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Public support of and attitudes toward decriminalization of possession of illegal drugs among the general population in British Columbia

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Abstract

Background Decriminalization of possession of illegal drugs was implemented in British Columbia, Canada for a three-year period starting from January 31, 2023. As public sentiment played a large role in the outcome of a similar reform in Oregon, United States, it is important to examine the public's perceptions of this policy. We examined public support of and attitudes toward decriminalization.

Methods Data were from an online, non-probability, cross-sectional survey of adults who spoke English and resided in British Columbia ($N=1{,}202$; March to April 2024). One item assessed support of decriminalization, and ten items assessed attitudes toward decriminalization. The analytical strategy involved descriptive statistics and multinomial logistic regression.

Results In regards to support of decriminalization, 41% did not support decriminalization, 26% were neutral or not sure about supporting decriminalization and 33% supported decriminalization. The majority agreed that decriminalization will reduce criminalization of drugs (50%) and encourage drug use experimentation (53%). More agreed (44%) than disagreed (28%) that decriminalization made them feel less safe. The majority disagreed that decriminalization will reduce overdoses (55%) and drug-related crimes (50%). Older age was associated with an increased likelihood of not supporting decriminalization compared with being neutral or not sure about supporting decriminalization (OR [95% CI]: 1.97 [1.35 to 2.88] for 40 to 59 years old; 1.89 [1.19 to 3.02] for ≥ 60 years old), and female or another gender was associated with a decreased likelihood of supporting decriminalization compared with being neutral or not sure about supporting decriminalization (0.66 [0.47 to 0.91]).

Conclusions Public support of decriminalization was not strong, which may be rooted in lack of robust confidence in decriminalization to achieve its goals and increased public safety concerns. These findings necessitate ongoing evaluations of the policy and increasing knowledge mobilization activities to keep the public abreast of the latest developments.

Keywords Canada, British Columbia, Drug and narcotic control, Drug overdose, Public opinion

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Introduction

North America is in the midst of a crisis featuring drug poisoning deaths. In Canada, drug poisoning deaths have more than doubled between 2016 and 2022, rising from 7.8 deaths per 100,000 to 19.4 deaths per 100,000 [1]. The vast majority of these deaths have been attributable to fentanyl and fentanyl analogues, with more recent involvement of psychostimulants and benzodiazepines [2]. Drug poisoning deaths currently represent one of the leading causes of accidental deaths among those ≤ 65 years old in Canada, with determinantal impacts on life expectancy [3, 4].

Drug poisoning deaths of all jurisdictions in Canada remain the highest in the province of British Columbia (45 per 100,000 in British Columbia vs. 19 per 100,000 in all provinces and territories in 2022) [1]. A range of interventions have been enacted to mitigate the public health impacts, including the expansion of pharmacotherapy medications approved for the treatment of opioid use disorder, scale up of harm reduction services (including supervised consumption sites and drug checking sites), distribution of the opioid poisoning antidote naloxone, and provision of prescribed pharmaceutical alternatives to the illegal drug market [5, 6]. Despite the breadth of interventions, the crisis continues unabated in British Columbia.

The deteriorations in the social determinants of health due to the ongoing affordability and housing crises, absence of and barriers to treatment and support services, and changes in the constituents of the illegal drug supply are all relevant contributors to the drug-related harms [7]. Another potential contributor is the continued criminalization of drugs, which results in significant economic, social, and health impacts among people who use drugs. Indeed, criminalization of drugs leads to stigmatization, deters access to services, hinders peer response to poisonings, and perpetuates risky drug use practises [8, 9]. Consequently, some jurisdictions have experimented with decriminalization of possession of illegal drugs (referred from here on as decriminalization), a public health approach to drug-related harms that broadly entails suspension of criminal code provisions related to drug possession. Decriminalization is accordingly suggested to reduce drug-related harms and improve public safety and health. Jurisdictions that have previously enacted decriminalization include Portugal and the State of Oregon in the United States. In Portugal, decriminalization was accompanied by significant investments in health and social services (including outreach and harm reduction services) [10]. In Oregon, there were significant challenges and delays in the implementation of similar services [11]. While decriminalization in Portugal is largely regarded as a success [12], the same does not hold true of decriminalization in Oregon. Despite emerging evidence indicating no changes in drug poisoning deaths in comparison to other states [11], as well as reductions in drug possession arrests in comparison to other states [13], decriminalization was repealed within three years of the implementation of the policy in Oregon. The main reasons included concerns about public drug use and the increased toll of drug poisoning deaths [14–16]. Importantly, proponents of decriminalization indicated that mental health problems exacerbated by the coronavirus pandemic, and increased homelessness due to the rising costs of living, were responsible for an increase in public drug use [14–16]. Furthermore, the emergence of fentanyl in the illegal drug supply, which was responsible for the increased toll of drug poisoning deaths, coincided with the implementation of the policy [14–16].

