances have brought a wide range of policy approaches. This has created many "natural experiments" and opportunities to measure their outcomes.

In 1990, Marks noted that regulatory policies governing psychoactive substances created a "paradox of prohibition."[10] The concept describes a continuum of drug policy approaches for psychoactive substances and indicates that changing laws and policies can either increase or decrease health and social harms (see Figure 1). At one end of the continuum are illegal substances, which cannot be effectively regulated, monitored, or researched because they are illegal. These substances are produced and distributed by organized crime and are therefore outside of laws and regulations. This leads to people being exposed to substances of unknown composition and increasing toxicity, significant health and social harms, and revenues flowing to organized crime. At the other end are legal substances that could be strictly regulated but are not. Instead, these substances are broadly marketed and promoted with revenues to both industry and governments, resulting in widespread consumption and associated health and social harms. The middle of the continuum is where effective regulations are consistently applied to minimize health and social harms.[10,11] Policies that can reduce consumption and thereby minimize harms include controlling pricing, restricting availability through minimum age for purchase or limiting locations and times of sale, and reducing social desirability of the substance by banning advertising and promotion, health labelling, and education.[12] Regulation of production ensures that the substance is of known and consistent composition.[13]

Figure 1. The Policy Continuum



	ILLEGAL, NOT REGULATED	ILLEGAL WITH HARM REDUCTION & DECRIMINALIZATION	LEGAL WITH STRICT, PUBLIC HEALTH-ORIENTED REGULATION	LEGAL WITH WEAK MARKET REGULATION	LEGAL, NOT REGULATED, WITH COMMERCIAL PROMOTION
OUTCOMES	• Revenue to organized crime • Stigma, fear, violence, and increased inequities • Shift to more concentrated and hazardous products • Contamination with toxic adulterants • Disease, injury, death • Health and social costs • Enforcement costs • Limited ability to monitor or to generate knowledge	• Reduced enforcement costs • Complex policy environment • Overdose prevention sites and take-home naloxone programs to immediately respond to drug poisonings	• Evidence-based policies that reduce consumption (pricing, access, health promotion) • Implementation and evaluation of evidence-generating interventions • Monitoring of trends and adjustment of policies	• Revenue to industry • Tax revenue to governments • Market strategies to increase consumption that lead to health harms	• Revenue to industry • Tax revenue to governments • Increasing use • Disease, injury, death • Health and social costs

Source: Adapted from *Marks, J. (1990). The paradox of prohibition. In Hall, W. (Ed), Controlled availability: Wisdom or disaster? (pp. 7-10). Kensington, NSW: National Drug and Alcohol Research Centre.*[10]

Evidence-Informed Policy Approaches

Evidence-informed policies and regulations that govern psychoactive substances exist at various jurisdictional levels, such as municipal, provincial, and federal levels, for legal and illegal substances (see examples in Table 1). Legal status is determined at the federal level and enables other levels of government to pass legislation or policies regulating the substance. For legal substances (alcohol, tobacco, and cannabis), several policy domains have been demonstrated to influence the consumption of substances and result in positive health impacts. Many of these policy tools are within provincial and municipal jurisdictions. They mainly relate to promotion, regulation, distribution, and sale of the substance, and physical access. For illegal substances, policy actions are limited to situations with an exemption to federal legislation that makes a substance illegal. Legalization enables a number of policy tools that are highly effective at reducing harm; as long as a substance is illegal, we miss opportunities to use these tools to improve health.

Table 1. Available Policy Tools

Legal Substances	Illegal Substances
• Comprehensive strategy (provincial or federal) • Pricing and taxation • Reduced availability and access (e.g., reduced density and type of outlets, reduced hours of sale) • Minimum legal age for purchase • Prohibiting marketing and advertising • Control system for production and distribution • Monitoring and reporting on consumption and health consequences • Health and safety messages • Impaired driving countermeasures • Law enforcement • Brief interventions and other preventive strategies[12]	• Provision of alternatives to the toxic supply through a prescriber-based model, utilizing prescribing guidelines[14,15] • Decriminalization[16] • Targeted regulatory exemptions (e.g., exemption to Section 56 of the Controlled Drugs and Substances Act enabling supervised consumption sites)[17]

Promising Policy Option for Illegal Substances: Legalization with Regulation

Global and Canadian-based organizations[18,19] have proposed legalization with strict regulation under a public health framework "as the approach that offers the greatest potential for both individual and community health, safety and well-being."[13(p. 14)]

A health-promoting policy approach to substances recognizes that it is complex and challenging to balance the aim of limiting consumption of potentially harmful substances with the need to avoid further harm to those who do use. Changing the policy approach to any one substance needs to take into consideration where the substance is on the continuum of drug policy today and how existing policy approaches are creating the conditions for health harms.

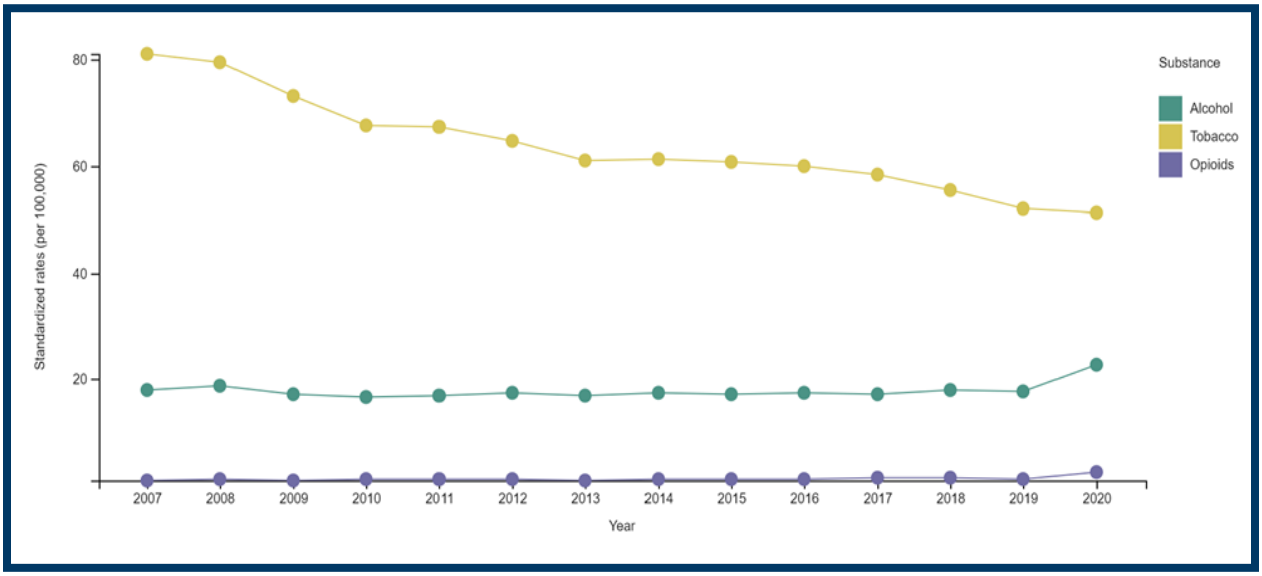
The ideal policy landscape would be one where all psychoactive substances were strictly regulated and controlled under a public health framework. This means that regulations would be devised, monitored and evaluated, and changed as needed to address potential and actual harm of each substance. Creating and maintaining effective policies and regulations is a societal challenge that requires sustained commitment to public health goals and implementing, evaluating, and adjusting regulations as needed.

Burden of Illness

To understand the health consequences of substance use, multiple data sources were explored. Since psychoactive substances contribute to illness, injury, and mortality either directly or indirectly, these multiple sources of information were used to get as complete a picture as possible about how these substances affect people's health. Key measures are cause of death, premature mortality, and potential years of life lost. Potential years of life lost is the number of years of life a person loses when they die prematurely from any cause.[20]

Deaths attributed to tobacco are significantly higher than for alcohol or opioids. Up to 2019, substance use-attributable deaths in B.C. were declining due to tobacco and had been stable for alcohol and opioids since 2007. In 2020, the rate of deaths attributed to alcohol and opioids both increased (Figure 2).

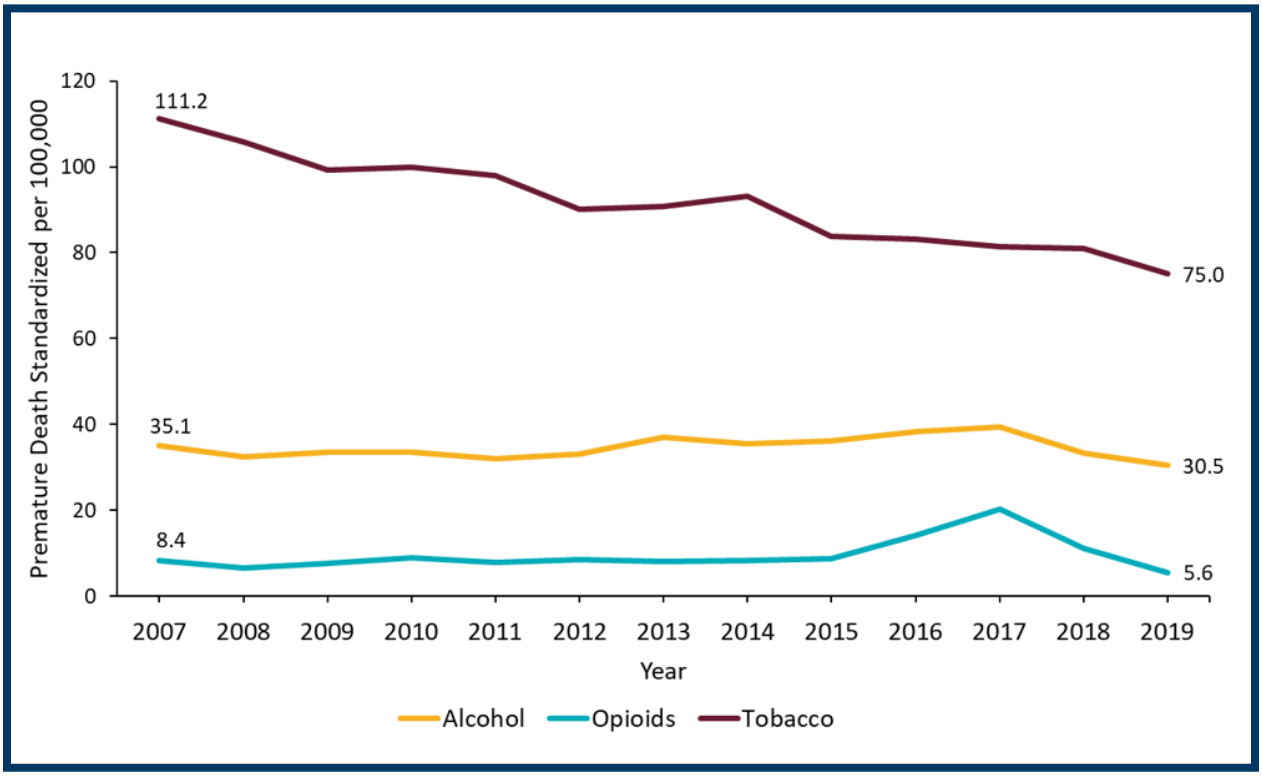
Figure 2. Substance Use-Attributable Deaths, Alcohol, Tobacco, and Opioids, B.C. (2007–2020)



Source: Canadian Centre on Substance Use and Addiction & Canadian Institute for Substance Use Research, 2023, *Canadian substance use costs and harms (CSUCH) visualization tool.*[21]

Premature death refers to mortality as a result of avoidable causes of death before the age of 75. Premature deaths in Island Health continue to be higher for tobacco and alcohol than for opioids (Figure 3). In 2016, a substantial increase in premature deaths attributed to opioids was observed in Island Health, followed by a decline between 2017 and 2019, prior to the declaration of the COVID-19 pandemic in 2020 (data are not yet available for 2020).

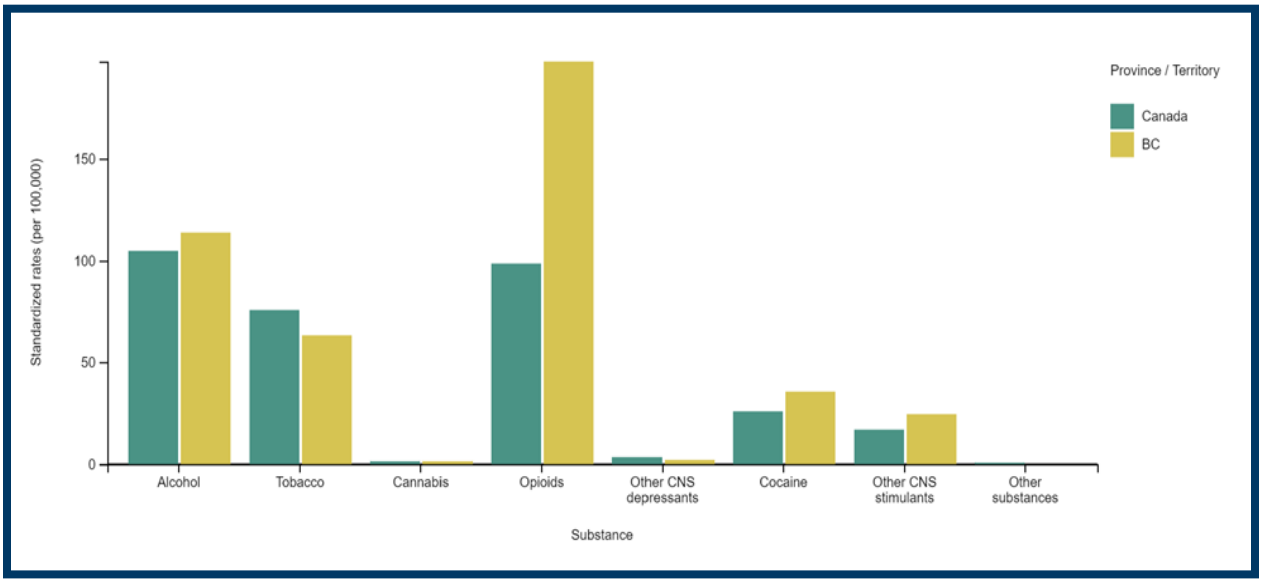
Figure 3. Premature Deaths Attributed to Alcohol, Opioids, and Tobacco, Island Health (2007–2019)



Source: Canadian Institute for Substance Use Research, 2022, *Interactive data visualization tool*.[22]

Despite the higher death rates due to tobacco, potential years of life lost are higher for opioids than for tobacco because deaths due to opioids occur at much younger ages. Among psychoactive substances, alcohol, opioids, and tobacco contribute the most to potential years of life lost in Canada and B.C., with B.C. having twice the rate of years lost for opioids compared to Canada in 2020 (Figure 4).

Figure 4. Substance Use-Attributable Potential Years of Productive Life Lost, by Substance, B.C. and Canada (2020)

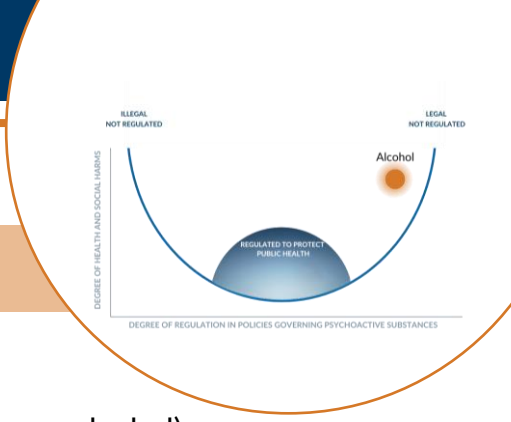


Source: Canadian Centre on Substance Use and Addiction & Canadian Institute for Substance Use Research, 2023, *Canadian substance use costs and harms (CSUCH) visualization tool*.[21]

Population Health Assessment: Health Consequences of Substance Use in Island Health

The following sections provide an analysis of the current situation in Island Health. These sections are based on varied sources of information, notably population health data and reviews of policy landscapes and dominant narratives, as available and known. The policy analyses are limited in scope. Data should not be compared across sources without reviewing each respective source's data notes and limitations.

A significant knowledge gap exists due to the lack of local Indigenous data to inform robust policy decisions. More meaningful engagement with, and in support of, Indigenous communities and organizations is needed to gather data, stories, and Indigenous knowledge and to govern this information appropriately.

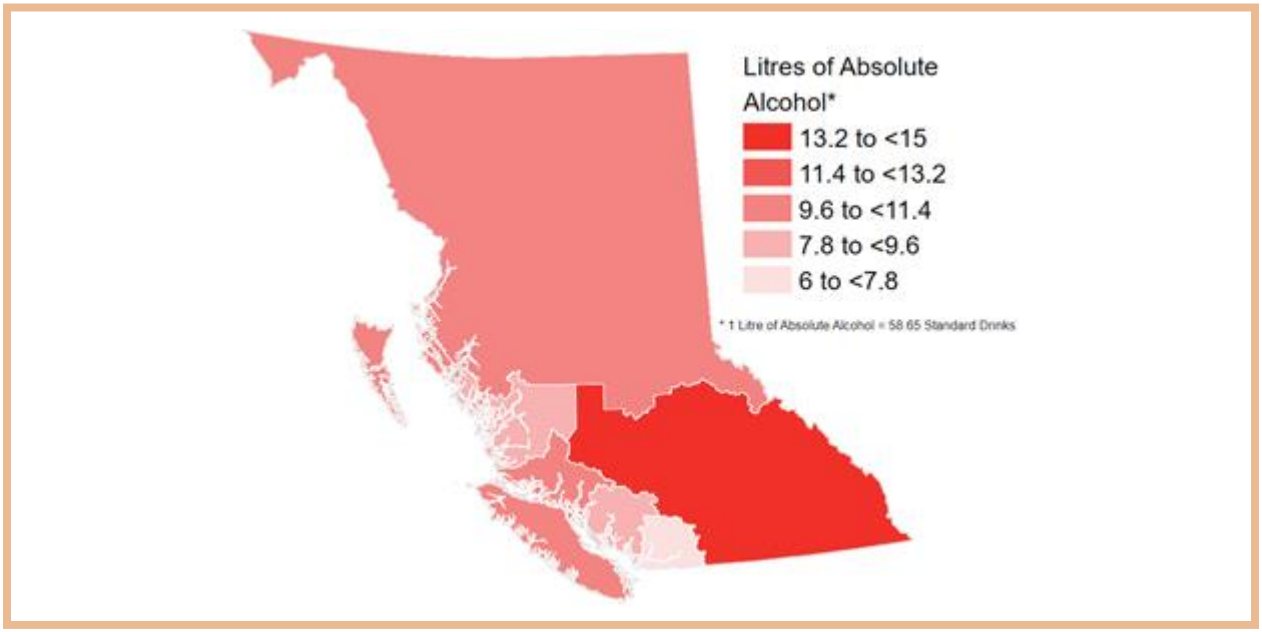


Alcohol

Consumption Trends

Estimated annual per capita consumption of absolute alcohol (i.e., pure alcohol) within the Island Health region was 11.45 L (equivalent to 671.5 standard drinks) in 2022, the second highest consumption of all B.C. regional health authorities (Figure 5). It was also 24% higher than the provincial average of 9.2 L (equivalent to 539.6 standard drinks) in 2022 (data not shown).[22] These numbers are for the whole population aged 15+ and include the 20% or so considered to be non-drinkers.

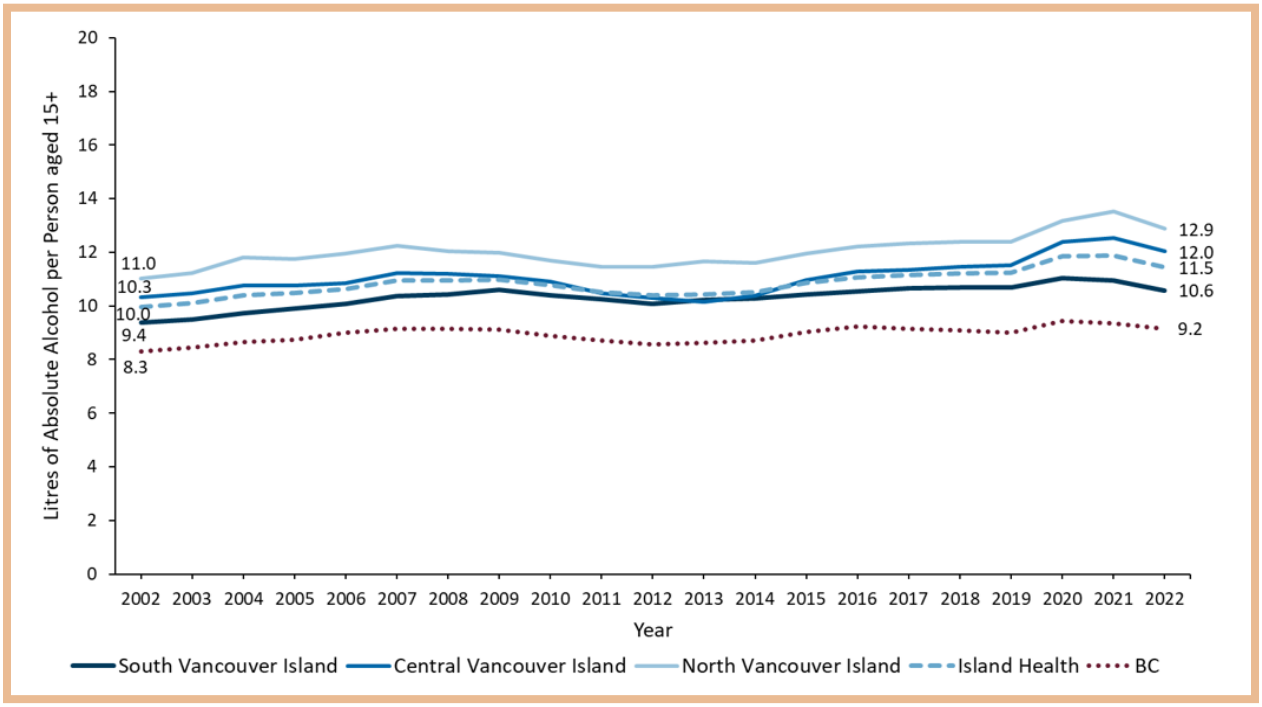
Figure 5. Total per Capita Alcohol Consumption by Health Authority, B.C. (2022)



Source: Canadian Institute for Substance Use Research, 2022, *Interactive data visualization tool.*[22]

Alcohol consumption (based on alcohol sales) has been gradually increasing over the past 20 years, both in Island Health and in B.C. There were notable increases in 2013–14 and in 2019–20 coinciding with the liberalization of liquor policies following the provincial liquor policy review and again during the COVID-19 pandemic. There has been some decline in consumption since the pandemic peak (Figure 6). Within the Island Health region, consumption is highest in North and Central Vancouver Island, with 12.9 and 12.0 L of absolute alcohol consumed per person aged 15+ years in 2022, respectively. The annual per capita consumption of alcohol in 2022 was 16% higher in North Vancouver Island than in South Vancouver Island (Figure 6), although there were notable variations across the LHAs within each of the HSDAs (data not shown).[22]

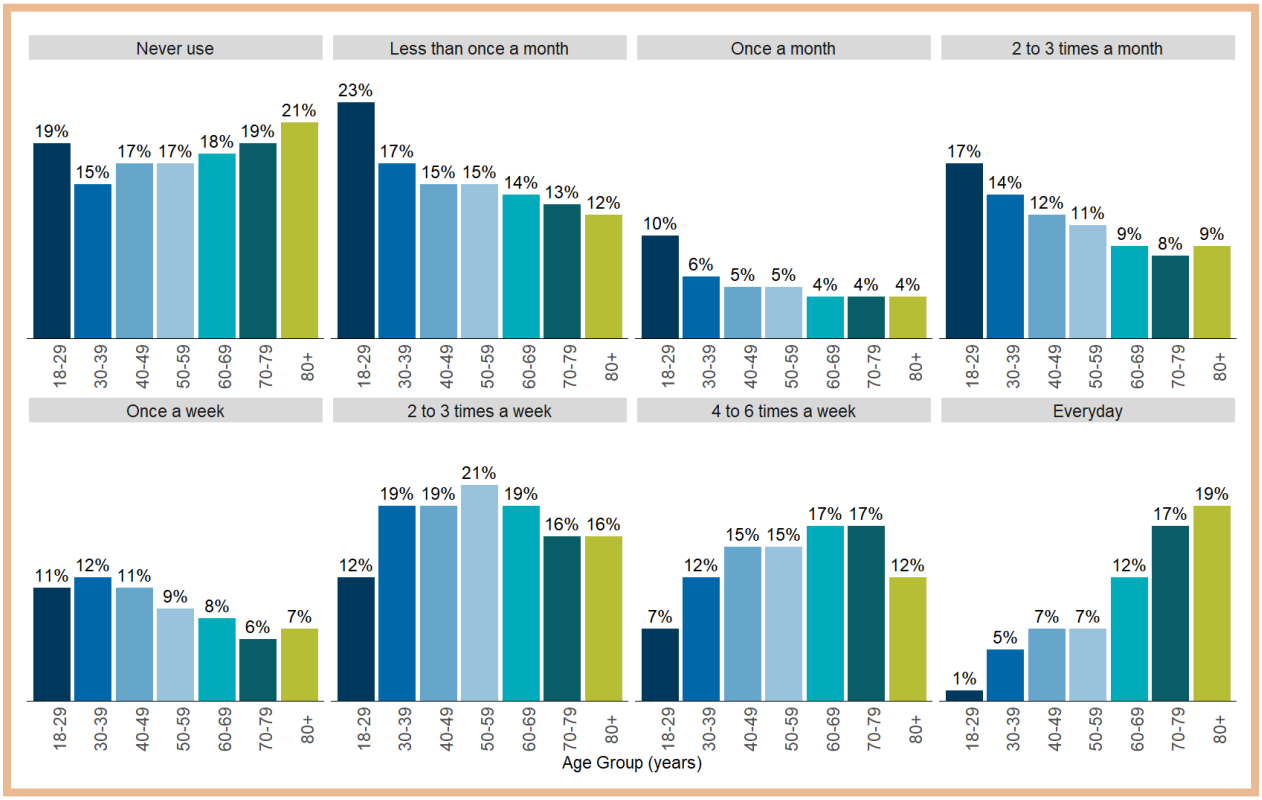
Figure 6. Annual per Capita Alcohol Consumption (Litres) by Year by Health Service Delivery Area, Island Health and B.C. (2002–2022)



Source: Canadian Institute for Substance Use Research, 2022, *Interactive data visualization tool*.[22]

Alcohol consumption patterns vary by both age and sex in the Island Health region. In 2021, daily drinking was more common with increasing age, with nearly 20% of the 80+ age group reporting drinking every day compared to 1% of the 18–29 age group (Figure 7). It is important to note that these data were collected during the pandemic and may not necessarily represent consumption rates during non-pandemic times.

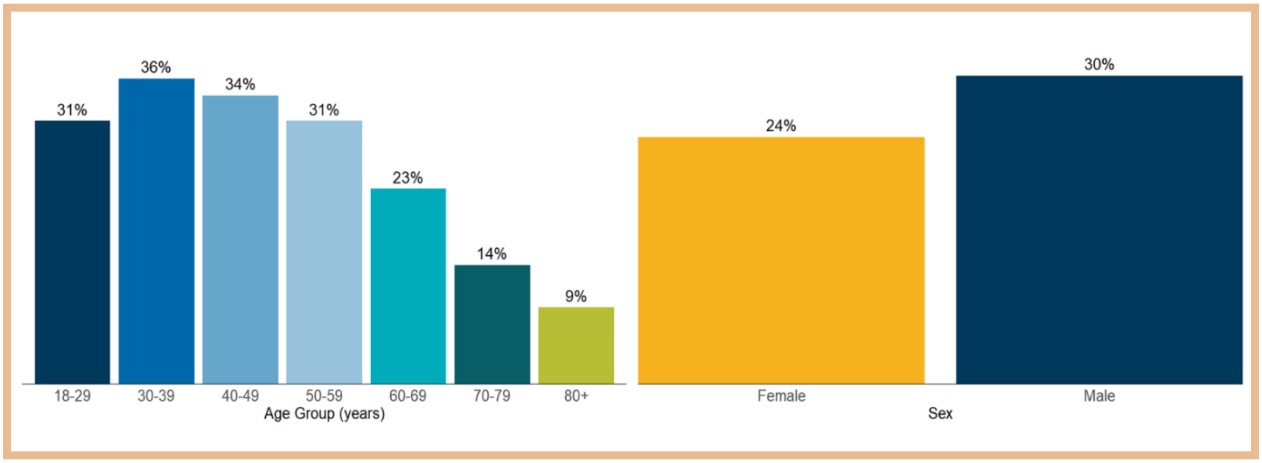
Figure 7. Frequency of Alcohol Consumption by Age Group, Island Health (2021)



Note: Frequency refers to frequency of consumption in the past 12 months.
Source: Data provided by BC Centre for Disease Control, BC COVID-19 Survey on Population Experiences, Action and Knowledge (SPEAK) Round 2 (2021), and analysis conducted by Island Health Population Health Assessment, Surveillance & Epidemiology (PHASE) team.

Binge drinking (5+ drinks for males, 4+ drinks for females on one occasion), however, was reported less frequently among those 80+ years old, with 91% reporting binge drinking never or less than once a month (Figure 8). The highest proportion of binge drinking at least once a month was reported among those aged 30–39 (36%) and 40–49 (34%). Overall, binge drinking was higher among males (30%) than females (24%).

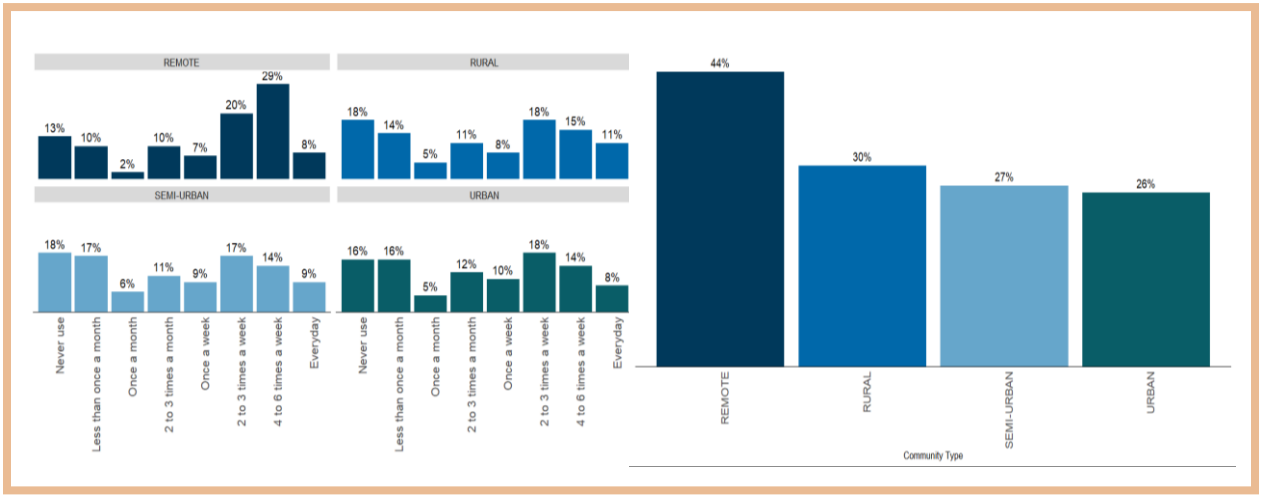
Figure 8. Frequency of Binge Drinking at Least Once per Month by Age Group [left] and Sex [right], Island Health (2021)



Note: Binge drinking defined as 5+ drinks (males), 4+ drinks (females) once per month or more in the past 12 months.
Source: BC Centre for Disease Control, 2022, *BC COVID-19 SPEAK Survey Round 2 results*.[23]

The frequency of alcohol consumption and binge drinking also varied by community type (remote, rural, semi-urban, urban) (Figure 9). In remote communities, 29% of people reported drinking 4 to 6 times a week and nearly 44% reported binge drinking at least once a month. These are much higher reported proportions than those in urban communities, where 14% reported drinking 4 to 6 times a week and 26% reported binge drinking at least once a month.

