OVERVIEW

1. For many, the term "drug dealer" conjures a shadowy figure trafficking in human exploitation while living lavishly off of their ill-gotten profits. It's a powerful, convenient image, but largely inaccurate, at least when it comes to who is being arrested and convicted on possession and trafficking related charges at the street-level in Canada.[1]

2. The expert evidence led in this case supports previous research findings from the BC Centre on Substance Use that many people who deal drugs use drugs themselves.[2] In fact, among people who use drugs, the most common reason for dealing is to pay for their own drug use.[3] A full forty to fifty percent of people who use drugs are, according to these statistics, also engaged in drug trafficking.[4] The motivations behind concurrent use and dealing are complex and illuminating. Critically, they do not include inherent criminality or a lack of morality; therefore, 'tough on crime' approaches to drug-related offences, including trafficking, tend to be ineffective and outdated, especially as compared to the growing trend toward a 'public health' approach to drug use.

3. Law enforcement disproportionately targets the most marginalized of street-level dealers: those who are racialized, and those living in poverty, those experiencing homelessness, and those experiencing addiction.[5] This is the same group of people who are at great risk of fatal overdose due to a toxic illicit drug supply and the endangering effects of drug prohibition.[6] Incarceration has proven ineffective in deterring drug use and drug dealing. In fact, as borne out by the expert testimony in this case, incarceration is associated with an *increased* likelihood of being involved with high-risk income-generating activities, including drug dealing. More policing creates a self-perpetuating cycle wherein policing fuels drug dealing, which in turn necessitates more policing, more prosecutions, and more custodial sentences.[7] Again, policing is disproportionately weaponized against racialized and low-income communities.[8]

4. Society's understanding of drug use, informed by neuroscience, medicine, and psychology is rapidly evolving, particularly as fatalities stemming from the opioid crisis sweep every corner of the country without abatement. The Canadian government's designation of drug use as an issue of public health should prompt a consistent shift away from laws based on enforcement and

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[1] Peter Kim, "On the stereotype of the "drug kingpin": Why tougher penalties for fentanyl trafficking won't end the overdose crisis" Pivot Legal Society, October 23, 2017 online at: https://www.pivotlegal.org/on_the_stereotype_of_the_drug_kingpin_why_tougher_penalties_for_fentanyl_trafficking_won_t_end_the_overdose_crisis

[2] *Ibid.* Throughout these submissions, Ms. Ellis uses a variety of terms to refer to street-based trafficking, per section 5 of the *CDSA*: "dealing", "drug dealing", "street dealing", "low-level dealing" etc.

[3] *Ibid.*

[4] TR p. 68, l. 4-13.

[5] *R v Le* 2019 SCC 34 at para. 59, 60, 89, 90. Pivot Legal Society. *Project Inclusion: Confronting Anti-Homelessness & Anti-Substance User Stigma in British Columbia*, by Darcie Bennett and D.J. Larkin, 2019 (online: https://d3n8a8pro7vhmx.cloudfront.net/pivotlegal/pages/32 97/attachments/original/1543970419/project-inclusion-digital.pdf?1543970419; archived version: https://www.scc-csc.ca/cso-dce/2020SCC-CSC14_8_eng.pdf) at p. 52

[6] *Supra* note 1.

[7] *Ibid.*

[8] *R v Le* 2019 SCC 34 at para. 97.

punishment (both of which are revealed to have been ineffective in curbing drug use), toward legislation fostering harm reduction and rehabilitation. However, the reality of the current legal and juridical landscape is startlingly inconsistent with the accepted science, social studies research, and societal reaction to drug use and addiction.

5. Ms. Tanya Ellis' case provides fertile ground to re-assess the value and utility, or lack thereof, of deterrence (general and specific) and denunciation as paramount sentencing objectives in marginalized 'street level trafficking.'[9] Addressing drug use and the corresponding opioid crisis first requires an end to stigma and criminalization, to be replaced by increased social supports: i.e. comprehensive, integrated health care that addresses physical and mental health needs, provides addiction treatment, and offers individualized support in accessing necessary services, such as housing and harm reduction. At the point of sentencing, rehabilitation must replace denunciation and deterrence as the primary sentencing principle.

6. This appears to be the first case in Canada to introduce leading expert evidence directly related to the efficacy and utility of punishment in deterring and denouncing marginalized street-level trafficking and drug use more generally. Ms. Ellis requests a critical appraisal of criminal deterrence theory as it applies to: people who use drugs, the analysis in *R v Smith,* and the corresponding 'range' of sentence for those convicted of marginalized street level drug dealing.

7. In Part I of this factum we review the evidence proffered in the *Gardiner* hearing. Part II reviews the analysis in *R v Smith* and its progeny. Part III moves to explain that the social and behavioral assumptions underlying the *Smith* line of jurisprudence are no longer valid. Part IV relies on the *Bedford* test to advocate for a departure from the *Smith* range.

PART I. STATEMENT OF FACTS

8. Ms. Tanya Ellis pleaded guilty to trafficking fentanyl and cocaine in November of 2019. An Agreed Statement of Fact was tendered at the outset of the *Gardiner* hearing (the "Hearing).[10] Ms. Ellis advised the Public Prosecution Service of Canada ("PPSC") and the sentencing court that she would be: i) challenging the sentencing range set out in *R v Smith,* and ii) forming the evidentiary basis to move away from principles of denunciation and deterrence as the primary factors in the sentencing of marginalized street level dealers.

9. The Hearing took place over the course of four days. Testimony was first received from Cst. Paul Jones, a proposed expert called upon by the PPSC.

The Evidence of PPSC Expert, Cst. Jones

10. The qualifications of Cst. Jones were not challenged. The Crown sought to declare Cst. Jones as an expert in the usual panoply consisting of: i) Methods of packaging and concealment, ii) trafficking (including dial-a-dope trafficking and street level trafficking), iii) prices, iv) usage, v)

[9] Referring to the language used in *R v Smith*, 2017 BCCA 112.
[10] Exhibit 1 on sentence.

drug jargon and slang used for certain drugs under the *Controlled Drugs and Substances Act* (*CDSA*) - in particular heroin, fentanyl, and cocaine, or a combination of those substances.

11. In direct examination, Cst. Jones explained he was currently assigned to the "bike unit" of the Comox Valley RCMP detachment. He had been a member of the RCMP for approximately 19 years. In the past, he had worked as an officer on the "Whalley Strip" in Surrey and professed to law enforcement experience in both the low-level drug trade and larger, more sophisticated importation and conspiracy rings. In direct examination, Cst. Jones primarily confirmed what was already evident: Ms. Ellis was selling fentanyl and cocaine on two occasions in November of 2019 and in the nominal amounts specified in the Agreed Statement of Fact.

The Cross-Examination of Cst. Jones

12. In cross-examination, Cst. Jones agreed that he had never been engaged in qualitative or quantitative research associated with the role law enforcement approaches play in generating health-related harm among drug users. Nor was he familiar with the ways law enforcement contributes to deterring (or failing to deter) illicit drug consumption. He agreed he had never conducted any research into the demographics of drug users or street level dealers in BC. His expertise was admittedly confined to his direct personal experience as a law enforcement officer. Aside from the odd and sporadic conversation, he had never spoken to users or dealers about their substance use outside of his authority as a law enforcement officer.

13. Cst. Jones conceded that he did not know "anything" about Ms. Ellis' personal circumstances, including how long she has been a drug user, why she started consuming drugs, or why she started selling drugs.

14. It was put to Cst. Jones that drug dealing is inherently clandestine, in part due to its criminalized status. Consequently, law enforcement officers in particular were not likely to receive the same insights as a peer, doctor, or clinician in public health, whose roles do not include charging or arresting people who use drugs. Cst. Jones disagreed with that suggestion and believed that while he was interacting with people who use drugs, that as a police officer, he was receiving honest and candid responses. He generally denied the inherent power dynamics at play between an officer of the law and a person who relies on illicit drugs in the context of drug prohibition. This dynamic would later be underscored by Dr. McNeil in his evidence as being marked by 'a power disparity' that adversely impacts the willingness of people who use drugs to discuss their personal experiences to police, given the risk of criminal sanction.[11]

15. Cst. Jones agreed that the drug trafficking hierarchy is complex and includes a spectrum of roles. Street level dealers were, in his opinion, at the lowest rung of the hierarchy. He disagreed with what would later be tendered as the statistical evidence: a significant portion of street level dealers are selling drugs to pay for their own drug use.

16. Cst. Jones somewhat reluctantly agreed that many of the people he encounters who both use and sell drugs are struggling with unstable housing and had been recently incarcerated. He disagreed that many people, particularly women, are often engaged in sex work, that many had been

[11] TR p. 18, l. 15-23.

exposed to blood-borne infections as a result of intravenous drug use, and could not say whether those he had come in contact with had recently suffered from an overdose. Cst. Jones' testimony on these matters contrasts with what would later be tendered as the expert evidence of Dr. McNeil: people who use drugs face innumerable barriers to employment and often have no choice but to engage in illicit income-generating activities.

