Facing up to an epidemic: drug policy in Canada

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> [D]rug users are citizens: they include our sons, daughters, brothers and sisters and, increasingly, our parents. They deserve humane responses; let us not wage war on them.[1]

The Problem

Canada is facing a public health crisis with respect to injection drug use.[2] Rates of blood borne infections among people who inject drugs increased during the 1990s at an alarming rate. By 1996, almost half of all new HIV diagnoses were in people who inject drugs.[3] Since 1997, the proportion of new HIV infections annually that are attributable to people who inject drugs has decreased slightly; by 1999, the number had dropped to 26 percent.[4] However, HIV and AIDS infection remain a major problem. Overall, the number of adult AIDS cases related to injection drug use has increased to 21.7 percent of all new reported AIDS diagnoses in 2001, up from 8.3 percent of new AIDS cases in 1995.[5] As noted by Health Canada, the "absolute number of infections in this group is still unacceptably high."[6]

Rates of infection with hepatitis C (HCV) are also high. Among Montréal street youth, 35 percent of injection drug users have the virus,[7] while 88 percent of participants in the Vancouver Injection Drug User Study (VIDUS) are infected.[8] More recent data found that rates of HCV infection among injection drug users reach 85 percent in Vancouver and 70 percent in Montréal, with annual incidence rates of 26 percent and 27 percent respectively.[9]

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[1] Margaret Hamilton, Transcript of Proceedings, NSW Drug Summit 1999, 17 May 1999, available at: http://drugsummit.socialchange.net.au.

[2] Canadian HIV/AIDS Legal Network. *Injection Drug Use and HIV/AIDS—Legal and Ethical Issues.* Montréal: The Network, 1999, at 1.

[3] Health Canada (Division of HIV/AIDS Epidemiology and Surveillance, Bureau of HIV/AIDS, STD and TB, Centre for Infectious Disease Prevention and Control). HIV/AIDS Among Injecting Drug Users in Canada. HIV/AIDS Epi Update, May 2001. Ottawa: Health Canada, 2001 (available at www.hc-sc.gc.ca/hpb/lcdc/bah).

[4] Ibid.

[5] Health Canada (Division of HIV/AIDS Epidemiology and Surveillance, Bureau of HIV/AIDS, STD and TB, Centre for Infectious Disease Prevention and Control). *HIV and AIDS in Canada: Surveillance Report to December 31, 2000*. Ottawa: Health Canada, 2001 (available via www.hc-sc.gc.ca/hpb/lcdc/bah) at 31.

[6] HIV/AIDS Among Injecting Drug Users in Canada, *supra* note 3.

[7] E Roy et al. Hepatitis C among Montreal street youth cohort participants who injection drugs (MSTC-IDUs). *Canadian Journal of Infectious Diseases* 2001; 12: 60B.

[8] SA Strathdee et al. Needle exchange is not enough: lessons from the Vancouver injecting drug use study. *AIDS* 1997; 11: F59-65.

[9] Hepatitis C – prevention and control: a public health consensus. *Canada Communicable Disease Report* 1999; 25S2 (Supplement, June 1999). Available at www.hc-sc.gc.ca/hpb/lcdc/publicat/ccdr/99vol25/25s2/index.html.

The prevalence of HIV among injection drug users is on the rise in larger Canadian cities.[10] In Montréal, HIV prevalence among people who inject drugs was 19.5 percent in 1997, nearly four times what it was in 1988.[11] In Toronto, HIV prevalence among injection drug users was 8.6 percent in 1997-1998, up from 4.8 percent in 1992-1993.[12] Similar trends have been observed in Québec City, Winnipeg, and Ottawa.[13,14] The available (limited) data also shows that the HIV epidemic among injecting drug users is increasingly being seen outside major urban areas.[15] The mobility of people injecting drugs and their interactions with people who do not use suggest that the problem is not limited to cities or to injection drug users, but rather affects all of Canadian society. Further, the problem of drug use among Aboriginal communities has been the subject of increasing concern.[16]

The problems are most apparent in Vancouver. The city's Downtown Eastside is Canada's poorest urban neighbourhood.[17] Street-based drug use is rampant in this area, and HIV prevalence among injection drug users was estimated to be between 23 to 30 percent in 2000.[18] The prevalence of HCV was even higher, at approximately 88 percent in the same year.[19] While fatal overdoses and other health concerns related to drug use have been observed in the area since the 1970s,[20] they have increased dramatically. There have been more than 2000 overdose

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[10] HIV/AIDS Among Injecting Drug Users in Canada, *supra* note 3.

[11] C Hankins, T Tran, D Desmarais et al. Moving from Surveillance to the Measurement of Programme Impact: CACTUS—Montreal Needle Exchange Programs. *Canadian Journal of Infectious Diseases* 1997; 8 (Suppl A): 28A (abstract 223).

[12] P Millson, T Myers, L Calzavara et al. *Prevalence of HIV and Other Blood-Borne Viruses and Associated Behaviors in Ontario IDUs*. Proceedings of the 7th Annual HIV Epidemiology Meeting Organized by the Division of HIV Epidemiology, Bureau of HIV/AIDS and TB, Laboratory Centre for Disease Control, Health Canada, 12-14 November 1998; M Millson. *WHO Multi-City Study on Drug Injecting & Rise of HIV Infection*. Toronto: National Health Research & Development Program (Health Canada), 1996.

[13] M Alary, C Hankins, R Parent et al. Updated Results from the SurvIDU Surveillance Network. Proceedings of the 7th Annual HIV Epidemiology Meeting organized by the Division of HIV Epidemiology, Bureau of HIV/AIDS, STD and TB, LCDC, Health Canada. *Inventory of HIV Incidence/Prevalence Studies in Canada.* Ottawa: Health Canada, May 1999.

[14] J Blanchard, L Elliott. Winnipeg Injection Drug Epidemiology Study: Interim results, April 1999, cited in *Injection Drug Use and HIV/AIDS—Legal and Ethical Issues*, *supra* note 2.