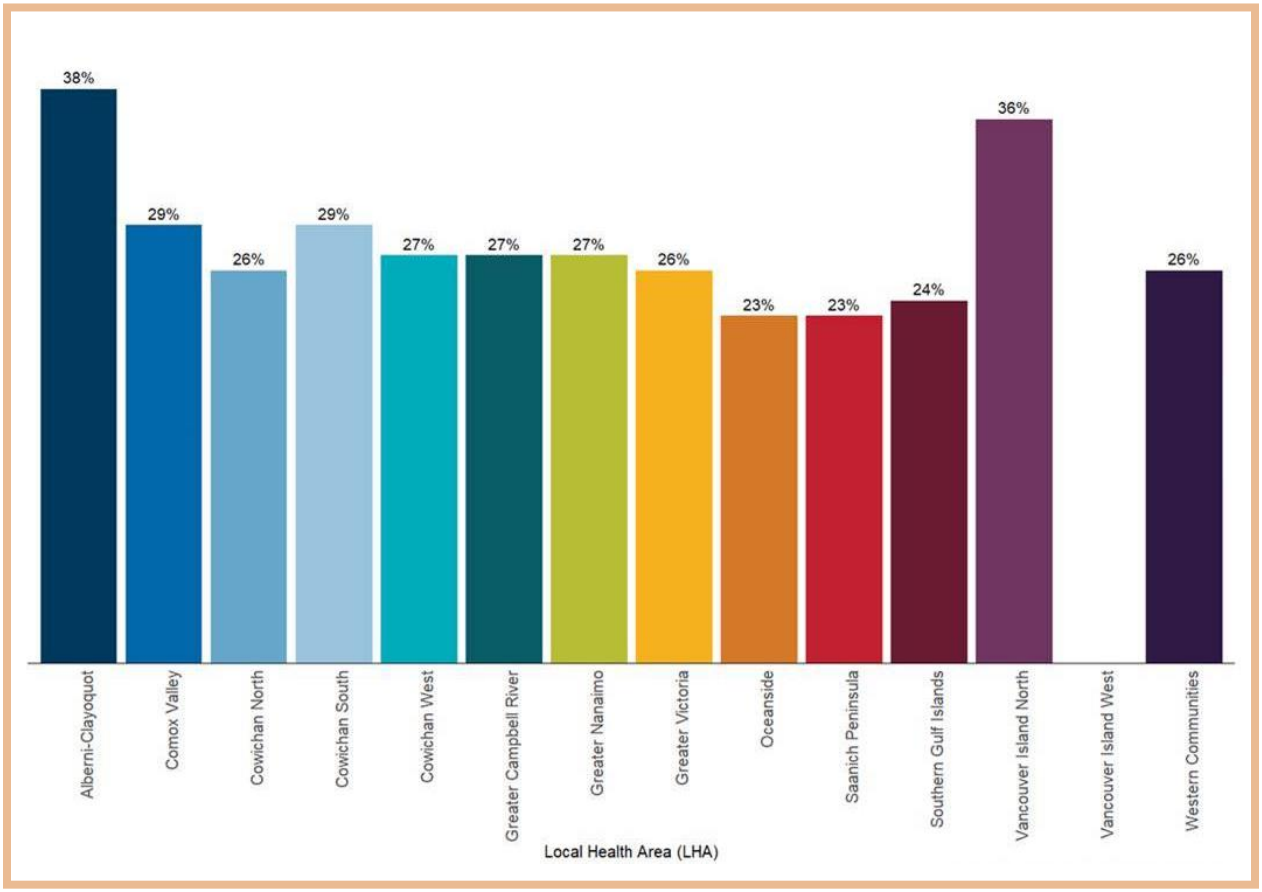
Figure 9. Frequency of Alcohol Consumption [left] and Binge Drinking [right] by Community Type, Island Health (2021)



Note: Community type determined by Community Health Service Area urban-rural classifications as per 2016 census population. Frequency refers to frequency of consumption in the past 12 months. Binge drinking defined as 5+ drinks (males), 4+ drinks (females) on at least one occasion in the past 12 months.
Source: Data provided by BC Centre for Disease Control, BC COVID-19 SPEAK Round 2 (2021), and analysis conducted by Island Health PHASE team.

The highest proportion of people who reported binge drinking at least once in the past 12 months in Island Health were in Alberni-Clayoquot (38%) and Vancouver Island North (36%) LHAs (Figure 10).

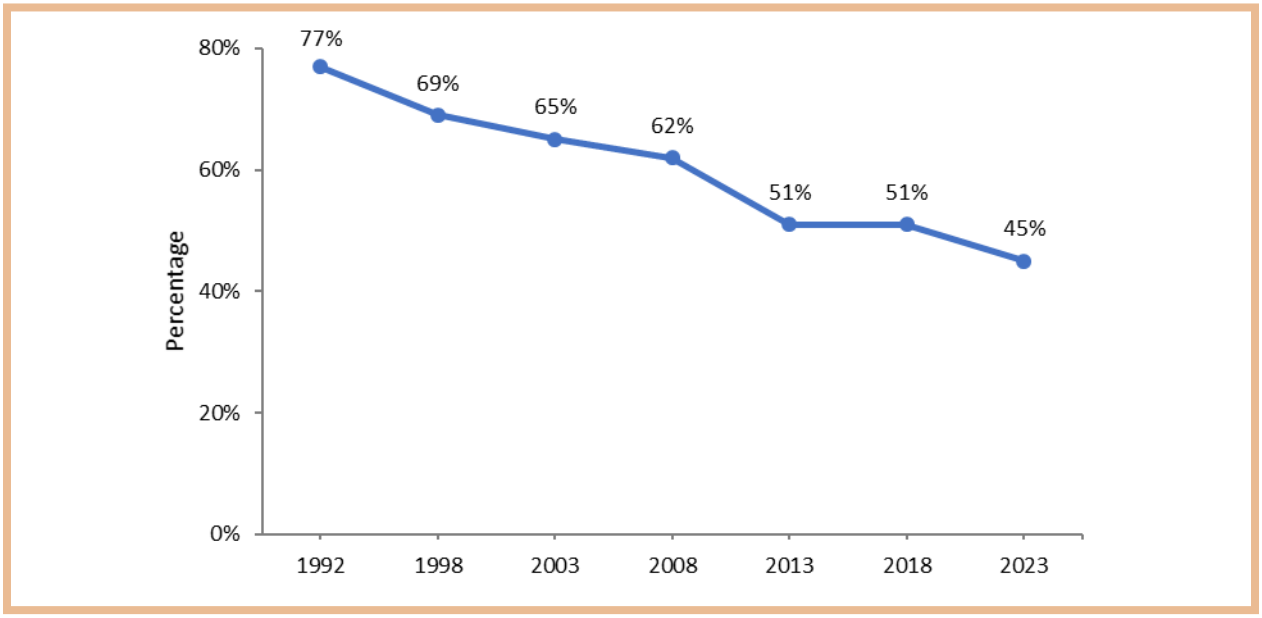
Figure 10. Binge Drinking by Local Health Area, Island Health (2021)



Note: Binge drinking defined as 5+ drinks (males), 4+ drinks (females) on at least one occasion in the past 12 months. Data not available for Vancouver Island West LHA.
Source: BC Centre for Disease Control, 2022, *BC COVID-19 SPEAK Survey Round 2 results*.[23]

The proportion of youth aged 12–19 attending grades 7–12 in schools within Island Health who have reported trying alcohol has decreased steadily over the past 30 years, from 77% in 1992 to less than half (45%) in 2023 (Figure 11).

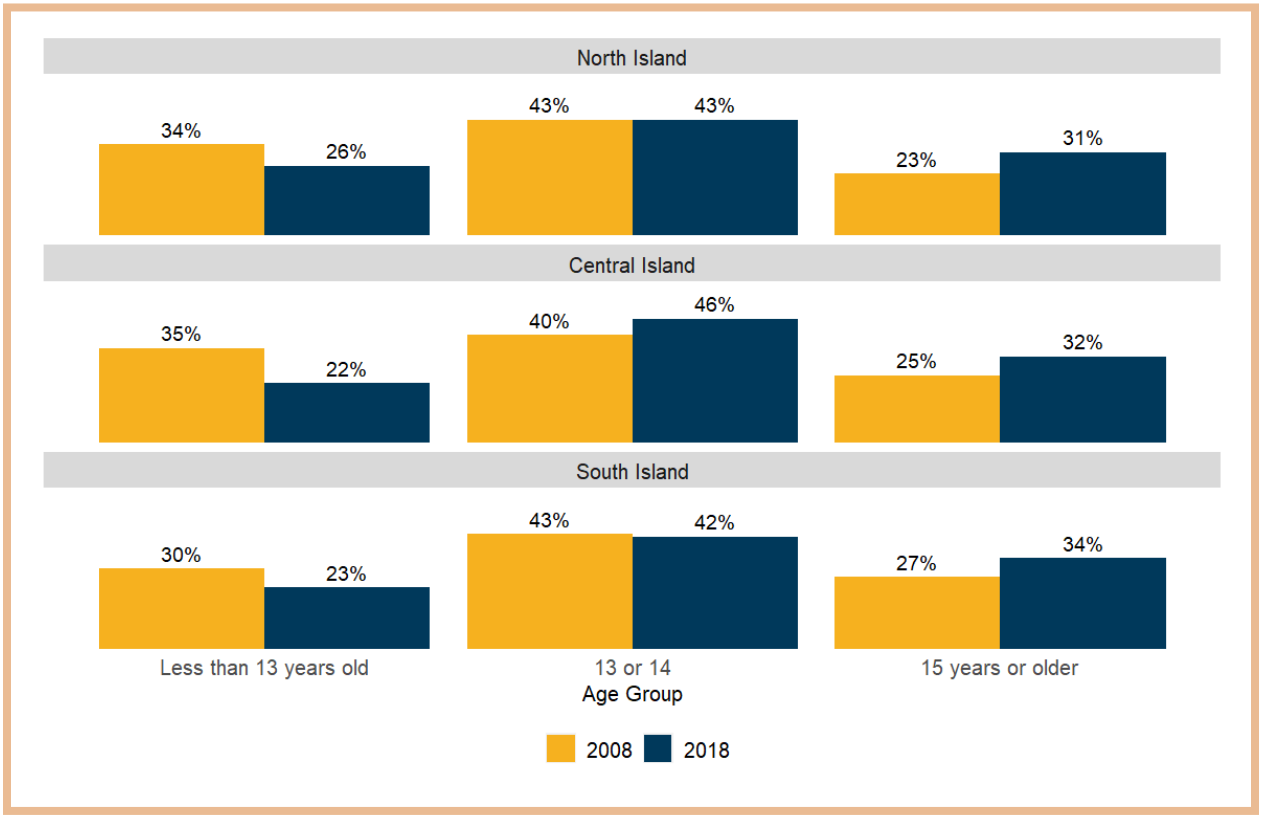
Figure 11. Youth Ever Having Tried Alcohol, Island Health (1992–2023)



Note: Survey administered to students in Grades 7–12 (aged 12–19) every 5 years.
Source: Data provided by McCreary Centre Society, BC Adolescent Health Survey, 1992 through 2023.

When comparing across Island Health, in 2018 (geographic breakdown for 2023 is not yet available), reported alcohol use by students was highest in North Island (54%) and Central Island (52%) compared to 48% in South Island. When asked how old they were when they had their first drink, fewer youth in all Island Health HSDAs reported having their first drink prior to age 13 and more reported having their first drink at 15 years or older in 2018 compared to 2008 (Figure 12).

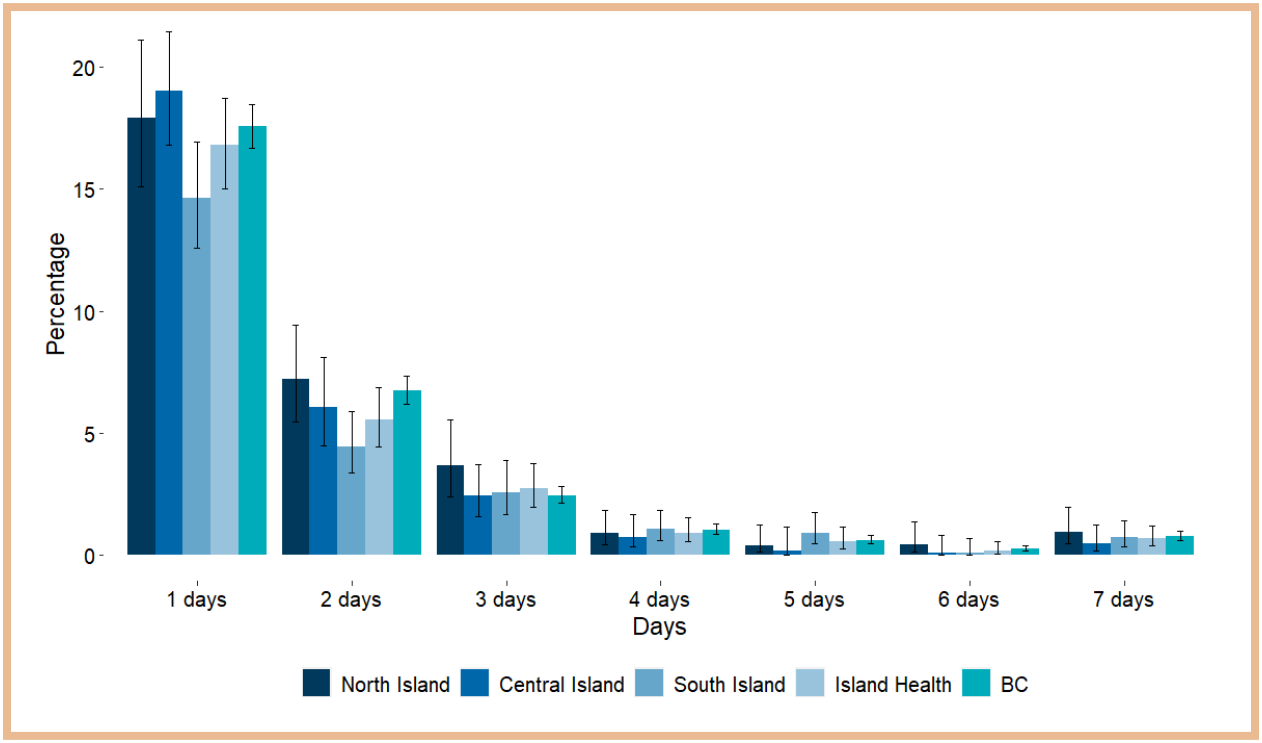
Figure 12. Initial Youth Alcohol Use Among Youth Who Have Ever Used Alcohol by Age Group and Health Service Delivery Area, Island Health (2008 and 2018)



Source: Data provided by McCreary Centre Society, BC Adolescent Health Survey, 2008 and 2018, and compiled by Island Health PHASE team.

In 2018 (2023 data pending) across Island Health, of youth who reported alcohol use, 16.8% reported binge drinking (more than 2 drinks in 1 day in the past week), 5.5% reported binge drinking twice in the past week, and 4.9% reported binge drinking 3 to 7 times in the past week. The reported rate was higher in Central Island and North Island than in South Island (Figure 13).

Figure 13. Number of Days in the Past Week Where Youth Reported Drinking More Than Two Drinks on One Day by Health Service Delivery Area, Island Health and B.C. (2018)

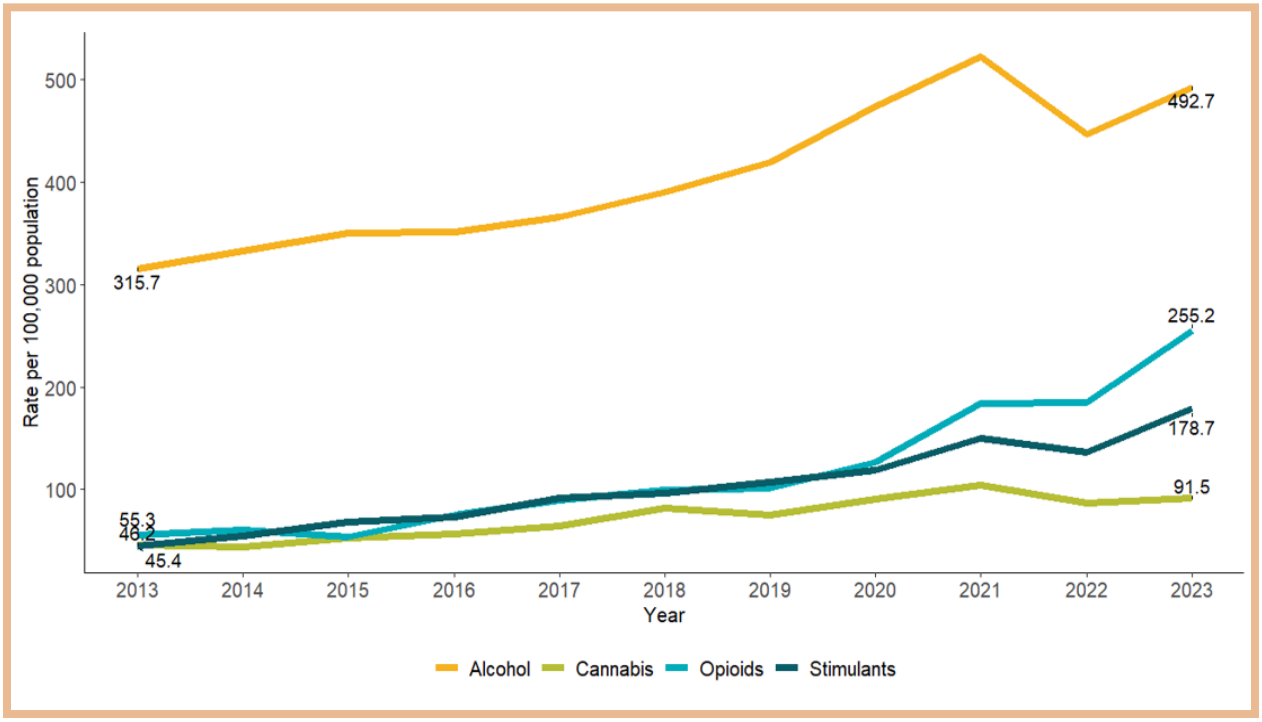


Note: Among youth who have ever used alcohol.
Source: Data provided by McCreary Centre Society, BC Adolescent Health Survey, 2018, and analysis conducted by Island Health PHASE team.

Burden of Illness

Excluding tobacco, alcohol-related hospital admissions consistently account for the highest rate of substance-related hospital admissions in Island Health. In 2023, there were nearly two times more admissions related to alcohol than the next leading cause of substance-related admissions, opioids (Figure 14). These numbers also likely underrepresent hospital admissions due to substance use as they do not take into account admissions for diseases for which substance use is a contributing factor. For example, alcohol contributes to breast cancer, but that substance-related contribution is not captured in the hospital admission data included in this report.

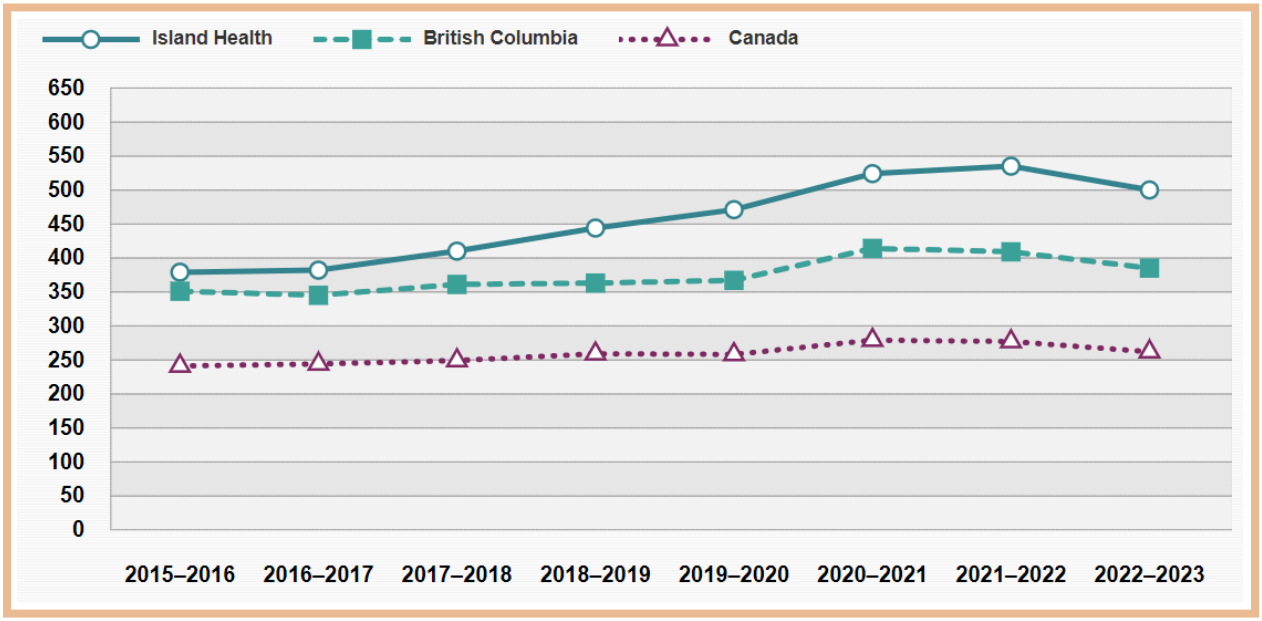
Figure 14. Rate of Substance-Related Hospital Admissions, Island Health (2013–2023)



Source: Data from Island Health Enterprise Data Warehouse, Discharge Abstract Database, and compiled by Island Health PHASE team.

The rate of hospital admissions entirely caused by alcohol in 2022–2023 in Island Health was 500 per 100,000, which was 1.3 times higher than B.C. (385 per 100,000) and nearly 2 times higher than Canada (262 per 100,000) (Figure 15). Prior to the declaration of the pandemic in 2020, the rates of alcohol-related hospital admissions had remained fairly stable in B.C. and Canada but had been increasing in Island Health since 2016–17. In 2020, the rates increased in Canada, B.C., and Island Health and have yet to return to pre-pandemic levels in both B.C. and Island Health.

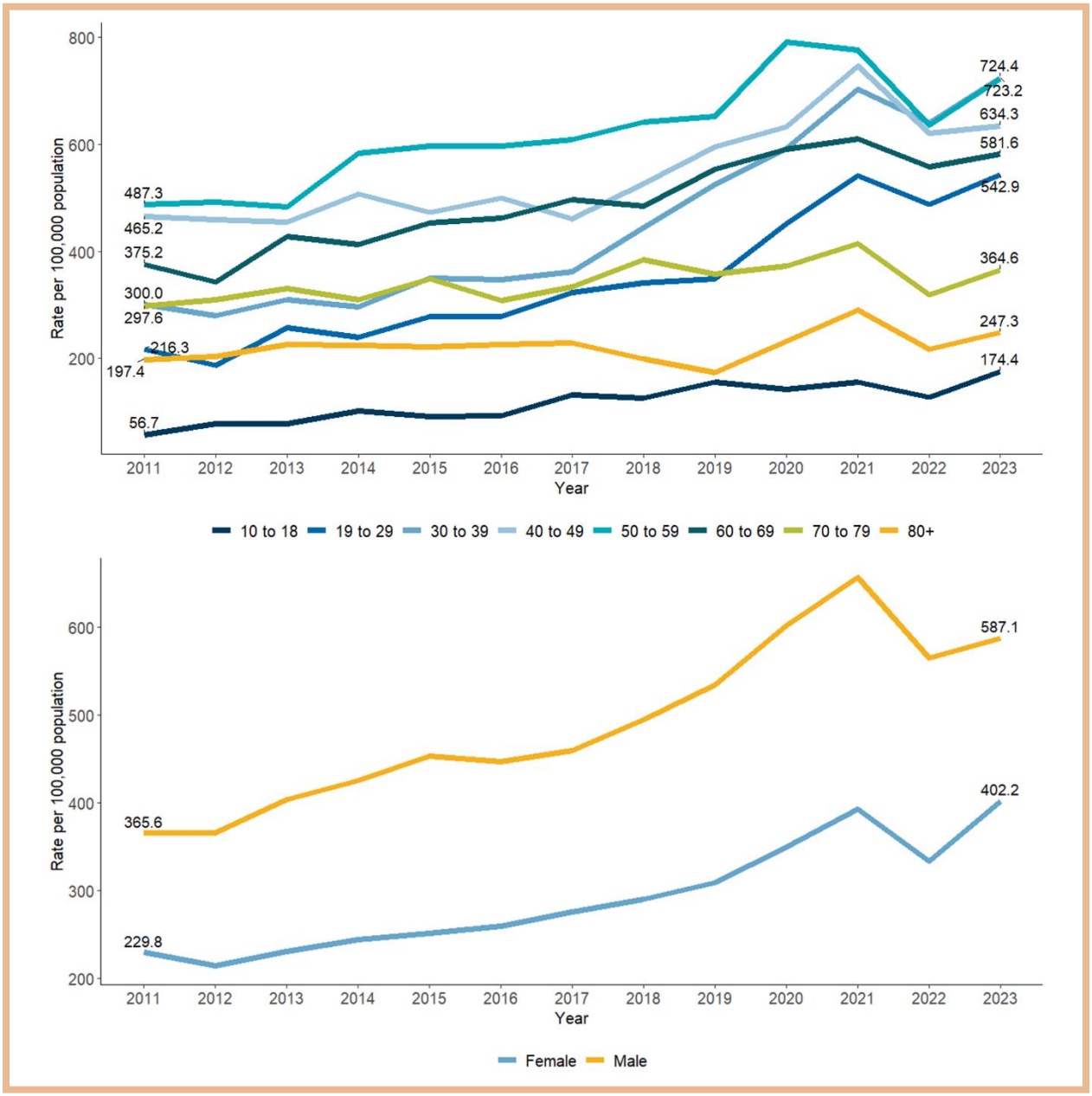
Figure 15. Rate of Hospital Admissions Entirely Caused by Alcohol (per 100,000 Population), Island Health, B.C., and Canada (2015–2023)



Note: Entirely caused by alcohol is defined as 100% attributable to alcohol.
Source: Canadian Institute for Health Information, 2023, *Your health system: Hospitalizations entirely caused by alcohol details for Island Health*.[24]

In Island Health, the highest rates of hospital admission for harm caused by alcohol in 2023 were in the 30–39 and 50–59 age groups (724.4 and 723.2 per 100,000, respectively) and males (587.1 per 100,000) (Figure 16). However, hospital admission in females in Island Health was 1.5 times higher than B.C. and 2.4 times higher than Canada (data not shown).[24]

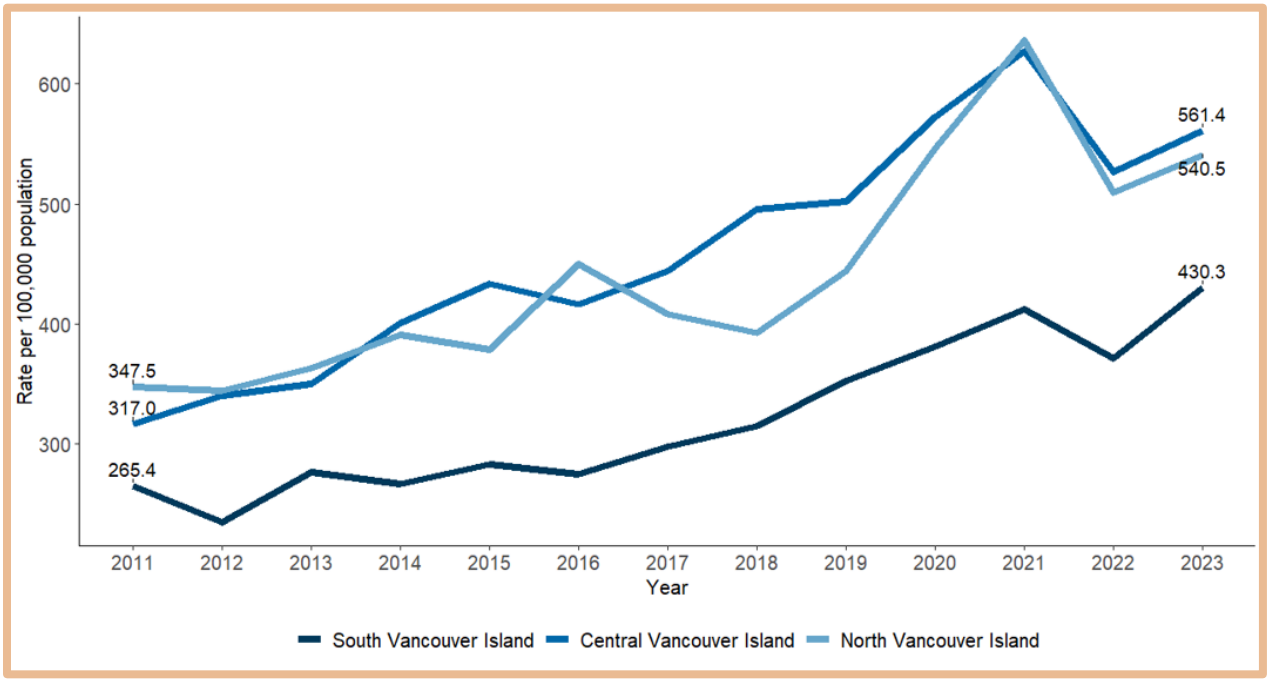
Figure 16. Rate of Alcohol-Related Hospital Admissions by Age Group [top] and Sex [bottom], Island Health (2011–2023)



Source: Data from Island Health Enterprise Data Warehouse, Discharge Abstract Database, and compiled by Island Health PHASE team.

Alcohol-related hospital admissions vary by geography and age within the Island Health region. Rates in North and Central Vancouver Island in 2023 were 1.3 times higher than in South Island (Figure 17).

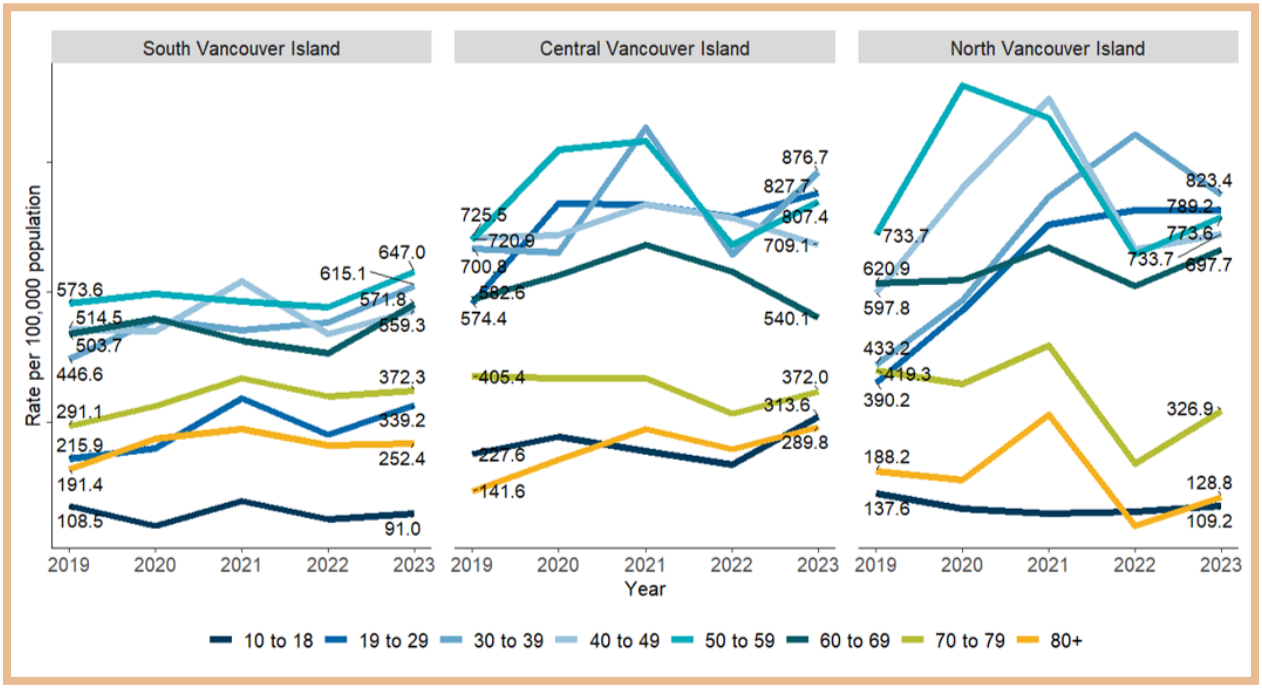
Figure 17. Rate of Alcohol-Related Hospital Admissions by Health Service Delivery Area, Island Health (2011–2023)



Source: Data from Island Health Enterprise Data Warehouse, Discharge Abstract Database, and compiled by Island Health PHASE team.