17. A portion of cross-examination was focused on the utility of placing the low-level user/seller in custody. Cst. Jones was asked whether he agreed that it is easy for suppliers at higher levels of the hierarchy to find new recruits to replace the individual who is no longer working on the street because they are in custody, thus creating a game of "whack a mole" for law enforcement attempting to reduce drug-related crime. He agreed. He also agreed that from the standpoint of the user/seller, they are "willing" to take the risk of criminal sanction, often because there are stronger, countervailing pressures at play: namely, the needs associated with being in the active throes of addiction and of responding to a strong and compelling need to maintain one's own baseline wellness or to avoid withdrawal.[12]

18. Cst. Jones accepted that street dealers who are also users will continue to use drugs despite attendant risks of drug prohibition and other potentially negative consequences. For instance, the need to use drugs will override fears associated with drug prohibition and drug user stigma such as unemployment, loss of family, and threats of criminal punishment.[13]

19. Cst. Jones did not contest that individuals at higher levels of the trafficking operation, including couriers, mid-level dealers, or high-level dealers, have the resources to insulate themselves from detection and are more difficult for police to apprehend. As a consequence, beat cops do not typically interact with drug "kingpins", because the kingpin has insulated himself at the same time as he can afford to have other people to do his biddings for him, including the oftentimes visible and vulnerable business of street-level dealing. Law enforcement predictably apprehend, arrest, and initiate charges against "the low hanging fruit" – those individuals who are not afforded the protection of an indoor location to conduct business; who may be drug users themselves; and whose own survival is often the key determining factor for "accepting" the risk of criminalization.

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[12] This court later learns, through the testimony of Dr. McNeil and Ms. Tanya Ellis that the term "willing" is misplaced: the notion that people who use drugs are "willing" to take the risk can ignore the real biological compulsion/survival techniques that motivate drug use (and the ancillary 'acceptance' of criminal risk). In Canada *(Attorney General) v. Bedford*, 2013 SCC 72 the Court refused to accept that sex work was a "choice" in all instances, given the set of systemic and structural challenges sex workers faced and the need to survive. Instead, the Court held: "Realistically, while they may retain some minimal power of choice - what the Attorney General of Canada called "constrained choice"...these are not people who can be said to be truly "choosing" a risky line of business" (at para. 86).

[13] This much was recognized by the Supreme Court of Canada in *Canada (Attorney General) v. PHS Community Services Society*, [2011] S.C.J. No. 44 at para. 10: "For injection drug users, the nature of addiction makes for a desperate and dangerous existence. Aside from the dangers of the drugs themselves, addicts are vulnerable to a host of other life-threatening practices. Although many users are educated about safe practices, the need for an immediate fix or the fear of police discovering and confiscating drugs can override even ingrained safety habits."

20. After 19 years in policing, Cst. Jones conceded that he does not know a lot about drug kingpins because that world is inherently nebulous and shrouded. But what he professed to knowing was that the motivations between "the kingpin of a drug lab" and "the person selling a few slaps of drugs out a car" tended to be seriously different.

The Evidence of Dr. Ryan McNeil on the Voir Dire

21. Dr. Ryan McNeil joined the proceedings remotely via Microsoft Teams from Yale University, where he is the Director of Harm Reduction Research at the Yale School of Medicine. The defence sought to qualify Dr. McNeil in the following areas of expertise:

    i) Overdose risk, prevention and harm reduction including the effect of criminalization on overdose risk and addiction treatment;

    ii) Demographics of drugs users in BC including socio-economic backgrounds of drug users in BC and the intersection of drug use with other causes of marginalization;

    iii) Physiology of opioid addiction including the effect of opioid addiction on decision making and the effectiveness of denunciation and deterrence on drugs users; and

    iv) Drug jargon and slang.

22. The PPSC took the position that while Dr. McNeil was properly qualified, his evidence was neither necessary nor relevant. Consequently, a *voir dire* canvassing the *Mohan* criteria commenced.

23. Dr. McNeil's *Curriculum Vitae* is in evidence.[14] His prolific publications are before the court. Throughout direction examination, the court heard that through his National Institutes of Health and CIHR-funded community-engaged qualitative and ethnographic research, he examines how forces operating within the risk environments of people who use drugs shape risk and harm.

24. He explained that he is the Principal Investigator of multiple grants examining: (1) social, structural, and environmental influences on the implementation and effectiveness of harm reduction and addiction treatment interventions, including supervised consumption services; (2) the influence of housing and housing-based interventions on overdose-related risks; (3) approaches to the management of stimulant use disorders.

25. Direct examination also established that Dr. McNeil regularly provides expert advice to health care organizations and governments on the development, implementation, and optimization of harm reduction and addiction treatment interventions.

26. Importantly, he testified that his research requires extensive collaboration with community-based organizations, including peer-driven drug user, sex worker, and tenant rights organizations. He is

[14] Marked as Exhibit 5.

the co-creator and scientific lead of *Crackdown,* a podcast launched in January 2019 to mobilize research and amplify the voices of people who use drugs. This innovative media collaboration has been called the "podcast most likely to save lives" and has received the Radio Impact Award from the Third Coast International Audio Festival, Canadian Hillman Prize, and a silver medal from the New York Festivals Radio Awards.

27. Dr. McNeil was ultimately qualified in all areas of proposed expertise.

Dr. McNeil's Evidence on the Trial Proper

28. Dr. McNeil began his testimony by explaining the concept of the social determinants of health, or "the factors…outside of a person that impact their health".[15] He described those determinants as including "housing" or "how much money we make." He also provided us with an example: "if we take housing status…as one of the key determinants of health…we would understand that there's significant evidence showing that people who are unhoused, homeless, have significantly poorer health than people who are properly housed".[16]

29. Dr. McNeil went on to explain that there are also key factors that lead people to use drugs and potentially develop addictions. He prefaced his response by noting that these factors are "complex" and "varied."[17] He listed socioeconomic marginalization, intersecting with histories of engagement with the child welfare system, substance misuse in the home, and physical, sexual and emotional abuse as a child.[18]

30. Throughout his research in British Columbia, Dr. McNeil has recognized certain life circumstances that people who experience drug addiction often share. He explained that a disproportionate number are Indigenous, living in extreme poverty, struggling with homelessness, involved in the criminal justice system, and facing significant barriers to engagement in formal employment and education.[19]

31. The concept of social determinants applies not only in the context of drug use, but also drug dealing, as Dr. McNeil's evidence demonstrated. A significant element of his testimony revolved around the intersection of poverty and the need to support "one's own use" by way of criminalized income-generating activities, including drug trafficking. Dr. McNeil described the demographic of people experiencing addiction as severely marginalized and thus left with little options to access the "drugs they need and ward off withdrawal."[20] He underscored the paramountcy of this need as follows:

> Within that kind of situated rationality of drug use, that need to ensure access to drugs and to effectively avoid going into withdrawal…is so much more critical than any of the risks that may be associated with potentially being arrested or for selling again.[21]

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[15] TR 1, p. 36, l. 23-24, 26-27.
[16] TR 1, p. 36, l. 26-47.
[17] TR 1, p. 37, l. 4.
[18] TR 1 p. 37, l. 8-20.
[19] TR 1 p. 38, l. 1-31.
[20] TR 1 p. 40, l. 6-15.
[21] TR p, 49, l. 16-21.

32. Dr. McNeil explained that it is common to learn of people who use drugs committing petty theft, breaking into cars, because in the face of barriers to formal employment, "these are the various ways that people can make money that are criminalized."[22] Dr. McNeil testified that it is exceedingly common to learn that people who use drugs also sell drugs. Throughout the course of his own studies, Dr. McNeil found that forty per cent of people who use drugs also sell drugs. The rate could be as high as fifty percent.[23] Selling drugs for this demographic was described as one of the only means to "access a form of income generation" because "if someone is using, they're usually tied into a kind of broader networker scene and are able to access that as a form of employment."[24]

33. Dr. McNeil opined that society has developed a false dichotomy between the drug user victim and the drug dealer villain. He explained that if we, the criminal justice system participants, spent time with the more realistic composite of the person who deals drugs to support his own use, we would realize how "unglamorous it is" and how it is oftentimes "wrapped up in very severe poverty and marginalization." The "reality for the person on the ground, selling drugs, living in poverty, it's a subsistence activity that...generates...barely enough money, if enough money, or drugs, to sustain one's own use."[25]

34. In direct examination. Dr. McNeil explained how the dealer can even play a protective, public health function in the midst of an opioid crisis:

> We have found that when people are able to access the dealer that they trusted and that they had a strong relationship with, that improved communication about what was in the drugs that they were purchasing...better positioned people to mitigate their own overdose risks.[26]

35. Dr. McNeil further explained that it is common for dealers to use the drugs they sell and thus perform a kind of self-test in relation to potency prior to sale. He also confirmed that a large number of people selling drugs will access drug checking technology when it is available:[27]

> ...what we found is that people who were selling drugs were often accessing this drug checking technology that could tell them everything that was in the drugs that they were selling, (A), so that they would better...understand what they had; (B), so they could communicate that information to the people that they were selling to, so that they could manage their risks by doing things like insuring someone was there while they were injecting; (C), so that they could effectively avoid selling to people who they felt might not be experienced enough opioid users to use, for example, drugs with fentanyl, other concentrations that they...ended up with.[28]

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[22] TR 1 p.39, l. 4-18.
[23] TR p. 39, l. 23-35.
[24] TR p. 40. 1. 1-5.
[25] TR p. 41. L. 21-39.
[26] TR p. 44, l. 20-34.
[27] TR p. 46, l. 5-10.
[28] TR p 6-7, l. 38-47; 1-5.