[15] HIV/AIDS Among Injecting Drug Users in Canada, *supra* note 3.

[16] *Injection Drug Use and HIV/AIDS—Legal and Ethical Issues*, *supra* note 2; Canadian Aboriginal AIDS Network. *Joining the Circle: An Aboriginal Harm Reduction Model* (undated); Health Canada (Division of HIV/AIDS Epidemiology and Surveillance, Bureau of HIV/AIDS, STD and TB, Centre for Infectious Disease Prevention and Control). HIV/AIDS Among Aboriginal Persons in Canada Remains a Pressing Issue. *HIV/AIDS Epi Update*, May 2001. Ottawa: Health Canada, 2001 (available at www.hc-sc.gc.ca/hpb/lcdc/bah).

[17] Statistics Canada. *Population Census of Canada*, 1996.

[18] T Kerr. Safe Injection Facilities: Proposal for a Vancouver Pilot Project. Prepared for the Harm Reduction Action Society. Vancouver, 2000, at 10, citing: B Fischer, J Rehm, & T Blitz-Miller. Injection drug use and preventive measures: A comparison of Canadian and Western European jurisdictions over time. *Canadian Medical Association Journal* 2000; 162 (12): 1709-1713.

[19] Strathdee et al, *supra* note 8; M McLean. Vancouver drug epidemiology and drug crime statistics 2000. Canadian Community Epidemiology Network on Drug Use (draft dated 21 June 2000), cited by Kerr, *supra* note 18 at 11.

[20] MV O'Shaughnessy et al. Deadly public policy. *International Conference on AIDS* 1998; 12: 982 (abstract no. 44233).

deaths in British Columbia since 1992, and it has been the leading cause of death among people aged 30 to 49 for five years in a row.[21] Among those participating in the Vancouver Injection Drug User Study, overdose is the leading cause of death, regardless of HIV status.[22]

There are many reasons for the escalating problem of drug use and overdose in Canada. These include a rise in the number, variety and potency of drugs that are produced, sold and used on streets, a decline in the street cost of drugs, and the fact that people using drugs are beginning to do so at a younger age.[23] Users who inject quickly in order to reduce the risk of being detected and arrested are also more likely to inject in an unsafe fashion. The shift from heroin to cocaine use also contributes to the escalation, as cocaine users may inject as many as 20 times a day.[24] A greater frequency of injection, and the incentive to inject quickly, increases the likelihood that individuals will share needles and other equipment, putting themselves at risk for HIV and HCV infection.

Drug Policy and Strategy in Canada: From Prohibition to Harm Reduction?

Criminal laws to control illicit drugs and their use have been in place in Canada since the early 1900s.[25] The current statute, the *Controlled Drugs and Substances Act* (*CDSA*),[26] enacted in 1996 and brought into force in 1997, consolidated several preceding acts.

The *CDSA* prohibits the import or export of illegal drugs, as well as drug possession and trafficking. Trafficking of drugs is defined to include providing, administering, transferring, and selling illegal substances.[27] The *CDSA* also prohibits the *unauthorized* possession of equipment intended for ingesting drugs into the human body, or meant for the production of such substances, if it contains traces of a prohibited drug; therefore, possessing used injection equipment is itself a crime.[28]

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[21] City of Vancouver website citing BC Coroners' Service and BC Provincial Health Officer (2000) http://www.city.vancouver.bc.ca/greaterdot/gv2000/episode9.htm#link7

[22] M Tyndall et al. HIV incidence and mortality among injection drug users in Vancouver ─ 1996-2000. *Canadian Journal of Infectious Diseases* 2001; 12: 69B.

[23] *Injection Drug Use and HIV/AIDS—Legal and Ethical Issues*, *supra* note 2 at 9-11.

[24] Canadian HIV/AIDS Legal Network. Injection Drug Use and HIV/AIDS: The Facts [Info Sheet #1: Injection Drug Use and HIV/AIDS]. Montréal: The Network, 2002 (2nd, revised edition), available at www.aidslaw.ca.

[25] For a discussion of the recent history surrounding the adoption of the *Controlled Drugs and Substances Act*, see: B Fischer. The Battle for a New Canadian Drug Law: A Legal Basis for Harm Reduction or a New Rhetoric for Prohibition? A Chronology, in *Harm Reduction: A New Direction for Drug Policies and Programs* (P Erickson et al, eds). Toronto: University of Toronto Press, 1997.

[26] SC 1996, c 19 (hereinafter *CDSA*).

[27] *CDSA*, s 2(1).

[28] *CDSA*, s 2(2)(b)(ii). The *CDSA* uses the definition of possession found in the *Criminal Code*, RSC 1985, c C-46, s 4(3) .

The current legal status of syringes distributed to drug users is also somewhat uncertain. Needles are produced and sold for medical purposes and therefore technically qualify as "devices" under the *Food and Drugs Act* (*FDA*).[29] However, the *Criminal Code* prohibits the promotion or sale (which includes free distribution) of "instruments for illicit drug use", which is defined as including anything "intended under the circumstances" for ingesting illegal substances.[30]

There are several negative consequences that flow from pursuing strictly prohibitionist policies.[31] They encourage users to inject quickly, out of fear of police apprehension.[32] Zero tolerance also produces an underground market for drugs, with associated crime and corruption.[33] Further, drug users are often compelled to use unclean equipment or to inject in unsafe or unhygienic circumstances (particularly in the case of street-based injecting), increasing the risk of contracting infections.[34] Riley notes that a zero-tolerance model creates a culture of marginalized and stigmatized people who are difficult to reach with educational messages about safe practices or treatment. This is the product of a "drug war" mentality, abstinence-based morality, and the fact that "AIDS and other drug-related harms are sometimes viewed as just deserts [*sic*]"[35] for drug users. The prohibitionist mindset undermines community caring, by fostering "public attitudes that are vehemently anti-drug, and the view that drug-users do not care about their own lives."[36]

Put simply, prohibition alone, as a public health strategy, is not a success. Wodak and Owens note that "[p]rohibition is increasingly regarded as flawed in principle and a resounding failure in practice."[37] They conclude that

> increasing the health, social, legal and economic costs of drug use in order to minimise the number of people who use drugs, the very basis of prohibition, produces more net harm to individuals and society than accepting the inevitability of some drug use … Authorities around the world are increasingly recognising

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[29] RSC 1985, c F-27, s 2 (hereinafter *FDA*).