The highest rates of alcohol-related hospital admissions in 2023 were among the 30–39 age group in Central and North Island HSDAs, with rates of 876.7 and 823.4 per 100,000, respectively (Figure 18). The highest rate observed in South Island was among the 50–59 age group (647.0 per 100,000), followed by the 30–39 age group (615.1 per 100,000). The most notable increase in alcohol-related hospital admissions over the past 5 years is among those 19–29 and 30–39 years of age in North Island, where the rates have nearly doubled. This regional variation in hospital admissions is correlated with a higher rate of consumption in North and Central Island and is noted to be in areas with lower service availability.

Figure 18. Rate of Alcohol-Related Hospital Admissions by Age Group and Health Service Delivery Area, Island Health (2019–2023)

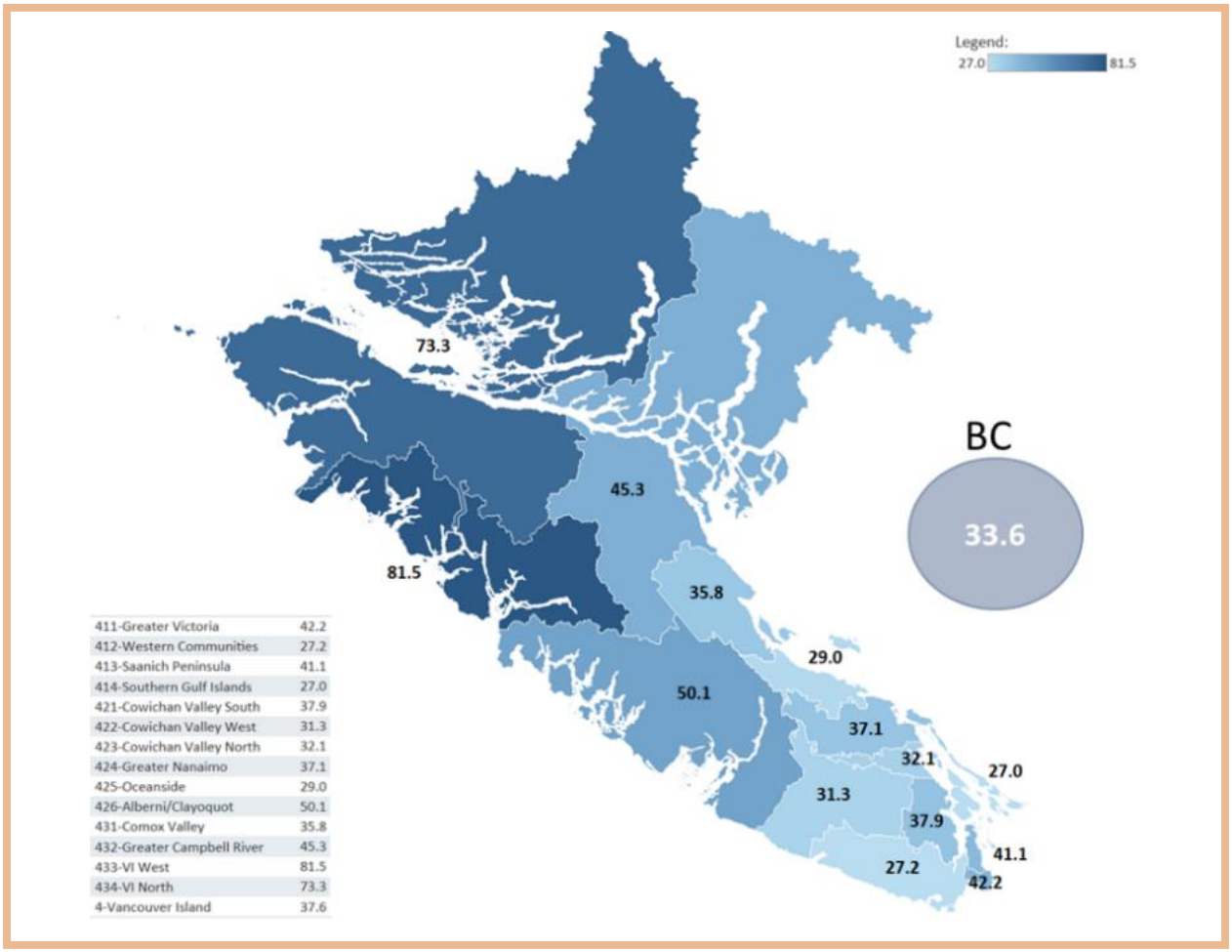


Source: Data from Island Health Enterprise Data Warehouse, Discharge Abstract Database, and compiled by Island Health PHASE team.

The highest rates of alcohol-related hospital admissions in North and Central Island were in the Vancouver Island North and Alberni/Clayoquot LHAs, where they were 3 to 4 times higher than in LHAs with the lowest hospital admission rates in Vancouver Island, most notably in South Island. Alberni/Clayoquot, Vancouver Island North, and Vancouver Island West had the most notable spikes in hospital admissions related to alcohol during the pandemic (data from Island Health's Discharge Abstract Database, not shown).

The rate of deaths wholly or partially attributed to alcohol was also notably higher in North and Central Island, with some communities in North Island having more than double the rate of deaths than Island Health and B.C. (Figure 19).

Figure 19. Age-Standardized Death Rate Wholly or Partially Attributed to Alcohol (per 100,000 Population), Island Health (2019)



Source: Canadian Institute for Substance Use Research, 2022, *Interactive data visualization tool*.[22]

Other Health Effects of Alcohol

In addition to the diseases and conditions attributable entirely to alcohol, there are others to which alcohol contributes in part. These include, but are not limited to cancer, heart diseases, gastrointestinal diseases, unintentional injuries, mental health conditions, loss of productivity, and violence.[25] Further, binge drinking has been shown to be associated with poorer self-rated mental health. In the SPEAK Survey Round 2 (2021), 38% of respondents who reported binge drinking at least once a month reported fair or poor mental health

compared to 28% of those who reported binge drinking never or less than once a month (data provided by BC Centre for Disease Control, not shown).

Summary of Key Findings

Alcohol is a legal, weakly regulated substance, with laws, policies, media, and public perception that promote consumption. Health harms of alcohol use in Island Health are substantial and increasing with increased consumption.

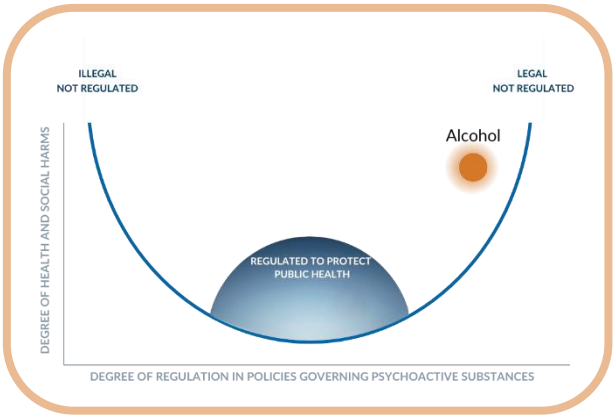
Alcohol consumption in Island Health:

- Higher than in B.C. overall and the second highest of the five regional Health Authorities in B.C.
- Increased over the past decade
- Highest in North Island, lowest in South Island
- Age of starting to use alcohol is increasing
- Regular drinking increases with age
- Binge drinking decreases with age after age 40
- Frequency of alcohol use is highest and binge drinking most common in remote communities

Hospital admissions related to alcohol in Island Health:

- Higher than for opioids or cannabis
- Higher for males than for females
- Worsened during the pandemic
- Increased most for youth and young adults

Policy Landscape



Alcohol sits at the extreme right of the policy continuum. Alcohol is generally considered as the only psychoactive substance with addictive potential "that is not controlled at the international level by legally binding regulatory frameworks,"[26(p. xii)] even though it has major population and public health consequences. Currently, alcohol is fully legal with few restrictions in B.C. and across the country. Regulations exist concerning alcohol manufacturing, distribution, and sale, but accessibility and availability are very high and increasing across communities, leading to increased exposure to alcohol use and contributing to its normalization.

Alcohol is hyper-normalized in the media and society, but this has not always been so. As illustrated in the timeline of alcohol policies, alcohol consumption increased from 65% to 82% in a span of less than 30 years.[27] Current media narratives across the country tend to focus on the benefits of artisanal and local brewers as economic drivers and good neighbours, as well as their rights to make a profit, and on the need to "modernize" old-fashioned laws,[28,29] that is, abolish government-controlled sales and distributions.[28,30–32] These media narratives influence public perception, laws, regulations, and policies around alcohol.

In 2013, a B.C. Liquor Policy Review was undertaken and recommendations made to change B.C.'s liquor laws to support manufacturers and distributors of alcohol and to increase convenience, choice, and selection to consumers. Based on this review, in 2015, the Liquor Control and Licensing Act was changed to allow wine sales in grocery stores and permit alcohol sales at reduced prices during happy hour, along with several other changes that promoted sale and consumption of alcohol.[29] The trend continued, and in 2017, a liquor policy panel was established to "improve efficiency and outcomes for business and government in relation to government responsibilities, regulations and oversight roles that intersect with the activities of B.C.'s private liquor businesses."[33]

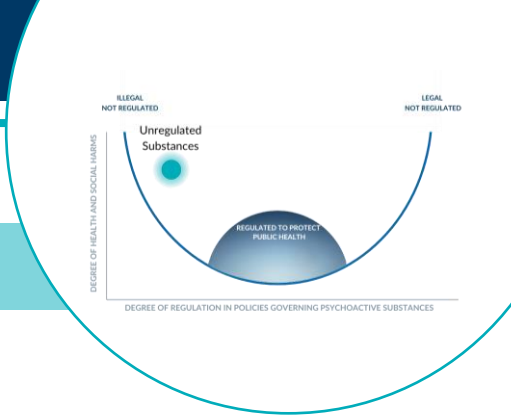
"Alcohol is a social and cultural lynchpin in our society." – Chris Edwards, a person with lived experience

"My family was happy to see me drinking alcohol, because it meant I wasn't using drugs." – Aran Wilson, in recovery

"I saw alcohol and tobacco use as a rite of passage, from teenage to adulthood." – Gordon Harper, a person in very long-term recovery

When the pandemic was declared and pandemic restrictions were put in place, a series of temporary changes to the existing regulations were introduced, such as wholesale pricing for hospitality venues,[34] authorizing licensees (i.e., restaurants and pubs) to deliver packaged liquor with the purchase of a meal, [34] extended hours of service for retailers and expanded service areas,[35] and consumption in parks in certain municipalities.[36] Many of these regulatory changes have now been made permanent.

Overall, there are now fewer strategies aimed at limiting consumption of alcohol than for cannabis and tobacco, and when a strategy is in place, it is usually applied below the level recommended by research evidence.



Unregulated Substances

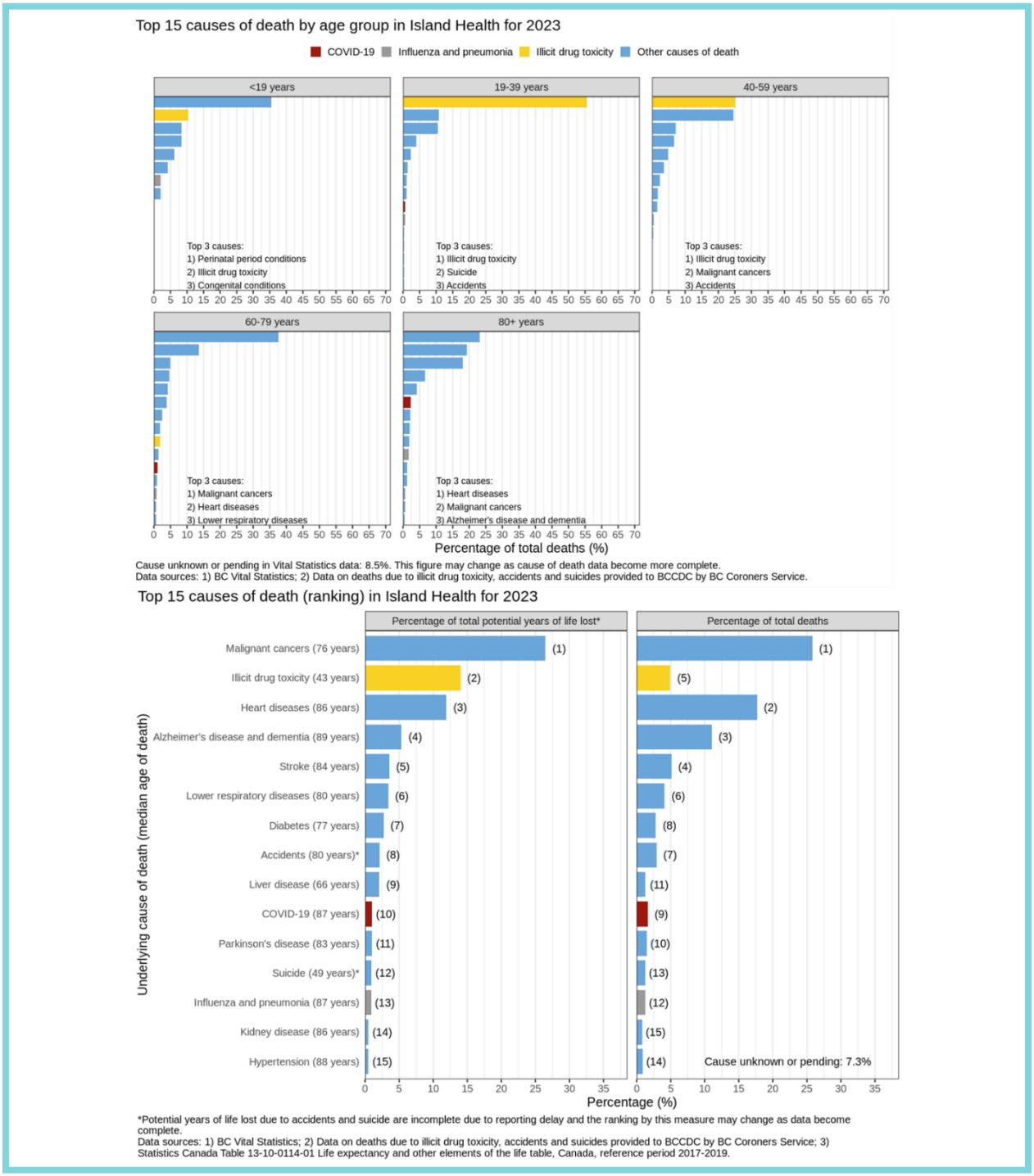
Burden of Illness

Substances that are illegal cannot be regulated, making their composition and potency unpredictable. The emergence of synthetic opioids such as fentanyl in the illegal drug supply is causing profound physical dependence and a high rate of death among people who use these substances. Although it is common for individuals to use multiple substances (intentionally or unintentionally), most unregulated drug deaths are due to opioids.

Unregulated Drug Deaths

In 2023, unregulated drug poisoning was the leading cause of death for Island Health residents between 19 and 59 years of age and the second leading cause for residents less than 19 years of age (Figure 20). Further, unregulated drug poisoning continues to be one of the leading causes of death and is the second leading cause of overall potential years of life lost in Island Health (with only malignant cancers causing more lost years of life). Unregulated drug poisoning deaths rank fifth in proportion of all deaths; however, since the average age of death is 43 years, the youngest of any of the top 15 causes of death, potential years of life lost are disproportionately high.

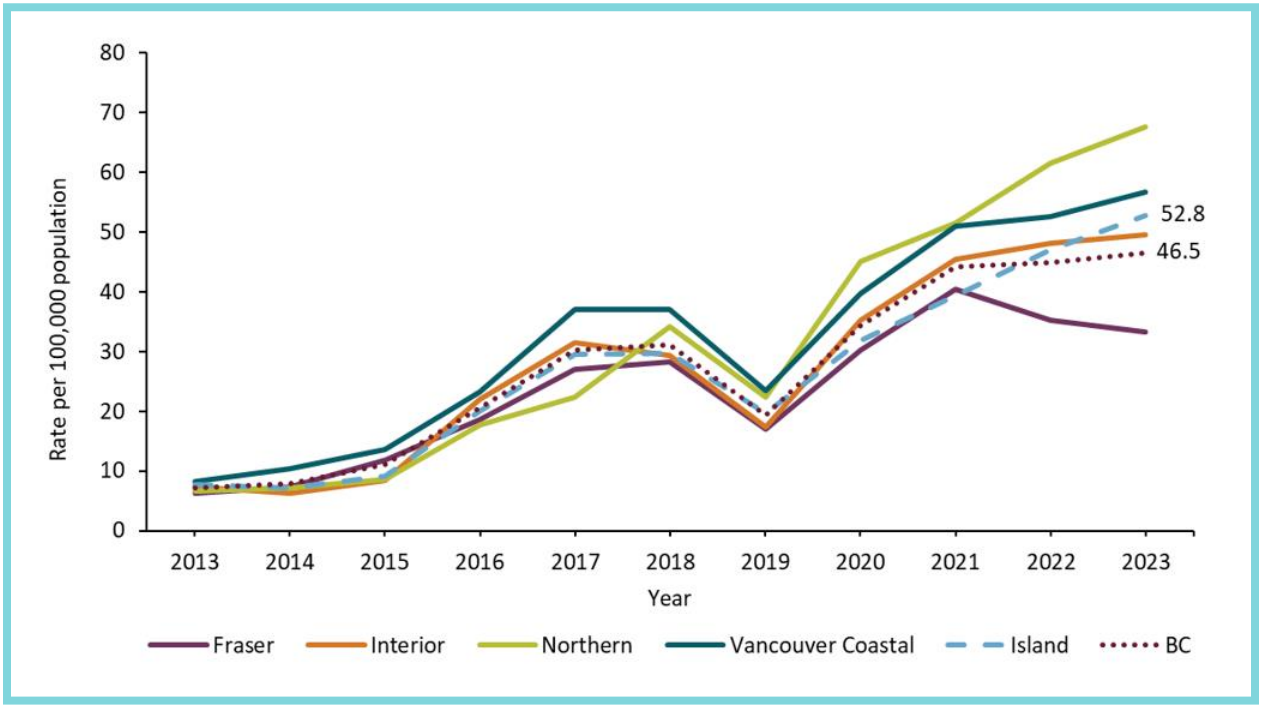
Figure 20. Leading Causes of Death by Age Group [top] and Ranking [bottom], Island Health (2023)



Source: BC Centre for Disease Control, 2024, *BCCDC mortality context application*.[37]

For the past 2 years, Island Health has had a higher rate of unregulated drug poisoning deaths compared to B.C. overall. In 2023, Island Health had the third highest rate of unregulated drug deaths (52.8 per 100,000) across all B.C. regional health authorities and a higher rate than B.C. overall (46.5 per 100,000) (Figure 21).

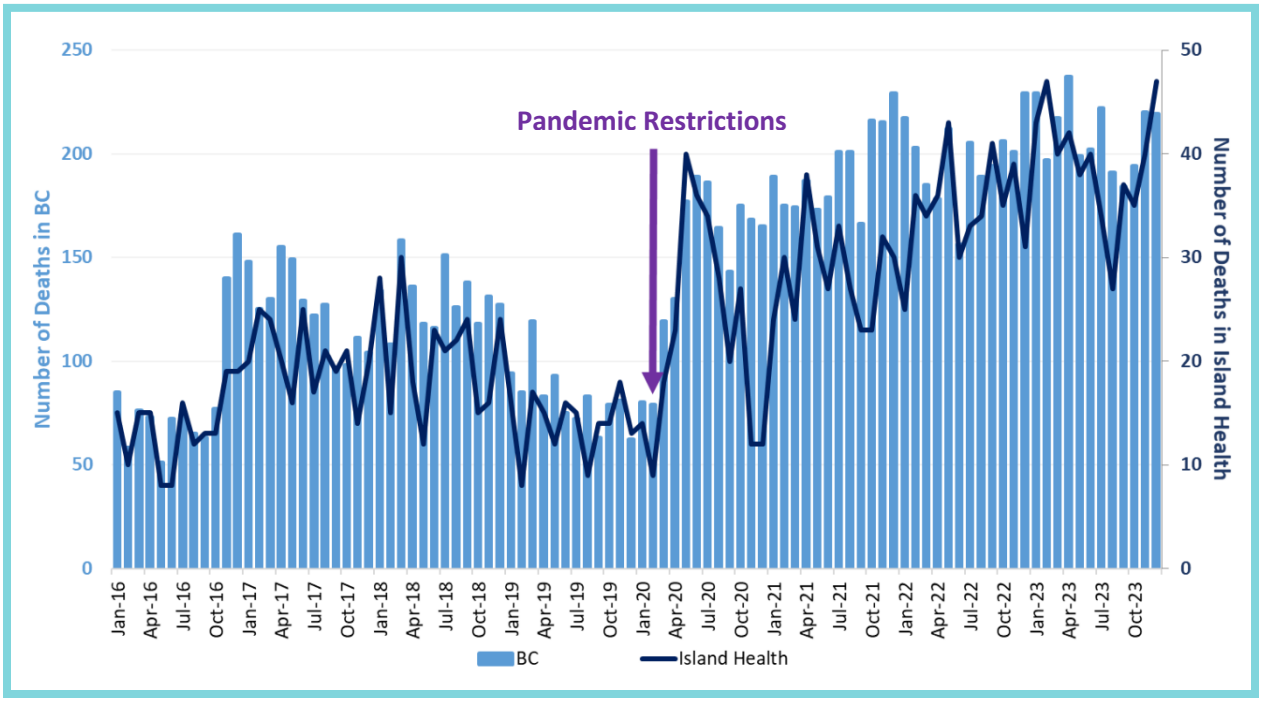
Figure 21. Rate of Unregulated Drug Deaths by Health Authority, B.C. (2013–2023)



Source: BC Coroners Service, 2024, *Unregulated drug deaths in B.C. dashboard*.[38] Accessed August 2024.

Prior to the pandemic, the number of unregulated drug poisoning deaths in B.C. and Island Health was declining. However, after restrictions were introduced in response to COVID-19 in February 2020, a significant increase in the number of deaths occurred (Figure 22).

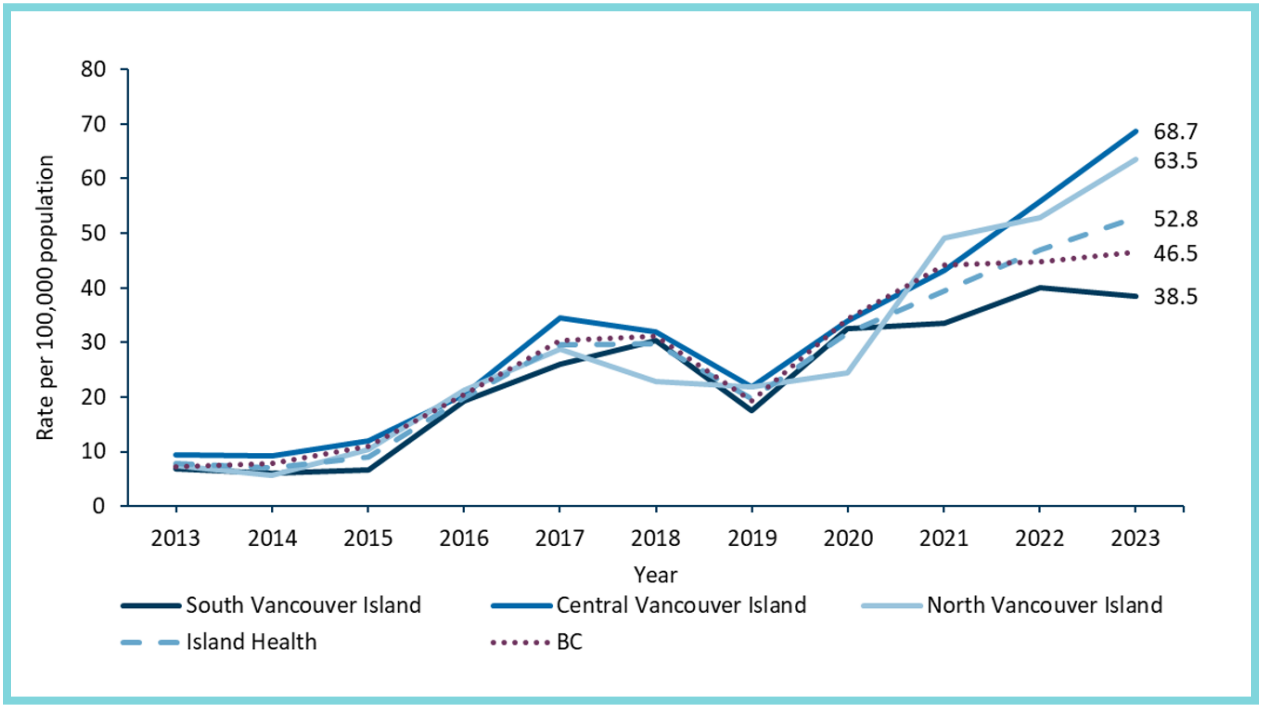
Figure 22. Number of Unregulated Drug Deaths, B.C. and Island Health (2016–2023)



Source: Data from BC Coroners Service, 2024, *Unregulated drug deaths in B.C. dashboard*,[38] and analysis conducted by Island Health PHASE team.

In 2023, unregulated drug deaths were highest in Central and North Island, with rates of 68.7 and 63.5 per 100,000, respectively (Figure 23). In South Island, the rate of unregulated drug deaths has declined in the past year and continues to be lower than both Island Health and B.C. overall.

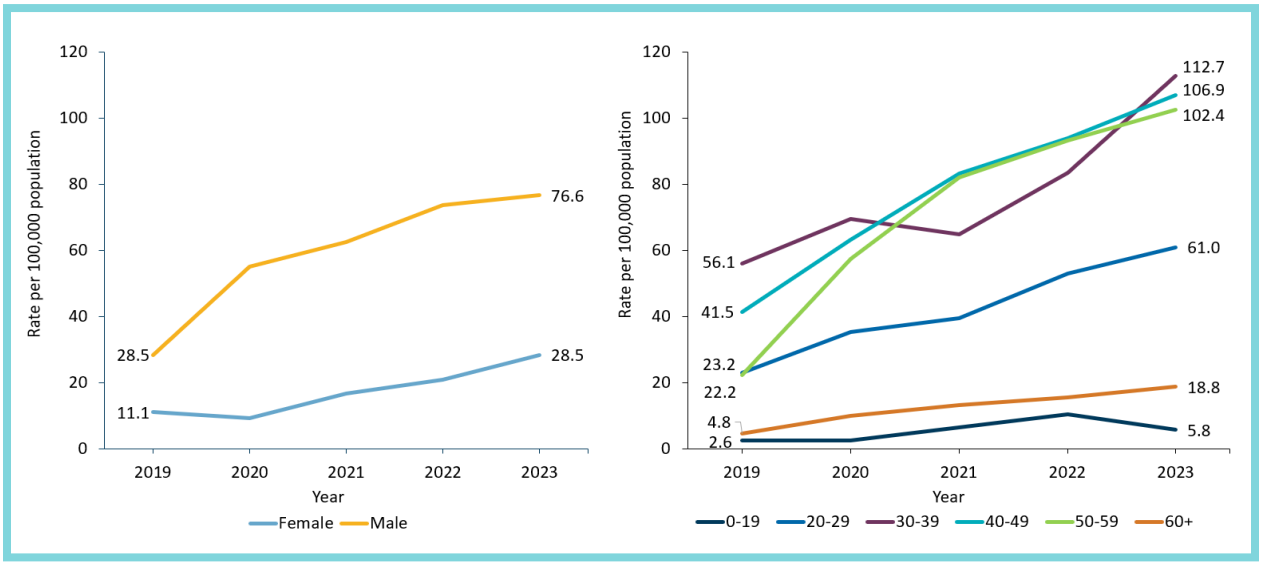
Figure 23. Rate of Unregulated Drug Deaths by Health Service Delivery Area, Island Health and B.C. (2013–2023)



Source: BC Coroners Service, 2024, *Unregulated drug deaths in B.C. dashboard*.[38] Accessed August 2024.

Men continue to be disproportionately affected by unregulated drug deaths, with a rate of 76.6 per 100,000 in 2023 and an overall increase of 2.7 times since 2019 (Figure 24). There has also been a substantial increase in the rate of deaths among women, which has nearly tripled since 2019. In 2023, deaths were highest among the 30–39 age group; this is the first year since 2020 that the rate of deaths in this age group surpassed that of the 40–49 and 50–59 age groups (Figure 24).

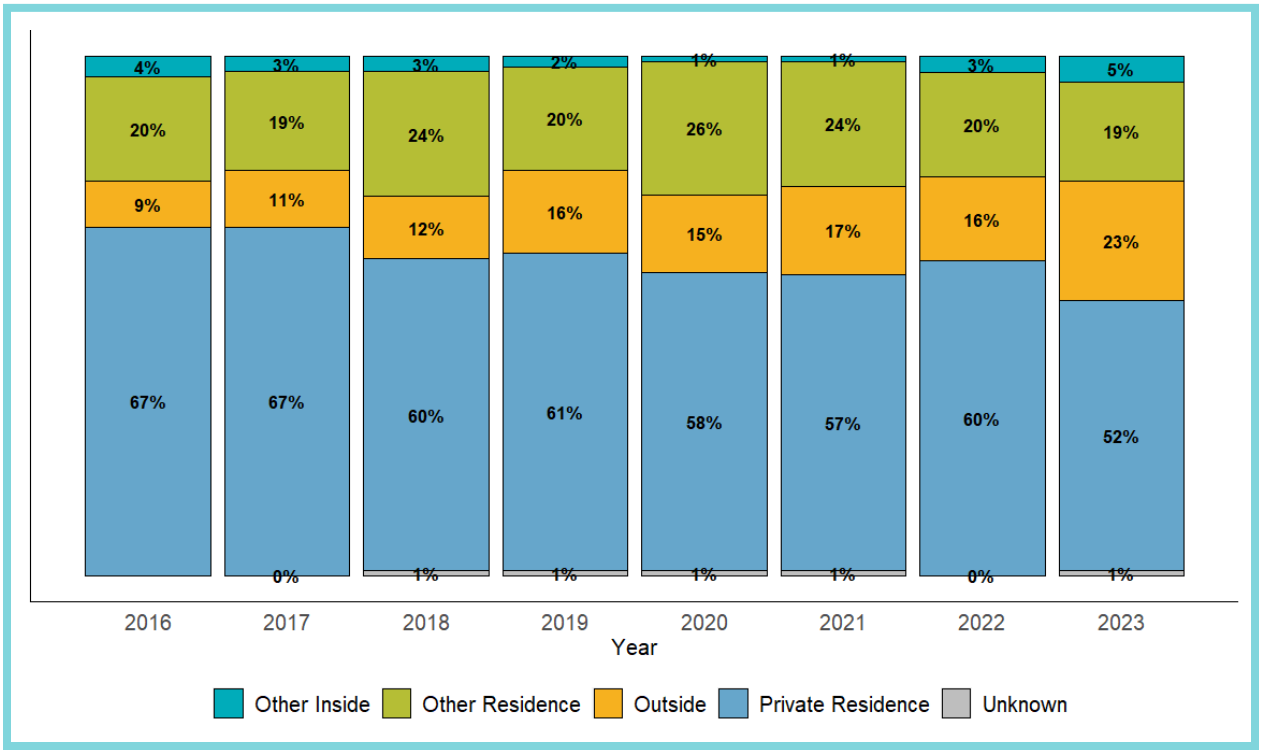
Figure 24. Rate of Unregulated Drug Deaths by Sex [left] and Age Group [right], Island Health (2019–2023)



Source: Data provided by BC Coroners Service via BC Centre for Disease Control, and compiled by Island Health PHASE team. Accessed August 2024.