36. When the trusted dealer is removed from the street and placed into custody, Dr. McNeil "worries most about people" because customers will now be forced to "try to locate someone new to purchase drugs from. It's going to typically be someone that they don't have a relationship with that can facilitate communication in the same way, about what's in the drugs."[29] He explained that a common piece of health advice is to "know your source."[30] When the dealer is incarcerated, the risk of overdose amongst his customers grows, as well as for the dealer himself, post-custody, since people being released in the community are "marked by an incredibly elevated risk of overdose because of the lower tolerance".[31]

37. Incarcerating the dealer not only increases the risk of overdose to the dealer and his clientele, it also has little deterrent effect on the dealer regarding future instances of trafficking, as Dr. McNeil explained:

> And I would say very specifically that the high prevalence of drug selling, especially after periods of engagement with the criminal justice system, would certainly suggest that that's not serving as an effective deterrent for engagement in drug selling.[32]

38. By contrast, the research demonstrates that evidence-based treatment such as methadone, buprenorphine, diacetylmorphine (heroin), and hydromorphone, is the effective deterrent.[33] Jail, the research demonstrates, "is so poorly positioned to address the factors that push people into drug selling, especially when it stems from socioeconomic marginalization, limited opportunities, often severe and unmanaged substance use disorders or opioid use disorders."[34] The same applies to probation.[35]

39. The rationale for Dr. McNeil's response lies in the research: no amount of counselling is likely to address the actual systemic factors requiring the drug user to sell. Outpatient counselling will not cure poverty.[36] A six-week residential treatment program will not erase a history of trauma.

40. Drug use is complex, and so must be our approach to addressing it. On one point, Dr. McNeil expressed certainty: drug prohibition and criminalization are not the appropriate mechanism to deal with addictions and drug use. Near the close of his testimony, Dr. McNeil opined as follows:

> ...to put it in really direct terms, if we are accepting that a substance use disorder or an opioid use disorder is a health thing, how and why are we leading with the criminal justice system...our current approach to drug use really does nothing but drive harm, including increasing overdose risk, while really not producing positive outcomes for people.[37]

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[29] TR p. 46-47, l. 41-47; l. 1-7.
[30] TR p. 47, l. 1-13.
[31] *Ibid.* p. 4, l. 41-43
[32] TR p. 23, l. 20-25
[33] TR p. 47, l. 22-39.
[34] TR p. 49, l. 2-15
[35] TR p. 50, l. 12-26
[36] TR p. 51, l. 6-44
[37] TR p. 55, l. 13-22

41. Dr. McNeil pointed to leading research and findings associated with the United Nations Aids Program which advocates for a shift toward drug decriminalization, which would remove criminal sanctions for the offence of personal drug possession.[38]

42. Near the close of direct-examination, Dr. McNeil was taken to Cst. Jones' report.[39] Dr. McNeil emphasized that the report contains a false assumption: that fentanyl is being sold as heroin. In fact, "at this point, fentanyl is being sold as fentanyl."[40] Not surprisingly, the entrance of fentanyl into the illicit drug market (itself the result of drug prohibition and the ease with which fentanyl can be clandestinely imported and trafficked)[41] has resulted in people becoming dependent on fentanyl itself, a drug notorious for its addictive effects. Cst. Jones' report also referred to a median lethal dose of fentanyl to which Dr. McNeil responded "there is actually no agreement on that."[42]

Cross-Examination of Dr. McNeil

43. In cross-examination, the Crown attempted to distinguish the risk of overdose-related harm post-release by referring to the length of jail terms (implicitly asking Dr. McNeil whether the risk of overdose decreases with longer jail sentences). Dr. McNeil responded that custody is "an exposure" regardless, and he did not believe the research differentiated between short and long-term custodial stays. The Crown pursued and asked Dr. McNeil whether there would be a difference in overdose risk if a jail sentence was 30 days versus two years and his response was as follows:

> No, because they would both carry the risk in the sense that, you know, that person is still highly likely to use opioids, post-incarceration. And whether it's a thirty-day period or a longer, two-year period, that's more than enough time for someone to develop decreased opioid tolerance that would place them at a heightened risk of overdose.[43]

44. A better solution was offered by Dr. McNeil:

> Those medication-based treatments for opioid use disorder, be they methadone, buprenorphine, [indiscernible] morphine, or where available, injected hydromorphone. And you know, those programs, especially where they're operating within treatment paradigms that don't penalize people on the basis of concurrent drug use, are certainly much, much more effective at managing and reducing overdose risks and other related harms, more generally.[44]

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[38] TR p. 55, l. 5-8
[39] TR p. 57, l. 3-22.
[40] TR p. 57 l. 34-40
[41] TR p. 10 L. 1-12
[42] TR p. 58, 11-12
[43] TR p. 64, l. 18-24
[44] TR p. 65, l. 1-10

> My team has published a couple of recent papers looking at the pilot state supply programs that have been implemented in British Columbia, including a paper published in Drug and Alcohol Dependence and another published in the Journal of Urban Health, that looked at – so, this program operating at an overdose prevention site in Vancouver that's distributing hydromorphone to people at high risk of fentanyl overdose. And what we effectively found is that providing people with a pharmaceutical grade drug that's an alternative to illicit fentanyl, was actually, you know, highly efficacious in decreasing their engagement with the illegal drug market.[45]

45. Crown counsel also sought to establish that, based on Dr. McNeil's previous testimony about the statistics relating to people who both use and sell (40% to 50%), the majority of people who are addicted to drugs do not sell. His response was as follows:

> So, part of this, I think, is just what we can clarify. You know, when we're talking about something like homelessness being a risk factor for engagement in drug selling, what that effectively means is, yes, this isn't to say that someone who's not drug selling might not also be homeless. But, the data would show that someone who is, is more likely to be. So, I think that's an appropriate way to think about it, that the odds of engaging in selling increase, you know, if for example, you're homeless. Now, I think one of the things, and certainly this would track with my field experience, you know, among folks who are particularly socioeconomically marginalized and engaged in drug selling to support their own use, those are among some of the most marginalized people that I encounter, even in comparison to other people who use drugs.[46]

The Evidence of Ms. Tanya Ellis

46. Ms. Ellis testified several weeks after the testimony of Cst. Jones and Dr. McNeil. She was previously hospitalized due to a suspected "C. Difficile" infection. Similar to Dr. McNeil, her testimony offered powerful insight into the complex socioeconomic reasons why people who use drugs engage in street-level drug dealing – all from the unique and under-represented standpoint of a mother who uses drugs whilst navigating poverty, precarious housing, challenges with mental health, and child custody. Ms. Ellis is an expert in her own right.

47. Ms. Ellis is 42 years of age. She grew up in this community. Her description of being raised by her mother and father is fraught with challenges. The familial environment included severe alcohol abuse and domestic violence. She specifically recalled occasions where she would hide in the bathroom and hear her father inflicting physical abuse upon her mother. She described her father as being "not a nice drunk." For these reasons, she tried to spend as little time at home as possible. She started associating with a group of friends that were experimenting with drugs. She quickly stopped attending school and was transitioned into an alternative education program.

48. By grade 8, she was smoking crack cocaine and experimenting with a host of other substances. She began a relationship with an older male who was also involved in criminal activity and

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[45] TR p. 65, l. 29-42
[46] TR p. 68 l. 32-47, p. 69-

substance use. She described being sexually and physically assaulted by this male. When that relationship ended, she started to date Mr. Arthur Nelson.

49. Mr. Nelson was using heroin and cocaine at the time. His family and associates were engaged in criminal activity. Ms. Ellis, as a teenager, moved in with Mr. Nelson and his family on the Quinsam reserve.[47] She described Mr. Nelson's household as beset with violence and negative influences. She also described that "everyone on reserve was using." Mr. Nelson and Ms. Ellis eventually had two daughters: Hailey, now 21, and Kailey, age 12.

50. She testified that as a result of her addiction and criminal involvement, MCFD has been involved in her life and had a significant and challenging impact on her. She recounted a 9-month period when she was incarcerated when the children were young. The children were placed in the care of Mr. Nelson's family member on reserve. She described carrying "a lot of guilt" about that separation. She explained that she knew the environment they were living in was "not good." Today, her youngest daughter resides with her on reserve. She expressed that her youngest daughter "isolates like me" and does not want to attend school. However, her eldest daughter is thriving: she is attending the University of Victoria and has aspirations to pursue to a career in psychiatry.

51. Ms. Ellis has attended approximately seven different residential treatment centers over the course of her life including Peardonville (on two separate occasions), Round Lake, Nenqayni, and at least four others across the province. Ms. Ellis has used numerous programs (both abstinence-based and maintenance-based) to address her substance use. She has been on the methadone program for nearly two decades. For a very brief period of time, she was on the Kadien program. Finally, she has sporadically attended "AA and NA" meetings, and has received outpatient services from a variety of providers both on and off reserve. The longest period of sobriety she believes she has achieved is approximately two years. As noted later in these submissions, Ms. Ellis has felt consistently unsupported by her doctor, medical professionals and probationary services, all assigned to help her with her drug use.