Recognizing the potential impact of criminalization of drugs on drug-related harms, British Columbia requested an exemption to the Controlled Drugs and Substances Act (CDSA) to decriminalize select illegal drugs. Health Canada granted this exemption for a three-year period from January 31, 2023 to January 31, 2026 [17]. Under decriminalization, adults can now legally possess up to a cumulative 2.5 g of illegal drugs including opioids, cocaine, methamphetamine, and ecstasy [17]. The overarching goal of decriminalization is to reduce the stigma associated with drug use and fear associated with criminalization, which often prevents people who use drugs from seeking health and social services [17]. However, it includes other long-term objectives as well, such as reductions in non-fatal and fatal drug poisonings, increases in engagement and retention in treatment and support services and improvements in interactions between law enforcement and people who use drugs [17]. In preparation for the implementation of decriminalization, the Government of British Columbia informed the public about the impending changes through advertising across various channels. Frontline harm reduction services and drug advocacy groups also distributed materials to inform people who use drugs. The Government of British Columbia also made commitments to expanding health and social services. For instance, in regards to mental health and substance use services, there were investments of $1 billion in the provincial budget in 2023 and $215 million in the provincial budget in 2024 [18]. However, these commitments were not explicitly tied to the implementation of decriminalization, and it remains unclear to what extent they translated into tangible service enhancements or on-the-ground implementation efforts.

After decriminalization came into effect on January 31, 2023, concerns related to increased public drug use and lack of tools for police to address public drug use were raised by municipalities, law enforcement officials, health care workers, and community members [19]. In response

to these concerns, the Government of British Columbia proposed an amendment to the original exemption that prohibited illegal drug possession and use within 15 m of parks, skate parks, and spray or wading pools, which received approval from Health Canada on September 18, 2023. The Government of British Columbia additionally proposed Bill 34, which prohibited the public consumption of illegal drugs within a six meters radius of additional spaces not included in the original exemption (such as building entrances and public transit stops) and within 15 m radius of parks, beaches, and sports fields [20]. In addition, it proposed powers for police to remove people engaging in illegal drug use within these places, as well as powers to arrest people for non-compliance and seize or destroy illegal drugs regardless of quantity [20]. However, a successful injunction suspended the implementation of Bill 34 until June 30, 2024 [21]. The Government of British Columbia in the interim proposed another amendment to the original exemption to supersede Bill 34 in order to re-criminalize illegal drug possession and use in public spaces, which received approval from Health Canada and came into effect on May 07, 2024 [17]. This amendment restricts illegal drug possession and use to private residences, communal shelters, and select harm reduction and addiction treatment facilities [17]. These restrictions disproportionately affect those who are unhoused or those who are disconnected from or do not trust health and social services. This amendment may convey a message about the social acceptability of drug use to the public, and undermine decriminalization by reinforcing stigma against people who use drugs, which can lead to alienation, social isolation, increased risk of using alone, and an environment that discourages accessing services [7]. Importantly, much of the evidence concerning public drug use is anecdotal in nature, as robust provincial data demonstrating increases in public drug use post-decriminalization are not available.

As reduction of stigma is central to decriminalization, assessments of public support of and attitudes toward decriminalization are necessary to help decision makers understand the public sentiment and address concerns or misconceptions that may further perpetuate stigma. A number of public opinion surveys on decriminalization have been conducted to this end. Support of decriminalization ranged from 47% to 59% in Canada and from 49% to 66% in British Columbia in the lead up to decriminalization between 2020 and 2022 [22–24]. In a national public opinion survey conducted a few months after the implementation of decriminalization between February 2023 and March 2023, when asked about approaches to address substance use, 49% favored an approach focusing on access to health and social services, while 35% favored an approach focusing on both access to health and social services and police enforcement [25]. In addition, 62% agreed decriminalization would make it easier to access health and social services and 56% agreed decriminalization would reduce the stigma towards people who use drugs. However, 51% agreed decriminalization would increase harms associated with drug use, while 43% agreed decriminalization would make their community less safe [25]. The contrast in these attitudes underscores the complexity of the public's perceptions regarding decriminalization. These public opinion surveys also demonstrated that support of decriminalization varied based on certain demographic characteristics. Specifically, males, younger adults, university graduates and residents of urban areas indicated higher levels of support [22–24]. In regards to males and younger adults, the higher levels of support may stem from their higher rates of drug use [26], which has been shown to be associated with more positive attitudes towards less intrusive substance use policies [27–29]. In regards to university graduates and residents of urban areas, the higher levels of support may stem from their greater political leaning to the left [30, 31], which features less intrusive substance use policies.