Since 2016, the proportion of unregulated drug deaths occurring outside has increased from 9% to 23% in 2023, while the proportion occurring in private residences has decreased from 67% in 2016 to 52% in 2023 (Figure 25).

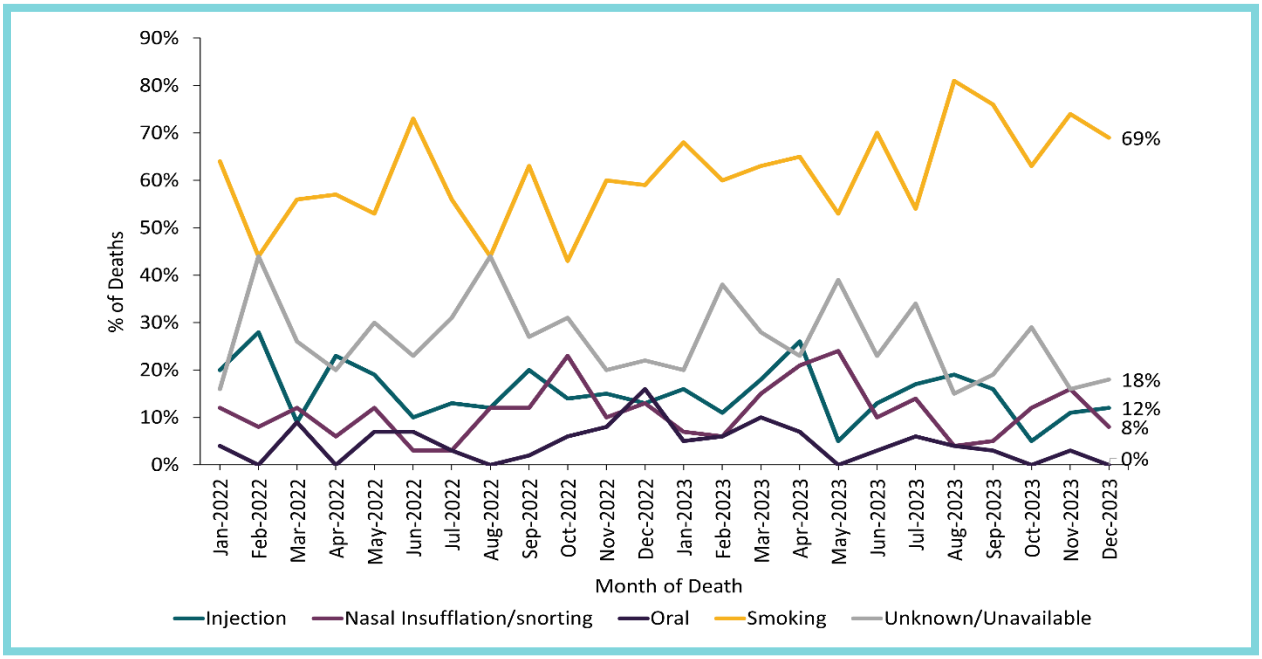
Figure 25. Proportion of Unregulated Drug Deaths by Place of Injury, Island Health (2016–2023)



Note: 'Other Inside' includes public buildings, medical facilities, retail buildings. 'Other Residence' includes hotels, supportive housing, rooming houses, shelters.
Source: Data provided by BC Coroners Service via BC Centre for Disease Control, and compiled by Island Health PHASE team.

In preliminary data provided by the BC Coroners Service, smoking has consistently been the most common mode of consumption among unregulated drug deaths in 2022 and 2023 (Figure 26).

Figure 26. Mode of Consumption Among Unregulated Drug Deaths, Island Health (January 2022–December 2023)



Note: Percentages can add up to more than 100% as individuals could have had multiple modes of consumption. Data is based on information gathered by the coroner which may include scene investigation, witness interviews, or a review of circumstances. Data is preliminary and subject to change.
Source: BC Coroners Service, 2024, *Unregulated drug deaths in B.C. dashboard*.[38] Accessed February 2024.

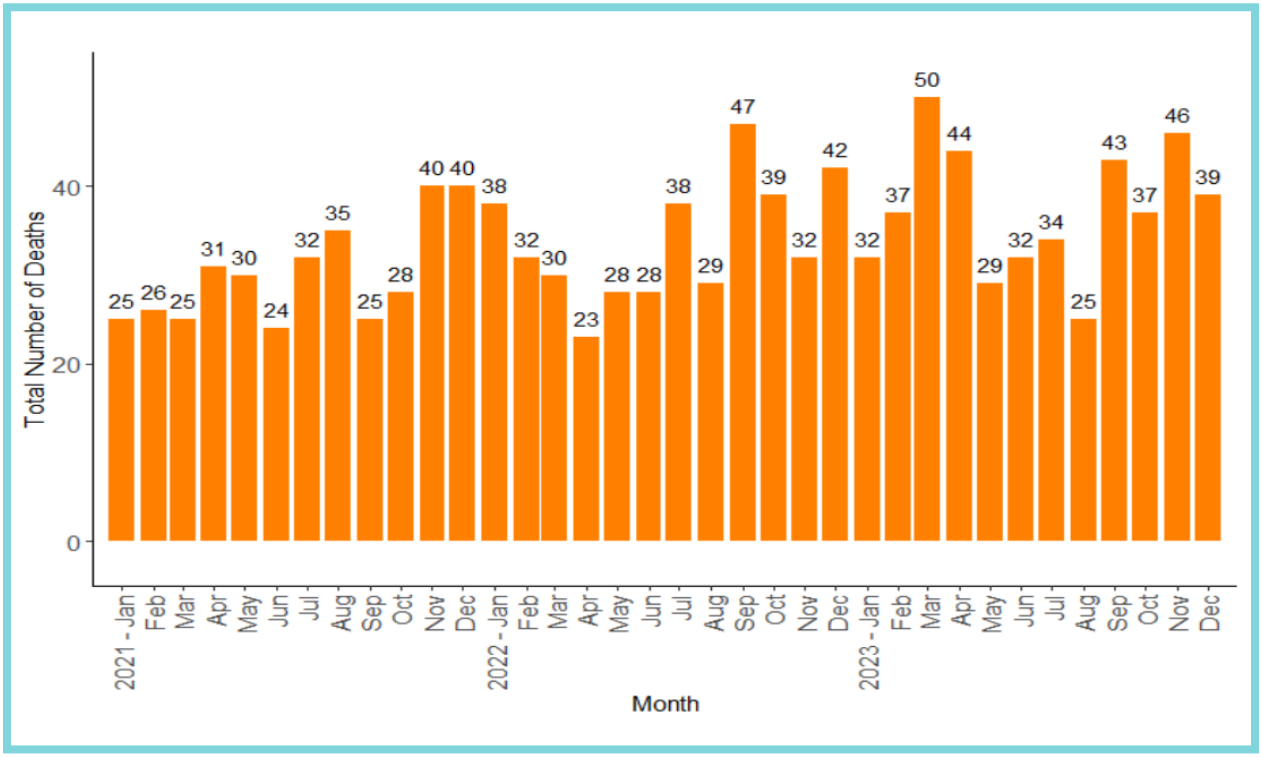
Burden on First Nations Communities

First Nations people in B.C. bear a disproportionate burden of the harms caused by the unregulated drug supply affecting their families and communities across all regions of the province. This reality serves as a reminder of the enduring legacies of colonialism and systematic racism that persist in our society to this day.

From January 1, 2021 to December 31, 2023, First Nations people represented 16.9% of deaths due to toxic drug poisoning in B.C. and 17.9% in Vancouver Island, while representing 3.4% and 4.5% of the population, respectively (data not shown).[39]

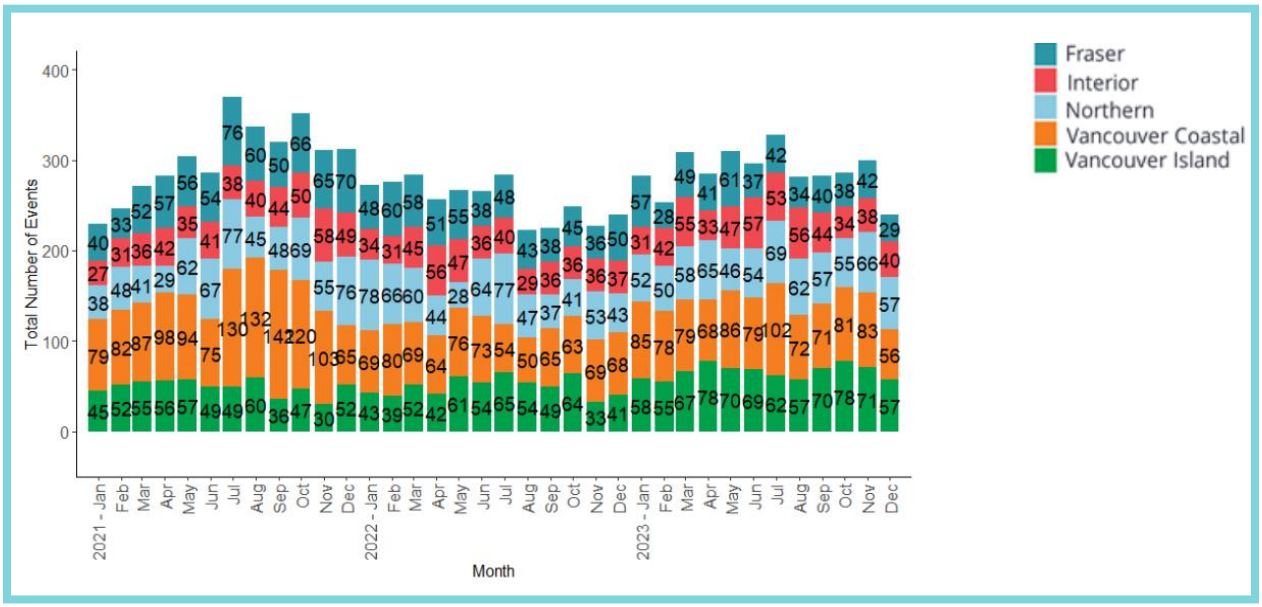
Similar to overall population trends, the number of unregulated drug deaths among First Nations people in B.C. has increased since 2021 (Figure 27). In contrast, the number of paramedic-attended drug poisoning events among First Nations people between 2021 and 2023 has decreased overall provincially but remained relatively stable within Island Health (Figure 28).

Figure 27. Number of Unregulated Drug Deaths Among First Nations People, B.C. (January 2021–December 2023)



Source: First Nations Health Authority, 2023, *Toxic drug crisis events and deaths and FNHA's response: Community situation report: December 2023*.[39]

Figure 28. Number of Paramedic-Attended Drug Poisoning Events Among First Nations People by Health Authority, B.C. (January 2021–December 2023)

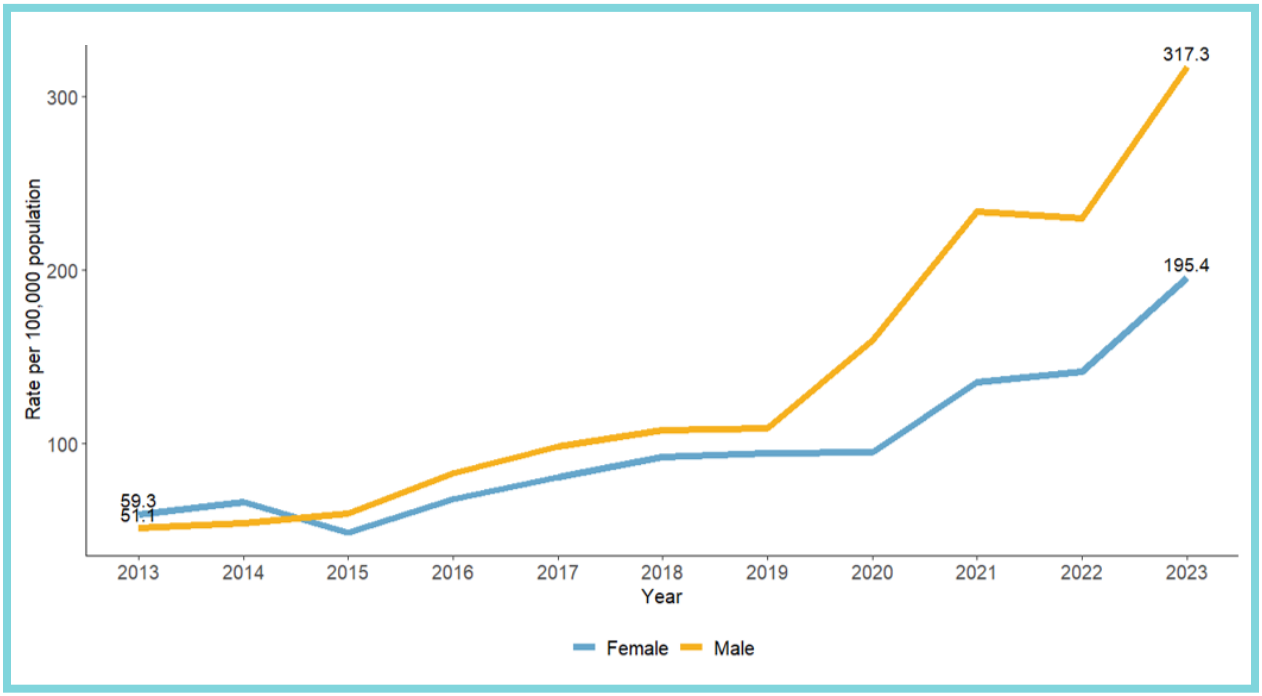


Source: First Nations Health Authority, 2023, *Toxic drug crisis events and deaths and FNHA's response: Community situation report: December 2023*.[39]

Opioid-Related Hospital Admissions

Opioid-related hospital admissions have continued to increase across Island Health (Figure 29). Between 2015 and 2019, the rate of opioid-related hospital admissions was similar for males and females. However, in 2020, the rate of hospital admissions for males increased by 40%, while the rate for female hospital admissions remained relatively stable. Since 2020, the rate of opioid-related hospital admissions for males has remained approximately 1.5 times higher than for females.

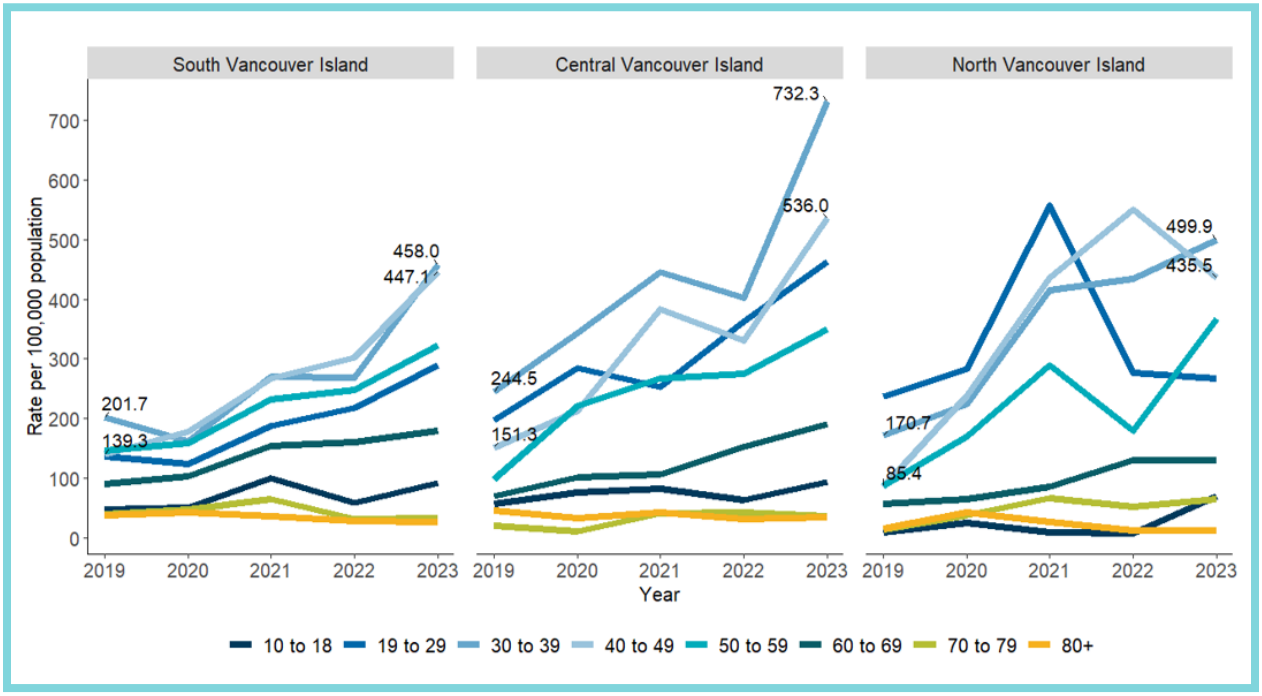
Figure 29. Rate of Opioid-Related Hospital Admissions by Sex, Island Health (2013–2023)



Source: Data from Island Health Enterprise Data Warehouse, Discharge Abstract Database, and compiled by Island Health PHASE team.

From 2022 to 2023, the most notable increases for opioid-related hospital admissions have been among those 30–39 and 40–49 years of age, and in particular in Central Island where the rate of hospital admissions nearly doubled for each of these age groups (Figure 30).

Figure 30. Rate of Opioid-Related Hospital Admissions by Age Group and Health Service Delivery Area, Island Health (2019–2023)

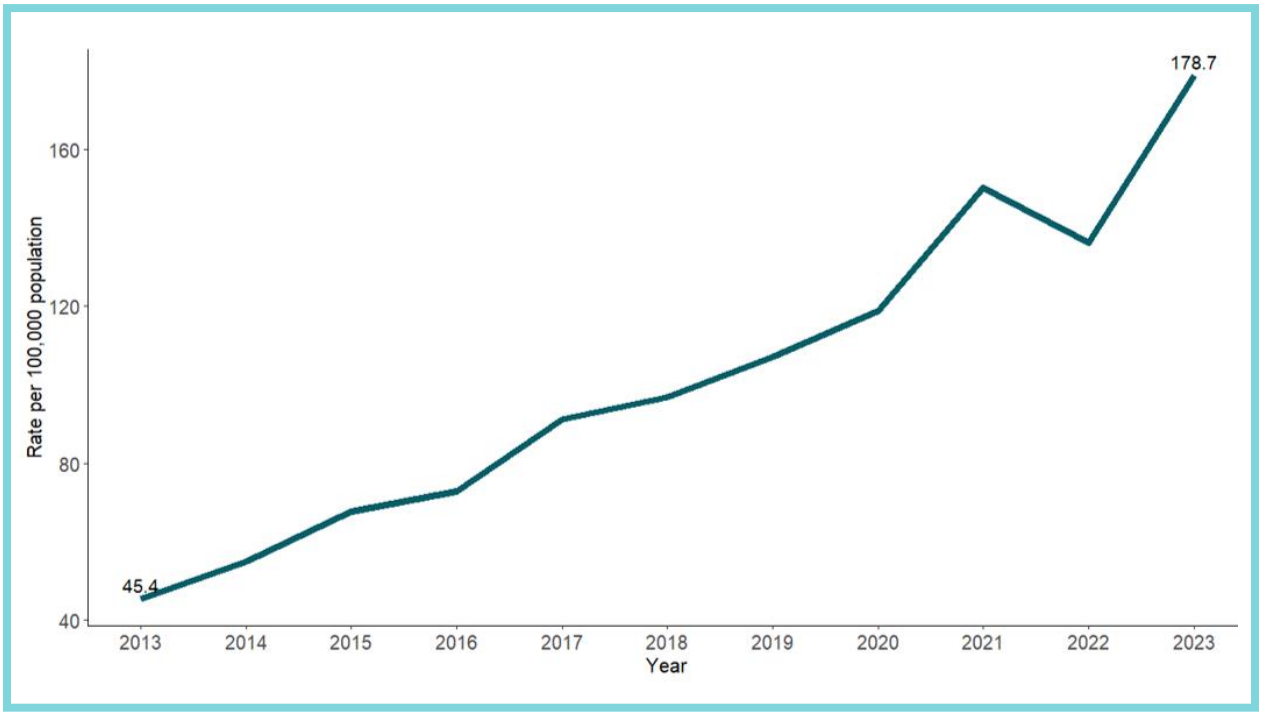


Source: Data from Island Health Enterprise Data Warehouse, Discharge Abstract Database, and compiled by Island Health PHASE team.

Stimulant-Related Hospital Admissions

Stimulant drugs include crystal methamphetamine and cocaine. In the past 10 years, the rate of stimulant-related hospital admissions has increased significantly. Although the rate decreased in 2022, the rate increased again in 2023 and was 4 times higher than the rate in 2013 (178.7 per 100,000 vs. 45.4 per 100,000) (Figure 31).

Figure 31. Rate of Hospital Admissions Due to Stimulants, Island Health (2013–2023)

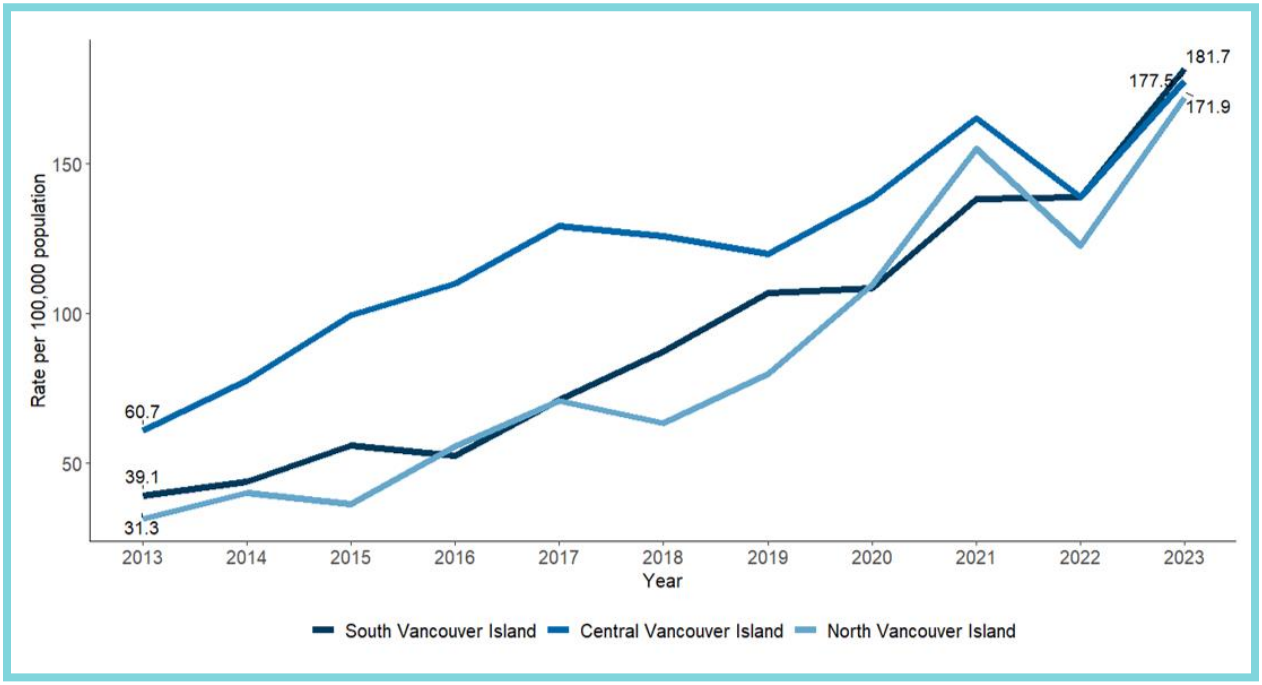


Source: Data from Island Health Enterprise Data Warehouse, Discharge Abstract Database, and compiled by Island Health PHASE team.

"Stimulants are my whole story of substance use. I couldn't get help because I was 'only' a stimulant user." – Aran Wilson, in recovery

In 2023, the rate of stimulant-related hospital admissions was highest for South Island (181.7 per 100,000) followed by Central and North Island (177.5 and 171.9 per 100,000, respectively) (Figure 32). The rate in South and North Island has increased by 5 times since 2013, while the rate for Central Island has increased nearly 3 times.

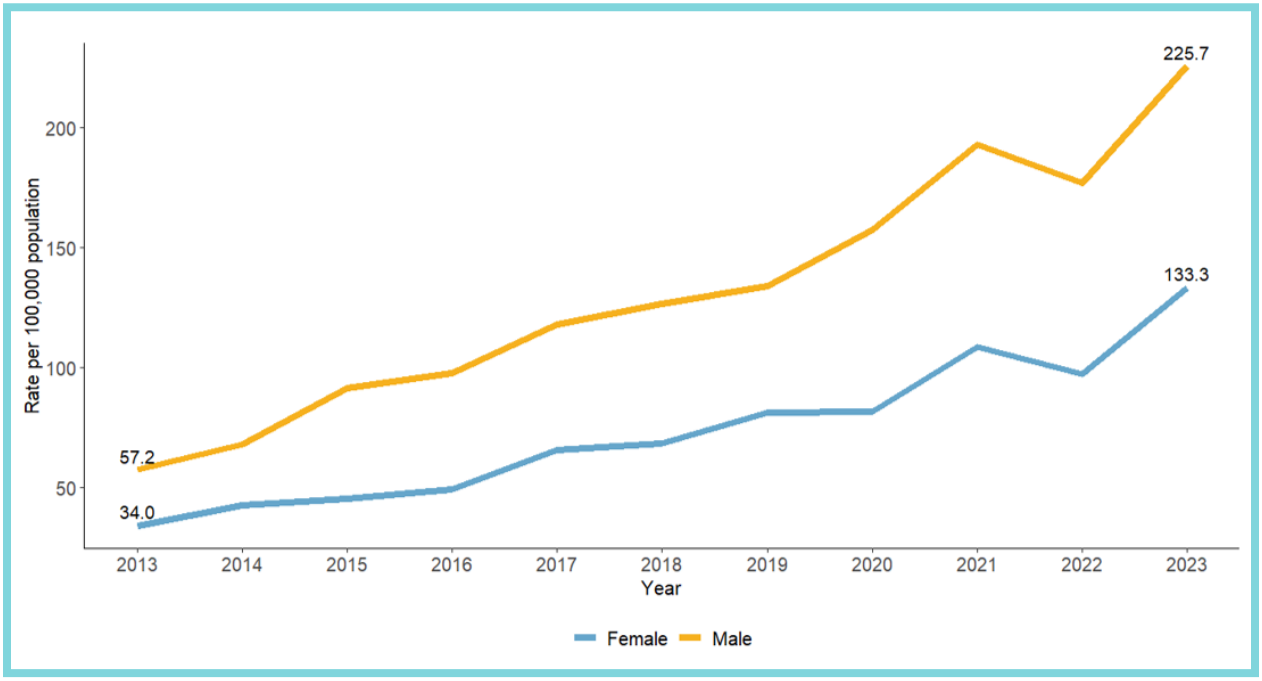
Figure 32. Rate of Hospital Admissions Due to Stimulants by Health Service Delivery Area, Island Health (2013–2023)



Source: Data from Island Health Enterprise Data Warehouse, Discharge Abstract Database, and compiled by Island Health PHASE team.

Similar to other substances, the rate of stimulant-related hospital admissions has historically been higher among males than females. In 2023, the rate of hospital admissions among males was 1.7 times higher than females, with a rate of 225.7 per 100,000 and 133.3 per 100,000, respectively (Figure 33).

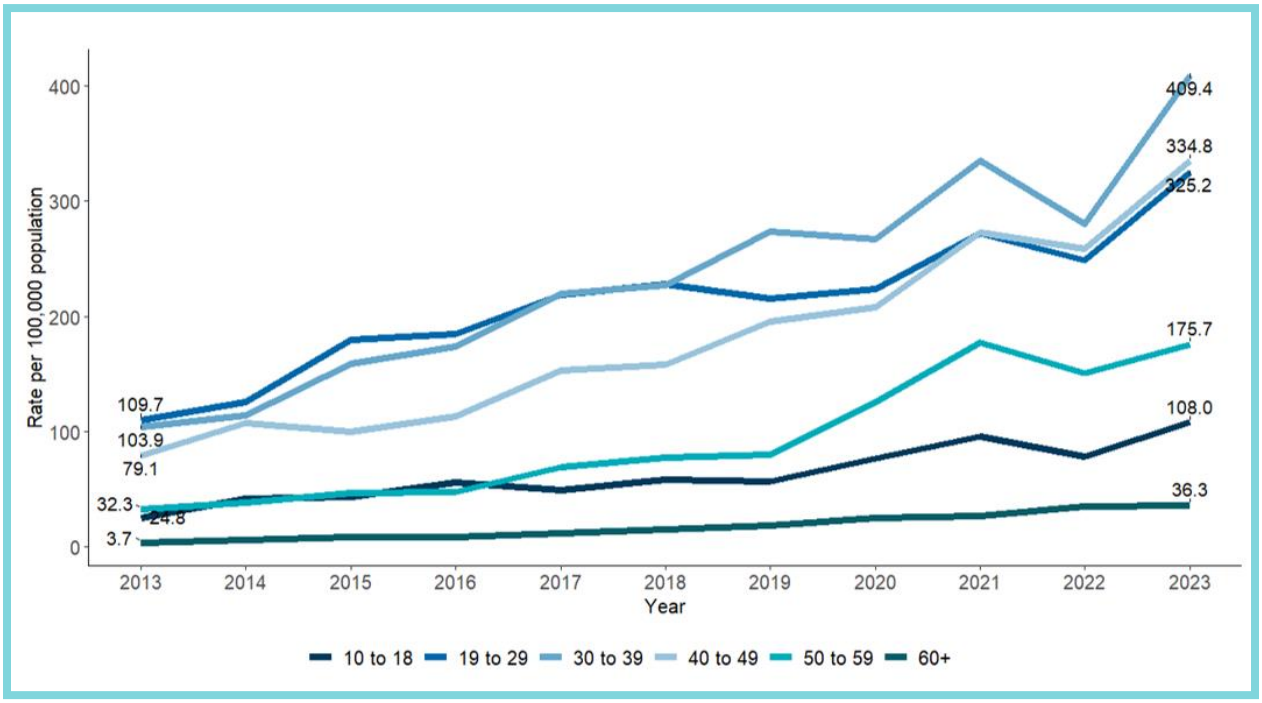
Figure 33. Rate of Hospital Admissions Due to Stimulants by Sex, Island Health (2013–2023)



Source: Data from Island Health Enterprise Data Warehouse, Discharge Abstract Database, and compiled by Island Health PHASE team.

The rate of stimulant-related hospital admissions has increased across all age groups over the past 10 years. In 2023, the rate of stimulant-related hospital admissions was highest among those aged 30–39 years (409.4 per 100,000), followed by those 40-49 (334.8 per 100,000) and 19-29 (325.2 per 100,000) (Figure 34). Although it has the lowest rate overall, the largest relative increase since 2013 was seen in the 60+ age group (9.8 times), followed by the 50–59 age group (5.4 times).