52. During her testimony she explained that she likely started using drugs to "numb the pain" associated with her home environment. She also testified that she has struggled for decades with diagnosed depression. She has in the past been prescribed medication for depressive disorder but does not take the medication. Her explanation for this is that when she was young, her brother was diagnosed with depression, was placed on anti-depressants and soon thereafter suffered from suicidal ideation. That experience appears stained in Ms. Ellis' mind and has discouraged her from addressing her own depression via the pharmaceutical routes characteristic of medicine and psychiatry.

53. Mr. Nelson also suffered from depression. Ms. Ellis recounted an event just prior to their attendance at the Round Lake Treatment program in 2019 where he stabbed himself and was taken to hospital. A few weeks later, while at the Round Lake Treatment program, Mr. Nelson was described as being "still heavily medicated from the hospital" and unable to participate fully

[47] As explained in direct examination, Ms. Ellis does not identify as an Indigenous woman, however, Mr. Nelson belonged to the Cape Mudge Band. The children they had together identify as Indigenous.

in programming with Ms. Ellis. However, they ultimately completed the program and returned to Campbell River at the end of August of 2019. 48 hours later, Mr. Nelson died from an apparent overdose. The circumstances of his death and the impact on Ms. Ellis and her children are devastating.

54. Three months after Mr. Nelson's overdose, Ms. Ellis was caught by an undercover officer selling small quantities of fentanyl and cocaine as described in the Agreed Statement of Fact. She explained that she had no choice but to sell some of the drugs she was using in order to deal with her drug dependence and its underlying causes. Ms. Ellis' criminal record is before the court. It is replete with low level property crime. She had, in the past, stolen items from local stores in exchange for money to purchase the drugs she needed.

55. She described her client base as consisting of eight to ten people who she knew. She explained that she routinely tested the drugs she sold not only in the interests of her clients but also because she was using from the same supply herself – a practice noted in Dr. McNeil's evidence for providing a "protective" benefit to clients.[48] Her fentanyl supplier was one she trusted and she had purchased from them for the last decade.[49] She testified she only sold to the undercover officer because a routine client "vouched" for her. She ordinarily would not sell to people she did not know, communicating to the court that she would be unaware of their tolerance level and the effect her drugs may have on them.

56. Ms. Ellis was asked whether any money was left over at the end of each month, after she sold drugs and secured her own drugs. Her answer was "not much…maybe like $100 if I am lucky." That money would then be used to purchase food, gas, or the occasional clothing item for her daughter. She confirmed that the car she operated at the time of the offence was her mother's.

57. In direct examination, Ms. Ellis was asked why she could not find a legal and gainful line of employment. Ms. Ellis stated "I have lived here my whole life and people don't forget ...I couldn't even get a job at McDonalds. I tried." She was then asked why she does not relocate to another city or town and she responded: "It's not that simple. My kids are here. My only family is here." Her response evoked the testimony of Dr. McNeil, who noted the systemic barriers faced by people who use drugs and the attendant lack of formal employment opportunities for that population.

58. Aside from being unable to gain or maintain stable employment, she also expressed that for most of her life she struggled to maintain stable housing: her early home life was plagued by domestic violence and alcohol; Mr. Nelson's home presented similar hardships; she, for a period of time lived in cooperative housing and was eventually evicted. Today, she resides with her mother on reserve. Her father passed away seven years ago. Her relationship with her mother is "not

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[48] TR p 44, l. 24

[49] She explained that she purchased her cocaine elsewhere and very rarely sold cocaine in either crack or powdered form.

good…she doesn't understand addiction." At the present time, she described having no stable supports in her life.

59. A lack of supports to address Ms. Ellis' drug use realistically (and non-punitively), is an ongoing theme in her life. Most unfortunately, she communicated that she feels unsupported by her methadone doctor. She finds it difficult to access her and maintain a steady dose and very rarely are alternatives suggested to her. She also described a lengthy history with probation services. She described a negative relationship with community corrections believing that "they don't help me…they work with the police." Ms. Ellis' characterization of police speaks to the existence of rigid power dynamics between police and criminalized people, fear of criminalization, and mistrust and avoidance of law enforcement (a dynamic generally denied by Const. Jones in his testimony). Not once in the decades of being placed on an administrative court order did her probation officer facilitate a treatment plan for her.[50]

60. She also explained, echoing the testimony of Dr. McNeil that criminalization fails to address drug use, that incarceration has not served to curtail her addiction or decrease her involvement in criminal activity instead she "comes back to the same town and has the same problems."

Cross-Examination of Ms. Tanya Ellis

61. The Crown commenced cross-examination by inquiring how much fentanyl and cocaine Ms. Ellis was using between the time of Mr. Nelson's death in August of 2019 and her trafficking activity in November of 2019. Ms. Ellis estimated she was consuming up to a "half ball" of fentanyl per day. Her use of crack cocaine was much less standardized, though still consistent: "sometimes I would smoke every ten minutes, every hour," or sometimes just once per day. Based on the quantum and associated cost, the court can glean that she was trying to support a habit that equated to $350-$450 dollars per day. After Mr. Nelson's death, Ms. Ellis did not leave the home unless it was to purchase items at the corner store or to respond to a call for fentanyl and, on occasion, cocaine, the income from which would again be used primarily to support her own drug use.

62. The Crown asked if she cut her down drugs [i.e. if she adds 'bulk' to her supply prior to sale, including other substances and synthetic opioids such as fentanyl]. She explained she does not and that it "goes out the same way it comes in…I don't like messing with it…I wouldn't know how. I don't want anyone putting shit in my drugs so I wouldn't put it in anyone else's." Ms. Ellis is located at the bottom of the drug supply hierarchy: She testified that she did not have anyone working for her and she would arrange her own deals. She did not have a sophisticated way of keeping track of sales, instead she testified "I would just count the money at the end of the day." This comports with Dr. McNeil's characterization of street-level drug dealers as having the least amount of power and the greatest amount of risk:

[50] In this context, it is important to consider a common request from the PPSC: probation is required in order to "assist" the offender with her addiction.

> ...there's a huge power disparity there, with the person at street level having the least amount of power, the greatest degree of risk, but also the lowest level of control over what's ultimately in the drugs that they're selling. Therein they might just have it communicated to them what it is they're selling, you know, and unless they have access to something that lets them test that, you know, they're really going by what they're told.[51]

63. Ms. Ellis was also receiving social assistance in the amount of $740.00 per month. She listed her expenses as follows:

> -vehicle insurance: $120 per month
> -gas: $20 per day
> -phone bill: $80 per month
> -groceries: $100 per month
> -rent: she was not paying rent on reserve at her mother's residence between August and November 2019

64. She confirmed for Crown counsel that she carries a naloxone kit and that she in fact was briefly paid by AIDS Vancouver Island to hand out harm reduction supplies. The following exchange between Crown counsel and Ms. Ellis then occurred:

> Crown: Are you aware how dangerous fentanyl is?
> Ellis: Yes, but I know Narcan [naloxone] saves people's lives and that people will use no matter what
> ...
> Crown: Would you [sell drugs again] to support yourself in the future?
> Ellis: If it meant to avoid withdrawal...yeah.

65. Contrary to stereotypes that drug use is always driven by a need to get "high", the evidence of both Dr. McNeil and Ms. Ellis speak to the function of drug use to simply avoid withdrawal, a condition both debilitating and dangerous. In Dr. McNeil's terms:

> Within that kind of situated rationality of drug use, that need to ensure access to drugs and to effectively avoid going into withdrawal...is much more critical than any of the risks that may be associated with potentially being arrested for drug selling again...If I can take a moment just to impress upon you, we really don't take opioid withdrawal seriously, as an experience, as we probably should...Imagine the worst flu you have ever had...I think a lot of us have had the experience of nausea, and the sweats, maybe some anxiety...diarrhea and your nose is running and you have goosebumps. That severe flu is what someone is experiencing going through opioid withdrawal. Within that context, the risks associated with drug selling and the potential risk of arrest and incarceration are completely overwhelmed by how, in the moment, the most critical thing you can do is address those symptoms of withdrawal...I've known people who literally...sold the boots

[51] TR p. 43, l. 20-28

off their feet because they were going through withdrawal and needed to purchase drugs to manage those experiences.[52]

66. In Ms. Ellis' terms, "it is disgusting," … "you feel like you have chicken skin," ... "I can't stop my legs from shaking." She went on to describe loss of bowel functions and the general symptoms Dr. McNeil described.

67. The testimony of Dr. McNeil comports with the findings of Pivot Legal Society's *Project Inclusion*, a Report referenced by the Supreme Court of Canada in *R v Zora* 2020 SCC 14:

> Over years of working alongside people who use drugs and alcohol, we appreciate that substances can play a critical role in people's wellbeing. Whether it's conducting an interview while driving someone to the liquor store so they don't get sick or hearing from someone while they inject drugs, using substances can be the way people stay well and participate socially and politically. This is an important counterpoint to popular but misguided perceptions of drug use and its motivations. Participants' descriptions of using powerful drugs just to maintain or 'get to normal' has a basis in neuroscience. As people continue to use opioids in larger dosages, scientists believe the brain is altered so that function is impaired when drugs are not present, rather than the other way around. That is the reality for many of the people who took part in this study.[53]

Summary

68. The evidence this court received from Dr. McNeil, Ms. Ellis, and even PPSC's expert, Cst. Jones reveals the complicated landscape in which drug use and drug dealing take place. Drug use cannot be understood in a silo; rather, as Dr. McNeil illustrated, systemic factors such as poverty, homelessness, colonialism and racism, trauma, mental illness, pain (both physical and psychological) all drive drug use. Understood this way, drug use is not the problem: it is the only available solution to many people struggling against state and/or social machinations of oppression and inequality that are in desperate need of solution and yet go entirely unaddressed by periods of incarceration.