While these surveys have provided valuable insights, they were conducted either before or during the early stages of the implementation of decriminalization. As such, they may not reflect support of and attitudes toward decriminalization after it has been implemented for an extended period. Continued monitoring is therefore required to determine whether decriminalization is achieving its goals, including the reduction of stigma. This is especially relevant given the heightened concerns about public drug use post-decriminalization in British Columbia, which have prompted amendments to the policy. Accordingly, we sought to address these knowledge gaps by conducting a public opinion survey in the second year after the implementation of decriminalization among adults in British Columbia. Our specific objectives were twofold: (1) to characterize the public support of and attitudes toward decriminalization; and (2) to examine the demographic characteristics associated with public support of decriminalization.

Materials and methods

Data sources

The public opinion polling firm Ipsos conducted an online, non-probability, cross-sectional survey between March 26, 2024 and April 1, 2024, which sampled adults (≥ 18 years old) residing in British Columbia who spoke English. The sampling frame was comprised of established panels maintained by Ipsos (see Supplementary Methods in the Supplementary Material for additional details). The sampling methodology entailed quota sampling by age, gender, and region based on the population of British Columbia. Participants were routed to the

survey through a generic email invitation or could select the survey from those available to them on the panelist website or mobile application maintained by Ipsos. The survey was developed in consultation with experts from the national decriminalization evaluation [32], and informed by another survey on knowledge and attitudes around decriminalization conducted by Health Canada [25]. All participants provided informed consent before starting the survey. All participants were offered incentives in the form of points, which could be redeemed for merchandise and prepaid cards (see https://www.ipsosisay.com/en-ca/rewards). A total of 6,694 participants were invited to complete the survey. After initial assessments of the participants, 366 were screened out due to eligibility criteria and 1,441 were over the desired quotas. From the remaining 4,887 participants, 1,202 participated in the survey, resulting in a response rate of 25%.

Measures

Outcomes

Support of decriminalization was assessed using the item, "I support the decriminalization of illicit drugs policy in BC [British Columbia]" (Responses: strongly disagree, disagree, neutral, agree, strongly agree, not sure, and prefer not to answer). Support of decriminalization was classified into one of three categories: did not support decriminalization (strongly disagree, disagree), neutral or not sure about supporting decriminalization, and supported decriminalization (agree, strongly agree).

Attitudes toward decriminalization were assessed using ten items (Responses: strongly disagree, disagree, neutral, agree, strongly agree, not sure, and prefer not to answer): (1) "decriminalization will reduce the criminalization of people who use drugs in BC [British Columbia]" (2), "decriminalization will reduce rates of drug overdoses" (3), "decriminalization will reduce the stigma associated with drug use" (4), "decriminalization has positively influenced my views of people who use drugs" (5), "decriminalization will encourage drug use experimentation" (6), "decriminalization has made me feel less safe in my community" (7), "decriminalization will decrease drug-related crimes in my community" (8), "decriminalization will reduce policing and law enforcement costs and resources" (9), "decriminalization will improve access to treatment and supports for people who use drugs" and (10) "decriminalization is a positive step towards recognizing drug use as a health issue rather than a criminal issue".

Covariates

Covariates included demographic characteristics: age (18 to 39 years old; 40 to 59 years old; ≥ 60 years old), gender (male; female or another gender [combined due to small sample size]), regional health authority (Vancouver Coastal Health; Fraser Health; Vancouver Island Health; Interior Health or Northern Health), educational attainment (up to high school education; college or trade school education; university education), income (< $40,000; $40,000 to $59,999; $60,000 to $99,999; ≥ $100,000), household composition (children; no children), marital status (living with a partner or married; single, never married, widowed, divorced, or separated) and employment status (employed; unemployed; homemaker, full-time parent, student, military, or retired).