Figure 34. Rate of Hospital Admissions Due to Stimulants by Age Group, Island Health (2013–2023)

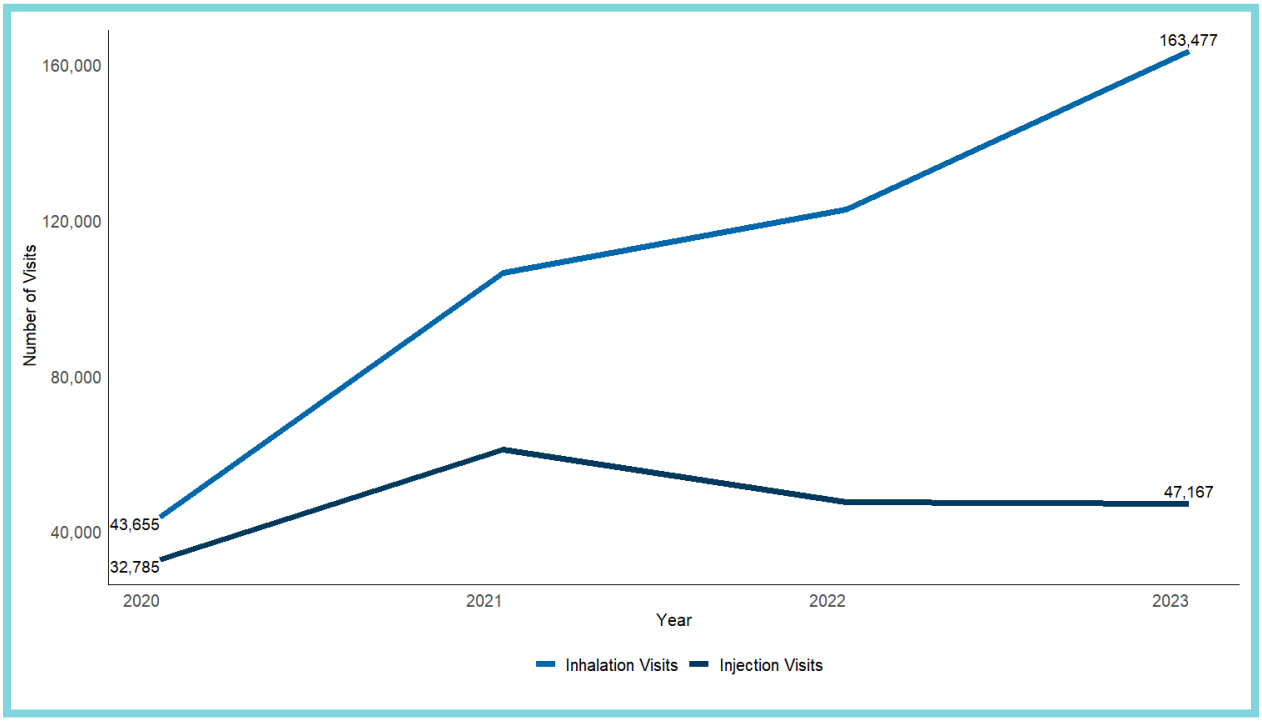


Source: Data from Island Health Enterprise Data Warehouse, Discharge Abstract Database, and compiled by Island Health PHASE team.

Service Utilization Trends

Overdose prevention services (OPS) refer to witnessed consumption of substances for the purpose of preventing or responding to an overdose. OPS are either offered at established sites or practised as part of other care and services for people who use substances.[40,41] Since the introduction of inhalation spaces at OPS locations in 2020, the number of inhalation visits has continued to increase. In 2023, inhalation visits accounted for nearly 80% of witnessed consumption at OPS sites, while the number of injections visits has steadily decreased since 2021 (Figure 35).

Figure 35. Number of Injection and Inhalation Visits to Overdose Prevention Services (OPS) Sites, Island Health (2020–2023)



Source: Data collected from OPS sites and compiled by Island Health PHASE team.

In 2023, 591 drug poisonings occurred at OPS sites across the Island Health region. As expected, with the increased number of visits, there has been an increased number of drug poisonings occurring at OPS locations (Figure 36). However, the rate of drug poisonings occurring at OPS sites has increased at a slower rate compared to the number of poisonings overall. Further, as of December 31, 2023, no drug poisonings at OPS locations within Island Health have been fatal.

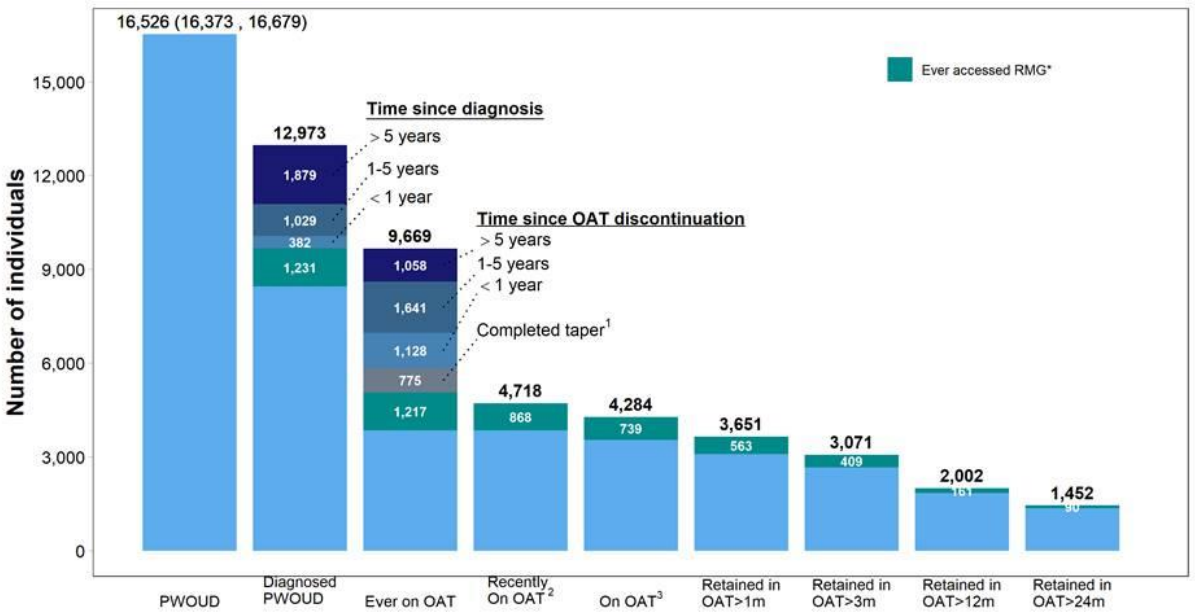
Figure 36. Number [top] and Rate (per 100,000 OPS Visits) [bottom] of Drug Poisonings at Overdose Prevention Services (OPS) Sites, Island Health (2017–2023)

Source: Data collected from OPS sites and compiled by Island Health PHASE team.

Cascade of Care

Opioid agonist therapy (OAT) is an evidence-based treatment for opioid addiction that reduces health harms and prevents overdose death.[42] Figure 37 shows the cascade of care developed by Dr. Bohdan Nosyk for Island Health that provides an estimate for the number of people with opioid use disorder (PWOUD) and measures patient retention for opioid agonist therapy (OAT). As of August 31, 2021, there was an estimated 16,526 PWOUD in Island Health, of whom 80% were diagnosed. Of those diagnosed, 74.5% were on OAT at least once, and approximately half (48.8%) were on it recently (within the past month). Overall, less than 10% of PWOUD are retained on OAT for over 24 months.

Figure 37. The Cascade of Care in Island Health (Updated to August 31, 2021)



Percentage	2.1	78.5	74.5	48.8	44.3	85.2	84.1	65.2	72.5
Numerator	16,526	12,973	9,669	4,718	4,284	3,651	3,071	2,002	1,452
Denominator	779,849	16,526	12,973	9,669	9,669	4,284	3,651	3,071	2,002

Note: OAT = opioid agonist therapy, PWOUD = people with opioid use disorder, RMG = risk mitigation guidance.
Source: Updated, and stratified for Island Health, from Piske et al., 2020, "The cascade of care for opioid use disorder: A retrospective study in British Columbia, Canada" in *Addiction*, *115*(8).40.[43]

Drug Checking

Drug checking is a harm reduction intervention aimed at providing relevant and timely information about the composition of an unregulated substance. Access to this information enables more informed decision-making as individuals using the service may choose to adjust their use based on the information they receive (e.g., whether to use, how much to use). Drug checking aims to provide the safety information that we expect from other regulated consumable products, such as food, drinks, and legal psychoactive substances.

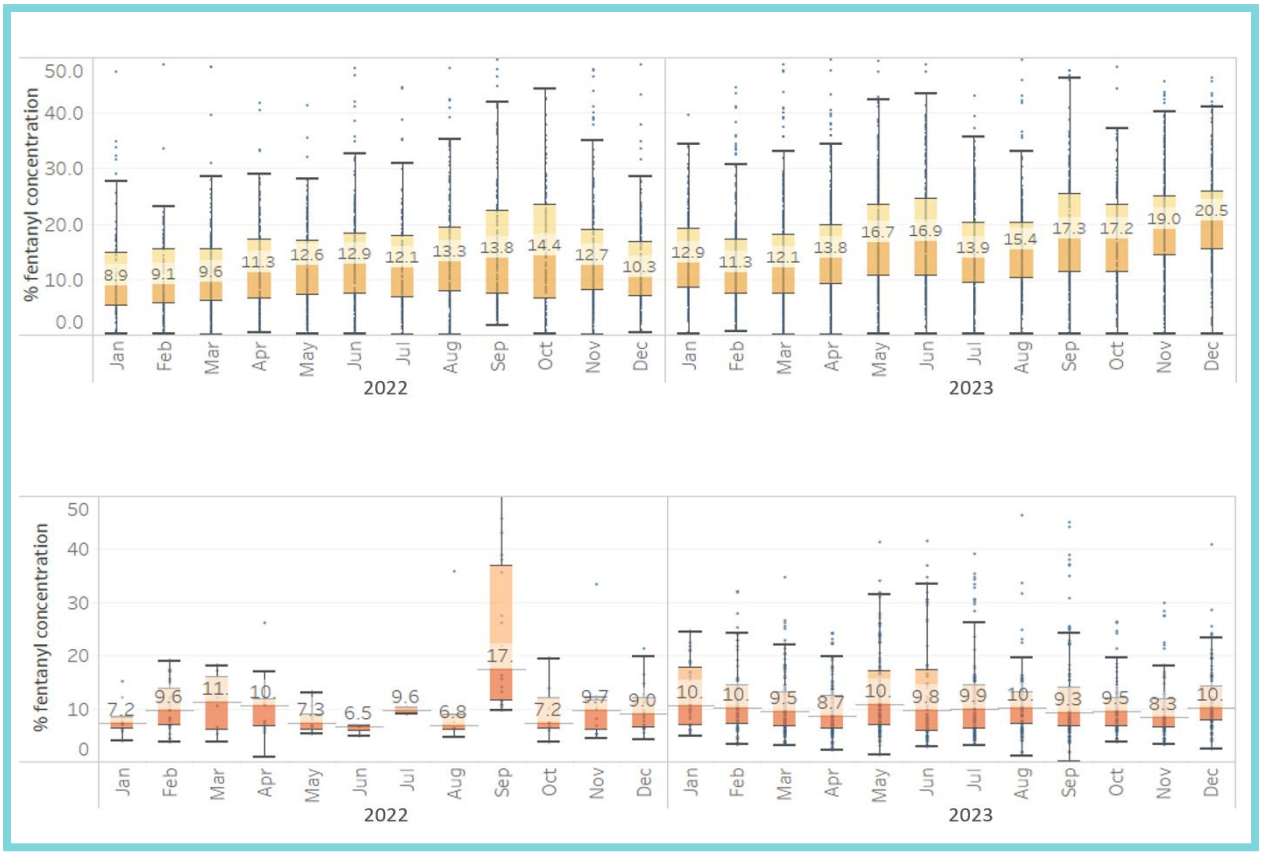
Drug checking was introduced in Island Health in 2019. Results from drug checking have varied geographically between samples tested in South Island (Victoria) and Central Island (Nanaimo). In Victoria, approximately half of expected opioid samples in 2023 tested positive for benzodiazepines and/or etizolam (range: 34%–57%) (Figure 38). Nanaimo saw significantly more samples testing positive for benzodiazepines and/or etizolam in 2023, with approximately 90% of samples testing positive (range: 84%–94%).

Figure 38. Percentage of Expected Opioid/Down Samples Positive for Benzodiazepines and/or Etizolam in Drug Checking Results From Victoria [top] and Nanaimo [bottom] (2022–2023)

Source: Data provided by Substance Drug Checking, University of Victoria [top], and BC Centre on Substance Use [bottom], and compiled by Island Health PHASE team.

Further, the median fentanyl concentration in samples tested in Victoria has been consistently higher than the fentanyl concentration of drugs tested in Nanaimo. Between January and September 2023, the median fentanyl concentration of drug samples tested in Victoria ranged from 11.3%–20.5%, compared to a range of 8.3%–10.7% in Nanaimo (Figure 39).

Figure 39. Median and Interquartile Ranges of Fentanyl Concentrations in Samples Where Fentanyl Was Detected in Victoria [top] and Nanaimo [bottom] (2022–2023)



Source: Data provided by Substance Drug Checking, University of Victoria [top], and BC Centre on Substance Use [bottom], and compiled by Island Health PHASE team.

Summary of Key Findings

Health data for two classes of unregulated substances, opioids and stimulants, are presented. Since these substances are illegal, regulatory tools such as monitoring consumption and controlling production and distribution are not available. In this context, and with the availability of synthetic opioids, the unregulated drug supply has become highly and increasingly toxic. While using more than one substance is the norm, the majority of deaths are caused by opioids. The presence of benzodiazepines and/or etizolam, along with the high variability in the concentrations of fentanyl, increases the risk of serious or fatal drug poisoning.

Unregulated drug deaths in Island Health:

- Leading cause of death for 19–39 and 40–49 age groups; second leading cause of death for those under 19
- Second leading cause of overall potential years life lost in the population; second only to cancer
- Third highest death rate in B.C. and higher than the provincial rate
- Significant increase in 2020 after the introduction of restrictions to respond to the COVID-19 pandemic
- Highest rates in Central and North Island—1.5 times higher than South Island
- Death rate much higher among men than women
- Majority of deaths among those 30–59 years with a notable increase in the 40–49 and 50–59 age groups since 2019
- First Nations people in B.C. are disproportionately affected
- Over half of deaths occur in private residences
- Smoking is the most common mode of consumption

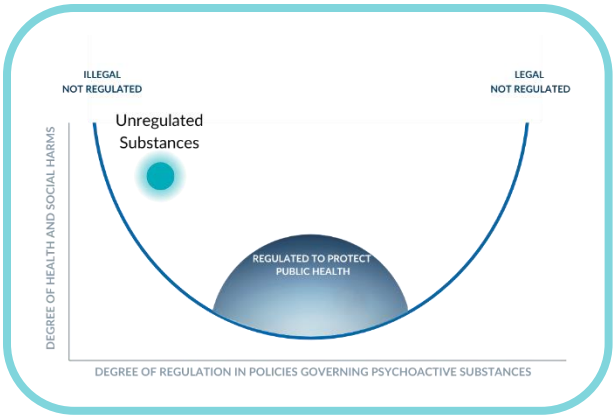
Hospital admissions:

- Both opioid- and stimulant-related hospital admissions quadrupled over the past decade
- More hospital admissions among men
- Rates highest among those 30–39 and 40–49 years in Central Island

Service utilization:

- About 80% of OPS visits are for inhalation
- Many drug poisonings at OPS—none resulting in death due to rapid response to observed overdoses
- Geographical differences in drug checking results
- Less than 10% of people with opioid use disorder are retained on opioid agonist therapy for more than 24 months

Policy Landscape



Illegal substances are on the extreme left of the policy continuum. Since these substances are illegal, there are no regulations in place for their manufacturing and distribution. Opioids in the unregulated market have become increasingly potent and contaminated over the past decade.[44] It is documented that "efforts to interrupt and suppress the illicit drug supply produce economic and logistical pressures favouring ever-more compact substitutes."[45(p. 156)] In addition, in the context of prohibition, interventions to support people who use substances are difficult to initiate, maintain, and evaluate, and access to these services is very limited.

The dominant media and public narratives focus on the illegal nature of these substances with the assumption that they are inherently worse (i.e., more harmful, needing moral and social sanction) than legal psychoactive substances.[46,47] People who use these substances experience widespread stigma,[48] and there has been extensive public opposition to interventions that can reduce harm associated with use.[49,50]

This public and media discourse illustrates how policy approaches shape public perception and dominant narratives. Since criminalization of these substances has been in place for the entire lifetime of people in B.C., it has played a role in shaping societal views of these substances. Shifting these perceptions will require ongoing gathering and translation of evidence, and engagement and conversation about public perceptions.

Within the past few years, several policy changes were introduced in B.C. to reduce harms caused by illegal substances. Two examples are prescribed alternatives and decriminalization of possession of small amounts of certain illegal substances (see Table 2).

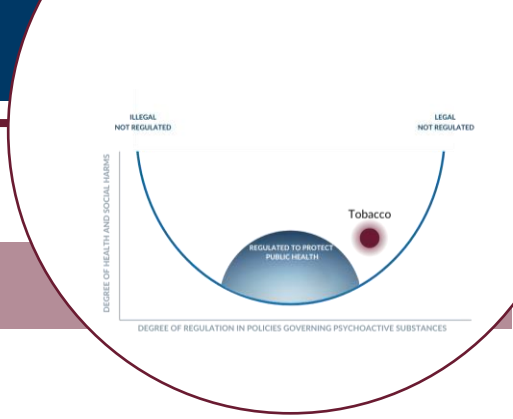
Table 2. Recent Drug Policy Changes in B.C.

Prescribed Alternatives	Decriminalization
To address the high number of drug poisoning deaths from the increasingly toxic illegal drug supply, a small number of programs have been introduced that provide, by prescription, pharmaceutical alternatives for people who use substances from the illegal, unregulated market.[51] At this time, these pharmaceutical alternatives are available only through a few targeted programs or at the discretion of individual health care providers.[52,53] A number of concerns about these programs have been raised. These include the inadequate scale of programs that rely on individual prescriptions, the available medications failing to meet people's needs,[54] and the potential for diversion.[55] Systematic implementation, monitoring, and evaluation of outcomes for individuals and the community are needed to create effective programs in the current unregulated drug poisoning crisis.	Beginning January 31, 2023, the Province of British Columbia was granted a "three-year exemption from the federal government to remove criminal penalties for people who possess small amounts of illicit drugs for personal use."[56] The Province's goal was to reduce stigma associated with drug use that makes people hide their use and avoid accessing services.[57] In 2024, the federal exemption was amended to prohibit possession and use of these substances in public spaces.[58,59] Since using alone is a significant risk factor for death, it is more critical than ever that people who use these substances have accessible, acceptable and dignified spaces to use where they can be observed by someone trained to respond to an overdose.

Prohibition of Psychoactive Substances

Prohibition refers to policy approaches to substance use that forbid possession, distribution, and production of substances, unless authorized. Those who break the laws face criminal penalties.[60] This approach was used for alcohol in the past and is currently in use for heroin, cocaine, methamphetamine, and others. Extensive harms have been demonstrated as a result of this type of policy, including:

- illegal markets and organized crime[60]
- violence[60,61]
- increasingly potent substances[45,60]
- criminalizing groups already marginalized by society[60]
- stereotypes, discrimination, and stigma[9,60,62,63]
- reduced access to supports and services[44]

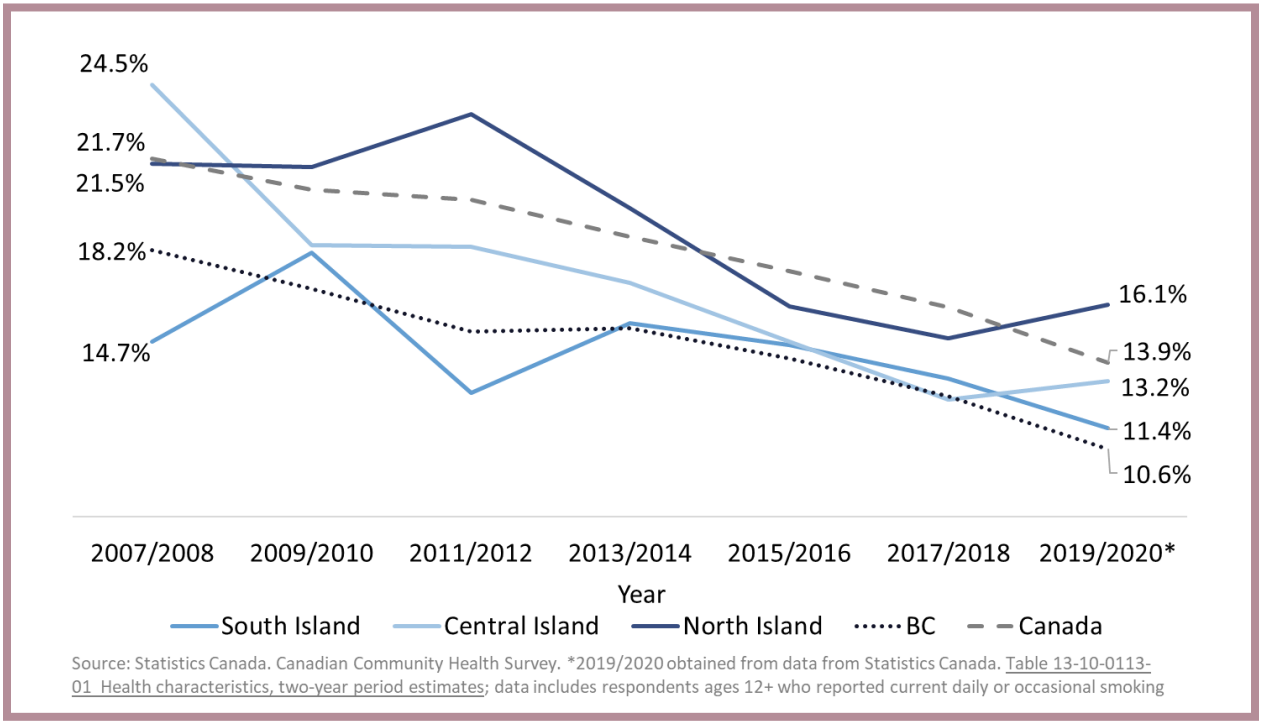


Tobacco

Consumption Trends

Between 2007 and 2020, cigarette smoking declined in Island Health; this is consistent with declining smoking trends Canada-wide. The most notable decrease was in Central Island, where nearly a quarter of residents reported smoking in 2007–08 compared to 13.2% in 2019–20, a 46% decrease (Figure 40). In 2019–20, all HSDAs reported a higher rate of smoking than B.C. overall but, with the exception of North Island, a lower rate of smoking than the rest of Canada. Despite an overall decrease since 2007, North Island and Central Island both saw an increase in the proportion of people who reported smoking cigarettes in 2019–20 compared to 2017–18. In contrast, South Island, B.C., and Canada continued to see decreasing trends. Despite these decreasing trends, it is important to note that smoking rates in Island Health remain above rates in B.C. and well above the target of Canada's Tobacco Strategy, which is 5% by 2035.

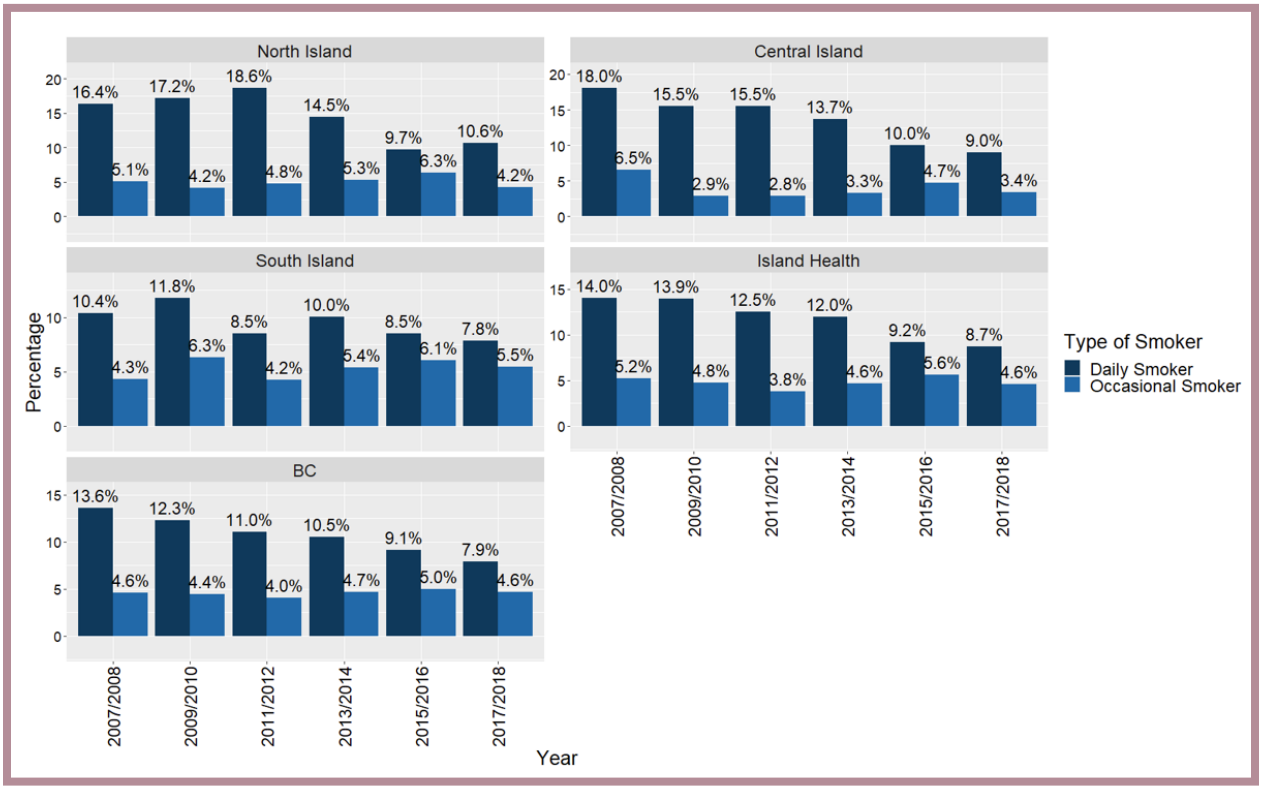
Figure 40. Proportion of Respondents Who Reported Daily or Occasional Smoking of Cigarettes, Island Health, B.C., and Canada (2007–2020)



Source: Data provided by Statistics Canada, Canadian Community Health Survey, and compiled by Island Health PHASE team.

Similar to B.C., decreasing smoking rates in Island Health are largely driven by a decrease in daily smokers across all HSDAs, while the proportion of occasional smokers has remained relatively stable (Figure 41).

Figure 41. Type of Smoker by Health Service Delivery Area, Island Health (2007–2018)

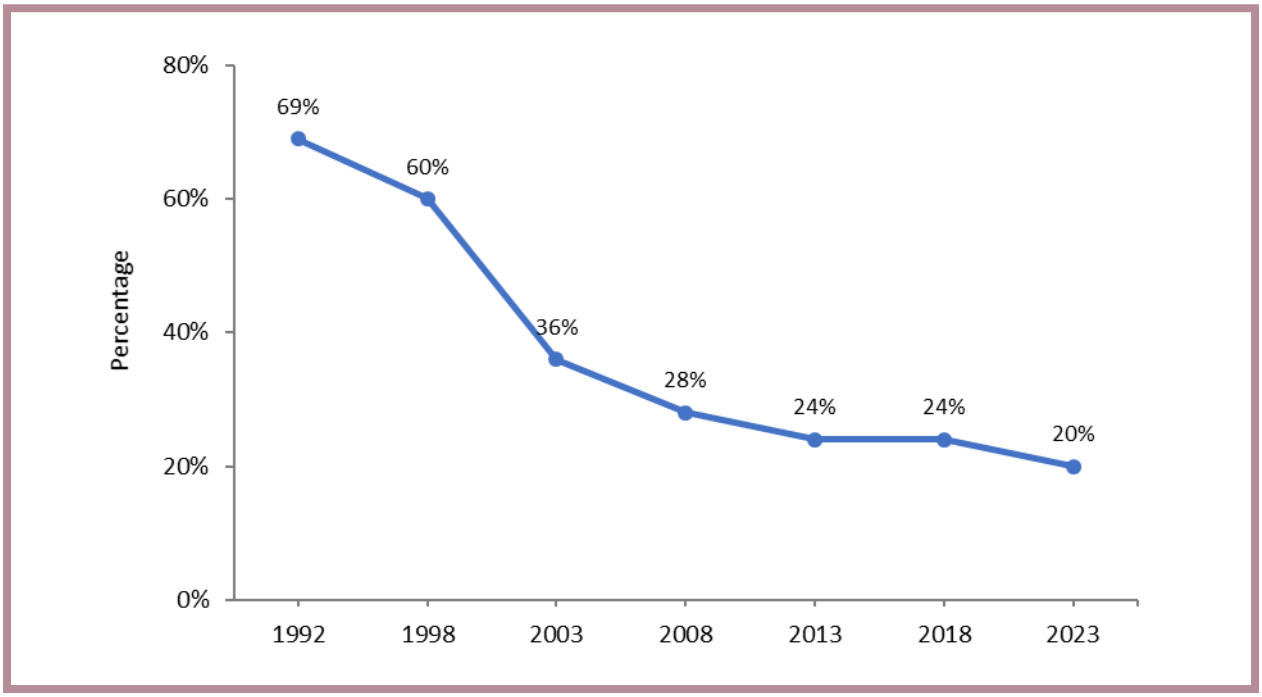


Source: Data provided by Statistics Canada, Canadian Community Health Survey, and compiled by Island Health PHASE team.

Consumption Trends Among Youth

Youth cigarette smoking is declining in Island Health, with 20% of youth reporting ever smoking tobacco in 2023 compared to 24% in 2018 (Figure 42).

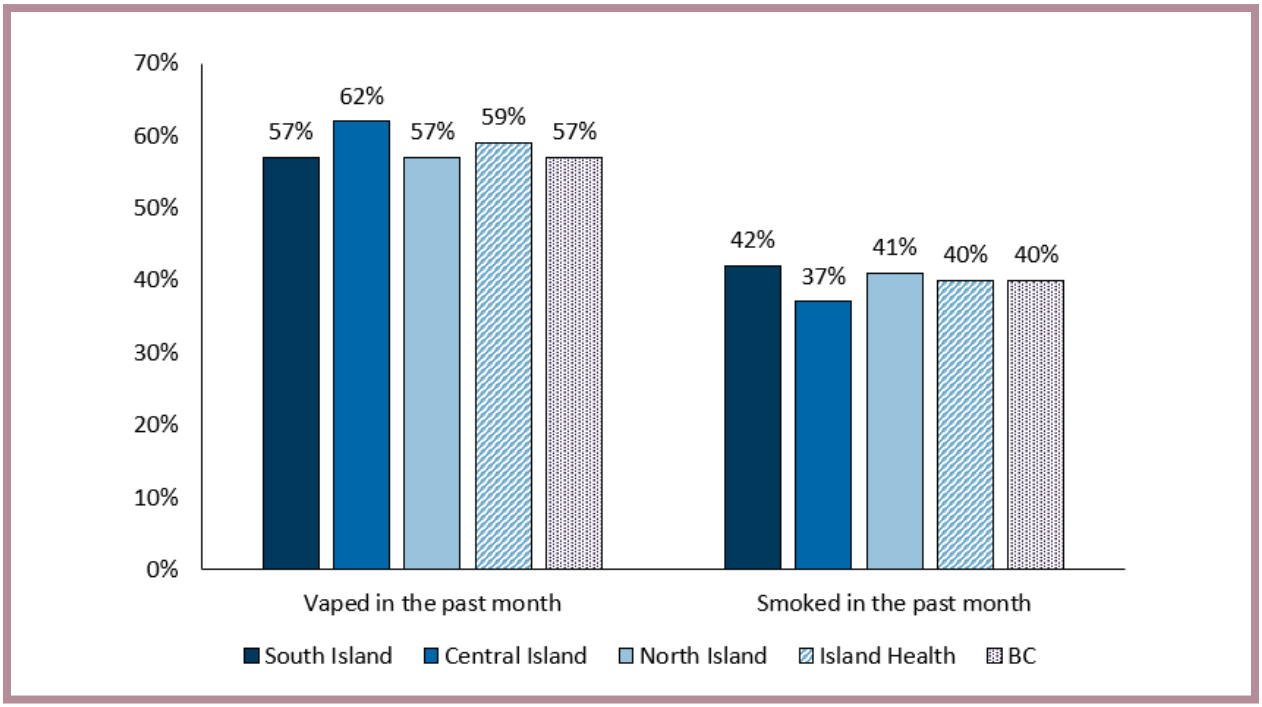
Figure 42. Youth Who Have Ever Smoked Tobacco, Island Health (1992–2023)



Source: Data provided by McCreary Centre Society, BC Adolescent Health Survey, 1992 through 2023.