[30] *Criminal Code*, s 462.1.

[31] For a general review of these negative consequences, see: D Riley. Injection Drug Use and HIV/AIDS: Policy Issues. In : Canadian HIV/AIDS Legal Network. *Injection Drug Use and HIV/AIDS: Legal and Ethical Issues -- Background Papers*. Montréal: Legal Network, 1999, at C3-C6; D Riley, E Oscapella. Canada's new drug law: implications for HIV/AIDS. *The International Journal of Drug Policy* 1996; 7(3): 180-182.

[32] *Injection Drug Use and HIV/AIDS: Legal and Ethical Issues*, *supra* note 2 at 26, referencing American Bar Association. *AIDS: The Legal Issues*. Discussion draft of the ABA AIDS Coordinating Committee. Washington, DC, 1998 (at 233).

[33] Kerr, *supra* note 18 at 24.

[34] Riley, *supra* note 31, C3-C4.

[35] Ibid, at C10. See also: E Oscapella, R Elliott. Injection Drug Use and HIV/AIDS: A Legal Analysis of Priority Issues. In: Canadian HIV/AIDS Legal Network. *Injection Drug Use and HIV/AIDS: Legal and Ethical Issues - Background Papers*, *supra* note 31, at A8 (available via www.aidslaw.ca).

[36] Riley, *supra* note 31 at C4.

[37] A Wodak & R Owens, *Drug Prohibition: A Call for Change*. Sydney: University of New South Wales Press, 1996, at 4.

> that most problems associated with illegal drugs are caused by prohibition rather than being the inevitable result of their pharmacological properties.[38]

A large number of policy-makers and community members in Canada as in many other countries have recognised that strictly prohibitionist policies are ineffectual in stopping drug use, and can have damaging consequences, as outlined above. [39] A policy of "harm minimisation" or "harm reduction" has been recommended by many. The philosophy underlying harm reduction is the desire to reduce the negative consequences associated with drug use. It tolerates (but does not condone) drug use, and accepts that abstinence from drugs is not realistic for some users. Drug use is acknowledged as a fact of life, and effort is directed to diminishing the harmful consequences of drug use on the user and the community.[40]

Following a harm reduction approach, drug addiction and the risk of the spread of disease are understood as public health issues. The Joint United Nations Programme on HIV/AIDS (UNAIDS) observes that if comprehensive, wide-ranging harm reduction programs are implemented to combat the spread of HIV among injecting drug users — including education, promotion of condom use, drug treatment and needle exchanges — infections can be contained at a low level.[41] It emphasises that this is particularly the case "in the many countries where drug injection is a major driving force for the spread of HIV."[42]

As indicated by Riley, "[o]ne of the main barriers to the adoption of non-prohibitionist policies is idealism. Adopting harm reduction means accepting that some harm is inevitable."[43] It is an admission that a zero-tolerance approach based on abstention has failed. A harm reduction approach acknowledges that the police cannot eliminate illicit drug use and, in particular, the problems associated with street-based injecting.

The Canadian federal government's stated position for two decades has been that "[t]he criminal law should be employed to deal only with that conduct for which other means of social control are inadequate or inappropriate, and which interfere with individual rights and freedoms only to

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[38] Ibid, at 7-8.

[39] National Action Plan Task Force. *HIV, AIDS and Injection Drug Use: A National Action Plan*. Ottawa: Canadian Centre on Substance Abuse and Canadian Public Health Association, May 1997; J Millar. HIV, hepatitis, and injection drug use in British Columbia: pay now or pay later. Report from the Office of the Provincial Health Officer. Victoria: British Columbia Ministy of Health, 1998; JV Cain. Report of the British Columbia Task Force into Illicit Narcotic Overdoses. Victoria, BC : British Columbia Ministry of Health, 1994; DEYAS. Something to eat, a place to sleep and someone who gives a damn – HIV/AIDS and Injection Drug use in the DTES. Vancouver: Downtown Eastside Youth Activities Society, September 1997; R Jürgens. *HIV/AIDS in Prisons: Final Report*. Montréal: Canadian HIV/AIDS Legal Network and Canadian AIDS Society, 1996; Y Dandurand, V Chin. Towards a Lower Mainland Crime and Drug Misuse Prevention Strategy. British Columbia: Lower Mainland Municipal Association, September 2000; British Columbia Aboriginal AIDS Task Force. The Red Road - Pathways to Wholeness: An Aboriginal Strategy for HIV and AIDS in BC. Victoria, 1999 (available at: www.htlh.gov.bc.ca/cpa/publications/index.html#R).

[40] Riley, *supra* note 31 at C3-4.

[41] UNAIDS. *Report on the Global HIV/AIDS Epidemic* (June 2000) at 76, available via: www.unaids.org.

[42] Ibid 77.

[43] Riley, *supra* note 31 at C10.

the extent necessary for the attainment of its purpose."[44] Such a position lends support to proposals for a drug policy based on harm reduction principles.

