Evidence from British Columbia's Drug Decriminalization Pilot: Findings and Implications for the Opioid Epidemic and Toxic Drug Crisis in Canada

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Study of the *Opioid Epidemic and Toxic Drug Crisis in Canada*

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Policy background and scope

On January 31, 2023, a federal exemption under section 56(1) of Canada's *Controlled Drugs and Substances Act* took effect in British Columbia (BC). The exemption permitted adults aged 18 years and older to possess a cumulative total of up to 2.5 grams of specified opioids, cocaine, crack cocaine, methamphetamine, and MDMA for personal use, subject to location and other conditions, without arrest, charges, or seizure of those drugs.[1,2]

The exemption was amended on May 7, 2024 to exclude most public spaces.[3] Protections remained in specified settings, including private residences, designated health clinics, shelters, and overdose prevention and supervised consumption sites. This amendment substantially narrowed the scope of the exemption, with the original framework operating for approximately 15 months before these changes took effect. The exemption expired on January 31, 2026, and was not renewed.[4]

Developed as one component of BC's response to the toxic drug public health emergency, the policy sought to reduce criminalization and stigma, improve interactions with police, and increase comfort accessing health and social services. Broader health benefits were expected to emerge through these pathways but depended on accessible services, complementary supports, and government investment in health and social service infrastructure.[1,2] The policy's effects must therefore be understood within the broader context of the toxic drug supply, housing conditions, and service availability.

About the Ontario CRISM Node and the Evaluation

The Ontario Node of the Canadian Research Initiative in Substance Matters (CRISM), based at the Centre for Addiction and Mental Health (CAMH) in Toronto, brings together researchers, people with lived and living experience, service providers, policy makers, and other partners to generate evidence that improves substance use policies, programs, and services. It is part of CRISM's national network of five regional nodes.[5]

Our team received five-year funding from the Canadian Institutes of Health Research (2022–2027) to conduct an independent national evaluation of BC's decriminalization pilot, separate from the provincial government's monitoring and evaluation. Co-developed with experts and people with lived and living experience, the evaluation integrates administrative data, annual interviews with people who use drugs and police, service

provider surveys and interviews, public opinion polling, and analyses of implementation and communications. An Advisory Board and sub-study working groups guide the work.[1]

Key findings across the evaluation

Possession enforcement fell and rose again after the amendment

Interrupted time-series analyses identified a 68% reduction in police-reported drug possession seizures of any quantity and an 87% reduction in seizures involving 2.5 grams or less during decriminalization in BC. The policy was also associated with reductions of 57% in recorded possession incidents and 46% in persons charged, relative to other provinces.[6,7] Following the May 2024 amendment, possession seizures and incidents returned to levels statistically indistinguishable from those observed before decriminalization, indicating a reversal of reductions in enforcement directly aligned with the policy's objectives.[7,8]

Legal protections improved some experiences but policing remained uneven

Across interviews with nearly 300 people who use drugs, some participants described less fear of arrest, more safety and security, and better interactions with police during the original policy period. Others reported continued confiscations, including quantities below the threshold, stigmatizing treatment, and unpredictable encounters that depended on the individual officer.[9-13] Interviews with police identified uneven training, unclear guidance, liability concerns, and continued reliance on discretion. Officers also described increasing pressure to respond to public drug use and difficulties balancing community concerns about public order with the legal protections afforded to people who use drugs.[14,15] Following the May 2024 amendment, participants who use drugs described heightened concerns about surveillance and confiscation.[9] Officers generally welcomed the restoration of authority to respond to public drug use but continued to report uncertainty about implementing the amended policy.[16]

No statistically significant changes were detected in health or service indicators

Interrupted time-series analyses identified no statistically significant changes following either the original decriminalization policy or the May 2024 amendment in opioid agonist treatment (OAT) dispensing, supervised consumption or overdose prevention site visits, emergency medical service attendances for opioid poisonings, hospitalizations related to drug use and drug use disorders, or drug poisoning deaths.[17-19] These outcomes are more distal to the policy's direct effects on criminalization, with potential changes expected to emerge over longer periods through reduced stigma, improved trust, and greater engagement with services. Such changes also depend on service availability and broader structural conditions, limiting the conclusions that can be drawn from the absence of statistically significant effects within the available follow-up period.