Vaping is more common among youth than smoking tobacco. In 2023, 30% of youth in Island Health reported ever vaping compared to the 20% who reported having ever smoked tobacco; of those, 59% reported vaping in the past 30 days compared to 42% who reported smoking in the past 30 days (Figure 43). Of those who vaped or smoked, 15% reported vaping daily compared to 3% reporting smoking daily, respectively (data provided by McCreary Centre Society, not shown).

Figure 43. Proportion of Youth Who Report Vaping in the Past Month Compared to Smoking Tobacco, B.C. and Island Health (2023)



Note: Among those who ever vaped/smoked.
Source: Data provided by McCreary Centre Society, BC Adolescent Health Survey.

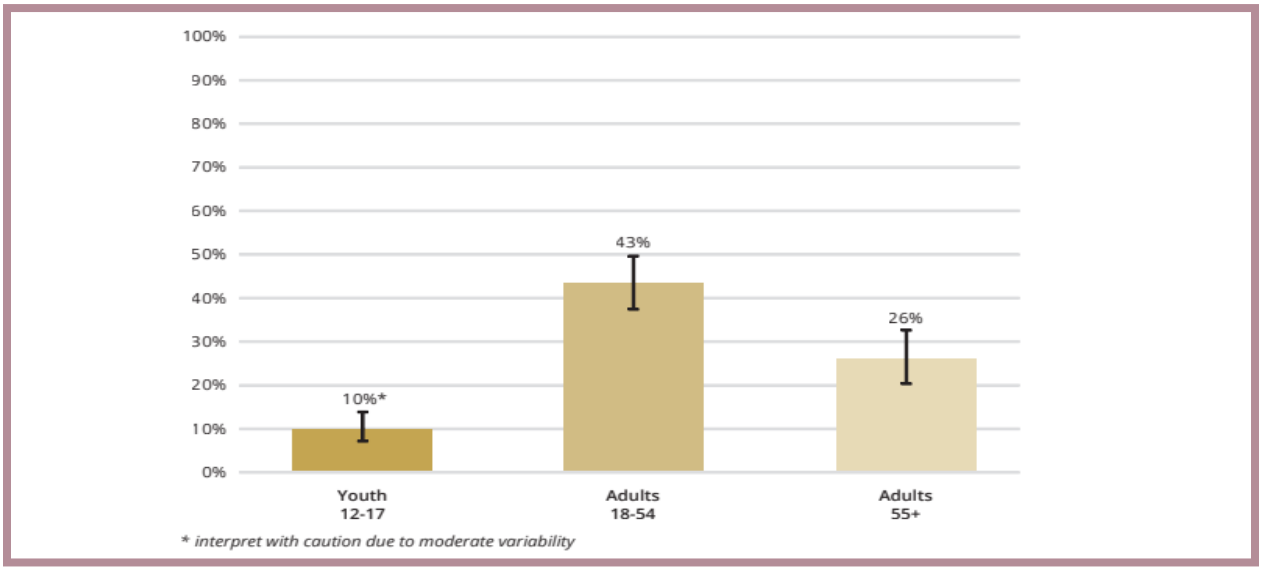
Consumption Trends in First Nations Communities

For millennia, First Nations people have incorporated tobacco into their ceremonies, rituals, and prayers, attributing it with traditional, spiritual, and medicinal significance. While tobacco retains its cultural value, the commercialization of tobacco and subsequent adoption of commercial products like cigarettes, cigars, and pipes can lead to harmful outcomes.

According to the 2015–2017 First Nations Regional Health Survey, 39% of First Nations adults in the Island Health region reported currently smoking cigarettes.[65] In comparison, data from the Canadian Community Health Survey[e] for the same period showed 15% of Island Health residents aged 12 and older reporting smoking daily or on occasion (data not shown).[66]

The percentage of youth respondents from the First Nations Regional Health Survey who reported currently smoking (10%) was much lower than the proportion of adults who reported smoking, with 43% and 26% of those ages 18-54 and 55+ years, respectively, reporting currently smoking (Figure 44).

Figure 44. First Nations People Who Reported Currently Smoking, Vancouver Island Region (2015–2017)



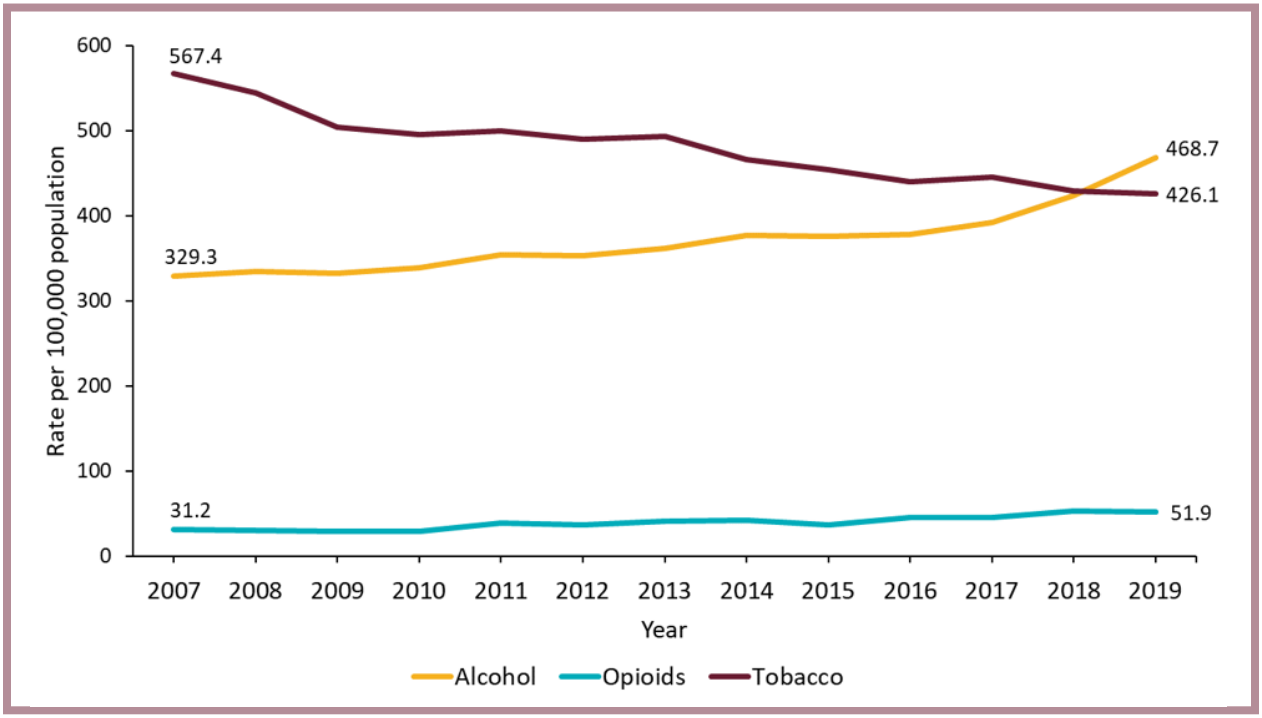
Source: First Nations Health Authority, 2019, *First Nations Regional Health Survey Phase 3 (2015–17): Vancouver Island Region*.[65]

[e] Methodology available at https://www23.statcan.gc.ca/imdb/p2SV.pl?Function=getSurvey&Id=329241

Burden of Illness

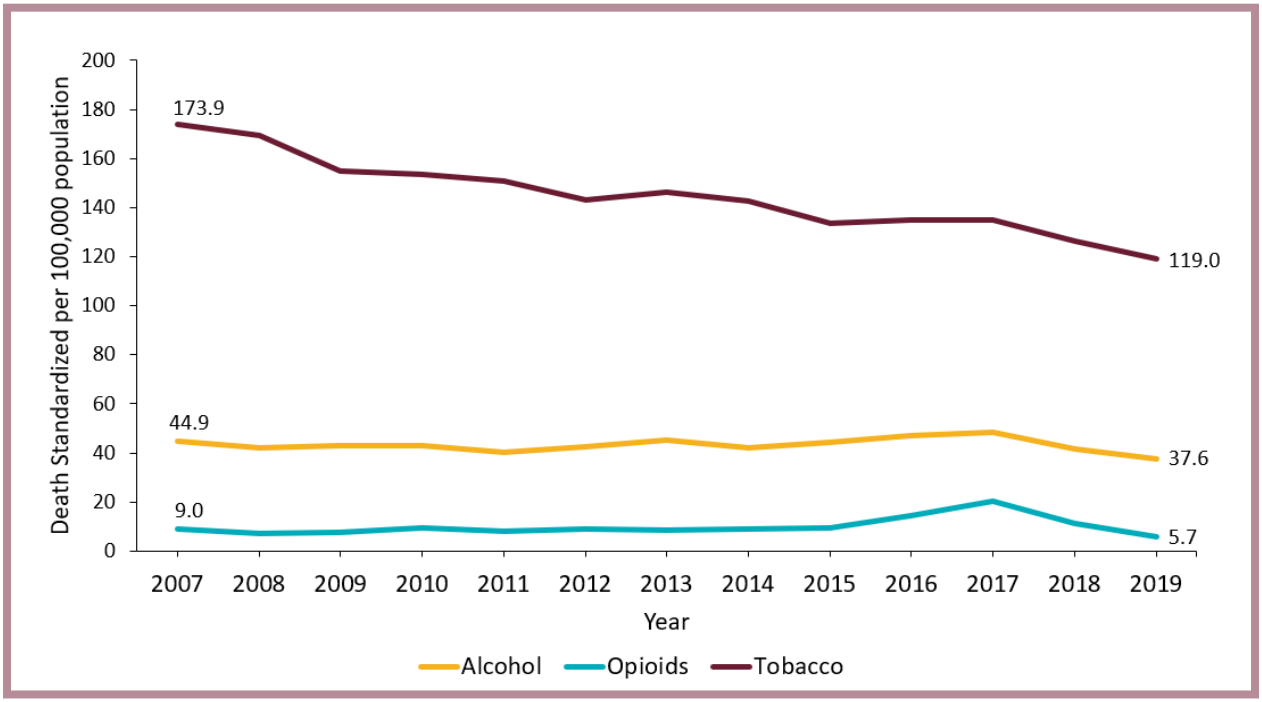
Between 2007 and 2019, the rates of hospital admissions and deaths attributed to tobacco have steadily declined. For the first time in 2019, hospital admissions due to tobacco were lower than those due to alcohol (Figure 45). Mortality due to tobacco is still higher than alcohol and opioids, but it is continuing to decline (Figure 46).

Figure 45. Hospital Admission Rate for Tobacco, Alcohol, and Opioids, Island Health (2007–2019)



Source: Canadian Institute for Substance Use Research, 2022, *Interactive data visualization tool*.[21]

Figure 46. Death Rate for Tobacco, Alcohol, and Opioids, Island Health (2007–2019)



Source: Canadian Institute for Substance Use Research, 2022, *Interactive data visualization tool*.[21]

Summary of Key Findings

Tobacco is a legal substance that is regulated at the federal, provincial, and local levels. Decades of regulation have successfully reduced tobacco consumption. However, consumption remains higher than the national target of 5%, with recent increases in some local regions and substantial inequities across Island Health.

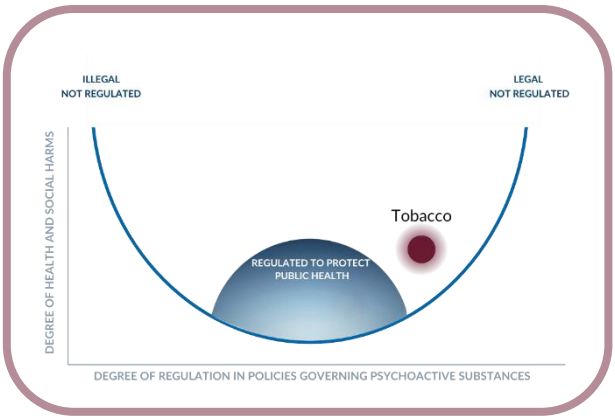
Tobacco consumption in Island Health:

- Higher than in B.C.
- Highest in North Island, followed by Central Island, and lowest in South Island
- Higher rates reported in the First Nations Regional Health Survey compared to the Canadian Community Health Survey
- Proportion of people smoking cigarettes daily or occasionally has decreased over time across all HSDAs, but has increased recently in North and Central Island
- Daily cigarette smoking has significantly decreased over the past 10 years
- Vaping is more common among youth than smoking tobacco
- Proportion of youth who report ever trying tobacco is declining

Health harms of tobacco in Island Health:

- Tobacco remains the top substance-related cause of premature death
- Hospital admissions and deaths attributed to tobacco have continually decreased and are projected to continue decreasing
- Hospital admissions related to tobacco are now lower than those due to alcohol

Policy Landscape



Tobacco is a legal substance that is closer to the middle of the policy continuum, where harms are minimized. Cigarettes are strictly regulated, notably at the federal level and bolstered by additional provincial regulations and municipal bylaws. Local governments have had a substantial role in reducing and minimizing health consequences of second-hand exposure to tobacco, cannabis, and vapour products by implementing clean air bylaws that define public smoke-free spaces. Over time, these regulations have had the expected public health effects, with the proportion of the population who smoke tobacco decreasing over the decades. Whereas the first federal smoking survey in 1965 found a smoking rate of 50% in Canada, by 2019 that had dropped to 15%.[67] The Island Health data shown above highlight the more recent decline in both consumption and associated harm. This illustrates the potential of regulation to help minimize health harms associated with a previously broadly marketed and used psychoactive substance. Island Health's Tobacco and Vapour Prevention and Control Program (TVPCP) will continue to play an important role in enforcement of federal and provincial tobacco and vapour legislation and the Capital Regional District's Clean Air Bylaw.

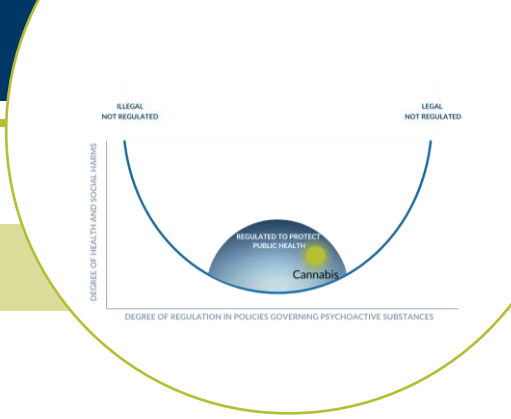
Despite the progress in tobacco control in Canada, much remains to be done. The 15% smoking rate is well above the target of 5% by 2035 set by Canada's Tobacco Strategy. The tobacco industry is continuously attempting to innovate and expand both its tobacco products and its addictive non-tobacco nicotine products. The industry spends considerable time and money revamping its products' appeal, shifting public perception and portrayal of tobacco use, rebranding new products with harm reduction narratives, and attempting to rehabilitate the industry's reputation.[68] Non-tobacco nicotine delivery products such as vapour products and nicotine pouches are being designed and marketed to youth using lifestyle marketing tactics.

The tobacco industry has had a long history of adapting and shifting to the policy landscape, including influencing policies to advance its own interests over those that protect public health.[68] In response, Island Health's TVPCP continues to prioritize prevention of tobacco, vapour, and emerging nicotine products, particularly among youth,

"When it's difficult to smoke, I smoke less." – Aran Wilson, in recovery

through community engagement and education. Existing users of tobacco products are supported in cessation through referral to provincial resources such as QuitNowBC.

Further, regulations can and should be reviewed to keep up with new evidence and new nicotine delivery products available to Canadian consumers. The B.C. government just announced its intent to place buccal nicotine pouch products behind pharmacy counters, thereby limiting access for youth wanting to use them for non-cessation purposes.[69] Additional strategies that have been implemented in other jurisdictions, such as Smoke Free Generation,[70] should be considered for future policy options.

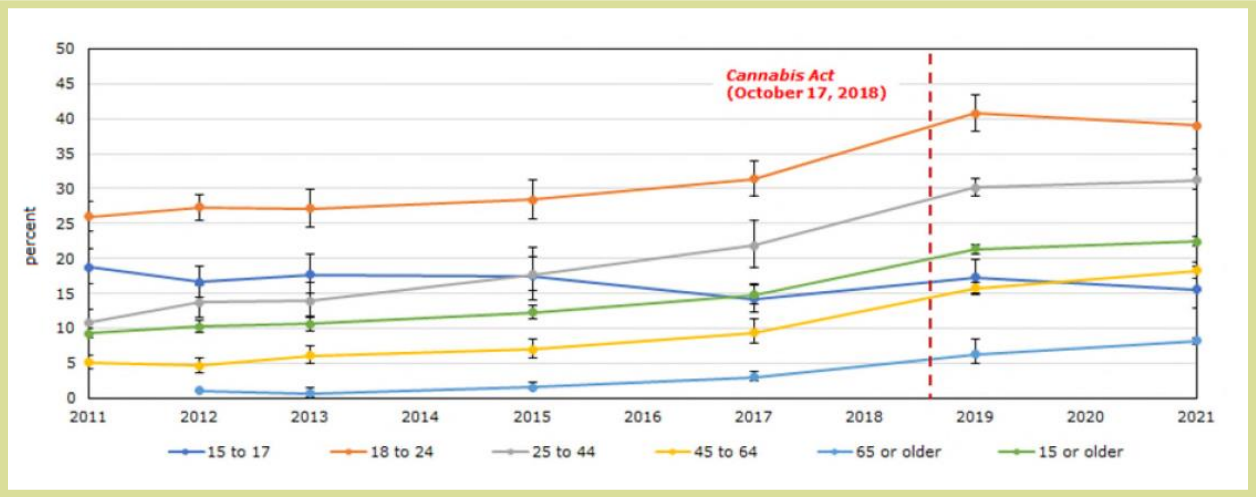


Cannabis

Consumption Trends

Cannabis (dried, fresh, or cannabis oil) was legalized for recreational use in B.C. in October 2018; edible cannabis was legalized in October 2019. Across Canada, overall reported consumption has increased moderately since legalization (Figure 47).

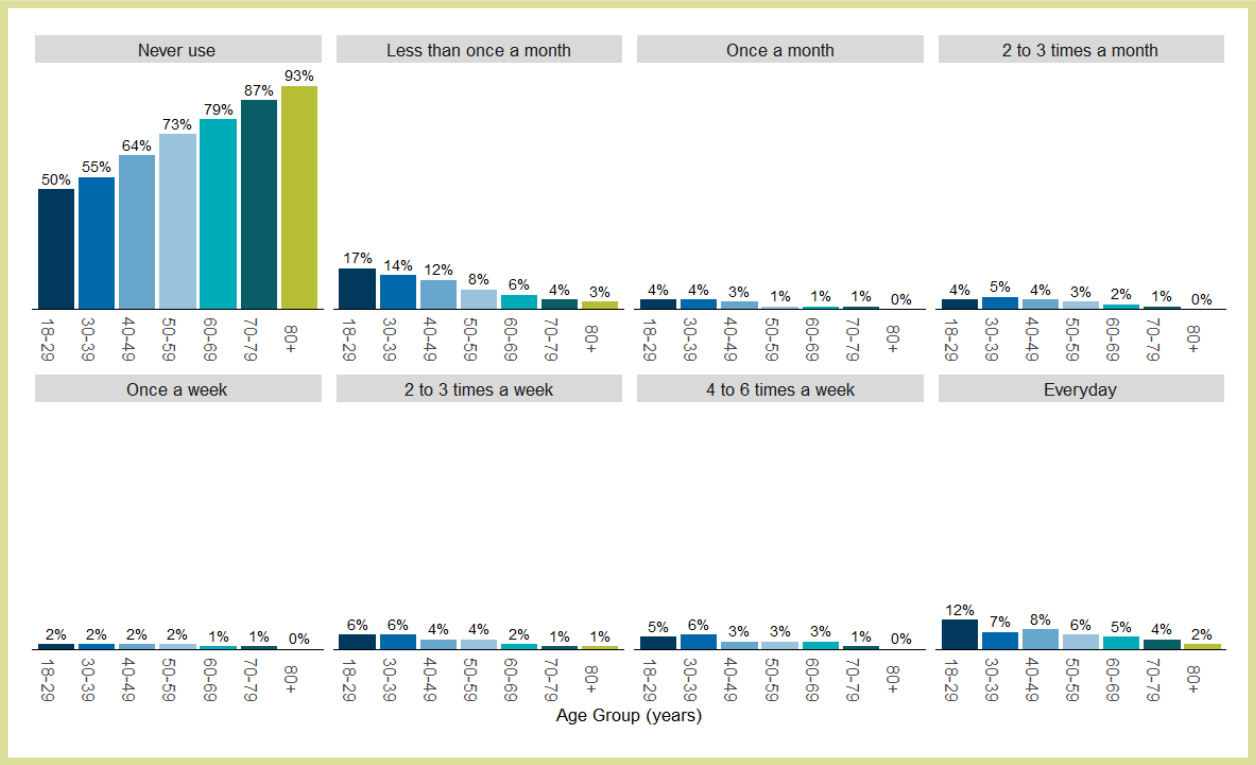
Figure 47. Cannabis Use in the Past 12 Months by Age Group, Canada (Provinces Only) (2011–2021)



Note: Among household population aged 15 or older. The red line refers to the enactment of the Cannabis Act (October 17, 2018). Error bars represent the lower and upper 95% confidence interval.
Source: Statistics Canada, 2023, *Research to insights: Cannabis in Canada*.[71]

In 2021, 50% of Island Health residents aged 18–29 reported never using cannabis in the past 12 months (Figure 48). This proportion increased with age, with 95% of those 80 and over reporting never using cannabis in the past year. Those in the 18–29 age group reported using cannabis most often, with 12% reporting daily use.

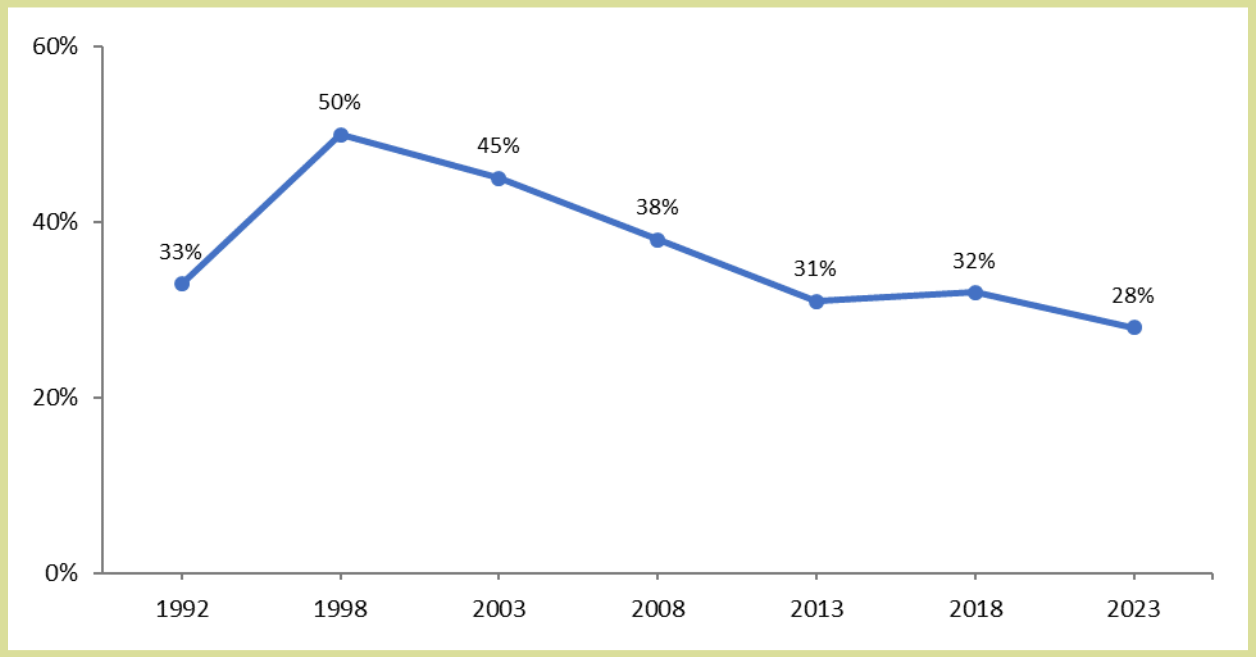
Figure 48. Frequency of Cannabis Use in the Past 12 Months by Age Group, Island Health (2021)



Source: Data provided by BC Centre for Disease Control, BC COVID-19 SPEAK Round 2 (2021), and analysis conducted by Island Health PHASE team.

In 2023, fewer youth reported that they had ever used cannabis compared to 2018 (28% vs. 32%) (Figure 49). Over the past 20 years, the proportion of youth who reported ever using cannabis has decreased by 1.6 times.

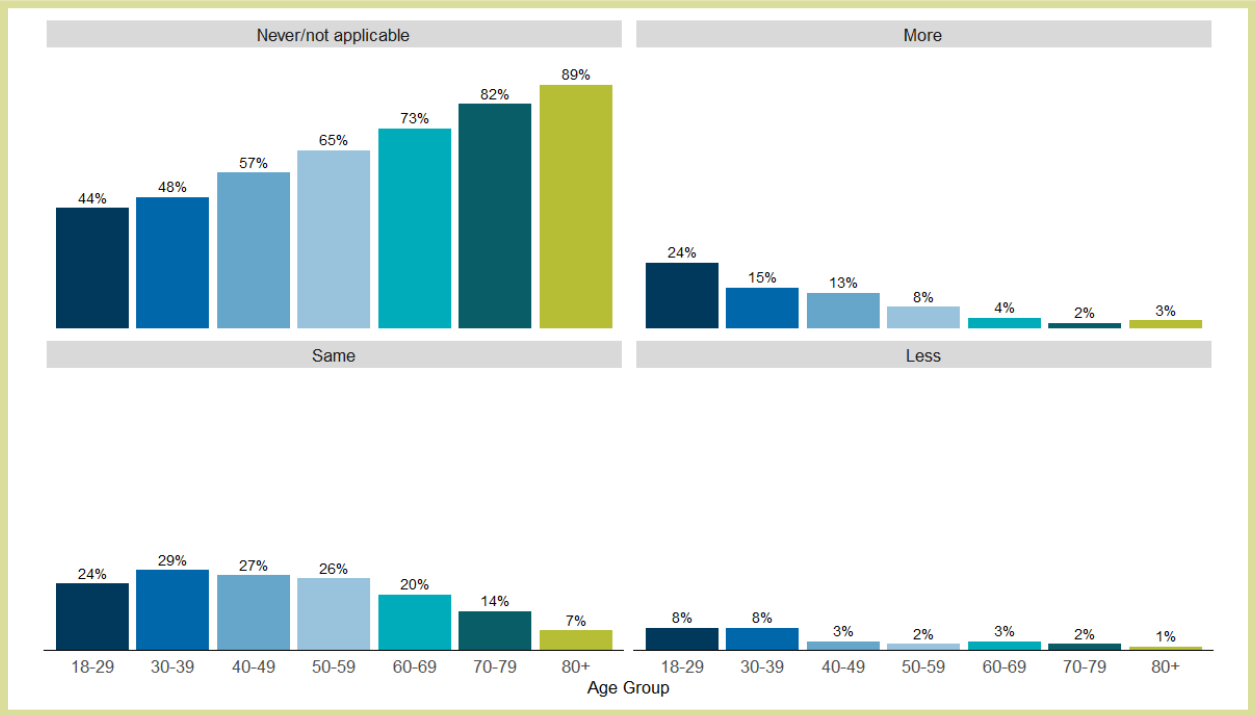
Figure 49. Youth Who Have Ever Used Cannabis, Island Health (1992–2023)



Source: Data provided by McCreary Centre Society, BC Adolescent Health Survey, 1992 through 2023.

When Island Health residents were asked how their frequency of cannabis use changed compared to before the pandemic, the highest proportion of respondents who reported increased use were in the 18–29 age group (24%), followed by the 30–39 and 40–49 age groups (15% and 13%, respectively) (Figure 50).

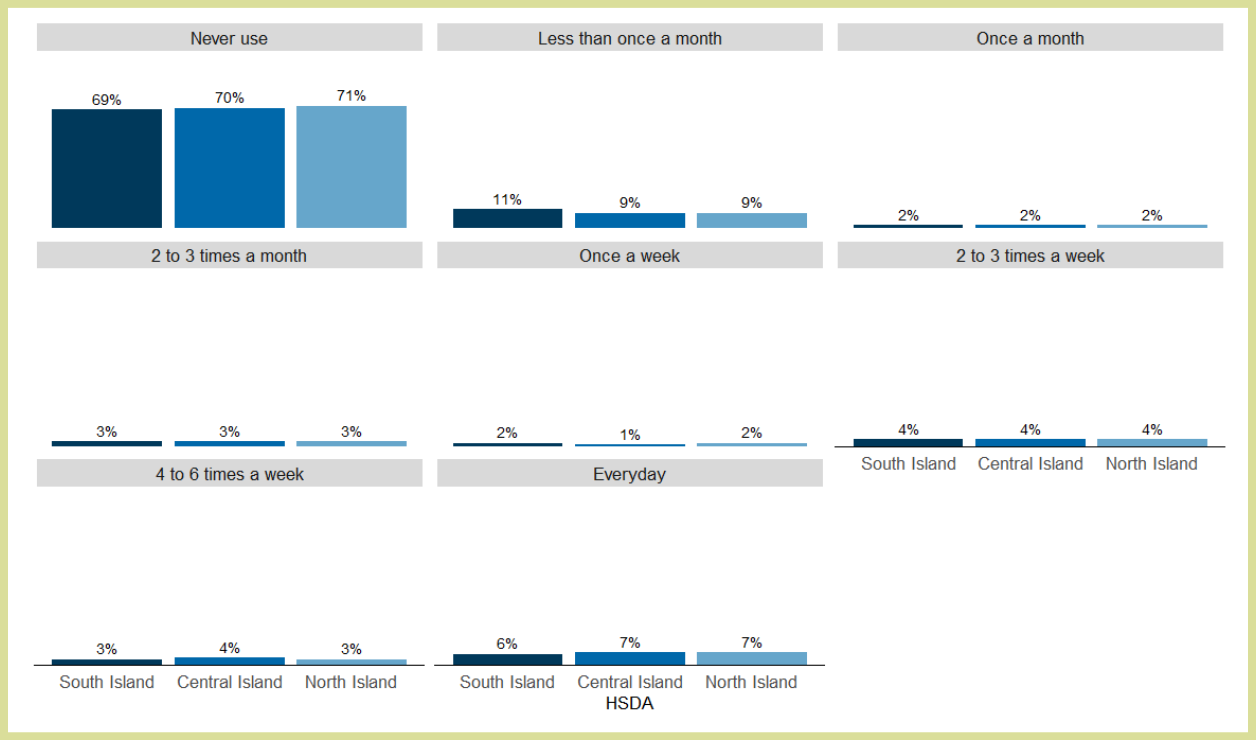
Figure 50. Frequency of Cannabis Use Compared to Before the Pandemic by Age Group, Island Health (2021)



Source: Data provided by BC Centre for Disease Control, BC COVID-19 SPEAK Round 2 (2021), and analysis conducted by Island Health PHASE team.

Frequency of cannabis use was similar across all HSDAs in Island Health, with the majority of respondents (approximately 70%) reporting never using cannabis and approximately 7% of respondents reporting daily use (Figure 51).