Statistical analyses

Demographic characteristics of participants were tabulated. Subsequently, support of and attitudes toward decriminalization were characterized. Thereafter, the associations between demographic characteristics and support of decriminalization were tested. Rao-Scott chi-square tests were conducted to identify differences in support of decriminalization according to demographic characteristics. The identified demographic characteristics were then selected for inclusion in a multinomial logistic regression model. Odds Ratios (ORs) were generated estimating the likelihood of not supporting decriminalization compared with being neutral or not sure about supporting decriminalization, as well as the likelihood of supporting decriminalization compared with being neutral or not sure about supporting decriminalization. Survey weights were constructed based on age, gender, region, and education. All analyses were weighted to reflect the general population and conducted using survey procedures in SAS Version 9.4.

Ethics approval

Research ethics committee review and approval were obtained from the Research Ethics Board at the Centre for Addiction and Mental Health (File Number: 2023/173).

Results

Participant characteristics

The demographic characteristics of participants are presented in Table 1. The largest proportion were between 18 and 39 years old (35%), identified as female or another gender (52%), resided in the geographic region of the Fraser Health Authority (40%) and had a university education (40%). The largest proportion were employed (54%) with an income between $60,000 to $99,999 (29%), were living with a partner or married (53%) and had no children in their household (78%).

Support of and attitudes toward decriminalization

In regards to support of decriminalization, 41% did not support decriminalization (16% disagreed and 26% strongly disagreed), 26% were neutral or not sure

Table 1 Demographic characteristics of participants

Demographic Characteristics		*N* (%) [a, b]
Age	18 to 39 Years Old	450 (35.0)
	40 to 59 Years Old	409 (30.1)
	≥ 60 Years Old	343 (34.9)
Gender	Male	569 (48.2)
	Female or Other Gender	627 (51.8)
Regional health authority	Vancouver Coastal Health	270 (21.1)
	Fraser Health	452 (39.9)
	Vancouver island health	211 (18.8)
	Interior Health or Northern Health	181 (20.2)
Educational Attainment	Up to High School Education	236 (31.0)
	College or Trade School Education	376 (28.8)
	University Education	590 (40.2)
Income	< $40,000	281 (28.1)
	$40,000 to $59,999	201 (19.3)
	$60,000 to $99,999	329 (28.6)
	≥ $100,000	302 (24.0)
Household Composition	Children	307 (22.1)
	No Children	895 (77.9)
Marital Status	Living with a Partner or Married	652 (53.0)
	Single, Never Married, Widowed, Divorced or Separated	550 (47.0)
Employment Status	Employed	716 (54.4)
	Unemployed	131 (11.8)
	Homemaker, Full-time Parent, Student, Military or Retired	336 (33.8)

[a] Sum of cell sizes may not equal total sample size ($N = 1,202$) due to missing data

[b] Frequencies are unweighted and percentages are weighted

about supporting decriminalization and 33% supported decriminalization (22% agreed and 11% strongly agreed).

The attitudes toward decriminalization are displayed in Fig. 1 (see Table S1 in Supplementary Appendix for the underlying data). Half of participants agreed that decriminalization will reduce the criminalization of people who use drugs (50% [39% agreed and 12% strongly agreed]), while the majority of participants agreed that decriminalization will encourage drug use experimentation (53% [29% agreed and 24% strongly agreed]). More participants agreed (44% [22% agreed and 22% strongly agreed]) than disagreed (28% [9% strongly disagreed and 19% disagreed]) that decriminalization made them feel less safe in their community.

The majority of participants disagreed that decriminalization will reduce rates of drug overdoses (55% [29% strongly disagreed and 27% disagreed]) and decrease drug-related crimes (50% [26% strongly disagreed and 24% disagreed]), and that decriminalization had positively influenced their views of people who use drugs (53% [27% strongly disagreed and 25% disagreed]). More participants disagreed (45% [19% strongly disagreed and 26% disagreed]) than agreed (28% [22% agreed and 6% strongly agreed]) that decriminalization will reduce the stigma associated with drug use.