69. The evidence of Ms. Ellis and Dr. McNeil also reveals the inter-relatedness between drug use and drug dealing. Factors such as poverty, racism, and disability (to name a few) not only contribute to drug use, but also create barriers to formal employment, thus leading to illicit income-generating activities such as drug dealing. As a result, marginalized street-based drug dealing is oftentimes the by-product of a coalescing of employment barriers: those that derive

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[52] TR p. 49-50.

[53] Pivot Legal Society. *Project Inclusion: Confronting Anti-Homelessness & Anti-Substance User Stigma in British Columbia*, by Darcie Bennett and D.J. Larkin, 2019 (online: https://d3n8a8pro7vhmx.cloudfront.net/pivotlegal/pages/32 97/attachments/original/1543970419/project-inclusion-digital.pdf?1543970419; archived version: https://www.scc-csc.ca/cso-dce/2020SCC-CSC14_8_eng.pdf) at p. 33

from the fact of being marked as a drug user, and those stemming from the lived experiences of poverty, racism, disability, etc. – many of which underpin drug use in the first place.

70. Faced with the evidence of Ms. Ellis and Dr. McNeil regarding this complicated relationship between drug use and drug dealing, we witness the crumbling of an eponymous false dichotomy: the villain drug dealer versus the victim drug user. This dichotomy, which mistakenly treats drug users and drug dealers as mutually exclusive, abounds societally, and is relied upon specifically in the leading case of *R v Smith* and its progeny.

71. There is no doubt that stereotypes have empowered and influenced the legal architecture surrounding the opioid crisis and Canada's treatment of people who use and deal drugs. Like most stereotypes surrounding drug use, however, the case law's reliance on the addict/dealer dichotomy is not only false but dangerous. Just as drug use is understood to be driven by systemic factors, so too must engagement with criminal income-generating activities (such as street-based drug dealing where the profit is used to support the individual's own drug use).

72. The fact of one's engagement with drug dealing does not negate the complex social patterns giving rise to that activity, particularly not when drug dealing is a means to support drug use. In the face of a now five-years-old opioid crisis that refuses to slow down under the current legal landscape, there is no reason why society's and the Court's burgeoning understanding of drug use as being complicated by the social determinants of health ought not to apply in the context of drug dealers like Ms. Ellis, whose means of generating income is a product of something far more complex and nuanced than a lack of morality.

73. If the criminal justice system continues to compartmentalize drug use and drug dealing – i.e. by ignoring the social determinants of drug dealing and treating all drug dealers as worthy of harsh punishment – it will continue its legacy of mistreating people who use drugs and its failure to address the problem in any meaningful way. As always, the impact will fall disproportionately to poor and racialized drug users.

PART II. *R v SMITH* AND ITS PROGENY

74. In what follows, Ms. Ellis advances that the severity of the recommended sentence in *R v Smith* and its progeny is disproportional to its deterrent effect. These prosecutions are not achieving their avowed purposes and the result is "pernicious climate for people who use drugs in the wake of the opioid crisis."[54]

75. The 'range' of sentence for fentanyl trafficking was defined by the British Columbia Court of Appeal in *R v Smith*: a prison sentence of "18-36 months and possibly higher." This range is a

[54] Haley Hrymak, A Bad Deal: British Columbia's Emphasis on Deterrence and Increasing Prison Sentences for Street-Level Fentanyl Traffickers, (2018) 41:4 Man LJ 149 – 179 at para. 41

marked step up from the six to eighteen-month range for trafficking in other schedule I substances in British Columbia. In advocating for a higher sentencing range for street-level fentanyl dealers, the PPSC filed evidence of the tragic effects of the fentanyl crisis across Canada and particularly within BC.

76. The Court of Appeal dismissed the sentence appeal but accepted it should establish a longer range for street-level trafficking of fentanyl to appropriately respond to the magnitude of the opioid crisis. Madam Justice Newbury, in her dissenting judgment, acknowledged PPSC's proposal as a means of "[addressing] the public's legitimate sense of moral outrage over the systematic distribution of a pernicious drug responsible for grievous loss of life, immense and unsustainable strain on our public health system, and devastating impacts on the safety and integrity of our communities."[55]

77. Madam Justice Newbury impressed upon lower courts to "consider the proliferation of Fentanyl and the fatal consequences of its illegal sale and distribution. These consequences inform the "circumstances of the offence" and "the culpability of the offender."[56] She also characterized lower-level custodial sentences for street-level dealers as "particularly troubling given that according to statistics prepared by the Canadian Centre on Substance Abuse [since renamed the Canadian Centre on Substance *Use and Addiction*], British Columbia has one of the worst, if not the worst, problems of fentanyl abuse in Canada."

78. She further referenced "various media campaigns, public alerts and outreach efforts by police and social workers who are involved in seeking to contain this scourge."[57] However, it was also acknowledged that "fentanyl abuse continues to claim lives every day in our communities. The danger posed by such a drug must surely inform the moral culpability of offenders who sell it on the street, and obviously increases the gravity of the offence beyond even the gravity of trafficking in drugs such as heroin and cocaine."[58]

79. The majority judgment similarly acknowledged the "public message campaign intended to increase awareness of fentanyl-related overdoses and recommended precautionary strategies".[59] In the majority's view, "the inevitably heightened public awareness of the risks associated with illicit fentanyl must increase the responsibility or culpability of anyone dealing in the product."[60]

80. The position adopted by physicians and addiction specialists, that addiction is a "chronic, relapsing brain disease," and that "drug addicts are essentially choiceless victims of their illness" was not recognized.[61] Nor could it have been; the required expert evidence was not tendered.[62]

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[55] *R v Smith*, 2017 BCCA 112 at para. 2.
[56] *R v Smith*, at para. 37
[57] *R v Smith*, para. 44
[58] *Ibid.*
[59] *Ibid.* at para. 62.
[60] *Ibid.*
[61] Linda C. Fentiman, Rethinking Addiction: Drugs, Deterrence, and the Neuroscience Revoltion, 14 U. PA. J.L. & Soc. CHANGE 233 (2011) at p. 234
[62] While the Court of Appeal in *Smith* did not hear this evidence, the SCC has recognized addiction as a health condition in *Insite* supra, and Canada did not contest that categorization in that case.

81. A proliferation of cases from both trial and appellate courts, across the jurisdictions, have echoed the sentiments espoused by both the majority and minority judgments. There are now too many cases to list. However, the following serve as an example.

82. In *R v Frazer*, [2017] A.J. No. 500, the Alberta Provincial Court noted that "[t]rafficking in fentanyl is almost the equivalent of putting multiple bullets in the chambers of a revolver and playing Russian roulette. It is the most efficient killer of drug users on the market today".[63]

83. In *R v Loor*, 2017 ONCA 696, the Ontario Court of Appeal held that "fentanyl is a highly dangerous drug. Its widespread abuse, though recent, has quickly become entrenched in our country. Every day in our communities, fentanyl abuse claims the lives of Canadians."[64] For this reason, "offenders…who traffic significant amounts of fentanyl should expect to receive significant penitentiary sentences."[65]

84. In *R v Fyfe*, 2017 SKQB the Saskatchewan Court of Queen's Bench commented that:

> The prevalence of fentanyl use and its contribution to many deaths in this country, an increasing number, is notorious. However, the statistics set out in the Crown's evidence provide stark illustration that this is a growing problem right here in Saskatchewan, particularly within a specific demographic (young males). I have been cautious not to treat this as an aggravating factor, per se, but this fact falls within the range of considerations behind this decision on sentence. This is especially so when individual and general denunciation and deterrence are considered in the context of determining the appropriate sentence for Mr. Fyfe.[66]
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> …
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> The presumption of incarceration should remain when dealing with hard drugs where the social costs and the potential for enormous profit in the retailing and wholesaling of the drug exists"[67]

85. More recently in *R v White*, the Nova Scotia Court of Appeal held:

> Although the particular issue addressed in *R. v. Stone*, [1999] 2 S.C.R. 290, involved domestic violence against women, the observations of Justice Bastarache, writing for the majority, are instructive in this case in the face of mounting judicial alarm over the devastation caused by the illegal distribution of highly addictive and lethal opioids. In his reasons, Bastarache, J. observed at para. 244:

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[63] *R v Frazer*, at para. 11.
[64] *R v Loor*, at para. 33
[65] *Ibid.* at para. 50
[66] *R v Fyfe*, at para. 100
[67] *Ibid.* at para. 123

> One function of appellate courts is to minimize disparity of sentences in cases involving similar offences and similar offenders; see *M. (C.A.)*, *supra*, at para. 92, and *McDonnell*, *supra*, at para. 16, *per* Sopinka J. ...[68]

