Decriminalization in Interior Health Acute Care - A Failure of Implementation

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**Wicked Problems**

Due to the growing number of unregulated drug deaths in British Columbia (BC), a Provincial Public Health Emergency was declared in 2016 (Ministry of Health, 2016). Following numerous changes to the policy landscape and introduction of various innovative health services, BC obtained an exemption to the Federally Controlled Drugs and Substances Act in January 2023, removing criminal penalties for adults possessing small amounts of illegal substances for personal use. Decriminalization was meant to reduce the stigma of substance use and to support access to health and social services. After 15 months, the province narrowed decriminalization to designated clinics, those sheltered lawfully, and private residences (Government of Canada, 2024).

**What Makes this Problem Complex or Difficult to Solve**

Decriminalization in acute care settings across Interior Health (IH) must be understood in the broader context of an affordability crisis, housing crisis, systemic healthcare shortages, a history of stigma towards people who use drugs (PWUD), the large rural service area, and the wider discourse regarding decriminalization across the province (Bardwell et al., 2022; Chan et al., 2019; Furlong et al., 2025). Hospitals, however, present unique challenges related to substance use, as stakeholder and service user priorities overlap and at times are in direct contradiction.

Although consultations were held with health authorities, the decision to move forward was mandated by the Provincial Government. As a result, decriminalization took effect across the province despite local lack of support and resources. Consequently, PWUD admitted to hospitals were permitted to use substances in settings where staff and other patients were present, and staff were unable to discharge clients due to their unregulated substance use (Nolan, 2022).

IH failed to ensure clients had a safe space to use during their acute care stay without facing ongoing discrimination. Staff were not equipped to support PWUD in a trauma-informed manner, and access to specialty services aimed at maintaining client dignity, reducing harms, and mitigating the need for unregulated substances was not provided.

In other words, what was meant to be an improvement to equity and access to care for all, and specifically for illicit substance users, resulted in confusion around health professionals’ rights and responsibilities as related to new rights of the patients, which in turn delivered an insult to the concept of therapeutic relationship and further alienated this group of patients during hospital admissions.

**Why is it Considered a "Wicked" Problem?**

This situation is considered a wicked problem because there is no straightforward solution. Addressing hospital operations, patient care for PWUD individuals using substances and those who are not, staff resource allocation, funding allocation, and training require a multi-system approach. This approach, involving the health authority, the province, community partners, and professional organizations, is crucial to ensure a successful implementation (Interior Health, 2025).

While this problem has parallels to decriminalization throughout the province, it is distinct because hospitals and acute care settings have specific policies, care goals, constraints, culture, and responsibilities impacting autonomy, self-determination, and safety (Furlong et al., 2025)

Although frameworks exist for resource allocation, staff education, and policy development, the successful strategies utilized in other health authority acute care settings would not be sufficient to support a diverse service region like IH, making implementation particularly challenging (Dogherty et al., 2022).

Most importantly, this issue is considered wicked due to conflict of values among staff, families, and management. This conflict of values can lead to tension and disagreement, making it even more challenging to find a solution that satisfies all parties.

**Population Affected by this Problem**

Multiple interest holders were affected by these policy changes, the primary being PWUD, since criminalization (arrest, seizure of substance possession) was affected.  The second group that was particularly impacted were health care workers who interact directly with patients.  These include physicians, nurses, allied health, and ancillary staff.  Unions represent some of these groups, while most are affected by occupational health and safety legislation (WorkSafe BC, 2025).  Local operational leaders, such as managers, clinical nurse leaders, and site operations, had to pivot rapidly in response to a shifting policy landscape.

On-site security at hospitals (when present), or law enforcement personnel rapidly had their procedural processes changed, as it relates to PWUD.  The last group to mention (not an exhaustive list), is the general population, for instance other non-substance using patients, and visitors, including children.

**Demographic Characteristics**

Adults over the age of 18 years old, were referenced in the Exemption to s.56 of the Controlled Drugs and Substances Act granted by Health Canada (Government of Canada, 2024).  While substance use crosses all socioeconomic status and walks of life, the largest demographic group dying from unregulated drugs, are adult males at approximately 81.7% of the total, up from 74.9% pre-pandemic (Palis et al., 2022).  While the numbers vary slightly per year, the vast majority of those dying of unregulated drugs, are between the ages of 19-59 (87%), with the highest proportions split equally (at approximately 23% each respectively) between the age groups of 30–39; 40–49; and 50–59 (Government of BC, 2025).  Health care workers and people who access acute care vary in age, however, we will focus our exploration on adults.

**Context: Key Challenges and Uncertainties Related to Geography, Culture, and Politics**

Interior BC, unlike the Coastal Health region where the prototypes for decriminalization originated, is characterized by vast, geographically diverse, and sparsely populated territory, where municipalities act as resource and service hubs for First Nation and non-indigenous residents. Tertiary hospitals (Royal Inland and Kelowna General) provide the bulk of specialized acute care services, while several smaller regional hospitals look after less acute, local population health needs throughout the region. The public purse attached to each of these hospitals varies dramatically, and so do the material and human resources.

Thus, operationally, the concept of "every door is the right door" to support PWUD throughout IH necessitates the reliable provision of evidence-based services and clear service delivery pathways (Parent & Bertrand-Deschenes, 2025). These were not in place, especially in rural areas. Inadequate resources perpetuated staff concerns regarding a lack of support from leadership, further creating an adversarial and divisive work environment (Hodgson et al., 2025).