Participants were split regarding whether decriminalization will reduce policing and law enforcement costs and resources (36% disagreed [16% strongly disagreed and 20% disagreed] vs. 37% agreed [26% agreed and 11% strongly agreed]) and improve access to treatment

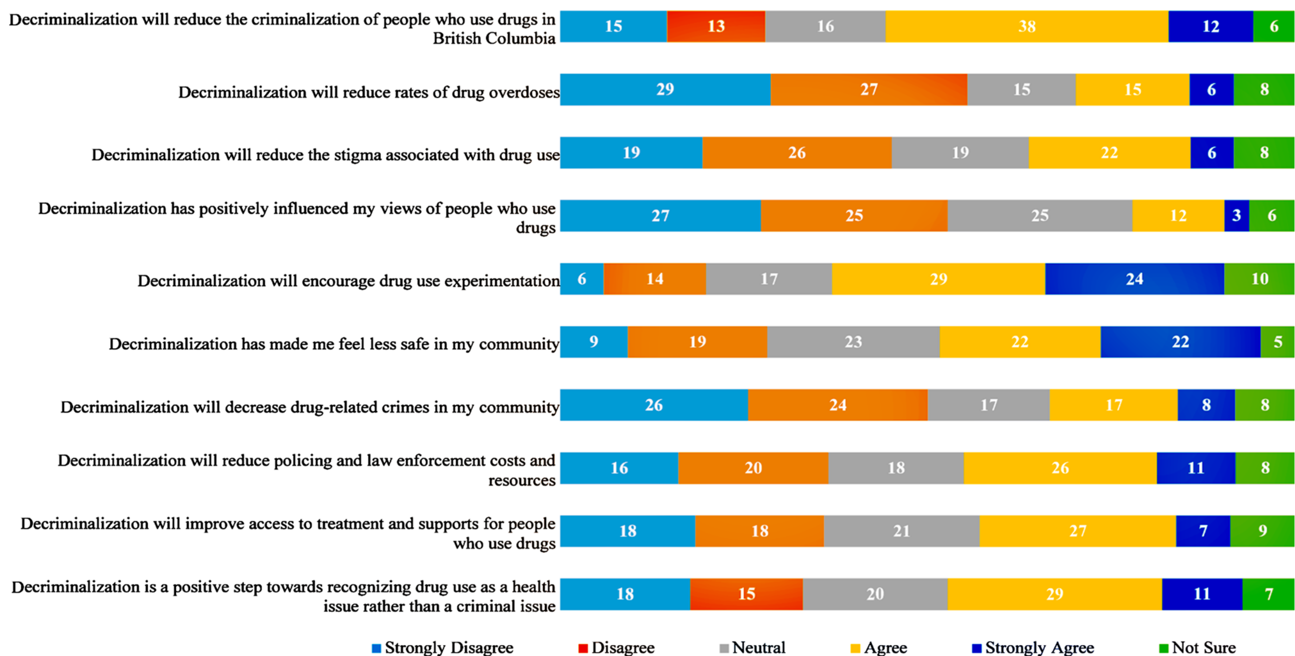

Fig. 1 Attitudes toward decriminalization of possession of illegal drugs

Table 2 Associations of demographic characteristics with support of decriminalization