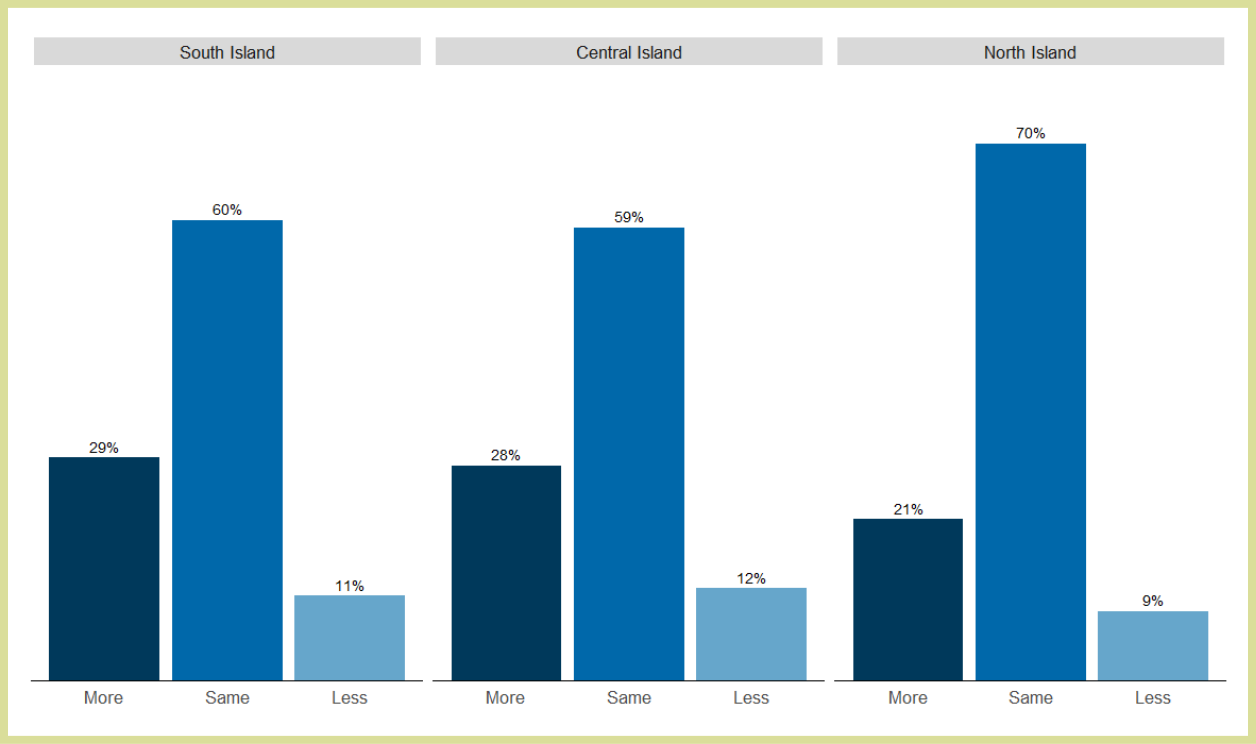
Figure 51. Frequency of Cannabis Use in the Past 12 Months by Health Service Delivery Area (HSDA), Island Health (2021)



Source: Data provided by BC Centre for Disease Control, BC COVID-19 SPEAK Round 2 (2021), and analysis conducted by Island Health PHASE team.

Of those who did report using cannabis in the past 12 months, nearly 30% in South and Central Island reported using more than before the pandemic, compared to 21% in North Island (Figure 52).

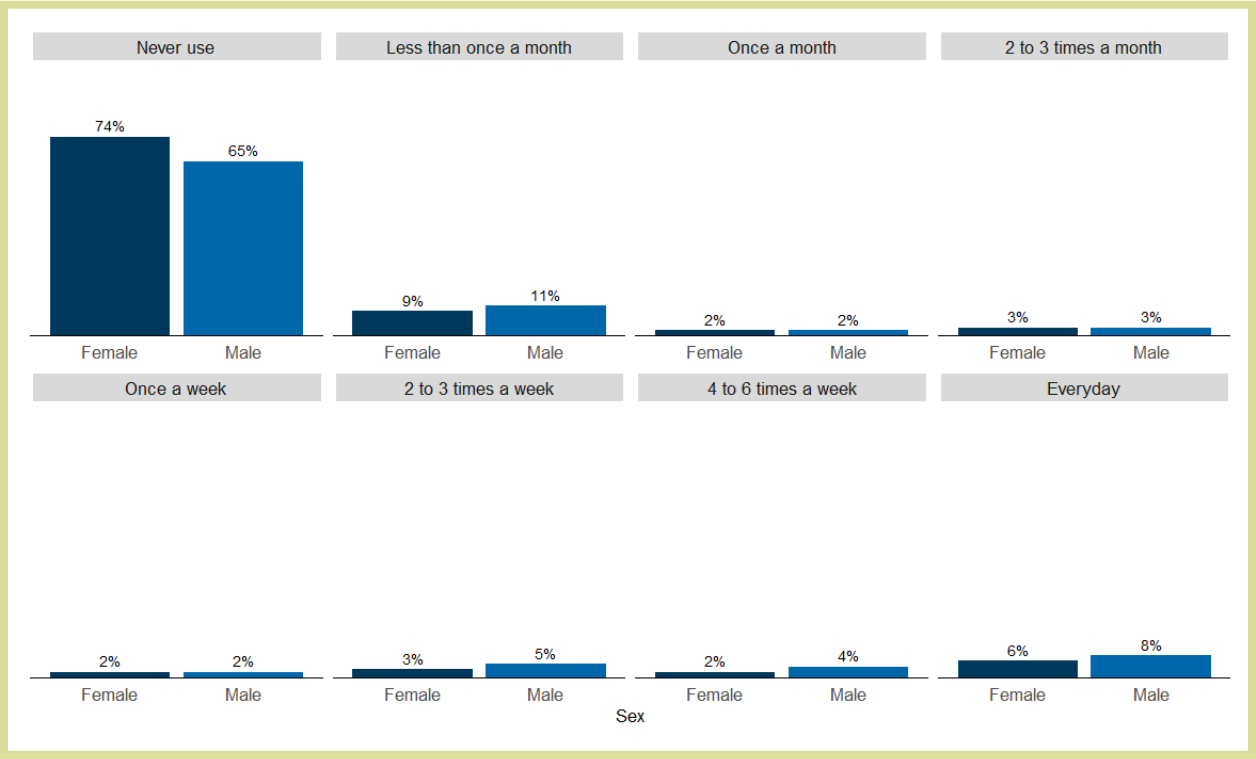
Figure 52. Frequency of Cannabis Use Compared to Before the Pandemic by Health Service Delivery Area (HSDA), Island Health (2021)



Source: Data provided by BC Centre for Disease Control, BC COVID-19 SPEAK Round 2 (2021), and analysis conducted by Island Health PHASE team.

Nearly three quarters of females (74%) reported never using cannabis in the past 12 months, compared to approximately two thirds of males (65%) (Figure 53). In the 2021 SPEAK survey, of those who reported cannabis use in the past 12 months, 27% of both males and females in the Island Health region reported increased use compared to before the pandemic (data provided by BC Centre for Disease Control, data not shown).

Figure 53. Frequency of Cannabis Use in the Past 12 Months by Sex, Island Health (2021)

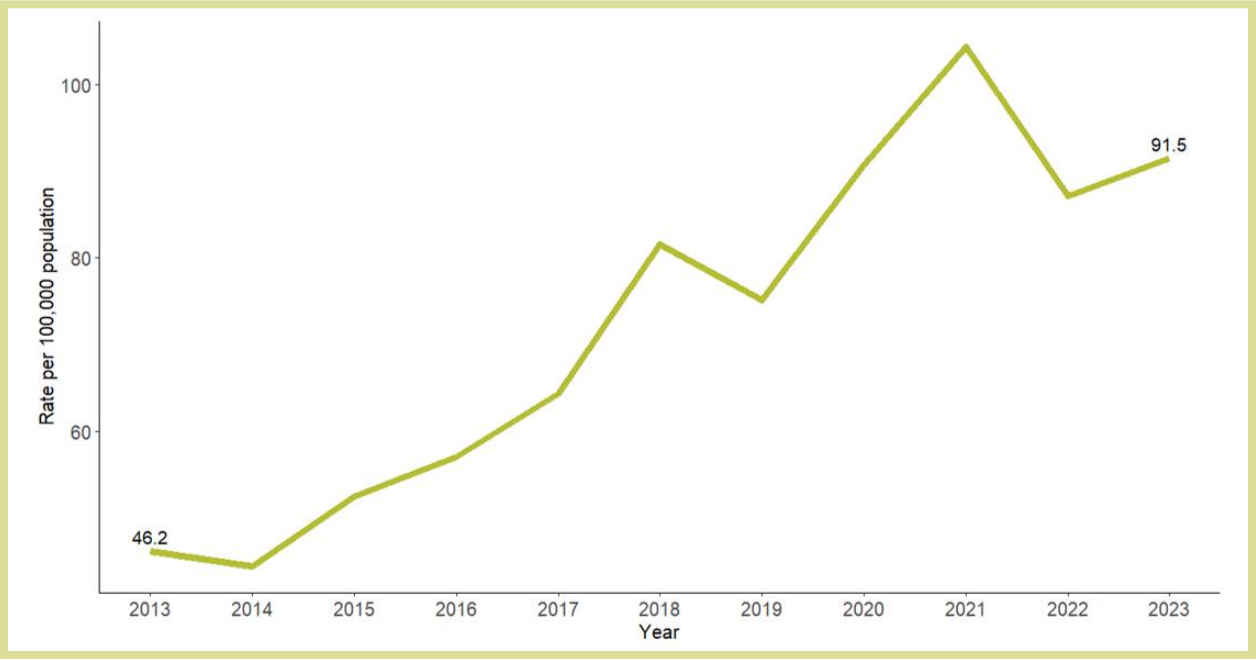


Source: Data provided by BC Centre for Disease Control, BC COVID-19 SPEAK Round 2 (2021), and analysis conducted by Island Health PHASE team.

Burden of Illness

Between 2018 and 2019, the rate of cannabis-related hospital admissions decreased from 81.6 per 100,000 population to 75.1 per 100,000 (Figure 54). However, similar to trends observed for other substances during the pandemic, the rate of cannabis-related hospital admissions increased, with a peak of 104.3 hospital admissions per 100,000 in 2021. The rate of cannabis-related hospital admissions has since decreased but has yet to come down to pre-pandemic levels.

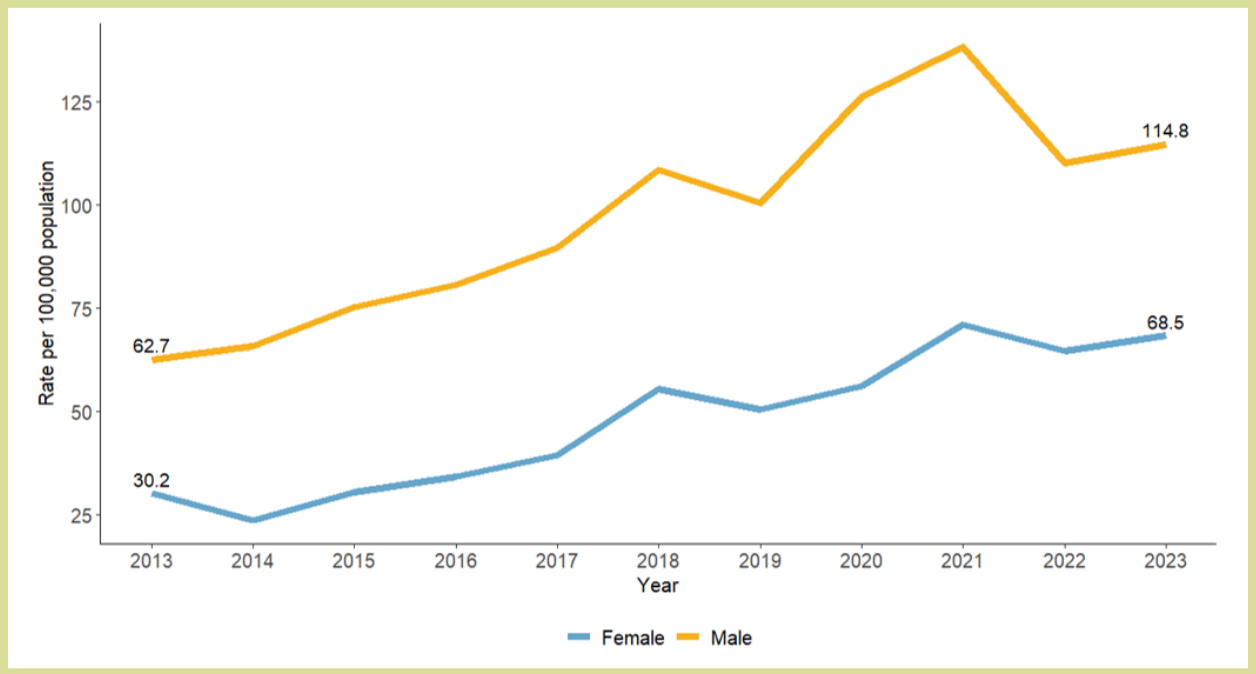
Figure 54. Rate of Cannabis-Related Hospital Admissions, Island Health (2015–2023)



Source: Data from Island Health Enterprise Data Warehouse, Discharge Abstract Database, and compiled by Island Health PHASE team.

The rate of hospital admissions for harms caused by cannabis has increased for both males and females since 2015. The rate of cannabis-related hospital admissions for males was 1.7 times the rate for females in 2023 (Figure 55).

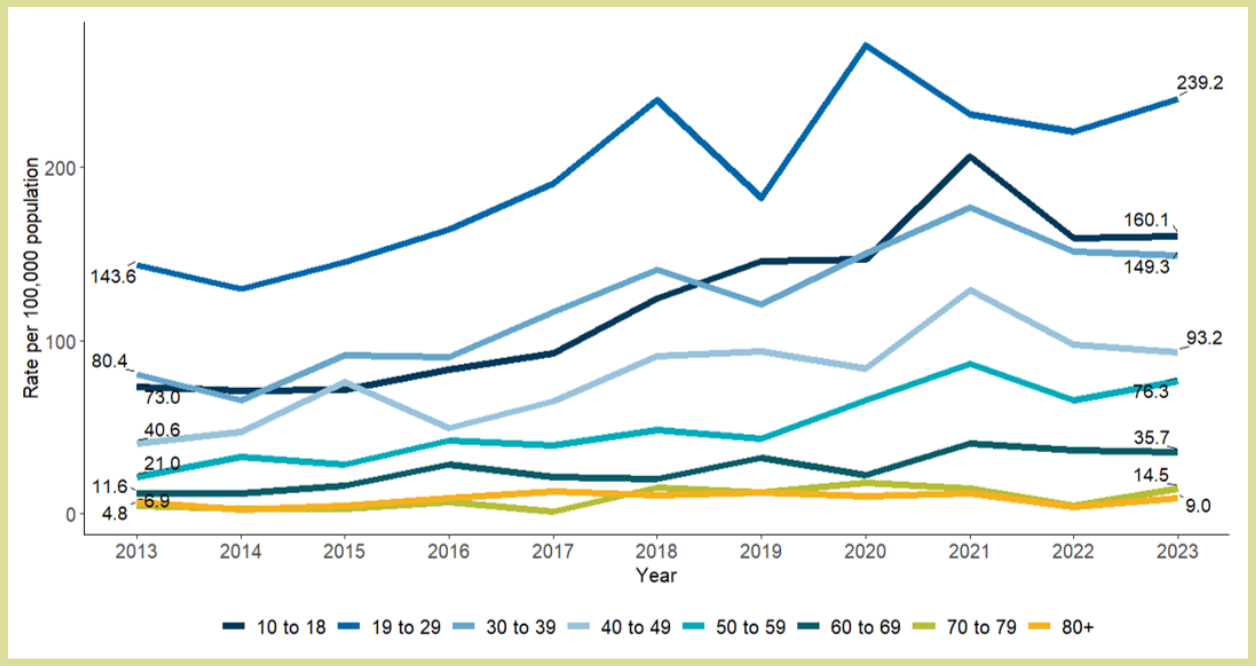
Figure 55. Cannabis-Related Hospital Admissions by Sex, Island Health (2015–2023)



Source: Data from Island Health Enterprise Data Warehouse, Discharge Abstract Database, and compiled by Island Health PHASE team.

The highest rate of cannabis-related hospital admissions continues to be among those 19–29 years of age (239.2 hospital admissions per 100,000 in 2023) (Figure 56). Of note, this was a younger age group than that of the highest rate of hospital admissions for both alcohol and opioids in 2023, which was 30–39 years of age. In 2019, the rate notably decreased for this age group following cannabis legalization in late 2018, then increased in 2020. While the rate has since decreased, it has not yet returned to pre-pandemic levels.

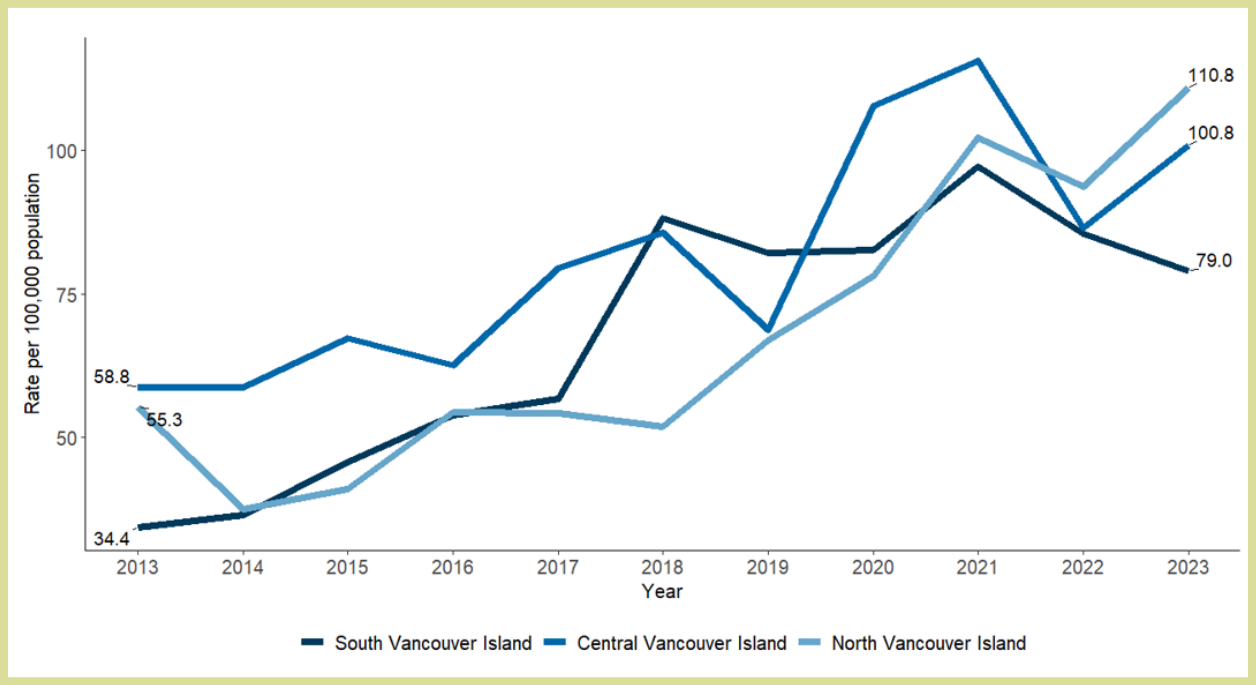
Figure 56. Cannabis-Related Hospital Admissions by Age Group, Island Health (2013–2023)



Source: Data from Island Health Enterprise Data Warehouse, Discharge Abstract Database, and compiled by Island Health PHASE team.

Hospital admissions for harm caused by cannabis have increased across all HSDAs since 2013, with the highest rate in 2023 observed in North Island (110.8 per 100,000), where the rate has doubled since 2013 (Figure 57).

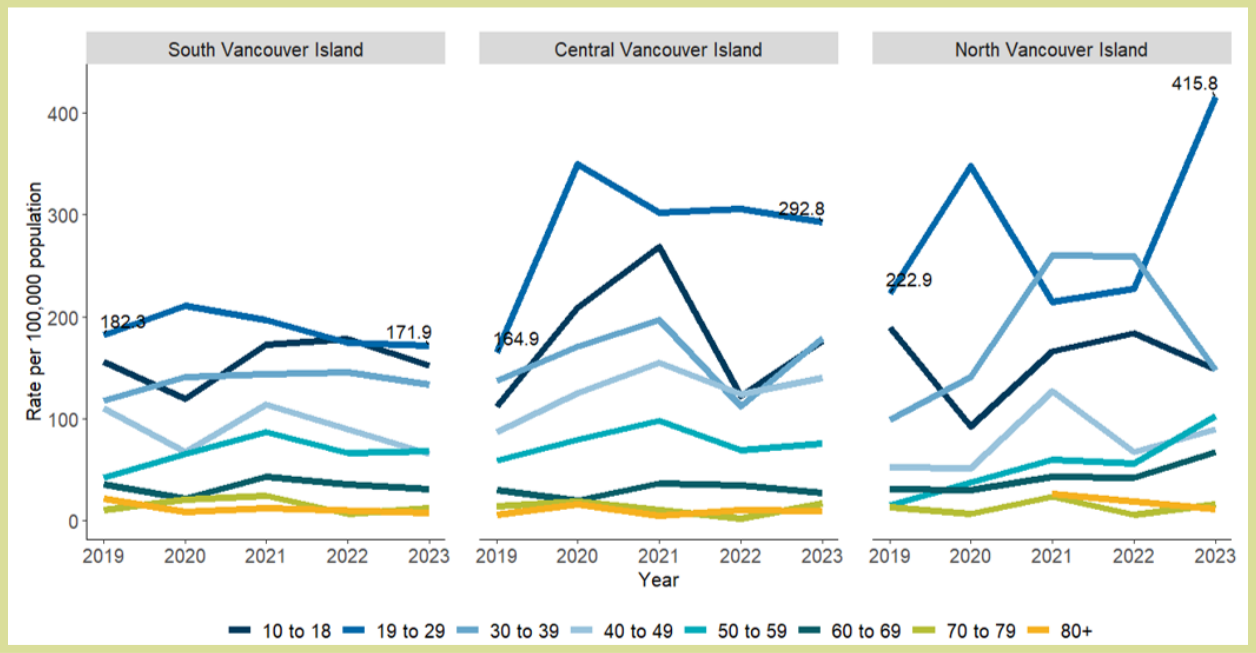
Figure 57. Rate of Cannabis-Related Hospital Admissions by Health Service Delivery Area, Island Health (2013–2023)



Source: Data from Island Health Enterprise Data Warehouse, Discharge Abstract Database, and compiled by Island Health PHASE team.

In 2023, the rate of cannabis-related hospital admissions was highest among those 19–29 years of age across all HSDAs (Figure 58). Rates were much higher in Central and North Island (292.8 and 415.8 per 100,000, respectively) compared to South Island (171.9 per 100,000). However, the rate of hospital admissions for the 19–29 age group decreased for both South and Central Island in 2023 compared to 2022, while North Island had a notable increase in hospital admissions among this age group, 1.8 times higher compared to 2022.

Figure 58. Cannabis-Related Hospital Admissions by Age Group and Health Service Delivery Area, Island Health (2019–2023)



Source: Data from Island Health Enterprise Data Warehouse, Discharge Abstract Database, and compiled by Island Health PHASE team.

Summary of Key Findings

Cannabis is a psychoactive substance that became legal and regulated in 2018. What is unique for cannabis is that legalization and the implementation of a regulatory framework with public health as a goal happened at the same time.

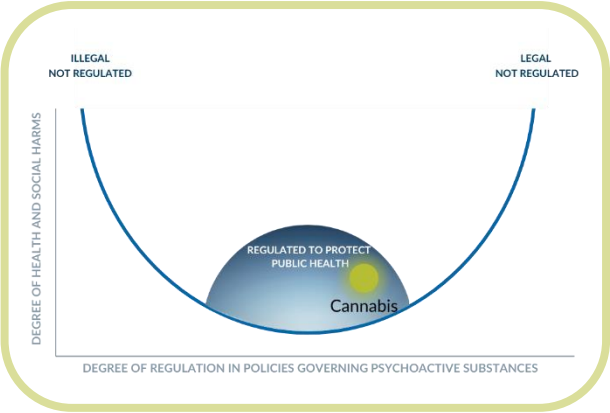
Cannabis consumption in Island Health:

- Does not vary significantly regionally
- While most people in Island Health don't use cannabis, 50% of young adults reported using cannabis in the past 12 months
- 28% of youth in school reported having tried cannabis in 2023 (slightly lower than in 2018 when the Cannabis Act came into force)
- Among those using cannabis, nearly a third reported increased use compared to before the pandemic

Health harms of cannabis in Island Health:

- Hospital admissions related to cannabis are substantially lower than hospital admissions due to alcohol, opioids, stimulants, or tobacco
- Reported cannabis-related hospital admissions have doubled over the past 10 years—although it is not known if this increase is due to an actual change in hospital admissions or a greater willingness to disclose cannabis use after legalization, or both
- Rate of cannabis-related hospital admissions increased after the pandemic was declared in 2020; they have since decreased but have not returned to pre-pandemic levels
- Rate of cannabis-related hospital admissions is higher for men than for women
- Highest rate of cannabis-related hospital admissions is among those 19–29 years old
- Cannabis-related hospital admissions in 2023 decreased in South Island but increased in North and Central Island

Policy Landscape



Cannabis is now a fully legalized substance, regulated at the federal level via the Cannabis Act and in some provincial provisions. Since a strong public health framework was part of the legalization of cannabis, it is less promoted and normalized than alcohol.

The Cannabis Act states that its main objectives are to keep cannabis out of the hands of youth, keep profits out of the pockets of criminals, and protect public health and safety by allowing adults access to a quality-controlled supply of legal cannabis.[72] The stated aim of decriminalizing, legalizing, and regulating cannabis under a public health framework is therefore not to enhance economic and business opportunities. This is important to recall in the context of recent reports of advocacy from the cannabis industry to loosen rules and promote more business opportunities.[73–76] At this time, monitoring the population impact of legalizing and strictly regulating cannabis remains a priority in order to ensure that any changes to that policy maintain the goal of minimizing health harms.

A recent legislative review of the Cannabis Act highlights a number of areas for monitoring and improvement. In particular, the expert panel recommended setting targets and monitoring the rate of youth and young adult use, which is some of the highest in the world. The expert panel also stated that it would be a mistake to become complacent or to move away from a public health and public safety approach to cannabis policy.[77]

Discussion

Summary of Findings

Psychoactive substances have significant negative health and societal consequences for people in Island Health. Health harms are proportionate to consumption amount and patterns, and to the toxicity characteristic to each substance. Substance use is deeply embedded in our history, culture, and practices. Substance use patterns are also strongly shaped by the policies and regulations in place with respect to a specific substance.

Unfortunately, with the exception of tobacco, our policy approaches to psychoactive substances are largely historical and not rooted in evidence of harms or benefits. But tobacco control, one of the top public health achievements of the last several decades, does highlight the potential of concerted and sustained policy efforts to minimize harm. Due to the widespread use of tobacco for many decades, tobacco remains the top cause of preventable deaths worldwide. However, addressing price through taxation, access through regulation of where tobacco can be sold, and societal norms through regulation of where tobacco can be used has resulted in a sustained decline in use and harms. Although these policy changes took decades to achieve, they have resulted in sustained declines in hospital admissions and deaths in Island Health since at least 2012.

At this time, tobacco is a legal, highly regulated substance, with declining health harms. The successes of tobacco control are not complete, however, with smoking rates in Island Health higher than in B.C. and significant disparities existing within Island Health. Recent increases in smoking rates in North and Central Island are particularly concerning since most of the reduction in smoking rates and health harms comes from people not initiating smoking, rather than from quitting. Regulation needs to be further optimized to address youth vaping initiation, ease of access to tobacco and vaping products, and programs to support current users of tobacco and vaping products to reduce use or quit.

In stark contrast to tobacco, alcohol is a product that today is hyper-normalized, promoted, and celebrated in our society. There is no international or national alcohol control strategy, and provincial policies over the past decade have largely promoted greater access to alcohol. During the pandemic, changes to alcohol distribution regulations further increased access. These policy changes correlate with a steady increase in alcohol consumption and related harms. Alcohol consumption is higher in Island Health than in B.C., and markedly higher in North and Central Island than in South Island.

Alcohol is the leading cause of substance-related hospital admissions in Island Health, with men being hospitalized at a substantially higher rate than women. Hospital admissions directly related to alcohol increased markedly during the pandemic. While hospital admissions directly related to alcohol declined in most age groups since the lifting of

pandemic restrictions, they remain above pre-pandemic levels in young adults between 19 and 29 years of age. Youth alcohol consumption is also higher in Island Health than in the province as a whole; fortunately, there is a declining trend over the past 30 years. At this time, alcohol is a legal, weakly regulated substance causing increasing harms in our population.

Taking a Public Health Approach to Substance Use

According to the Canadian Public Health Association, a public health approach is "an approach to maintaining and improving the health of populations that is based on the principles of social justice, attention to human rights and equity, evidence-informed policy and practice, and addressing the underlying determinants of health."[78(p. 4)]

"The goal of a public health approach is to maximize benefits and minimize harms of psychoactive substances, promote the health and wellness of all members of a population, reduce inequities within the population, and ensure that the harms associated with interventions and laws are not disproportionate to the harms of the substances themselves. The public health approach ensures that a continuum of interventions, policies, and programs are implemented."[79(p. 177)]

This context suggests that to effectively address substance use in Island Health, we must take a comprehensive approach across all sectors, beyond health and social services, and focus efforts on the promotion of health, wellness, dignity, and rights of those who use substances, while creating environments where people can better support their own health.

The substance causing the greatest number of potential years of life lost in Island Health is unregulated opioids. Opioids are second only to malignant cancers in taking more years of life from people in Island Health. The very high death toll of unregulated opioids is directly related to the toxicity of the drug supply. A public health emergency was declared in B.C. in 2016 in response to the increased deaths after the appearance of fentanyl in the illegal supply. Interventions such as overdose prevention sites, take-home naloxone, and opioid agonist therapy resulted in a decline in mortality. Unfortunately, in 2020, pandemic restrictions resulted in a disruption of services and an immediate increase in deaths. In addition, the concentration of fentanyl in the unregulated drug supply increased

substantially and has remained much higher than before the pandemic. As a result, mortality related to unregulated opioid toxicity is now more than two times higher than when the public health emergency was declared. For illegal, unregulated opioids, we are unable to use the evidence-informed policy and regulatory mechanisms that can ensure that they are less toxic and accessed in ways that cause less health and societal harm.

Hospital admissions due to cannabis are much lower than for opioids and alcohol—threefold lower than opioids and fivefold lower than alcohol—with modest increases since 2015. Cannabis became a legal, regulated substance in Canada in 2018. Between 2018 and 2023, the number of youth reporting ever having tried cannabis declined.

Island Health data show that health harms of all psychoactive substances are inequitably distributed. Consumption and health harms of tobacco, alcohol, opioids, and cannabis are substantially higher in North Island than in South Island. The death toll of illegal, unregulated opioids in nearly four times higher for First Nations people than for non-First Nations people in Island Health. These health inequities occur in the context of the history and trauma related to colonization, and past and ongoing racism. We need improved monitoring of consumption patterns and health consequences of these substances to ensure that policies and regulations are proportionate and equitable and minimize health harms.