There is evidence that the Canadian drug strategy has shifted, if slowly and not always consistently,[45] towards a harm reduction philosophy, with an emphasis on initiatives such as needle exchange and methadone programs. Canada's Drug Strategy adopted in 1998 by the federal government states that its long-term goal is to reduce the harm associated with drugs to individuals, families and communities.[46] The Strategy also states that because "substance abuse is primarily a health issue rather than an enforcement issue, harm reduction is considered to be a realistic, pragmatic, and humane approach as opposed to attempting solely to reduce the use of drugs."[47]

In April 2000, a Special Senate Committee on Illegal Drugs was established with a goal to "develop a national harm reduction policy in order to lessen the negative impact of illegal drugs in Canada [and to] study harm reduction models adopted by other countries and determine if there is a need to implement them wholly or partially in Canada."[48] As well, Health Canada has indicated that programs aimed at HCV prevention should adopt a harm reduction approach.[49]

In September 2001, Canada's federal, provincial and territorial ministers of health "acknowledged" a report jointly prepared by several inter-governmental advisory committees that set out a harm reduction approach and a framework for action.[50] The ministers tasked a working group of the committee with examining the feasibility of establishing a safe injection facility as a scientific, medical research project.

Also welcome is the indication of Allan Rock, then federal Minister of Health, that more steps would be taken in the direction of harm reduction in the future. In Health Canada's public response to the Final Report of the Canadian HIV/AIDS Legal Network on *Injection Drug Use and HIV/AIDS: Legal and Ethical Issues*, the Minister acknowledged that "a comprehensive

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[44] Government of Canada. *The Criminal Law in Canadian Society* (Aug 1982) at 52-53. Note that this statement of policy is cited in Oscapella & Elliott, *supra* note 31 at A9, and in G Gilmour. The international covenants "prohibiting" drug activities. Paper submitted to Canada's Senate Standing Committee on Legal and Constitutional Affairs, 14 December 1995, at 11 (available via www.cfdp.ca./gilmour.html). The Law Reform Commission of Canada has also concluded that "criminal law is a blunt and costly instrument… It must be an instrument of last resort. It must be used as little as possible." In: Law Reform Commission of Canada. *Our Criminal Law*. Ottawa: Minister of Supply and Services Canada, 1976, at 27-28, cited in Oscapella/Elliott, *supra* note 35 at A9.

[45] See the commentary by Fischer, *supra* note 25.

[46] *Canada's Drug Strategy*. Prepared by Interdepartmental Working Group on Substance Abuse. Ottawa: Public Works and Government Services Canada, 1998: at 4 (available via www.hc-sc.gc.ca).

[47] Ibid.

[48] Canadian Foundation for Drug Policy. *Special Senate Committee on Drug Policy* (2000), cited in Kerr, *supra* note 4 at 19.

[49] *Canada's Drug Strategy*, *supra note* 46.

[50] *Reducing the Harm Associated with Injection Drug Use in Canada*. Report of the Federal/Provincial/Territorial Advisory Committee on Population Health, 2001. The document was prepared in conjunction with: the F/P/T Committee on Alcohol and Other Drug Issues; the F/P/T Advisory Committee on AIDS; the F/P/T Heads of Corrections Working Group on HIV/AIDS; and a multi-disciplinary committee of senior Justice and Health officials.

response to IDU requires a partnership approach involving other disciplines and jurisdictions."[51] The Minister pledged his commitment to "support efforts to reduce injection drug use-related harm in correctional settings."[52]

According to Health Canada's response, Health Canada recognizes that "changes are needed to existing legal and policy frameworks - both national and international - in order to effectively address IDU as a health issue." Health Canada continues by saying that "the required changes are complex and must be developed collaboratively over time."[53] However, in the interim Health Canada advocates a harm reduction approach within the current frameworks. For example, the response refers to needle exchange programs as an important harm reduction measure as well as an example of "strong co-operation between the health and law enforcement sectors."

A Multi-faceted Response: the "Four-Pillar Approach"

In November of 2000, the City of Vancouver released the draft discussion paper *A Framework for Action: A Four-Pillar Approach to Drug Problems in Vancouver*.[54] The paper establishes a framework for action to "appropriately and effectively deal with city-wide substance misuse and associated crime." The approach is based on the "four pillars" of prevention, treatment, enforcement, and harm reduction:

- *Prevention* focuses on education regarding substances, as well as on building awareness about the reasons behind drug abuse and what can be done to avoid addiction.
- *Treatment* involves numerous interventions and support programs, including detoxification, counselling, social programs, and medical care.
- *Enforcement* consists of a "redeployment of officers" in the Downtown Eastside to combat organized crime and drug dealing, and to strengthen ties with health services and similar agencies.
- *Harm Reduction* is a "pragmatic approach that focuses on decreasing the negative consequences of drug use for communities and individuals." The paper draws upon successful harm-reduction initiatives undertaken in other parts of the world.

Following the document's release, the public was consulted on the various aspects of the proposal. In general, the public was supportive of the framework, including harm reduction measures. In many ways, this four-pillar approach has become the basis for drug policy not only in Vancouver, but in all of Canada.

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[51] Health Canada. *Injection Drug Use and HIV/AIDS : Health Canada's Response to the Report of the Canadian HIV/AIDS Legal Network*. Ottawa: Minister of Public Works and Government Services, 2001.

[52] Ibid.

[53] Ibid, at 3.

[54] D MacPherson. *A Framework for Action : A Four-Pillar Approach to Drug Problems in Vancouver (Revised).* 24 April 2001.

Harm Reduction Strategies: An Ethical Imperative

The criminal approach to drug use was ostensibly designed to decrease the various health and social problems that result from the use of and addiction to various substances. However, many Canadian experts have pointed out that this approach has simply failed to achieve its objectives. Rather than solving problems, the model both exacerbates existing dilemmas and creates new ones. The criminal approach has been characterized as failing to achieve the goals for which it is designed and promoted; excluding those who inject drugs from the community; misusing limited resources; "stimulating the rise to power of socially destructive and violent empires;" and fuelling the "decline of humanity that is essential to civilized societies."[55]

Adopting an ethic of harm reduction acknowledges that prohibitionist approaches to drug use have not worked. A harm reduction approach does not identify abstinence as the necessary goal of any intervention. It is deemed unethical to demand from someone something of which they are physically or mentally incapable. That said, proponents of harm reduction measures would certainly recognize abstinence as being a worthwhile goal for some people. "While harm reduction approaches do not preclude abstinence as a worthwhile goal, they question the long established notion that abstinence is the only acceptable drug policy or program outcome."[56]

The harm reduction ethic emphasizes pragmatism in dealing with the problems associated with drug use: for instance, the utilization of methadone treatment programs to combat heroin addiction, or the establishment of needle exchange facilities to reduce the sharing of needles and associated spread of disease. The emphasis is on keeping those who choose to use drugs alive and disease-free, with rehabilitation open as a possibility. Moralizing about the intrinsic evils of drugs and drug use is avoided, recognizing that many of the ills associated with drug use result from the approach we as a society use to deal with these individuals.