	Support of Decriminalization					
	Did Not Support	Neutral or Not Sure	Support	Rao-Scott Chi-Square *P*-Value	Did Not Support vs. Neutral or Not Sure	Support vs. Neutral or Not Sure
	N (%) [a, b]	N (%) [a, b]	N (%) [a, b]		OR (95% CI) [c]	OR (95% CI) [c]
Age						
18 to 39 Years Old	137 (25.0)	119 (38.5)	187 (44.3)	**< 0.0001**	Reference	Reference
40 to 59 Years Old	185 (32.9)	85 (25.1)	133 (29.9)		**1.97 (1.35–2.88)**	1.01 (0.69–1.48)
≥ 60 Years Old	167 (42.1)	89 (36.4)	86 (25.8)		**1.89 (1.19–3.02)**	0.72 (0.45–1.16)
Gender						
Male	239 (49.3)	118 (41.8)	207 (52.2)	**0.0333**	Reference	Reference
Female or Another Gender	249 (50.7)	173 (58.2)	197 (47.8)		0.73 (0.54–1.01)	**0.66 (0.47–0.91)**
Regional Health Authority						
Vancouver Coastal Health	109 (20.5)	64 (21.2)	93 (21.4)	0.8389		
Fraser Health	187 (39.7)	112 (41.4)	148 (39.0)			
Vancouver Island Health	78 (17.4)	55 (19.2)	76 (20.4)			
Interior Health or Northern Health	82 (22.4)	41 (18.2)	56 (19.2)			
Educational Attainment						
Up to High School Education	86 (28.3)	71 (37.2)	75 (29.2)	**0.0095**	Reference	Reference
College or Trade School Education	170 (32.4)	93 (27.9)	108 (24.8)		1.39 (0.91–2.13)	1.12 (0.71–1.75)
University Education	233 (39.2)	129 (34.9)	223 (46.0)		1.39 (0.92–2.09)	1.52 (1.00-2.32)
Income						
< $40,000	95 (23.7)	83 (33.9)	99 (28.7)	0.0817		
$40,000 to $59,999	93 (22.3)	43 (16.7)	64 (17.7)			
$60,000 to $99,999	150 (30.9)	69 (26.0)	106 (27.6)			
≥ $100,000	119 (23.0)	68 (23.4)	114 (26.0)			
Household Composition						
Children	126 (21.8)	65 (19.9)	111 (24.0)	0.4297		
No Children	363 (78.2)	228 (80.1)	295 (76.0)			
Marital Status						
Living with a Partner or Married	285 (57.3)	147 (49.0)	214 (51.2)	0.0642		
Single, Never Married, Widowed, Divorced or Separated	204 (42.7)	146 (51.0)	192 (48.8)			
Employment Status						
Employed	290 (52.8)	162 (50.7)	257 (59.0)	**0.0132**	Reference	Reference
Unemployed	41 (9.5)	35 (12.7)	54 (14.1)		0.78 (0.45–1.33)	1.10 (0.65–1.86)
Homemaker, Full-time Parent, Student, Military or Retired	153 (37.7)	92 (36.6)	87 (26.9)		0.90 (0.58–1.41)	0.87 (0.55–1.39)

Abbreviations: CI, Confidence Interval; OR, Odds Ratio

[a] Sum of cell sizes may not equal total sample size (*N* = 1,202) due to missing data

[b] Frequencies are unweighted and percentages are weighted

[c] Multinomial logistic regression model included age, gender, educational attainment and employment status

and supports for people who use drugs (36% disagreed [18% strongly disagreed and 18% disagreed] vs. 34% agreed [27% agreed and 7% strongly agreed]). Similarly, one-third of participants disagreed (33% [18% strongly disagreed and 15% disagreed]) and one-fourth of participants agreed (40% [29% agreed and 11% strongly agreed]) that decriminalization was a positive step towards recognizing drug use as a health issue rather than a criminal issue.

Characteristics associated with support of decriminalization

The chi-square tests and multinomial logistic regression model examining the associations between demographic characteristics and support of decriminalization are presented in Table 2. The chi-square tests demonstrated that participants who did not support decriminalization, who were neutral or not sure about supporting decriminalization and who supported decriminalization differed in regards to age, gender, educational attainment, and employment status. These demographic characteristics were subsequently selected for inclusion in

the multinomial logistic regression model. Being 40 to 59 years old (OR, 95% Confidence Interval [CI]: 1.97, 1.35–2.88) and being ≥60 years old (OR, 95% CI: 1.89, 1.19–3.02) were associated with an increased likelihood of not supporting decriminalization compared to being neutral or not sure about supporting decriminalization. On the other hand, being female or another gender (OR, 95% CI: 0.66, 0.47–0.91) was associated with a decreased likelihood of supporting decriminalization compared with being neutral or not sure about supporting decriminalization.

Discussion

We conducted a public opinion survey to examine public support of and attitudes toward decriminalization of the possession of illegal drugs in the second year of implementation of the policy among adults in British Columbia. Overall, our findings indicated that about one-third supported decriminalization, while two-third were neutral or not sure about supporting decriminalization or did not support decriminalization. However, there were variations in attitudes toward decriminalization, where the majority agreed that it will reduce the criminalization of people who use drugs, but disagreed or were split if it will yield other benefits. Importantly, the majority agreed that decriminalization will encourage drug use experimentation and more agreed than disagreed that decriminalization made them feel less safe. Being ≥40 years old and female or another gender were associated with not supporting decriminalization.