86. The Court went on to hold, "it is incumbent on the judiciary to bring the law into harmony with prevailing social values. This is also true with regard to sentencing."[69] It was ultimately concluded that "the time has come for this Court to ensure that trafficking in fentanyl does not gain a foothold in this province, and to send a message to traffickers that this is not a place where they would wish to do business."[70]

87. The current opioid crisis in British Columbia (and across Canada) has the courts calling for enhanced deterrence and lengthier prison terms.[71] Indeed, in this case, the Crown urges the Court to consider *R v Schneider* which comments on "the need to keep the sentencing goals of general deterrence and denunciation paramount when sentencing offenders involved in trafficking fentanyl due to its deadly nature and the escalating crisis it presents in our communities."[72] The Crown also references: *R v Cisneros*, 2014 BCCA 154 which advocates for custodial sentences in order to curb the "social harm engendered by dial-a-dope operation;"[73] *R v Lloyd* 2019 BCCA 128 which refers to the "public health crisis rocking the country in recent years"[74] and the corresponding need to jail people who use drugs; *R v Johnson* 1996 Canlii 3148 to encourage this court to erroneously accept that "communities will rightfully express outrage"[75] if we fail to impose "harsh sentences."[76] The Crown references and emphasizes these judgments in the face of its own policy directive that recognizes "substances use has a significant health component" and "criminal sanctions, as a primary response, have a limited effectiveness as specific or general deterrents."[77]

88. The discourse surrounding the opioid crisis as contained in these judicial narratives, positions incarceration as our solution. However, as explained by Dr. McNeil in his testimony and corresponding publications and research studies, empirical evidence shows no relationship between increasing sentences and the prevention of drug use and marginalized street-level dealing. In fact, by insisting on custodial sentences we are fueling a harmful response.

89. Criminal courts need to re-envision their perceived role in addressing crime impacted by drug use. A failure to do so would constitute a failure to adapt to an ongoing and wide-spread re-

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[68] *R v White*, at para. 99
[69] *R v White*, at para. 100, citing *R v M. (C.A.)*, *supra* at para. 81.
[70] *R v White*, at para. 104
[71] As noted in Hayley Hrymak's article "A Bad Deal: British Columbia's Emphasis on Deterence and Increasing Prison Sentences for Street-Level Fentanyl Traffickers" (2018) 41:4 Man LJ 149 – 179, referencing *R v Creuzot*, 2017 BCSC 1075.
[72] At para. 10
[73] At para. 9.
[74] At para. 32
[75] At para. 30
[76] At para. 43
[77] Public Prosecution Service of Canada Deskbook, Guideline of the Director under Section 3(3) of the *Director of Public Prosecutions Act* (August 17, 2020) online at: https://www.ppsc-sppc.gc.ca/eng/pub/fpsd-sfpg/fps-sfp/tpd/p5/ch13.html

reckoning of drug use currently underway in Canada, among the general public, the health professions, the police, and various levels of government, including the federal government and Health Canada. In recent years, these entities have increasingly insisted upon a public health approach to substance use, rather than a criminal approach, in order to realistically address drug use and its social determinants.

PART III. THE PROBLEM WITH DENUNICATION, DETERRENCE AND INCARCERATION

The Goal of Deterrence

90. Deterrence is the keystone of the arch of the criminal law. The theory of deterrence contends that when applied appropriately, punishments can effectively shape behavior so as to prevent future offending.[78] The assumption underlying deterrence as a goal of sentencing is that the threat or example of punishment discourages crime.[79] Based on the initial observations of Thomas Hobbes, Cesare Beccaria, and Jeremy Bentham, criminal deterrence theory implies that individuals evaluate the positive and negative outcomes of committing a crime before acting.[80]

91. Deterrent sentences theoretically work on two levels. General deterrence targets society itself, including potential offenders, to demonstrate the consequences of committing the offence in question.[81] Specific or individual deterrence aims to prevent the offender from repeating the crime.[82]

92. The assumption that before the commission of a crime, an individual makes a rational, cost-benefit analysis concerning a given offence and only acts when the potential benefits are outweighed by the expected costs is misplaced. This approach clearly fails to account for the myriad socioeconomic factors known to impact decision-making processes, particularly in the case of an offender experiencing addiction. Due to the nature of drug use and the factors underlying it, people who use drugs are, in general, not accurately represented by the archetypal (and highly contestable) 'rational man,' which problematically adopts classical deterrence theory as a one-size-fits-all response to any and all criminal behavior, with disastrous effects and unequal application.

93. Research suggests that a punitive approach to drug use, or one that increases prison sentences for people who use drugs or who engage in street-level trafficking is not an effective response to the opioid crisis. Addiction and drug use cannot be "cured" or necessarily prevented by the threat

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[78] Ronald L. Akers, Rational Choice, Deterrence, and Social Learning Theory in Criminology: The Path Not Taken, 81 J. CRIM. L. & CRIMINOLOGY 653, 654 (1990)
[79] Clayton Ruby, Sentencing, 4th Ed., Toronto, Butterworths, 1994 at p. 7
[80] CESARE BECCARIA, ON CRIMES AND PUNISHMENTS AND OTHER WRITINGS 21 (Richard Bellamy ed., Richard Davies trans., Cambridge Univ. Press, 1995) (hereinafter BECCARIA Davies trans.); 1 JEREMY BENTHAM, Principles of Penal Law, in THE WORKS OF JEREMY BENTHAM 361 (Russell & Russell 1962) (1843) (hereinafter Penal Law); THOMAS HOBBES, LEVIATHAN: OR THE MATTER, FORME, & POWER OF A C COMMON-WEALTH ECCLESIASTICALL AND CIVILL 18 (Lerner Publ'g Grp., Inc. 2018) (1651).
[81] Ruby, *supra,* p. 11
[82] Ruby, *supra,* p. 13

of punishment. It would be similarly acontextual and lacking an evidentiary basis to expect that the criminalization of drug-related activities – activities that were oftentimes undertaken in the first place by the individual to address addiction and other social determinants, per the evidence of Dr. McNeil – will prevent or deter the commission of these offences.

94. As the evidence of both Ms. Ellis and Dr. McNeil attest, so long as the social factors underpinning drug use and drug dealing persist, so too will drug use and drug dealing themselves, regardless of how hard the criminal justice system comes down. As deterrence and addiction are incompatible, so too is 'cracking down' on people who deal drugs to get by in the face of immense structural barriers and setbacks.

95. Cracking down on drug dealers also ignores the fact that street-based drug dealers oftentimes play a key role in harm reduction during the opioid crisis, as Dr. McNeil's evidence demonstrates. There is increasing research that drug dealers test their supply prior to sale when they have access to drug-checking technology. They offer a relatively consistent supply of drugs to their regular clientele, which is particularly important amid an illicit drug market of increasingly unknown toxicity.

96. By contrast, and as Dr. McNeil's evidence shows, extracting the street-based drug dealer from his role puts his clientele at greater risk of overdose and of purchasing supply of unknown toxicity from a lesser- or unknown dealer. Criminalizing the drug dealer does not, as Ms. Ellis noted, deter the drug dealer from dealing again, much less deter either the dealer or his clientele from buying or selling drugs in future. Instead, it makes the dealer vulnerable to withdrawal, and overdose upon release.

The Goal of Denunciation

97. The principle of denunciation attempts to publicly announce society's attitudes towards the offence committed.[83] Lamer C.J.C., speaking for the Supreme Court of Canada, stated that a sentence with a denunciatory element "represents a symbolic, collective statement that the offender's conduct should be punished for encroaching on our society's basic code of values as enshrined within our substantive criminal law.

98. As described in Part IV, society's "basic code of values" has undergone a seismic shift since the onset of the opioid crisis and its catastrophic effects, which have touched lives everywhere throughout the country, particularly so amid the second public health crisis of COVID-19. Between January 2016 and June 2020, 17,602 apparent opioid toxicity deaths were recorded in Canada.[84]

PART IV. *STARE DECISIS* AND THE BEDFORD TEST

99. The doctrine that lower courts must follow the decisions of higher courts is fundamental to our legal system. It provides certainty while permitting the orderly development of the law in

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[83] Ruby, *supra*, p. 6

[84] Government of Canada, Opioid- and Stimulant-related Harms in Canada (Decemeber 2020) online at: https://health-infobase.canada.ca/substance-related-harms/opioids-stimulants/

incremental steps. However, *stare decisis* is not a straitjacket that condemns the law to stasis. Trial courts may reconsider settled rulings of higher courts in two situations: (1) where a new legal issue is raised; and (2) where there is a change in the circumstances or evidence that "fundamentally shifts the parameters of the debate."[85] In essence, under the *Bedford-Carter* approach, there can be a revisiting of precedent based either on significant changes in the legal context or in the factual context for a legal decision.

100. Both requirements are satisfied here. Ms. Ellis has equipped this Court with the necessary tools to depart from the analysis and proposed range as set out in *Smith*. The time has come to recognize that Ms. Ellis is not a "unique" or "exceptional offender."[86]

(1) A new legal issue is raised

101. Ms. Ellis advances that the presumptive effectiveness of jail as a general deterrent is misplaced in the context of marginalized street-level dealers. Ms. Ellis recognizes that a similar argument was (peripherally) raised in *R v Rutter*, a 2016 provincial court decision out of Nanaimo. For this reason, it is important to review the content of that decision and its distinguishing features.