Harm Reduction Strategies: A Legal Imperative

In Canada, it has been convincingly argued that there are not only ethical, but also legal obligations to undertake harm reduction initiatives, such as the establishment of safe injection facilities. In particular, it has been argued that international law demands that such initiatives be undertaken, as part of the international legal obligation to provide Canadians with the highest standard of health possible.

Furthermore, it has been shown that international drug conventions do not prevent such initiatives. Canada is a party to:

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[55] D Roy. Injection Drug use and HIV/AIDS: An Ethics Commentary on Priority Issues. In: Canadian HIV/AIDS Legal Network. *Injection Drug Use and HIV/AIDS—Legal and Ethical Issues: Background Papers.* Montréal: Legal Network, 1999, at B10.

[56] Kerr, *supra* note 18 at 7.

- the 1961 *Single Convention on Narcotic Drugs* (as amended by the 1972 *Protocol Amending the Single Convention on Narcotic Drugs*);
- the 1971 *Convention on Psychotropic Substances*; and
- the 1988 *United Nations Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances*.[57]

It is often incorrectly assumed that these treaties require signatory countries to adhere strictly to a criminal prohibitionist approach to drug use. In reality, they incorporate provisions permitting various health-based approaches, including harm reduction measures. Indeed, a 1972 UN conference led to the adoption of a Protocol Amending the [1961] Single Convention which "highlights the need for treatment and rehabilitation of drug addicts."[58]

Several articles in the international drug control treaties can be interpreted as permitting or even supporting harm reduction efforts, requiring states to implement particular policies that are not concerned with criminal penalty. Importantly, Article 38(1) of the 1961 *Single Convention*, entitled "Measures Against the Abuse of Drugs," states:

> The Parties shall give special attention to and take all practicable measures for the prevention of abuse of drugs and for the early identification, treatment, education, after-care, rehabilitation and social reintegration of the persons involved and shall co-ordinate their efforts to these ends.

In addition, the vagueness of the conventions permits parties to look to state practice to help determine how to interpret the provisions.[59] In global terms, state practice is undeniably inconsistent. This lends support to the argument that responses to harms associated with injection drug use should be left to the discretion of states, which can, on their own terms, assess the best way of serving their communities. The conventions themselves concede a degree of latitude to a state's "prevailing conditions," "constitutional limitations" and "legal system and domestic law."[60] In fact, these important provisions allow for the undertaking of harm reduction initiatives.

Four Examples of Pragmatic Canadian Drug Policy

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[57] The full text of the Conventions can be found via the website of the International Narcotics Control Board at www.incb.org.

[58] UN International Narcotics Control Board (INCB). The International Drug Control Treaties. Background Note No 1 (23 February 2000), available via www.incb.org.

[59] *Vienna Convention on the Law of Treaties*, 23 May 1969, 1155 UNTS 331, Article 31(3)(b) (entered into force 27 January 1980).

[60] G Gilmour. The International Covenants 'Prohibiting' Drug Activities. Paper submitted to Canada's Senate Standing Committee on Legal and Constitutional Affairs, 14 December 1995. See also: C Gatto (ed Allen St Pierre). European Drug Policy: Analysis and Case Studies. NORML Foundation, 1999 (available at: www.norml.org/legal/european_policy.shtml).

Needle Exchange Programs

A cornerstone of HIV prevention for IDUs in Canada has involved making sterile syringes available through needle exchange programs (NEPs). The first NEPs were opened unofficially in Toronto in 1987 and officially, with government funding, in Toronto and Vancouver in 1989.[61] By the end of 1990, eight publicly funded NEPs existed in Canada. Today, needle exchange programs operate with government funding in all provinces with the exception of Prince Edward Island (a remote island with a small population), and it is estimated that there are hundreds of locations at which needles are exchanged or distributed. Syringes are distributed to IDUs in various ways, including through fixed locations, outreach workers, mobile units (e.g., vans), and vending machines.

Benefits of NEPs[62]

NEPs have been found to reduce risk behavior, HIV and hepatitis C incidence, and be associated with substantial savings in health care expenditures.[63] The specific biologic action of NEPs is a form of vector control, by reducing the time that needles spend in circulation.[64] NEPs are generally regarded as the single most important factor in preventing HIV epidemics among IDUs.[65] An international investigation of NEPs found that in cities with needle exchange or distribution programs HIV seroprevalence decreased by 5.8 percent per year, while HIV prevalence increased by 5.9 percent per year in cities without such programs.[66] NEPs have also been found to increase access to various health care programs, including addiction treatment and voluntary HIV testing.[67] Several studies have also demonstrated that the implementation of NEPs have not lead to increases in drug use locally.[68]

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[61] Canadian Centre on Substance Abuse. Needle exchange programs FAQs (frequently asked questions. Available via www.ccsa.ca.

[62] See, T Kerr, R Jürgens. Syringe exchange programs in prisons : reviewing the evidence. Canadian HIV/AIDS Legal Network, 2004 (available via www.aidslaw.ca/Maincontent/issues/prisons.htm).