The present findings are not in alignment with a previous public opinion survey from Health Canada, which was conducted a few months after the implementation of decriminalization [25]. A comparison of attitudes between the two surveys suggests a shift in attitudes. Specifically, compared to the public opinion survey conducted by Health Canada, agreement was lower in the present survey that decriminalization will make it easier to access health and social services (62% vs. 34%) or reduce stigma towards people who use drugs (56% vs. 28%) [25]. About one-fourth in both surveys agreed that decriminalization would make them feel less safe in the community (43% vs. 44%) [25]. There were differences in the sampling strategy (non-random sampling vs. random sampling) and examined jurisdictions (British Columbia vs. Canada) between the surveys that could have contributed to the variation in findings. In addition, there were differences in the phrasing of the survey items that may have contributed to the variation in findings. The item on access to health and social services was phrased as "Decriminalization will improve access to treatment and supports for people who use drugs" in the present survey versus "I believe decriminalization would make it easier to access health and social services such as drug treatment centers and recovery programs" in the public opinion survey conducted by Health Canada. Similarly, the item on reduction in stigma was phrased as "Decriminalization will reduce the stigma associated with drug use" in the present survey versus "I believe decriminalizing drugs would reduce the stigma towards people who use drugs" in the public opinion survey conducted by Health Canada. However, these differences in findings are more likely to reflect a shift in public attitudes toward decriminalization, suggesting an increase in opposition to the policy.

Two themes follow from the present study's findings. First, there is a lack of robust confidence in decriminalization to achieve its goals. The overarching goal of decriminalization is to reduce stigma associated with drug use and the fear of criminalization to support greater access to health and social services [17, 33]. Indeed, about half disagreed that decriminalization will reduce stigma and that decriminalization had positively influenced their views of people who use drugs, while about half were neutral, disagreed, or were not sure that decriminalization will reduce criminalization. There was a split whether decriminalization will improve access to health and social services, as about one-third disagreed and one-third agreed. Similar to the overarching goal of decriminalization, there is also a lack of robust confidence in decriminalization to achieve its other peripheral, long-term goals, including reductions in drug overdoses, improvements in law enforcement's ability to prioritize crimes, and reductions in economic burden of disease due to criminalization of drugs [17, 33]. Indeed, about half disagreed that decriminalization will reduce drug overdoses, whereas there was a split whether decriminalization will reduce policing costs and resources, given about one-third disagreed and one-third agreed. It is acknowledged that decriminalization alone cannot achieve these goals without other system level changes, such as expansion and improvement of health and social services, and investments into measures that mitigate the social determinants of health, including alleviation of poverty, systemic racism, and lack of housing. However, the lack of robust public confidence may signal the public's perception of decriminalization as being too ambitious or the inability of decriminalization to address other matters (e.g. improving access to health and social services).

Second, there are increased public safety concerns. Indeed, about half agreed that decriminalization will encourage drug experimentation and felt less safe after decriminalization, while about half disagreed that decriminalization will reduce drug-related crimes. Part of these findings may stem from the concerns about public drug use. Similar sentiments have been expressed in the establishment of harm reduction services, such

as supervised consumption sites, where members of the community indicated concerns about subsequent increases in drug-related crime and public disorder [34]. There have been some reports from the police regarding instances of public drug use in locations such as parks, beaches, and around public transit [35]. However, robust provincial data on the extent of public drug use is not available, which can establish increases or decreases pre-post decriminalization. Relatedly, homelessness has increased in British Columbia, with recent estimates indicating 11,352 people experiencing homelessness in 2023, representing a 31% increase between 2020 and 2023 [36]. The increase in homelessness is likely contributing to the perceived increases in public drug use. People who use drugs may not have access to designated spaces for drug use, especially people who inhale drugs as less than half of all supervised consumption and overdose prevention services offer inhalation services [37]. Consequently, people who use drugs may be forced to use drugs publicly in the absence of housing, increasing the risk of further criminalization and stigmatization. A balance needs to be struck between managing the concerns of the community and of people who use drugs. The recent amendment to the original exemption restricts illegal drug possession and use to private residences, communal shelters, and select harm reduction and addiction treatment facilities. These changes may promote community health and minimize public drug use harms from the community's standpoint, but they may also reinforce stigma, undermine decriminalization, and increase drug-related risks and harms from the people who use drugs' standpoint [7]. Importantly, in order to ensure the effectiveness of decriminalization, there is a glaring need to simultaneously address the upstream social determinants of health, which will ensure that people who use drugs have adequate access to stable housing, comprehensive support services, and harm reduction services [7].