The Provincial Court Decision in R v Rutter

102. In 2016, the Honourable Judge Gouge released his decision in *R v Rutter*.[87] The accused acknowledged that "he had been a partner and active participant in a dial-a-dope operation for four to five months before his arrest."[88] At the time of sentence, "Mr. Rutter was 22 years of age. He began to use illicit drugs at age 17 and, by age 20, had become addicted to cocaine, heroin and fentanyl. At the time of his arrest, fentanyl was his drug of choice."[89] Since his arrest, he had taken significant steps toward rehabilitation.[90] He had no prior criminal record.[91]

103. Judge Gouge acknowledged that "fentanyl overdoses are a serious and rapidly growing problem in British Columbia."[92] However, in referencing the decision of *R v Preston*, Gouge, J. commented: "denunciation and deterrence, general or specific, are not often effective in relation to addicts who commit offences to feed their habits. If attempts at denunciation and deterrence are often futile, it will be appropriate in many cases to focus on attempts at rehabilitation."[93] He also observed that "it is not unusual for a drug trafficker to be an addict, nor for an addict to be a

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[85] *Canada (Attorney General) v. Bedford*, 2013 SCC 72 at para. 42; *Carter v. Canada (Attorney General)*, [2015] S.C.J. No. 5 2015 SCC 5 at para. 44.
[86] The language used to *R v Voong* 2015 BCCA 285 To signal when sentencing courts may depart from custodial sentences.
[87] 2016 BCPC 321
[88] *Ibid.* para. 2
[89] *Ibid.* para. 3
[90] *Ibid.* para. 4-5.
[91] *Ibid.* para. 7
[92] *Ibid.* para. 9.
[93] *Ibid.* para. 11

trafficker. Anecdotally, that appears to be the norm, at least in Nanaimo. An addicted trafficker is not an exceptional circumstance."[94]

100. Mr. Rutter was sentenced to a period of probation on the basis that:

> There is little doubt that a jail sentence would put Mr. Rutter's rehabilitation at risk. It is likely that, if sentenced to jail, Mr. Rutter will use drugs while in jail and will resume trafficking in them upon his release. Considering only Mr. Rutter as an individual, the public is more likely to be well protected by a suspended sentence and a period of probation than by a jail sentence.[95]
>
> ...
>
> The more difficult question is whether the deterrent effect which a jail sentence for Mr. Rutter might have on others is a more important factor, from the point of view of public safety, than the risk to Mr. Rutter's rehabilitation which would result from such a sentence. Unfortunately, I have very little information to assist me in answering that question. Unlike the medical profession, we who work in the criminal justice system do not measure outcomes and do not follow patients. Intuitively, one would expect jail sentences to be an effective deterrent for some cohorts of offenders and not for others. I am not aware of any reliable source of information about the deterrent effect of jail sentences on drug traffickers. I am mindful of the admonition in *Voong* and other cases, to the effect that denunciation and deterrence are primary sentencing objectives in drug trafficking cases. However, that does not assist me when I am trying to weigh the risk to public safety which I believe would result from a jail sentence for Mr. Rutter (because I think that he would be a serious risk to re-offend upon his release) against the reduced risk to public safety which might result if other traffickers and potential traffickers were deterred by a jail sentence for Mr. Rutter. In the end, I think that the known reduction in risk to public safety which would result, in this individual case, from a suspended sentence and probation is more likely to benefit the public than the unknown benefit of general deterrence which might result from a jail sentence.[96]

101. The PPSC appealed Gouge J's decision on the basis that the sentence was "manifestly unfit in light of the deadly and devastating effects of fentanyl."[97]

The Appeal Court's Decision in R v Rutter

102. Madam Justice Fenlon, writing for the Court prefaced her decision by holding:

> It is clear that going forward, the sentencing range for street-level trafficking in fentanyl begins at 18 months' imprisonment, and extends up to or beyond 36 months' imprisonment. It is also clear that this range is a guideline, not a straightjacket, and that

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[94] *Ibid.* para. 17
[95] *Ibid.* para. 28
[96] *Ibid.* para. 29
[97] *R v Rutter*, 2017 BCCA 193, para. 1

sentencing judges retain the discretion to depart from this range where there are case-specific exceptional circumstances (*Smith* at para. 35)[98]

103. In Fenlon J's view, "it was open to the trial judge to recognize that drugs may be available to Mr. Rutter in jail. However, it was mere speculation to assume that Mr. Rutter, who had maintained abstinence in the community, would more readily relapse if sent to jail and resume trafficking on his release."[99] She further held that "the sentencing judge lost sight of the presumptive effectiveness of jail as a general deterrent."[100]

104. The Court of Appeal concluded, without further analysis, that "these errors" led Gouge J to impose a sentence that was demonstrably unfit. The sentence was replaced with a period of six months' incarceration followed by 24 months' probation on the terms directed by the sentencing judge.[101]

Why Ms. Ellis' Case is Different

105. The necessary evidentiary foundation for Gouge J's conclusions in *Rutter* was unfortunately not provided. He did not have the benefit of expert testimony that would allow him, as the sentencing judge, to safely arrive at the conclusions he did.[102] Ms. Ellis has tendered leading expert evidence and has explained the relevance of the expert evidence in relation to the specific material issues in this case. To our knowledge, this is the first case in Canada to introduce the type of evidence offered by Dr. McNeil.

106. As acknowledged by the Supreme Court in *R v R.D.S.*, [1997] 3 S.C.R. 484:

> Certainly judges may, on the basis of expert evidence adduced, refer to relevant social conditions in reasons for judgment. In some circumstances, those references are necessary, so that the law may evolve in a manner which reflects social reality. For example, in R. v. Lavallee, [1990] 1 S.C.R. 852, expert evidence of the psychological experiences of battered women was used to inform the standard of reasonableness to be applied when self-defence is invoked by women who have been victims of domestic violence.[103]
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> ...
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> Similarly, judges have recently made use of expert evidence of social conditions in order to develop the appropriate legal framework to be utilized for ensuring juror impartiality. In Parks, supra, Doherty J.A. referred to a body of studies and reports documenting the

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[98] *Ibid.* para. 4
[99] *Ibid.* para. 14
[100] *Ibid.* para. 23
[101] *Ibid.* para. 24
[102] Regardless of how accurate those observations and conclusions may have been.
[103] At para. 123.

prevalence of anti-black racism in the Metropolitan Toronto area. On the basis of his conclusions, at p. 338, that anti-black racism is a "grim reality" in that community he developed a legal framework permitting jurors to be challenged for cause on the basis of racial preconceptions. This legal framework is applicable in circumstances where a realistic possibility exists that such preconceptions might threaten juror impartiality.[104]

107. Through the leading expert evidence of Dr. Ryan McNeil, Ms. Ellis has demonstrated that the most effective way to deter drug use and drug-fueled crime is a reliance on evidence-based treatments for addiction. Prescribing longer custodial sentences during the opioid crisis ignores the complexities of addiction, the vast medical research and only serves to perpetuate harm.[105]

(2) A fundamental shift in the parameters of the debate has occurred

108. In the last five years and since *R v Smith*, there has also been a change in the circumstances and evidence that has fundamentally shifted the parameters of the discussion around drug use in Canada – namely *away* from the criminal model and *toward* a public health model.

109. This shift in perspective and approach is in part owing to practical, real-world changes relating to the illicit drug market. In BC today, according to the evidence of Dr. McNeil, "there's certainly the expectation at this point…that if it is an illicit opioid that it contains fentanyl, because…it's a relatively rare thing to, for example, get heroin at this point."[106] The literal saturation of the illicit market with unknown quantities of synthetic opioids such as fentanyl has given rise to an astronomically high rate of overdose fatalities. Though fentanyl had entered the illicit drug market at the time of *R v Smith* and overdose deaths were of course a prominent concern, both factors have accelerated dramatically in recent years, with numerous provinces (including BC) having declared the rate of overdose deaths a public health emergency since 2016. The illicit drug market and corresponding fatalities continue to be a driving force behind the extensive law and policy reforms we currently see in BC and Canada.

110. In 2016, the federal government of Canada replaced its National Anti-Drug Strategy with the new Controlled Drugs and Substance Strategy (CDSS): "a comprehensive, collaborative and evidence-based approach to drug policy, which uses a public health approach when considering and addressing drug issues."[107]

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[104] At para. 125

[105] Hayley Hrymak's article "A Bad Deal: British Columbia's Emphasis on Deterence and Increasing Prison Sentences for Street-Level Fentanyl Traffickers" (2018) 41:4 Man LJ 149 – 179

[106] TR p 44, l. 1-9. Dr. McNeil's evidence also refers to a University of Victoria drug checking project, wherein recent data revealed more than ninety percent of the illicit opioids that were tested were positive for fentanyl: TR, p. 44, l. 10-15.