[63] Des Jarlais DC, Marmor M, Paone D, et al.: HIV incidence among injecting drug users in New York City syringe-exchange programmes. Lancet 1996; 348(9033): 987-91; Hagan H, Jarlais DC, Friedman SR, Purchase D, Alter MJ: Reduced risk of hepatitis B and hepatitis C among injection drug users in the Tacoma syringe exchange program. American Journal of Public Health 1995; 85(11): 1531-7; Bluthenthal RN, Kral AH, Gee L, Erringer EA, Edlin BR: The effect of syringe exchange use on high-risk injection drug users: a cohort study. Aids 2000; 14(5): 605-11; Monterroso ER, Hamburger ME, Vlahov D, et al.: Prevention of HIV infection in street-recruited injection drug users. J Acquir Immune Defic Syndr 2000; 25(1): 63-70; Lurie P, Gorsky R, Jones TS, Shomphe L: An economic analysis of needle exchange and pharmacy-based programs to increase sterile syringe availability for injection drug users. J Acquir Immune Defic Syndr Hum Retrovirol 1998; 18 Suppl 1: S126-32.

[64] Drucker E, Lurie P, Wodak A, Alcabes P: Measuring harm reduction: the effects of needle and syringe exchange programs and methadone maintenance on the ecology of HIV. AIDS 1998; 12(Suppl A): S217-30.

[65] Des Jarlais DC, Hagan H, Friedman SR, et al.: Maintaining low HIV seroprevalence in populations of injecting drug users. JAMA 1995; 274(15): 1226-31.

[66] Ibid.

[67] Strathdee SA, Celentano DD, Shah N, et al.: Needle-exchange attendance and health care utilization promote entry into detoxification. J Urban Health 1999; 76(4): 448-60; Watters JK, Estilo MJ, Clark GL, Lorvick J: Syringe and needle exchange as HIV/AIDS prevention for injection drug users. JAMA 1994; 271(2): 115-20.

[68] Fisher DG, Fenaughty AM, Cagle HH, Wells RS: Needle exchange and injection drug use frequency: a randomized clinical trial. J Acquir Immune Defic Syndr 2003; 33(2): 199-205; Normand J, Vlavhov D, Moses I: Preventing HIV Transmission. The Role of Sterile Needles and Bleach. Washington DC. National Academy Press., 1995.

Misinterpretation of a Canadian study

In some circles, two Canadian studies demonstrating an association between HIV infection and use of NEPs have been misinterpreted and misused by people opposed to NEPs.[69] The studies did create confusion, albeit primarily among politicians and not scientists. Some have claimed that the Vancouver study demonstrates a causal relationship between HIV infection and syringe exchange, despite the fact that the study merely demonstrated an association between frequent use of syringe exchange and HIV prevalence. The authors of the paper stated that "our study was not intended to evaluate the effectiveness of NEP…the fact that frequent NEP attendance was associated with HIV prevalence should not be interpreted as causal" (p. F64).[70]

Given the confusion created by the study, the relationship between frequent syringe exchange attendance and HIV incidence or infection was studied in a follow-study titled "Do Needle Exchange Programmes Increase the Spread of HIV Among Injection Drug Users? An Investigation of a Vancouver Outbreak".[71] The paper, published in the prestigious journal *AIDS,* demonstrates that the previously observed association between syringes exchange attendance and HIV prevalence reflected a "selection bias" – meaning that syringe exchanges do not cause HIV infection, but rather high risk individuals are the people most likely to frequently attend a syringe exchange program. Consistent with this, the authors of the second paper pointed out that frequent syringe exchange attendees were more likely than non-frequent syringe exchange attendees to live in unstable housing, to inject frequently, inject cocaine, work in the sex trade, inject in "shooting galleries" and to have recently been incarcerated. These characteristics have previously been found to be associated with HIV infection in several studies, and the authors calculated that the rate of HIV infection found among frequent syringe exchange attendees was at the level that would be expected given their risk profile. The authors did investigate the unlikely explanation that syringe exchange prompted increases in risk behaviour, but found no evidence to support this explanation. The authors also ruled out the explanation that syringe exchange prompted the formation of social networks.

Summary

In summary, the evidence to date indicates that NEPS are the most effective HIV prevention intervention that can be offered to IDUs. A wealth of scientific studies suggests that NEPs have been associated with significant declines in HIV incidence, as well as higher uptake of health services, including drug treatment. As well, investigation has shown that many of the concerns expressed in regard to NEPs (NEPs prompting increases in drug use) have proven to be unfounded and in some cases contrary to empirically-derived evidence.

Therefore, NEPs have an important place in Canada's response to HIV/AIDS and to IDU.

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[69] Strathdee SA, Patrick DM, Currie SL, et al.: Needle exchange is not enough: lessons from the Vancouver injecting drug use study. Aids 1997; 11(8): F59-65 ; Bruneau J, Lamothe F, Franco E, et al.: High rates of HIV infection among injection drug users participating in needle exchange programs in Montreal: results of a cohort study. American Journal of Epidemiology 1997; 146(12): 994-1002.

[70] Strathdee, note 67.

[71] Schechter MT, Strathdee SA, Cornelisse PG, et al.: Do needle exchange programmes increase the spread of HIV among injection drug users?: an investigation of the Vancouver outbreak. Aids 1999; 13(6): F45-51.

Methadone Maintenance Treatment
Methadone remains the only opioid approved for long-term treatment of opiate dependence in Canada.

The safety and effectiveness of methadone maintenance treatment (MMT) has been documented in scientific and medical publications.[72] MMT programs have been credited with decreasing opioid use, reducing criminality, and improving the general health of the drug user. Moreover, MMT reduces individual mortality and morbidity. Another important benefit of MMT is that it helps decrease the spread of HIV, as methadone is typically administered orally rather than by syringe. MMT has thus become a "critical resource in the struggle against injection drug use and AIDS." Methadone clinics are also potentially excellent sites for disease prevention and education. Patients can be offered screening and counselling for transmissible diseases; and can be provided information on safe sex, on the dangers of sharing needles, and on methods for cleaning syringes.