The lack of robust confidence in decriminalization to achieve its goals coupled with increased public safety concerns may explain the absence of strong support of decriminalization. In general, debates about addressing drug-related harms have intensified in Canada, featuring opposition to progressive policies and interventions [38–40]. Such debates may result in instances of public perceptions driving policies instead of or in spite of evidence. In the context of British Columbia, anti-harm reduction sentiments have gained momentum, mainly through right leaning politicians and media outlets, leading to closures of low-barrier vending machines providing access to harm reduction supplies and naloxone [41], rejection of recommendations to expand the provincial prescribed alternatives program [42], and proposed expansion of involuntary care for people with brain injury, mental illnesses, and severe addiction [43]. In the context of decriminalization in Oregon, concerns about public drug use were among the pivotal reasons for repealing the policy less than three years after its implementation [14–16]. Public perceptions implicated decriminalization for the public drug use despite likely contributions of other developments, including exacerbation of mental health problems due to the coronavirus pandemic and increased homelessness due to the rising costs of living [14–16]. One avenue to bolster support of decriminalization is ongoing comprehensive evaluations and knowledge mobilization activities, which ensure that the public is kept abreast with the policy goals, latest developments and emerging impacts. In particular, media engagement geared towards educating and mitigating concerns of the public should be prioritized. For instance, a mass media campaign that disseminated information about the carcinogenic properties of alcohol was associated with an increase in awareness of alcohol consumption as a risk factor for cancer and public support for more restrictive alcohol-related public health policies [44]. However, further bold reimagining of the efforts required to bolster support of decriminalization is needed. Examples of such innovative efforts include drug use and drug policy discussions grounded in research led by people who use drugs in an easily accessible format [45]. Furthermore, ongoing surveillance is needed to examine if support of and attitudes toward decriminalization change over time, especially following the recent amendment to the original exemption that aims to restrict public drug use.

In regards to the demographic characteristics associated with decriminalization, the present findings demonstrating lower support among older adults and females are consistent with prior public opinion surveys [22–24]. The lower support among these subgroups of the population may be due to their lower rates of drug use, as personal substance use has been shown to be associated with less positive attitudes towards more intrusive substance use policies [27–29]. Indeed, drug use is higher among males compared with females [26], and drug use declines throughout the life course after peaking in young adulthood [46]. In addition, the lower support among these subgroups may be attributable to their higher religiosity [47], which may be related to more conservative attitudes towards drug use and drug policy [48–50].

Limitations

There are some limitations that should be considered in the interpretation of our study's findings. Some segments of the population may not have been adequately represented, as the survey was restricted to participants with internet access who spoke English. Furthermore, the sampling frame was restricted to established panels, the sampling strategy did not include random selection procedures, and the survey response rate was 25%. As

such, the generalizability of the findings may have been limited. However, the impacts are expected to be minimal, as quota sampling in online surveys is an established practice to rapidly collect data [51–53], and only about 6% of the population reports lack of internet access at home in Canada [54]. In addition, other items, such as substance use, political affiliation, religiosity, and housing status, were omitted from the survey to maintain brevity and minimize response burden, all of which could also influence perceptions of and attitudes towards decriminalization.

Conclusions

In the current public opinion survey examining public support of and attitudes toward decriminalization of possession of illegal drugs among adults in British Columbia, support of decriminalization was not strong, as about one-third supported decriminalization and two-third were neutral or not sure about supporting decriminalization or did not support decriminalization. These findings may be rooted in the lack of public confidence in decriminalization to achieve its goals and increased public safety concerns. These findings have important implications, given the experience with decriminalization in Oregon, where public perceptions were a driving factor in the decision to repeal the policy less than three years after its implementation. There is a need for ongoing evaluations of the policy and increasing knowledge mobilization activities to keep the public abreast of the latest developments.

Abbreviations

CDSA	Controlled Drugs and Substances Act
CI	Confidence Interval
OR	Odds Ratio

Supplementary Information

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Supplementary Material 1

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Author contributions

SI, CR and FA conceived the research question and outlined the analytical design. CR managed the data acquisition. SI conducted the data analyses, with input from JR. SI prepared the draft of the manuscript, with critical revisions for intellectual content made by all other authors. All authors approved the manuscript for submission to the journal.

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Data availability

The datasets generated and analysed during the current study are not publicly available due to data confidentiality requirements, but they may be made available by the corresponding author on reasonable request.

Declarations

Ethics approval and consent to participate

Research ethics committee review and approval were obtained from the Research Ethics Board at the Centre for Addiction and Mental Health (File Number: 2023/173).

Consent for publication

Not applicable.

Competing interests

The authors declare no competing interests.

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