[107] Government of Canada, "The New Canadian Drugs and Substances Strategy" (December, 2016) online at: https://www.canada.ca/en/health-canada/news/2016/12/new-canadian-drugs-substances-strategy.html

111. The CDSS entailed reframing drug use as a public health issue rather than a criminal matter and moved the drug portfolio from the jurisdiction of the Minister of Public Safety to the Minister of Health. The CDSS restored harm reduction as a key pillar of Canada's drug policy and underscored the government's commitment to "ensuring that its policies under the CDSS are based on a strong foundation of evidence, including data related to harm reduction policies, program and interventions."[108] A key component of the CDSS was the legal regulation of cannabis under the *Cannabis Act* in 2018.

112. The federal government's new strategy has had a ripple effect on non-federal orders of government and police across Canada.

113. In April 2016, BC's then-Provincial Health Officer, Dr. Perry Kendall, declared a public health emergency under the *Public Health Act* "due to the significant rise in opioid-related overdose deaths reported in BC since the beginning of 2016."[109]

114. In 2016 the Province also unveiled its Ministry of Mental Health and Addictions, reinforcing its commitment to "an all-of-the-province approach to combat the overdose crisis that includes crucial additional investments and improvements to mental health and addictions services."[110] An unprecedented Ministerial Order in the same year from then-Minister of Health Terry Lake ordered the establishment of "overdose prevention services" across the Province to address the mounting number of overdose fatalities. In most cases, these services operate similarly to supervised consumption sites, wherein simple possession charges do not routinely apply.

115. In 2019, the Provincial Health Officer, Dr. Bonnie Henry, released a report titled "Stopping the Harm: Decriminalization of People Who Use Drugs in BC" (the "Henry Report").[111] The Henry Report calls on the Province of BC to decriminalize simple drug possession at the provincial level.

116. On the "history of Canada's drug laws, national strategies, and international drug conventions" the Henry Report issues the following key messages:

- Canada has had a long history of prohibition-based drug laws and drug policies.[112]
- The "war on drugs" has been recognized as a failure at a global level.[113]
- In recent years, the federal government has adopted more evidence-based strategies, such as reinstating harm reduction as a pillar of the national drug strategy, and has invested in progressive legislation, such as the Cannabis Act and the Good Samaritan Drug Overdose Act.[114]

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[108] *Ibid.*
[109] Province of Britsh Columbia, Overdose Awareness, "How the Province is Responding" online at: https://www2.gov.bc.ca/gov/content/overdose/how-the-province-is-responding
[110] *Ibid*
[111] Office of the Provincial Health Officer, Special Report: "Stop the Harm: Decriminalization of People Who Use Drugs in BC" online at: https://www2.gov.bc.ca/assets/gov/health/about-bc-s-health-care-system/office-of-the-provincial-health-officer/reports-publications/special-reports/stopping-the-harm-report.pdf
[112] *Ibid* at page 16.
[113] *Ibid.*
[114] *Ibid.*

- Criminal penalties for drug-related offences remain disproportionate compared to penalties for other, more violent crimes.[115]

117. The Henry Report makes a number of key findings related to the harms of drug prohibition.

- Criminalizing non-violent individuals for possessing a substance for personal use has considerable negative harms both to the individual and society.[116]
- Prohibition and punitive-based drug policy magnify harms associated with substance possession, such as communicable disease transmission, increase stigmatization of people who use drugs, and increase drug-related mortality, while having little to no impact on reducing drug use rates.[117]
- There are potentially long-lasting harms associated with incarceration, including a criminal record for otherwise law-abiding British Columbians who in turn may experience barriers to employment, travel, and other situations that require a criminal background check.[118]
- Law enforcement and health officials recognize that BC cannot arrest its way out of the overdose crisis.[119]

118. In July 2020, the Canadian Association of Chiefs of Police released a report titled "Decriminalization for Simple Possession of Illicit Drugs: Exploring Impacts on Public Safety & Policing" (the CACP Report).[120] The CACP Report affirms that the CACP:

- Recognize substance use disorder as a public health issue.[121]
- Agree that the evidence suggests, and numerous Canadian health leaders support, decriminalization for simple possession as an effective way to reduce the public health and public safety harms associated with substance use.[122]
- Agree that the evidence from around the world suggests our current criminal justice system approach to substance use could be enhanced using health care diversion approaches proven to be effective.[123]
- Endorse alternatives to criminal sanctions for simple possession of illicit drugs, requiring integrated partnerships and access to diversion measures.[124]
- Agree that diversion provides new opportunities to make positive impacts in communities. These impacts may include reducing recidivism, reducing ancillary crimes and improving health and safety outcomes for individuals who use drugs.[125]

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[115] *Ibid.*
[116] *Ibid.* at page 22
[117] *Ibid.*
[118] *Ibid.*
[119] *Ibid.*
[120] Canadian Association of Chiefs of Police, Special Purpose Committee on the Decriminalization of Simple Possession of Illicit Drugs: Exploring Impacts on Public Safety and Policing" (July, 2020) online at https://www.cacp.ca/index.html?asst_id=2189
[121] *Ibid.* at page 2.
[122] *Ibid.*
[123] *Ibid.*
[124] *Ibid.*
[125] *Ibid.*

119. The CACP Report acknowledges that "Currently, people who experience substance use disorder face repercussions including criminal records, stigma, risk of overdose and the transmission of blood-borne diseases. The aim is to decrease these harms by removing mandatory criminal sanctions, often replacing them with responses that promote access to harm reduction and treatment services."[126]

120. The CACP Report is preceded by the public affirmations of law enforcement and various police forces, including the Vancouver Police Department and the RMCP, that we are "not going to arrest our way out of this problem."[127]

121. In August 2020, the PPSC issued Guideline 5.13: Prosecution of Controlled Substances Contrary to s. 4(1) of the *CDSA*.[128] Context for the Guideline lists "realities" on which the Guideline is premised:

- substance use has a significant health component;
- in addition to the personal health component, substance use may be associated with conduct that poses separate serious public safety concerns requiring a criminal enforcement component; and,
- simple possession may result in a criminal record as well as a fine or a short period of incarceration. *Criminal sanctions, as a primary response, have a limited effectiveness as*
- *specific or general deterrents and*
- *as a means of addressing the public safety concerns when considering the harmful effects of criminal records and short periods of incarceration.* [Emphasis added].[129]

122. In February 2021, BC's Minister of Mental Health and Addictions wrote Federal Health Minister Patty Hajdu to ask whether she would consider granting a province-wide exemption against the offence of simple possession under the *CDSA*.[130] The inquiry followed the City of Vancouver's exemption request, submitted in December 2020 and currently undergoing planning between Vancouver and Health Canada. Since Vancouver submitted its request, numerous city councils across BC have passed motions in support of drug decriminalization and/or calling on the federal government to decriminalize drug possession nationally.

123. These rapidly evolving perspectives within government and police apparatuses are reflected in the changing public opinion surrounding approaches to drug use in Canada. A 2018 poll by

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[126] *Ibid.* at page 3.

127 Office of the Provincial Health Officer, Special Report: "Stop the Harm: Decriminalization of People Who Use Drugs in BC" online at: https://www2.gov.bc.ca/assets/gov/health/about-bc-s-health-care-system/office-of-the-provincial-health-officer/reports-publications/special-reports/stopping-the-harm-report.pdf at p. 18.; Vancouver Police Department, "The opioid crisis: the need for treatment on demand. Review and recommendations" Vancouver, BC: (May, 2017) online: https://vancouver.ca/police/assets/pdf/reports-policies/opioid-crisis.pdf. RCMP: https://www.cbc.ca/news/canada/british-columbia/bc-police-say-fentanyl-a-game-changer-struggle-to-stop-ovderdoses-on-the-street-1.3762446

[128] Public Prosecution Service of Canada Deskbook, Guideline of the Director under Section 3(3) of the *Director of Public Prosecutions Act* (August 17, 2020) online at: https://www.ppsc-sppc.gc.ca/eng/pub/fpsd-sfpg/fps-sfp/tpd/p5/ch13.html

[129] *Supra*, online at https://www.ppsc-sppc.gc.ca/eng/pub/fpsd-sfpg/fps-sfp/tpd/p5/ch13.html

[130] Ethan Sawyer, "BC proposes drug decriminalization as overdose deaths climb" CBC News, online at: https://www.cbc.ca/news/canada/british-columbia/bc-proposes-drug-decriminalization-1.5910565

Angus Reid found that 59% of Canadians favour the decriminalization of all illegal drugs. Just 45% of Canadians are in favour of getting "tougher on people who use drugs" as an approach.[131]

PART V. SENTENCE SOUGHT

124. Ms. Ellis seeks a suspended sentence without any optional conditions. The proposed sentence is not sought because the defence believes the order will truly rehabilitate, deter or denounce her 'behaviour,' but because the defence has no other viable option. Incarceration and probation have proven and will prove ineffective in 'curing' her substance use disorder; to fine Ms. Ellis would simply serve to tax her addiction; an absolute discharge is unavailable to Ms. Ellis given the maximum penalty for these offences prescribed by the *Code*. This case showcases that the criminal courts are not equipped to solve a public health crisis.

ALL OF WHICH IS RESPECTFULLY SUBMITTED

Dated at Campbell River, British Columbia this 24th day of March, 2021

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[131]Angus Reid Institute, "Canada's other epidemic: As overdose deaths escalate, majority favour decriminalization of drugs" (February, 2021) online at: https://angusreid.org/opioid-crisis-covid/