History of MMT in Canada
In 1959, Vancouver physician Dr Robert Halliday obtained approval from the federal Department of Health to conduct a study of methadone as a method of treating opiate-dependent persons. Dr Halliday was successful in establishing that methadone maintenance was a legitimate form of treatment for drug-dependent persons. By 1972, two dozen methadone treatment programs existed in Canada. The Commission of Inquiry into the Non-Medical Use of Drugs, known as the Le Dain Commission, stated in the early 1970s that methadone "is the cheapest and most effective weapon we have for dealing with large-scale heroin dependence." The Commission recommended that methadone maintenance be available to persons dependent on opiates throughout Canada.

Possible misuses of methadone became a concern of the federal government in the early 1970s. In 1972, the government passed regulations to the *Narcotic Control Act* that stated that no doctor or pharmacist could prescribe, administer, give or sell methadone to any person unless so authorized by the federal government. The regulations had a drastic impact on the methadone programs that existed in Canada. Between 1972 to 1975, methadone prescribers as well as patients involved in methadone programs decreased by one-third.

In the mid-1990s, the federal government transferred licensing and control of methadone programs to the provinces. Some provinces have delegated to the College of Physicians and Surgeons the responsibility of regulating the methadone maintenance programs. It is still necessary for physicians to obtain federal authorization to prescribe and administer methadone to their patients. However, since the mid-1990s, access to MMT has been vastly expanded in Canada, and today MMT is considered as an essential component of Canada's response to HIV/AIDS and IDU.

[72] See, T Kerr, R Jürgens. Methadone maintenance therapy in prisons : reviewing the evidence. Canadian HIV/AIDS Legal Network, 2004 (available via www.aidslaw.ca/Maincontent/issues/prisons.htm) for references.

Safe Injection Facilities

Another partial solution to the crisis of injection drug use, HIV/AIDS, and HCV (as well as overdoses) that has more recently been introduced in Canada by way of a scientific trial is the establishment of safe injection facilities (SIFs – also known as "supervised injection facilities" or "sites").

SIFs are places in which drug users are able to inject using clean equipment under the supervision of medically trained personnel. The drugs are not provided by anyone at the facility, but are brought there by the drug users. The professional staff do not help to administer the drugs, but assist users in avoiding the consequences of overdose, blood borne diseases or other negative health effects (such as abscesses) that may otherwise result from using unclean equipment and participating in unsafe injecting practices.[73]

SIFs also help direct drug users to treatment and rehabilitation programs, and can operate as a primary health care unit. Facilities provide free sterile equipment, including syringes, alcohol, dry swabs, water, spoons/cookers, and tourniquets. The facilities are intended to reduce incidents of unsafe use of injection drugs and to prevent the negative consequences that too often result from unsafe injection. They are not "shooting galleries," which are not legally or officially sanctioned and are often unsafe because they do not offer hygienic conditions, access to sterile injection equipment, supervision and immediate access to health-care personnel, or connections to other health and support services.

There are three main ways in which SIFs can be effective at improving public health: (1) preventing fatal overdoses, (2) preventing the spread of blood borne diseases and other injuries caused by unsafe injecting, and (3) acting as a gateway to education, treatment and rehabilitation.

The debate

Before the first trial was authorized in Canada, some suggested that establishing SIFs would send the wrong message to the community – namely, that injection drug use is acceptable and has official support. It was argued that this would contribute to increased use. In fact, in cities in Europe that have SIFs the total number of drug users has decreased.

Another concern was that the introduction of SIFs would increase the concentration of drug users in the area in which the SIF is located, thereby affecting the quality of life in the neighbourhood. In reality, SIFs are expected to reduce nuisance and visibility problems: crime, violence, loitering, drug dealing and property damage could be diminished, and many needles would be disposed of safely rather than discarded on the streets. European studies support this contention, with police reporting declines in street robbery, car break-ins, and heroin trafficking and related offences after the introduction of injection facilities.

[73] Canadian HIV/AIDS Legal Network. Info sheets on injection drug use and HIV/AIDS. Info sheet 10 on safe injection facilities. Montréal : The Network, 2002 (second, revised edition). Available via www.aidslaw.ca/Maincontent/infosheets.htm#isoidua ; Canadian Centre on Substance Abuse. Supervised injection facilities FAQs (frequently asked questions). Available via www.ccsa.ca.

Other countries' experiences
SIFs *can* be established. This is demonstrated by their successful implementation as pragmatic, practical and effective harm reduction strategies in one Australian and many Swiss, German and Dutch cities. SIFs have been instituted in places where high-level public drug scenes existed with typically associated harmful consequences, such as deteriorating health conditions and increasing public nuisances. SIFs now appear to be accepted in those jurisdictions, despite some initial opposition.

Conclusion
In 2003, Canada recognized that SIFs are an important component of a comprehensive harm reduction strategy. Canada's first government-funded safe injection site opened in Vancouver. The provincial Ministry of Health is supporting the operations costs and the federal Ministry of Health is providing funding to support the scientific evaluation of the three-year pilot research project. After one year of operation, first results are positive. Among other things, a study in the Canadian Medical Association Journal confirms that the Vancouver SIF has resulted in substantial reductions in public disorder related to injection drug use. In this study, the authors compared rates of public drug use, discarded syringes, and drug-related litter before and after the opening of the Vancouver SIF. After considering the influence of police presence and rainfall, the SIF was found to be associated with substantial declines in each of the indicators of public disorder.[74]

Decriminalization of Small Amounts of Marijuana

Making good on a promise made in December 2002, the Canadian federal government tabled a bill that would decriminalize possession of small amounts of marijuana (up to 15 grams) and cannabis resin (hashish, up to one gram) on 27 May 2003 in the House of Commons. Reports from committees of the Senate and the House of Commons had all recommended this, concluding that treating cannabis possession as a criminal offence has expended enormous judicial resources to little effect and that cannabis is not harmful enough to merit serious legal sanction. Because of elections that took place in Canada in June 2004, the Bill did not proceed, but the new government has made it clear that it will re-introduce it.