From a cultural perspective, larger service hubs located within major transportation corridors attract an influx of newcomers and represent a more diverse population, while smaller ones have distinct, but somewhat more homogenous population bases (Statistics Canada, 2022). Meanwhile, politically, BC Interior represents a very diverse group of voters, with some municipalities holding unwavering liberal views, while others are historically conservative (Elections BC, 2025). These differing political convictions and priorities percolated into local provincially administered acute care settings, often challenging the buy-in process to provincial drug-related policy implementation.

Other constraints to effective policy implementation included fractured societal views related to decriminalization, which carried into individuals’ nursing practice; lack of training and education related to substance use disorders and specialty nursing skills related to caring for this patient population; personal beliefs that all drug consumption is harmful; desire not to harm the patient; and inner ethical battles. Key challenges centered around clinical hesitation, as staff were unsure of how to operationalize decriminalization without clear policies, educational support, clinical expertise, or additional services, such as safe consumption spaces for clients (Hodgson et al., 2025).

Addressing a culture of stigma across various settings and professional disciplines requires broad upskilling in principles of harm reduction, anti-racism, and trauma-informed care (Hodgson et al., 2025). Given the varied individual, cultural and political beliefs surrounding decriminalization, re-education of staff, from housekeeping to executive leadership, cannot be accomplished overnight and was inadequate to meet expectations.

**Solutions**

**Solution #1 - Upscaling Substance Use Peer Across IH**

With decriminalization unlikely in the near term, BC hospitals must address the systemic, cultural, and economic barriers preventing PWUD from receiving trauma-informed, equitable care. I propose scaling substance-use peer (SUP) support across all IH inpatient settings, via in-person and virtual access.

***Rationale Behind Solution***

Peers would (1) bring lived experience to counter stigma, provide client-centred support, and advocate for PWUD; (2) accompany patients to sanctioned spaces when on-site overdose prevention is absent, reducing covert use and ensuring overdose-response capability; (3) initiate or flag referrals to addiction medicine for early, evidence-based intervention; (4) integrate with existing services—EDs for early assessment, Indigenous Patient Navigators for culturally safe care, and hospital overdose prevention sites; and (5) provide 24/7 virtual coverage when in-person peers aren’t available, prioritizing rural access.

Eric Eligh will present this solution during the student-led café.

**Solution # 2: Enhancing Treatment Resources Available to Acute Care, and in Tandem with Decriminalization Policy Implementation**

The second solution will investigate the extent and planned treatment and recovery services that were offered at the time of the Decriminalization roll-out in British Columbia, to ascertain if adding additional treatment resources would have been an effective leverage point to shift the outcome of Decriminalization policy change in a positive direction, potentially forestalling the amendment to the policy that later occurred.  Attention will also be paid to current approaches (Interior Health, 2025), in allocation of resources for substance use treatment, and its potential impact on the situated in acute care, while considering fiscal constraints at the time and now.

***Rationale Behind Solution***

While we know that BC is considered a frontrunner in leading policy relating to harm reduction approaches to substance use (Ali et al., 2025), access to substance use treatment beds has lagged.  At the time of the decriminalization implementation, an enhanced community resource access line was instituted, with the intention for law enforcement to divert PWUD towards health and social services (Ali et al., 2024); however, it is not clear that additional treatment resources were also brought online around the same time.

This solution will be presented by Oona Jean during the student-led café.

**Solution # 3: In-hospital awareness-raising campaign aimed at addressing ethical dilemmas, fear, and uncertainty related to care for patients who use illicit substances during acute care stay.**

            The following components will be included: 1)Multidisciplinary education sessions on Mental Health and Substance Use disorders delivered by Mental Health Unit Educators to each Medical and Surgical Ward; 2) Hospital’s Spiritual Health staff-led sessions that explore ethical and moral dilemmas associated with care for these patients. 3) Monthly Feature Article in Interior Health  Online Newsletter presenting patient or family narrative that describes desired support with safely continuing their addiction-related routine within acute care. This can be supplemented by a monthly anonymous staff survey that elicits feedback on staff perceptions of competency in caring for this patient population and highlights missing resources.

***Rationale Behind the Solution***

Nurses who work on wards other than mental health and addiction often report ambivalence about caring for patients who use recreational drugs (McCall et al., 2023). Patients, in turn, sense this hesitancy and covert judgement, and feel stigmatized during their medical or surgical acute care journey. Little attention has been paid to the effects of decriminalization within the acute care context, and existing studies fail to incorporate acute care nursing feedback into their design (Russell et al., 2024). Meanwhile, stakeholder involvement is crucial to project success and buy-in is often emotionally driven (French-Bravo and Crow, 2015). In addition, patients' and families lived experiences are impactful in conveying the importance of decriminalization and the emotional burdens of drug policy failure (Jenkins et al., 2021). Thus, it seems plausible that enhanced focus on stakeholder involvement in acute care settings, supplemented by exposure to impactful, real-life patient stories, should increase nursing buy-in and engagement, and result in proactive bottom-up solutions to currently ineffective and muddled policy around drug use in acute care facilities.

This solution will be presented by Olga Sawatzky during the student-led café.

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