Structural conditions shaped risks and access to legal protections

Qualitative interviews with people who use drugs identified stable patterns of drug use, while the toxic drug supply, housing insecurity, and other structural conditions continued to shape risks and access to legal protections.[11,20] Housing became particularly consequential following the May 2024 amendment, as restrictions on public possession left people without private spaces with few protected alternatives.[21] Some participants described shifting to more hidden or isolated settings, potentially increasing overdose risk. People in smaller or remote communities described purchasing larger quantities to reduce travel, increasing their likelihood of exceeding the possession threshold.[11] Racialized participants and those visibly identified with drug use also reported targeted policing.[21] Participants generally described little improvement in stigma, although some viewed the original policy as signalling recognition and dignity and experienced the amendment as reinforcing stigma and undermining safety.[10] The policy's protections and potential benefits were therefore unevenly experienced, depending on housing, geography, and exposure to stigma and policing.

Service capacity and implementation constrained broader benefits

Surveys and interviews with harm reduction and OAT service providers across BC found few policy-related changes to operations, visits, or treatment engagement.[22,23] Providers described staffing and space shortages,

limited additional funding, and gaps in inhalation services, housing, and wraparound supports.[24] A seminal systematic review of 27 studies examining BC's decriminalization policy across its lifespan identified recurring barriers involving policy design, public communication, training and guidance, and funding and infrastructure. Interviews with decriminalization implementation staff also identified fragmented communication and reporting challenges, including issues providing feedback to decision-makers.[25]

Public concerns and expectations exceeded perceived achievements

Annual online surveys of BC adults showed opposition to decriminalization increasing from 41% in 2024 to 47% in 2026, while the proportion agreeing that the policy made them feel less safe increased from 43% to 47%.[26] Respondents also reported substantial gaps between expected and perceived outcomes, often evaluating decriminalization against expectations of fewer overdoses, reduced crime and public drug use, and improved community safety.[27] These expectations extended beyond the policy's immediate objectives related to criminalization and encompassed broader outcomes whose improvement would likely require sustained investment in complementary services and longer implementation periods.

Additionally, a content analysis of 310 media articles and 98 government resources identified increasingly negative media coverage alongside gaps in government communication. Misinformation was identified in 24% of media articles, including misconceptions about the policy's scope and intent and unsubstantiated claims about its effects. Government resources offered limited accessible educational content tailored to general audiences, leaving gaps in public understanding of the policy's objectives, legal parameters, and relationship to the broader toxic drug crisis.[28]

Implications for responses to the toxic drug crisis

BC's experience highlights three primary implications for understanding decriminalization's contribution to a broader response to the toxic drug crisis.

First, decriminalization should be evaluated against its intended objectives and expected pathways of change. The policy was associated with substantial reductions in possession enforcement and, for some participants, reduced fear of arrest. Reducing criminalization is a meaningful outcome in itself. Broader health benefits were expected to emerge through pathways such as reduced stigma, improved trust, and greater engagement with services. Although no statistically significant changes were detected in the health and service indicators examined, these findings do not establish that longer-term benefits were unattainable. Public expectations frequently encompassed reductions in overdose deaths, crime, and public drug use, highlighting the importance of distinguishing immediate policy objectives from broader outcomes influenced by multiple factors and potentially requiring longer periods to change.

Second, policy design and implementation shape who benefits and who remains exposed to risk. The possession threshold, enforcement practices, geographic differences, and access to legally protected spaces influenced how people experienced the policy. Uneven training and guidance contributed to inconsistent implementation, while public-space restrictions particularly affected people without private places to use drugs. Some described shifting to more hidden or isolated settings following the amendment, potentially increasing overdose risk. The amendment also substantially narrowed the exemption after approximately 15 months and was followed by a reversal of reductions in possession seizures and incidents. These findings demonstrate the importance of examining the specific protections offered, how they operate in practice, and how changes to them affect both outcomes and the opportunity to assess longer-term effects.

Third, decriminalization alone cannot address the toxic drug crisis. Removing criminal penalties may reduce some barriers to seeking support, but it does not itself expand treatment capacity, provide housing, or change the toxicity of the unregulated drug supply. Providers described persistent shortages in staffing, infrastructure, and services that constrained opportunities to translate legal protections into improved access to care. Broader health improvements therefore depend on sustained investment in treatment, harm reduction, housing, and

other essential supports, alongside efforts to address stigma. Decriminalization's potential contribution must be understood in relation to these complementary measures and the structural conditions shaping drug-related harms.

Interpretation and ongoing work

The evaluation identified clearer changes in possession enforcement than in broader health and service outcomes. Interpretation requires consideration of the short original policy period, subsequent amendment, differing follow-up periods across sub-studies, and concurrent changes in the drug supply and service environment. Qualitative accounts illuminate experiences and potential mechanisms but do not establish their prevalence across BC; online survey findings likewise require consideration of sampling limitations. Our independent evaluation continues until 2027, with planned work including updated administrative analyses, further examination of implementation and differential impacts, and an economic assessment.

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