The Way Forward

Despite the above-mentioned examples of how Canada's drug policy has become more pragmatic, many feel that much remains to be done.

[74] Changes in public order after the opening of a medically supervised safer injecting facility for illicit injection drug users. Evan Wood, Thomas Kerr, Will Small, Kathy Li, David C Marsh, Julio SG Montaner, and Mark W Tyndall. *Canadian Medical Association Journal* 2004;171: 731-734.

In particular, most of the government resources still go towards supply-reduction initiatives that have limited effectiveness, while spending on effective harm reduction measures remains comparatively low. In 2001, a report by Canada's Auditor General stated that 95 percent of the federal government's expenditures related to illicit drugs was used for supply-reduction initiatives.[75] A great part of expenditures by the Royal Canadian Mounted Police (RCMP) on illicit drug issues are related to complex and resource-intensive operations aimed at reducing organized crime and the supply of illicit drugs.[76] The available evidence suggests that supply-reduction activities such as those undertaken by the RCMP have little if any impact on illicit drug supplies and community drug-use patterns. For example, one study from Australia found no evidence that heroin seizures affected the price, purity, or perceived availability of heroin.[77] Similarly, analyses conducted by the United Nations Office for Drug Control and Crime Prevention suggest that a maximum of five percent of the global illegal drug flow is seized by law enforcement.[78] For this reason, heroin purity has increased and prices have decreased since the late 1980s,[79] despite massive expenditures on drug interdiction efforts.[80]

Several experts have presented compelling arguments suggesting that the current emphasis on prohibitionist drug laws, and the related practices of enforcement and incarceration, have made the problem of injection drug use and HIV/AIDS worse.[81] It has been well established that a prohibitionist response produces a black market, which results in increased crime, violence, corruption, and harm to individuals who use drugs and to the greater society. The impact of enforcement approaches and incarceration on HIV/AIDS treatment and prevention has been demonstrated empirically. For example, incarceration has been found to be an independent predictor of HIV infection and interruption of antiretroviral treatment.[82] In terms of prevention, a recent study found police intervention to be a barrier to sterile-needle acquisition – a disturbing finding, given that difficulty accessing needles has been found to be independently associated with syringe sharing.[83]

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[75] Auditor General of Canada. *2001 Report of the Auditor General of Canada*, Chapter 11 – Illicit Drugs: The Federal Government's Role. Ottawa: Office of the Auditor General of Canada, 2001 (available via www.oag-bvg.gc.ca).

[76] Ibid.

[77] D Weatherburn, B Lind. The impact of law enforcement activity on a heroin market. *Addiction* 1997; 92(5): 557-569.

[78] United Nations Office for Drug Control and Crime Prevention. *Global Illicit Drug Trends 2001*. New York: The Office, 2001.

[79] PB Bach, J Lantos. Methadone dosing, heroin affordability, and the severity of addiction. *American Journal of Public Health* 1999; 89(5): 662-665.

[80] US Office of National Drug Control Policy. ONDCP Provides Overview of FY 2002 Drug Control Budget. 2001. Press release, 9 April 2001 (available via www.whitehousedrugpolicy.gov).

[81] S Brochu. Estimating the costs of drug-related crime. Paper prepared for the Second International Symposium on the Social and Economic Costs of Substance Abuse, Montebello, October 2-5, 1995 (available via www.ccsa.ca/brochu.htm). E Oscapella. *How Canadian Laws and Policies on "Illegal" Drugs Contribute to the Spread of HIV Infection and Hepatitis B and C.* Toronto: Canadian Foundation for Drug Policy, 1995.

[82] A Palepu et al. Adherence and sustainability of antiretroviral therapy among injection drug users in Vancouver. *Canadian Journal of Infectious Diseases* 2001; 12(Suppl B): 221B. MW Tyndall et al. Intensive injection cocaine use as a primary risk factor of HIV seroconversion among polydrug users in Vancouver. *Canadian Journal Infectious Diseases* 2001; 12(Suppl B): 70B.

[83] E Wood et al. Unsafe injection practices in a cohort of injection drug users in Vancouver: could safer injecting

A further problem relates to the fact that Canada's drug policy does not adequately address the broad determinants of illicit drug use and the associated harms. It appears there has been little if any coordinated effort to address key determinants of injection drug use such as poverty, homelessness, childhood abuse, and cultural dislocation. Any meaningful change in drug policy will necessarily require simultaneous changes in social policy.[84] Until such action is taken, Canada's approach to illicit drug use will remain a "band-aid" approach.

In conclusion, while Canada's drug policy has been on the right path, further considerable changes in policy and law are needed to reduce the harms associated with injection drug use. The federal government will have to recognize that it is no longer acceptable to invest a majority of its resources in supply-control strategies. Acknowledging the limitations of the current prohibitionist approach, the government must focus on promoting public health approaches to dealing with problems of illicit drug use. Among other things, in addition to methadone maintenance treatment programs, needle exchange programs in the community, the trial safe injection facility in Vancouver, and moves towards the decriminalization of the possession of small amounts of marijuana, there is an urgent need for federally funded pilots of programs such as heroin maintenance and prison-based needle exchanges, and a need for additional safe injection facilities. As a further step in the right direction, the government has provided funding to conduct a multi-city trial of heroin maintenance, expected to begin in Vancouver in January 2005. Beyond this, much investment and coordination are needed to address the complex needs of current injection drug users as well as the factors that lead to injection drug use in the first place.

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rooms help? *Canadian Medical Association Journal* 2001; 165(4): 405-410.

[84] BK Alexander. *The Roots of Addiction in a Free Market Society.* Vancouver: The Canadian Centre for Policy Alternatives, 2001 (available via www.policyalternatives.ca). J Skirrow. A review of *A Framework for Action: A Four Pillar Approach to Drug Problems in Vancouver*. *Canadian HIV/AIDS Policy & Law Review* 2001; 6(1): 89-91.