Opportunities for Action

In this section, we focus on actions we can take today. As we learned from tobacco, the path to healthier public policies related to psychoactive substances is a long and difficult one, but one that can be walked with sustained effort. While working toward psychoactive substance policies and regulations that minimize harm, there are short- and medium-term investments and efforts to improve health and reduce the harms of substance use. ‘

1. **Invest in prevention**

    a. **Develop, implement, and evaluate evidence-informed approaches to youth and family engagement to prevent higher-risk substance use throughout Island Health.** Preventing or delaying initiation of substance use is one path to preventing higher-risk substance use later in life. To do so, early engagement and education with youth and families around substance use is critical. Such engagement needs to occur through programs that are evidence-informed and high quality and that have universal reach.

    b. Invest in programs that intentionally connect children and youth to supportive adults, increase their sense of belonging in community and in school, provide additional supports to bridge education-employment gaps created during the pandemic, and build autonomy and resilience. Higher-risk substance use does not occur in isolation but in the economic, biological, social, cultural, and environmental contexts of people and communities. Worsening mental health indicators for youth and young adults in the past several years identify the need for focused attention on the well-being of young people in Island Health.

    c. **Identify and address health care system contributors to higher-risk substance use, such as inadequate pain management.** Many people turn to psychoactive substances to manage pain, particularly chronic pain, which is often rooted in trauma and may be physical and/or psychological. Prevention requires appropriate training and resources in a system of care that seeks to understand and support each person in their pain journey. Adequate management and follow-up of acute pain and trauma is a key to reducing development of chronic pain.

    d. **Continue to carry out our responsibility and mandate related to enforcement of federal, provincial, and Capital Regional District tobacco and vapour legislation.** This regulatory approach has been highly successful and is the reason that tobacco occupies the position it does on the Policy Continuum diagram. This approach needs to be expanded to new tobacco and nicotine products as they come to market. Since smoking rates in Island Health remain

higher than in the province, and are increasing in some areas, Island Health needs to strengthen interventions at the local level, such as retailer density, retailer compliance, and engagement and education to reduce initiation of smoking.

2. **Empower communities with evidence to influence and support policy changes**

    a. **Support local development of evidence-informed solutions by providing local health data and meaningfully engaging with Indigenous communities and organizations, people with lived and living experience of substance use, service partners, and community members to gather knowledge and design and deliver effective services to meet the needs of each community.**

    b. **Address gaps in local and population-specific data through robust and ongoing monitoring and evaluation to ensure that the policies and services in Island Health are evidence-informed and evidence-generating**. One of the most important information gaps is due to the very limited local data available to understand the burden of substance use-related harms for Indigenous Peoples in Island Health. Meaningful engagement with Indigenous communities to gather data, stories, and knowledge to inform policies is a key priority for the work ahead.

3. **Develop a system of care for people who use substances in Island Health**

    The burden of illness of substance use in Island Health clearly indicates the need to invest in a system of care for addiction and substance use.

    a. Recognize that addiction is a chronic relapsing condition and implement the full spectrum of screening, diagnosis, treatment, and recovery, complemented by a safety net of harm reduction programs. Services that are accessible regardless of where the person is on their journey are critical, along with an appreciation that recovery can begin before abstinence is achieved. Recovery from addiction is a lifelong process that requires accessible, compassionate care that is not dependent on an individual's stage of change. To be effective, services must be low barrier and not require people to navigate

"Abstinence is not for everyone. We need to make sure that we have the services available for people no matter where they are in their relationship with substances." – Beth Haywood, a person with lived experience

complex health systems at times of their lives when they are least able to do so.

b. **Focus on care and treatment of higher-risk alcohol and illegal substance use, ensure that care and treatment for tobacco use are available, and develop the knowledge and capacity to address emerging issues related to cannabis and e-cigarettes.** To ensure equitable substance use services throughout Island Health, disproportionate investment is needed in the regions and for the populations most affected, in particular Central and North Vancouver Island. To meet the scale of unmet need, addiction and substance use care will need to be integrated into all clinical service areas from primary to acute care.

4. **Meaningfully address health inequities**

   Health consequences of substance use are borne disproportionately by Indigenous Peoples in Island Health.

   a. **Meaningfully engage with Indigenous communities to advance Indigenous-led solutions that are culturally safe and recognize the legacy of colonialism, past and current racism, and the urgency and scale of substance use-related harms.**

   b. Engage and involve people with lived and living experience in the design, delivery, and evaluation of programs. People with lived and living experience have a degree of understanding and expertise that is invaluable. Meaningful opportunities to engage and adjust programs and services are needed to ensure the system provides care in a way that reflects the expressed needs of the population.

Alberni Valley Toxic Poisoned Drugs (Opioid) Crisis Strategy

Tseshaht First Nation's Alberni Valley Toxic Poisoned Drugs (Opioid) Crisis Strategy is a great example of collaborative work happening in a community that is experiencing challenges with the impacts of substance use. Released in December 2023, the Strategy is a collaborative, multisectoral, Indigenous-led approach to addressing substance use and the current crisis.

The Strategy uses the symbol of "Pillars of a House" to put forward a plan for action "to ensure we protect what is inside our house, our people" (p. 8). Developed collaboratively, the Strategy aims to support a "unified response that embraces the voices and wisdom of all community members, particularly the First Nations and local governments" (p. 4).

The Strategy takes a holistic approach. It goes beyond conventional substance use programming and also advocates for:

- resources people need for healing (e.g., housing, employment, community connection)
- action to address the barriers that prevent people from accessing services (e.g., racism, stigma)
- ongoing, community-based, and culturally relevant supports
- collection of data "measuring patient satisfaction among First Nations, marginalized, and substance disorder patients" (p. 14) that is shared with community to inform continued community-led work

The Strategy's priority actions are:

People

- Coalition Building and Advocacy
- Community Mobilization
- Patient Satisfaction

Programs

- Cultural Training
- Comprehensive Continuity of Healing, Learn from Successful Models
- Transportation

Places

- Inclusive Detox/Recovery Facilities
- Housing Support

Prevention

- Education
- Prevention
- Recovery Focused Language

5. **Advance healthy public policies for substance use**

   Current policy approaches to psychoactive substances are the consequence of decisions made over many decades. Many of these policy decisions were considered separately for each substance, resulting in a patchwork of inconsistent policies that not only fail to minimize but in fact increase harm. Alcohol use and harms are enabled by policies that encourage consumption at the same time that criminalization of unregulated substances leads to increased potency and stigmatization, contributing to a toxic drug supply that results in an average of almost 10 preventable deaths in Island Health every week.

   a. **Adopt the recommendations of the Health Officers Council of BC position statement on healthy public policies for alcohol**. Endorse the goal of reducing consumption, and work at the municipal and health authority level to stop increasing and start reducing availability and accessibility, adjust

pricing to support lower-risk consumption, increase information about risks of alcohol, reduce promotion and advertising, reduce harms related to alcohol-impaired driving, improve services for people experiencing higher-risk use, and enhance monitoring and reporting. In many communities, working to limit expansion of access to alcohol is the first important step.

b. **Establish access, strictly regulated under a public health framework, to the class of opioid and stimulant drugs for those at current risk of overdose death.** Until such access can be provided, continue support for decriminalization and avoid administrative sanctions that stigmatize individuals and groups. Ensure that services such as drug checking, overdose prevention services, and the full spectrum of treatment options are available and accessible to those who need them.

c. Monitor consumption trends for tobacco and nicotine products, especially for youth and new users, and proactively update regulations to support lower consumption and minimize harmful health consequences.

d. **Monitor the consumption and health consequences of cannabis use and maintain the health goals of legalization and regulation of cannabis.** This means maintaining concentration limits and limits on promotion and advertising, and considering implementing other regulatory mechanisms such as limiting density of outlets.

e. Increase prevention programs for youth and young adults who have the highest reported rate of cannabis use and who are most vulnerable to the health harms of cannabis.

The data and opportunities for future action shared in this report are not the end of the work. This report is intended to serve as an engagement tool to support future conversations with communities, organizations, and people who use substances in Island Health to identify and bring about meaningful change.

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Appendix

A Brief History of Psychoactive Substances in Canada – More Details

Humans have used psychoactive substances for a very long time. Many societies have used substances to alter the mind to create art, participate in ceremonies or religious rituals, and enhance social activities, or simply for the individual experience.[5,7–9]

The following timelines for alcohol, unregulated substances and cannabis, and tobacco products outline some of the significant events in the history of policies pertaining to psychoactive substances in Canada. These timelines are not exhaustive, but they do aim to illustrate how policies, laws, industry influence, and dominant social narratives and norms have created the current landscape of substance use in Canada.

History of Alcohol in Canada

1500s	Fur traders, missionaries, and European colonizers introduced alcohol and other psychoactive substances to Indigenous communities in North America. Alcohol was the preferred psychoactive substance of Europeans and was often traded with Indigenous communities.[9]
1700s – early 1800s	Psychoactive substances were commonly used in medicines throughout Canadian society. No legal sanctions relating to psychoactive substances existed yet.[9] Grain production was an important component of the economy. Fermenting grains into alcohol was commonplace, and brewing and distilling industries grew and brought immense wealth.[80] The temperance movement, a social movement originating in Protestant religious communities in England, started promoting abstinence and called alcohol and other intoxicants the source of society's evils.[9] In addition, colonizers and missionaries who worked toward religious conversion and assimilation of Indigenous Peoples viewed alcohol as a corruptive force and fought to include prohibition of its use by Indigenous Peoples.[9,80]

Late 1800s	In 1878, the Canada Temperance Act became the first federal legislation to enable provinces to enact local alcohol bans for non-Indigenous Canadians.[80] In 1884, an amendment to the Indian Act made it a nation-wide felony for alcohol to be sold to and consumed by Indigenous people who were classified as "Status Indians".[9,81] The laws banning consumption of alcohol by Indigenous individuals led to people consuming alcohol rapidly and in secret to avoid being arrested or fined. This created the harmful stereotype that Indigenous people binge drink and cannot tolerate alcohol.[62,81] Alcohol prohibition for Indigenous Peoples lasted much longer than for other residents in Canada.[9]
1900 – 1930s	For the first two decades of the 1900s, most provinces went "dry." Media narratives at this time framed alcohol consumption as "needless spending" and as a vice that reduced productivity of workers manufacturing materials needed for success in World War I.[80] During the war, Canada passed the first and only national act prohibiting alcohol importation, production, and sale across the country.[9] When World War I ended and soldiers returned, support for prohibition dropped. Beginning in 1921, the federal government, followed by each province, repealed its alcohol prohibition laws. Alcohol use was once again legal.[80] Negative perceptions of alcohol at this time were primarily focused on public drinking and drunkenness,[27] so for the first two decades after prohibition ended, alcohol (aside from beer) was only sold for consumption in private homes. Sale of wine and spirits was restricted to stores run by the provincial government. In these stores, alcohol was kept behind a counter, and individuals had to engage with multiple staff before getting access to their purchases.[27] The quantity of alcohol purchased at one time was also restricted. Permits had to be presented at the store to buy alcohol, and store staff were able to suspend or cancel permits.[27] Beginning in 1925, B.C. allowed on-premises beer consumption at provincially licensed beer parlours, but effort was made to limit the appeal of these places. Alcohol consumption in any other public venue remained prohibited into the 1940s,[27,82] due to a push from the temperance movement.[27]

	In the United States, alcohol prohibition began in 1920 and lasted until 1933.[83] The continuation of prohibition in the United States created massive opportunity in Canada for black market production and trade.[80]
1940s – 1950s	By the mid-1940s, alcohol consumption in licensed establishments was gaining social acceptance, and consumption rates were rising. Cocktail lounges were developed as places where people could go for food, drinks, and entertainment.[82] By the end of the 1950s, a thriving restaurant culture had developed where food was served alongside beer and wine, and opposition to on-premises alcohol consumption was uncommon.[27] While the provinces controlled regulating, importing, and wholesale sales of alcohol, production of alcoholic beverages was done by private businesses. In 1943, the Brewers Association of Canada was established, and the Association of Canadian Distillers followed in 1947. Both groups "engage[d] in lobbying the provincial and the federal government on alcohol policies."[27] In 1955, while undergoing various amendments, the Indian Act was changed to allow provinces to provide "Status Indians" the same drinking rights as other residents in Canada. Provinces slowly did this over the course of the next decade.[9] However, it was not until 1985 that all Indigenous-specific alcohol legislation was removed from the Indian Act.[84] In the 1950s, perceptions of excessive alcohol consumption shifted from being a sign of weak willpower to being an illness, called alcoholism, which is characterized by an "inborn, physiological addiction" that leads to "physical addiction."[82(p. 122)] The rise of the Alcoholics Anonymous movement contributed to this narrative, arguing that alcoholics could fix themselves with the help of others who have similar drinking problems. The alcohol industry supported this narrative since it placed responsibility on "the minority of drinkers with physiological defects"[82(p. 122)] rather than on the alcohol itself.
1960s – 1970s	Until this point, the legal drinking age was 21 in most provinces, linked to the age of majority.[85,86] In the 1960s, children born in the post-World War II population boom were beginning to reach adulthood. The growing young adult population and counterculture movement opposed government intrusion in their lives and pushed for more individual autonomy.[82] In response, provincial, territorial, and federal governments lowered the age of majority during the late 1960s

	to the early 1970s.[86,87] From 1970 to 1972, all provincial and territorial governments also lowered the legal drinking age to 18 or 19.[82,85] Some provinces opened self-serve liquor stores, and some provinces extended the hours of provincial liquor stores.[82] The prevalence of alcohol consumption grew. The proportion of Canadian adults who consumed alcohol rose from 65% in 1958 to 82% in 1985, with the prevalence being consistently higher among those under age 50.[27] Increases in the sale of alcoholic beverages brought with it increases in revenue for government and contributed to the growth of the Canadian gross domestic product (GDP).[27] In 1960, an article published by the Addiction Research Foundation in Ontario pointed out a relationship "between alcohol taxes, level of alcohol consumption, and the rates of death from alcoholic cirrhosis."[27] The Foundation's researchers also contributed significantly to a leading international report published in 1975, *Alcohol Control Policies in Public Health Perspective* by Bruun et al., which demonstrated the role and impacts of alcohol control policies. It and subsequent research demonstrated a need to be cautious in increasing access to alcohol.[27] The alcohol industry companies disagreed and debated some of these findings.[27]
1980s – 1990s	Canada and the United States began negotiating towards a free trade agreement. Key elements of the agreement included the elimination of tariffs and the reduction of many non-tariff barriers.[88] "The long-term result of the new market situation has been a further consolidation of the Canadian wine industry"[27] as well as the beer industry. With increased competition, Canadian brewers acted to portray their beers as national symbols, such as with Molson's "I am Canadian" advertising campaign.[27] Companies often "linked their products and companies to sports, music, and other forms of popular culture [that] blurred boundaries between selling beer and promoting Canadian culture."[27] Alcohol advertising became common everywhere.[89] "There is extensive advertising and promotion of alcohol, and concurrently a reduction of government having a direct role in screening alcohol advertising."[90(p. 458)] Trends in pop music showed an increase in positive mentions of alcohol.[91]

	Local chapters of Mothers Against Drunk Driving (MADD) came together to advocate for regulations to prevent drinking and driving. They brought forward the idea of "responsible drinking," which the liquor industry and media continued and emphasized. The message "If you drink, don't drive" became prevalent.[82] Although no other alcohol-related issue attracted public interest to the same extent as drunk driving, public pushback occurred when governments proposed loosening of restrictions on access to alcohol (such as when Ontario tried to bring alcohol sales into corner stores in the mid-1980s).[27] Off-premises consumption was allowed, but government-run stores maintained a monopoly.[27] All provinces (except Alberta) had maintained a government monopoly on off-premises alcohol sales thanks to strong public support for this.[27]
2000s – 2010s	The B.C. government undertook an extensive review of liquor policies to "modernize B.C.'s antiquated liquor laws and recommend improvements."[92(p. 53)] In line with the generally positive public perception of alcohol and the interests of the tourism, food, and alcohol manufacturing industries, the B.C. Liquor Policy Review's recommendations focused on removing restrictions, "streamlining," and "cutting red tape," thereby increasing access to alcohol.[92] While the B.C. Liquor Policy Review report included several potentially potent recommendations to protect public health and safety (such as labelling and pricing), they were either not implemented or weakly implemented in comparison to recommendations furthering business, consumer, and revenue goals.[12] The alcohol industry began "corporate social responsibility" initiatives. By financially supporting causes of interest to the public, companies raised their profile in the public sphere as a company that cares and wants to do good. They used these initiatives, and the resulting positive perception of their brand, as an opportunity "to frame issues, define problems and guide policy debates … [away] from those who manufacture and promote alcoholic products to those who consume them."[93(p. 1)] Multiple attempts to introduce warning labels on alcohol products failed.[90]

2020 – present	The restrictions implemented in response to COVID-19 disrupted legal and illegal markets. In 2020, in the midst of the pandemic, regulations were further loosened. While originally temporary, many of these changes have been made permanent. New national alcohol consumption guidance was released in 2023, providing the public with updated recommendations and information about the health and safety risks associated with alcohol.[94] The document states that evidence now shows a clear link between alcohol consumption and cancers, and that no amount of alcohol consumption is safe. It also states that individuals should minimize their alcohol consumption to reduce the risks associated with it.[94,95]

History of Unregulated Substances and Cannabis in Canada

1700s – early 1800s	Psychoactive substances were commonly used in medicines throughout Canadian society. No legal sanctions relating to psychoactive substances existed yet.[9] The temperance movement, a social movement originating in Protestant religious communities in England, started promoting abstinence and called alcohol and other intoxicants the source of society's evils. Shifting views were also connected to the colonial discourse that saw substance use as a "contagion brought to the west by racialized outsiders, and thus, a threat to white middle-class morality."[9]
1830 – 1860	Opium had been introduced to China in the eighth century. Although opium was illegal in China, by the 1700 and 1800s opium smoking in China had increased, with the British East India Company smuggling in large quantities for trade. China's efforts to end the opium trade led to two Opium Wars (1839–1842 and 1856–1860), with Britain forcing China to permit the trade.[9] These conflicts gave Christian missionaries in Britain, Canada and the U.S an opportunity to promote their views of opium smoking as a dangerous,

	foreign habit tied to Chinese men, that would threaten white Christian society. They failed to acknowledge that in some societies, opium farming and personal use was a largely unproblematic, long-standing practice that was often used medicinally, particularly in India.[9]
1880 – 1910	In the 1880s, Chinese men came to Canada to work on the Canadian Pacific Railway. After its completion, many settled in Vancouver. Some of these men smoked opium for pain relief and relaxation. Moral reformers and the media linked Chinese men with opium smoking and vilified them as a moral threat to white Christians. At the same time, there was an economic downturn, and white workers feared that Chinese and Japanese immigrants would take their jobs.[9] In 1907, a large protest in Vancouver lead to a riot where Chinese- and Japanese-owned businesses were vandalized. This drew attention from government leaders, and anti-opium moral reformers seized the opportunity to lobby the federal government to oppose opium use.[9] In 1908, the Opium Act "to prohibit the importation, manufacture and sale of opium for other than the medicinal purpose"[9] was adopted without debate. The Opium and Drug Act of 1911 expanded prohibition to include cocaine and morphine.[9]
1920 – 1930s	Narratives of the foreign "other" intensified, with public figures, media, and organizations framing Chinese men as corrupting the nation. Media campaigns advocated for harsher drug laws and deportation of Chinese Canadians as solutions to "the Chinese menace," leading to the Chinese Exclusion Act of 1923.[9] Media also depicted Black men as part of the problem. Common tropes at this time portrayed Black men as drug traffickers who would exploit White women.[63] Chinese and Black men were commonly singled out by law enforcement under suspicion that they were breaking opium laws.[63] Moral reformers also began speaking about cannabis, and with no debate in Parliament, it was added to the list of prohibited substances in 1923.[9,96] (Note: Historians are unable to determine why and how cannabis was added and also note that cannabis was not commonly used in North America at the time.[9,96]) During the Great Depression (1929–1939), several anti-cannabis articles and films were produced in the United States, depicting White middle-class

	teenagers becoming immediately addicted, going insane, and becoming criminals after smoking cannabis.[9] More substances continued to be added to the list of prohibited substances during this time. By 1938, 11 groups of substances were included.[9]
1940s – 1950s	The association between addiction and criminality grew in the 1940s. Legal heroin was available, but in 1955, Canada stopped issuing permits for its importation.[9] With perceptions of alcoholism as a disease becoming prominent, the medical community began seeing drug addiction as a disease as well.[82]
1960s – 1970s	Canada signed the international Single Convention on Narcotic Drugs in 1961 and passed the Narcotic Control Act in the same year. These pieces of legislation reinforced a punitive, criminal justice approach to substance use.[9] The international agreement required signatories to repress cannabis and suggested expanding maximum sentences for drug offenses to life in prison. Canadian legislators at the time agreed with health professionals about the potential for rehabilitation. The Narcotic Control Act included the option for judges to sentence people to treatment in place of incarceration.[82] With the emergence of the hippie counterculture movement, White university students began using hallucinogens and cannabis more than previous generations. Young people saw embracing cannabis as a way to challenge the social order. They pushed for a societal reckoning on the criminalization of illegal drugs, arguing that more powerful and harmful substances remained legal for prescribing and were protected by the "medical establishment."[82] Over time, mainstream Canadian society began to doubt the characterization of cannabis users that had been perpetuated over the decades, as this was a behaviour that their friends, family, and neighbours engaged in.[97] The medical community at this time was divided on the issue of cannabis.[82] Arrests for cannabis possession increased during this time, including among White middle-class youth. Mainstream media and White middle-class parents coalesced to advocate against the harsh punishments.[9]

	In 1969, the Le Dain Commission recommended reducing criminal sanctions for drug use, offering medical treatment in place of punishment, and decriminalizing cannabis possession.[9] The Commission emphasized that the negative impacts of enforcing criminal law—particularly for those who use drugs—were more severe than the harms linked with substance use.[98] The recommendations from this Commission were never implemented.[9] In 1971, Canada signed the international Convention on Psychotropic Substances, which identified four schedules of substances to be controlled by signatory countries.[99] While the public discourse of the 1960s made the federal government consider decriminalizing cannabis, it argued that international treaties limited its ability to set independent drug policies.[82]
1980s – 1990s	By the early 1980s, the general public and politicians in Canada had lost interest in debating drug policy. Then, in 1986, the American president declared a renewed "war on drugs," calling drugs a menace to society. A few days later, the Canadian prime minister publicly stated that "drug abuse has become an epidemic," even though the substance use environment had remained fairly stable over the previous decade.[97] Canada's first National Drug Strategy was released in 1987. The majority of the funding associated with the strategy was allocated towards prevention and treatment.[97] However, this was quickly followed by the creation of new prohibitionist policies, such as banning the sale of drug paraphernalia.[97] In 1988, Canada signed the United Nations Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances that provided "additional legal provisions to enforce the other international conventions."[8(p. 13),100] Law enforcement efforts increased, and media reports emerged that perpetuated the narrative of substance use as having become an epidemic. Many of these stories (baselessly) showed Black individuals as dangerous drug criminals.[63] Harm reduction movements began in Canada in the late 1980s. The first needle exchange programs opened despite drug paraphernalia laws, as a way to prevent HIV transmission and save lives. When there was a rise in overdoses and HIV and hepatitis C infections in Vancouver's Downtown

	Eastside in the early 1990s, activists opened unofficial safe injection sites to address the public health need.[9] The 1996 Controlled Drugs and Substances Act replaced the Narcotic Control Act, continuing prohibitionist policies and adding more substances to the list of scheduled substances.[8] A new iteration of the federal government's drug strategy released in 1998 identified four pillars of the strategy's efforts: education and prevention, treatment and rehabilitation, harm reduction, and enforcement and control. This was the first time that harm reduction was explicitly included within the federal strategy.[101] The cannabis legalization movement re-emerged in the 1990s, advocating for access to cannabis for its medical benefits for individuals with AIDS.[9,82] OxyContin, a strong opioid, was being heavily promoted to physicians across Canada as a safe, non-addictive painkiller.[102]
2000s – 2010s	In response to the cannabis legalization movement, the Marihuana Medical Access Regulations were released in 2001, allowing those with critical or chronic illnesses to legally access cannabis.[103] The regulations provided a system for the federal government to govern the production, distribution, and use of cannabis for medical purposes.[103] Canada was the second country globally to adopt a system for this purpose.[8] Harm reduction gained momentum in the 2000s, leading to the opening of Insite, Canada's first legally sanctioned supervised injection site, in 2003. This was made possible by an exemption granted under Section 56 of the Controlled Drugs and Substances Act. Despite the demonstrated success of Insite, the federal government did not grant the required exemptions to operate other similar sites for well over a decade.[8] In 2007, the federal government put out the National Anti-Drug Strategy, which no longer included harm reduction as one of the four pillars of the government's strategy. It heavily emphasized law enforcement efforts, including introducing mandatory minimum sentences for even minor drug offenses.[8] Following the commercial success of OxyContin, the number of prescriptions for these opioids skyrocketed.[102] Upon discovering the addictive nature and harms being caused by excessive prescribing, strategies

	and guidelines were put in place across Canada in the 2010s to quickly reduce opioid prescribing. Many individuals were cut off or had their dosage reduced quickly. Unable to access the substance to which they had become dependent, many individuals went to the illegal market.[104] The 2010s saw the emergence of an unprecedented overdose crisis and a toxic drug supply, leading to thousands of deaths. In April 2016, facing this overdose crisis, B.C. declared a public health emergency under the Public Health Act.[105] This enabled the province to collect real-time information and expand services. In December 2016, the federal government introduced a new national strategy, the Canadian Drugs and Substances Strategy. In it, harm reduction returned as one of the pillars. With this new strategy, the federal government increased access to naloxone, granted exemptions to the Controlled Drugs and Substances Act for supervised consumption services to once again be accessible, and created a process to streamline approvals for potential overdose prevention services.[106] In 2017, the federal government passed the Good Samaritan Drug Overdose Act to protect people from being charged or convicted under the Controlled Drugs and Substances Act if they called for emergency assistance when at the scene of an overdose, recognizing there might be reluctance if police are involved.[107] In 2018, cannabis became legal for recreational use with the passing of the Cannabis Act and related amendments to the Criminal Code. This created a legal, regulated model for cannabis production, distribution, and sale, applying a public health approach to cannabis.[108]
2020 – present	The restrictions implemented in response to COVID-19 disrupted legal and illegal markets. This resulted in the already highly potent supply of unregulated substances becoming more inconsistent and increasingly toxic. Pandemic restrictions also disrupted access to harm reduction services and forced people to use their substances alone without anyone nearby and able intervene if an overdose occurred.[109] In order to make it possible for people who use unregulated substances to physically distance and self-isolate, the B.C. government put out new interim clinical guidance for health care providers, called Risk Mitigation Guidance, in March 2020. This guidance allowed and guided off-label prescribing of

	controlled medications that could be used as pharmaceutical alternatives to those that individuals had been obtaining from the unregulated market.[110,111] Seeing a need to enable access to prescribed alternatives beyond COVID-19, the B.C. government released *Access to Prescribed Safer Supply in British Columbia: Policy Direction* in July 2021.[112] Beginning January 31, 2023, the Province of British Columbia was granted a "three-year exemption from the federal government to remove criminal penalties for people who possess small amounts of illicit drugs for personal use."[57] The Province's goal with decriminalization was to reduce stigma associated with drug use that makes people hide their use and avoid accessing supports.[57] In May 2024, the federal exemption was amended to prohibit possession and use of these substances in public spaces.[58,59]

History of Tobacco Products in Canada

Before European settlers arrived	For thousands of years, tobacco species indigenous to Turtle Island (commonly known as North America) have been used by many Indigenous communities in ceremony and prayer as a sacred, medicinal plant.[113,114]
1500s	European settlers developed the tobacco plant as a plantation crop and treated it as a commodity for trade.[113]
1800s	Tobacco was commonly used by men, in both settler and Indigenous communities in Canada, mainly by smoking pipes or cigars or chewing "plugs."[67] Among settler communities, tobacco was considered a luxury item for wealthy men to use.[67]
1880 – 1930s	Mass production of cigarettes made tobacco smoking inexpensive. Advertising worked to remove class-based norms associated with tobacco use.[67]

	Temperance movement actors expressed concern for moral and public health consequences of cigarette smoking, but tobacco companies pushed back.[67] Cigarette smoking by young soldiers in World War I was promoted as a symbol of masculinity.[67] After the war, various advertising techniques were used to further normalize and promote cigarette smoking, including using movie stars as role models.[67]
1940s – 1950s	During World War II, the federal government relied on revenue from cigarette taxes. Cigarette smoking for women was further normalized as "cigarettes became an emblem for women serving on the home front in munitions factories or other roles that supported the war effort."[67(p. 41)] Cigarettes were also sold to women as sexy and empowering.[82] Marketing to men shifted to portraying cigarette use by rugged cowboys with the introduction of the Marlboro man.[82] In the 1950s, large studies by prominent researchers firmly demonstrated tobacco smoking as a cause of cancer.[67,115] Tobacco companies worked to hide the harms of smoking from consumers and prevent government from regulating the industry, undertaking extensive advertising and ongoing public polls to monitor the impact of the scientific reports on public perception.[67]
1960s – 1970s	Following leading health organizations, the Canadian government formally accepted that smoking causes cancer. This led to the development of Canada's first Smoking and Health Program, which focused on monitoring Canadians' smoking and using health education to discourage smoking.[67] Because the approach appeared ineffective, politicians pushed for legislation banning cigarette advertising, health warnings on packaging, and requirements that companies limit the tar levels in their cigarettes. These ideas were seen as unrealistic until 1968, when a new health minister was appointed who opened a parliamentary committee on cigarette smoking.[67] In place of legislation governing the actions of tobacco companies, the industry agreed to a voluntary code that came into effect in 1972, limiting advertising, adding health warning labels, and encouraging consumers to switch to cigarettes with lower levels of tar.[67]

	Civil society organizations began to organize to advocate for policy change and counter the lobbying efforts of the tobacco industry.[67] Municipalities began to pass non-smoking bylaws.[67]
1980s – 1990s	In 1988, the federal government passed two tobacco control bills, the Tobacco Products Control Act and the Non-Smokers' Health Act. These banned advertising, instituted a substantive tax on tobacco sales, required warning labels, and made federal workplaces smoke-free.[67]The tobacco industry responded by challenging the advertising ban in court and running campaigns to stoke anger about the new taxes among the public.[67] The prevalence of tobacco smoking decreased. The proportion of Canadians who smoke dropped from 50% in 1965 to 31% in 1990.[116] Throughout the 1990s, the federal government continually passed new legislation to address legal concerns and close loopholes.[67] Provincial and municipal governments also introduced tobacco legislation and bylaws, such as increased taxes, second-hand smoke protections, sanctions on flavoured cigarettes, restricted smoking in certain workplaces and public spaces, licensing fees for tobacco retailers, and expanded supports for those wanting to quit smoking.[67]
2000s – 2010s	Tobacco companies were expanding into global markets, and there was an identified need for a global response.[67] The World Health Organization negotiated an international treaty on tobacco and, in 2003, passed the Framework Convention on Tobacco Control.[67] The treaty focused on requiring countries to adopt measures to reduce the demand for tobacco, and it included supply reduction provisions as well as to protect these regulations from the commercial interests of the tobacco industry.[67] The federal government quietly ended the decades-running Steering Committee for the National Strategy to Reduce Tobacco Use and stopped funding tobacco-specific health agencies.[67] In 2008, electronic nicotine products came into the Canadian market. Though the federal Food and Drugs Act banned the sale of nicotine products, few enforcement actions were taken. Vape stores became common.

	There was no consensus in the medical community on how to approach these products: as a smoking cessation aid or a way to get new people using nicotine.[67] Beginning in the mid-2010s, many provinces passed e-cigarette legislation, including banning vaping where smoking was banned and preventing sale to minors.[117] In 2018, the federal Tobacco and Vaping Products Act was passed, legalizing the sale of e-cigarettes with more relaxed marketing regulations than tobacco and no requirement for meeting any safety or quality standards. In 2019, Health Canada acknowledged an uptick in vaping among youth and recognized the need for stronger controls. The pan-Canadian committee of Chief Medical Health Officers released a consensus statement on additional tobacco and nicotine control policies to adopt,[118] and some provinces have imposed additional measures.[67]
2020 – present	In 2020, the B.C. government introduced a 10-point youth vaping action plan "to protect young people from the harms of vaping and vapour products".[119(p. 2)] The plan included introducing additional regulations, such as limiting the nicotine content allowed in vapour products and requiring plain packaging and health warning labels.[119] In 2021, the federal government passed legislation that limits the nicotine concentration permitted in vaping products sold in Canada.[120] It also put forward proposed legislation that would limit the flavours in vaping products to only tobacco, mint, and/or menthol. This legislation has been under review since August 2022, and there is currently no publicly available plan to move forward with it.[121]